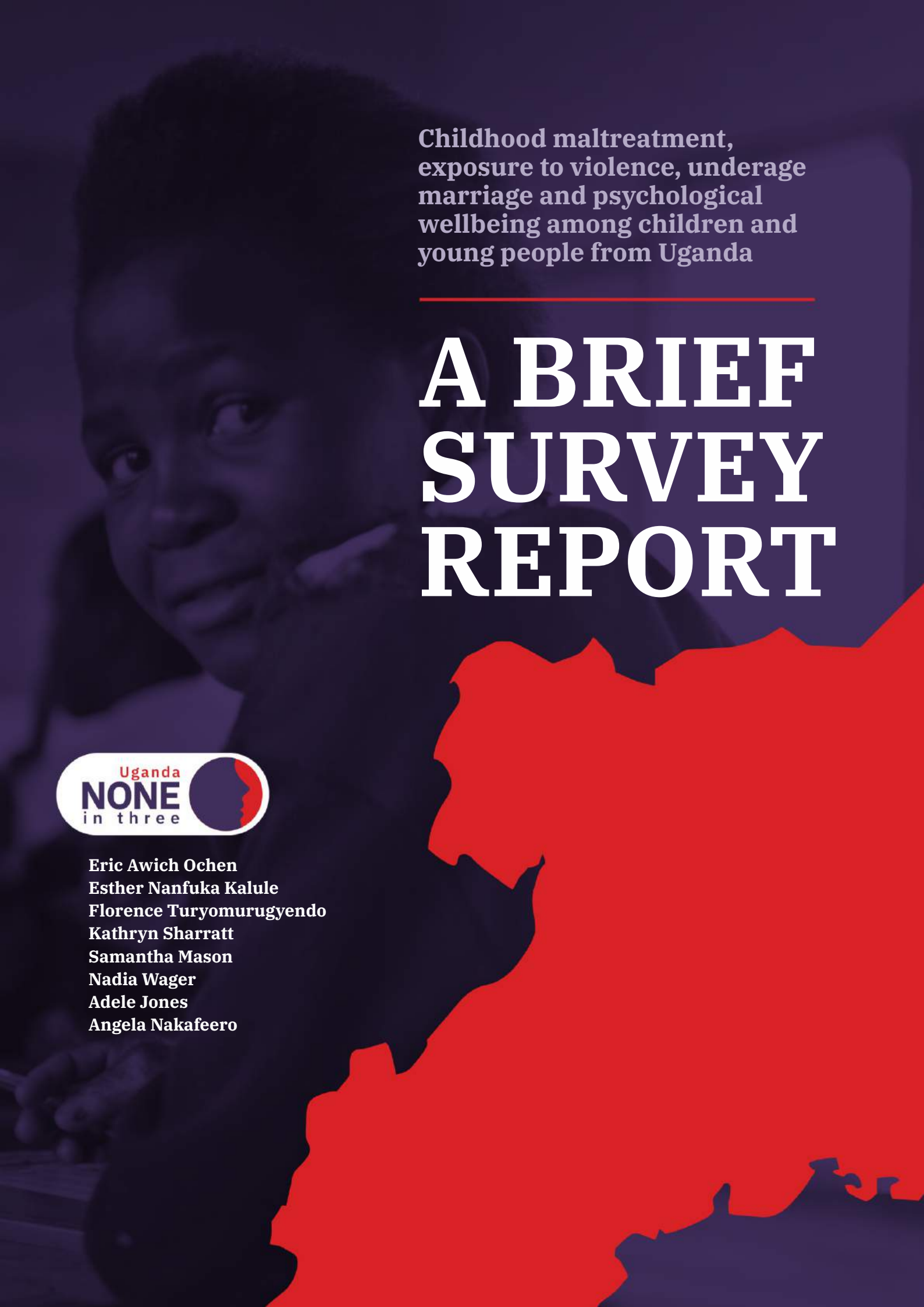

Childhood maltreatment, exposure to violence, underage marriage and psychological wellbeing among children and young people from Uganda

A BRIEF SURVEY REPORT

Uganda NONE in three

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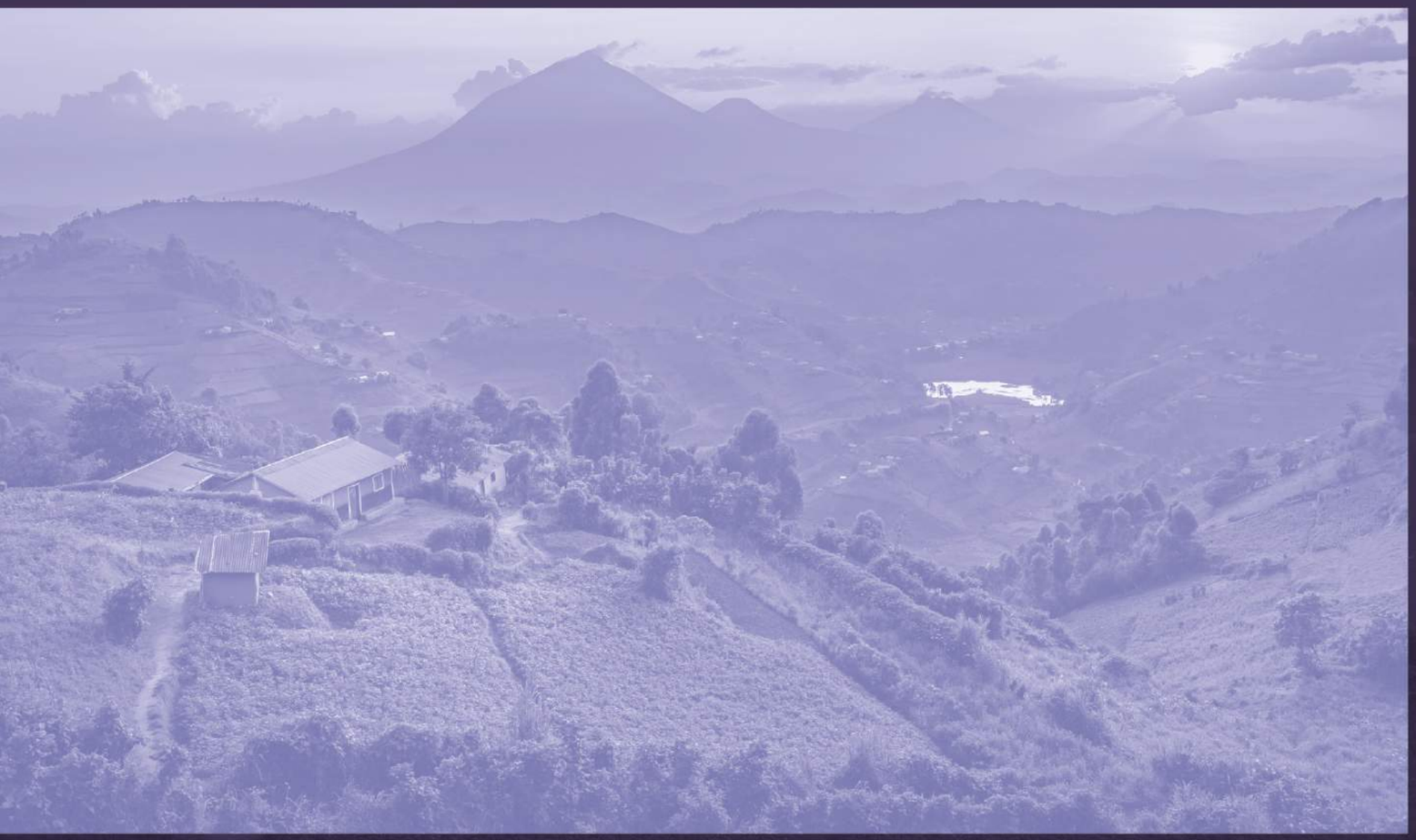

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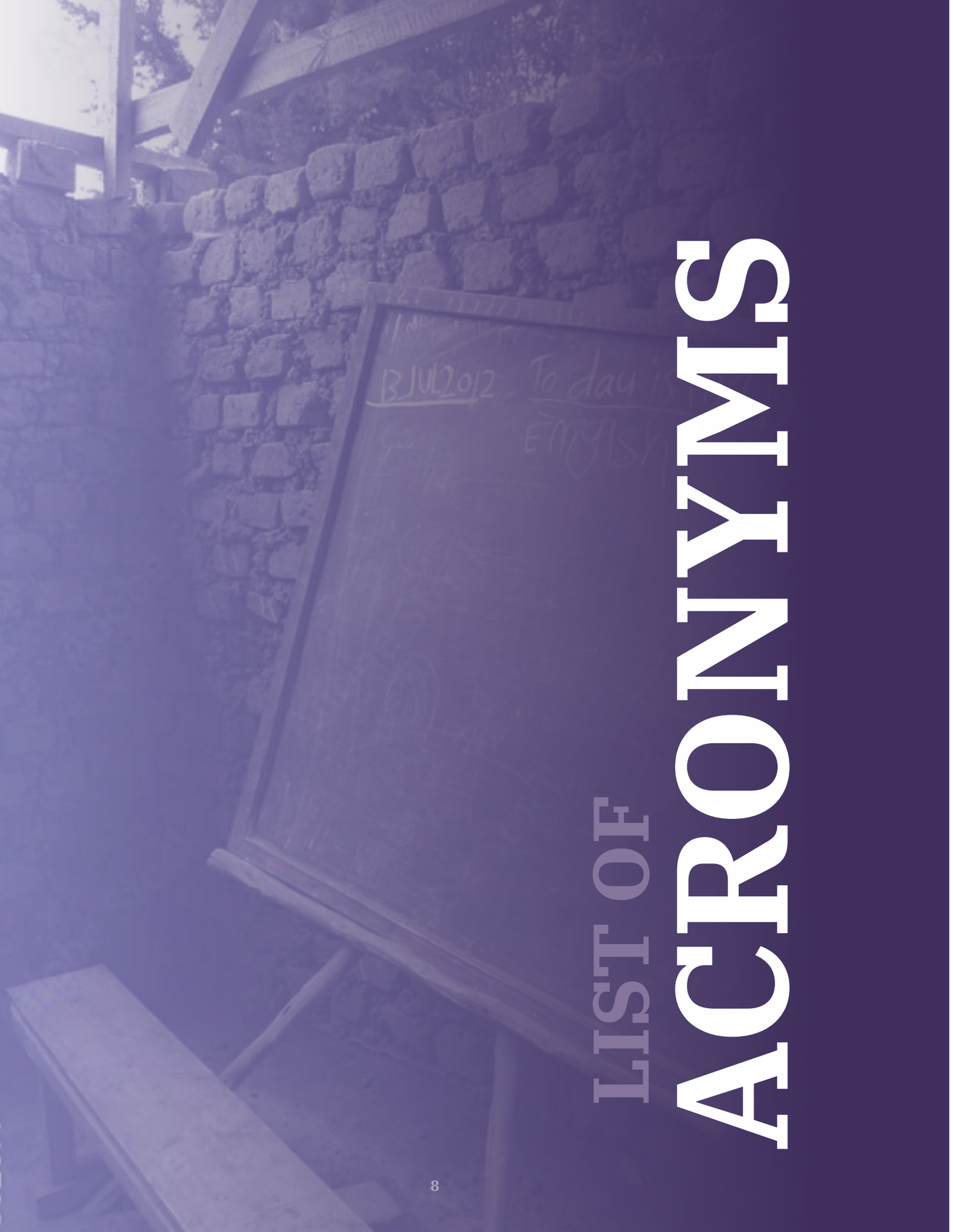
- **The Makerere University Department of Social Work and Social Administration**
- **Kampala Capital City Authority**
- **The District Administrations of Gulu, Kitgum, Lira, Masaka, Nakasongola, Omoro and Wakiso**



LIST OF ACRONYMS

ACPF	African Child Policy Forum
CAO	Chief Administrative Officer
CSOs	Civil Society Organisations
DIS	District Inspector of Schools
GBV	Gender-based Violence
KCCA	Kampala Capital City Authority
M	Mean (average score)
MGLSD	Ministry of Gender, Labour and Social Development
MoES	Ministry of Education and Sports
N	Number of participants
NGOs	Non-Governmental Organisations
p	Probability (statistical significance)
r	Rho (effect size statistic)
SD	Standard deviation
U	Mann Whitney U statistic
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UNHS	Uganda National Household Survey
VAC	Violence Against Children
WHO	World Health Organisation
x2	Chi-Square test statistic
φ	Phi (effect size statistic)

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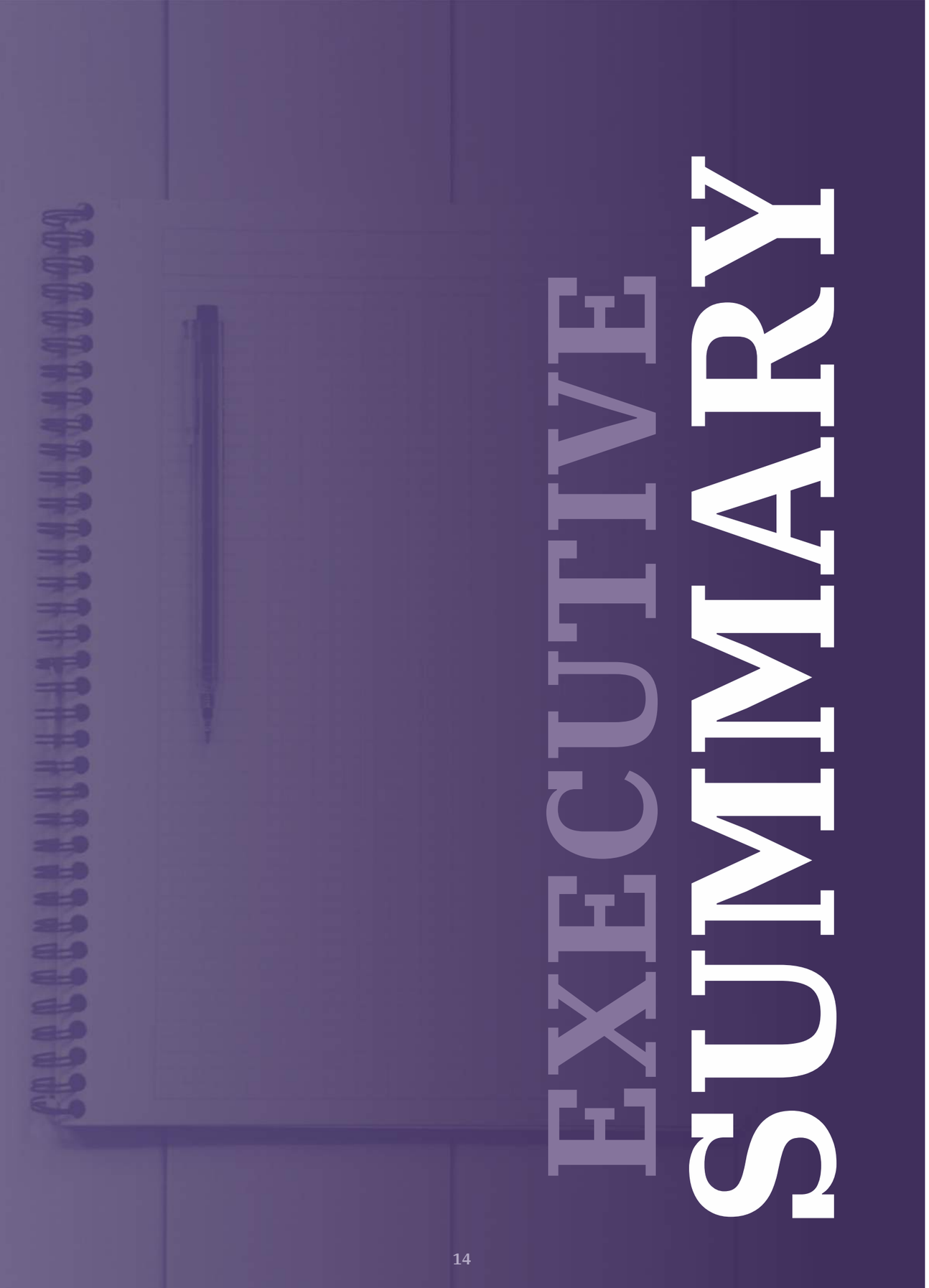


EXECUTIVE SUMMARY

Introduction

This is the report of a study carried out in Uganda during 2018-2019 by the None in Three (Ni3) Centre (www.noneinthree.org/). Ni3 is an international team of transdisciplinary researchers committed to the investigation and prevention of gender-based violence (GBV), including child abuse and neglect (CAN). Based at the University of Huddersfield, UK, the Centre has satellite offices in several other countries, including Uganda (Makerere University, Kampala). The Centre takes its name from the World Health Organisation statistic that one in three women and girls will be subject to sexual or physical violence in their lifetime. Our Centre exists to help make this none in three.

Together with local experts, we undertake the following work:

- Qualitative research with survivors and perpetrators GBV and CAN to better understand their social and cultural drivers in our partner countries. **This research is translated into policy briefs, publications, and educational interventions.**
- Quantitative research in the form of psychosocial surveys with children and young people to learn about their **experiences of violence** and how this has **impacted them** and randomized control trials of the developed games to test their effectiveness in tackling some of the drivers of GBV.
- Educational interventions are developed using our research findings. These include culturally-authentic, prosocial, video games and facilitator guides that include curriculum activities to support the learning from the game. The interventions have been designed for use as educational tools in schools, other youth-serving settings. Some of the games are also suitable for professional training, to prevent GBV by positively influencing the attitudes and behaviours.
- Policy hub, which is an online repository of GBV legislation and policy in each of our partner countries (www.noneinthree.org/global-policy-hub/), regularly updated, this provides a **valuable resource** for practitioners, policy makers and academics.
- **IDEA**, which stands for Impact, Dissemination, and Engagement Activities. turns our research into messages and information that is easily accessed by a variety of audiences, including the general public. Targeted to be particularly culturally and socially relevant in our partner countries, our social media and public engagement events attract attention across the world. The IDEA hub can be found at: www.noneinthree.org/impact/.

Background

Child maltreatment refers to any behaviour that may cause harm to persons under the age of 18 years and includes, but is not limited to, physical, sexual, and emotional abuse and neglect (WHO, 2020). The causes of violence against children are complex and multifaceted, but there is a consensus that this partly reflects an intersection between poverty, a lack of educational and economic opportunities, social and cultural values that condone certain forms of violence against children, patriarchal structures, and gender bias and inequality (Krug et al., 2002). Alarmingly, the Uganda Violence Against Children Survey found that three in four respondents aged 18 to 24 years had experienced some form of maltreatment before the age of 18 (MGLSD, 2018).

"the Uganda Violence Against Children Survey found that three in four respondents aged 18 to 24 years had experienced some form of maltreatment before the age of 18"

In 1990, Uganda ratified the UN Convention on the **Rights of the Child** (UNCRC), signalling a commitment to "ensure that children are protected from all forms of violence, abuse, neglect and bad treatment" (Article 16). Despite the enactment of national laws and policies designed to protect children from maltreatment, the problem remains widespread in Uganda (MGLSD, 2018). The implementation of effective preventative strategies is dependent on accurate information about the extent, nature and location of violence victimisation. Notwithstanding the importance of official statistics, there is agreement that these do not provide the depth of knowledge needed to effectively guide strategies designed to protect children from maltreatment (Bott et al., 2005). In contrast, self-report surveys that enable children to confidentially disclose their experiences without fear of repercussion, can produce more reliable estimates (Rumble et al., 2017). Therefore, through the administration of an anonymous self-report survey, the current study sought to **understand the prevalence of eight maltreatment subtypes both within and outside the home**, including corporal punishment, physical abuse, contact sexual abuse, non-contact sexual abuse, emotional abuse, and physical, medical and emotional neglect.

Domestic abuse and underage marriage are also widespread in Uganda (MGLSD, 2018). Women and girls disproportionately comprise the victims of these phenomena compared to men and boys (UN General Assembly, 2013). Again, national laws and policies have been enacted to protect women and girls from GBV, but despite this, domestic violence and child marriage continues unabated (UBOS, 2018). The World Health Organisation (WHO, 2020) has **recommended the implementation of social and educational strategies** to combat gender-discriminatory practices, especially the social and cultural norms that underpin them. Childhood is recognised as a critical period for the internalisation of attitudes and beliefs that normalise violence against women and children (see Social Learning Theory, Bandura, 1977). Therefore, early intervention through the delivery of school-based programmes designed to sensitise children to the rights of women and children, is a crucial component in producing a lasting change for future generations. Given that the nature of GBV and the concomitant attitudes and beliefs vary across regions (Cicchetti & Lynch, 1993), there is a need for culturally specific programmes and interventions. To facilitate the development of such initiatives, the current survey also inquired into children's and young peoples' experience of GBV, including exposure to domestic abuse and underage marriage.

Although poor mental health represents a significant public health concern for Uganda, country-specific information on the psychological wellbeing of children and young people is generally scarce. By inquiring into experiences of anxiety, depression, suicidal phenomena and self-harm, it is anticipated that the current survey can **illuminate the level of service need among children and young people in the country.**

"Childhood is recognised as a critical period for the internalisation of attitudes and beliefs that normalise violence against women and children"

Participants and Procedure

Survey data was collected from 11,606 children and young people from Uganda. Respondents were aged 9 to 17 years. The sample consisted of 6,202 females (M age = 13.83; SD = 1.90) and 5,314 males (M age = 14.16; SD = 1.98). Participants were recruited from 36 primary schools and 34 secondary schools. Survey items related to: experiences of predominantly adult-perpetrated maltreatment inside and outside the home; exposure to domestic violence; experiences of child marriage; symptoms of anxiety, depression and anger; and self-harm, suicidal thoughts and suicide attempts.

Specific Objectives

1. To examine the prevalence of **childhood maltreatment**, both within and outside the home, drawing comparisons based on gender (boys versus girls), regions (central versus northern) and districts (urban versus rural).
2. To assess the **prevalence of exposure to violence** within the home across genders (boys versus girls), regions (central versus northern) and districts (urban versus rural).
3. To investigate the **prevalence of underage marriage** across genders (boys versus girls), regions (central versus northern) and districts (urban versus rural).
4. To examine the **psychological wellbeing** of Uganda's children, including comparative analysis on gender (boys versus girls), regions (central versus northern) and districts (urban versus rural).
5. To examine the **association between experiences** of child marriage and psychological well-being.

RESULTS

Maltreatment within the home

- Corporal punishment and emotional abuse from a parent, guardian or other adult were the most **common forms of maltreatment** within the home, with 60% of children reporting experiencing each of these forms of abuse.
- 23% of children were **physically abused** by a parent, guardian or other adult living in their home.
- 19% of children experienced **non-contact sexual abuse**, and 6% **contact sexual abuse**, from a parent, guardian or other adult living in their home.
- 46% reported **emotional neglect**, 16% **medical neglect** and 15% **physical neglect**.
- There were some small differences in the prevalence of **maltreatment between boys and girls**, but no differences between the central and northern regions, and rural and urban districts, with the exception of emotional abuse, which was slightly more common in the central than northern region.

Maltreatment outside the home

- 65% of children experienced **emotional abuse** at least once from a non-family member, making this the most frequently experienced type of maltreatment by adults outside the home.
- Almost 56% of children experienced **corporal punishment** outside the home.
- 39% of children experienced **non-contact sexual abuse** and 16% **contact sexual abuse** by an adult outside their home.
- 34% of children were **physically abused** by an adult outside their home.
- There were some small differences in the prevalence of **maltreatment between boys and girls**, but no differences between the central and northern regions, and rural and urban districts, with the exception of emotional abuse, which was slightly more common in the central than northern region.

Exposure to violence within the home

- 28% of children witnessed **verbal violence** between adults in their home, 25% physical violence and 13% a serious violent threat.
- There was little difference in **exposure to violence** between boys and girls, central and northern regions, or rural and urban districts.

Experience of underage marriage

- 14% of children had been **promised in marriage**, **formally engaged**, **had a partner identified for them**, or **had married** or **lived with another person** as though they were married.
- 12% of children reported that they were **worried about being pressured** into marriage.
- There was little difference in the **prevalence of underage marriage**, or perceived **pressure to marry**, between boys and girls, the central and northern regions, and rural and urban districts.

Psychological Wellbeing

- 18% of children and young people reported moderate to severe symptoms of **anxiety**; 17% reported moderate to severe symptoms of **depression**.
- 24% of children reported a lifetime history of **non-suicidal self-injury**, 29% **suicide ideation**, and 14% reported a **suicide attempt**.
- There was little difference in the prevalence of any of these **mental health outcomes between boys and girls**, the central and northern regions, and rural and urban districts.

CONCLUSIONS

While high rates of child maltreatment were reported by the children who completed this survey, in some instances these were higher than previous findings and in others they were lower.

Although girls experienced more of some forms of child maltreatment than boys in the home environment, and boys were more likely to experience some forms of abuse outside of the home than girls, often these gender differences were relatively small.

Overall, there was little evidence of greater maltreatment of girls over boys which is contrary to the findings of previous studies in Uganda. Several potential explanations are offered for this finding.

RECOMMENDATIONS

- Through **age-appropriate education programmes** facilitated by school-based social workers, empower children and young people to recognise and report physical, sexual and emotional abuse and neglect. Since child abuse and neglect (CAN) is most likely to be investigated when a child self-reports abuse, such educational programmes are crucial to child protection efforts.
- **Support and empower young people** to a void child marriage and the associated harms such as exploitation, sexual abuse, and teenage pregnancy. The Ni3 interactive prosocial computer game Peace, designed for 14-17 year-olds in Uganda, could increase understanding about how adult's and older teenagers can misuse their power to groom, coerce and silence victims. Additionally, the game might support young people to make sound decisions that can enable them to realise their dreams and aspirations in life, in spite of adverse life experiences.
- Professionals who have contact with children, including teachers, social workers and school guidance counsellors, **should be trained at entry level to recognise** the signs of child maltreatment, including abuse, neglect and forced marriage. **Early identification and response are crucial** in preventing the occurrence (and re-occurrence) of maltreatment and minimising the traumatic consequences.
- **Support parents** who are at an increased risk of subjecting their children to abuse, neglect or forced marriage through appropriate workshops that concentrate on improving their parenting skills, equipping them with non-violent discipline techniques, and combatting beliefs and attitudes that justify harmful actions towards children. Community engagement strategies based on dialogue can usefully challenge such negative behaviours, norms, customs and values, including those around child marriage. These approaches would require additional resources and appropriate training for staff from community organisations, and so a feasibility study is recommended in this regard.
- **Cultural attitudes that normalise and reinforce the perpetration of child maltreatment need to be challenged**. Media campaigns should seek to raise awareness of what constitutes child maltreatment and identify the frequency of child maltreatment, in addition to highlighting the unacceptability of violence against children. This might be achieved through print and social media campaigns, low-budget television and radio broadcasts, as well as through popular music by leading recording artists.
- **Empower children and young people** to recognise the signs of poor mental health, express how they are feeling, and seek help. Interactive digital technologies such as smartphone applications can assist with the self-monitoring of psychological wellbeing, as well as signposting children and young people to relevant support services.
- **Future research should aim to**: (a) investigate the prevalence of child abuse and neglect to identify the ages at which children and young people are most vulnerable; (b) ascertain the prevalence of peer- and sibling-perpetrated violence; (c) adopt a longitudinal design to identify risk and protective factors for child maltreatment and to directly assess the impact of CAN on children's psychological well-being; (d) explore attitudes towards using violence against children, seeking to identify those at increased risk of using such tactics; and (e) analyse existing legislation and policy to identify gaps in the current mechanisms intended to protect children from maltreatment.

1 BACKGROUND & AIMS

1.1 Country Profile

Uganda is in East Africa and lies across the equator, about 800 kilometres inland from the Indian Ocean. The country is landlocked, bordered by Kenya to the East; South Sudan to the North; The Democratic Republic of Congo to the West; Tanzania to the South; and Rwanda to the South-West. It has a total area of 241,551 square kilometres, of which 18% is water (UBOS, 2014).

The 2014 census (UBOS, 2014) indicated a **total population of 34.9 million people,** an increase of 10.7 million since the 2002 census. With an average annual growth rate of 3.03%, the country's population is projected to increase to 47.4 million by 2025 and 69.7 million by 2040 (UBOS, 2016). Uganda has the second youngest population in the world with 48.5% below 15 years, 21.2% aged between 15-24 years and 28.3% aged 25-64 years (World Population Review, 2021).

Uganda is a low-income country, with **over 70% of the population employed in subsistence agriculture** (UBOS, 2019). Over the past two decades, poverty levels initially reduced from over 50% to 19.7% and then started to rise again. Based on data from the 2016/17 Uganda National Household Survey (UNHS), it is estimated that 21.4% of Ugandans are poor, an equivalent of about 10 million people living below the poverty line. This poverty level constituted an increment from 19.7% in 2012/13. The incidence of poverty is higher in rural areas than in urban areas, with rural areas accounting for about 89% of national poverty. The poor in Uganda consist mainly of women, orphaned children, people with disabilities, the elderly, displaced and refugee populations, out-of-school young people, and urban informal sector workers. Income inequality as measured by the Gini coefficient has also shown an increasing trend over recent years, reported at 0.42 in 2016/17 compared to 0.40 in 2012/13 (UBOS, 2016).

1.2 Child Maltreatment: Nature and Prevalence

With a human development index (HDI) of 0.516, **the country is classified in the low human development category** - ranking it at 162 out of 189 countries. Uganda's human capital index (HCI) of 38% implies that, with the current state of education and health, a child born in Uganda is expected to achieve only 38% of their productive potential at age 18 (World Bank, 2019). The government has formulated the Third National Development Plan covering the period 2020-2025, whose goal is to increase household incomes and improve the quality of life of Ugandans. Human capital development is one of the priority focus areas of the National Development Plan (National Planning Authority, 2020).

Uganda is an ethnically diverse country constituting four main ethnic groups, with the **Bantu** being the majority. Other groups include the **Nilotics, Nilo Hamites** and the **Hamites**. These groups constitute about 56 tribes with distinct languages and culture (Transforming Uganda, 2015). Baganda is the predominant tribe constituting 16.5% of the population, followed by Banyankole (9.8%), Basoga (8.8%), Bakiga (7.1%), Itesot (7%), Langi (6.3%), Bagisu (4.9%) and Acholi (4.4%). Ugandans are highly religious, with Catholics constituting the largest religious denomination (39.3%), followed by Anglicans (32.0%) and Muslims (14.0%) (UBOS, 2014).

Global estimates indicate that, **every seven minutes, at least one child dies as a result of violence** (UNICEF, 2019a). This translates to approximately one billion children annually (Palermo et al., 2019), rendering violence against children a significant public health concern for governments worldwide (Taylor et al., 2016). The World Health Organisation (2020) defines child maltreatment as any behaviour that may cause harm to persons under the age of 18 years, and includes, but is not limited to, physical, sexual and emotional abuse, and neglect. **It is estimated that three in every four children between the ages of 2-4 years (equivalent to 300 million children globally) are victims of physical or psychological violence at the hands of their parents or caregivers** (WHO, 2020). Although childhood maltreatment is more common within the home, children are also vulnerable to victimisation outside the home (WHO, 2020). Notwithstanding the usefulness of worldwide statistics, country-level data is essential given that the prevalence and expression of CAN differs across societies (Cicchetti & Lynch, 1993).

In Uganda, many children are **routinely exposed to maltreatment in various forms**, including physical, sexual and emotional abuse and neglect (Walakira & Nyanzi, 2012). A national survey conducted by the Ministry of Gender, Labour and Social Development (MGLSD, 2018) found that three quarters of respondents aged 18 to 24 (females - 75%; males - 76%) had experienced some form of violence before the age of 18. **Gender differences were found in relation to sexual violence** with 35.3% of female and 16.5% of males reporting a history of child sexual abuse, and 59% of females reporting a history of childhood physical violence in comparison to 68% of the male respondents. Just over one third of the respondents reported experiencing emotional abuse as children (females – 33.8%; males – 36.0%).

Children's exposure to domestic abuse is increasingly considered to be a form of CAN. Such domestic abuse is a highly gendered phenomenon, where the majority of perpetrators are men and the majority of victims are women or girls (UN General Assembly, 2013). The 2016 Uganda Demographic and Health Survey (UDHS) showed that 56% of women aged 15-49 years had experienced physical violence since age 15, whilst 22% had suffered sexual violence. In contrast, only 8% of men in the same age group reported experiencing sexual violence (UBOS & ICF International, 2018). Women in urban areas (9%), the Acholi sub-region (5%), and never married women (1%) were less likely than other women to report recent experiences of sexual violence (UNFPA, 2017). With regards to **children's exposure to domestic violence,** findings from a national survey in Uganda indicated that two thirds of girls (66.7%) and boys (65.3%) report witnessing physical violence by a parent against another parent or by a parent against a sibling in the home (MGLSD, 2018).

Women are also subjected to harmful cultural practices such as female genital mutilation (FGM). While the national prevalence of FGM is low (1%), the rates surge to as high as 95% in some of the practising communities such as among the Pokot and Kadama in the north-eastern sub-region of Uganda (UNFPA, 2017). FGM and forced early marriage are embedded in both cultural beliefs and tradition. Other risk factors for these behaviours include poverty, large family size, unemployment and low educational attainment (Walakira & Nyanzi, 2012).

Further, in 2013, Uganda was identified as one of the countries with the **highest prevalence of child and forced marriage** – ranked 16th among 25 countries with the highest rates of child marriage. Child or forced marriage is another phenomenon that disproportionately affects girls. The 2015 Violence Against Children (VAC) study reports that, at least 8.2% of girls aged 13-17 years had ever been married or lived as if they were married, compared to only 1.4% of boys in the same age group (MGLSD, 2018). Moreover, retrospective research with 500 Ugandan girls carried out by the African Child Policy Forum revealed that almost half said they had been pressured to marry (ACPF, 2006). The 2016 UDHS shows that the **percentage of underage girls that enter marriage has only declined marginally over the years**. Those that marry or enter a union before the age of 15 decreased slightly from 9.9% in 2011/12 to 7% in 2016, whilst those who married before the age of 18 declined from 39.7% to 34% in the same period. The prevalence of child marriage is highest in the northern region (59%), followed by the eastern region (52%), east central (52%), West Nile (50%), Central (41%), South West (37%), and is lowest in Kampala (21%) (UNICEF, 2015).

Child marriage is not only a form of CAN, but it also **potentiates risk for other forms of GBV in early adulthood.** Finding from a 34 country national household survey, including Uganda, identified child marriage to be a significant risk factor for sexual and physical violence within intimate relationships in young women in their early 20's. (Kidman, 2017). Kidman's (2017) study indicates that women in Uganda who were married under the age of 18 were more than twice as likely to experience sexual and or physical domestic violence in their early 20s.

1.3 Causes of Child Maltreatment

The causes of violence against children and complex and multifaceted, but this is believed to partly reflect an intersection between poverty, a lack of educational and economic opportunities, social and cultural values that condone certain forms of violence against children, patriarchal structures, and gender bias and inequality (Krug et al., 2002). In relation to this, certain forms of child maltreatment are considered socially acceptable in Uganda. **Corporal punishment, for instance, is regarded as a justifiable approach to "disciplining" children as opposed to a form of "violence"** (Naker, 2005).

1.4 Prevention of Child Maltreatment

Notably, Uganda ratified the UN Convention on the Rights of the Child (UNCRC) in 1990, signalling a commitment to **"ensure that children are protected from all forms of violence, abuse, neglect and bad treatment"** (Article 16). The complex phenomenon of child maltreatment necessitates a multi-level approach to protection, and several strategies have been implemented by government, non-governmental organisations (NGOs), and civil society organisations (CSOs), as well as community-based groups. Key among them is the formulation of legislation, policy and strategic frameworks, such as the recently launched Child Policy (2020), the Children Act (as amended) 2016, the Prohibition of Female Genital Mutilation Act (2010), the National Action Plan on the Elimination of the Worst Forms of Child Labour (2012-2017) and the National Strategy to End Child Marriage and Teenage Pregnancy (2015-2020).

In addition, large-scale campaigns to promote awareness about children's rights and the obligations of duty bearers have been implemented throughout the country. Behaviour-change communication initiatives have also been adopted by various organisations and child protection systems to promote a shift in attitudes in a wider society. Public events and ceremonies in the form of national events organised around children's rights, are recognised as offering an opportunity for enhancing social mobilisation and awareness raising at district and community levels. CSOs have been instrumental in skills building and training which involves providing adolescents with skills, knowledge, and confidence to challenge discriminatory social norms to create change in their schools and communities (Joy for Children Uganda, 2013).

Uganda's **commitment to end violence** against women and girls, including but not limited to domestic abuse, FGM, and child marriage, is reflected in recent policy enactments. These include the National Strategy to End Child Marriage and Teenage Pregnancy (2015-2020), the National Policy on the Elimination of GBV in Uganda (2016) and the framework for its implementation - the National Action Plan on the Elimination of GBV in Uganda (2015-2020). These policies seek to reduce the prevalence of child marriage and other forms of GBV by enacting and reforming laws to address gender-discriminatory practices, as well as fostering a zero-tolerance environment, and promoting comprehensive care and support services for survivors/victims.

These policies also **provide for the education of girls as one of the strategies** for empowerment and reducing vulnerability to GBV and child marriage. Following the adoption of Universal Primary Education (UPE) in 1997, national total enrolment steadily increased from 3,068,625 to 8,264,317 in the financial year 2015/16 (MOES, 2017). The **impact of this increment has been particularly beneficial for girls whose enrolment increased relative to that of boys**. Enrolment rates currently stand at 4,141,654 girls and 4,122,663 boys, signalling a ratio of 1:1 (MOES, 2017).

Moreover, the government **pledged to develop interventions** to sensitise communities to the rights of women and girls, alongside combatting the social and cultural norms and values that serve to perpetuate inequality and bias. The "start awareness support action" (SASA) methodology has been popularly adopted for disseminating messages against GBV in Uganda (Kyegombe et al., 2014). However, its success has been constrained by non-prioritisation of GBV in the district budgets and socio-cultural challenges in form of beliefs and "closed" attitudes that still promote GBV.

Further to this, the World Health Organisation (2012) has r**ecommended that children should be included** in social and education strategies designed to challenge the social and cultural values that reinforce violence against women and girls. The social environment in which children grow up is a key source of information about attitudes, beliefs and socially accepted behavioural norms for males and females. According to Social Learning Theory (SLT; Bandura, 1977), children learn through observation and vicarious reinforcement. This means that behaviours and attitudes modelled by significant others (e.g. parents, peers and other role models) are more likely to be internalised and imitated when they are accompanied by rewards for the actor (or at least the absence of negative consequences). Thus, childhood is a critical period for the internalisation of attitudes that place women and girls at a relative disadvantage to men and boys (UN General Assembly, 2013). Disrupting this cycle of intergenerational transmission is crucial to producing a lasting change for future generations (WHO, 2016).

Prosocial video games have been identified as an **innovative, engaging and child-friendly approach** to tackling attitudes that underpin violence or bias against women and girls (see Boduszek et al., 2019 for a discussion). One such example is Jesse, a bespoke video game developed by the None in Three Centre to tackle attitudes that underpin domestic abuse in the Caribbean (see Smith, Ma, Jones, & Unver, 2017 for a description of the game). The game is also designed to raise awareness of the impact of intimate partner violence, and has been shown to be effective in increasing empathic concern for victims among 9-17 year-olds in Barbados (Boduszek et al.,2019).

1.5 Psychological Wellbeing: Prevalence and prevention of psychological illness and distress

Globally, it is estimated that **10-20% of children and young people suffer from mental health conditions** (WHO, 2021). Among 5 to 17 year-olds, anxiety and depression are the most commonly cited mental health problems (experienced by 6.2% and 3.2% respectively) (Erskine et al., 2017). However, adolescence is a time of increased vulnerability, with 20% of those aged 10 to 19 experiencing a mental health problem each year (UNICEF, 2019b).

Mood disorders, including depression, are reliably associated with an increased risk for suicidal behaviour among children and adolescents (e.g. Hawton et al. 2013; Ordaz et al., 2018). It is estimated that 67,000 adolescents die from self-harm each year, whilst approximately 10% have intentionally harmed themselves (Kapungu et al., 2018). Indeed, suicide and self-harm are cited as the third leading causes of death among older adolescents aged 15-19 (WHO, 2020). In 2015, just over 9% of deaths (girls - 9.6%; boys – 9.1%) among 15-19 year olds were due to suicide (WHO, 2016). Although evidence pertaining to the mental health status of children and young people in Uganda is generally scarce, one survey revealed that more than half (53.6%) of the children aged 13-17 had experienced mental distress in the past 30 days (MGLSD, 2018). Moreover, 22.3% had ever thought of suicide, 11.4% had ever intentionally hurt themselves, and 34.8% had ever attempted suicide.

In Uganda, numerous factors have been found to demonstrate an association with poorer mental health outcomes for children and adolescents. This includes being affected by armed conflict and associated harms such as displacement, murder, poverty, high incidence of orphanhood, and forceful conscription to the armed forces (Derluyn, Broekaert, Schuyten & Temmerman, 2004; MacMullin & Loughry, 2004; Betancourt, Onyango & Bolton, 2009).

The association between childhood maltreatment and adverse mental health outcomes is also well documented in the literature (WHO, 2013). For instance, the Uganda VAC survey showed that females aged 18-24 who suffered sexual abuse during their childhood were more likely to report serious mental distress than those who did not (19.5% compared to 7.0%) (MGLSD, 2018). Mental distress was also reported by almost 50% of males aged 18-24 who experienced physical violence during their childhood.

The consequences of **child maltreatment are wide-ranging** but can include major depressive disorder (Brown, Cohen, Johnson, & Smailes, 1999), anxiety disorders (Cohen, Brown, & Smailes, 2001), post-traumatic stress disorder (Ghazali et al., 2018), non-suicidal self-injury (Baiden et al., 2017), and suicide ideation and attempts (Miller et al., 2013). The effects of childhood maltreatment can also be **long-lasting**, with longitudinal studies demonstrating that experiences of abuse before the age of 18 can have a profound impact on psychological wellbeing in adulthood, including reduced self-esteem, happiness, and life satisfaction (Herrenkohl et al., 2012), increased symptoms of depression and post-traumatic stress, and an increased number of medical contacts for physical health complaints (Fergussen et al., 2013; Trickett et al., 2011).

Strategies designed to **promote positive mental health outcomes** among children and young people aim to strengthen individual capacities and facilitate supportive environments (WHO, 2020). This includes legislation to redress stigma, discrimination and other human rights violations, the provision of healthy living conditions, programmes that impart life skills and promote nurturing and positive relationships between children and care givers during their formative years. For children showing signs of poor mental health, early identification and access to support services and treatment is critical, and this might also necessitate restricting access to means of self-harm such as reducing access to sharp objects (WHO, 2013). However, in Uganda, mental health services, particularly those for children and adolescents, **have not yet received the prioritisation they deserve in health**. Official reports show that mental health receives 0.7% of the national health budget, which is way below the minimum required to provide basic services (MoH, 2017).

1.6 Concluding Remarks & Study Aims

Despite the enactment of national laws and policies designed to protect children from abuse, neglect, exposure to domestic violence, and forced marriage, t**hese phenomena remain widespread in Ugandan society**. Notwithstanding the importance of official statistics, these do not provide the depth of knowledge needed to effectively guide strategies designed to protect children from maltreatment (Bott et al., 2005). Mental health problems among children and young people are a significant public health concern for governments worldwide, though the status of the psychological wellbeing of Ugandan youth is largely unknown due to the scarcity of population-specific data. Therefore, the objective of this project was to build a better understanding of the current situation in relation to child abuse and neglect, exposure to domestic violence, child marriage and to provide an overview of children and young people's psychological well-being. Since research evidence in child victimisation indicates that self-report surveys elicit more honest responses than face-to-face interviews (Rumble, Ramly, Nuryana, & Dunne, 2017), self-report, anonymous survey methodology was utilised in the current investigation.

Impact Aim

The findings provide **crucial information regarding the prevalence** of abuse and neglect, exposure to domestic violence, underage marriage and mental health issues among children and young people in Uganda. The results can inform policy and practice and provide the evidence base for refining prevention and intervention strategies, subsequently reducing the risk of violence victimisation and enhancing positive mental health outcomes for children and young people.

Specific Objectives

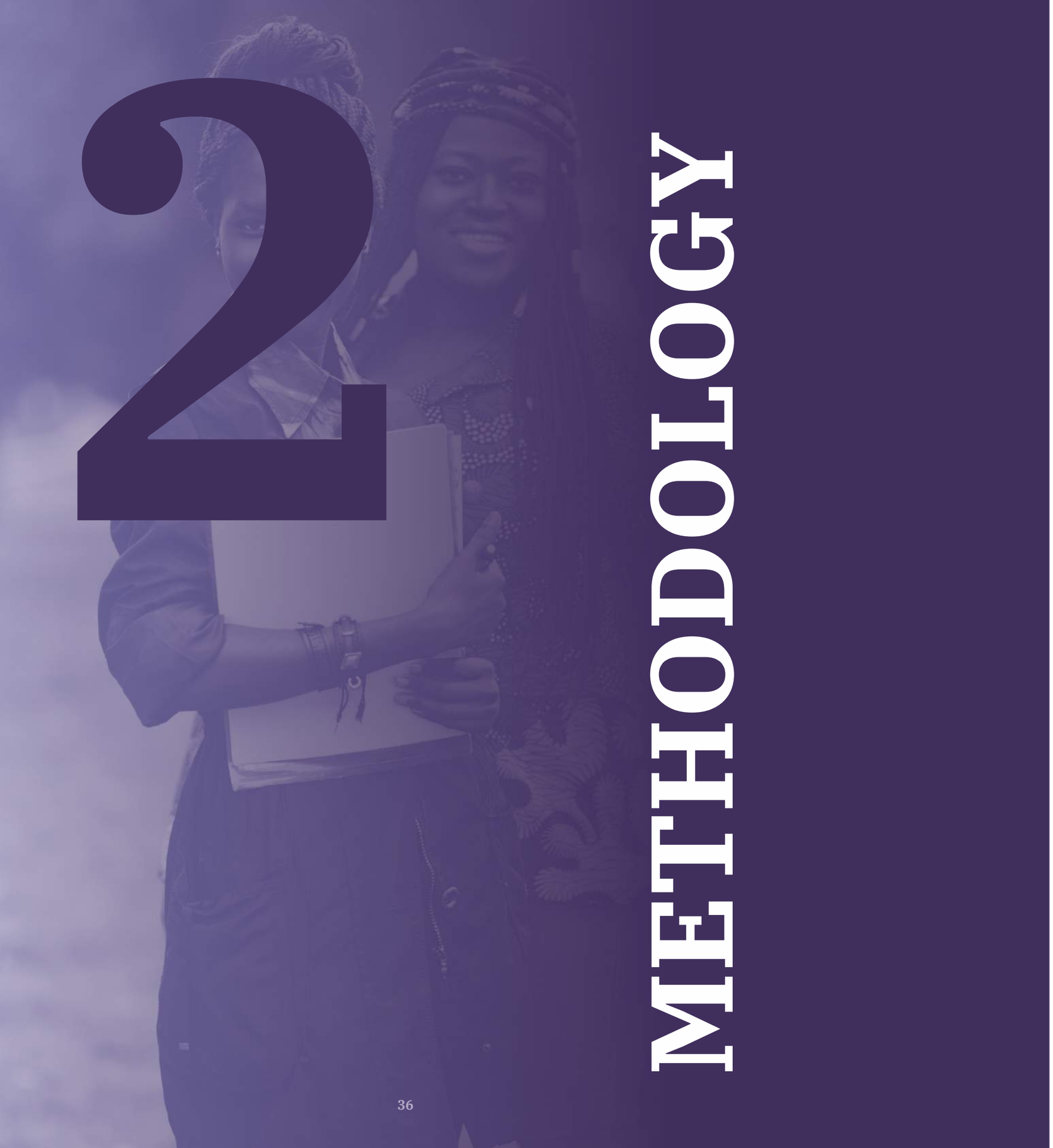
1. To **examine the prevalence of childhood maltreatment**, both within and outside the home, drawing comparisons based on gender (boys versus girls), regions (central versus northern) and districts (urban versus rural).

2. To **assess the prevalence of exposure to violence** within the home across genders (boys versus girls), regions (central versus northern) and districts (urban versus rural).

3. To **investigate the prevalence of underage marriage** across genders (boys versus girls), regions (central versus northern) and districts (urban versus rural).

4. To **examine the psychological wellbeing** of Uganda's children, including comparative analysis on gender (boys versus girls), regions (central versus northern) and districts (urban versus rural).

"...the objective of this project was to build a better understanding of the current situation in relation to child abuse and neglect, exposure to domestic violence, child marriage and to provide an overview of children and young people's psychological well-being."



2 METHODOLOGY

2.1 Participants

Analysis is based on **self-reported survey data** collected from 11,606 children and young people from Uganda. Participants were recruited from 36 primary schools and 34 secondary schools. Respondents were aged between 9 and 17. The sample consisted of 6,202 females (M age = 13.83; SD = 1.90) and 5,314 males (M age = 14.16; SD = 1.98). Additional sample information is presented in **Table 1**.

		Girls	Boys
Region	Northern	2772(24.6%)	2717(24.1%)
	Central	3285(29.1%)	2502(22.2%)
District	Urban	3941(35.7%)	3298(16.3%)
	Rural	1999(18.1%)	1805(16.3%)

Table 1: Frequency (%) of boys and girls from the northern/central region and urban/rural districts

2.2 Survey Design

Based on a review of the literature, and conversations with both researchers and stakeholders, the following scales were selected for inclusion in the survey:

Child maltreatment was measured using the Child Victimisation Experiences Questionnaire (Choo, Dunne, Marret, Fleming & Wong, 2011). 29 items measured lifetime experiences of maltreatment by parents, guardians, or other adults in the household. This included two items on corporal punishment (e.g. “did a parent, guardian or other adult in the home slap your face, head, or ears?”), five items on physical abuse (e.g. “…burn your skin with something hot?”), six items on non-contact sexual abuse (e.g. “…make you see sexual scenes in real life?”), two items on contact sexual abuse (e.g. “…make you have sex with them or anybody else?”), six items on emotional abuse (e.g. “…embarrass you or shame you in front of other people?”), two items on physical neglect (e.g. “…make you wear dirty clothes?”), one item on medical neglect (“…not take you to a doctor when you were sick?”) and five items on emotional neglect (e.g. “…make you feel that they did not care about you?”). A further 19 items measured lifetime experiences of maltreatment by adults who are not part of the family. Items were as described above, with the exception that one item pertaining to emotional abuse was removed from the scale (i.e. “…threaten to abandon you or throw you out of the house?”), as were all items regarding physical, medical and emotional neglect. Response options were “never”, “once or twice” and “many times”. Participants were regarded as having experienced a specific form of maltreatment if they endorsed at least one of the associated items.

Exposure to violence refers to witnessing violence within the family without being a direct victim. One item measured verbal violence (“Have you seen adults in your home shouting and screaming in a way that frightened you?”), one item measured physical violence (“Have you seen adults in your home physically hurt each other, e.g. hitting, slapping, kicking?”) and one item measured serious violent threat (“Have you seen adults in your home use knives, guns, sticks, or other objects to hurt or scare someone else inside your home?”). These questions required a “yes” or “no” response.

Experience of underage marriage was measured using the items “Have you ever heard that you were promised in marriage?”, “Have you ever been formally engaged or had a partner identified by your family for marriage?”, and “Have you ever been married or lived together with someone as if you were married?”. Questions were answered “yes” or “no” and participants were regarded as having experienced underage marriage if they endorsed at least one of the items. Moreover, perceived pressure to marry was measured by the item “In the past three months, have you worried about being pressured into getting married?”. This question was also answered “yes” or “no”.

Anxiety was measured using the Patient-Reported Outcomes Measurement Information System (PROMIS) Anxiety Short Form measure (PROMIS Health Organization and PROMIS Cooperative Group, 2012a). The questionnaire consists of 13 items and asks respondents to indicate how often they had experienced certain thoughts and feelings in past seven days (e.g. “I worried about what could happen to me” and “I woke up scared at night”). Items are answered on a scale from 1 (never) to 5 (almost always). Total scores range from 13 to 65, with scores of 27 and below indicating no or slight symptoms of anxiety, 28-33 indicating mild symptoms of anxiety, 34–47 indicating moderate symptoms of anxiety, and 48 or more indicating severe symptoms of anxiety. Cronbach's alpha was 0.89 for both girls and boys.

Depression was measured using the Patient-Reported Outcomes Measurement Information System (PROMIS) Depression Short Form measure (PROMIS Health Organization and PROMIS Cooperative Group, 2012b). The questionnaire consists of 14 items and asks respondents to indicate how often they had experienced certain thoughts and feelings in past seven days (e.g. “I thought that my life was bad” and “I felt too sad to eat”). Items are answered on a scale from 1 (never) to 5 (almost always). Total scores range from 14 to 70, with scores of 31 and below indicating no or slight symptoms of depression, 32-38 indicating mild symptoms of depression, 39-53 indicating moderate symptoms of depression, and 54 or more indicating severe symptoms of depression. Cronbach's alpha was 0.93 for girls and 0.92 for boys.

The PROMIS scales have previously been used in studies on children aged 9 -17 years (e.g., Arvanitis et al., 2016; Brandon et al., 2017), although their cross-cultural validity to the Ugandan context have yet to be established (Kulhawy-Wibe et al., 2020).

Suicide and self-harm behaviours were measured using three items. Non-suicidal self-injury was measured by asking “Have you ever harmed yourself on purpose in a way that was not to take your life?”. Suicide ideation was measured by asking “Have you ever felt so unhappy that you have thought about killing yourself?” and suicide attempt was measured by asking “Have you ever tried to commit suicide or tried to do something that meant you could die?”. These questions required a “yes” or “no” response.

2.3 Ethics

None in Three (Ni3) research is based on ethical standards which assure confidentiality, privacy, anonymity, informed consent, duty of care and the proper safeguarding of participants and safe and confidential storage of data. These standards are reflected in the Centre's Ethics Protocol which details procedures, principles and practices which must be applied to all research and in all contexts. The Ni3 Centre aligns its philosophy with the UNICEF International Charter for Ethical Research Involving Children. As a research community working with children, we are committed to undertaking and supporting high quality ethical research that is respectful of children's human dignity, rights and well-being. Owing to the sensitive nature of our research and the potential for cases of abuse to be disclosed, commitment to confidentiality is always balanced by the primary need to safeguard the welfare of children (and vulnerable adults), first and foremost. Ethical adequacy of the research is also assured through ensuring that the research outcomes are geared towards policy reform and that the participants are not exposed to detriment or harm.

Our research is also carried out in accordance with the University of Huddersfield's Research Ethics Guidance (https://research.hud.ac.uk/strategy/concordat-research-integrity/). Researchers for this study were trained in research methods, ethics and duty of care to children. The study received approval from the Ethics Committees of the University of Huddersfield, UK and Makerere School of Social Sciences Research Ethics Committee, Uganda, as well as the Uganda National Council for Science and Technology. Further approvals were provided by the Ministry of Education and Sports, and Head Teachers of participating schools. Parental/guardian consent was obtained, and young people also gave their assent. Recognising that the survey would potentially provide children with an opportunity to talk about experiences of violence, specific measures were put in place to ensure children had access to counselling and support and that effective de-briefing was undertaken.

2.4 Study Procedure

All data collection procedures, including recruitment and training of the researchers and data collection and quality control were guided by the **best practice guidelines** for the conduct of survey research across cultures and countries outlined by the World Mental Health (WMH) Data Collection Coordination Centre (www.ccsg.isr.umich.edu).

1. The team obtained **lists of primary and secondary schools** from the Uganda Ministry of Education and Sport (MOES).
2. The team clustered schools into region, district (urban and rural), and institution status (private and public). Participating schools were **systematically selected** to represent one private primary school, one public primary school, one private secondary school and one public secondary school from both rural and urban clusters, making a total of 8 schools per region.
3. All **researchers were trained for two days prior to data collection** to orient them on methodological issues of the study and acquaint them with the study objectives. The training covered the methodology of the study including study participants, sampling procedure, child protection approaches and referral services available to the participants.
4. At the district level, the Chief Administrative Officers (CAOs - the head of the technical wing at the district) was **approached for approval**. The CAOs endorsed the formal letter addressed to them and referred the team to the District Education Office. Here the District Education Officers normally referred projects to the District Inspector of Schools (DIS) (since they were more conversant with the schools and their locations) to advise teams on how to access the selected schools.
5. For schools in the **Municipal Councils**, additional authorisation was also obtained from both the Town Clerks and Principal Education Officers at this level before accessing them.
6. For the schools in **Kampala,** authorisation was obtained from the Kampala Capital City Authority (KCCA) Education and Social Services Directorate.
7. Printed self-reported **anonymous survey questionnaires** were delivered by local researchers to all participating institutions and distributed among those taking part.
8. In addition to the parental consent obtained prior to young people's participation, participating children were **verbally informed** that they were not compelled to participate in the study.
9. Data collection in schools took place in classroom settings and was **monitored/facilitated** by research assistants.
10. Upon completion, **surveys were collected by research assistants**. The participants were debriefed and given a leaflet with information on where to report abuse.

2.5 Data Entry and Analysis

Data was entered and analysed in SPSS Version 26. Inferential tests were performed to examine whether experiences of childhood maltreatment, exposure to violence, underage marriage and psychological well-being differed across genders (boys versus girls), regions (central versus northern) and districts (urban versus rural).

Caution should be exercised when interpreting p values based on large samples (as in the current study) because this can lead to an over-estimation of the meaningfulness of results (see Sullivan & Feinn, 2012). Instead, it is recommended that readers interpret effect sizes since these are computed independently of sample size, providing a reliable estimation of the actual magnitude of the difference in children's experiences (i.e. between boys and girls; central and northern regions; and urban and rural districts).

To examine the association between gender, region and district and experiences of maltreatment, exposure to violence, suicide and self-harm related behaviours, and experiences of child marriage, the **Chi-Square test** was used. The Chi-Square test is suitable for examining associations between categorical variables (i.e. male/female and yes/no responses). Phi (φ) was used to indicate the strength of the association between variables, where 0.1 = a small effect, 0.3 = a medium effect, and 0.5 = a large effect (Cohen, 1988).

The Mann-Whitney U test was used to examine whether symptoms of anxiety and depression differed across genders, regions and districts. The Mann-Whitney U test is used when data is ordinal or non-normally distributed. The size of the difference between groups is denoted by r, where 0.1 = a small effect, 0.3 = a medium effect, and 0.5 = a large effect (Cohen, 1988).

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3

RESULTS

3.1 Maltreatment within the Home

In this survey, children and young people were asked to **report on their experiences of maltreatment** by parents, guardians or other adults living within the household. Questions related to eight types of maltreatment including corporal punishment, physical abuse, non-contact sexual abuse, contact sexual abuse, emotional abuse, physical neglect, medical neglect and emotional neglect. As can be seen in **Table 2**, the proportion of children who had experienced maltreatment within the home ranged from 5.9% for contact sexual abuse to 60.7% and 61.4% for corporal punishment and emotional abuse, respectively.

	Frequency (%)
Corporal punishment	6975 (60.7%)
Physical abuse	2590 (22.7%)
Non-contact sexual abuse	2172 (18.7%)
Contact sexual abuse	678 (5.9%)
Emotional abuse	7045 (61.4%)
Physical neglect	1744 (15.2%)
Medical neglect	1855 (16.1%)
Emotional neglect	5337 (46.5%)

Table 2: Experiences of maltreatment within the home

Next, using Chi-square tests, we examined whether the prevalence of maltreatment within the home differed between genders, regions and districts.

Gender: The percentage of boys and girls who indicated experiencing abuse or neglect within the home is presented in **Figure 1**. Compared to boys, girls were statistically significantly more likely to experience corporal punishment (x2 (1, N = 11410) = 10.12, p < .001, φ = .03), emotional abuse (x2 (1, N = 11379) = 48.40, p < .001, φ = .07), medical neglect (x2 (1, N = 11412) = 26.06, p < .001, φ = .05), and emotional neglect (x2 (1, N = 11391) = 2383, p < .001, φ = .05). In all instances, effect sizes were close to zero, indicating that the magnitude of the difference between boys and girls was small. **There were no statistically significant gender differences in other forms of maltreatment (p > 0.05).**

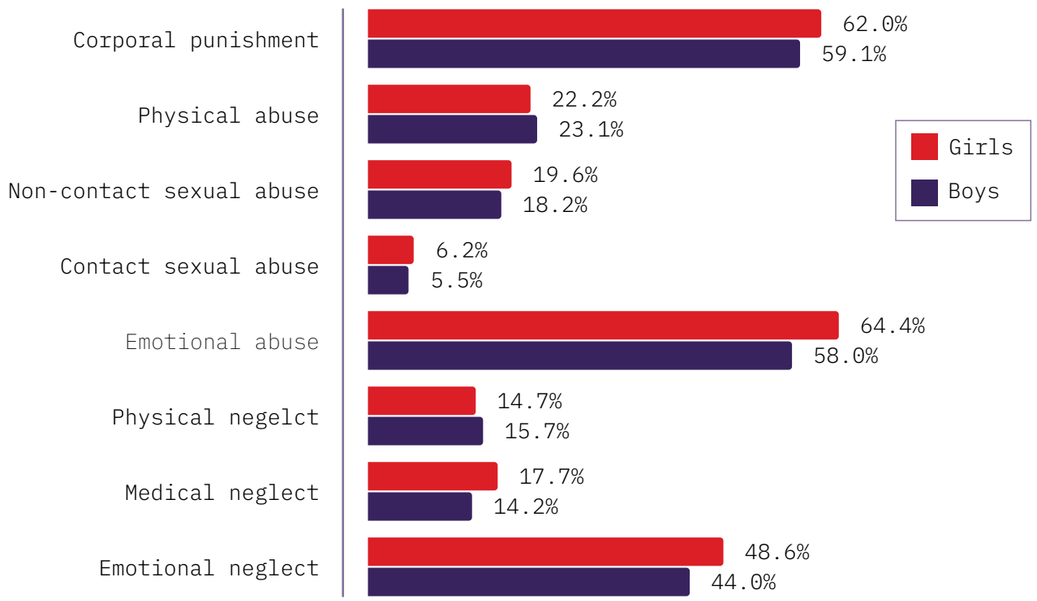

Figure 1: Gender differences in maltreatment within the home

Region: The percentage of children from central and northern regions who indicated experiences of abuse or neglect within the home is presented in **Figure 2**. Children from the central region were statistically significantly more likely to experience corporal punishment (x2 (1, N = 11257) = 25.94, p < .001, φ = .05), emotional abuse (x2 (1, N = 11228) = 236.87, p < .001, φ = .15) and emotional neglect (x2 (1, N = 11242) = 51.47, p < .001, φ = .07) than children from the northern region. In contrast, children from the northern region were statistically significantly more likely to experience physical abuse (x2 (1, N = 11164) = 9.38, p = .002, φ = .03) and physical neglect (x2 (1, N = 11231) = 26.83, p < .001, φ = .05) than children from the central region. With the exception of emotional abuse, which demonstrated a small effect size, all other effect sizes were close to zero, indicating that the magnitude of the difference between regions was small. **There were no statistically significant differences in other forms of maltreatment between regions (p > 0.05).**

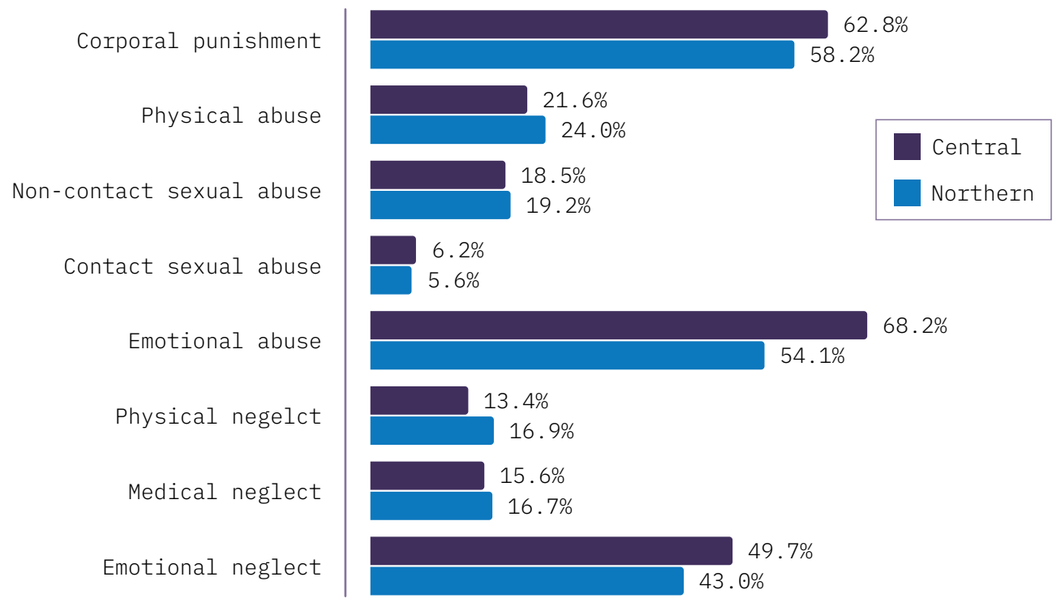

Figure 2: Regional differences in maltreatment within the home

District: The percentage of children from urban and rural areas who indicated experiences of abuse or neglect within the home is presented in **Figure 3**. Children living in urban areas were statistically significantly more likely to experience corporal punishment (x2 (1, N = 11029) = 3.94, p = .047, φ = .02) and emotional abuse (x2 (1, N = 10993) = 6.39, p = .011, φ = .01) than children living in rural areas. In contrast, children living in rural areas were statistically significantly more likely to experience physical abuse (x2 (1, N = 10937) = 47.01, p < .001, φ = .07), non-contact sexual abuse (x2 (1, N = 10990) = 27.81, p < .001, φ = .05), physical neglect (x2 (1, N = 11000) = 31.93, p < .001, φ = .05) and medical neglect (x2 (1, N = 11022) = 10.50, p = .001, φ = .03) than children living in urban areas. In all cases, effect sizes were small. **There were no statistically significant differences in other forms of maltreatment between districts (p > 0.05).**

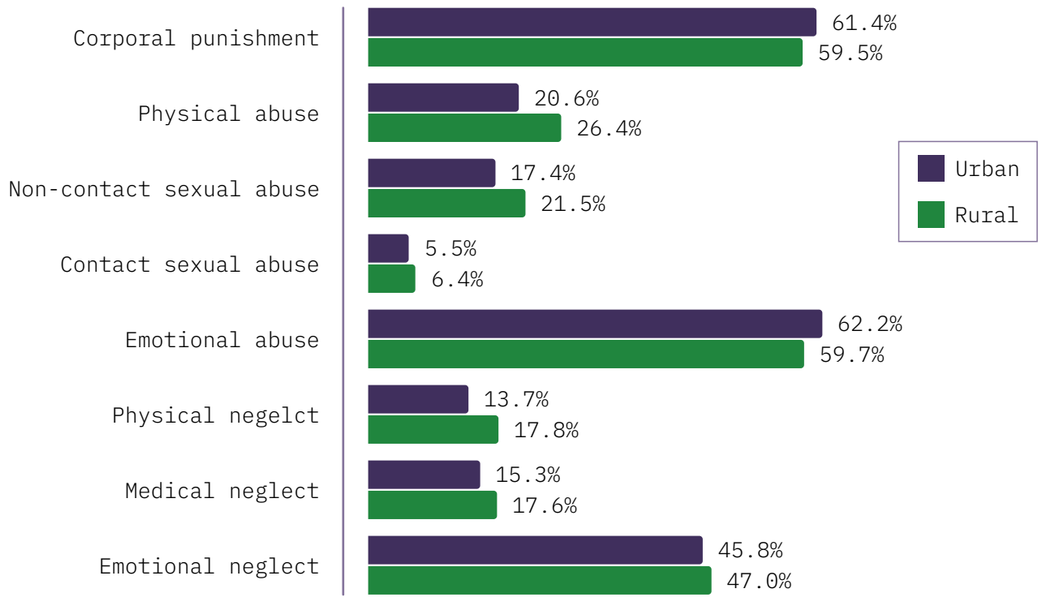

Figure 3: District differences in maltreatment within the home

3.2 Maltreatment outside the Home

Children and young people were also asked about their experiences of maltreatment from adults outside the family. Questions related to five types of maltreatment including corporal punishment, physical abuse, non-contact and contact sexual abuse, emotional abuse and physical neglect.

As can be seen in **Table 3**, the proportion of children who had experienced maltreatment outside the home ranged from 15.5% for contact sexual abuse to 65.0% for emotional abuse.

	Frequency (%)
Corporal punishment	6372 (46.8%)
Physical abuse	3882 (34.1%)
Non-contact sexual abuse	4509 (39.3%)
Contact sexual abuse	1784 (15.5%)
Emotional abuse	7474 (65.0%)

Table 3: Experiences of maltreatment outside the home

Next, using Chi-square tests, we examined whether the prevalence of maltreatment outside the home differed between genders, regions and districts.

Gender: The percentage of boys and girls who indicated experiencing abuse or neglect outside the home is presented in **Figure 4**. Girls were statistically significantly more likely than boys to experience contact sexual abuse (x2 (1, N = 11406) = 9.07, p = .003, φ = .03) and emotional abuse (x2 (1, N = 11435) = 17.28, p < .001, φ = .04) than boys. In contrast, boys were statistically significantly more likely to experience corporal punishment (x2 (1, N = 11378) = 69.92, p < .001, φ = .08) and physical abuse (x2 (1, N = 11316) = 103.14, p < .001, φ = .10) than girls. Effect sizes were small. **There was no statistically significant gender difference in experiences of non-contact sexual abuse (p > 0.05).**

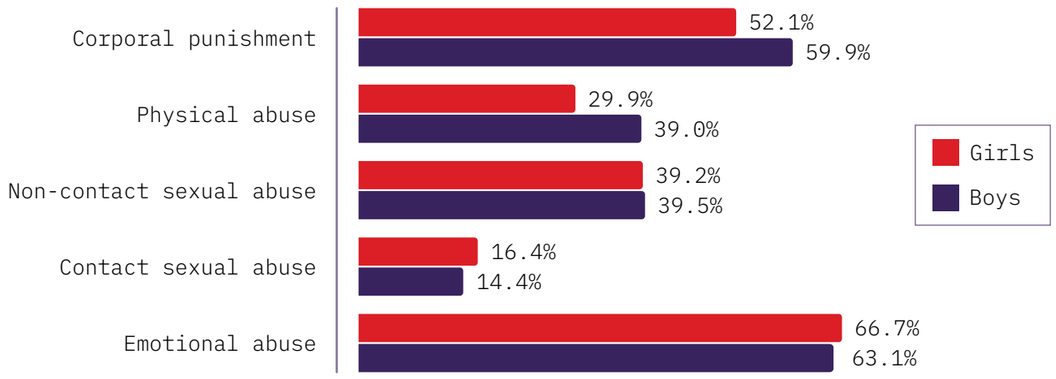

Figure 4: Gender differences in maltreatment outside the home

Region: The percentage of children from central and northern regions who indicated experiencing abuse or neglect outside the home is presented in **Figure 5**. Children from the central region were statistically significantly more likely to experience corporal punishment (x2 (1, N = 11226) = 78.96, p < .001, φ = .08), non-contact sexual abuse (x2 (1, N = 11227) = 36.28, p < .001, φ = .06), contact sexual abuse (x2 (1, N = 11253) = 15.98, p < .001, φ = .04) and emotional abuse (x2 (1, N = 11257) = 247.64, p < .001, φ = .15) than children from the northern region. All the effect sizes were small. **There was no statistically significant difference in physical abuse between regions (p > 0.05).**

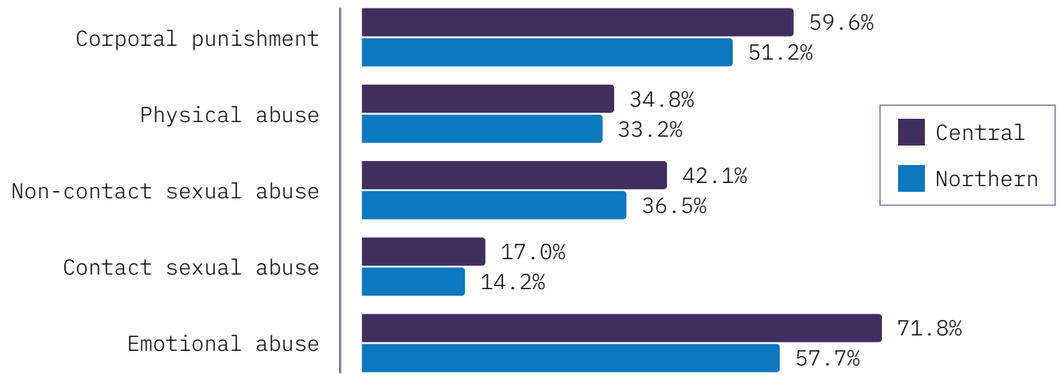

Figure 5: Regional differences in maltreatment outside the home

District: The percentage of children from urban and rural areas who indicated experiencing abuse or neglect outside the home is presented in **Figure 6**. All forms of maltreatment were statistically significantly more common among children living in rural than urban areas, including corporal punishment (x2 (1, N = 10995) = 42.06, p < .001, φ = .06), physical abuse (x2 (1, N = 10931) = 83.82, p < .001, φ = .09), non-contact sexual abuse (x2 (1, N = 10992) = 86.12, p < .001, φ = .09), contact sexual abuse (x2 (1, N = 11017) = 24.05, p < .001, φ = .05) and emotional abuse (x2 (1, N = 11022) = 7.33, p = .007, φ = .03).

In all instances, effect sizes were small.

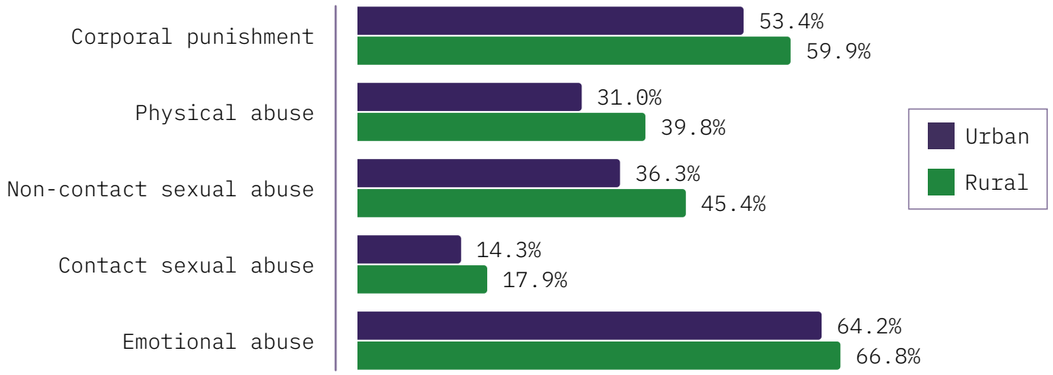

Figure 6: District differences in maltreatment outside the home

3.3 Child sexual abuse

Across both environments (home and non-home) and both types of assessed CSA (contact and non-contact) 45.1% of the children reported experiencing adult perpetrated CSA. No differences were observed based on gender of the respondents (44.6% of boys and 45.6% of girls). However, there was indication of a regional difference, with children in rural areas (51.1%) being more likely to report adult perpetrated CSA than those in urban areas (41.9%, x2(1, 10992) = 8.655, p <.000, φ = .09), although the effect size of this difference was very small.

3.4 Exposure to adult-perpetrated domestic violence

Children and young people were asked whether they had witnessed violence in the home without being a direct victim. Questions related to verbal violence, physical violence and serious violent threat (see section 2.3 for definitions). As can be seen in **Table 4**, children were most likely to report witnessing verbal violence, followed by physical violence and serious violent threat.

	Frequency (%)
Verbal violence	3159 (27.8%)
Physical violence	2860 (24.9%)
Serious violent threat	1519 (13.2%)

Table 4: Exposure to violence within the home

Next, using Chi-square tests, we examined whether the prevalence of exposure to violence within the home differed between genders, regions and districts.

Gender: The percentage of girls and boys who indicated being exposed to violence within the home is presented in **Figure 7**. Girls were statistically significantly more likely than boys to report exposure to verbal violence (x^2 (1, N = 11293) = 4.31, p = .038, φ = .02) and serious violent threat (x^2 (1, N = 11401) = 10.78, p = .001, φ = .03). Both effect sizes were small. **There was no statistically significant gender difference in exposure to physical violence (p > 0.05).**

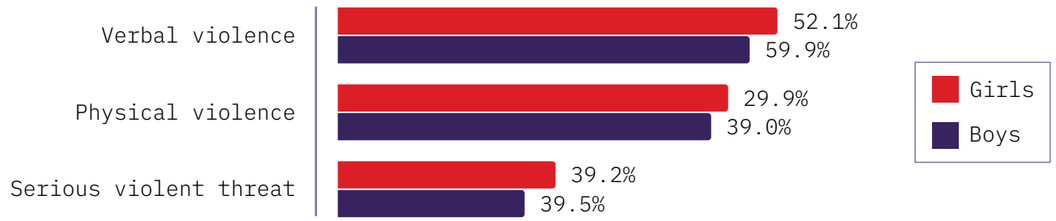

Figure 7: Gender differences in exposure to violence within the home

Region: The percentage of children from central and northern regions who reported being exposed to violence within the home is presented in **Figure 8**. Compared to children from the central region, children from the northern region were statistically more likely to report exposure to verbal violence (x^2 (1, N = 11143) = 31.68, p < .001, φ = .05), physical violence (x^2 (1, N = 11264) = 83.85, p < .001, φ = .08) and serious violent threat (x^2 (1, N = 11401) = 10.78, p = .001, φ = .03). **All the effect sizes small.**

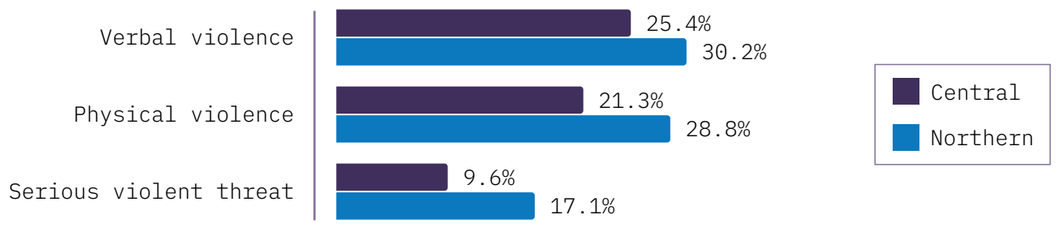

Figure 8: Regional differences in exposure to violence within the home

District: The percentage of children from urban and rural areas who indicated being exposed to violence within the home is presented in **Figure 9**. Children living in rural areas were statistically significantly more likely to report exposure to verbal (x^2 (1, N = 10913) = 8.07, p = .005, φ = .03) and physical (x^2 (1, N = 11032) = 24.11, p < .001, φ = .05) violence than children living in urban areas. In both cases, effect sizes were small. **There was no statistically significant difference between districts for exposure to serious violent threat (p > 0.05).**

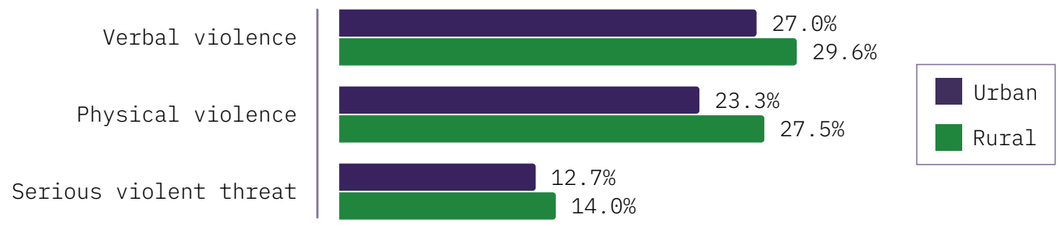

Figure 9: District differences in exposure to violence within the home

3.5 Experience of Underage Marriage

Survey items also inquired into **children's and young people's experiences of underage marriage** (see section 2.3 for a description of items). As shown in **Table 5**, 13.7% of children reported that they had either been promised in marriage, formally engaged, had a partner identified for them, or had married or lived with another person as though they were married. Almost 12% of children reported that they had worried about being **pressured into marriage** within the past three months.

	Percentage		
	All Respondents	Boys	Girls
Children who reported they were or had been married or lived with someone as though married	4.5% (n = 516)	6%	3.3%
Child who reported being engaged	4.9% (n = 564)	5.5%	4.4%
Children who reported that they had heard they were promised in marriage	8.2% (n = 950)	9.2%	4.3%
Experienced underage marriage	13.7% (n = 1,494)		
Children who reported being worried about the pressure to get married	11.8% (n = 1,338)	11.3%	12.1%

Table 5: Experience of and perceived pressure to marry underage

Chi-square tests were used to compare the experiences of underage marriage and perceived pressure to marry based on genders, region and districts.

Gender: The percentage of girls and boys who reported experience of underage marriage is presented in **Figure 10**. Boys were statistically significantly more likely than girls to report having experienced child marriage ($x^2(1, 10{,}851) = 21.86$, $p < .001$, $\varphi = .05$), but the effect size small. Specifically, boys were more likely than girls to report all three of the experiences linked to child marriage, however, the gender difference that demonstrated the largest effect size was in relation to being married or living as though married (6% boys vs 3.3% girls $x^2(1, 10{,}851) = 45.592$, $p < .000$, $\varphi = .06$). **There was no statistically significant gender difference in children's reports of worrying about the pressure to marry ($p > .05$).**

Figure 10: Gender differences in experience of and perceived pressure to marry underage

Region: The percentage of children from central and northern regions who reported experience of underage marriage is presented in **Figure 11**. Compared to children from the central region, children from the northern region were statistically significantly more likely to have experienced child marriage (x2 (1, N = 10701) = 111.09, p < .001, φ = .11) or perceived pressure to marry (x2 (1, N = 11097) = 26.50, p < .001, φ = .05). **Experience of child marriage just satisfied the criteria for a small effect size, but the magnitude of the difference in perceived pressure to marry across regions was very small.**

Figure 11: Regional differences in experience of and perceived pressure to marry underage

District: The percentage of children from urban and rural areas who reported experience of underage marriage is presented in **Figure 12**. Children living in rural areas were statistically significantly more likely to report experiencing underage marriage than children living in urban areas (x2 (1, N = 10476) = 12.80, p < .001, φ = .04), the effect size was very small. **There was no statistically significant difference in perceived pressure to marry between the districts (p > .05).**

Figure 12: District differences in experience of and perceived pressure to marry underage

Association between underage marriage and child sexual abuse:

Experiences of underage marriage were found to be associated with significantly higher rates of adult perpetrated CSA (67.9% vs 44.1% - x2 (1, 10,505) = 102.98, p < .000, φ = .1).

3.6 Psychological Well-being

The **mental health of children and young people** was measured using items relating to anxiety, depression, and suicide and self-harm related behaviours (see section 2.3 for a description of survey items). As shown in **Table 6**, 18.0% of children reported moderate to severe symptoms of anxiety, and 17.1% reported moderate to severe symptoms of depression.

	Frequency (%)	
	Anxiety	Depression
None to slight	7038 (68.8%)	7352 (70.1%)
Mild	1343 (13.1%)	1351 (12.9%)
Moderate	1536 (15.0%)	1373 (13.1%)
Severe	306 (3.0%)	417 (4.0%)

Table 6: Symptoms of anxiety and depression

Mann Whitney U tests, were used to test whether symptoms of anxiety and depression differed between genders, regions and districts.

Gender: The percentage of boys and girls who reported none to slight, mild, moderate and severe symptoms of anxiety and depression are presented in **Figures 13 and 16**. Compared to boys, girls were statistically significantly more likely to report moderate to severe symptoms of both anxiety (U = 11893031.00, p < .001, r = .08; girls M rank = 5256.67; boys M rank = 4878.12) and depression (U = 12186175.00, p < .001, r = .10; girls M rank = 5445.38; boys M rank = 4938.37). **The effect sizes did not exceed 0.1, indicating that the magnitude of the difference between genders was very small.**

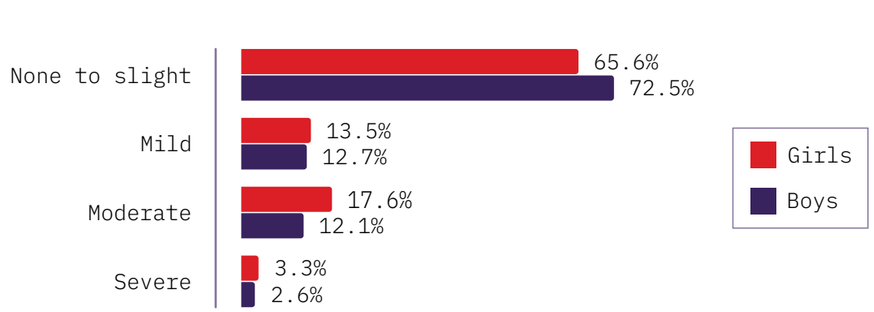

Figure 13: Gender differences in symptoms of anxiety

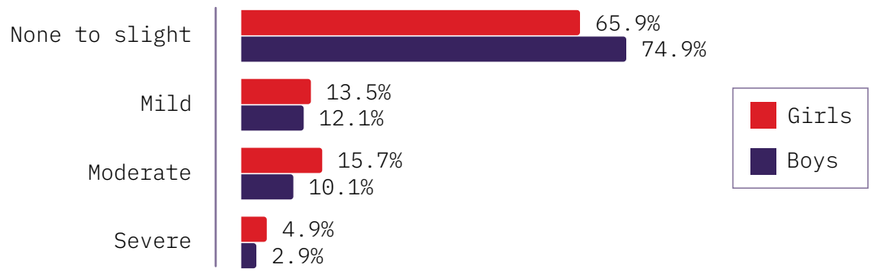

Figure 16: Gender differences in symptoms of depression

Region: The percentage of children from central and northern regions who reported none to slight, mild, moderate and severe symptoms of anxiety and depression are presented in **Figures 14 and 17**. **There was no statistically significant difference in symptoms of anxiety and depression between children from the northern and central regions (p > .05).**

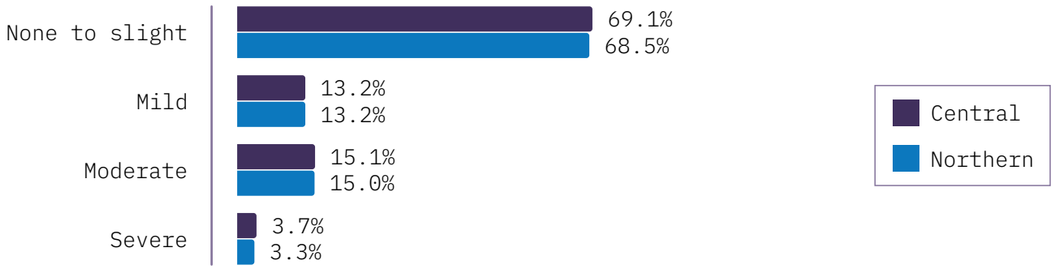

Figure 14: Regional differences in symptoms of anxiety

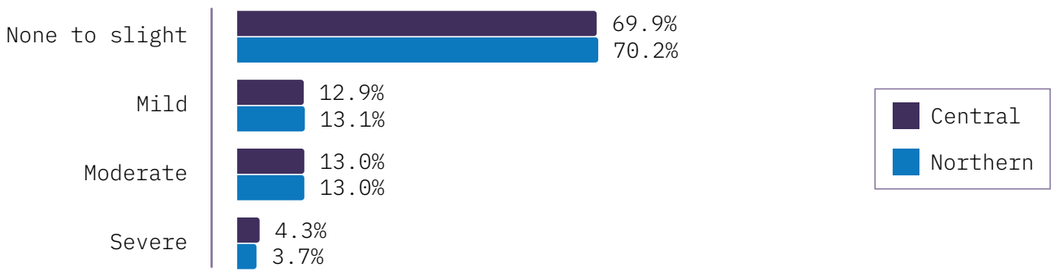

Figure 17: Regional differences in symptoms of depression

District: The percentage of children from urban and rural areas who reported none to slight, mild, moderate and severe symptoms of anxiety and depression are presented in **Figures 15 and 18**. Compared to children living in urban areas, children living in rural areas were statistically significantly more likely to report elevated symptoms of anxiety (U = 10642777.00, p < .001, r = .03; urban M rank = 4859.84; rural M rank = 5014.87). The effect size was close to zero indicating that the magnitude of the difference between districts was very small. **There was no statistically significant difference in symptoms of depression between children living in rural and urban areas (p > .05).**

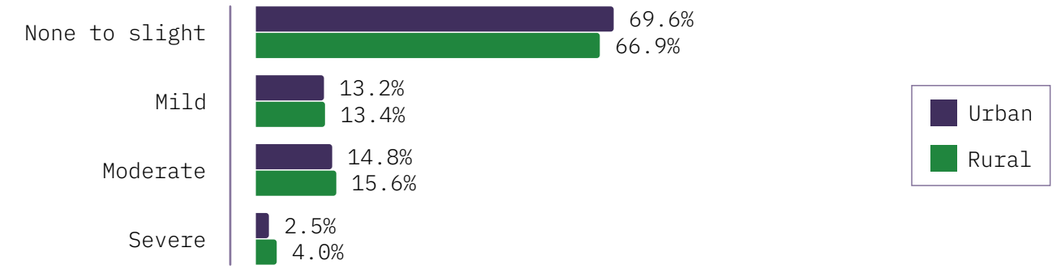

Figure 15: District differences in symptoms of anxiety

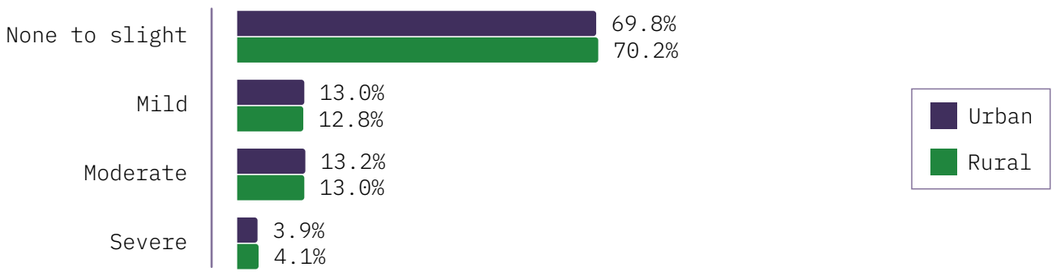

Figure 18: District differences in symptoms of depression

Table 7 shows the number of children that reported a lifetime history of non-suicidal self-injury, suicide ideation and suicide attempt.

	Frequency(%)
Non-suicidal self-injury	2726 (24.2%)
Suicide ideation	3346 (29.3%)
Suicide attempt	1582 (14.2%)

Table 7: Non-suicidal self-injury, suicide ideation and suicide attempt

Next, using Chi-square tests, we examined whether the prevalence non-suicidal self-injury, suicide ideation and suicide attempt differed between genders, regions and districts

Gender: The percentage of boys and girls who reported non-suicidal self-injury, suicidal ideation and suicide attempts are presented in **Figure 19**. There was a significantly higher rate of reported non-suicidal self-injury among boys than girls (x^2 (1, N = 11168) = 7.67, p = .006, φ = .03).

In contrast, suicide ideation (x^2 (1, N = 11328) = 65.61, p < .001, φ = .08) and suicide attempt (x^2 (1, N = 11031) = 15.10, p < .001, φ = .04) were statistically significantly more common among girls than boys. **All effect sizes were very small.**

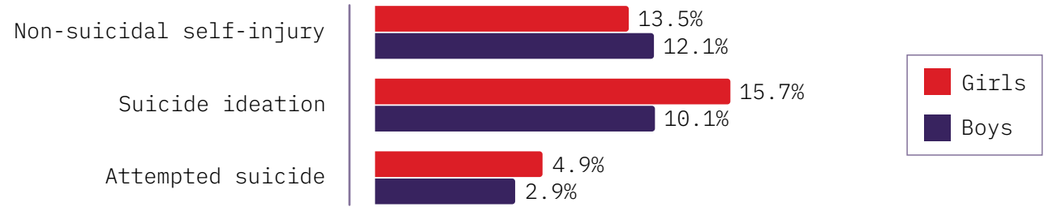

Figure 19: Gender differences in non-suicidal self-injury, suicide ideation and suicide attempt

Region: The percentage of children from central and northern regions who reported non-suicidal self-injury, suicidal ideation and suicide attempts are presented in **Figure 20**. There was a significantly higher rate of reported non-suicidal self-injury among children from the northern region than children from the central region (x2 (1, N = 11020) = 9.03, p = .003, φ = .03). In contrast, suicide ideation was more common among children from the central region than children from the northern region (x2 (1, N = 11176 = 23.82, p < .001, φ = .05). In both cases, effect sizes were close to zero, indicating that the magnitude of the difference between regions was very small. **There was no statistically significant difference in suicide attempts between the regions (p > .05).**

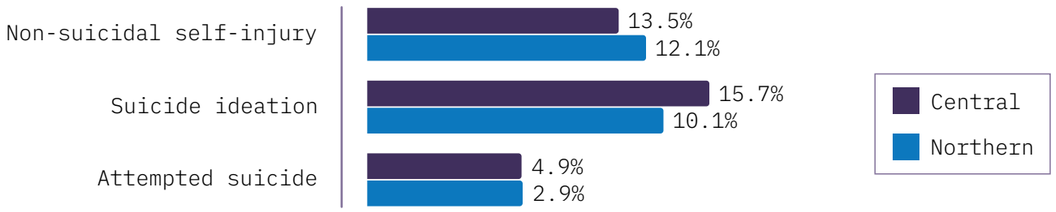

Figure 20: Regional differences in non-suicidal self-injury, suicide ideation and suicide attempt

District: The percentage of children from urban and rural areas who reported non-suicidal self-injury, suicidal ideation and suicide attempts are presented in **Figure 21**. Children living in urban areas were statistically significantly more likely to report suicide ideation than children living in rural areas (x2 (1, N = 10942 = 4.88, p < .027, φ = .02). The effect size was close to zero, indicating that the magnitude of the difference was very small. **There was no statistically significant difference in non-suicidal self-injury or suicide attempt between children living in rural and urban areas (p > .05).**

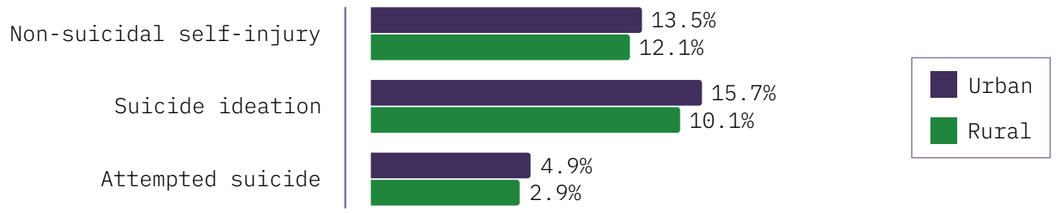

Figure 21: District differences in non-suicidal self-injury, suicide ideation and suicide attempt

4

CONCLUSIONS & RECOMMENDATIONS

4.1 Conclusions

Although Uganda has adopted international treaties and implemented national policies to protect children from abuse and neglect, **maltreatment of children is still widespread in the region**. Corporal punishment and emotional abuse from a parent, guardian or other adult were the most common forms of maltreatment within the home, with 60% of children reporting experiencing each of these forms of abuse. The fact that corporal punishment is commonplace amongst the surveyed Ugandan children concurs with evidence that this is widely considered an acceptable approach to disciplining children (Naker, 2005).

The **observation of significant rates of emotional abuse is also cause for concern** given that this form of maltreatment is the least studied, understood, and publicised type of abuse, which can lead to under-reporting as children do not interpret the acts as abusive (Moody et al., 2018). Other forms of abuse were also common within the home, including physical abuse (23%), non-contact sexual abuse (19%) and contact sexual abuse (6%). Furthermore, 46% of children and young people reported experiencing emotional neglect, 16% medical neglect and 15% physical neglect.

With the exception of emotional abuse in the home, which was slightly more common in the central than northern region (68% compared to 54%), generally speaking, there was **little difference in the prevalence of maltreatment in the home between the central and northern regions, and rural and urban districts**.

In respect of comparisons of maltreatment in the home based on the child's gender, girls reported **slightly higher prevalence than boys of experiences of corporal punishment, emotional abuse, and emotional and medical neglect**.

Emotional abuse was also the most common type of **maltreatment outside the home** – 65% of children indicated that they had experienced this at least once. This was followed by corporal punishment (56%), non-contact sexual abuse (39%), physical abuse (34%), and contact sexual abuse (16%).

Again, **emotional abuse was slightly more common in the central than northern region** (71% compared to 57%), but overall, there was little difference in the prevalence of maltreatment outside the home between the central and northern regions, and rural and urban districts.

Adult-perpetrated child sexual abuse appears to be problematic and the levels reported in this survey exceed the levels identified in the retrospective survey conducted with young Uganda adults (Uganda National Violence against Children Survey - MGLSD & UNICEF, 2018). The current survey revealed that 45% of children were affected by adult-perpetrated contact or non-contact sexual abuse (excluding online facilitated sexual abuse that is a growing concern in many countries). This contrasts with about 33% of girls and 16% of boys in the MGLSD survey. Retrospective surveys, such as the MGLSD, that invite young adults to reflect on and report about their experiences in childhood are often superior when investigating the long-term impact of abuse. However, they are likely to underestimate the extent of maltreatment particularly in males who have internalised dominant forms of masculinity that avoid the recognition and adoption of victim status, particularly in relation to what are traditionally seen as crimes against girls.

Girls were found to have slightly higher prevalence than boys of contact sexual abuse and emotional abuse, and boys had higher prevalence of corporal punishment and physical abuse.

Domestic abuse also appears to be widespread in Ugandan homes, with 28% of children reporting exposure to verbal violence, 25% physical violence and 13% a serious violent threat.

With respect to child marriage, 14% of children and young people surveyed indicated that they had been promised in marriage, formally engaged, had a partner identified for them, or had married or lived with another person as though they were married. Just 4.5% specifically reported being married or living with someone as though they were married. This is considerably lower than the proportion identified in the Ugandan Household Survey (MGLSD, 2018). Overall, 12% of participants reported that they were worried about being pressured into marriage.

Evidence of the gender disparity in experiences of child abuse and neglect with girls reporting higher rates of maltreatment than boys was not always evident in the current findings, although a consistent finding in previous studies (Clarke et al., 2016; MGLSD, 2018; Ogbonnaya et al., 2021). Indeed, while girls were more likely to report experiencing corporal punishment, emotional abuse, medical and physical neglect in the home than were boys, boys were significantly more likely than girls to report experiences of child marriage, and corporal punishment, and physical abuse outside of the home in this study. Thus, while the findings concur with those of Clarke et al. (2016) that being a girl places children at risk of abuse within the home, the effect size of the differences found were relatively small. Additionally, while the earlier study by the Ministry of Gender, Labour and Social Development (2018) reported twice the rate of child sexual against girls (35.3%) compared to boys (16.5%), the **current survey found equivalent rates for girls and boys, but a considerably higher prevalence figure across both genders** (45.1%). Similarly, in contrast to previous findings which have found girls to be disproportionately affected by child marriage, in this instance an equivalence between the genders was found with 4.5% of the children who completed the survey reporting being married or having lived with someone as though married.

Potential explanations for much of the gender symmetry seen in child maltreatment in this study might arise from the **framing of the abuse related questions and the recruitment strategy**. Specifically, the focus of the questions being on adult-perpetrated forms of maltreatment and the sampling method which meant that the survey respondents were draw from children (aged 9 -17) attending school.

With regards to the issue of focusing on **adult perpetrated maltreatment**, this excludes peer and sibling perpetrated abuse which accounts for a significant proportion of abuse in children's lives (e.g. Clarke et al., 2016; Wandera et al., 2017). For example, recent study of adolescent intimate partner violence against young people in Uganda aged 13-19 years (Ogbonnaya et al., 2021) found that girls were almost four times more likely to experience physical and sexual abuse at the hands of their partners (many of whom would be classified as peers) as were boys.

Since all the survey respondents were **children who were attending school**, it might mean that only children from families who were less likely to engage in selective resource allocation that favours male children were included in the sample. This might be particularly so for the children in the upper age range since **girls typically receive less formal education than boys in Uganda** and other low to middle income countries (Björkman-Nyqvist, 2013), particularly in contexts where education incurs costs to parents despite being a universal provision (Lamichhane & Tsujimoto, 2017, Unicef, 2019a). Additionally, according to the Unicef (2019a) report, **one in four girls aged 15-19 had already begun bearing children and thus are unlikely to be in school**, but potentially more at risk of child maltreatment, particularly sexual and physical intimate partner violence. Indeed, the survey results revealed that underage marriage was associated with significantly higher rates of sexual abuse (68% vs 44%) compared to children who had not been married.

Despite Government efforts to eliminate violence against children, there remains a need to improve the recognition, reporting and investigation of cases of child maltreatment. **Greater participation of children in addressing the problem should be considered, including empowering children to recognise and report abuse.**

The causes of domestic abuse and child maltreatment are complex and multifaceted, but there this partly reflects an intersection between poverty, a lack of educational and economic opportunities, social and cultural values that condone certain forms of violence against children, patriarchal structures, and gender bias and inequality (Krug et al., 2002). Childhood is recognised as a critical period for the internalisation of attitudes and beliefs that normalise violence against women and children (see Social Learning Theory, Bandura, 1977). Therefore, early intervention through the delivery of school-based programmes designed to sensitise children to the rights of women and children, is a crucial component in producing lasting change for future generations (WHO, 2020). **There is also a need to support and empower young people to avoid child marriage by educating them** about the associated harms and developing the perseverance and ambition to fulfil their life ambitions despite adversities they might experience.

Funding for mental health services in Uganda is limited (MoH, 2017), but the findings of the current study suggest that the psychological wellbeing of children and young people is cause for significant public health concern. In this survey, 18% of children reported moderate to severe symptoms of anxiety, and 17% reported moderate to severe symptoms of depression. Meanwhile, 24% reported that they had engaged in non-suicidal self-injury, with 29% reporting at least one occurrence of suicide ideation or attempt; finding that are concordant with the figures presented in the MGLSD (2018) survey. **Given the magnitude of the problem, it is imperative that public health measures are urgently implemented to promote positive psychological wellbeing among children and young people.**

"Childhood is recognised as a critical period for the internalisation of attitudes and beliefs that normalise violence against women and children"

4.2 Recommendations

- Through **age-appropriate education programmes facilitated by school-based social workers**, empower children and young people to recognise and report physical, sexual and emotional abuse and neglect. Since child abuse and neglect (CAN) is most likely to be investigated when a child self-reports abuse, such educational programmes are crucial to child protection efforts.
- **Support and empower young people** to avoid child marriage and the associated harms such as exploitation, sexual abuse, and teenage pregnancy. The Ni3 interactive prosocial computer game Peace, designed for 14-17 year-olds in Uganda, could increase understanding about how adult's and older teenagers can misused their power to groom, coerce and silence victims, and supporting young people to make sound decisions that can enable them to realise their dreams and aspirations in life, in spite of adverse life experiences.
- Professionals who have contact with children, including teachers, social workers and school guidance counsellors, **should be trained at entry level to recognise the signs of child maltreatment**, including abuse, neglect and forced marriage. Early identification and response are crucial in preventing the occurrence (and re-occurrence) of maltreatment and minimising the traumatic consequences.
- **Support parents who are at an increased risk** of subjecting their children to abuse, neglect or forced marriage through appropriate workshops that concentrate on improving their parenting skills, equipping them with non-violent discipline techniques, and combatting beliefs and attitudes that justify harmful actions towards children. Community engagement strategies based on dialogue can usefully challenge such negative behaviours, norms, customs and values, including those around child marriage. These approaches would require additional resources and appropriate training for staff from community organisations, and so a feasibility study is recommended in this regard.
- **Cultural attitudes that normalise and reinforce the perpetration of child maltreatment need to be challenged.** Media campaigns should seek to raise awareness of what constitutes child maltreatment and the frequency of child maltreatment, in addition to highlighting the unacceptability of violence against children. This might be achieved through print and social media campaigns, low-budget television and radio broadcasts, as well as through popular music by leading recording artists.
- **Empower children and young people** to recognise the signs of poor mental health, express how they are feeling, and seek help. Interactive digital technologies such as smartphone applications can assist with the self-monitoring of psychological wellbeing, as well as signposting children and young people to relevant support services.
- Future research should aim to: (a) **investigate the prevalence of child abuse and neglect** to identify the ages at which children and young people are most vulnerable; (b) ascertain the prevalence of peer- and sibling-perpetrated violence; (c) adopt a longitudinal design to identify risk and protective factors for child maltreatment and to directly assess the impact of CAN on children's psychological well-being; (d) explore attitudes towards using violence against children, seeking to identify those at increased risk of using such tactics; and (e) analyse existing legislation and policy to identify gaps in the current mechanisms intended to protect children from maltreatment.

Community engagement strategies based on dialogue can usefully challenge such negative behaviours, norms, customs and values, including those around child marriage.

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