THE REPUBLIC OF UGANDA

YOUTH AND ADOLESCENTS THEMATIC REPORT

BASED ON UDHS 2022

JULY 2025

THE REPUBLIC OF UGANDA

Thematic Report on the Adolescents and Youths in Uganda

Uganda Bureau of Statistics
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The Thematic Report on Adolescents and Youth in Uganda is produced by the Uganda Bureau of Statistics. (UBOS). P.O Box 7186, Colville Street. Kampala, Uganda. Email: ubos@ubos.org; website: www.ubos.org . the report is based on further analysis of the Uganda Demographic and Health Survey (UDHS) datasets.

Information about the 2022 UDHS should be obtained from the Directorate of Population and Social Statistics, Uganda Bureau of Statistics, Colville Street, P.O. Box 7186, Kampala, Uganda; Telephone +256-414-706-000; E-mail: ubos@ubos.org; Internet: www.ubos.org

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PREFACE

This report provides an in-depth overview of the situation of adolescents and youth in Uganda, who account for 31% of the country's population approximately 14 million people aged 15 to 30. This age group represents a critical stage of life, with vast potential for personal and national development. However, many young people face challenges and have limited participation in decisions affecting their lives.

The report consolidates data from the Uganda Demographic and Health Surveys (UDHS) offering a multi-sectoral analysis across key areas such as health, education, skills development, protection from violence, and access to water, sanitation, and hygiene (WASH). It identifies major trends and gaps, aiming to guide evidence-based policy, advocacy, and planning for improved youth development outcomes.

UBOS, in partnership with UNICEF encourages all stakeholders, government institutions, development partners, civil society, educators, and communities to use this report as a tool for action. By leveraging the insights it provides, we can collectively invest in the wellbeing of Uganda's youth and ensure they are empowered to contribute meaningfully to the country's future.

We urge policymakers, development partners, civil society organizations, educators, researchers, and community leaders to actively use this report. Let it guide your decisions, shape your programs, and strengthen advocacy efforts aimed at improving the lives of Uganda's adolescents and youth. By using this evidence-based resource, we can collectively build a more inclusive and supportive environment where every young person has the opportunity to thrive.

Chris N. Mukiza (PhD)

EXECUTIVE DIRECTOR

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INTRODUCTION 1

Youth is best understood as a period of transition from the dependence of childhood to adulthood's independence. That's why, as a category, youth is more fluid than other fixed age-groups. The United Nations, for statistical purposes, defines adolescents" as individuals in the 10–19-year age group and "youth" as the 15-24-year age group while Uganda defines the youth as a person aged between 18-30 years. This report will confine adolescent to 15-19 years due to source of data (UDHS) mainly used in the analysis.

1.0 Introduction

Studying adolescents and youth in Uganda is vital, as they constitute a significant portion of the country's population. This age group represents a unique phase of life transition from childhood to adulthood, offering immense opportunities for personal and societal growth. With approximately 14 million adolescents and youth aged 15 to 30, they make up 31% of Uganda's total population. However, only a small fraction of this group actively participates in decision-making processes that impact their lives and communities. UNICEF collaborates with public, private, and civil society organizations to empower vulnerable groups, including adolescents and youth, to reach their full potential.

1.1 Objectives of the study

The objectives of this thematic report on adolescent and youth include:

- to consolidate Uganda Demographic and Health Surveys data on adolescent and youths (15-30) and provide an up-to-dated holistic situation of adolescent and youth in Uganda
- Tease out key stylized facts/trends from the UDHS modules
- serve as a resource for advocacy with the Government and dialogues with multiple stakeholders on increasing the investment in adolescent and youth development and wellbeing
- serve as a background report that can be used for resource mobilization by the Government and development partners for adolescent and youth-focused programmes

1.2 Scope of the study

This report provides a multi-sectoral overview of the situation of adolescents and youth by covering selected youth and adolescent thematic areas which include among others:

- Adolescent and Youth Health (broad range of health indicators, including MCH, SRHS, MHM, and nutrition indicators),
- Protection, violence and GBV,
- Education and skilling and
- WASH

1.3 Data sources

The primary data sources for this report include the Uganda Demographic and Health Surveys (UDHS), the National Labor Force Surveys, and the National Population and Housing Censuses. These surveys and censuses provide vital information on adolescents and youth, offering key insights into their health trends and socio-economic conditions across Uganda, which are essential for thorough analysis.

1.4 Organisation of the report

The structure of the report includes sections on Adolescent and Youth demographics, Health, covering a broad range of health indicators such as Maternal and Child Health (MCH), Sexual and Reproductive Health and Services (SRHS) and nutrition. It also addresses Protection, Violence, and Gender-Based Violence (GBV), Education and Skilling, and Water, Sanitation, and Hygiene (WASH). Each section provides a comprehensive analysis of the relevant issues, drawing on data to inform policy and program recommendations

DEMOGRAPHICS 2

2.0 Introduction

Analysis of the youth and adolescents' demographic characteristics is crucial for understanding their unique needs and challenges, and for developing effective policies and interventions to support their well-being and development. This allows for better allocation of resources, targeted health and social services, and promotion of positive youth development. Demographic data, such as age, gender, race/ethnicity, socioeconomic status, and geographic location, helps identify specific needs and risks faced by different groups of young people.

2.1 Population

The data from 2024 clearly shows that Uganda has a predominantly young population, with over 73% of its approximately 46 million people under the age of 30. Adolescents aged 15 to 19 alone account for 12% of the total population, while youth aged 18 to 30 represent nearly a quarter (23%). This demographic trend highlights a significant youth bulge, which presents both opportunities and challenges.

On one hand, this youthful population can drive economic growth and social development if adequately supported through targeted investments in education, healthcare, and employment. Such investments are crucial to harness the demographic dividend—a potential boost in economic productivity resulting from a larger working-age population. On the other hand, failure to meet the needs of this large young population could strain resources and limit Uganda's development prospects. Therefore, strategic planning and policies focused on youth empowerment are essential for sustainable national growth.

Table 2. 1: Adolescents and youth population by Census years and sex (000's)

	2002			2014			2024		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
15-19	1,324.2	1,383.9	2,708.1	1,917.8	2,038.8	3,956.6	2,563.2	2,765.5	5,328.7
20-24	982.0	1,193.6	2,175.6	1,444.4	1,744.2	3,188.6	1,994.9	2,427.8	4,422.6
25-29	831.1	947.4	1,778.5	1,143.5	1,342.7	2,486.2	1,612.2	2,035.4	3,647.6
18-30	2,515.4	2,956.7	5,472.1	3,571.3	4,233.9	7,805.2	4,842.8	5,926.3	10,769.2
Population	**11,824.3**	**12,403.0**	**24,227.3**	**16,897.9**	**17,736.8**	**34,634.7**	**21,566.7**	**24,338.7**	**45,905.4**

Source: National Population and Housing Census

2.2 Education

Education plays a transformative role in the lives of adolescents and youth. In Uganda, the official school-going age for primary education is 6 to 12 years. Data from the Uganda Demographic and Health Surveys (UDHS) between 2006 and 2022 highlight progress in educational access. On average, six out of every ten adolescents aged 15–19 years reported primary school as their highest level of education (Table 2.2). While this age group is expected to attend secondary school, only three in ten do so, with slight variations observed between males and females.

Table 2.2 also shows unique trends worth highlighting. First, the table shows a stagnation of the proportion of female adolescents with no education—at about 3%. However, female adolescents are twice as likely to have no education as their male counterparts. Second, there is generally increased higher education attainment by female youths. For example, the percentage of female youths with secondary or more education nearly doubled between 2006 and 2022. Also, the proportion of those aged 25-29 years with no education reduced from 19.7% in 2006 to 6.4% by 2022. A comparison with male trends shows that females aged 25-29 years have gained more than their male counterparts.

Table 2. 2: Percentage of adolescents and the youth population by highest level of education

	Women				Men			
	2006	**2011**	**2016**	**2022**	**2006**	**2011**	**2016**	**2022**
No education								
15-19	3.5	2.9	1.8	3.8	0.6	1.0	0.8	1.7
20-24	11.5	4.9	3.3	2.9	2.4	2.4	2.9	2.0
25-29	19.7	11.2	6.5	6.4	6.5	3.0	3.4	3.4
Primary								
15-19	66.7	64.8	64.7	64.3	71.5	68.2	64.8	73.4
20-24	59.2	54.7	50.9	53.3	59.9	50.0	47.1	52.3
25-29	58.6	57.6	52.4	50.9	57.6	55.9	45.7	49.4
Secondary or more								
15-19	29.8	32.3	33.5	31.9	27.9	30.8	34.4	24.9
20-24	29.2	40.4	45.8	43.8	37.6	47.6	49.9	45.7
25-29	21.7	31.3	41.1	42.7	36.0	41.1	50.9	47.2

Source: Uganda Demographic and Health Survey

2.3 Marital status

Data from the Uganda Demographic and Health Surveys (UDHS) between 2006 and 2022 offer valuable insights into the marital status of adolescents and youth, shedding light on trends and challenges related to early marriage. On average, 20% of females aged 15–19 years were married or in a union, compared to less than 2% of their male counterparts (Table 2.3). The proportion of adolescents and youth in unions increases with age for both males and females, with higher rates observed among females. These findings highlight the persistence of early marriage, particularly among adolescent girls, which can have significant social and economic consequences.

Table 2.3 shows that the rates of female adolescents who are in unions have remained fairly constant at 20%. The trends among older female youths who are not married suggest that an increasing share of both those aged 20-24 years and those aged 25-29 years are delaying getting married. Higher education attainment, as shown in Table 2.2 above, may explain this. On the other hand, male youth aged 20-24 years are also increasingly delaying to get married from 56.3% in 2006 to 65.4% by 2022. However, the rates of being single among male youths aged 25-29 years have remained the same at about 23%. In addition, female youths do not get married to their peers. In 2022, 63.1% of female youths aged 20-24 years were married/in a union compared to 30.3% for male youths. These differences in rates of in-union between women and men suggest that most female adolescents and youths are married to relatively older partners.

Table 2. 3: Percentage of adolescents and youth population by marital status

	Women				Men			
	2006	**2011**	**2016**	**2022**	**2006**	**2011**	**2016**	**2022**
Not married								
15-19	77.6	77.3	77.2	79.7	98.1	96.9	97.5	98.2
20-24	21.9	23.9	25.5	25.0	56.3	63.4	61.2	65.4
25-29	5.8	5.6	10.0	8.8	22.8	19.9	21.3	23.5
In union								
15-19	19.6	20.0	19.9	20.0	1.8	1.9	1.9	1.5
20-24	67.1	67.3	64.0	63.1	40.0	31.9	33.8	30.3
25-29	80.4	82.5	77.3	75.7	69.5	74.6	72.0	63.9
Ever married								
15-19	2.8	2.7	2.9	0.3	0.1	1.2	0.6	0.3
20-24	11.0	8.8	10.5	11.9	3.7	4.7	5.0	4.3
25-29	13.8	11.9	12.7	15.5	7.7	5.5	6.7	12.6

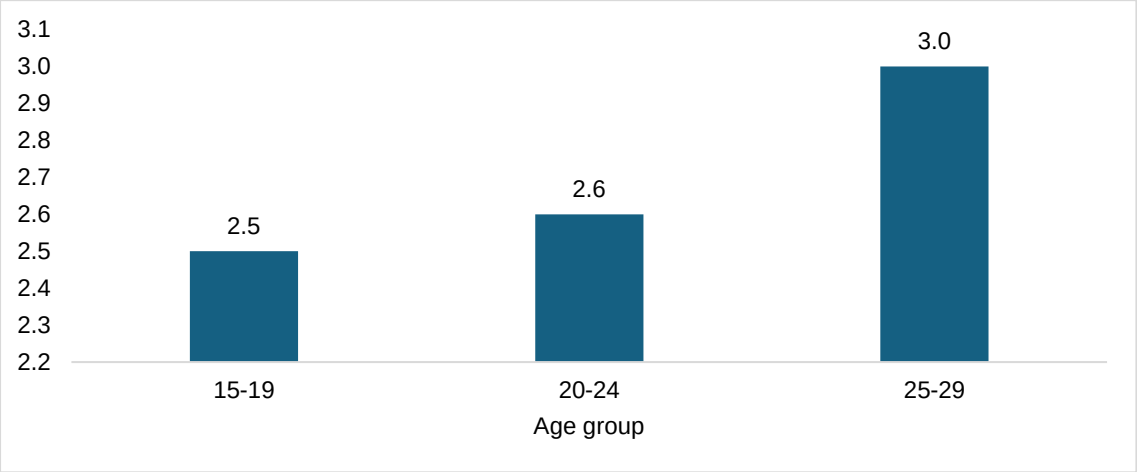
Source: Uganda Demographic and Health Survey

For the category of the ever married, Table 2.3 shows that marital dissolutions kick in after adolescence i.e. from age 20-24 years and increase with an increase in age. Worth noting that the marital dissolutions among male youths aged 25-29 years have increased overtime, from 7.7% in 2006 to 12.6% by 2022.

2.4 Disability

The Uganda Demographic and Health Survey (UDHS) 2022 offers valuable data on various aspects of the country's population, including disability. As shown in Figure 2.1, the prevalence of disability varies by age. Approximately 3% of adolescents experienced some difficulty in areas such as walking, seeing, hearing, communication, and self-care.

Figure 2. 1: Percentage of adolescents and youth with some difficulty in the main disability domains



HEALTH 3

3.0 Introduction

Adolescent and youth health is a critical area of focus as young people face unique health challenges that can affect their well-being and growth. Addressing these issues is essential for ensuring the development of a healthy, productive generation. Key Health Issues Among adolescents and youth in Uganda include sexual and reproductive health (early pregnancy, limited access to SRH services and HIV), nutrition, injuries and accidents,

3.1 Sexual and reproductive health

Sexual and reproductive health (SRH) among adolescents and youth in Uganda is a critical issue, as this group faces numerous challenges, including early sexual activity, unintended pregnancies, sexually transmitted infections (STIs), and limited access to comprehensive SRH services. These challenges have implications on their future health, education, and growth as young people. Addressing these issues is essential not only for safeguarding their well-being but also for empowering them to make informed decisions in future.

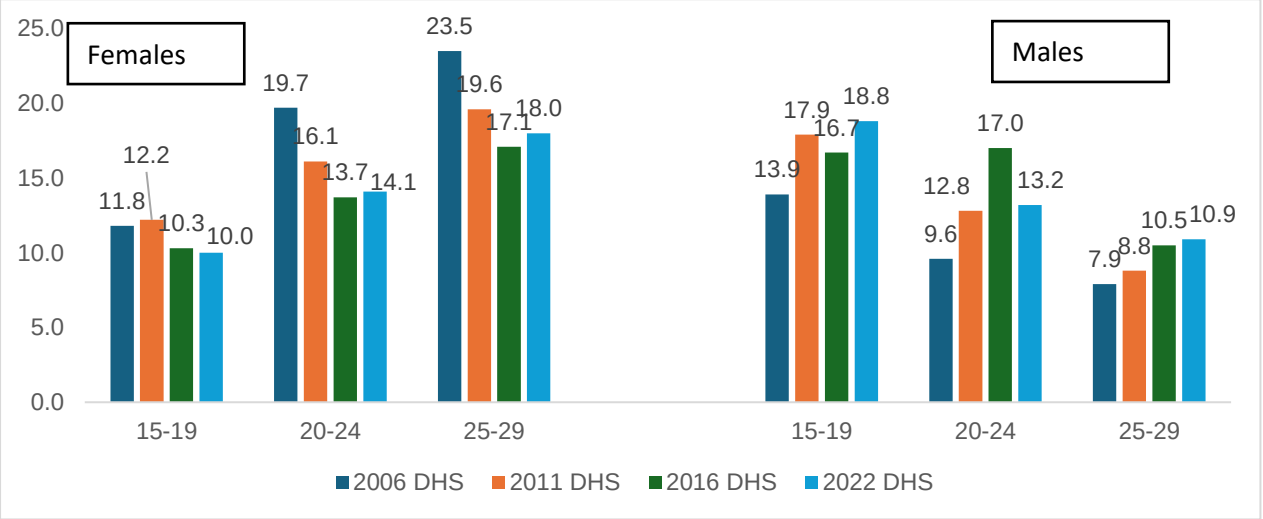
3.1.1 Age at First Sex

Age at first sex is a significant factor influencing sexual and reproductive health outcomes among adolescents and youth in Uganda. Early sexual initiation, often before the age of 18, is associated with higher risks of unintended pregnancies, sexually transmitted infections (STIs), including HIV, and unsafe sexual practices. In Uganda, many adolescents begin sexual activity at a young age due to factors such as peer pressure, lack of comprehensive sexual education, and socio-cultural influences.

The Uganda Demographic and Health Survey (UDHS) 2022 offers important data on the age of first sexual intercourse among Ugandans. Among individuals aged 20–49, the median age at first sexual activity is 19.7 years for women and 18.2 years for men. As illustrated in Figure 3.1 about 12% of female adolescents aged 15–19 and 14% of male adolescents in the same age group reported experiencing their first sexual encounter at exactly 15 years old.

These findings highlight the need for targeted sexual and reproductive health education and services for adolescents, emphasizing early intervention to address risks associated with early sexual activity, such as unintended pregnancies and sexually transmitted infections (STIs).

Figure 3. 1: Percentage of Adolescents and youth who had sexual intercourse at exact age 15

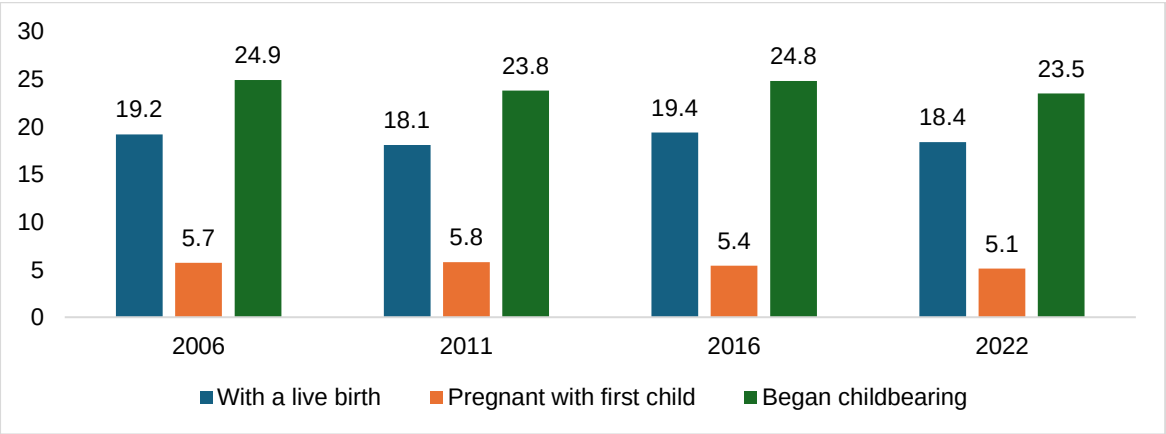


3.1.2 Adolescent pregnancy and child motherhood

Adolescent pregnancy and early motherhood remain pressing health and social challenges in Uganda, with profound implications for young girls. These issues expose them to significant health risks, including maternal complications and higher rates of infant mortality, while also disrupting their education and limiting future opportunities. Rooted in factors such as child marriage and unprotected sex, teenage pregnancies often entrench cycles of poverty, perpetuating inequality and vulnerability.

The 2022 Uganda Demographic and Health Survey (UDHS) revealed that 24% of women aged 15-19 years had started childbearing (pregnant or with a first child), with 18.4% having had a live birth and 5.1% pregnant with their first child (Figure 3.2). These figures align with trends observed since 2006, indicating minimal progress in reducing adolescent pregnancies. Addressing this issue is critical for safeguarding the health, education, and empowerment of young girls, while also fostering broader social and economic development in the country.

Figure 3. 2: Percentage of adolescents (15-19) who have began childbearing

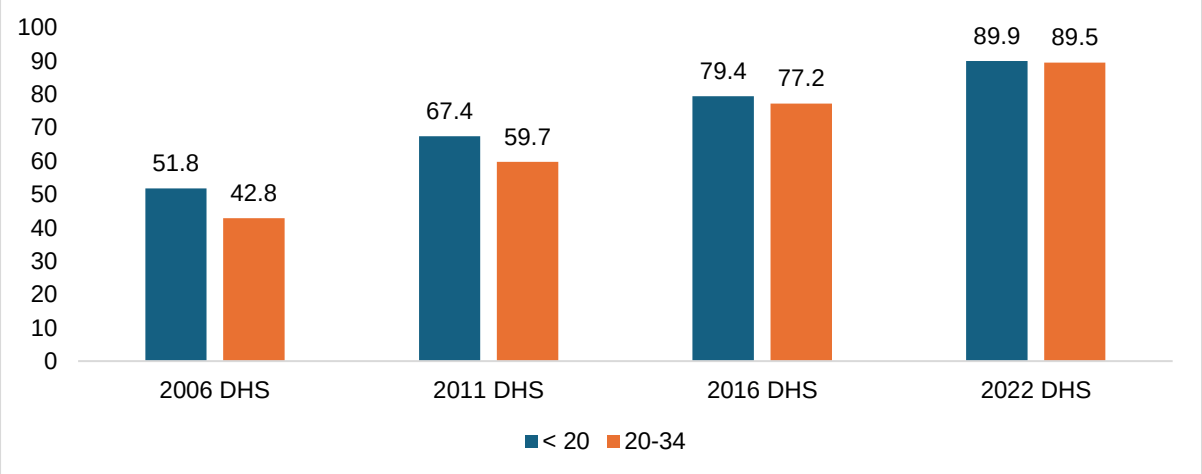


The current use of any modern contraceptive method by adolescents increased by over 4-fold between 2006 and 2022—from 5.2% in 2006 to 21.8% by 2022. As indicated in Figure 2.3, the teenage pregnancy rate remained relatively the same at about 24%. Previous research shows that the stagnation of teenage pregnancy rates in Uganda, despite increased contraceptive use, is driven by a combination of limited access to contraceptives, socio-cultural norms, and economic factors. For example, research from refugee settings in Uganda suggests that gender and power imbalances may be at play with married adolescents or those with older partners are less likely to use contraceptives—indicating a power imbalance in fertility decision-making (Bakesiima et al., 2020; Otika et al. 2024). Other studies point to behavioral influences such as having multiple sexual partners, peer pressure, and irregular contraceptive use as factors that can significantly increase the likelihood of teenage pregnancy (Ochen et al., 2019).

3.1.3 Births assisted by skilled health personnel

Skilled birth attendance is the process by which women are provided with adequate care during labour, delivery and the postpartum period. Figure 3.3 shows that births from adolescents less than 20 years are more likely to be attended to by skilled health personnel compared to those who are more than 20 years. The percentage of births assisted by skilled health personnel among adolescents 15-19 years increased from 52% in 2006 to approximately 90% in 2022.

Figure 3. 3: Percentage of births assisted by skilled health personnel by age of mother



3.2 Adolescent and youth self-reported with an STI

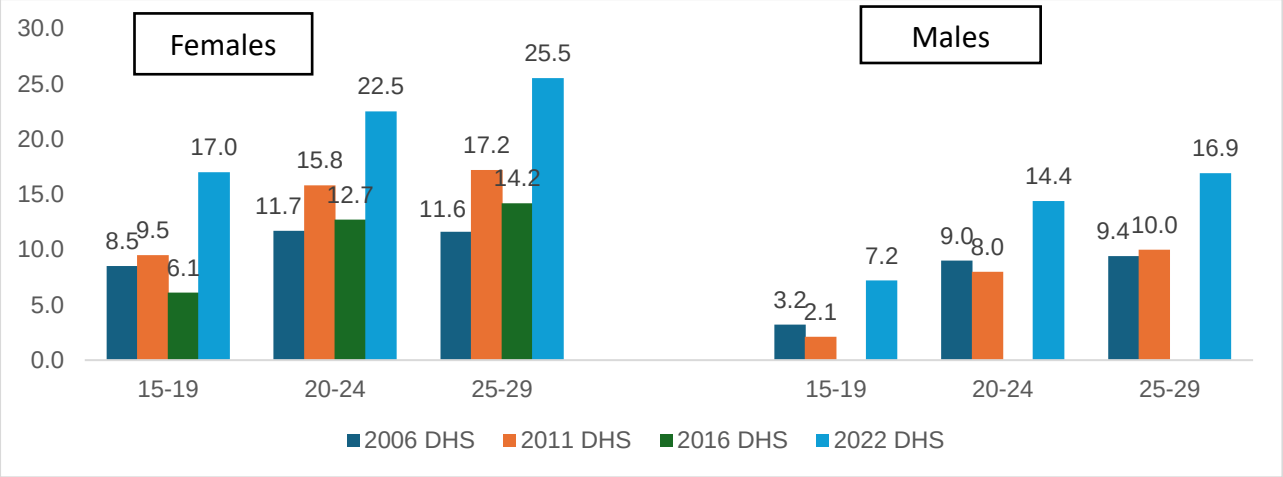
Youth and adolescents are at an increased risk of sexually transmitted infections (STIs) and HIV due to limited access to sexual health education and services. STIs not only share common risk factors with HIV but also heighten the likelihood of contracting the virus.

The Uganda Demographic and Health Survey (UDHS) gathers data on respondents' experiences with STIs and related symptoms, such as abnormal or foul-smelling discharge from the vagina or penis, and genital sores or ulcers. In 2022, among adolescents who had ever engaged in sexual intercourse, 17% of women and 7% of men reported STI symptoms (Figure 3.4). The corresponding rates for 2006 were 8.4% and 3.1%, respectively. As such, there is an increase in the percentage of adolescents and youth reporting STI symptoms between 2006 and 2022.

Previous research shows that out-of-school adolescent girls have higher sexual risk behaviors, such as multiple partners, compared to their in-school counterparts; this group also reported lower condom use, contributing to higher STI prevalence (Matovu et al, 2021).[i] Indeed, the UDHS surveys show that condom use among adolescents engaged in higher-risk sexual intercourse reduced from 34.9% in 2006 to 8.7% by 2022.

This trend highlights the urgent need for continued efforts in STI prevention, early diagnosis, and treatment. Untreated STIs can lead to serious health complications and significantly impact young people's well-being and future opportunities.

Figure 3. 4: Adolescents and youth with symptoms of STI



3.3 Contraceptive knowledge and Use

Contraceptive knowledge and use are vital components of sexual and reproductive health for adolescents and youth. Adequate knowledge of contraceptive methods enables young people to make informed decisions about their sexual health, reduce unintended pregnancies, and prevent the transmission of sexually transmitted infections (STIs), including HIV.

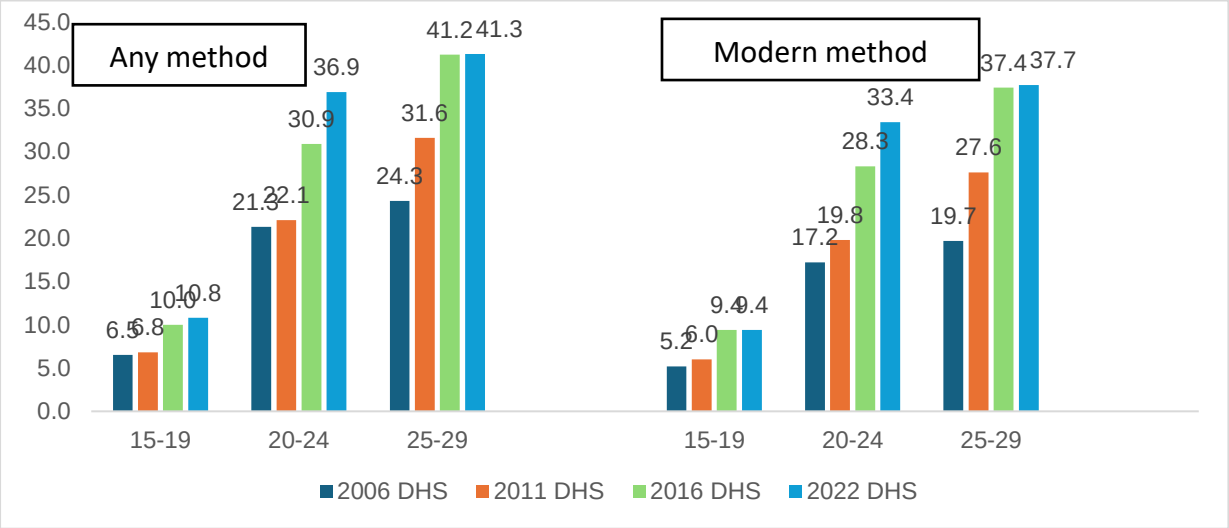
3.3.1 Adolescents and youth currently using Contraceptives

Analysing the current use of contraception among adolescents and youth is crucial for identifying specific subgroups that require targeted family planning services.

As shown in Figure 3.5, the distribution of adolescents and youth currently using family planning methods reveals that 11% of the population is using any contraceptive method, while 9% are using modern methods.

The data also indicates that contraceptive use increases with age, highlighting a growing acceptance or need for family planning as adolescents transition into young adulthood. Furthermore, the trend over multiple survey periods suggests a steady increase in contraceptive use, implying that awareness and access to family planning methods may be improving.

Figure 3. 5: Adolescents and youth currently using family planning methods



Given the changes observed in Figure 3.4, it is also important to understand the drivers of the changes. Table 3. 1 shows the trends in contraceptive use among adolescents and youths from 2006 to 2022. The percentage of all adolescent women aged 15-19 using any modern method increased from 6.5% to 10.8%. For current married women in the same age group, usage rose from 11.4% to 25%. Among sexually active unmarried women, contraceptive use was highest at 37.2% in 2006, declining to 33.9% by 2022. The table also indicates a notable increase in using implants as the modern contraceptive choice across all age groups and marital statuses from 2006 to 2022. For example, for married youths aged 20-24, implant use rose from 0.1% in 2006 to 5.9% in 2022 while among single unmarried youths in the same age category, use of implants rose from 0.5% in 2006 to 6.4% in 2022. This suggests a growing acceptance and adoption of implants as a modern contraceptive method.

Table 3. 1: **Trends in current use of contraceptives among adolescents and youth,2006-2022(%)**

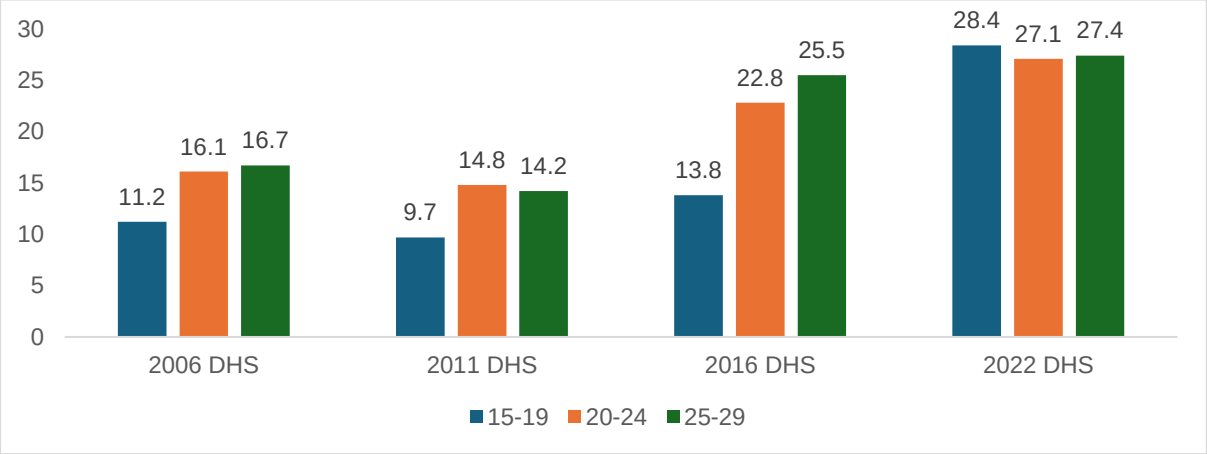
Age Group	Any Method		Any Modern Method		Type of Modern Method									
					Injectables		Implants		Male Condoms		Pills		Other Modern Method	
	2006	2022	2006	2022	2006	2022	2006	2022	2006	2022	2006	2022	2006	2022
	All Women													
15-19	6.5	10.8	5.2	9.4	1.3	3.1	0	2.4	3.1	2.3	0.8	0.5	0	1.1
20-24	21.3	36.9	17.2	33.4	8.5	12.8	0.1	10.9	5.6	3.3	2.8	1.3	0.2	5.1
25-29	24.3	41.3	19.7	37.7	12.3	15.3	0.3	13.2	2.7	1.5	3.8	1.8	0.6	5.9
	Current married women													
15-19	11.4	25	8.3	21.8	4.3	9.9	0	7.2	2.6	1.5	1.4	0.7	0	2.5
20-24	21.7	41	16.2	37.2	10.8	16.3	0.1	12.4	2.1	1.5	3.1	1.1	0.1	5.9
25-29	23.8	44.4	18.4	40.2	12	17.1	0.2	14.1	1.8	0.8	3.9	2	0.5	6.2
	Sexually Active unmarried women													
15-19	37.2	33.9	28.2	29.9	3.5	5.6	0	5.9	16.6	11.9	8	2.1	0.1	4.4
20-24	56.6	51.9	50.5	47.5	9.8	12.9	0	11.9	37.9	12.8	2.3	3.5	0.5	6.4
25-29	60.1	45	53.2	41.4	19.6	16.3	0	11.1	25.2	6.1	7.1	1.8	1.3	6.1

Previous research indicates that the increased use of implants in Uganda is driven by strategic family planning initiatives, improved accessibility, and user preferences for long-acting contraceptive methods. Averbach et al. (2017) in a study in Kampala, show that offering implants immediately after delivery had significantly increased their utilization.[ii] On the other hand, Callahan et al. (2019) show that women in Uganda have a strong preference for long-acting contraceptives like implants—that require less frequent medical visits—because of their effectiveness and convenience.[iii] Kamanga et al (2023) point to efforts to strengthen health systems, including training health workers and improving supply chains, which have increased the availability and uptake of implants in public health facilities.[iv]

3.3.2 Adolescents with correct knowledge of their fertile period

The basic understanding of reproductive physiology is essential for the effective use of the rhythm method; it also essential for reducing unintentional pregnancies and associated health risks. The results from 2022 indicate that approximately 28% of adolescents were able to correctly identify their fertile period (Figure 3.6). Overall, there has been an increase in the proportion of adolescents and youth with knowledge of their fertile period across the survey periods, especially between 2016 and 2022. The increased knowledge about fertility period may be explained by increased female education attainment. Kate (2018) and Masuda and Yamauchi (2018) demonstrate that the Universal Primary Education (UPE) policy in Uganda significantly improved women's education, resulting in increased knowledge about reproductive health, including fertility periods. [v] [vi]

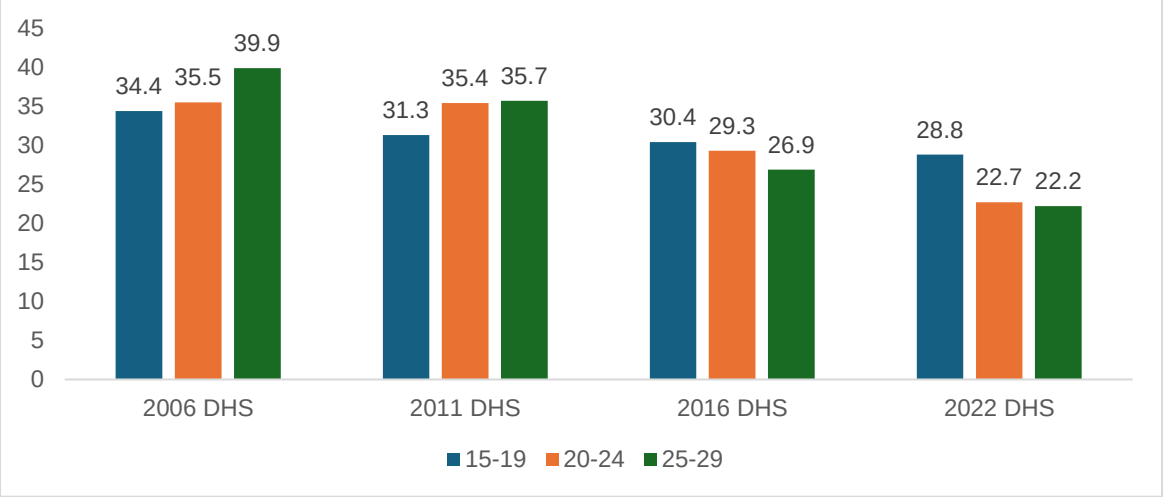
Figure 3. 6: Percentage of adolescents and youth with correct knowledge of their fertile period



3.3.3 Adolescents with unmet need for family planning

Adolescents and youth who want to postpone their next birth for two or more years or who want to stop childbearing altogether but are not using a contraceptive method are considered to have an unmet need for family planning. Figure 3.7 shows that the total unmet need for family planning among adolescents and youth has been declining. In 2022 It was highest among the adolescents (29%). Overall, the declining unmet need for family planning among adolescents and youth in Uganda suggests progress in reproductive health services, as shown in Figure 3.4, showing increased trends in using modern family planning methods. Addressing this unmet need is particularly important for adolescents and youth, as it directly impacts their ability avoid unintended pregnancies that can lead to social and economic challenges, as noted earlier.

Figure 3. 7: Percentage of adolescents and youth with Total unmet need for family planning



3.4 Human Immunodeficiency Virus (HIV)

Analysing HIV among adolescents and youth is essential to understand the specific challenges they face, such as early sexual activity and limited healthcare access, which increase their vulnerability to HIV. By focusing on this age group, we can develop targeted prevention strategies, improve access to testing and treatment, and reduce stigma, ultimately improving their health and breaking the cycle of transmission for long-term progress in the fight against HIV in Uganda

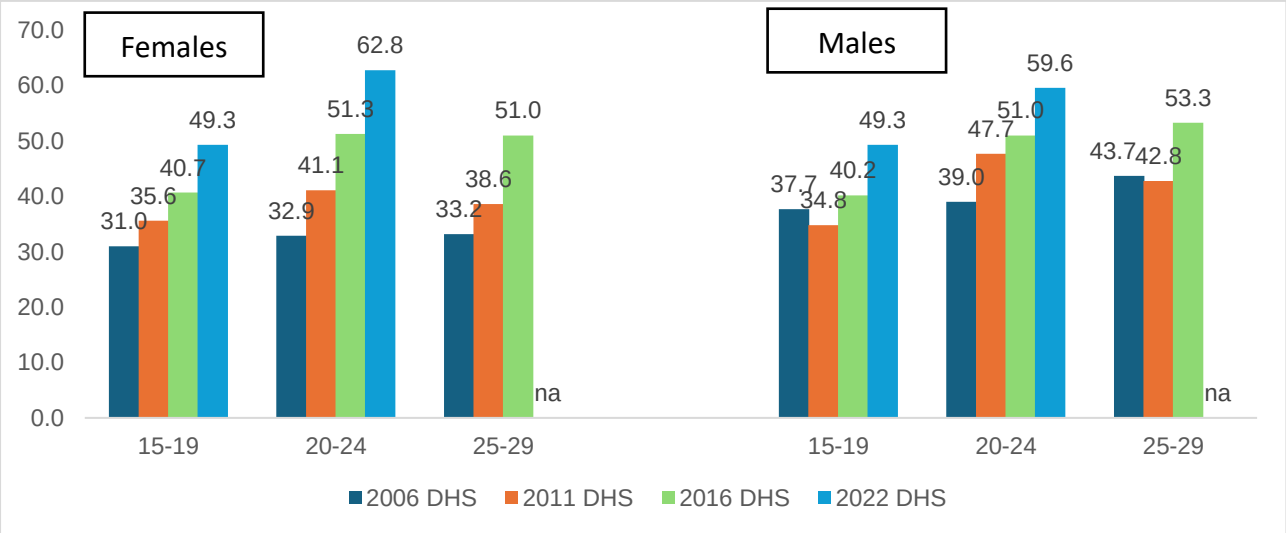
3.4.1 Adolescents and youth with comprehensive knowledge about HIV

In addition to knowing effective ways to avoid contracting HIV, it is useful to be able to identify incorrect beliefs about HIV transmission. Common misconceptions about HIV and AIDS include the following: a healthy-looking person cannot have HIV, it can be transmitted by mosquito bites, HIV can be transmitted by supernatural means, and a person can become infected by sharing food with a person who has HIV.

In 2006 respondents were asked about these misconceptions and 31% of the female adolescents had comprehensive knowledge about HIV compared to 38% of their male counterparts (Figure 3.8). The trend shows males having more comprehensive knowledge about HIV than the females in the 25-29 years age category; otherwise, knowledge is similar for the other age groups, except for adolescents aged 15-19 years.

This gender difference highlights the need for targeted interventions to enhance HIV education for both male and female adolescents, with a particular focus on dispelling misconceptions. By addressing these false beliefs and improving knowledge across both genders, HIV prevention efforts can be more effective, reducing stigma and promoting healthier behaviors in young people.

Figure 3. 8: Percentage of adolescents and youth with comprehensive knowledge about HIV

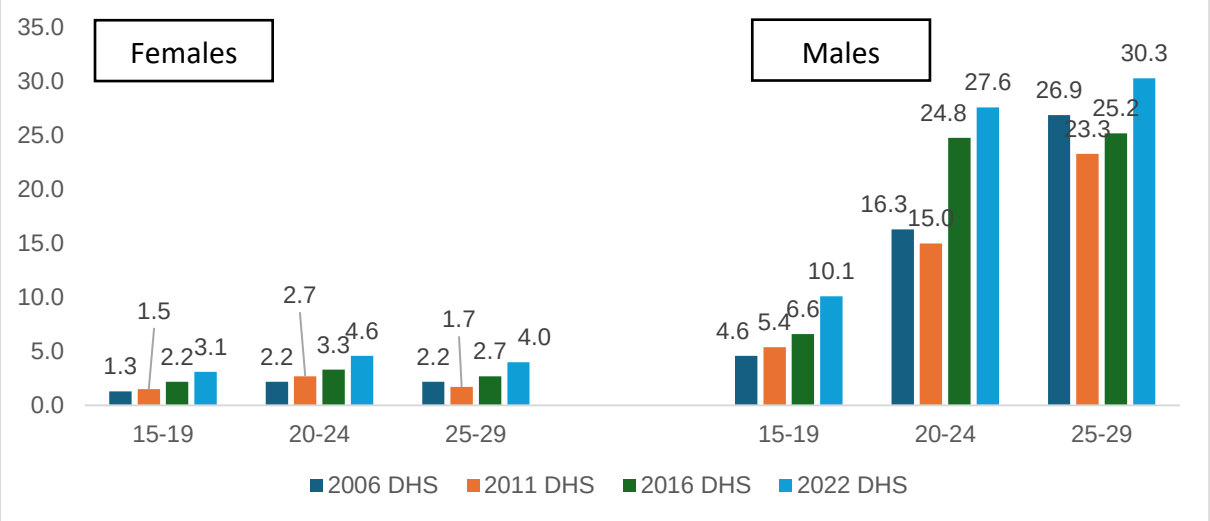


**na=Not applicable given Question asked for persons aged 15-24 only*

3.4.2 Adolescents and youth with more than one sexual partner

Figure 3.9 presents information on adolescents who have ever engaged in sexual intercourse, focusing on the number of sexual partners reported within the 12 months preceding the survey. The findings reveal a notable gender disparity: female adolescents are significantly less likely than male adolescents to report having multiple sexual partners (3 percent compared to 10 percent). This trend is consistent across all the youth. The results further show an increase in the proportion of adolescents reporting multiple sexual partners over successive survey periods, highlighting potential implications for the heightened risks for HIV infections, other sexually transmitted infections (STIs), and teenage pregnancies. This calls for public health interventions, particularly in areas such as sexual education, and prevention of sexually transmitted infections (STIs).

Figure 3. 9: Percentage of *adolescents and youth with more than one sexual partner*

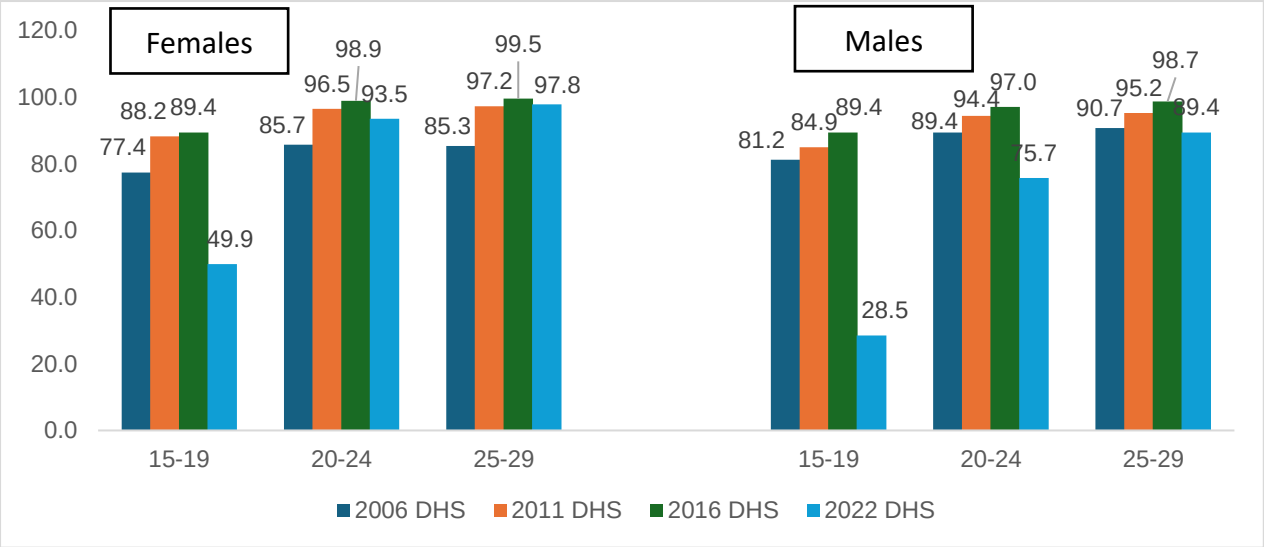


3.4.3 Adolescents and youth with knowledge of where to take an HIV test

Expanding knowledge of HIV status is an important goal of the national HIV response. In the case of persons who are HIV negative, knowledge of their HIV status helps in making specific decisions that will reduce the risk of becoming HIV positive and enable them to remain HIV free. For those who are HIV positive, knowledge of their HIV status allows them to live an affirming life, protecting their sexual partners, accessing care and treatment, and planning for the future. Figure 3.10 shows that in 2022 there was a decline in percentage of adolescents and youth who know a place where they can get an HIV test compared to other surveys. By age group, women adolescents (50%) are least likely while women age 25-29 (98 percent) are most likely to know where to obtain an HIV test. The same pattern is observed among the male adolescents and youth.

Given that improved access to testing facilities is crucial for enhancing HIV prevention and control efforts among adolescents and youth in Uganda, the observed decline in knowledge about HIV testing locations among Ugandan adolescents (during 2016 and 2022) could hinder efforts to control the spread of HIV, as undiagnosed individuals may unknowingly transmit the virus.

Figure 3. 10: Percentage of adolescents and youth with knowledge of where to take an HIV test

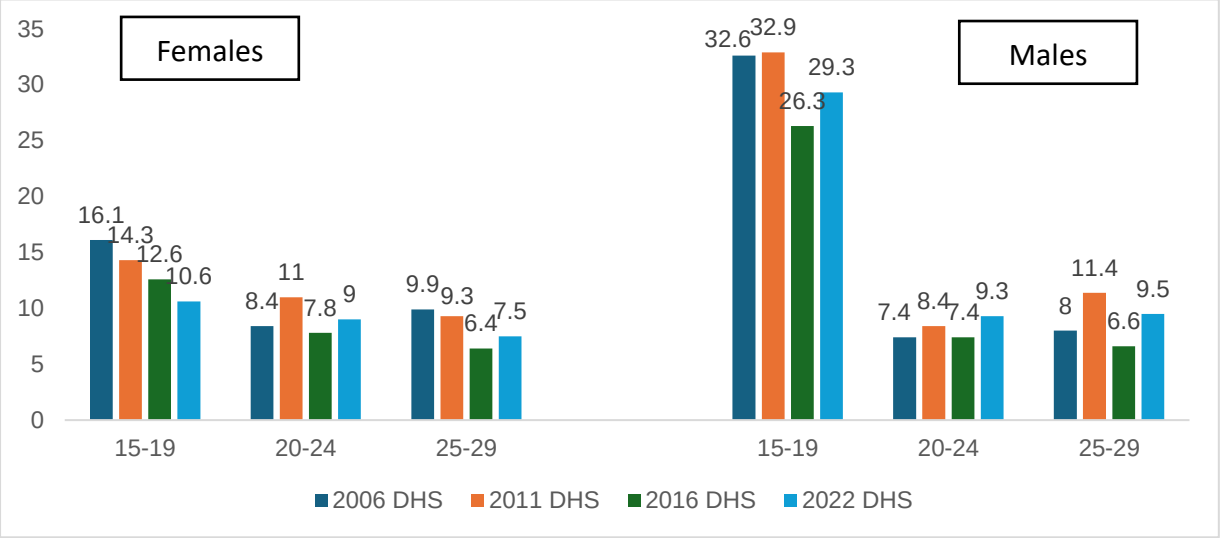


3.5 Nutrition

Adolescent nutrition plays a critical role in supporting growth, health, and learning for both current and future generations. Enhancing nutrition during this stage can contribute to building healthier and more prosperous societies. However, adolescents and youth often face challenges related to eating disorders, which are characterized by abnormal eating behaviors and an intense focus on food, body weight and shape.

The Body Mass Index (BMI) is used to measure thinness or obesity. BMI is defined as weight in kilograms divided by height in metres squared (kg/m2). A BMI below 18.5 indicates thinness or acute undernutrition. Overall, in 2022 about 12 percent of the female adolescents were thin or undernourished (BMI less than 18.5 kg/m2) compared to 29% of their male counterparts (Figure 3.11). The percentage of males who are thin is higher compared to the females among the adolescents and youth. Research on the African continent points to puberty as the reason male adolescents on the continent may have a lower BMI than their female counterparts—female adolescents gain more body fat after their first menstrual period because of hormonal changes, which can lead to higher BMI compared to males (Cameron and Getz, 1997).[vii]

Figure 3. 11: Percentage of adolescents and youth who are thin



3.6 Tobacco and alcohol use

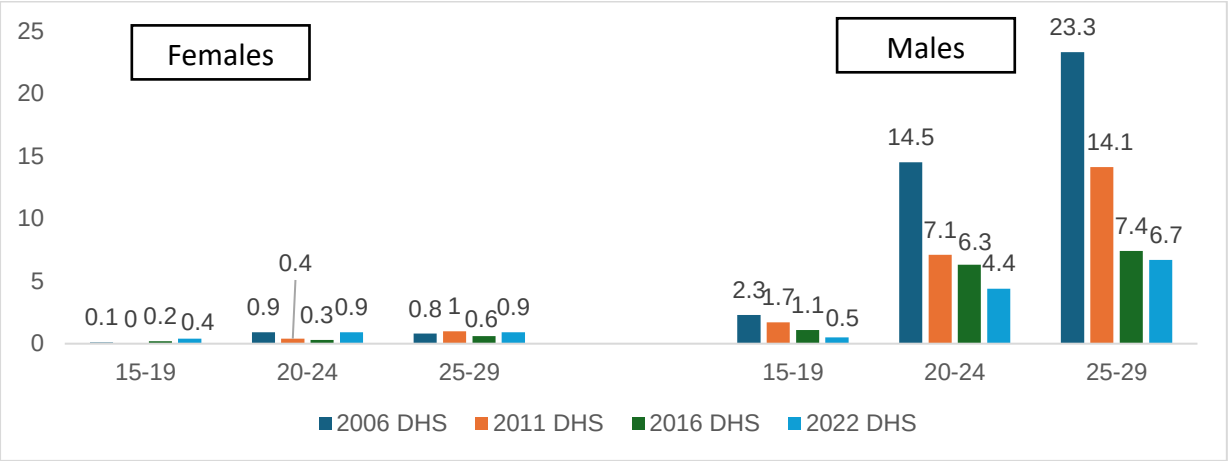
Although substance abuse in Uganda may not yet reached critical levels, it is steadily increasing, particularly in the use of tobacco and alcohol. Smoking and drinking among young adults pose significant health risks, including respiratory diseases, heart problems, liver damage, and an increased likelihood of addiction. These behaviors also contribute to social issues such as impaired judgment, accidents, and reduced productivity.

3.6.1 Tobacco use

Smoking has an impact on population health. Smoking is a known risk factor for cardiovascular disease, it causes lung cancer and other forms of cancer, and it contributes to the severity of pneumonia, emphysema, and chronic bronchitis. It may also have an impact on individuals who are exposed to second-hand smoke.

Figure 3.12 shows that smoking is somewhat more common among male adolescents and youth than in females. The likelihood of a man using tobacco increases with age for example in 2022 the percentage of adolescents who smoked any tobacco was less than one percent (0.5%) compared to 7% among the 25-29 age group. Generally, there is a declining pattern of smoking among the adolescents and youth over the survey periods. The decline in tobacco use among Ugandan adolescents and youths may be partly explained by increased cigarette prices (due to increased taxation); other African countries have shown that such increases significantly reduce both smoking prevalence and the initiation of tobacco use among youths. Indeed, Ntale and Kasirye (2018) demonstrate that a 26% increase in excise tax could lead to an 8.7% reduction in cigarette consumption in the short term, with more significant reductions over the long term.[viii]

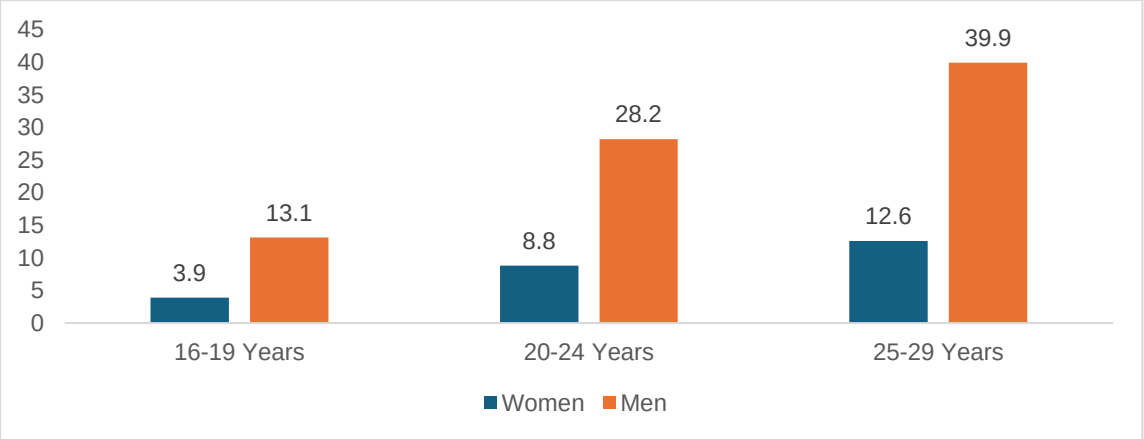
Figure 3. 12: Percentage of adolescents and youth who smoke any tobacco



3.6.2 Alcohol use

Alcohol use among adolescents and youth is a significant concern due to its health, social, and developmental implications. In Uganda, factors such as peer influence, cultural norms, accessibility of cheap alcohol, and weak enforcement of regulations contribute to early initiation and high consumption rates. Figure 3.13 shows that alcohol intake increases with age for example in 2022 the percentage of female adolescents who took any alcohol was 4% compared to 13% among the 25-29 age group. The trends show that the legal drinking age significantly affects consumption patterns. The Liquor Act, Cap. 93 of 1960, currently prohibits the sale or supply of alcohol to anyone under 18 years of age. The chart also shows that alcohol use is significantly higher among male youths. Social and cultural norms that encourage drinking as a form of socialization or coping mechanism may explain this higher rate among males. Kabwama et al (2021) based on a study in Kampala shows that the presence of alcohol in family settings, such as parents or siblings who drink, also increases the likelihood of alcohol use among male youths.[ix]

Figure 3. 13: Percentage of adolescents and youth who took at least one alcoholic drink in the last one month (2022)



3.7 Mortality

Adolescents and youth in Uganda face significant health challenges that contribute to mortality within this age group. According to the World Health Organization (WHO), leading causes of death among adolescents globally include pregnancy complications and unsafe abortions. These are the leading causes of death among girls aged 15-19 years.

3.7.1 Mortality among the adolescents and youth

Adolescent and youth mortality rates often exhibit significant gender disparities, influenced by varying risks and social determinants of health. Males face higher mortality rates due to increased engagement in risk-taking behaviors and societal roles that expose them to danger. On the other hand, females are disproportionately affected by reproductive health issues, including complications during pregnancy, unsafe abortions, and childbirth. In 2022, the male adolescent mortality rate (2 per 1,000 adolescents) exceeded that of females (Figure 3.14). Overall, mortality rates have shown a general decline over time. However, Figure 3.15 highlights that pregnancy-related mortality rates increase with age, peaking among women aged 25–29.

Figure 3. 14: Adult Mortality Rates

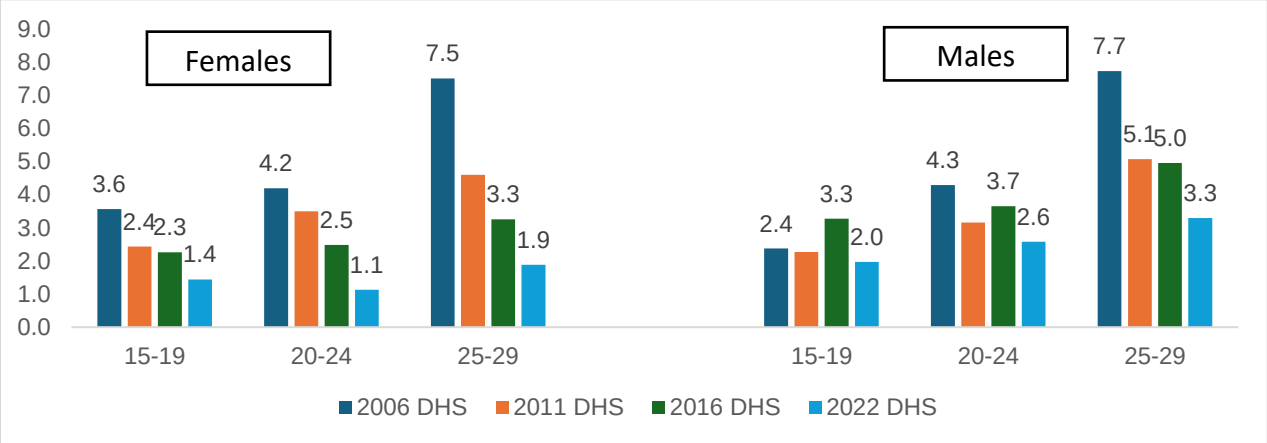
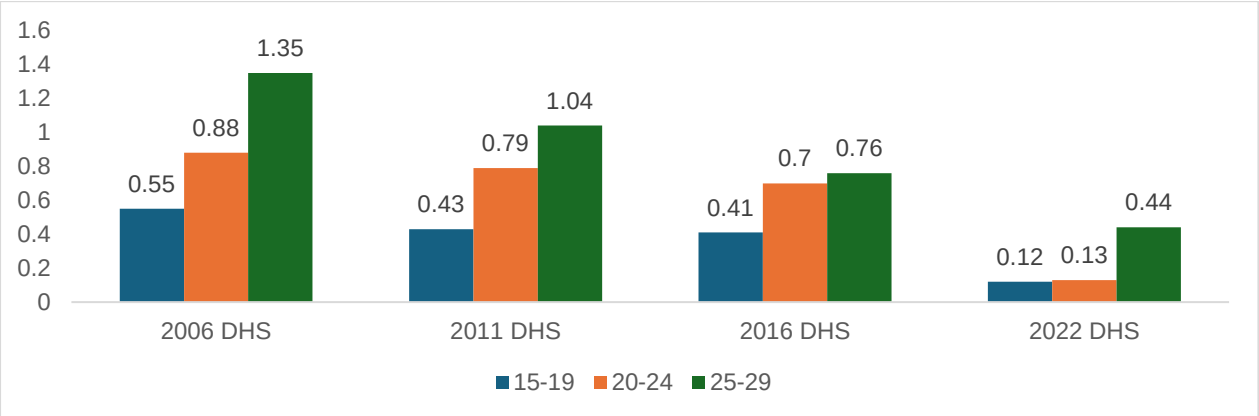


Figure 3. 15: Pregnancy related mortality rates



3.8 Conclusion

Adolescent and youth health in Uganda faces significant challenges spanning sexual and reproductive health, nutrition, substance use, and mortality. Early sexual initiation, limited access to family planning, and a high prevalence of adolescent pregnancies disrupt education, exacerbate poverty, and hinder gender equity.

Rising rates of sexually transmitted infections (STIs), inadequate contraceptive use, and limited comprehensive HIV knowledge highlight the urgent need for enhanced sexual health education, early intervention, and accessible services. Nutrition-related challenges, including undernutrition more pronounced among males further threaten young people's development.

Substance use, particularly tobacco and alcohol, though declining, continues to pose serious health and social risks. Gender disparities in mortality underline varying vulnerabilities, with males affected by risk-taking behaviors and societal roles, while females face heightened risks from reproductive health complications.

Encouraging trends, such as increased skilled birth attendance and growing contraceptive use, demonstrate progress. However, addressing persistent gaps in sexual and reproductive health services, STI prevention, nutrition, and substance use management is critical for empowering youth and fostering a healthier, more productive generation.

GENDER EQUALITY, VIOLENCE AND PROTECTION 4

4.0 Introduction

Gender equality, violence prevention, and social protection are critical components of Uganda's development agenda. UNICEF has been actively involved in addressing these issues through various initiatives and programs.

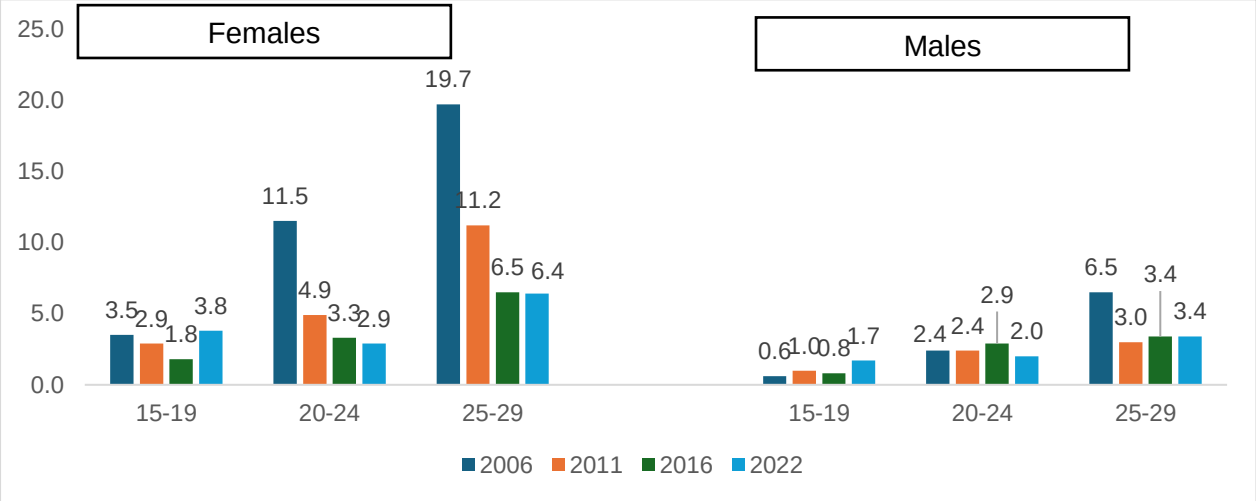
4.1 Gender equality

Gender equality, violence prevention, and social protection are pivotal to Uganda's socio-economic development. While legislative efforts and policy reforms have been initiated, persistent challenges hinder progress toward achieving gender equity and providing comprehensive safeguards for vulnerable populations, particularly women, children and youth.

4.1.1 Education

Figure 4.1 highlights gender disparities in education, showing that a higher percentage of adolescent and youth females have never attended school compared to males. This gap underscores barriers that limit girls' access to education. In 2022 about 4% of the female adolescent had never attended school compared to two percent of their male counterparts. The percentages of adolescents and youth who have never attended school have declined between 2006 and 2022.

Figure 4. 1: Percentage of adolescents and youth who have never attended school by sex

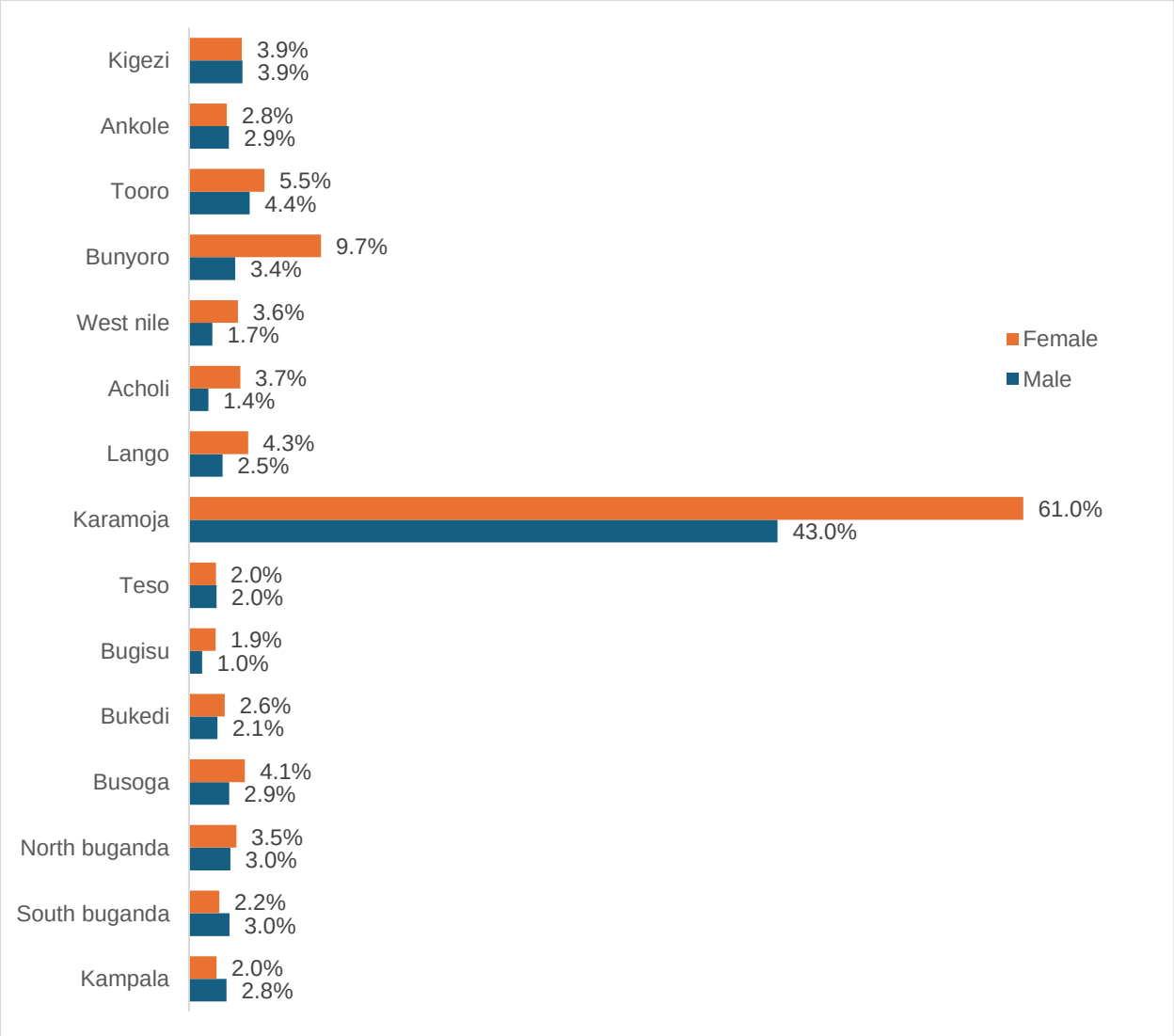


The chart shows a significant decrease in the proportion of adolescents and youths without education. For example, the proportion of female youths aged 25-29 years without education reduced from 19.7% in 2006 to 6.4% by 2022. Similarly, the proportion of male youths in the same age category without education reduced from 6.5% in 2006 to 3.4% by 2022.

The implementation of the Universal Primary Education (UPE) program partly explains the increasing school attendance—by removing tuition fees, making education more accessible to a broader population.

There are minimal gender differences in non-school attendance by the Sub-region, except in the Karamoja and Bunyoro sub-regions. Figure 4.1. 1 shows that 43% and 61% of males and females aged 15-29 years have never been to school in Karamoja in 2016; the corresponding rates for Bunyoro are 3.4% against 9.7%, respectively. As such, in 2016, Karamoja and Bunyoro accounted for 24.9% and 9.3% of males aged 15-29 years who had never been to school and for females, the rates were 27.2% and 11.1%, respectively. Hence, school non-attendance in Uganda is a heavily geographically concentrated challenge in Uganda.

Figure 4.1. a: Percentage of adolescents and youth who have never attended school by sub region, 2016

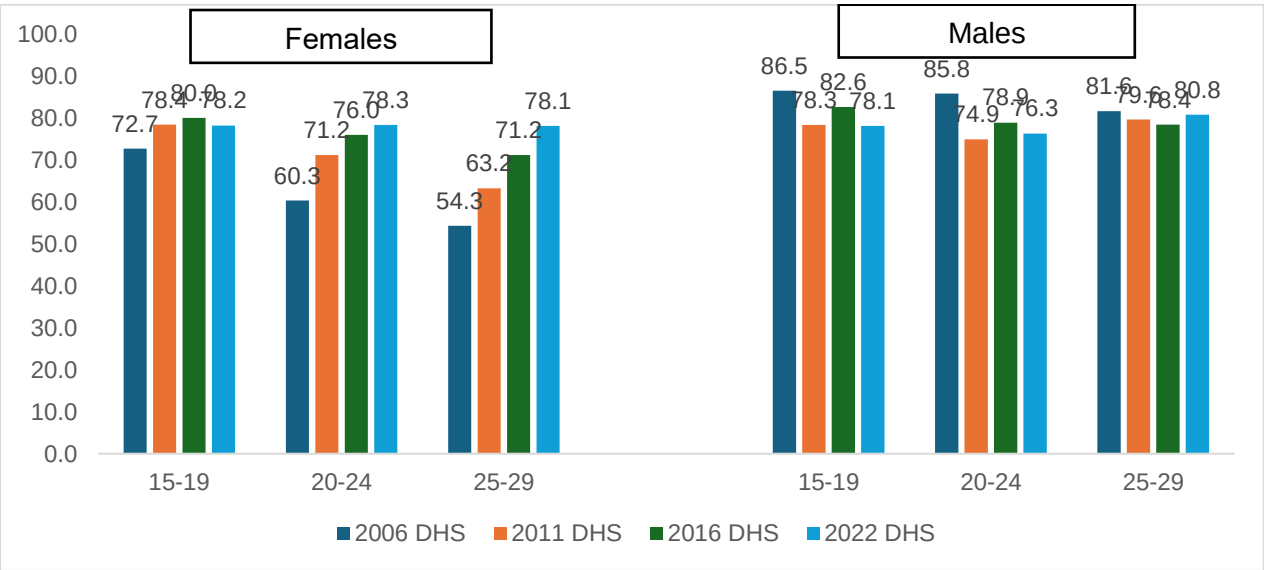


4.1.2 Literacy

The ability to read and write is an important personal asset that empowers women and men by increasing opportunities in life. Knowing the distribution of the literate population of a country can help programme managers especially those concerned with advocacy and publicity reach their targeted audiences through the right channels.

Figure 4.2 shows that men have a higher literacy level than women. In 2022, the literacy level of female adolescents was 78 percent and 78 among men. Literacy levels are highest among the 15-19 age group with male on average registering the highest.

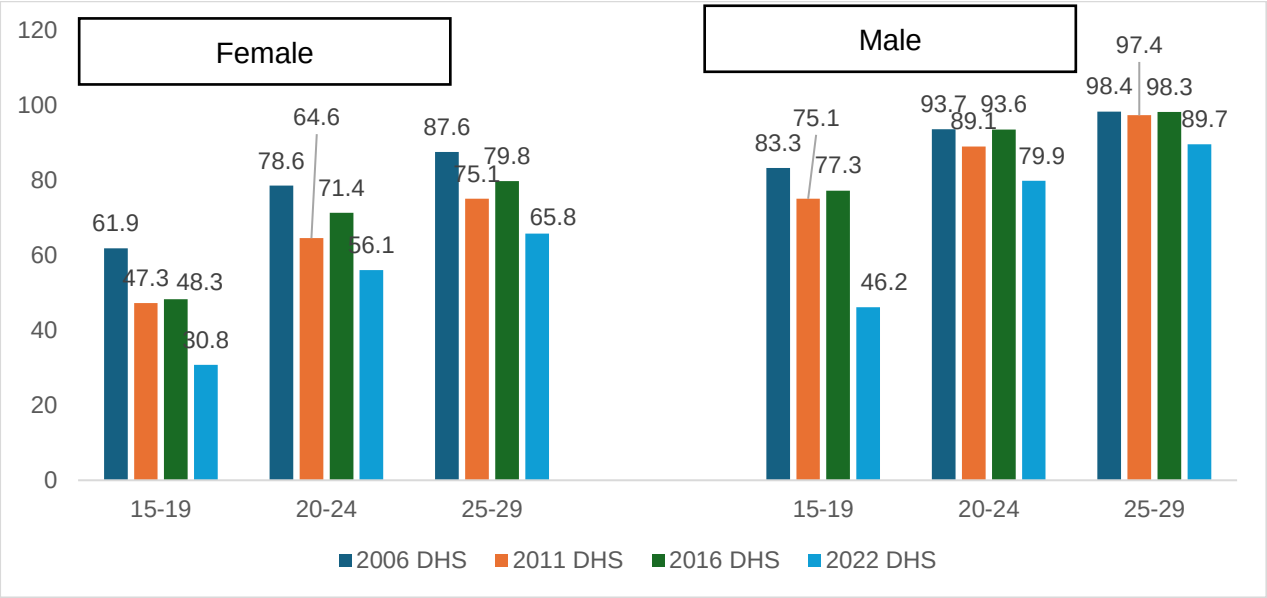
Figure 4. 2: Adolescents and youth who are literate by sex



4.1.3 Employment

The DHS has several questions regarding employment status, including whether respondents were working during the seven days preceding the survey and, if not, whether they had worked in the 12 months before the survey. The results for adolescents and youth who were employed in the last 12 are presented in Figure 4.3. In 2022, about 31% of female adolescents were currently employed compared to 46% of the males. This is an age group that adolescents are expected to be in school.

Figure 4. 3: Adolescents and youth who were employed in the last 12months before the survey by sex



4.2 Violence

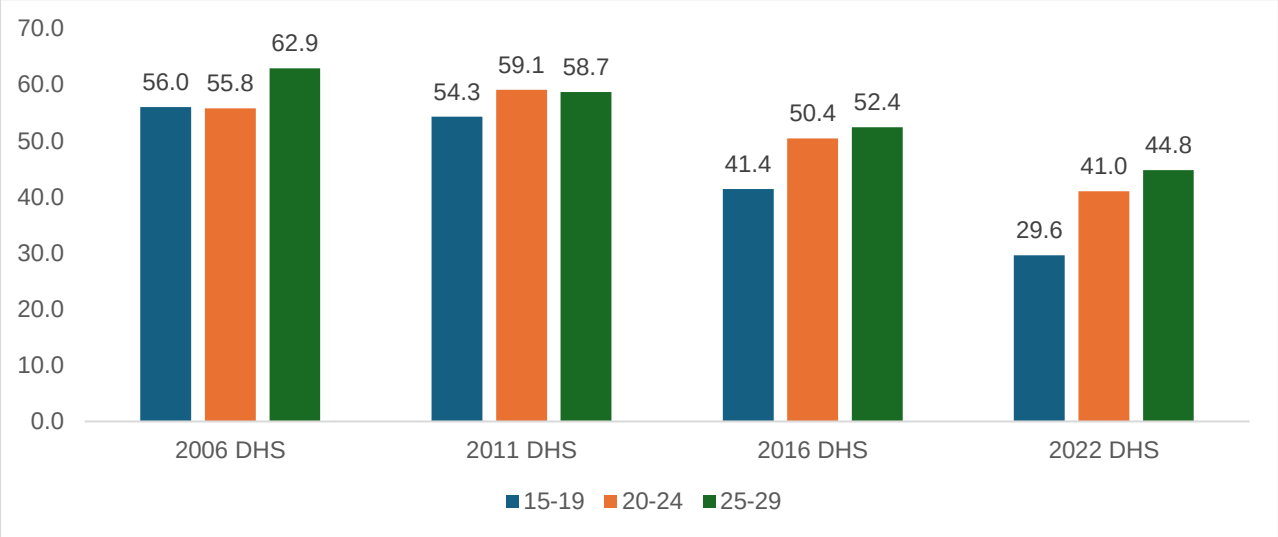
Gender-based violence (GBV) remains a pervasive issue in Uganda, affecting women and girls disproportionately. Forms of GBV include domestic violence, sexual violence, female genital mutilation (FGM) and child marriage. According to recent surveys, a significant proportion of women report experiencing physical or sexual violence in their lifetime. Such violence has far-reaching consequences, including physical and psychological harm, economic loss, and societal instability.

4.2.1 Physical Violence

Physical violence experienced by adolescents and youth, particularly from the age of 15, can have profound consequences on their development and overall well-being. This type of violence can lead to emotional trauma, diminished self-esteem, and difficulties in forming healthy relationships. Moreover, it can heighten the likelihood of future violent behaviors and contribute to both mental and physical health problems. Addressing and preventing violence during these critical years is essential for supporting healthy development and minimizing long-term harm.

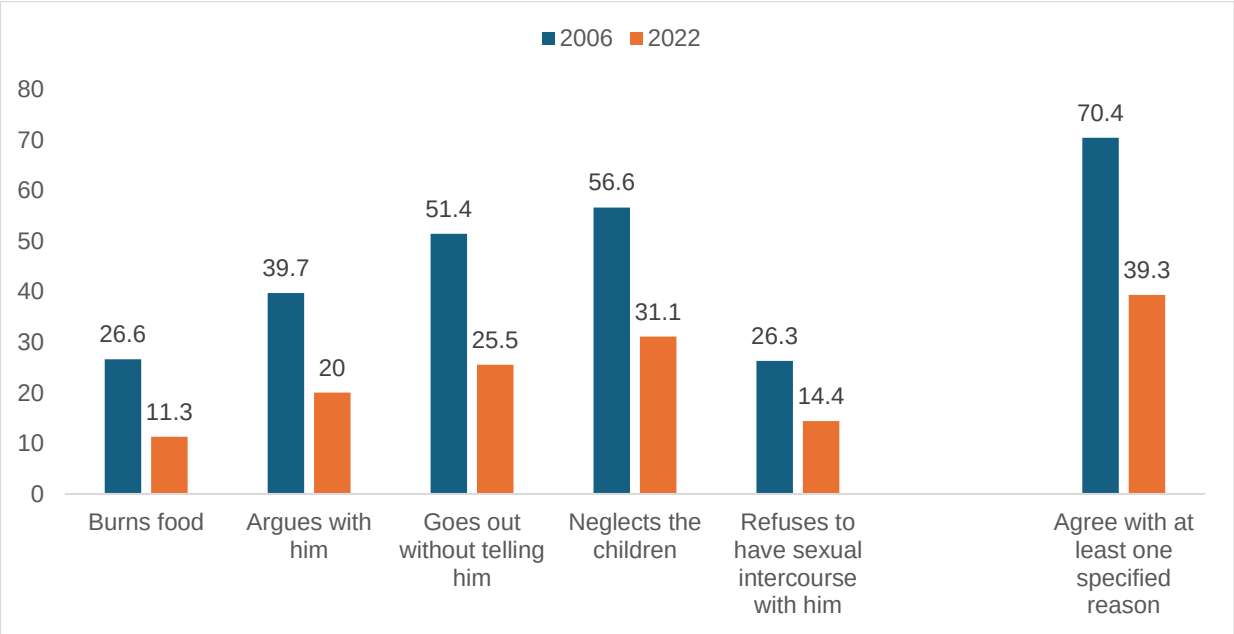
Figure 4.4 illustrates the distribution of adolescents and youth who have encountered physical violence since the age of 15. In 2022, approximately 30% of adolescents experienced physical violence during this period, down from 56% in 2006. Similar trends are observed for the 20-24 and 25-29 age categories.

Figure 4. 4: Percentage of female adolescents and youth ever experienced physical violence since age 15



Research by Wado et al (2021) shows that there has been a shift in societal attitudes towards violence, with increased disapproval of gender-based violence and intimate partner violence by young women in sub-Saharan Africa.[x] Changing adolescent attitudes toward wife beating in Uganda partly demonstrate these cultural shifts. Figure 4.4. a shows the trends in attitudes among women aged 15-19 regarding domestic violence, specifically focusing on the justification of a husband hitting or beating his wife. The proportion of adolescents who agree with at least one of the specified reasons reduced from 70.4% to 39.3%.

Figure 4.4. a: Percentage of all women age 15-19 who agree that a husband is justified in hitting or beating his wife for specific reasons

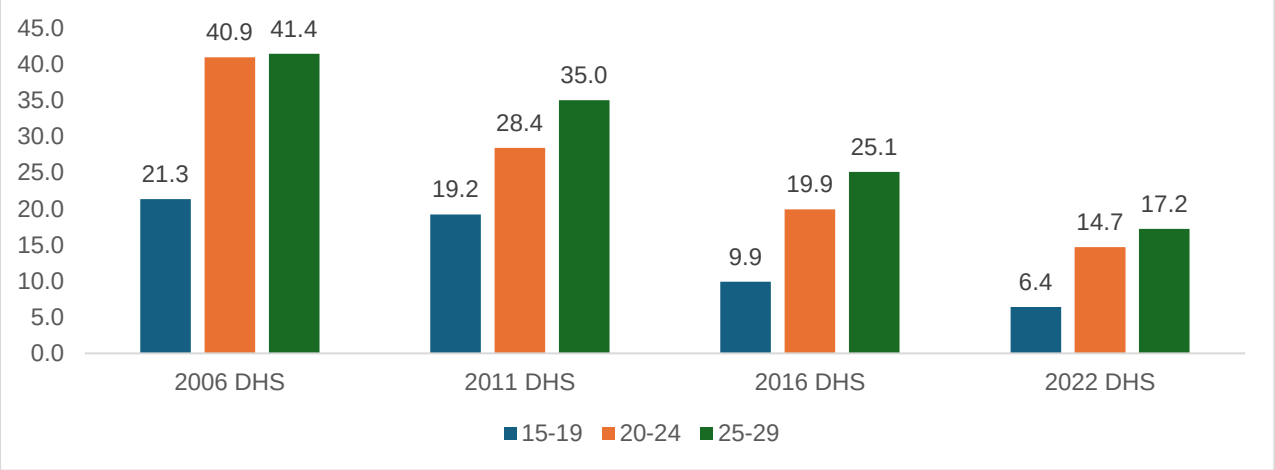


4.2.2 Sexual Violence

Adolescents and youth who experience sexual violence face significant emotional, physical, and psychological challenges, including trauma, depression, and potential physical injuries like sexually transmitted infections or unintended pregnancies. Factors such as gender inequality, poverty, and exposure to violence increase the risk for these young individuals, particularly girls. Barriers to reporting, such as fear of stigma, retaliation, or lack of trust in authorities, often prevent them from seeking help. Comprehensive sexual education, accessible healthcare, legal support, and community-based interventions are essential to preventing sexual violence and providing survivors with the necessary tools for recovery and empowerment.

Figure 4.5 shows the distribution of adolescents and youth who have ever experienced sexual violence. Similar to the experience of physical violence, there is a dramatic fall in experience of sexual violence for all age categories. For example, in 2022, about 6% of the female adolescents had ever experienced sexual violence, down from 26.6% in 2006. Research points to increased educational attainment as a factor in the decline in sexual violence among Ugandan adolescents and youth. Behrman et al. (2017) show that in Uganda and Malawi, education empowers women and girls, enhances their decision-making capacity, reduces early marriage, and shifts societal norms, which collectively contribute to reducing their vulnerability to sexual violence.[xi] The results also show that the prevalence of sexual violence increases with an increase in age since 2011.

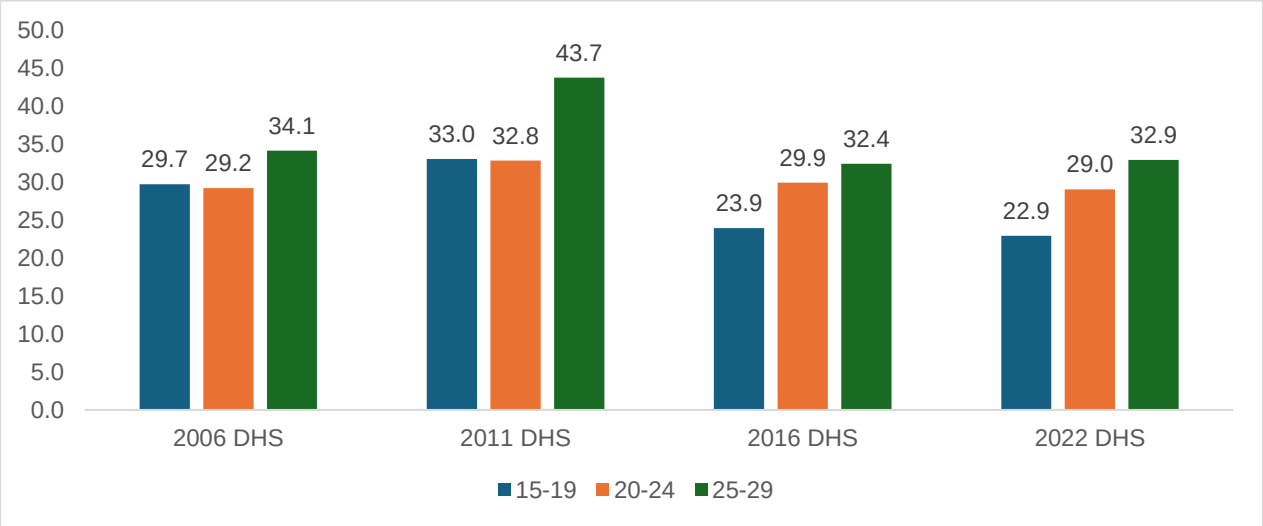
Figure 4. 5: Percentage of female adolescents and youth ever experienced sexual violence



Only 23% of the adolescents who had experienced violence sought help to stop violence (Figure 4.6). Several reasons explain why a large proportion of adolescents and youth and women overall in Uganda experiencing violence do not seek help. Patriarchal norms and societal expectations often discourage women from reporting violence. Gardsbane et al. (2021) show that women are socialized to accept certain forms of abuse as normal, and reporting is seen as bringing shame to the family rather than addressing the perpetrator's actions.[xii]

Economic dependency on the abuser and logistical challenges, such as distance to support services, further inhibits women from seeking help (Ghose and Yaha, 2019).[xiii] The authors also show that the drinking habits of partners are a significant barrier, as they are associated with increased IPV and reduced likelihood of seeking help. Indeed, the 2022 UDHS shows that 84% of women whose husbands are often drunk have ever experienced physical, sexual, or emotional violence, compared with 44% of women whose husbands do not drink alcohol.

Figure 4. 6: Percentage of female adolescents and youth ever sought help to stop violence

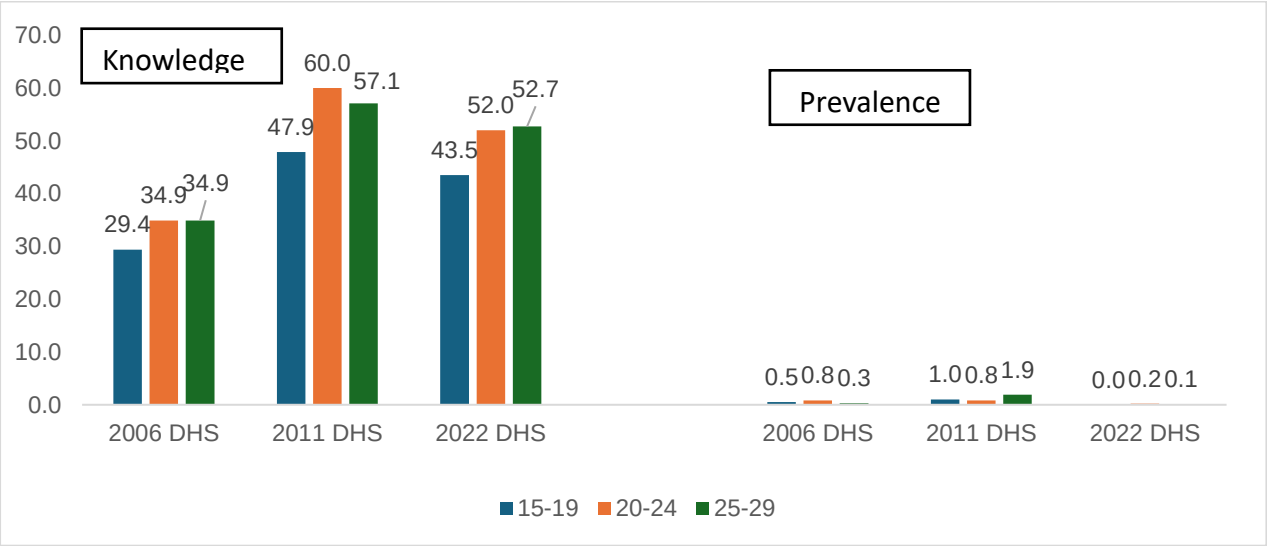


4.2.3 Female Genital Mutilation

Female Genital Mutilation (FGM) refers to the partial or complete removal of external female genitalia. It is a harmful practice with no health benefits, and it can cause a range of physical, psychological, and emotional consequences. FGM is typically carried out on girls between infancy and 15 years old. It is deeply rooted in cultural, social, and religious traditions. The practice is illegal in Uganda due to its severe health risks, which include infection, childbirth complications, and long-term trauma. Efforts to eradicate FGM focus on education, legislation, and supporting communities in abandoning the practice.

Women interviewed during the UDHS were asked whether they had ever heard of female circumcision. Those who had heard were asked if they were circumcised. The results show that 44 percent of adolescents had heard of female circumcision in 2022, an increase from 29 percent during the 2006 UDHS. Prevalence of female circumcision in Uganda is generally low with less than one percent of adolescents circumcised (Figure 4.7). The 2022 UDHS shows that most of the women who have experienced FGM are in Karamoja and Elgon sub regions—2.2% and 2.1% respectively.

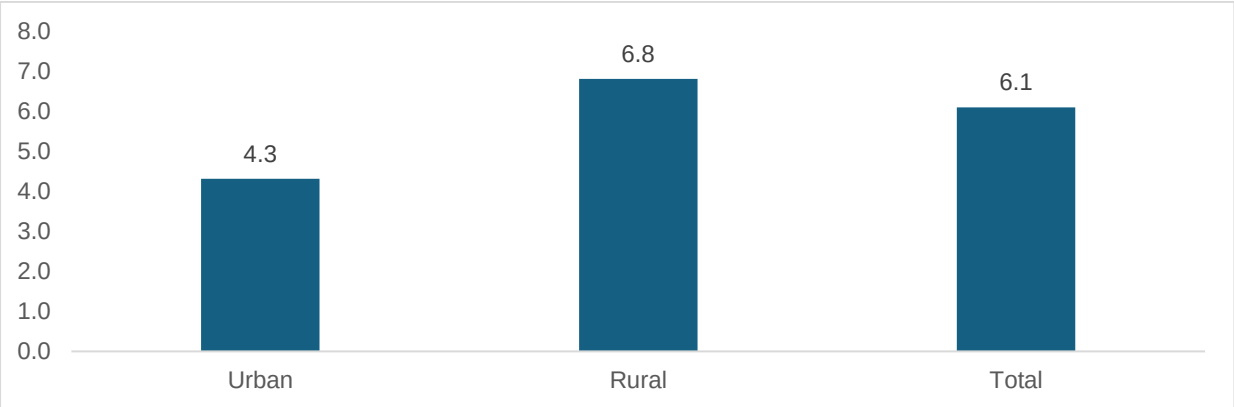
Figure 4. 7: Adolescents and youth who have ever heard and experienced FGM



4.3 Child marriage

The 1995 Constitution of Uganda guarantees the right to family and marriage, setting the minimum legal age for marriage at 18 for both males and females. Despite this legal framework, child marriage continues to be widespread among various ethnic groups in the country. This practice is closely linked to challenges like teenage pregnancies and high birth rates. As shown in Figure 4.8, child marriage remains a significant issue in Uganda, particularly in rural areas, with a prevalence rate of 7 percent. The persistence of child marriage has serious consequences, including increased health risks for young girls, such as maternal mortality and complications during childbirth. It also limits girls' access to education.

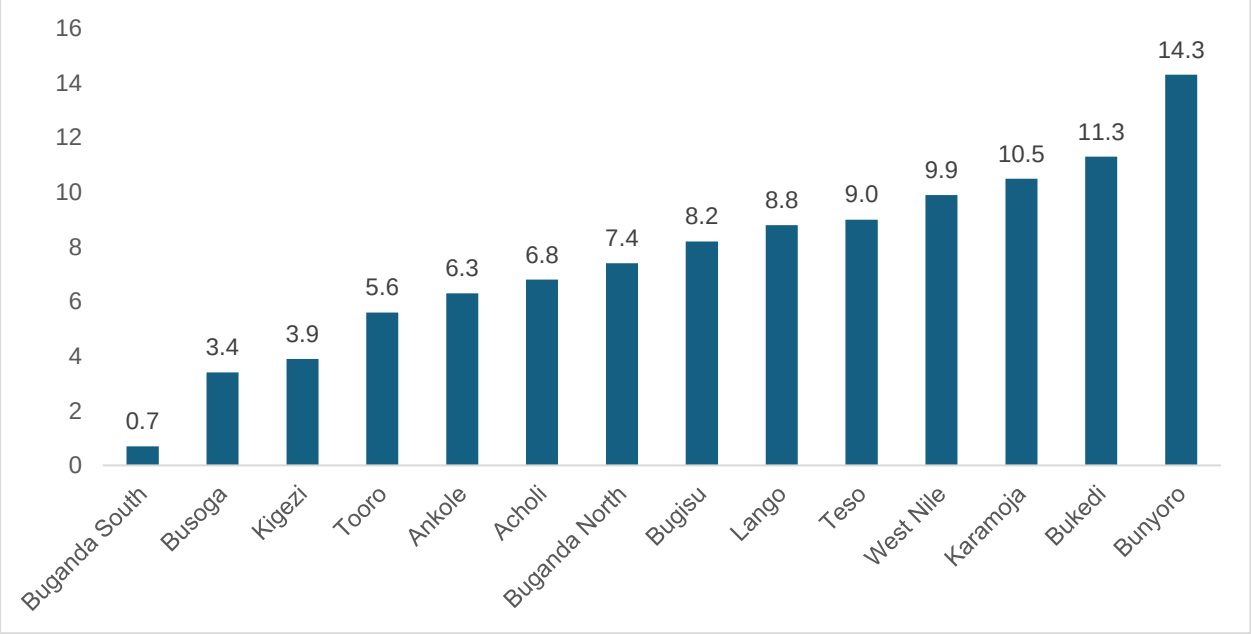
Figure 4. 8: Percentage of female Children (15-17 years) in marriage (2022)



Although the minimum legal age for a woman to get married is 18 years in Uganda, marriage among young girls is a common practice. Among women aged 20-49, in 2022 three percent of the adolescent were married by age 15 (Figure 4.9). Female adolescents and youth are likely to be married at a younger age compared to their male counterparts.

Child marriage is mainly a rural phenomenon and concentrated in specific sub regions of Uganda. Figure 4.9, which shows the percentage of female children in rural areas in marriage in 2016, shows that in four sub-regions—notably Karamoja, West Nile, Bukedi and Bunyoro, about one in every ten female children in the rural areas are in marriage. School dropouts are both a cause and consequence of child marriage in Uganda. Neema et al. (2021) show that girls who leave school early are more likely to marry young, and marriage often leads to further educational discontinuation.[xiv] According to the 2016 UDHS, for the rural female children who are married, 3.7% have no education, 88.4% have primary as the highest level of education, and 7.9% have secondary as the highest level of education. Hence, higher rates of early marriage correlate with lower educational attainment.

Figure 4. 9: Percentage of rural female children (15-17 years) in marriage, UDHS 2016



4.4 Child Protection

Protection against violence for adolescents and youth in Uganda remains a critical concern, given the widespread prevalence of gender-based violence (GBV), child abuse, and exploitation. Violence, particularly in the form of physical, sexual, and emotional abuse, has severe consequences for the health, well-being, and prospects of young people. UNICEF plays a vital role in protecting young people by strengthening child protection systems, creating safe spaces in schools, and supporting survivors with health care, legal assistance, and psychosocial support. It also works on raising awareness, advocating for stronger laws, and engages communities in preventing violence.

EDUCATION AND SKILLING 5

5.0 Introduction

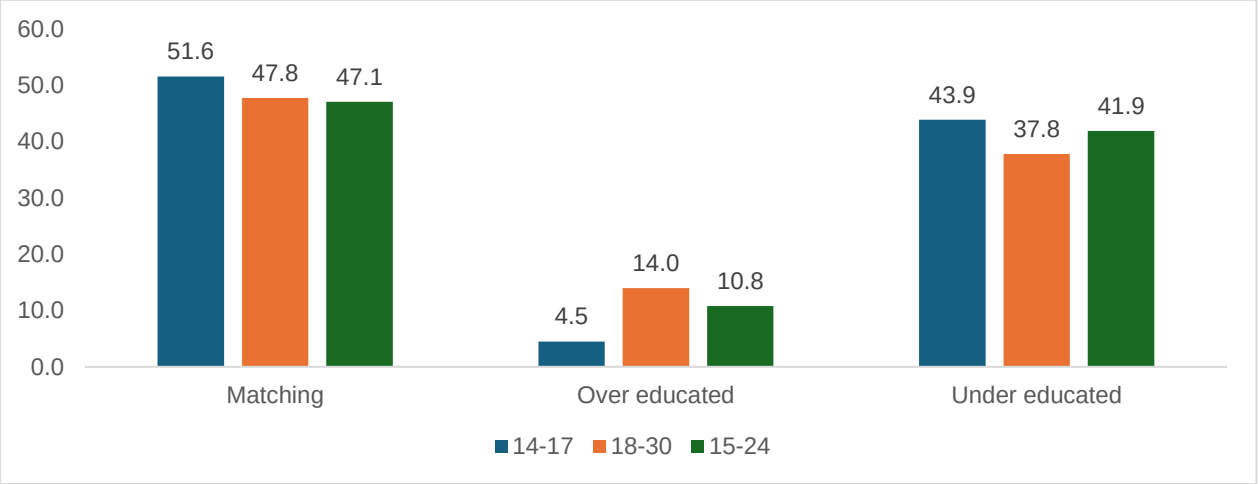
Despite the introduction of Universal Primary Education in 1997 and Universal Secondary Education (USE) in 2007, challenges such as high dropout rates and disparities in education quality continue to affect Uganda's education system. To address these challenges and equip youth with practical skills, Uganda has made Technical and Vocational Education and Training (TVET) a priority. In collaboration with the Ugandan government, UNICEF works to improve access to education and enhance its quality, with a focus on marginalized groups. Key initiatives include the development of inclusive policies, strengthening early childhood education, and ensuring that schools are safe and adequately resourced. By combining formal education with vocational training, Uganda seeks to empower its youth with the necessary skills for employment and entrepreneurship, driving socio-economic growth.

5.1 Skill mismatch among adolescents and youth

Skills mismatch is a discrepancy between the skills that are sought by employers and the skills that are possessed by individuals, that is, imbalances between skills offered and skills needed in the world of work. Educational mismatch is defined as the discrepancy between the worker's level of education and the level of education which is required for the job in the Labour market.

Figure 5.1 shows that about 42 percent of the youth (15-24 years) in employment were under-educated for the jobs they were holding, i.e. have lower educational qualifications than what is required for a job. This mismatch is exacerbated by the lack of transition opportunities into education-matching jobs. The skills mismatch among the youth in Uganda is primarily due to a combination of factors. Many Ugandan educational programs do not align with contemporary job market demands. The curricula often lack practical and relevant skills, leaving graduates under prepared for employment opportunities (Mukembo et al., 2020). xv On the other hand, Tukundane et al. (2015) note that many youths rely on social networks to find employment, and those without such networks face significant challenges.xvi Furthermore, current TVET practices often cannot equip students with the necessary skills for available jobs.

Figure 5. 1: Education mismatch of the population in employment

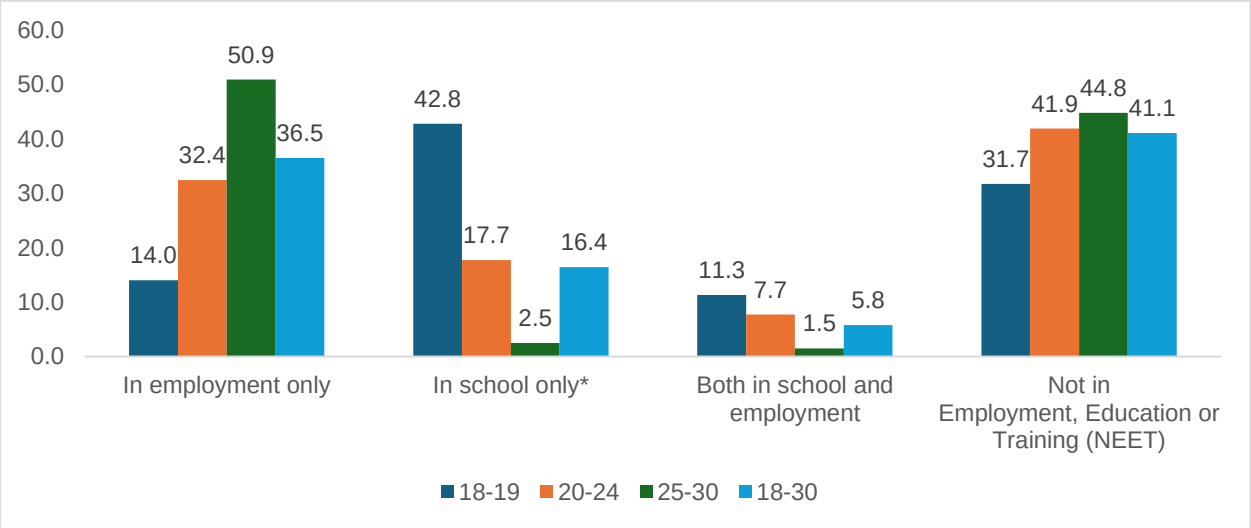


Source: National Labour Force Survey, 2021

5.2 Not in Employment, Education or Training

This section classifies the economic status of the youth into four categories i.e., youth in education, those who are in employment and no longer attending school, those in employment and attend school and those Not in Employment, Education or Training (NEET). Figure 5.2 shows that among the Ugandan Youth aged 18 to 30 years 37 percent were no longer in school and were in employment, while 16 percent were still in school and about 41 percent were neither in employment nor education training (NEETs). The large proportion of youths who are NEETs in Uganda reflects vulnerabilities such as unemployment, early school leaving, and labor market discouragement—where individuals stop actively seeking employment because of perceived poor chances of finding a suitable job.

Figure 5. 2: Percentage Distribution of Youths Activity Status



Source: National Labour Force Survey, 2021

WATER, SANITATION AND HYGIENE 6

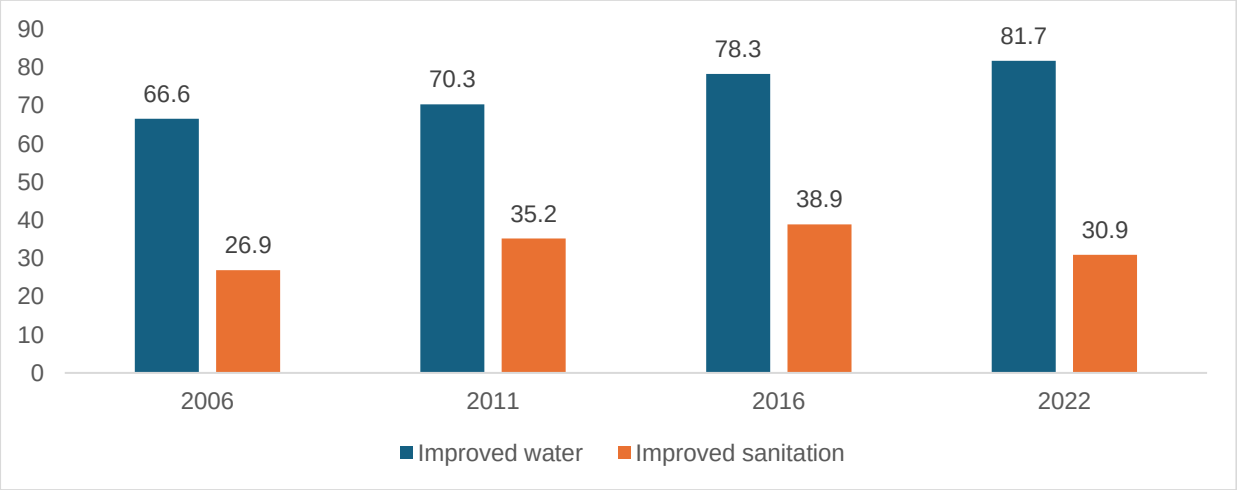
6.0 Introduction

In Uganda, inadequate Water, Sanitation, and Hygiene (WASH) infrastructure contributes to widespread waterborne diseases, particularly in rural areas, affecting public health and economic growth. Children under five and schoolgirls are especially vulnerable due to limited access to clean water, sanitation facilities, and menstrual hygiene management. Addressing these issues through improved infrastructure, education, and behavior change is essential for enhancing health outcomes and advancing Uganda's development goals.

6.1 Water

The proportion of households accessing improved drinking water sources increased by 15%, rising from 67% in 2006 to 82% in 2022 (Figure 6.1). Thirty-one percent of the households had improved sanitation facilities. This progress has significant implications for public health, as greater access to clean water reduces the prevalence of waterborne diseases, improves overall hygiene, and enhances quality of life. However, the remaining 18% without access underscores the need for continued investment in water infrastructure and equitable distribution to achieve universal coverage and maximize health benefits.

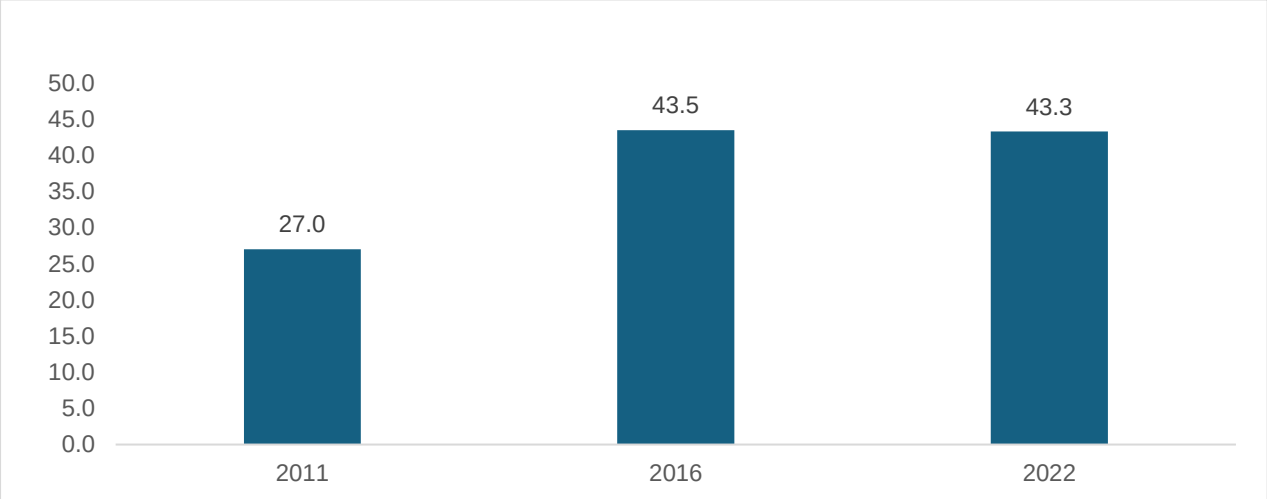
Figure 6. 1: Trends of improved drinking water source and sanitation (%)



6.2 Hygiene

Hand washing with soap and water is recognized as a top priority for hygiene in all settings. It is also considered a suitable indicator for national and global hygiene monitoring. Figure 6.2 shows that in 2022, the percentage of households with a place for hand washing with soap and water was 43% and increase from 27% in 2011.

Figure 6. 2: Percentage of households with a place for washing hands with soap and water



APPENDIX

Appendix 1: Educational attainment of the Male household population (2022)

Background characteristic	15-19			15-24			18-30		
	No education	Primary	Secondary and more	No education	Primary	Secondary and more	No education	Primary	Secondary and more
Residence									
Urban	3.9	53.1	43.0	3.8	45.5	50.0	4.1	34.6	61.3
Rural	4.1	78.2	17.7	4.3	71.1	24.4	5.1	59.2	35.7
Region									
Kampala	2.5	31.7	65.8	2.1	23.9	72.9	2.0	17.1	80.9
Buganda	3.4	51.7	44.4	3.8	47.3	48.2	4.2	40.3	55.5
Busoga	1.3	77.9	20.8	1.8	69.5	28.7	3.2	56.8	40.1
Bukedi	2.1	80.4	17.8	2.3	72.0	25.6	3.2	63.6	33.3
Elgon	1.0	79.3	19.7	1.2	68.7	30.1	1.4	53.3	45.3
Teso	4.5	77.7	17.8	3.9	71.0	24.6	3.0	56.8	40.2
Karamoja	24.7	68.4	7.2	25.8	54.9	19.3	30.3	41.1	28.6
Lango	3.7	88.0	8.3	3.5	80.8	15.7	4.3	66.1	29.6
Acholi	3.4	80.4	16.2	3.4	69.8	26.7	3.5	50.4	46.2
West Nile	5.6	82.4	12.0	5.6	73.0	21.3	5.9	59.7	34.4
Bunyoro	4.2	72.5	23.3	4.9	65.4	29.7	4.8	58.0	37.2
Toro	4.9	70.3	24.8	3.9	65.0	30.7	4.0	53.3	42.7
Ankole	5.4	79.9	14.7	5.5	71.6	21.8	5.7	59.8	34.5
Kigezi	4.2	74.6	21.3	5.2	67.2	27.2	4.8	55.3	39.9
Wealth quintile									
Lowest	9.2	83.2	7.6	8.5	78.0	13.3	9.4	68.2	22.4
Second	2.6	83.5	13.9	2.9	76.6	20.3	3.3	66.0	30.7
Middle	2.6	79.2	18.2	2.7	71.9	25.1	3.2	59.6	37.2
Fourth	3.5	66.5	30.0	4.1	57.0	38.7	5.3	42.5	52.2
Highest	3.2	46.7	50.2	3.0	37.9	58.3	3.0	25.3	71.7
Total	**4.0**	**72.0**	**24.0**	**4.1**	**63.8**	**31.7**	**4.8**	**51.1**	**44.1**

Appendix 2: Educational attainment of the Female household population (2022)

Background characteristic	15-19			15-24			18-30		
	No education	Primary	Secondary and more	No education	Primary	Secondary and more	No education	Primary	Secondary and more
Residence									
Urban	3.8	51.8	44.5	3.4	43.7	52.9	3.7	37.2	59.1
Rural	4.7	71.5	23.8	5.6	65.6	28.9	7.9	60.1	32.0
Region									
Kampala	2.9	39.1	58.0	2.4	30.3	67.4	3.0	24.4	72.7
Buganda	2.0	44.9	53.0	2.5	38.9	58.7	3.6	36.3	60.1
Busoga	1.0	64.4	34.6	1.1	61.8	37.1	1.8	57.3	41.0
Bukedi	1.0	73.2	25.9	1.5	72.1	26.5	2.4	69.9	27.7
Elgon	0.0	71.8	28.2	0.9	61.7	37.5	2.2	53.7	44.1
Teso	0.3	79.5	20.2	1.3	70.0	28.7	2.2	63.8	34.0
Karamoja	45.3	45.6	9.1	45.8	40.4	13.7	48.7	34.6	16.8
Lango	4.2	86.2	9.7	4.5	80.6	15.0	5.6	75.4	19.1
Acholi	3.2	82.9	13.9	3.4	75.6	21.0	4.0	65.5	30.5
West Nile	10.4	79.0	10.7	8.8	75.0	16.2	8.7	68.4	22.9
Bunyoro	7.2	72.9	19.9	7.4	64.6	28.0	7.9	58.5	33.6
Toro	7.0	67.2	25.8	5.3	62.1	32.7	5.8	57.5	36.7
Ankole	4.0	71.2	24.8	3.5	63.2	33.4	5.0	58.7	36.3
Kigezi	2.2	72.5	25.3	1.9	64.9	33.2	2.4	54.9	42.7
Wealth quintile									
Lowest	12.5	80.1	7.5	14.1	74.8	11.1	17.8	69.9	12.3
Second	3.0	81.2	15.8	3.2	75.6	21.2	4.3	69.8	26.0
Middle	2.4	73.6	24.1	3.0	66.3	30.7	4.5	60.1	35.4
Fourth	3.0	59.0	38.0	2.8	52.0	45.2	3.2	48.1	48.8
Highest	2.8	41.0	56.3	2.5	32.4	65.2	3.0	24.3	72.7
Total	**4.4**	**65.4**	**30.2**	**4.9**	**58.4**	**36.8**	**6.4**	**52.0**	**41.6**

Appendix 3: Percentage of youth women assisted by a skilled provider during delivery, according to background characteristics (2022)

	15-19	15-24	18-30
Sex of child			
Male	87.5	89.4	89.8
Female	92.6	89.2	88.9
Birth order			
1	92.9	94.0	94.1
2-3	78.2	85.3	88.2
4+		84.1	86.9
Place of residence			
Urban	87.9	93.1	93.4
Rural	91.0	87.7	87.6
Mothers Education			
No education	92.1	85.0	83.5
Primary	88.5	86.7	86.4
Secondary	95.0	94.7	94.6
More than secondary		97.5	97.7
Region			
Kampala	93.0	94.0	96.4
Buganda	88.4	92.4	91.9
Busoga	89.2	89.3	88.2
Bukedi	88.8	84.0	84.0
Elgon	89.0	87.4	88.7
Teso	94.4	84.3	85.4
Karamoja	100.0	89.6	90.4
Lango	83.9	89.2	89.2
Acholi	98.4	91.1	90.5
West nile	93.9	88.8	89.1
Bunyoro	85.5	89.4	87.9
Tooro	91.8	87.9	87.3
Ankole	96.0	89.0	88.3
Kigezi	89.4	88.5	90.5
Wealth quintile			
Lowest	85.3	85.0	85.2
Second	89.8	87.7	84.5
Middle	91.6	88.6	89.3
Fourth	92.9	90.6	91.7
Highest	93.2	96.6	97.0
Total	90.1	89.3	89.3

***Appendix 4:** Percentage of youth women with knowledge and experienced Fistula, according to background characteristics (2022)*

	Fistula knowledge and experience					
	Knowledge			experienced symptoms of fistula		
	15-19	15-24	18-30	15-19	15-24	18-30
Place of residence						
Urban	44.9	55.1	68.6	0.2	0.3	0.4
Rural	30.4	39.6	51.9	0.2	0.3	0.5
Mothers Education						
No education	12.2	19.7	29.1	0.0	0.3	0.3
Primary	29.0	38.0	52.9	0.3	0.3	0.4
Secondary	48.8	56.9	66.1	0.1	0.3	0.5
More than secondary	57.7	67.4	76.8	0.0	0.0	0.0
Region						
Kampala	54.1	63.6	75.3	0.0	0.2	0.3
Buganda	55.5	65.8	79.3	0.1	0.5	0.6
Busoga	39.7	51.8	66.7	0.7	0.4	0.6
Bukedi	33.1	36.2	42.9	0.0	0.2	0.2
Elgon	34.2	41.2	46.6	0.0	0.3	0.4
Teso	36.0	49.3	67.3	0.0	0.0	0.2
Karamoja	12.6	17.4	23.6	0.0	0.3	0.7
Lango	16.2	22.4	32.2	0.0	0.2	0.7
Acholi	23.2	29.2	41.6	0.0	0.3	0.7
West nile	32.9	40.3	53.2	0.0	0.0	0.5
Bunyoro	28.8	37.9	50.8	1.3	0.7	0.2
Tooro	27.7	35.3	46.0	0.0	0.1	0.1
Ankole	14.4	29.9	52.0	0.0	0.0	0.0
Kigezi	17.6	32.7	48.8	0.6	0.7	0.3
Wealth quintile						
Lowest	25.9	34.1	43.1	0.3	0.4	0.6
Second	29.0	37.1	50.7	0.1	0.2	0.5
Middle	29.9	41.8	55.4	0.4	0.4	0.2
Fourth	35.0	45.4	61.2	0.2	0.4	0.7
Highest	50.1	59.7	72.9	0.0	0.1	0.3
Total	34.9	44.7	57.9	0.2	0.3	0.4

Appendix 5: Percentage of Adolescent Women (15-19) with, mean body mass index (BMI), and the percentage with specific BMI levels, according to background characteristics, (2022)

Adolescent ***Women (15-19)***	**(mean) BMI**	**Thin (<18.5)**	**Normal (18.5-24.9)**	**Over-weight (25-29.5)**	**Obese (>=30)**	**Overweight Or Obese**	**Number of Adolescents**
Residence							
Urban	22.1	7.4	78.4	10.7	3.4	14.2	427
Rural	21.5	12.1	77.8	8.5	1.5	10.1	911
Education Level							
No Education	20.8	6.1	91.7	2.2	0.0	2.2	37
Primary	21.3	13.2	77.4	7.6	1.8	9.4	877
Secondary	22.6	5.8	77.7	13.2	3.2	16.4	407
Higher	22.2	*	*	*	*	*	**17**
Wealth-Quintile							
Poorest	20.7	15.2	80.3	3.2	1.3	4.5	233
Poorer	21.0	14.1	76.6	8.4	0.9	9.3	266
Middle	21.3	14.0	77.0	8.2	0.8	9.0	260
Rich	22.1	8.2	78.7	10.2	2.8	13.0	272
Richest	23.0	3.2	77.8	14.6	4.4	19.0	311
Sub-Regions							
Kampala	23.4	2.3	67.1	21.0	9.7	30.7	56
Buganda	22.6	3.0	83.0	11.1	2.9	14.0	283
Busoga	21.6	10.1	79.5	5.6	4.9	10.4	121
Bukedi	21.1	14.0	80.8	5.1	0.0	5.1	101
Bugisu	21.0	14.4	78.9	6.7	0.0	6.7	56
Teso	20.3	27.3	65.2	7.4	0.0	7.4	114
Karamoja	20.2	11.3	86.2	0.0	2.5	2.5	45
Lango	21.1	9.6	84.6	5.8	0.0	5.8	117
Acholi	20.2	21.5	75.1	3.4	0.0	3.4	68
West Nile	20.3	19.6	79.2	1.2	0.0	1.2	60
Bunyoro	21.4	12.3	79.4	8.3	0.0	8.3	72
Tooro	22.2	6.8	76.2	14.9	2.1	17.0	88
Ankole	23.1	5.4	72.4	17.9	4.3	22.2	114
Kigezi	22.4	5.8	75.0	16.3	3.0	19.3	47
Uganda	**21.7**	**10.6**	**78.0**	**9.3**	**2.1**	**11.4**	**1,342**

Appendix 6: Percentage of Youthful Women (18-30) with, mean body mass index (BMI), and the percentage with specific BMI levels, according to background characteristics, (2022)

.Background Characteristics *Women 18-30*	(mean) BMI	Thin (<18.5)	Normal (18.5-24.9)	Over-weight (25-29.5)	Obese (>=30)	Overweight Or Obese	Number of Youths
Residence							
Urban	23.7	5.4	64.2	21.4	9.0	30.4	1,025
Rural	22.2	9.9	74.2	12.7	3.3	16.0	1,902
Education level							
No Education	20.8	18.6	76.0	3.3	2.2	5.4	149
Primary	22.4	8.1	73.6	14.6	3.7	18.3	1,570
Secondary	23.2	7.0	67.8	17.6	7.6	25.2	1,032
Higher	23.9	9.0	57.3	24.8	8.9	33.7	176
Wealth Quintile							
Poorest	20.9	16.2	77.3	5.7	0.8	6.4	567
Poorer	21.8	10.5	76.3	11.5	1.7	13.3	514
Middle	22.6	6.4	75.9	15.2	2.5	17.7	536
Rich	23.3	6.3	67.9	19.7	6.1	25.8	545
Richest	24.3	3.7	60.5	23.4	12.4	35.8	768
Sub-Regions							
Kampala	24.5	3.6	56.6	28.5	11.3	39.8	152
Buganda	23.7	5.4	65.4	20.7	8.6	29.3	730
Busoga	22.1	10.2	72.8	12.9	4.0	17.0	238
Bukedi	21.6	10.7	79.4	7.9	2.0	9.9	168
Bugisu	22.2	8.6	76.8	10.9	3.8	14.6	145
Teso	21.2	16.7	74.8	6.6	1.9	8.5	206
Karamoja	20.4	23.7	72.1	0.0	4.2	4.2	168
Lango	21.3	7.5	85.7	6.2	0.6	6.8	224
Acholi	21.6	8.9	77.5	11.1	2.5	13.6	120
West Nile	21.5	12.2	78.7	9.1	0.0	9.1	125
Bunyoro	23.2	6.9	67.0	18.4	7.7	26.1	170
Tooro	23.7	5.2	66.0	23.7	5.1	28.8	195
Ankole	24.3	2.1	62.3	28.1	7.5	35.6	196
Kigezi	24.0	0.8	72.2	22.5	4.5	27.0	92
Uganda	**22.7**	**8.3**	**70.7**	**15.7**	**5.3**	**21.0**	**2,929**

Appendix 7: Percentage of Youthful Women (15-24) with, mean body mass index (BMI), and the percentage with specific BMI levels, according to background characteristics (2022)

Background Characteristics *Women (15-24)*	**(mean) BMI**	**Thin (<18.5)**	**Normal (18.5-24.9)**	**Over-weight (25-29.5)**	**Obese (>=30)**	**Overweight/ Obese**	**Number of Women**
Residence							
Urban	22.6	6.8	74.1	14.1	5.0	19.1	828
Rural	21.7	10.6	77.9	9.5	1.9	11.5	1,687
Education							
No Education	20.5	11.7	85.1	3.2	0.0	3.2	90
Primary	21.7	11.1	77.3	9.8	1.8	11.6	1,500
Secondary	22.7	6.0	75.5	13.4	5.1	18.5	837
Higher	23.0	8.8	68.5	18.5	4.2	22.7	88
Wealth Quintile							
Poorest	20.7	16.2	79.3	3.8	0.7	4.5	439
Poorer	21.2	12.4	78.3	8.8	0.5	9.4	471
Middle	21.9	9.6	78.7	9.9	1.8	11.8	514
Rich	22.5	6.9	76.2	13.3	3.6	16.9	471
Richest	23.3	3.8	72.4	17.1	6.7	23.8	620
Sub-Regions							
Kampala	23.7	2.0	66.5	21.7	9.8	31.5	112
Buganda	23.1	4.3	75.5	14.8	5.4	20.1	576
Busoga	21.6	10.2	79.7	7.5	2.6	10.1	226
Bukedi	21.3	12.8	81.8	4.4	1.0	5.4	169
Bugisu	21.3	11.4	79.5	9.1	0.0	9.1	120
Teso	20.7	19.5	73.5	5.9	1.0	6.9	189
Karamoja	20.3	17.9	79.4	0.0	2.6	2.6	112
Lango	21.2	8.7	85.9	4.8	0.6	5.3	219
Acholi	20.6	16.4	78.0	5.7	0.0	5.7	112
West Nile	20.7	18.3	79.0	2.7	0.0	2.7	105
Bunyoro	22.2	10.3	72.8	12.8	4.0	16.8	141
Tooro	22.6	6.1	74.4	17.2	2.3	19.5	162
Ankole	23.3	4.6	71.0	21.1	3.3	24.4	189
Kigezi	23.0	3.3	74.1	19.9	2.7	22.6	83
Uganda	**22.0**	**9.3**	**76.7**	**11.1**	**2.9**	**14.0**	**2,515**

Appendix 8: Percentage of women youth currently using contraceptives, by background characteristics, Uganda (2022)

	Current use of contraceptives								
	Any method			Modern method			Traditional method		
	15-19	15-24	18-30	15-19	15-24	18-30	15-19	15-24	18-30
Place of residence									
Urban	12.8	26.2	39.5	10.6	22.7	35.1	2.2	3.4	4.3
Rural	9.9	21.6	33.8	8.9	19.7	31.2	1.1	1.8	2.7
Mothers Education									
No education	5.8	13.2	19.3	5.2	10.8	15.7	0.6	2.4	3.6
Primary	10.0	21.5	36.1	8.8	19.6	33.4	1.2	1.9	2.7
Secondary	13.0	26.4	37.9	11.0	23.2	34.0	1.9	3.2	3.9
More than secondary		28.9	36.1		26.2	31.9		2.7	4.2
Region									
Kampala	13.3	29.6	42.3	11.9	27.1	39.1	1.4	2.5	3.2
Buganda	14.6	29.4	42.1	12.8	26.3	38.4	1.8	3.1	3.7
Busoga	13.1	22.7	34.6	12.6	20.8	31.8	0.5	1.8	2.8
Bukedi	9.5	15.5	25.0	9.1	15.3	24.6	0.4	0.3	0.4
Elgon	11.8	29.9	44.3	7.6	26.4	41.6	4.2	3.5	2.7
Teso	10.5	23.5	38.0	7.4	18.9	32.0	3.1	4.7	6.0
Karamoja	4.8	13.4	16.9	2.7	8.4	10.3	2.1	5.0	6.6
Lango	8.9	21.4	31.8	8.3	20.6	30.8	0.6	0.8	1.0
Acholi	6.9	15.0	27.7	6.9	14.2	26.2	0.0	0.8	1.5
West nile	4.1	12.7	24.5	4.1	12.0	21.6	0.0	0.7	2.9
Bunyoro	11.9	23.9	35.5	10.3	20.8	32.1	1.6	3.1	3.5
Tooro	12.4	22.8	38.6	10.0	20.2	35.3	2.4	2.6	3.3
Ankole	6.5	20.9	38.0	6.5	20.1	35.4	0.0	0.8	2.7
Kigezi	6.8	18.8	36.4	5.7	17.3	33.4	1.1	1.5	3.0
Wealth quintile									
Lowest	9.6	21.6	30.4	8.4	19.1	26.2	1.3	2.5	4.3
Second	10.5	21.6	34.2	9.3	19.4	31.7	1.2	2.2	2.4
Middle	10.5	24.4	38.0	9.0	22.6	35.2	1.5	1.9	2.8
Fourth	11.8	22.0	37.2	10.1	20.1	34.4	1.6	1.9	2.8
Highest	11.4	25.1	38.6	9.9	22.0	34.9	1.5	3.1	3.7
Total	**10.8**	**23.1**	**35.8**	**9.4**	**20.7**	**32.6**	**1.4**	**2.4**	**3.3**

***Appendix 9*: Percentage of women youth with unmet need for family planning and total demand for family planning and the percentage of the demand for contraception, by background characteristics, (2022)**

	Unmet need						Total demand					
	Spacing			Limiting			Spacing			Limiting		
	15-19	15-24	18-30	15-19	15-24	18-30	15-19	15-24	18-30	15-19	15-24	18-30
Place of residence												
Urban	8.5	12.4	14.9	0.2	0.7	2.1	20.1	36.4	49.1	1.4	2.9	7.3
Rural	11.9	15.0	18.5	0.4	0.7	2.2	21.5	35.0	47.7	0.7	2.3	6.8
Mothers Education												
No education	8.0	13.8	14.8	0.3	1.7	3.8	12.5	24.5	28.1	1.6	4.2	9.9
Primary	12.4	15.3	19.2	0.4	0.7	2.8	21.9	34.8	49.9	0.9	2.6	8.2
Secondary	7.9	12.7	15.4	0.2	0.5	1.1	20.1	37.5	49.0	0.9	2.1	5.4
More than secondary		10.2	13.2		0.6	1.4		37.7	46.7		2.0	4.0
Region												
Kampala	9.9	13.5	15.8	0.0	1.5	2.5	21.6	40.4	53	1.6	4.1	7.6
Buganda	7.5	11.1	14.3	0.2	0.5	1.6	20.7	38.4	50.6	1.6	2.6	7.4
Busoga	14.0	17.0	20.3	0.0	0.2	2.3	27	38.6	51.6	0	1.2	5.5
Bukedi	15.1	20.2	24	2.1	1.9	4.0	24.3	33.2	43.4	2.5	4.4	9.5
Elgon	13.6	15.4	15.5	0.0	0.2	1.6	25.1	42.1	53.2	0.3	3.4	8.2
Teso	12.0	15.8	20.8	0.0	0.5	1.9	22.5	37.7	55.7	0.0	2.1	5.0
Karamoja	6.1	7.1	11	0.0	1.0	2.5	10.9	19.8	25.5	0.0	1.7	4.9
Lango	14.8	18.3	22.4	0.3	0.7	1.8	23.1	38.4	50.9	0.9	2.0	5.1
Acholi	10.9	17.9	24.0	0.4	0.7	2.3	17.8	32.4	48.9	0.4	1.2	5.2
West nile	12.5	18.0	20.9	0.5	0.5	1.5	16.6	30.5	43	0.5	0.7	3.8
Bunyoro	14.6	18.2	19.9	0.0	1.7	2.8	25.7	38.4	48	0.7	5.5	10.3
Tooro	9.4	12.8	16.5	0.7	0.7	2.7	20.9	33.8	49.2	1.6	2.5	8.5
Ankole	7.6	8.3	11.3	0.0	0.0	3.2	13.6	28.3	44.3	0.5	0.9	8.2
Kigezi	3.4	6.6	11.8	0.0	0.3	1.0	10.2	23.5	40.9	0.0	2.2	8.2
Wealth quintile												
Lowest	14.9	18.2	19.1	1.2	1.4	3.1	24.2	37.7	45.1	1.5	3.5	7.6
Second	12.8	16.4	21.1	0.3	0.5	2.3	23.1	36.1	50	0.4	2.4	7.5
Middle	10.8	14.0	17.2	0.0	0.3	2.0	20.2	36.3	49.8	1.1	2.5	7.5
Fourth	10.2	13.2	16.8	0.1	0.4	2.0	21.8	33.9	48.9	0.3	1.8	7.1
Highest	7.0	10.5	13.6	0.1	0.7	1.5	17.1	34.0	47.8	1.4	2.3	5.9
Total	**10.8**	**14.2**	**17.2**	**0.3**	**0.7**	**2.2**	**21.1**	**35.5**	**48.2**	**0.9**	**2.5**	**7.0**

Appendix 10: Percentage of women youth who heard or saw a family planning message on radio, on television, in a newspaper or magazine, or on a mobile phone in the past few months, according to background characteristics, (2022)

	Exposure to family planning message by radio			Exposure to family planning message by TV			Exposure to family planning message by newspaper		
	15-19	**15-24**	**18-30**	**15-19**	**15-24**	**18-30**	**15-19**	**15-24**	**18-30**
Place of residence									
Urban	57.3	63.0	68.8	38.3	44.9	50.7	12.7	13.7	15.1
Rural	56.2	61.5	66.5	14.4	16.1	18.2	7.1	7.2	7.6
Mothers Education									
No education	27.4	59.1	65.3	7.4	6.4	7.3	1.2	1.6	1.8
Primary	54.1	69.5	73.4	13.8	15.4	17.7	4.3	4.1	4.0
Secondary	64.9	68.7	75.3	40.1	42.8	46.0	19.3	18.0	17.3
More than secondary		68.7	75.3		50.0	56.9		22.8	28.5
Region									
Kampala	54.7	62.3	68.5	59.7	65.7	70.7	14.8	19.0	21.1
Buganda	56.2	64.6	71.6	44.6	51.5	56.6	12.4	14.1	16.2
Busoga	64.6	70.2	77.3	21.7	21.5	23.0	17.0	14.0	13.9
Bukedi	43.0	47.2	50.9	6.4	6.4	6.8	7.0	6.3	4.9
Elgon	51.0	53.9	55.2	18.2	18.5	22.3	14.5	12.4	11.3
Teso	80.0	82.5	86.6	8.6	10.4	11.7	9.5	10.3	12.4
Karamoja	20.9	29.7	29.2	6.1	6.2	7.3	1.5	5.6	6.7
Lango	63.9	67.6	71.8	4.6	5.4	6.2	2.9	3.1	3.0
Acholi	40.8	44.7	50.5	4.3	7.1	10.5	2.1	3.8	4.3
West nile	64.0	69.4	75.2	13.2	13.3	15.5	6.4	5.7	6.6
Bunyoro	70.4	74.3	78.4	23.4	25.9	31.9	7.1	7.2	7.2
Tooro	58.3	63.9	70.5	17.9	21.0	20.7	4.1	4.7	3.3
Ankole	43.5	49.8	61.3	14.9	19.3	23.1	4.3	4.0	4.5
Kigezi	41.2	50.8	58.5	10.2	11.3	13.2	5.0	4.1	3.4
Wealth quintile									
Lowest	50.3	53.6	54.7	3.7	4.2	4.8	2.2	2.9	3.3
Second	53.2	59.1	65.1	5.2	7.4	8.9	4.2	4.6	4.9
Middle	59	63.4	70.9	9.3	12.5	15.1	8.2	7.6	8.1
Fourth	61.6	68.8	75.1	24.9	29	33.7	11	11.2	11.3
Highest	57.1	63.8	70.4	55.5	61.7	68.9	15.9	17.4	19.6
Total	**56.6**	**62**	**67.3**	**21.8**	**25.6**	**29.8**	**8.9**	**9.3**	**10.3**

Appendix 11: Percentage of youth who experienced physical violence since age 15

	Men			Women		
	15-19	**15-24**	**18-30**	**15-19**	**15-24**	**18-30**
Place of residence						
Urban	37.6	37.3	40.6	27.9	34.0	36.5
Rural	41.1	41.1	40.7	30.3	36.7	45.7
Mothers Education						
No education	48.8	33.9	44.6	20.2	31.4	41.5
Primary	39.0	38.0	39.1	29.4	38.6	49.0
Secondary	43.3	44.0	43.1	31.0	32.3	35.7
More than secondary		45.0	40.7		75.7	24.6
Region						
Kampala	23.5	34.5	39.5	34.9	34.3	29.6
Buganda	43.6	42.6	47.7	24.8	29.8	34.8
Busoga	72.3	66.9	64.1	43.3	47.3	51.9
Bukedi	34.5	34.3	37.0	33.8	38.9	44.4
Elgon	18.1	19.6	12.2	20.3	34.4	47.0
Teso	43.9	57.4	61.3	56.1	59.0	64.2
Karamoja	42.8	33.7	40.9	33.0	39.8	48.5
Lango	11.5	12.8	13.4	18.6	29.4	38.9
Acholi	49.8	54.4	64.0	28.5	43.2	54.9
West nile	22.1	36.6	41.6	27.1	36.0	45.0
Bunyoro	7.8	7.7	9.5	17.0	25.7	37.4
Tooro	55.4	45.7	30.1	22.7	27.0	37.3
Ankole	61.9	55.4	50.4	27.7	32.9	42.1
Kigezi	19.5	29.7	37.3	15.2	24.0	34.7
Wealth quintile						
Lowest	39.2	42.9	44.6	38.0	46.0	53.7
Second	40.9	40.7	43.6	27.9	35.4	44.7
Middle	34.9	33.4	34.5	28.5	33.7	46.3
Fourth	40.3	37.6	41.4	27.3	32.8	39.5
Highest	45.6	46.6	40.6	26.9	31.1	30.9
Total	**40.2**	**40.1**	**40.7**	**29.6**	**35.8**	**42.4**

Appendix 12: Percentage of youth who have ever experienced sexual violence

	Men			Women		
	15-19	**15-24**	**18-30**	**15-19**	**15-24**	**18-30**
Place of residence						
Urban	0.3	3.4	5.5	5.9	10.5	13.3
Rural	0.2	2.6	6.0	6.6	11.2	16.3
Mothers Education						
No education	0.0	0.0	0.0	4.8	6.9	8.4
Primary	0.3	3.2	7.1	7.0	12.2	18.1
Secondary	0.0	2.5	5.2	5.2	9.6	13.0
More than secondary		1.6	2.7		8.5	9.3
Region						
Kampala	0.0	4.7	3.5	5.4	10.5	13.3
Buganda	0.0	2.2	7.3	8.2	10.9	14.3
Busoga	0.0	9.0	11.1	8.9	14.1	19.6
Bukedi	0.8	5.9	14.4	10.1	20.5	28.1
Elgon	0.0	0.0	1.1	12.0	22.1	29.4
Teso	0.0	7.1	12.3	2.2	6.6	12.4
Karamoja	0.0	0.0	0.0	0.0	1.6	2.6
Lango	0.0	0.0	2.0	1.8	2.8	4.2
Acholi	0.0	2.9	4.9	2.9	6.9	10.2
West nile	0.0	3.6	4.7	3.4	12.6	19.3
Bunyoro	0.0	0.9	0.8	5.9	9.3	12.7
Tooro	0.0	0.0	0.0	6.9	13.3	17.8
Ankole	0.9	0.5	6.7	7.0	9.6	18.3
Kigezi	3.3	1.7	6.2	5.3	14.5	21.3
Wealth quintile						
Lowest	0.6	3.5	6.8	5.2	12.0	14.8
Second	0.0	4.3	6.5	7.1	11.7	17.6
Middle	0.3	2.7	5.9	6.7	11.7	19.5
Fourth	0.0	0.5	4.5	6.2	8.5	14.3
Highest	0.3	3.6	5.6	6.6	10.8	12.0
Total	**0.2**	**2.9**	**5.8**	**6.4**	**10.9**	**15.3**

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