THE REPUBLIC OF UGANDA

MINISTRY OF GENDER, LABOUR AND SOCIAL DEVELOPMENT

THE OPERATIONAL FRAMEWORK FOR SOCIAL CARE AND SUPPORT SYSTEM IN UGANDA

2024/25 – 2028/29

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FOREWORD

The Ministry of Gender, Labour and Social Development (MGLSD) formulated this Operational Framework for Social Care and Support System for Uganda as part of its effort to establish a Comprehensive National Social Protection System for Uganda. This Operational Framework provides a mechanism for operationalising the second pillar of the National Social Protection Policy (NSPP).

The framework defines services to be provided by both public and private sectors, standards for service provision, the required legal, regulatory and institutional frameworks, and coordination and resource mobilisation mechanisms.

The Operational Framework was developed through a highly consultative process and stipulates the potential of social care and support services to enhance Uganda's human capital development currently hampered by high levels of vulnerability in the socio-economic dimensions of Uganda's population. It seeks to promote the Government of Uganda (GoU)'s development agenda through principles of social equality and equity towards dignified living for all vulnerable individuals, families and communities in Uganda.

Key aspects of this Framework include a need to review the regulatory framework for the provision of Social Care and Support Services (SCSS); define and implement a minimum package of services; and entrench a case management approach in service delivery at the community, parish and lower local government (LLG) levels working within existing community development structures. Hence, this Framework presents an opportunity for provision of holistic social care and support services to vulnerable individuals by all the key actors through effective coordination mechanisms at all levels.

The Ministry will lead the implementation of this Operational Framework and will work in close collaboration with other Ministries, Departments and Agencies (MDAs) with a mandate to deliver social careservices; the Private Sector; Civil Society Organisations (CSOs); and Development Partners. At implementation, the focus will be on scaling up the delivery of social care and support services in line with the vision of establishing a society where all individuals live a dignified and productive life.

Amongi Betty Ongom (MP)

MINISTER OF GENDER, LABOUR, AND SOCIAL DEVELOPMENT

ACKNOWLEDGEMENTS

This Operational Framework for the Social Care and Support System (SCSS) in Uganda comes at a time when there is a need to scale up the delivery of comprehensive, coordinated and holistic services to address socio-cultural and economic vulnerabilities faced by some individuals in the Country.

It is an outcome of a participatory process which involved wide consultations with key stakeholders including those that directly deliver, collaborate with and or complement the efforts of the MGLSD in the delivery of social care and support services to the population.

First and foremost, the Ministry appreciates the team of consultants from Socio-Economic Data Centre (SEDC) Limited who accomplished the drafting of this framework at a very difficult time when the GoU had instituted a lockdown to contain the spread of the COVID-19 virus. The Ministry is particularly thankful to individual consultants:Prof. Narathius Asingwire (Strategic Advisor), Dr Patrick Igulot (International Consultant), Dr Jolly Nyeko (Governance and Institutional Specialist), Ms Laura Nyirikindi (Legal, Gender and Disability Specialist), Dr David Basangwa (Psychosocial Specialist), Mr John Okiror (Costing Specialist), and Mr Mathius Ofumbi (Monitoring and Evaluation Specialist).

Secondly, the Ministry is grateful to the core implementation team at the Expanding Social Protection Programme Management Unit namely, Mr Stephen Kasaija (Unit Head), Ms Beatrice Okillan (Social Protection Policy and Advocacy Coordinator), Mr Zephaniah Ogen (Senior Programme Officer) and Ms Lydia Nabiryo (Principal Social Development Officer, Rights), and Ms Martha Akello (Policy and Advocacy Assistant) for their dedication in coordinating the entire process of developing this Framework including identification of key stakeholders to be interviewed, organising consultative workshops and compiling comments and ensuring that views of key stakeholders shared at consultation meetings are appropriately integrated into this Operational Framework. Specially, the Ministry appreciates the technical input of Mr Marvin Joshua Onyang (Monitoring, Evaluation and Research Officer, Uganda Parliamentary Forum on Social Protection as a co-opted member of the Core Team).

Sincere gratitude is extended to the members of the Technical Reference Committee (TRC) constituted by the Ministry and chaired by Mr Fred Ngabirano, Commissioner for Youth and Children Affairs. The Committee fully delivered on its terms of reference drawing from the members' wealth of experience in the provision of social care and support services.

Specially, the Ministry appreciates Mr James Ebitu, the Director of Social Protection, for consistently guiding the Policy and Advocacy Unit Team throughout the process of developing this Framework. Last but not least, the Ministry compliments UNICEF Uganda for providing financial and technical assistance (particularly designating and facilitating the consultancy team), enabling the development of this Operational Framework.

Special recognition goes to Ms Irene Oluka (Child Protection Officer, UNICEF Uganda); and Ms Fathia Omar Hassan (Child Protection Specialist, UNICEF Uganda) for their unwavering support to the Ministry right from the inception process until the Operational Framework was finalised.

A. D. Kibenge

PERMANENT SECRETARY

MINISTRY OF GENDER, LABOUR, AND SOCIAL DEVELOPMENT

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ACRONYMS AND ABBREVIATIONS

ACDO	Assistant Community Development Officer
ADHD	Attention Deficit/Hyperactivity Disorder
ART	Anti-retroviral Treatment
AU	African Union
BOCY	Better Outcomes for Children and Youth
CBR	Community-Based Rehabilitation
CBSD	Community-Based Services Department
CDO	Community Development Officer
CFPU	Child and Family Protection Unit of Uganda Police
COMESA	Common Market for Eastern and Southern Africa
CSO	Civil Society Organisation
CSW	Commercial Sex Work
CWD	Children with Disabilities
DALYs	Disability Adjusted Life Years
DOVC	District OVC Committee
DRDIP	Development Responses to Displacement Impacts Project
DSPO	District Social Protection Officer
EAC	East African Community
ECCE	Early Childhood Care and Education
ECD	Early Childhood Development
ESP	Expanding Social Protection
FAL	Functional Adult Literacy
FBOs	Faith-Based Organisations
GBD	Global Burden of Disease
GBV	Gender-Based Violence
GoU	Government of Uganda
HC	Health Centre
IDP	Internally Displaced Person
IGAD	Intergovernmental Authority on Development
ILO	International Labour Organisation
INGO	International Non-Governmental Organisation
IOM	International Organisation on Migration
JCU	Justice Centres Uganda
JLOS	Justice, Law, and Order Sector
KPs	Key Populations
KPI	Key Performance Indicator
LC	Local Council
LLG	Lower Local Government
LIS	Livelihood Investment Support
MAAIF	Ministry of Agriculture, Animal Industry and Fisheries
M&E	Monitoring and Evaluation

MDAs	Ministries, Departments and Agencies
MFPED	Ministry of Finance, Planning, and Economic Development
MGLSD	Ministry of Gender, Labour, and Social Development
MIS	Management Information System
MES	Ministry of Education and Sports
MoH	Ministry of Health
MoIA	Ministry of Internal Affairs
MJCA	Ministry of Justice and Constitutional Affairs
MNS	Mental, Neurological and Substance abuse
NASWU	National Association of Social Workers of Uganda
NCDs	Non-Communicable Diseases
NCHE	National Council for Higher Education
NSR	National Single Registry
SADC	Southern African Development Community
UBOS	Uganda National Bureau of Statistics
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
NCPWG	National Child Protection Working Group
NDP	National Development Plan
NGBVD	National Gender-Based Violence Database
NGO	Non-Governmental Organisation
NNGO	National Non-Governmental Organisation
NOSC	National OVC Steering Committee
NPA	National Planning Authority
NSPP	National Social Protection Policy
NUSAF	Northern Uganda Social Action Fund
ODK	Open Data Kit for monitoring and evaluation
ODPP	Office of the Directorate of Public Prosecutions
OPM	Office of the Prime Minister
OVC	Orphans and Other Vulnerable Children
PDC	Parish Development Committees
PILAC	Public Interest Law Clinic
PIP	Policy Implementation Plan
PLHA	Persons Living with HIV and AIDS
PNFP	Private Not-for-Profit
PPI	Programme Plan of Interventions
PPP	Public-Private Partnership
PSPO	Parish Social Protection Officer
PSWO	Probation and Social Welfare Officer
PTSD	Post Traumatic Stress Disorder
RMC	Resource Mobilisation Committee
SACCO	Savings and Credit Cooperative Organisation
SAGE	Social Assistance Grants for Empowerment
SCC	Social Care Council

SCG	Senior Citizens' Grant
SCORE	Sustainable Comprehensive Responses for Vulnerable Children
SCS	Social Care and Support
SCSS	Social Care and Support Services
SDG	Sustainable Development Goal
SDSP	Social Development Sector Plan
SDSIP	Social Development Sector Investment Plan
SDS	Social Development Sector
SEDC	Socio-Economic Data Centre Limited
SOCY	Sustainable Outcomes for Children and Youth
SOP	Standard Operating Procedure
SSPO	Sub-County Social Protection Officer
SSW	Social Service Workforce
SWC	Social Work Council
TOC	Theory of Change
TRG	Technical Reference Group
UBOS	Uganda Bureau of Statistics
UFDS	Uganda Functional Disability Survey
UGX	Uganda Shilling
UN	United Nations
UNALP	Uganda National Adult Literacy Policy
UNFPA	United Nations Population Fund
UNHS	Uganda National Household Survey
UOTIA	Universities and Other Tertiary Institutions Act
UWEP	Uganda Women Entrepreneurship Programme
VAC	Violence Against Children
WHO	World Health Organisation
YIG	Youth Interest Group
YLP	Youth Livelihood Programme

GLOSSARY

Adoption	A legal process that creates a new and permanent parent-child relationship between people who are not biologically related.
Approved Home	Government or non-governmental home approved by theMinister responsible for children, older persons or persons with disability(PWD) affairs to provide substitute family.
Care	Practically helping a vulnerable individual with the daily needs of life such as personal hygiene, household work, mobility and sleeping arrangements.
Caregiver	A person or an institution/agency that provides care and support to a vulnerable person (s) including a partner, child, friend, relative or any person in need of care.
Carer	A person who provides care and support to his/her partner, child, friend, or another close relative who is 18 years or older. In peculiar or extreme vulnerability, mainly due to HIV/AIDS or forced migration, there are cases of informal carers below18 years of age in children-alone families
Care Leaver	A young person aged 15 - 24 years who has left institutional or alternative care and support system uponbecoming adult.
Care Needs	Basic services required by an individual arising from abuse,ill-health, disability or old age.
Case Management	An approach of providing care and support to vulnerable individuals whereby a professional social worker plans for, identifies, arranges, advocates for, coordinates, provides referrals, monitors, and evaluates a package of multiple services after conducting aproper assessment of the needs of the client.
Children's Home	A Government or non-governmental organization (NGO) home approved by the Minister to provide substitute family care for a child; includes a babies' home and children's home which provide care and accommodation for children aged six years and below and those aged three to under eighteen years respectively[1].
Child Protection	Measures taken by duty bearers to identify, report, prevent, respond to and mitigate all forms of abuse, neglect, exploitation and violence against children and their rights[2].
Dignity	Respect, privacy and autonomy that is accorded to clients in the course of providing social care and support services.
Disability	A substantial functional limitation of a person's daily life activities caused by physical, mental or sensory impairmentand environmental barriers, resulting in limited, inequitable and unequal participation in society.
Diversion	A process of referring a juvenile from the formal justice system to an alternative programme intended to effectively settle the case.

[1]The Children (Amendment) Act 2016
[2]MGLSD (2020). National Child Policy. Government of Uganda. Kampala, Uganda.

Domiciliary Care	Care and support services provided by qualified professionals to individuals who require help with daily living activities but want to remain in their own homes rather than move to a care facility.
Foster Care	Short or long-term care and maintenance of a child by a person who is not the parent or a relative under the supervision of a probation and social welfare officer.
Gate Keeping	A recognised and systematic procedure to ensure that the removal/movement of vulnerable individuals from theirfamilies/communities is done with t h e supervision ofcommunity leaders.
Guardianship	Parental responsibility for a child by a person who is not abiological father or mother.
Group Community Care	Care and support provided within the community by professional workers to a group of individuals with related challenges to enable them to live dignified lives.
Home Care	Home care services are a type of service that provides medical, personal, or supportive care to individuals in their own homes, rather than in a hospital or care facility. Home care services can be provided by healthcare professionals, such as nurses, therapists, and home health aides, as well as by non-medical caregivers, such as personal care attendantsand companions.
Home Based Care	A range of health services provided in the home or place of dwelling such as hospital-level or acute care, primary care, skilled nursing and therapy services and hospital.
Institutional Care	Care in a residential facility licensed by the government to provide a range of services to a large group of individuals including vulnerable children, PWDs, persons with mental illness, or Older persons.
Juvenile	A child aged twelve years and above.
Kinship Care	Fulltime care, nurturing and protection of a child by relatives, members of the clan, stepparents or any adult who hasa close bond with the child.
Nursing Home	A residential facility where specialised care is provided to older persons, PWDs, children with special needs or any other person that may require such services.
Palliative Care	Professional and holistic care provided to patients to relievepain and symptoms of terminal illness.
Personal Care	Practical help with daily living such as bathing, dressing, toileting, and grooming provided to a person who cannot take care of themselves due to vulnerability.
Rehabilitation	A wide range of services aimed at helping individuals to recover from physical, mental or emotional conditions and regain their functional abilities, potential and quality of life.
Reintegration	A range of services and support mechanisms provided to assist individuals in successfully resettling in their communities after overcoming challenges that led to their separation or isolation.
Remand Home	A place of custody for children in conflict with the lawpending disposal of their cases.

Safeguarding	Measures employed by organisations to ensure that their programmes and staff operations do not harm the clients who are accessing social care and support services.
Social Care and Support Services	Refer to a wide range of public and private services designed to alleviate the socio-cultural vulnerability of individualswho suffer or are likely to face neglect, abuse, exploitation and social exclusion.
Social Care and Support System	Interrelated and coordinated mechanism for delivery of holistic social care and support services.
Social Inquiry	Investigations conducted by a probation and social welfare officer to establish the facts about an offence committed by a juvenile for adducing evidence in the courts of law.
Transitional Care	Supporting individuals to make a successful transition fromcare to independent living.
Vulnerability	The state of having limited ability to manage risks or copewith shocks that may lead to undignified lives.

EXECUTIVE SUMMARY

The Government of Uganda recognises social protection as an indispensable intervention for promoting inclusive socio-economic growth and development. As a result, the Government formulated the National Social Protection Policy (NSPP) along with the Programme Plan of Implementation (PPI) which were approved by the Cabinet in 2015. The NSPP provides for the establishment of a comprehensive national social protection system for Uganda. It identifies social care and support services (SCSS) as the second pillar for addressing risks and vulnerabilities faced by vulnerable individuals.

Social care and support encompass a wide range of services designed to alleviate the socio-cultural vulnerability of individuals who suffer or are likely to face abuse, neglect, exploitation and social exclusion. The individuals in need of social care and support services include, among others, vulnerable children, distressed youth, frail older persons,Persons with Disabilities (PWDs), survivors of Gender-Based Violence (GBV), mentally ill persons, chronically ill persons, and homeless persons, among others.

Situation Analysis

Various categories of the population in Uganda face different forms of lifecycle risks that render them vulnerable to social deprivation and limit their capacity to harness their productive potential. At every stage in life, vulnerable individuals encounter unique risks with likely exposure to adverse lifetime consequences. In the early years of life, a significant proportion of children under 17 years of age experience childhood vulnerabilities such as malnutrition, neglect, abandonment, homelessness, orphanhood,child labour, violence, disability, delinquency, and detention with parents in conflict with the law. More than half of the children in Uganda[3] are affected by such vulnerabilities and these limit their access to vital social services such as education and health, and as such impose severe negative implications on their survival and development.

Some youth in the age range of (18 - 30) years in Uganda, exhibit precarious habits due to inadequate life skills and limited livelihood opportunities. Among other things, the youth get embroiled in drug and substance abuse, gambling like sports betting, social or civil unrest, criminal activities and transactional sex which aggravates their vulnerability. Many adolescent girls have become victims of sexual exploitation, teenage pregnancy, and early and forced marriages. According to the Uganda Demographic and Health Survey (UDHS) report (2022), 24 per cent of girls aged (15 -19) years were either mothers or pregnant with their first child, implying that they could no longer continue with education to guarantee access to decent employment.

The Uganda National Household Survey (UNHS) (2019/20) estimated the working-age population of Uganda at 21.4 million people, of whom 15.9 million were engaged in the production of goods and services. The working population is exposed to occupational accidents and health hazards at workplaces or while performing activities related to their work which is the likely cause of chronic ill-health or permanent disability. In addition, working-age adults face emotional and mental stress due to job insecurity, absence of social protection, poor working conditions, heavy workload, sexual harassment, and weak enforcement of social safeguards at the workplace, among others. Despite the existence of a strong legal framework for the protection of workers' rights in Uganda, the high level of informality and casualisation of labour renders most employed persons powerless.

Older persons in Uganda find it difficult to get paid employment and hence largely depend on their retirement package. However, over 90 per cent of the 1.8 million older persons don't have access to social security. Older persons are at risk of age-related health conditions such as arthritis, stroke, dementia, cataracts, osteoporosis, hypertension, Alzheimer's disease, Parkinson's disease, diabetes, ulcers, respiratory conditions, and orthopedic problems. The most common ailments among Older persons are cardiovascular disorders and cancer. Other vulnerabilities faced by Older persons include poor housing and sanitation, stigma, ageism, discrimination, violence, abuse, frailty, isolation, neglect, marginalisation, abandonment, malnutrition, and disability.

[3] UBOS (2019/20). Uganda National Household Survey (UNHS) Report. Kampala, Uganda.

PWDs constitute about 12.4 per cent of the Ugandan population of which about 20 per cent have multiple disabilities (UBOS 2014). There are different categories of disabilities; physical disability, mental or sensory impairment, epilepsy, difficulty in learning, leprosy, loss of feeling, strange behaviour, difficulty in seeing, hearing and conveying messages, albinism and multiple disabilities. Both men and women with disabilities experience some form of abuse or violence across the lifecycle.

It is estimated that 7.4 per cent of Ugandans are affected by common mental disorders, particularly depression, anxiety, and alcohol use. Mental health problems havevarious causes, which include drug and substance abuse, psychological or physical abuse,trauma, neglect, social isolation, loneliness, discrimination, stigma, bereavement, severe or long-term stress and prolonged illness. The categories of people that are particularly vulnerable to mental ill-health comprise of homeless people, ethnic minority groups, prisoners or offenders, people with learning disabilities, refugees and displaced persons,persons living with HIV and AIDS (PLWHA), victims of perpetual gender-based violence, and abused children. Services for persons with mental ill-health are scanty and mostly comprise of institutionalised medical care provided at Government national and regional referral hospitals.

The prevalence of chronic illnesses continues to rise. Chronic illnesses are attributed to non-communicable diseases such as cardiovascular, diabetes, high blood pressure, respiratory diseases and heart diseases. About 33 per cent of annual deaths in Uganda are attributed to the above five leading non-communicable diseases. The chronically ill are faced with issues such as lack of treatment, adherence to treatment, pain, isolation, stigma, discrimination, abandonment, poor sanitation, limited access to palliative care and impoverishment due to prolonged ill health and economic loss due to medical referrals out of their reach. Only a few service providers offer some palliative care services which are accessible to a few people in need.

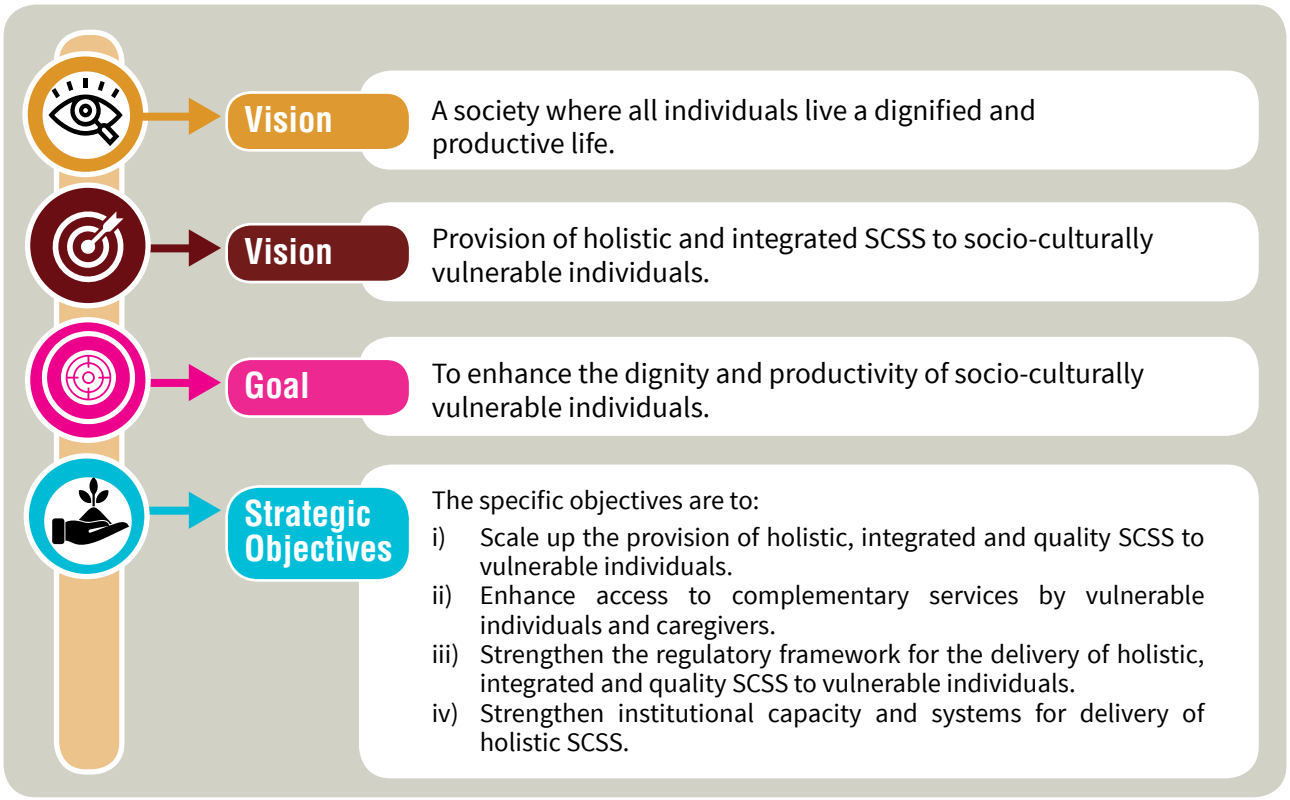
Vulnerable groups in Uganda have received emotional, material, and financial support through traditional and community-based mechanisms, including family, kinship, and clan systems. Both nuclear and extended families served as the primary sources of care the vulnerable persons. These systems were based on respect for individual dignity and well-being, aligned with cultural norms and traditions that governed family and kinship relationships. While many communities in Uganda continue to uphold the moral obligation of caring for vulnerable individuals, the effectiveness of these traditional support systems has significantly diminished over time.

Formal Social Care and Support Services (SCSS), which are meant to complement these informal mechanisms, are overwhelmed by the large and growing number of socially vulnerable individuals in the country. As a result, these services are limited in scope and coverage, underfunded, and poorly coordinated. The social service workforce responsible for delivering SCSS, face major challenges such as insufficient funding and a shortage of qualified personnel. Furthermore, the absence of regulation or professional standards for social work and community development negatively impacts the quality of SCSS provided in Uganda.

Strategic Direction

The strategic direction adopted under the Operational Framework is premised on the recognition that the individual is the target of SCSS. The provision of SCSS to the different categories of vulnerable individuals is aimed at establishing a society where all individuals live dignified and productive lives. In this context, SCSS will be tailored to meet the needs of vulnerable individuals based on their socio-cultural vulnerability.

This Operational Framework provides for the progressive development of a strong, preventive, protective, responsive, and sustainable system for the provision of services to vulnerable individuals, families, and communities. The functionality of the social care andsupport system will be enabled by: 1) Strong policy and legal framework; 2) Holistic and integrated package of services which meet needs of vulnerable individuals; 3) Adequate institutional capacity for delivery of SCSS; 4) Effective coordination of service providers; 5) Quality assurance on compliance with service delivery standards; 6) Functional Monitoring and Evaluation (M&E) system inclusive of a Management Information System (MIS) for collecting, processing, analysing and disseminating information on SCSS; and 7) Adequate financing for SCSS.



Priority Interventions

The components of SCS System include personal care, specialised care, safeguarding, protection and empowerment. Personal care involves providing vulnerable individuals practicalhelp with daily living; Specialised care encompasses care provided by skilled workers; Safeguarding entails preventing further harm of the SCSS beneficiaries by duty bearers while receiving care; Protection comprises measures taken to guarantee the safety, well- being and rights of individuals who receive care and support; Empowerment refers to the process of enabling individuals who receive care and support to make informed choices and decisions.

To ensure efficient and effective delivery of service packages, the Operational Framework lays out priority actions. These include Mechanisms to strengthen the provisionof social care and support at family and community levels; Support towards regulation ofservices, professionalisation of the social service workforce, standards setting and training; Advocacy; and pro-bono legal service mechanisms to support vulnerable individuals. Others are: Strengthening coordination, monitoring and supervision of service systems; Policy guidelines for mainstreaming of SCSS; and Expansion of the resource base for service delivery through public-private partnerships (PPP) and an endowment fund.

Under this Framework, the continuum of care is envisaged and includes the following:

- Preventive interventions
- Responsive services for vulnerable children, PWDS, Older persons, victims of violence and other vulnerable people.
- Early identification of vulnerable people in communities with problems that need redress.
- Scaling up case management, group community care and referral frameworks.
- Building and strengthening safe, secure and sustained community-owned social care responses.
- Linking Informal social care mechanisms such as community action groups to formal mechanisms for support and supervision.

The Operational Framework is organised under three broad thematic areas, namely, ***strengthening services***, ***enhancing the capacity to deliver***, and ***strengthening systems to support service delivery***. The objectives are designed to achieve the following results and impact:

1. Scaled up provision of quality social care and support services to vulnerable individuals; Statutory provision of social care and support services; enhanced provision of community social care and support services; enhanced health promotion and disease prevention activities; heightened advocacy and community mobilisation; and increased integration of social care and support services.
2. Enhanced access to complementary services by vulnerable groups and households; strengthened linkages to programs and services for enhancing the socioeconomic security of vulnerable groups for their sustained survival, participation and development.
3. Strengthened regulatory frameworks for protection and institutionalisation of vulnerable groups: regulated SCS services, framework for regulating the Social Work practitioners and the wider Social Service Workforce; and strengthened public-private partnership in social care and support.
4. Social Care and Support services mainstreamed in government policies, laws, programmes, projects and budgets.
5. Enhanced capacity of institutions, systems, human and financial resources for the delivery of integrated and quality social care and support services: human resources capacity to provide social care and services enhanced and developed and enhanced financial and logistical capacity to provide social care and support services.
6. Strengthened coordination, M&E for the delivery of holistic and integrated social care and support services.

Implementation Arrangements

Implementation of the SCSS Framework shall be multi-sectoral, multi-agency and multi-disciplinary. The Framework shall be operationalised through a partnership arrangement between the Government, Development Partners, the Private Sector, Civil Society Organisations (CSOs) and other relevant Regional and International Organisations. The Constitutional obligations at each level of Government - national and district local governments, about the provision of social care and support services, including functional relationships between the two levels, shall be considered.

The MGLSD, through its relevant departments, shall coordinate both public and private sector actors in social care and support across relevant sectors of Health; Education and Sports; Justice and Constitutional Affairs; Internal Affairs; Agriculture, Animal Industry and Fisheries; Public Service; and Local Governments. Implementation of the Operational Framework will be through integration into existing functional national and local government level committees.

In order to provide the overarching authority for the operational framework, a Social Care and Support Services Act shall be enacted to regulate the services and the actors, additional human resources will include Social Welfare Officers at district, lower local government and parish levels, as well as institutionalising the function of para-social workers.

Financing Arrangements

A Financial Planning Framework has been developed as an integral part of the Operational Framework for SCSS to provide a basis for mobilisation of resources and continuous performance monitoring of the budget. The MGLSD, being the parent ministry, shall harness partnerships with a number of stakeholders/ organizations at different levels across the country and globally to mobilize the technical, financial and political support necessary for implementation of this Framework. This Operational Framework for SCSS for Uganda will be implemented progressively over a five (5) - year period costing UGX 876.9 billion. After the initial five years which will be majorly for piloting and learning lessons, the Framework will be evaluated and rolled out progressively over a 10-year period or as and when resources allow.

Sources of Financing for the Operational Framework

The Operational Framework for SCSS for Uganda will be financed through multiple revenue streams from within the Government of Uganda (GOU) annual budgets and Medium-Term Expenditure financing for the MGLSD and other MDAs that are responsible delivering on the objectives

of this Framework. External resources will be mobilised from a wide spectrum of mechanisms notably, bilateral and multi-lateral Development Partners as well as through large global bilateral mechanisms such as the Global Fund for HIV/AIDS, Malaria and Tuberculosis (GFAMT). In addition, the private sector, local and international NGOs, and Community Based Organisations (CBOs) shall play a significant role in financing the SCSS. Collaboration and partnerships with Development Partners shall be strengthened around funding mobilisation for implementation of the SCSS framework. Development Partners will be key in providing technical assistance as well as funding for building the capacity for delivery of SCSS. Relatedly, MGLSD will require financial support from Development Partners to support aspects of coordination, networking, supervision, and capacity building of the community-level CSO

1.0 INTRODUCTION

The Government of Uganda (GoU) recognises the contribution of social protection to national development. Under the leadership of Ministry of Gender, Labour and Social Development (MGLSD), Government implements social protection along the lifecycle in alignmentwith one of the key objectives in the third National Development Plan (NDPIII) under Human Capital Development that aims to "reduce vulnerability and gender inequality along the lifecycle." Ultimately, this approach to social protection is expected to contribute to a more stable, cohesive and dignified society with improved people's dignity and well-being in fulfillment of their fundamental right to social protection.

The Operational Framework for Social Care and Support Services (SCSS) in Uganda aims at providing comprehensive and integrated care and support to vulnerable individuals. The framework emphasises a person-centred approach, which focuses on each individual's unique needs and circumstances and strives to empower them to lead fulfilling and dignified lives. The purpose of the Operational Framework for SCSS in Uganda is to ensure that individuals in need of services can access quality care in a safe and respectful environment that is culturally and socially appropriate, promotes social inclusion, and improves the quality of life for all those in need. It further seeks to ensure that services are properly coordinated and stakeholders work together, including sharing responsibility for delivering quality care.

1.1 Background

In Uganda, social protection is recognised as a critical contributor to inclusive socio-economic growth and development. Hence, in 2015, the Government formulated the National Social Protection Policy (NSPP) and its attendant Programme Plan of Implementation (PPI) which were approved by Cabinet. The NSPP provides a platform for establishing a comprehensive national social protection system for Uganda. The social protection system for Uganda is built on two pillars namely: social security and social care and support services. The social security pillar refers to interventions to mitigate income shocks and comprises: i) Social Insurance which are contributory arrangements to mitigate livelihood risks and shocks such as retirement, loss of employment, work-related disability and ill-health, among others; and ii) Direct Income Support which are non-contributory regular, predictable cash and in-kind transfers that provide relief from deprivation to the most vulnerable individuals and households in society. This Framework, therefore, operationalises the social care and support pillar of the NSPP.

Social care and support encompass a wide range of services designed to alleviate the socio-

cultural vulnerability of individuals who suffer or are likely to face neglect, abuse, exploitation and social exclusion. The individuals in need of social care and support services (SCSS) include, among others, vulnerable children, distressed youth, frail Older persons, PWDs, survivors of Gender-Based Violence (GBV), mentally ill persons, chronically ill persons and homeless persons.

Historically, most vulnerable groups in Uganda received emotional, material and financial support from traditional and community support mechanisms, including family, kinship and clan systems. Specifically, both nuclear and extended families act as the first line of care and support for orphans, widows, PWDs, Older persons and the chronically ill. The traditional and cultural system of supporting vulnerable groups was based on respect for individual rights to dignity and well-being in compliance with norms and traditions governing the family and kinship. Whereas most communities in Uganda still uphold the moral responsibility of taking care of vulnerable people, the traditional and community support mechanism has since greatly weakened.

The formal SCSS expected to complement the informal support mechanisms are overwhelmed by the high number of socially vulnerable individuals in the country resulting in service shortfalls, namely, limited in scope and coverage, grossly under-resourced and poorly coordinated. Similarly, while the Community-Based Services Departments (CBSDs) in local governments are responsible for the delivery of SCSS, underfunding and inadequate human resources in terms of numbers and skills are major constraints to addressing the concerns of the vulnerable groups. For instance, the ratio of social service workforce to vulnerable children is 1:6,000 compared to the global standard ratio of 1:2004. In addition, the lack of regulation or professional standards for social work and community development negatively affects the quality of SCSS provided in the country.

As the Government pursues the process of establishing a comprehensive social protection system for Uganda, it is imperative to enhance the provision of holistic SCSS to individuals and families at risk of social exclusion, neglect, abuse andexploitation. Among other priority actions to address the gaps, there is a need to develop strategies for the delivery of comprehensive SCSS to vulnerable groups; strengthen the capacity for delivery of SCSS at all levels; in addition to promoting community-based responses and specialised SCSS.

To clearly articulate pertinent interventions for responding to social care and support needs of the vulnerable groups, the GoU decided to formulate the Operational Framework within the context of the systems approach. The Framework focuses on strengthening the capacity for delivery of SCSS at all levels; Promoting community-based responses to the plight of vulnerable individuals in need of SCSS; and Enhancing access to specialised SCSS. The interventions in the Operational Framework will be appropriately sequenced with the aim of gradually operationalising all aspects of the social care and support system as well as providing a basis for alignment of the funding from both the Government and Development Partners.

1.2 Overview of Social Care and Support Services in Uganda

Existing SCSS in Uganda are patchy, limited in scope and coverage and mainly provided by non-state actors with support from development partners. Contemporary provision of SCSS by state and non-state actors in Uganda presents a piecemeal rather than a comprehensive coordinated service. It focuses on a few SCSS issues and categories of vulnerabilities which often results in a fragmented response marked by numerous inefficiencies and pockets of unmet needs. The challenge of providing SCSS has been exacerbated by the breakdown in the traditional social networks, particularly the extended family and community system, largely due to rural-urban migration, widespread poverty, civil strife, HIV and AIDS, besides natural disasters, among others.

Cognizant of the plight of the vulnerable groups who are adversely affected by socio-cultural risks, a model for the delivery of SCSS was developed as shown in figure 2. The model emphasises effective coordination of access to a broad range of SCSS for all socially vulnerable children, youth, women, working adults, Older persons and PWDs as a prerequisite for building a society where all individuals are secure and resilient to socio-economic risks.

[4] Bilson A., Nyeko J., Baskott J., and Rayment C. (2014) Developing Social Care and Support Services in Uganda;

1.3 Scope of the Operational Framework

The Operational Framework for the Social Care and Support System (SCSS) for Uganda aims to ensure provision of holistic and integrated services to vulnerable individuals through a systems-based approach. This Framework offers a comprehensive and unified approach to social care. It clearly defines what the social care and support system for Uganda is and specifies the target groups. It recognises the fact that the individual is the primary focus of interventions and emphasises family and community led initiatives as the foundation for delivering services.

The framework provides an in-depth analysis of the vulnerabilities, needs, and challenges faced by individuals at risk of social exclusion, neglect, and abuse due to factors such as disability, health issues, age, or other conditions. It outlines the scope and coverage of available services and sets a clear vision for delivering holistic and integrated social care and support services. It focuses on seven key pillars: laws and policies, institutional capacity, services, coordination, monitoring and evaluation (M&E)/management information systems (MIS), quality assurance, and financing. It underscores the fact that a robust legal framework underpins the social care and support system, ensuring that services are provided within a clear, enforceable structure.

It develops mechanisms for quality assurance of SCS services; describes an appropriate capacity-building approach to ensure a strong SCS services workforce including planning, developing and supporting; sets out key performance standards and indicators, along with monitoring and evaluation (M&E) mechanisms; and proposes an effective referral mechanism for various SCS service beneficiaries.

It further elaborates the approach for effective delivery of SCS services, including service packages, accessibility, governance, and quality monitoring; and identifies operational relationships across the SCSS to foster good coordination, collaboration, and accountability and governance. It recognizes the importance of strong public-private partnerships in the successful implementation of these services.

Lastly, the Framework outlines the investment requirements for the short and medium term to progressively operationalize the SCSS in Uganda. This ensures that the system is not only effective and sustainable but also adaptable to evolving needs.

1.4 Drivers of Socio-Cultural Risks and Vulnerabilities in Uganda

Child abuse

Child abuse has a devastating effect on the survival, development, protection and participation of children, often resulting in lifelong complications in a child's mental and physical health. The manifestations of child abuse include neglect, abandonment, child trafficking, child labour, defilement, and physical and psychological torture. Child abuse is usually perpetrated by parents, guardians, close relatives and deviant people in the community. Children with disabilities are more vulnerable to child abuse than the rest because their demand for care usually overwhelms the parents or guardians. The risks and vulnerabilities faced by children emanate from socio-cultural factors such as GBV, divorce, drug and substance abuse, household food insecurity, poor parenting practices, child marriage, single parenthood, orphanhood, poor learning environment in schools, peer pressure, social media and technology abuse, sexual and economic exploitation.

Youth

The youth in Uganda face diverse challenges which include unemployment, limited employable skills, lack of productive assets and limited access to sexual and reproductive health information and services. As a result of frustration, they get involved in drug and substance abuse, gambling like sports betting, social unrest, criminal activities and transactional sex which aggravates their vulnerability. Adolescents face specific vulnerabilities that include but are not limited to sexual exploitation, teenage pregnancy, and early and forced marriages. Many teenage girls are sexually abused resulting in child motherhood and a high risk of HIV/AIDS and other sexually transmitted infections.

Older persons

Older persons refer to the demographic category of the population aged 60 years and above. They represent 5.4 per cent of the total population in Uganda or nearly 2.21 million people and often

look after a significant number of the children who would ordinarily be raised by their parents. The children under the care of older persons are severely affected by the perpetual lack of basic requirements of life and marginal survival of older persons. In consideration that older persons shoulder the greater care burden of vulnerable children and PLWHA, they are a resilient vulnerable group which deserves attention.

The ageing process drains the physical energy of older persons and affects their ability to engage in productive activities. The reduced capacity to work or generate income throughother activities as well as the growing risk of prolonged illness usually increases the socio-cultural vulnerability of older persons. Increasing incidences of diet-related, chronic and non-communicable diseases such as hypertension, diabetes and heart disorders among older persons are exacerbated by poor nutrition. Inadequate food intake and poor diet predispose older persons to illness and chronic energy deficiency.

Persons with disabilities (PWDs)

In Uganda, disability is defined as "a substantial functional limitation of daily life activities caused by physical, mental or sensory impairment and environment barriers resulting in limited participation." Disability undermines the productive capacity of an individual, limits his or her ability to access services and is associated with additional costs such as increased need for private transport, medical care, assistive devices, rehabilitation services and personal care and support. Households with at least one severely or partially disabled member are more likely to be poor due to the burden of taking care of the PWDs.

The discrimination and marginalisation that accompanies disability deny the PWDs equal access to opportunities for development. The low level of education among PWDs heightens their vulnerability and enhances their dependence on others, as lack of training limits their ability to engage in income-generating activities for self-sustenance. Negativecultural practices are largely responsible for the marginalisation of PWDs in Uganda. Among some ethnic groups, mothers of children with disabilities are banished from their families and society as a whole because "their" children are considered a curse to the family.

2.0 LEGAL AND POLICY CONTEXT

SCSS are premised on numerous national laws and policies which address issues of risks and vulnerabilities. The framework is also guided international and regional instruments and protocols that Uganda has ratified.

2.1 National Policy Context

The policy environment in Uganda provides frameworks that define priority groups at risk and identifies values and principles to be followed. It also identifies targeted populations, centralised and decentralised functions of stakeholders, relationships with implementing partners and mechanisms for implementation. It further sets standards to be followed, and mechanisms for regulation, accountability as well as assessments. There is an adequate policy basis for Uganda to formulate an Operational Framework for Social Care and Social Support and design programmes to enhance the delivery of social care and support in the country. The following national policies are relevant to social care and social support:

The Uganda Vision 2040 highlights bottlenecks to socio-economic development in Uganda. The bottlenecks include an underdeveloped services sector, agriculture and human resources which all impact the provision of SCS. The Vision covers SCSS and specifically provides that: "The case for assistance to the orphaned children, disabled and destitute is equally justified. The government will also develop and implement social protection systems to respond to the specific needs of such vulnerable groups".

The Third National Development Plan (NDPIII) aims at increasing household incomes and improving the quality of life for Ugandans. The Plan emphasises the provision of SCSS to ensure that the population can access relevant social services. Under objective 5, the NDP aims to reduce vulnerability and gender inequality along the lifecycle. It identifies social care interventions as including expanding the scope and coverage of care, supporting social protection services of the most vulnerable groups and disaster-prone communities, and scaling up GBV prevention and response interventions at all levels.

The National Social Protection Policy 2015 provides for SCSS as one of the two pillars. It identifies child protection, prevention and response to GBV and care in addition to support of vulnerable persons such as children, youth, Older persons and PWDs as critical services to be provided.

The National Child Policy 2020 provides a framework for the promotion and protection of the rights of children. The policy restates survival, development, protection, and participation as key principles of providing services to children.

The Integrated National Early Childhood Development Policy 2016 seeks to address

the multi-dimensional needs of young children by building more effective and coherent efforts among sectors to achieve positive early childhood development (ECD) outcomes for all children. It addresses the need for essential ECD services and support for all children, responding to diversity, engagement of parents and families as partners, and harmonising plus maximising investment across sectors with the mandates to implement ECD interventions.

The National Youth Policy 2016 aims at unlocking the potential of youth for sustainable wealth creation and socio-economic development. It proposes interventions that address the key challenges and risks that young people face. The policy recognises the heterogeneous nature of youth across the country and the different challenges they face which are hinged on their ability to cope and offset any occurrence. It also provides for youth participation in socio-cultural, economic, civic, and political processes in the country.

The Child and Adolescent Mental Health Policy Guidelines 2017 recognises theburden and impact of Mental, Neurological and Substance abuse (MNS) disorders on young people. It provides a framework for the promotion of mental health and prevention ofmental, neurological and substance use disorders among children and adolescents.

The National Policy for Older Persons 2024 seeks to contribute to the empowerment of Older persons to effectively participate in and benefit from development initiatives. It provides a framework for advocating for equal treatment, social inclusion, and provision of livelihood support of Older persons. It further emphasises psycho-social support and care for Older persons which is one of the social care services that Older persons need.

The National Policy on Persons with Disabilities 2023 provides a framework for empowerment of PWDs in the development process. The policy focuses on enhancing accessibility of SCSS, promoting participation, strengthening capacity, awareness creation, enhancing prevention, and management of disabilities, supporting research, and strengthening communication as well as resource mobilisation.

The Uganda Gender Policy 2007 provides a framework for reducing gender inequalities so that all women and men, boys and girls manage to achieve improved and sustainable livelihoods. The policy is a tool for engendering SCSS interventions.

The National Policy for Disaster Preparedness and Management 2010 covers the broad subjects of vulnerability assessment, mitigation, preparedness, response and recovery, which constitute "comprehensive disaster management". It further recognises the need to emphasise the vulnerable groups and persons with special needs such as: unaccompanied minors, Older persons, persons with mental and physical disabilities, victims of physical abuse or violence and pregnant, lactating women and PLWHA.

The Second National Health Policy 2010 provides for health services to all people in Uganda through the delivery of promotive, preventive, curative, palliative and rehabilitative health services at all levels. Investing in the promotion of health and nutrition of the people ensures they remain productive and less vulnerable. The policy assures the provision of a minimum package of public health and clinical services to all populations with emphasison the poor, women, and children.

The National HIV/AIDS Policy 2011 provides for social care and support focusing on prevention of mother-to-child transmission of HIV, counselling and testing, anti-retroviral treatment, and support to Orphans and Other Vulnerable Children (OVCs).

The Uganda Food and Nutrition Policy 2003 provides for the promotion of food security and adequate nutrition for all Ugandans. It envisions the health as well as socio- economic well-being of the people of Uganda. It thus makes a case for proper nutrition as part of social care and support.

The Uganda National Culture Policy 2006 promotes cultural values considered as important dimensions of cultural identity and a form of social capital that creates an enabling environment for socio-cultural transformation.

The National Equal Opportunities Policy 2006 provides a framework for redressing imbalances, which exist against marginalised groups while promoting equality and fairness for all. The policy guides the planning processes, affirmative action, and implementation of programmes and allocation of resources to all stakeholders to ensure equal opportunities for all, especially vulnerable groups.

The National Adult Literacy Policy 2014 provides for basic education to illiterate individuals to

facilitate their access to healthcare, information, and financial literacy and guarantee their rights including property.

The National Community Development Policy 2015 seeks to empower communities to participate in, appreciate, demand and uptake government services as well as strengthen their resilience to withstand shocks and socio-economic risks.

2.2 National Legal Context

The legal framework relating to SCSS is contained in various legislations providing for rights of the vulnerable and marginalised groups of people. The following are laws relatedto SCSS in Uganda:

The Constitution of the Republic of Uganda 1995

The National Objectives and Directive Principles of State Policy give a firm legal basis for the government to provide social care and support. Specifically, Objective VII provides that, "The State shall make reasonable provision for the welfare and maintenance of the aged." Objective XI (i), "Enjoins the State to give highest priority to the enactment of legislation establishing measures that protect and enhance the right of the people to equalopportunities in development."

Article 32 of the Constitution enjoins the State to take affirmative action in favour of groups marginalised based on gender, age, disability or any other reason created by history, tradition or custom, for redressing imbalances which exist against them. Chapter four, on human rights, provides specific rights to women, children, and PWDs under Articles 33, 34 and 35 respectively. These provisions form the constitutional basis for providing social care and support services to such groups of the population.

The Children (Amendment) Act 2016 provides for the care and protection of children, guardianship, fostering and adoption procedures for children in need of alternative care. Section 42 A (1) of the Act, prohibits all forms of violence against children including sexual abuse and exploitation, child marriage, child labour, trafficking, sacrifice, female genital mutilation, and any forms of physical and emotional abuse.

The Local Council Courts Act 2006 empowers local council courts to adjudicate matters about violation of the rights of vulnerable people.

The Registration of Persons Act 2015 provides for the registration of births and deaths aswell as national identification. The Act further facilitates the identification of the various categories for purposes of establishing age and eligibility for SCSS.

The Institution of Traditional or Cultural Leaders Act 2011 provides for the promotion and preservation of cultural values, norms and practices that enhance the dignity and well-being of the people. The Act also promotes the development, preservation and enrichment of all the people in the community.

The National Council for Older Persons Act 2013 provides for promotion and protection of the well-being, safety, and security of Older persons. It offers a platform through which the needs, problems, concerns, potentials and abilities of Older persons are communicated to the government, and their recognition as a special interest group.

The Persons with Disabilities Act 2020 provides for the respect and promotion of thefundamental and other human rights and freedoms of PWDs. It stipulates that children with disability have the right to healthcare and education, along with family life. The law prohibits the cruel treatment of persons with disabilities and bans harmful cultural practices such as forced sterilisation.

The Domestic Violence Act 2010 provides for the protection and relief of victims of domestic violence and the punishment of perpetrators of domestic violence. Section 6 of the Act gives powers to the Local Council courts where the victim or perpetrators resideto handle matters related to domestic violence.

The Public Finance and Management Act 2015 provides for gender and equity certificationof plans and budgets at national and local government level entities to ensure that measures are put in place to address issues of inequalities and inequities amongst regions and socio-economic groups as well as women, men, boys and girls.

The Equal Opportunities Commission Act 2007 establishes the Equal Opportunities Commission with the mandate to handle cases related to discrimination, equal opportunities and affirmative action in favour of marginalised groups, which is majorly the population taken care of by the social care and support system.

The Mental Health Act 2018 provides for mental health treatment at primary health centres. It provides for the protection of the rights of patients and establishes the Uganda MentalHealth Advisory Board to spearhead the services of care to persons with mental health issues while giving courts the power to adjudicate disputes relating to the management of property of persons with mental illness.

The Special Needs Education Act 1994 stipulates national agreements and commitments for learners with special needs to attend school. Their home communities are required to promote inclusive classes, meeting individual needs that are meaningful to everyone. In terms of Social Care and Support, the instrument calls for access, equity, and quality with regards to educational services for persons with special learning needs.

The Prohibition of Female Genital Mutilation Act 2010 prohibits female genital mutilation and cutting (FGM/C), defines it, and clearly makes it an offence. The Act gives the court power to handle cases concerning FGM as a form of gender-based violence.

The Prevention of Trafficking in Persons Act 2009 prohibits the trafficking of persons and provides for the protection of victims and survivors as well as strengthening the constitutional right to dignity. It recognises Uganda's effort to implement the Optional Protocol to the Convention on the Rights of a Child (CRC) on the sale of children, child prostitution and child pornography.

The Prevention and Prohibition of Human Sacrifice Act 2021 criminalises human sacrifice to protect vulnerable groups of people, notably, children, albinos, PWDs and ethnic minorities.

The Succession Act (Cap 162) as amended provides for all cases of intestate or testamentary succession, thereby protecting the rights of orphans, widows and widowers to property upon demise of their spouses or parents.

The Local Governments Act (Cap 243) as amended makes provision concerning local governments in Uganda and provides for reform of local administration, a system based on the district as a unit under which there shall be lower local governments (LLGs) and administrative units. Among others, local governments are mandated to plan and implement SCSS for vulnerable persons.

The Uganda Prisons Act 2006 provides for the dignity of female prisoners and care for infants incarcerated with their mothers up to the age of 18 months. It prohibits the admission of juvenile offenders into a prison designated for adult prisoners.

2.3 Regional and International Frameworks

Uganda is a state party to numerous international protocols and instruments on the rights of marginalised groups and therefore, is under obligation to implement provisions that relate to SCSS under those Conventions to fulfill the rights enshrined thereunder to ensure social care service delivery. The following are some of the key legal frameworks related to SCSS:

2.3.1 Regional Legal Frameworks

EAC Commitments: The East African Community (EAC) is in the process of developing a Social Protection Strategy. The Strategy commits Partner States to cooperate in the field of social welfare concerning among others, the development and adoption of a common approach towards the disadvantaged and marginalised groups, including children, the youth, Older persons and PWDs. The community also developed The EAC Child Policy 2016 and its attendant frameworks (i.e. EAC Minimum standards on the provision of children and youth services; and The EAC Child Protection SystemsStrengthening Framework).

The Protocol to the African Charter on Human and People's Rights on the Rights ofWomen in Africa 2003 obligates Member States to ensure that the rights of women are promoted, realised and protected to enable them to enjoy fully all their human rights.

The African Youth Charter 2006 provides a framework for poverty eradication and socio-economic integration of the youth. Article 14 of the Charter focuses on the rights of youth to be free from hunger and improve access to services. Article 16 further stresses the right to healthy living, especially establishing programmes that focus on reproductive health and HIV/AIDS prevention.

The African Union Social Policy Framework 2008 commits member states to adoptminimum social protection policies including essential healthcare, social insurance, and social welfare. It provides for

a social protection minimum package to include essential healthcare, and benefits for children, informal workers, the unemployed, Older persons and PWDs.

The African Charter on the Rights and Welfare of the Child 1990 provides for the realisation of the child's rights to survival, development, protection and participation[20]. The Charter obligates state parties to promote, respect and fulfil the rights of children to enable them to grow and develop to their full potential.

The AU Agenda 2063 sets social protection targets for member states to achieve by 2023. These include at least 30 percent of vulnerable populations, including PWDs, Older persons and children provided with social protection, a minimum social protection package for vulnerable groups to be developed, and resources ring-fenced in the national budget.

2.3.2 International Legal Frameworks

The Universal Declaration of Human Rights 1948 sets out fundamental human rightsto be protected. It provides for social care in terms of adequate health and well-being including food, clothing, housing, and necessary social services; care for the elderly, PWDs, widowhood, motherhood, and childhood; right to education and the important role played by parents.

The UN Convention on the Rights of Persons with Disabilities 2006 stipulatesmeasures to promote, protect and ensure human rights. The convention guarantees the full and equal enjoyment of all human rights and fundamental freedoms by all PWDs and promotes respect for inherent dignity.

The Global Disability Summit Commitments (London: July 2018) sets commitments for Governments and other organisations to ensure dignity and respect for all, inclusive education, economic empowerment and harnessing technology and innovation as well asaddressing the needs of women and girls with disabilities, conflict, humanitarian contextsand data disaggregation.

The UN Convention on the Rights of the Child 1989 obligates Member States to provide care, support and protection to poor children and those in need, either directly or through their guardians or caregivers.

The UN Declaration on the Elimination of Violence against Women 1993 enjoins Governments to ensure that survivors of violence and, where appropriate, their children have specialised assistance. The type of care needed includes childcare and maintenance, treatment, counselling, and health and social services, among other support measures ofsafety and psychological rehabilitation.

The International Covenant on Economic, Social and Cultural Rights 1966 calls upon States to promote progressive realisation of the right to the highest attainable standard of health and social care. Family cohesion is highly regarded, and special care and assistance is called for children and young persons.

The 2030 Agenda for Sustainable Development commits the Governments to implement nationally appropriate social protection systems and measures for all, and by 2030 achieve substantial coverage of the poor and the vulnerable. It also recognises the value of unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate.

The International Labour Organisation (ILO) Social Security (Minimum Standards) Convention 1952 (No. 102) requires countries to ratify a minimum of three of the nine social security branches, which are: Medical care; sickness benefits; unemployment benefits; old-age benefits; employment injury benefit; family benefit; maternity benefit; invalidity benefit; and survivors' benefit. While these measures relate to social security, they are prerequisites for SCSS.

3.0 SITUATIONAL ANALYSIS

In Uganda, various categories of the population face social risks and vulnerabilities due to age, gender, disability, illness, violence and calamities. The socio-culturally vulnerable groups include children, youth, survivors of GBV, PWDs, frail Older persons, chronically ill persons, mentally ill persons and homeless persons. This section identifies the SCSS issues affecting vulnerable individuals and describes the current status of SCSS in Uganda. It presents an analysis of the vulnerable groups along the lifecycle, the challenges they encounter, existing interventions to address their socio-cultural vulnerabilities and gaps in the services provided by the different actors.

3.1 Lifecycle Socio-Cultural Risks and Vulnerabilities

3.1.1 Children

Uganda has a young population, with over 55 percent below 18 years and 48.7 percent being under the age of 15 years (UBOS, 2019). According to the Uganda National Household Survey (UNHS) report (2019/20), children aged 0 - 5 years constitute 19.2 percent of thepopulation, compared to those aged 3 - 5 years who constitute 10.1 percent. However, children aged 6 -12 years constitute 22.0 percent while those aged 13-17 years constitute 12.8%. Approximately 51 percent are either critically or moderately vulnerable, while 22.5 percent (UDHS 2022) live with caregivers other than their biological parents. Estimates indicate that up to 96% of children in Uganda experience some level of vulnerability. Over 60% of all refugees in Uganda are children and nearly 10% of the child refugees are unaccompanied and/or separated.

Socio-cultural vulnerabilities limit the ability of children to access mainstream social services delivered by key sectors such as education, health, agriculture, care and protection (justice, law and order). Vulnerable children in Uganda include orphans, children living in extremely poor households, children infected and affected by HIV and AIDS, children engaged in child labour, children experiencing violence, children living on streets, abused, neglected and abandoned children. There areother vulnerable groups such as children in conflict with the law, children in contact with the law, out-of-school children (dropouts or have never enrolled), children in child-headed households, children engaged in armed conflict, children living outside family care (living in institutions), internally displaced children, children in refugee settings, andchildren with disabilities.

About 16 per cent of Ugandan children have a disability. Children with Disabilities (CWD) are marginalised and are vulnerable to abuse, exploitation and social exclusion. The enrollment rate of CWDs in school is very low with only about

9 per cent of them attending primary school and only 6 per cent of these children complete primary school (UNICEF, 2019). Earlier reports indicate that, of all children with functional disabilities, only 0.5 per cent had walking assistive equipment, 0.3 per cent had used glasses or contact lenses, while only 0.1 per cent used hearing aids[5]. Misconceptions and stigmatisation associated with disability lead to the marginalisation and discrimination of CWDs by communities and families.

The MGLSD (2015) study report[6] estimated that between 40,000 to 50,000 children in Uganda were living outside of protective family environment. More than two-thirds of the children in residential care facilities had at least one living parent and many more had a known relative. It is also estimated that more than 10,000 children in Uganda are living or working on the streets. Children living outside of protective family care have limited access to basic needs such as food, clothing, shelter and healthcare. In addition, they suffer multiple abuse notably physical, sexual, and emotional abuse. The life of the children who live and or work on the streets is characterised by a vicious circle of vulnerability whereby some give birth while still children and raise their fellow children on the streets. As a coping mechanism to the hostile conditions on the streets, a significant number of children resort to drug and substance abuse, and consequently engage in crime.

Recent studies in Uganda indicate that about 28 per cent of children are experiencing child labour[7]. Child labour negatively impacts child health and education — impairing their opportunities for normal growth and development. Child labour affects a significant number of children who engage in strenuous work for survival or supplementing the income of the households where they live. The UNHS (2019/20) indicated that more than 2 million children (28 per cent) were engaged in childlabour of whom 1.8 million were aged between 5 -13 years, while 1.5 million were aged between 5 – 11 years and 289,000 aged between 12 – 13 years. The proportion of children in hazardous work was more than double in urban areas as compared to the rural[8]. Child labour is dangerous and harmful to the health, long-term development and well-being of children. The Government has implemented the Child Labour policy 2006 and is implementing child labour programmes. However, interventions are limited in scope and coverage.

One of the major causes of deprivation among children is orphanhood. Although the proportion of children who are orphans reduced to 11.3 per cent in 2016/17 from 14.7 per cent in 2005/06 in numerical terms, the number of children who had lost one or both parents increased slightly to 2.40 million in 2016/17 from 2.24 million in 2005/06. The UNHS (2016/17) report shows that 2.1 per cent of the children, corresponding to about 446,000 orphans, had lost both parents. While most orphans continue to live in families – typically with a surviving parent or members of their extended family – a considerable number, fall through the cracks of regular family support networks. Particularly, the double orphans who lack kinship care live by themselves in child-headed households. The UNHS (2019/20) indicates that close to 90,000 households that were headed by children and children in child-headed households had limited access to healthcare services, food and nutritional support, parental love, care, guidance and support and their rights were at risk of violation.

A significant proportion of children in Uganda are affected by violence. Findings from the National Violence Against Children (VAC) survey report (2018)[9] indicate that 4 in 10 girls and 6 in 10 boys aged (13 - 17) years reported physical violence, while one in 4 girls (25 per cent) and one in 10 boys (01 per cent) in the same age group reported sexual violence. In addition, 3 in 4 children in primary schools reported that they were subjected to corporal punishment, while 2 in 5 children in primary schools had experienced bullying, and nearly 50 per cent of children experienced emotional abuse by teachers. Violence against children negatively impacts their emotional well-being, physical health, and cognitive development. Majority of the children whose rights are violated through violence cannot seek redress from the justice system.

Despite the existence of a clear legal mechanism for addressing cases of juvenile offenders in Uganda, children in conflict with the law continue to encounter delays in the administration of justice. Out of 21,520 cases involving children committed

[5] UBOS (2017). Uganda Functional Difficulties Survey. Kampala, Uganda.
[6] MGLSD (2012). National Alternative Care Framework. Kampala, Uganda.
[7] UBOS (2019/2020). Uganda National Household Survey (UNHS) Report. Kampala, Uganda.
[8] United Nations (2018). Urbanisation: Emerging Global Challenges. New York
[9] MGLSD (2018), Violence Against Children Survey

to the High Court in 2017/18, only 9,156 (42.5 per cent) were concluded, implying that 57.5 per cent of the cases remained pending. According to a report published by the Public Interest Law Clinic (PILAC[10]) in August 2017, 284 children were living with their incarcerated mothers in 21 female prisons. The PILAC report (2017) indicates that about 11 per cent of the female prison population is detained with a child.

The Uganda Police Force Annual Crime Report (2017) cited 154 cases of victims of **child trafficking.** Both girls and boys are vulnerable to being trafficked. However, girls are disproportionally targeted and made to deal with the life-long effects of gender inequality and GBV. Traffickers target girls and women aged 13-24 years for domestic sex and commercial sex work (CSW). The emotional and psychological toll is devastating for victims of child trafficking, resulting in depression, suicidal thoughts and social anxiety disorders. Long-term effects of child trafficking include increased risk of communicable diseases, and long-term health complications of sexually transmitted diseases (e.g. HIV/AIDS, gonorrhea, and Chlamydia).

The enlistment and forceful conscription of children into **armed conflict** by insurgents is a dire and deplorable practice that violates moral, ethical, and international legal standards. Child soldiers are more likely to endure harsher psychological consequences, such as Post Traumatic Stress Disorder (PTSD), depression, hostility, sadness, loss of self-confidence and inability to cope with daily life.

Existing SCSS interventions for children

The GoU and other actors have put in place several interventions to address issues affecting children. Government services for children are mainly statutory and delivered through the Youth and Children Affairs Department in the MGLSD, the Community Based Services Department (CBSD) in cities and local governments, the Office of the Director of Public Prosecutions (ODPP), Police Child and Family Protection Unit, Family and Children's Court, Law Development Centre (Legal Aid Clinic) and local councils.

Services for children in conflict with the law are delivered through Seven (7) regional Remand Homes and one (1) National Rehabilitation Centre, namely: Naguru in Kampala, Mbale, Kabale, Fort Portal, Masindi, Gulu, Arua and Kampiringisa National Rehabilitation Centre. Some abandoned children are received and cared for at Naguru Reception Centre under the oversight of the Department of Youth and Children Affairs/MGLSD and other centres owned by non-state actors. The Remand Homes and the National Rehabilitation Centre are grossly under-resourced and consequently, the institutions find it extremely difficult to provide requisite services for rehabilitation (i.e. counselling, psychosocial support and provision of specialised mental healthcare services), skilling, tracing, resettlement and re-integration.

Figure 1: Children in remand homes in Uganda

Due to low levels of staffing and other capacity gaps, services for children in conflict with the law are very limited in reach and quality. These services predominantly adapt the case management approach to identify and address the needs of children and their families. Provision of these services is supported by development partners through projects which are often short-term, limited in scope and geographical coverage, lack sustainability plans and result in minimum impact. There is no central database to keep track of these services, neither are the actors effectively coordinated. Sometimes juveniles are mixed with adult offenders in police cells due to lack of separate detention facilities, and delayed presentation to courts is also common.

The Government institutions' efforts are complimented by CSOs, faith-based organizations (FBOs), private sector organisations, communities, families and individuals. As of September 2022, there were 164 approved Children and Babies Homes with an enrollment of 8,328 children (MGLSD, 2021-2022). The services provided to children are largely reactive and include counselling, psychosocial support, mediation, conflict resolution, rehabilitation, family tracing,

[10]Public Interest Law Clinic (PILAC) Report, 2018

resettlement, and reintegration in families and communities. Other care arrangements for children without parental care include kinship care, foster care, guardianship, and adoption.

There are no specific standard training guidelines for foster families, no defined package of services to families of child origin or foster families and, no consistent documented monitoring of fostered children by the Probation and Social Welfare Officer ((PSWO) as mandated. Several illegal children's homes still exist across the Country. The operational framework which is supposed to guide fostering and inter-country adoption had not been approved by the end of 2022. The lack of an approved alternative care framework to guide fostering and adoption has led to many separated children being institutionalised.

The MGLSD operates a national child helpline, branded as SAUTI 116, where cases of child abuse are reported. Although on average SAUTI receives 100 calls per day, there are challenges with follow up of cases to logical conclusion. The child helpline had only 64 District Action Centres for follow-up of cases received through the national helpline by the end of 2022.

Despite Government efforts, there is still a lack of comprehensive data on the number of children accessing services through PSWOs or Community Development Officers (CDOs) at the LLG level due to weak documentation and reporting at all levels of service delivery. A rapid assessment of case management data collected in 24 districts in 2020 indicated that a total of 1,908 cases were handled by PSWOs between April and June 2020.

The Kampiringisa National Rehabilitation Centre, where many children in conflict with the law are committed to, is under resourced and has limited provisions for counselling and reintegration of children back to their communities. Refugee children in contact with the law face additional challenges, including lack of translation services or fear of discrimination in the justice system. It is therefore important to strengthen systems that will provide child friendly services, effective child justice duty bearers and institutions and to ensure the speedy disposal of child related cases at all levels of the justice chain.

3.1.2 Youth

A youth is a person between the ages of (18 - 30) years (National Youth Policy, 2016). The youth constitute 19.1 percent of Uganda's population, representing 7.8 million people (out of these, 53 percent are females and 47 percent constitute males). The youth are exposed to many social risks and vulnerabilities including drug and substance abuse, involvement in crime, human trafficking, unwanted pregnancies, Gender Based Violence (GBV, HIV/AIDS, unemployment and under-employment, political manipulations, mental illness as well as emotional distress, 'anti-social behavior' which would include vandalism, drunkenness, and mob violence in public, or acts of aggression and harassment of other members of the community

According to the UDHS (2016/17), about 26 percent of young women and 74 percent of young men were reported engaging in high-risk sexual activity. By the age of 18 years, over 62 percent of young women and over 42 percent of young men have had their first sexual encounter. Over 17 percent of adolescents aged 10-19 years reported ever drinking alcohol (18.8 percent male and 15.4 percent female). Teenage pregnancy stands at about 43 percent› while 63 percent of inmates in prisons are youth. Many youths live and work on the street and are vulnerable to human trafficking and cross-generational sex which is grossly exploitative, especially for young girls. About 56% of young girls in Uganda reported experiencing physical violence (UBOS, 2021).

Alcohol and substance abuse among adolescents in Uganda remains a major concern, with about 57 percent of youth reported to abuse drugs, which is associated with negative risk taking behaviours which eventually affect their health and well-being. In the National Cross-Sectional Study of Adolescent Health Risk Behaviours in Uganda, 17 percent [11]of adolescents aged 10-19 years reported ever drinking alcohol (18.8 percent male and 15.4 percent female).

The consequences of these vulnerabilities include low self-esteem, alienation, hopelessness, poor well-being, social exclusion and frustration, which have led youth to engage in a range of deviant behaviour such as stealing, vandalism, drunkenness, mob violence, rape and defilement, acts of aggression and harassment of family and community members.

[11]MoH et al, 2016).

Existing SCSS interventions for youth

SCSS for vulnerable youth are delivered by the MGLSD through two departments - Youth and Children Affairs; and Disability and Elderly Department; as well as through the CBSD in cities and local governments. Other MDAs delivering youth services include: the Mental Health Department of the Ministry of Health (MoH), Ministry of Education & Sports, Justice, Law and Order Sector (JLOS), Office of the President (skilling). The services provided include rehabilitation for youth with disabilities, skilling and retooling out-of-school youth, counseling and psychosocial support, mainly provided through institutions like Ntawo, Kobulin and Mubuku skilling centres and Youth Skilling Hubs under the Office of the President. The reproductive health services are provided through government hospitals and health centres. Non-state actors complement Government services through short-term and long-term projects targeting selected categories of youth in specific localities.

There is, however, a disparity in the distribution of services for vulnerable youth as most of the NGOs are urban-based, thus limiting access for youth in rural and hard-to-reach areas. The existing youth skills centres are constrained by insufficient annual budget allocations to provide the requisite services to the youth. Besides, the skilling centres lack adequate specialised mental and psychosocial support services for youth addicted to drug and substance abuse. Actors providing services to the youth are not well coordinated leading to duplication, overlap and wastage of resources.

3.1.3 Working-age population

The age range for the working population in Uganda is set at (14 – 64) years. The population in the working age range constitute 55 per cent (23 million) of the population (National Labour Force Survey Report, 2021). The social risks and vulnerabilities faced by adults in the working age range include exposure to occupational accidents and health hazards at workplaces or while performing activities related to their work which may cause chronic illnesses or permanent disabilities. In addition, adults in the working-age face emotional and mental stress due to job insecurity, poor working conditions, heavy workload, GBV including rape exacerbated by weak enforcement of social safeguards, among others.

Adults in the working-age range are more likely to suffer from the three common non-communicable diseases (NCDs) i.e. diabetes, high blood pressure and heart attacks compared to the younger generations with females more likely to suffer from an NCD compared to the males (6 per cent versus 3 per cent respectively) (UBOS, 2019/20). Considering age distribution, self-reporting of NCDs increases with age, and about 10 per cent of the population aged 40-59 years reported suffering from at least one of the three NCDs compared to only 3.2 per cent between the ages of 25-39 years.

Although there is a general slight decrease in alcohol and drug abuse, there is an increase in alcohol and substance abuse among the working-age population. Tobacco abuse was highest amongst those aged 50 years and above estimated at 10.8 per cent, followed by those aged 40-49 years at 6.7 per cent while it was at 4.2 percent for those 30-39 years (UBOS, 2019/20).

The working age population undertakes a lot of unpaid care work. Care work includes serving people and their well-being; both personal care and other care-related activities, such as cooking, cleaning and washing clothes, wood fuel and water collection, childcare, elderly care, disability care and nursing care, among others. Care work entails the usage of time and energy. According to the UNHS (2019/20), about 68 per cent of the population aged five years and above was engaged in unpaid childcare work. More females (83 per cent) than males (53 per cent) participated in unpaid childcare work which reduces women's productivity. The Gross Domestic Product (GDP) compilation does not take into consideration care work for own use and households and yet care work consumes a lot of caregiver's time. Due to this invisibility, it is difficult to design relevant social policies and programmes that can recognise, reduce and redistribute the overall responsibility for unpaid care.

Sexual harassment at the workplace is very common but most times goes unnoticed or is not reported because of fear of losing jobs and the fear of being victimised. About 58 per cent of women experienced some form of sexual harassment by their employers. Unmarried and recruits in organisations were 36 per cent more likely to be targeted for harassment. Sexual harassment leads to marriage breakups and an increase in the spread of HIV/AIDS.

Existing SCSS for working-age adults

The government has put in place laws like the Penal Code (Amendment) Act 2009 that include clauses with strict penalties aimed at protecting women from sexual-related offences. Also, Section 7 of The Employment Act 2006 defines sexual harassment in employment and requires employers to put in place measures to prevent it. However, the implementation of these provisions is usually a daunting task that many women find difficult to pursue. Other private firms either do not have specific policies in place to address sexual harassment in their work environment or do not have the scope within other employment policies and procedures to deal with the problem should it arise.

3.1.4 Older persons

Older persons constitute about 2.3 million [12]representing 5 per cent of the total population of Uganda (UBOS, 2024). Reports [13]indicate that Older persons are at risk of age-related health conditions such as arthritis, stroke, dementia, cataracts, osteoporosis, hypertension, Alzheimer's disease, Parkinson's disease, diabetes, ulcers, respiratory conditions, and orthopedic problems. The most common ailments among Older persons are cardiovascular disorders and cancer.

Other risks and vulnerabilities faced by Older persons include loss of dignity, social exclusion, stigma and self-stigma, ageism, discrimination, violence, abuse, frailty, isolation, neglect, marginalisation, abandonment, malnutrition, loss of property rights, disability and poor sanitation. Older persons are often unable to maintain an adequate level of housing, sanitation and access to safe water. Financial insecurity caused by loss of income leads to inability to afford professional caregivers for complex medical conditions or physical disabilities. In addition, managing day-to-day finances is a challenge for Older persons, leaving them vulnerable to fraud, scams and food insecurity.

An adequate standard of living is closely related to physical and mental wellbeing, and a person's autonomy and dignity[14]. One in every four Older persons in Uganda does not have a permanent roof with only 21 per cent of Older persons in rural areas having improved latrines. While Older persons reported difficulties in squatting, research has found few examples of relatives altering the latrines for the convenience of Older persons.

Older persons aged 75 years and above report the highest number of sick days; an average of 11 days in a month. In general, older women are more likely to report being in poor health due to their unending domestic burden. Advanced age is also associated with psychological disorders, especially due to a loss of agency, a decreased social network, increased poverty and worsening health. In society, Older people suffer from social isolation, creating a lost sense of purpose caused by loneliness and marginalisation. Older persons have reported feeling emotional pressure, stress, depression and feelings of hopelessness, especially when they cannot afford treatment for ageing-related diseases or to provide for grandchildren.

Declining mobility and fitness, resulting from ageing, means everyday tasks and independent living becomes difficult, yet Older persons are challenged in finding the right affordable care provision when complete independence is no longer practical. The onset of disability during old age leaves a person more vulnerable than those who have been disabled since a younger age and have already created their own adaptive strategies. For example, Older Persons developing a disability are at risk of neglect as they can be viewed as a burden by household members. End-of-life preparations are a real challenge requiring emotional support since death is a difficult topic for people to discuss or make plans for.

Existing SCSS interventions for older persons

Current Government position in the provision of SCSS to Older persons is to encourage families to take care of Older persons in their homes where they are assisted with daily activities, such as bathing, dressing and meal preparation, as well as other support services such as medical care and transportation. However, where Older persons live in isolation or are extremely frail and do not have the required support and care, the Government and other institutions like the FBOs fill this gap. Uganda currently has two Older persons' homes; Mpumudde Older persons' home in Jinja which is Government-owned and Mapeera Bakateyamba Home for the Elderly which is run by the Good Samaritan Sisters of Nalukolongo.

[12]Uganda Bureau of Statistics (2024): Preliminary National Population and Housing Census Report; Kampala, Uganda
[13] https://www.developmentpathways.co.uk/wp-content/uploads/2020/10/ESP-OP-Study-Final-12-Oct.pdf
[14]Nygren, C., Oswald, F., Iwarsson, S., et al. (2007) 'Relationships between objective and subjective housing in very old age: results from the ENABLE-AGE Project', The Gerontologist, 47: 85–95.

Efforts by NGOs to provide social care and support to frail and homeless older persons include decent housing, provision of necessities, health care and counselling services. The gaps in this provision include limited psychosocial support, and lack of rehabilitation services, inadequate healthcare, recreation and personal care. Lack of awareness among Older persons and their families about the available SCSS results in low utilisation of the services. This is compounded by the fact that many of the Older persons live in rural areas and often face barriers to accessing SCSS, due to limited transportation options and long distances to health facilities.

3.1.5 Persons with disabilities

The Uganda Bureau of Statistics Report (UBOS 2019/20) indicates that 12.4 per cent of the Ugandan population lives with some form of disability, of which 20 per cent have multiple disabilities. The report shows that disability is more prevalent amongst women (15 per cent) than men (10 per cent); higher in rural areas (15 per cent) than in urban areas (12 per cent). There are different categories of disabilities: physical disability, mental or sensory impairment, and environmental barriers. These include epilepsy, difficulty in learning, leprosy, loss of feeling, strange behaviour, difficulty in seeing, hearing and conveying messages, albinism and multiple disabilities.

Both men and women with disabilities are more likely to experience some form of abuse or violence across the lifecycle than people without disabilities. Women witt disabilities experience combined disadvantages associated with gender and disability, such as sexual and gender-based violence, limited access to education opportunities, limited productive economic opportunities, lower incomes and poverty (UNFPA, 2018). Girls and young women with disabilities have limited knowledge about their sexual and reproductive health and rights, and limited access to services. They are also viewed as not in need of information about their sexual and reproductive health and rights or being capable of making their own decisions about their sexual andreproductive lives. They are, therefore, particularly vulnerable, as they are often the target of opportunistic men, many of whom abandon them when they become pregnant.

The prevalence of disability increases sharply with age, with around 40 per cent Older persons aged 65 years and above having a disability in Uganda rising to 57 per cent among those 80 years and above. Since Uganda has a young population, currently, the highest number of PWDs are below the age of 15 years. Among those aged 2– 4 years, 3.5 per cent have an identified disability but the number increases to 7.5 per cent among children aged 5 – 17 years.Key SCSS issues for PWDs include stigma and negative public attitudes towards disability, isolation, neglect, marginalisation, discrimination, functional difficulties, high costs and unavailability of suitable assistive devices (disability appliances), secondary disability, risk of sexual exploitation and rape.

Table 1: Age distribution of disability in Uganda

Age group	*Per cent disabled*
80 years and above	57%
65 – 79 years	40%
5 – 17 years	7.5%
2 - 4 years	3.5%

Source: UBOS, 2021

Existing SCSS Interventions for PWDs

Government of Uganda uses a twin track approach through provision of mainstream and specialised services to PWDs for inclusive development. Interventions for PWDs mostly focus on habilitation and rehabilitation services. The specialised services are implemented through programmes such as Community-Based Rehabilitation (CBR), vocational training, and Special Grant for PWDs as some of the key measures to empower them to participate in development initiatives. Other rehabilitation services are coordinated through the Disability and Rehabilitation Division of the Ministry of Health. SCSS to PWDs are also provided by associations of PWDs and CSOs.

The Community Rehabilitation Programme under the MGLSD currently covers 26 districts with significant gaps in services offered. There are only five Rehabilitation Centres across the country managed by the Ministry and about three others managed by NGOs. Negative attitudes exist among technical officers, leaders/politicians towards issues of disability inclusiveness and there is a tendency to refer to disability inclusion as an expensive venture. Financial and human

resources are not aligned to address disability issues at all levels of governance. Multi–sectorial coordination for disability and development is weak which leads to the exclusion of PWDs in the planning,implementation, monitoring, evaluation and reporting of programmes and activities to benchmark the issues of disability inclusiveness.

Even though adults and children with disabilities are estimated at 12.4 per cent of the Ugandan population, access to services is ad hoc and limited in scope and coverage. Not only are services underfunded, but also PWDs continue to face numerous social, cultural, administrative and financial barriers that limit their access to these services. They face protection risks, including a heightened risk of violence, exploitation and abuse, and high levels of stigma. They continue to face long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

3.1.6 Persons with mental health challenges

The burden of mental health conditions is high and increasing in the country. Mental health problems have various causes including childhood abuse, trauma, neglect, social isolation or loneliness, discrimination, stigma, racism, social disadvantage, bereavement, severe or long-term stress, COVID-19, and having a long-term physical health condition and delayed diagnosis & intervention. The categories of people that are particularly vulnerable to mental health conditions include substance users (alcohol and drugs), homeless people, ethnic minority groups, prisoners or offenders, people with learning disabilities, refugees and displaced persons, PLWHA, ex-combatants, juvenile offenders in custody (i.e. adult police cells/prisons, remand homes, National Rehabilitation Centre), and women and children facing domestic violence.

According to the World Health Organisation (WHO), at least 7.4 per cent of Ugandans are affected by common mental disorders, particularly depression,anxiety, and alcohol use disorders. The Global Burden of Disease findings indicate that the prevalence of depression and Generalised Anxiety Disorders in Uganda is 5.3 per cent and 4.1 per cent respectively. These figures are comparable to rates in high-income countries which rank Uganda amongst the top 5 countries in the world with the highest prevalence of depression.

A WHO report (2018) ranked Uganda among the highest per capita consumers of alcohol[15]. A recent study estimated the prevalence of alcohol use disorder in Uganda at 9.8 per cent. The latest Burden of Disease data indicates that mental and substance use disorders make up 3.35 per cent of the total disease burden of Uganda. About 4 per cent of households have at least one member with a mental disabilityand 43 per cent of Ugandans suffer from some form of mental disorder. According to the Health Sector Development Plan (2015/16 - 2019/20), from 1990 to 2010, there was a 71 per cent increase in years of life lost due to epilepsy, 102 per cent increase for self-harm, and 148 per cent increase in interpersonal violence. The prevalence of epilepsy in the general population has been estimated at 1 per cent, and the age-specific prevalence rate of epilepsy in children under 15 years is estimated at 2.0 per cent.

Mental health conditions remain highly stigmatized in Uganda and there is inadequate awareness of mental health issues among the population, particularly in rural areas. Consultations with stakeholders and past research suggest that mental health conditions are frequently interpreted as supernatural phenomenon or as a consequence of a person's intrinsic characteristics. Stigma can have a negative impact on help-seeking behaviours, adherence to treatment and recovery for people with mental disorders. Where services are available, there is also an issue of awareness, with people choosing not to seek qualified help due to prejudices, misbeliefs, or stigma. Self- and community stigma were found to significantly limit patient engagement and participation.

Persons with mental illness are more likely to face challenges including abuse, poor shelter, stigma, discrimination, isolation or loneliness, marginalisation, neglect, rejection, abandonment, poor sanitation, sexual exploitation, rape and unwanted pregnancies. Data from mental health facilities indicates that majority of the drug and substance users suffer from mood disorders, suicidal tendencies and epilepsy.

Existing Services for Persons with Mental Health Challenges

Services for persons with mental health challenges are mostly institutionalised medical care provided through a network of only two national and 20 regional referral hospitals. There are 28 outpatient

[15] WHO (2018). Global status report on alcohol and health. Geneva, Switzerland.

mental health facilities available in the country, with none having a special clinic for children and adolescents. Services include day treatment, in-patient care, forensic and community-based psychiatric care. Private Not for Profit (PNFP) services, especially in major faith-based hospitals such as Mengo, Rubaga and Kibuli, and private-for-profit facilities which provide rehabilitation for alcohol and drug use are mostly in big cities and towns. Examples of organisations include Serenity Centre, Hope, and various CSOs across the country.

Despite the interventions that have been put in place to address mental health issues, there is high stigma associated with mental health conditions in Uganda and inadequate awareness among the population, particularly in rural areas. It is unknown how many youth and other people in need of services access them since there is no system for identification and referral from the communities**.** Data from Butabika National Referral Mental Hospital records for the year 2020 shows that only 3,054 persons accessed services for alcohol and substance use disorders (Personal interview, August 10, 2021)[16]. Mental health systems and services also remain ill-equipped which constrains their service delivery to meet people's needs.

3.1.7 Persons living with chronic illnesses and the terminally ill

The prevalence of chronic illnesses continues to rise. The UNHS (2019/2020) report indicated an increase in the percentage of persons having at least one of the three NCDs (i.e. diabetes, high blood pressure and heart diseases) to 4.8 per cent in 2019/20 from 3.7 per cent in 2016/17. Additionally, an estimated 34,008 new cancer cases were registered in Uganda in the year 2020 alone. The WHO Non-Communicable Disease Country Profiles report (2018) indicated that about 33 per cent of annual deaths were attributed to the five leading non-communicable diseases (NCDs), namely: cardiovascular, cancers, diabetes, chronic respiratory diseases and other NCDs as outlined in Table 2 below. The prevalence rate of deaths among children less than 15 years old attributable to NCDs is 2.0 per cent.

The chronically ill are faced with issues such as lack of treatment, non-adherence to treatment, pain, isolation, stigma, discrimination, abandonment, poor sanitation, limited access to palliative care and impoverishment due to prolonged ill health and economic loss due to expensive medical treatment.

Table 2: Prevalence of deaths due to Non-Communicable Diseases in Uganda

Non-Communicable Disease	*Cases*
Cardiovascular diseases deaths	10%
Cancer deaths	9%
Diabetes deaths	2%
Chronic respiratory disease deaths	2%
Other NCDs related deaths	11%
Total %age of NCD Deaths	33%

Source: ***WHO – Non-Communicable Diseases (NCD) Country Profiles 2018***

The need for palliative care services has, therefore, become increasingly necessary in Uganda due to a surge in these life-threatening conditions. Available data shows that only 4.8 per cent of hospitals offer any form of palliative care services17 and only 10 per cent of Ugandans who need palliative care do receive it18. Palliative care workers are mostly medical and largely operate from PNFP health facilities.

3.1.8 Victims and survivors of GBV

GBV is a social concern affecting Ugandan societies and manifests itself in numerous ways including sexual exploitation, forced marriages, sexual, physical, verbal, psychological, and socio-economic violence. The UDHS (2016) showed that 51 per cent of women and 52 per cent of men had experienced physical violence since age 15, at the time of the survey. A total of 12 per cent had got married before their 15th birthday[19] and more than one in five women aged 15-49 years had experienced sexual violence at some point in their life compared to men at less than One in Ten. Reports indicate that 9 per cent of violent incidents forced women to lose time from paid work, amounting to 11 days a year, equivalent to half a month's salary, affecting not only the victim but her family and dependents[20].

[16] Butabika Regional referral hospital records – personal interview – 10.08.2021

[17] Ministry of Health (2015). The Uganda Health Sector Development Plan (HSDP) 2015/16 – 2019/20. Kampala, Uganda.

[18] https://hospicecare.com/what-we-do/publications/getting-started/principles-of-palliative-care/

[19] UDHS, 2016

[20] UN Women, 2016: The Economic Cost of Violence Against Women

The MGLSD launched the National Guidelines for GBV Prevention and Response Referral Pathways - nevertheless, there are outstanding challenges in GBV case management due to lack of services. Government responses to GBV involve services offered through the GBV desk in the Police department as well as in the Office of the Directorate of Public Prosecutions (ODPP) and special court sessions within the Judiciary. At the community level, SCSS for survivors of GBV are offered by the Secretary for Women and Local Council courts, para-social workers, male champions, women mentors, and SASA (Start, Awareness, Support and Action) activists, among others.

There are 17 GBV shelters across the country, where the Government is delivering a package of services to GBV survivors in collaboration with CSOs. Between 2015 and2020, a total of 20,864 GBV survivors accessed services through the GBV shelters. On the other hand, there are hardly any documented services for male survivors of GBV. The available services are limited in range and scope and largely target women. Within existing GBV services, mental health and psychosocial support services are grossly inadequate.

3.1.9 Persons affected by HIV and AIDS

The marginalised groups of people who are mostly affected by HIV and AIDS include children, youth, women, Older persons, PWDs, among others who have suffered negatively due to limited access to social care services. These categories of people require adequate provision of SCSS.

The number of PLWHA in Uganda by 2019 was 1.46 million. According to the Ministry of Health (2019) estimates, the HIV prevalence among adults (15 – 49 years) was 5.6 percent with a higher prevalence among females at 6.9 percent than males at 5.3 percent. The district with the highest HIV prevalence was Kalangala at 18 percent while Nabilatuk had the lowest at 0.2 percent.

The testing among children born to HIV+ mothers within two months of birth (Early InfantDiagnosis) had increased to 66 percent in 2020 from 40 percent in 2015. EID among children is important in detecting HIV (+) children for enrollment into care and for providing HIV prevention services to HIV (-) children. It was also estimated that 5.8 percent of the children got infected due to MTCT in the year 2020. Uganda is on course towards the attainment of the global goal of eliminating mother-to-child transmission of HIV.

However, PLWHA are at high risk of various fatalities. A study of over 15,000 cases of COVID-19 in PLWHA carried out by WHO established that:

- PLWHA were 13 per cent more likely to be admitted to hospital with severe or critical COVID-19 after controlling for age, gender and co-morbidities.
- PLWHA were more likely to die after admission to hospital with COVID-19; they had a 30 per cent increased risk of death independent of age, gender, severity at presentation, and co-morbidities.
- Among people living with HIV/AIDS, diabetes, high blood pressure; being male or over 75 years of age were each associated with an increased risk of death.

The percentage of PLWHA who report that they experience different forms of discrimination is 3.0 per cent and 0.5 per cent of PLWHA report experiencing it in communities. About 60 per cent of PLWHA report having no access to counselling and psychosocial services, and 30 per cent of PLWHA andOVC households are reported to be food insecure. PLWHA also report experiencing stigma, discrimination, emotional and mental stress, treatment fatigue, food and nutrition insecurity, isolation and poor health among others.

Table 3: New HIV infections disaggregated by age group and sex

Age Cohort	Timeline		
	2010	2015	2019
All age	94,000	67,000	53,000
Women (15+)	42,000	34,000	28,000
Men (15+)	30,000	23,000	20,000
Young people (15-24)	29,000	23,000	14,000
Children (0-4)	23,000	9,800	5,700

Source: ***Ministry of Health Estimates 2020***

Although Uganda has registered some strides in the development of policies on HIV/AIDS management at workplaces, very few MDAs, cities and districts are implementing these policies.

Existing SCSS interventions for Persons Affected by HIV/AIDS

The National HIV/AIDS Strategic Plan (2020/21-2024/25) outlines strategies to address stigma and HIV-induced GBV, provide counselling, and the material needs of PLWHA as well as those vulnerable to HIV due to their living conditions and occupations. These services are provided in health facilities owned by government, private sector and CSOs.By the end of 2020, the number of HIV-positive people who were acutely malnourished and receiving nutrition therapy was estimated at 85 per cent; access to counselling and psychosocial services at 40 per cent; and PLWHA and OVC households that are food insecure at 30 per cent.

Whereas interventions exist to address awareness, voluntary counselling and testing and provision of anti-retroviral treatment (ART), its coverage is still limited, with coverage available to the level of Health Centre III. At the community level, there is no dedicated institution to deal with the challenges of managing HIV/AIDS. Complacency has developed especially among young people arising from the existence of ART, hence the high prevalence rate among the youth. Up to 40 per cent have no access to counselling and psychosocial services yet it is a key social care service needed by persons affected and infected with HIV/AIDS. Peer groups are also limited at the community level coupled with limited nutrition support to HIV infected persons which affects ART effectiveness.

3.1.10 Persons affected by environment, climate change and disasters

Uganda, akin to the rest of the world, is experiencing the effects of climate change, with the country's otherwise mostly tropical climate now characterised by unpredictable rainfall patterns and severe droughts. The population experiencing drought as an impactof environmental degradation increased to 47 percent from 34 percent between 2015 and 2021. The Annual State of Disaster Report (ASDR, 2021) indicates that 686,883 people were affected by floods in 2021. Estimates indicate that as many as 12 million people, or 11 percent of the population could be internally displaced by 2050 due to climate change (World Bank, 2021).

The Disaster Risk Profile for Uganda shows that the risk is distributed and variable across the country, but on average, up to 45,000 people could be affected every year by natural disasters. The Internal Displacement Monitoring Centre estimated 40,000 new displacements due to disasters during the year 2020 and put the average expected number of displacements per year for sudden onset hazards at 47,121. At least 300,000 people were reported to have been affected by floods and an estimated 65,000 people were displaced as per the 2019 report[21].

An IOM report (2022) indicates that rising temperatures and unpredictable rainfall contribute to water crises, declining soil productivity, livestock losses, and ultimately a loss of livelihoods, forcing people to move. Conflicts over land and resources are common whenever people are forced to move. Such persons are affected by loss of access to social support networks, disruption of the social fabric, crime, displacements, isolation, poor nutrition, emotional and mental stress, and poor hygiene and sanitation, among others. Women, children, and PWDs are the worst affected. Addressing the care needs of children and other vulnerable persons affected by climate-induced migration is critical to safeguarding their physical and mental well-being; and ifunattended to, may deepen existing vulnerabilities across the country, potentially leading to greater poverty and fragility.

SCSS in humanitarian settings particularly among refugees and internally displaced persons (IDPs), and survivors of human and natural disasters, are coordinated by the Office of the Prime Minister (OPM). Most services are in the form of material food provision, safe water and sanitation, clothing, shelter, child protection, GBV prevention and response. Personal care, mental health and psychosocial support services are limited.

3.2 Informal Social Care and Support Initiatives

The NSPP 2015 recognises the important role of informal SCS systems but also acknowledges the capacity gaps. In response, the policy proposes, as one of its strategies to, 'strengthen family and community capacity to provide and care for the children, PWDs, Older persons and other individuals in need of care'[22]. The National Child Policy 2020 and its Implementation Plan (2020/2021-2024/2025)

[21]OCHA, 2019

[22] MGLSD, 2015. National Social Protection Policy, pp 27.

recognise informal structures and systems for child protection. Informal care is generally unpaid care provided to children, Older and other dependent persons by someone with whom they have a social relationship, such as a spouse, parent, child, another relative, neighbour, friend or other non-kin. Often, the care can be shared as family or even community and is bound together through kinship, marriage, consanguinity, and propinquity or surname identification. In Uganda, informal care for children typically involves the care of a child by a relative (kinship care).

Traditionally in Uganda, SCS is provided through the informal system that constitutes family and kinship systems and, social networks that include cultural groups, mutual support groups and burial groups operating at the village level. These social networks provide services like bereavement support, psychosocial support, dispute resolution, food support and home-based care. All these operate on the principle of *Ubuntu*, which is an African philosophical framework for interdependence and human relationships based on virtues of compassion and care for one another as a moral obligation.

The informal SCS has been significantly weakened over time due to the effects of HIV and AIDS, conflicts, rural-urban migration and widespread poverty, hence necessitating strong formal SCS services with concrete strategies to strengthen them.

In general, despite these pressures, the overwhelmed family and kinship system still bears the heaviest burden of providing SCS in Uganda in the face of extremely limited formal services.

3.3 Formal Social Care and Support Interventions

The provision of formal SCSS in Uganda to vulnerable groups is mainly by the Government complemented by non-state actors. Under the MGLSD, rehabilitation centres for PWDs include Kireka, Lweza, Mpumudde - Jinja, Sheltered Workshop - Jinja, Okoko - Arua, and Ruti - Mbarara. Activities at these centres include habilitation and rehabilitation, assessment of youth with disabilities, skills training in carpentry, welding, hairdressing, cosmetology, tailoring, knitting and weaving, among others. There are rehabilitation centres managed by FBOs and NGOs across the Country.

The MGLSD also runs Remand Homes (i.e. Naguru, Arua, Masindi, Gulu, Fort-Portal, Mbale, and Kabale) for custody of children in contact with the law and Kampiringisa National Rehabilitation Centre (KNRH) that rehabilitates children convicted of capital offences. Services provided at Remand Homes and KNRC include psychosocial support, skilling in different trades for both sexes, and tracing and re-integration/resettlement of children in their communities.

Further, the Ministry operates the Naguru Reception Centre for children who are abandoned in Kampala City and other places. Services provided include: nurturing for young children, counselling and psychosocial support; rehabilitation services for children with disabilities; tracing and resettlement of children with their families at the community level. Ideally, children to be admitted at Naguru Reception Centre are supposed to be within the age range of (0-3) years but in practice, children outside this age bracket are also admitted. Children are not expected to stay for more than 3 years. However, there are children with disabilities who have stayed at the reception centre for more than 18 years due to failure to trace their families for re-unification.

By December 2022, there were 175 Children's Homes licensed by the MGLSD spread across the country that provide care and support to OVC. Unfortunately, there are also unregistered NGO-operated children's homes whose number remains unknown to Government, hence a need for a framework to guide and regulate the operation of children's homes.

The MGLSD Kobulin Youth Skilling Centre temporarily serves as a centre for rehabilitating children withdrawn from Kampala streets with support from Kampala Capital City Authority (KCCA) and NGOs operating in Kampala, Karamoja and other cities and municipalities. Uganda Women's Effort to Save Orphans (UWESO) operates Masulita Orphanage Centre which provides care and rehabilitation services to vulnerable children including rehabilitation, tracing and resettlement of children withdrawn from streets.

At district/city and municipality level, formal SCSS are provided by the CBSD which is cascaded to LLGs under the stewardship of CDOs. Services provided include counselling, psychosocial support, protection of property for orphans, Older persons, PWDs, widows and widowers,

rehabilitation services for PWDs and linking the vulnerable to services, especially health facilities. However, SCSS are grossly underfunded by Central and Local Governments.

3.4 Existing Institutional Mechanism for Delivery of SCSS

The MGLSD through the Expanding Social Protection Programme Management Unit (ESP PMU) provides national direction and guidance on the delivery of SCSS. The Ministry is responsible for policy formulation, providing technical support supervision, setting standards, developing guidelines, quality assurance, capacity building, and monitoring and evaluation of SCSS at all levels. Actual delivery of SCSS to vulnerable individuals is undertaken by cities, local governments, CSOs, and public and private institutions, with support from relevant MDAs. Traditional and cultural, religious, and academic institutions, including development partners and local councils at all levels complement the Government in providing SCSS.

In best practices for social care and support services, human resource capacity is very critical. However, the workforce is insufficient in number and lacks the required competences, capacity and resources to meet the extent and range of social needs in the country.

At the city and local government levels, most of the SCSS are delivered by the CBSD. In particular, SCSS are provided by the SPWOs, Probation and Welfare Officers (PWOs), Senior Community Development Officer (SCDO) in charge of the Elderly and PWDs, and SCDO in charge of Gender and youth. At the LLG level, SCSS are delivered by the CDOs who attempt to respond to social welfare needs but are not specialists in social care and support. However, the formal structure for delivery of SCSS does not reach the parish and community levels where their services are required. At the community level, SCSS is mainly provided by CSOs, volunteers (i.e. Village Health Teams (VHTs), Para Social Workers (PSWs)) and community groups, most of which attempt to respond to needs of vulnerable individuals have inadequate capacity to deliver quality services.

Significant capacity gaps exist in terms of structure and staff establishment for Social Service Workforce (SSW) in cities and local governments. At the district level, three positions of the Principal Probation and Social Welfare Officer, Senior Probation and Social Welfare Officer, and Probation Officer (some districts, cities and municipalities do not have the PPWO) create significant challenges for post holders to fulfil the two demanding roles of Probation Officer and Social Welfare Officer. Similarly, the CDO in LLG holds a wide range of roles and responsibilities across the different functions of Local Government, including being the Planner, Gender Specialist, Elderly and Disability Specialist, Birth and Death Registrar,Social Protection Officer/ Child Protection Officer, NGO Liaison Officer/ Coordinator of partners and handling other auxiliary roles of youth, labour, family and culture affairs.

Although capacity gaps for the provision of SCSS in other sectors have not been well documented, it is evident that other MDAs are equally understaffed. For instance, the health sector has provided for Medical Social Workers at national and regional referral hospitals only, leaving HCIV, HCIII, HCII with no medical social workers. Physiotherapists, occupational therapists, psychiatrists and speech therapists are limited in number and in most cases located at regional level. Butabika National Referral Mental Health Hospital has only four social workers who serve as clinical staff despite the standard guideline that each patient must be assessed and attached to a social worker.

The SSW operate with minimum basic equipment, such as computers, internet connectivity, means of transport for field work, communications, appropriate office and counselling space and in some areas even lack of electricity. This limited logistical support coupled with low level of remuneration, limited promotional opportunities, and career progression, present challenges in attracting qualified staff and retaining them.

The majority of social care and support services, especially at community level in rural areas, are delivered by NGOs and other community initiatives, largely volunteer driven and donor funded. These services can be responsive and effective, but are currently poorly coordinated with government services and statutory duties, and are inconsistent and unsustainable, owing to the reliance on different donor initiatives aimed at addressing different needs over different timescales. They also lack a clear legal and operational framework.

Monitoring and Evaluation (M&E) of SCSS is provided in NSPP as well as the SDSP, which articulates the approach for systematic

monitoring of activities and the use of an electronic management information system (MIS). The planning frameworks provide for participatory M&E across sectors and levels of implementation that will be coordinated by MGLSD and aligned to the National Monitoring and Evaluation Policy. The MIS for collecting, processing and analysing SCSS data is fragmented and underdeveloped. There is a need to clarify the roles of different stakeholders in monitoring and evaluating SCSS at national, district, lower local government and community levels.

3.5 Gaps in the Policy and Legal Framework

Despite the existence of the various legal instruments at the international, regional and national level relating to SCSS, there is no consolidated national law for SCSS that defines it from a multi-dimensional perspective. What exists are various laws about different vulnerable groups as indicated earlier; vulnerable children, PWDs, the vulnerable youth, etc. Furthermore, the core of what would be the SCS package is not properly defined in these laws, but rather, inadequately referred to.

Additionally, the role of private providers and non-state actors in the provision of SCS is not spelt out. Furthermore, all the laws quoted, apart from the Children Act 2016 as amended that stipulate roles for PSWOs, Family and Children Courts and the role for local councils, do not address themselves to the issue of the SSW. Currently, no legislation serves as a regulatoryframework for social service practitioners.

Article 4 of the Convention on the Rights of the Child 1998 requires all governments to make the convention's provisions available to all children. This is being inadequately done. It is similarly so for most of the legislation for every specific area. For example, lawsconcerning PWDs are not known by the PWDs; laws concerning GBV are not known by the victims. In disposing of the cases under The Domestic Violence Act 2010, the local council court is given jurisdiction to make orderssuch as caution, apology to the victim, counselling, community service, a fine, compensation, etc. Unfortunately, this section has often been misused as many offenders tend to go free, and many cases remain unresolved or even unreported. In addition, the local council members meant to implement the law do not understand its legal provisions and often handle cases with bias especially where family members are involved.

There is a weak regulatory framework for the provision of SCSS. Prioritisation of SCSS and enforcing social safeguards are minimal. There is a need to harmonise coordination of providers of SCS in terms of setting standards and licensing in the provision of multi-sectoral SCSS.

In conclusion, therefore, there are several laws that exist nationally, and international human rights instruments that oblige Uganda to dedicate services and resources to ensure the rights under these conventions are upheld. However, these legal frameworks do not adequately cover SCS support in its entirety, nor are they sufficiently understood by the targeted persons.

3.6 Implications

The implications for the current state of social care and support are include:

Social care and support services are not accessible to the majority of the vulnerable persons who need them. For those who may be receiving some form of SCS services, the services are inadequate, and of low quality. There are no service and quality standards tailored to the different vulnerabilities. The net effect is the worsening condition of vulnerable persons leading to premature and painful death, destitution, and increased crime.

The delivery of SCS services is not well organised and coordinated. The identification and assessment of vulnerable persons who need care and support is not systematically done. Data on vulnerable persons is scanty and not readily available. The service providers operate in "silos" with little or no coordination with others. The effect is that SCS services do not reach the intended vulnerable persons in time, there are no synergies among service providers leading to duplication of efforts and wastage of the limited resources.

Overall, limited information exists regarding the status of SCSS in Uganda due to the absence of a comprehensive system for delivery and monitoring and the lack of information on SCSS from the National Service Delivery Surveys. Most of the social care and support programmes are chronically underfunded, inadequate in scope and coverage, and usually end up having short-term and minimal impact. Available services tend to be clustered around urban centres. Due to a lack of

comprehensive data on the activities of NGOs and CSOs, it is difficult to keep track of services and programmes.

The gaps in the policy and legal framework for SCS affect service delivery. The fragmentation of SCS laws among the various laws make it difficult to enforce them. Some of the laws are outdated and others are lacking. Lack of a specific legislation has affected resource mobilisation for SCS services. The effect of this is denial of justice for the vulnerable persons, unregulated SCS workforce and under resourcing of SCS services.

The institutional framework for SCS is fragmented and not well articulated. Social care and support service work is the responsibility of several MDAs. However, this service is not regarded as a core function of these MDAs. In the MDAs providing some form of SCS services, it is regarded as any other duties. The effect is lack of accountability for the delivery of SCS services.

Mechanisms to ensure effective inter-departmental and multi-stakeholder coordination and monitoring are critical, but currently inadequately defined. The absence of a national regulation for SCSS as a mechanism for planning, managing, coordinating, monitoring and evaluating is glaring. There are also issues related to regulatory mechanisms. Licensure, certification and registration are essential for the professionalization of the social service workforce, as well as for ensuring accountability.

Social care and social service work is the responsibility of several governmental departments or agencies, including social welfare, health, education and justice. Mechanisms to ensure effective inter-departmental and multi-stakeholder coordination and monitoring are critical, but are currently inadequately defined. The absence of a National Social Care Council as a mechanism for planning, managing, coordinating, monitoring and evaluating is glaring. There are also issues related to regulatory mechanisms. Licensure, certification and registration are essential for the professionalization of the social service workforce, as well as for ensuring accountability.

The traditional models for the provision of SCS rooted in the extended family is weakening because of changes in the social structure and migration. The vulnerabilities are increasing and becoming complex to the extent that traditional models of SCS cannot handle. The effect is that there is a gap in the provision of SCS to vulnerable persons which needs to be filled by complementary SCS systems/models.

3.7 Lessons Learnt

The lessons learnt in the current provision of SCS include:

The family/household plays a central role in the provision of SCS. It is the first line of care and support and has a greater influence on the outcomes. However, family care is not well structured, caregivers are not trained and lack technical backup support. This contributes to the low quality of home-based care.

Availability of data plays critical role in timely response to vulnerable persons in emergency situations. This was exemplified during COVID-19 lockdown when government decided to provide food to the vulnerable persons and there was no reliable data to guide the planning and distribution of food. Regular collection and updating of data on vulnerable persons is critical for the functionality of SCS system.

Coordination is very critical due to the multidimensional nature of SCS. The referral pathways must be coordinated to ensure timely interventions. Coordination is necessary to ensure uniform procedures and approaches, complementarity, and synergy among the service providers. SCS needs an institutional home to coordinate and regulate SCS services in the country.

SCS service delivery require a dedicate resource. If bundled with other duties as it is the case with Probation and Welfare Officer, it is either not prioritized or given lip service. The dedicated resource must be commensurate the number of vulnerable persons who need care and support.

Although the focus of SCS is on the individual (vulnerable person), for some vulnerabilities, the caregiver also need care and support because of the experiences they go through. The development of SCS service packages should cover caregivers for some vulnerabilities.

The demand of SCS services is increasing and service providers mushrooming. Some of the vulnerable persons have fallen victims to these unregulated service providers. The workforce is

not regulated which compromises professionalism in delivery of social care. A SCS system require a specific legislation to regulate the services, service providers and workforce.

3.8 Rationale for Operational Framework for SCSS

Although Uganda has over the years progressively developed and implemented laws, policies and sector-specific interventions to facilitate social transformation, socio-cultural vulnerabilities pose significant challenges to the attainment of the national development goals. The abuse, neglect, exploitation and social exclusion of vulnerable individuals have serious implications for the participation of a large proportion of the population in the development process. It is estimated that 17 per cent or 7 million people (2.2 million people with care and support-related health conditions, 3.4 million PWDs, and 1.5 million Older persons) in need of SCS are socially excluded and do not contribute effectively to national development.

Income inequality in Uganda has improved but remains high at 0.41 or 41 per cent, making Uganda the 48th most unequal country out of 126 countries (World Bank, 2018). Uganda has low human development and ranks 159 out of 189 countries with an index of 0.544 (UNDP, 2020). Absolute poverty in Uganda has reduced considerably to 20.3 per cent or 8.3 million, however, multi-dimensional poverty is 66 per cent or 27 million (UBOS, 2021).

Empowerment of vulnerable groups: The provision of SCSS empowers vulnerable groups to participate in education, production and employment thereby enabling them to live to their full potential and contribute to national development. For example, provision of assistive devices to PWDs facilitates mobility and enables their engagement in income-generating activities.

A good social care and support system could save Uganda an estimated 588,733.70 productive hours currently lost due to the burden of social care and support-related diseases and health conditions[23]. The loss of development potential due to disease burden, higher poverty levels and the attendant low human development undermine national development of the country.

[23] Our World in Data https://ourworldindata.org/grapher/bipolar-disorder-dalys-age-rate?tab=chart&country=UGA (Accessed 10/11/2021)

A well-functioning social care and support system provides an array of quality services for vulnerable individuals and families which promotes well-being and protection from harm and enables persons affected to live dignified lives.

Reduce the occurrence of vulnerabilities: A good social care and support system addresses underlying social and behavioural factors that lead to poorhealth and disabilities. Early identification, prevention and intervention in these factors may prevent the initial onset of a condition, while secondary prevention may reduce the impact of the condition on the population and good follow-up interventions may prevent its reoccurrence altogether.

Improves uptake of other social services like health services for people living with chronic illnesses and educational services for children with disabilities. Well-organised SCSS improve access and adherence to treatment, reduce isolation, stigma, discrimination, abandonment and poor sanitation, among others.

Quality of services: a strong quality assurance system for the SSW helps to advance the profession, maintain and upgrade the quality of work performed by the SSW while holding them accountable to defined standards to protect the public from unregulated practitioners.

Well-regulated SCSS address the social determinants of health, (i.e. poverty, social exclusion, poor nutrition and housing, hazardous living conditions, abuse and violence). According to the WHO report (2008), social determinants of health account for between 35-55 per cent of health outcomes and are responsible for health inequities existing between countries. Countries with more positive health outcomes are often visible among countries with greater total investment in health and social care spending compared to health spending alone (Bradley et al., 2011; Davis, 2015).

Case management approach proposed under the operational framework enables early identification, coordinated intervention and conclusive follow up of cases and, therefore, reducing the cost of management of cases that get out of control.

Social care enables a holistic approach to healthcare resulting in reduced hospital readmission rates, reduced length of patient stays in hospital, and reduced costs for health providers and/or patients.

Quality of life: Social care enables individuals to live normal lives and carry out tasks they otherwise wouldn't be able to whether it is emotional support, physical support or social support. Social care can completely change the lives of individuals and offer them experiences they wouldn't otherwise have.

Independence and dignity of social care give everyone the opportunity to live with dignity and where possible, with as much independence as they can. This can be life changing to individuals that would otherwise struggle to carry out daily tasks and care for themselves. This can be a very big confidence booster, without social care, many individuals could face isolation and struggle with confidence. Legislation of social care and support systems is critical for keeping those in need of care safe and protected.

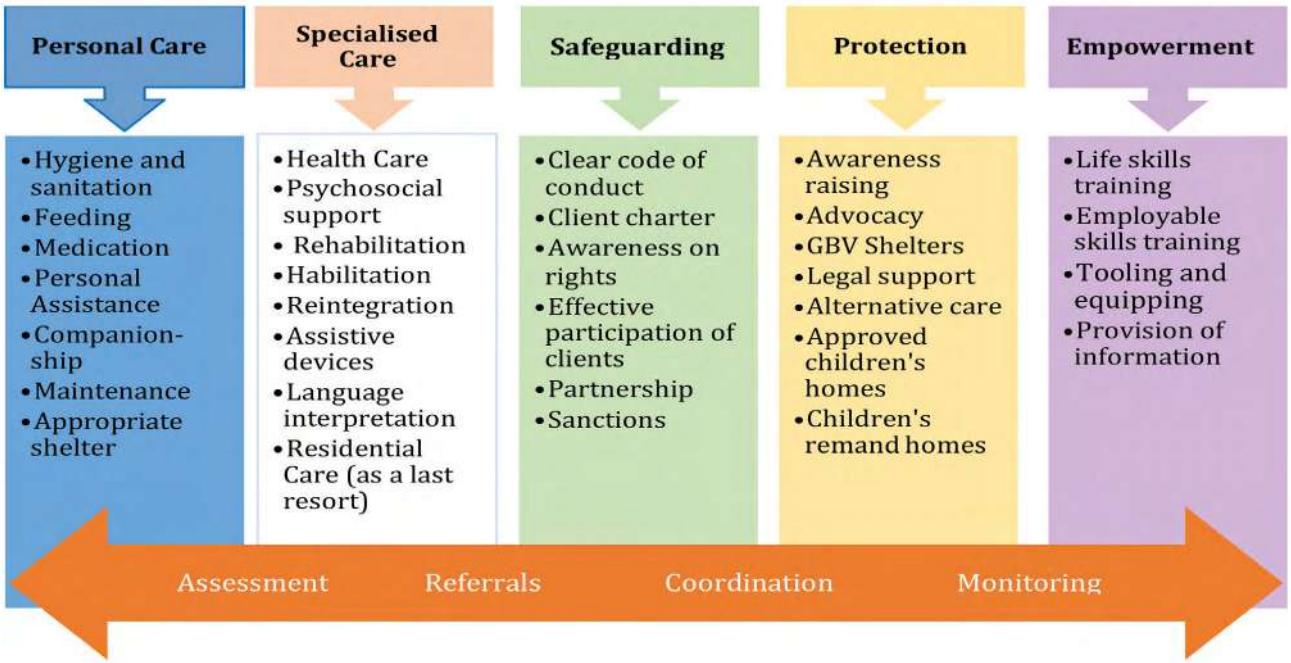
Strengthens multi-sectoral linkages and coordination of services for those in need of care and support: Standardised systems for assessment, referral and follow-up in combination with a mandatory multi-sectoral coordination framework can contribute toimproved outcomes.

4.0 STRATEGIC DIRECTION

4.1 Overview

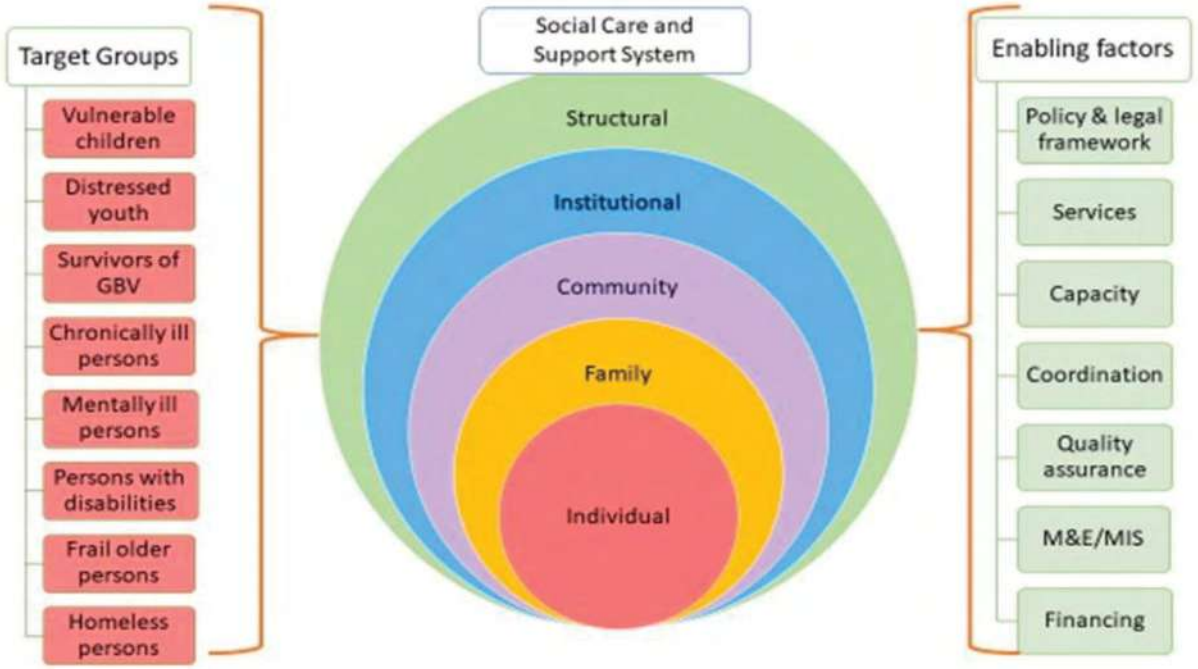
Social Care and Support in Uganda covers a range of public and private services designed to alleviate the socio-cultural vulnerability of individuals who suffer or are likely to face neglect, abuse, exploitation and social exclusion. Specifically, the services target individuals affected by socio-cultural vulnerabilities due to age, gender, disability or illness. The components of SCSS include Personal care, specialised care, safeguarding, protection and empowerment. Personal care involves providing vulnerable individuals practical help with daily living; Specialised care encompasses care provided by skilled social service workers; Safeguarding entails preventing further harm to the SCSS beneficiaries by duty bearers while receiving care; Protection comprises measures taken to guarantee the safety, well-being and rights of vulnerable individuals; Empowerment refers to the process of enabling individuals who receive care and support to make informed choices and decisions.

Figure 2: Components of the social care and support system in Uganda



As depicted in the conceptual model in Figure 3, the strategic direction adopted under the Operational Framework is premised on the recognition that an individual is the target of the SCS System. In this context, the SCS system is tailored to meet the needs of vulnerable individuals based on an assessment of their socio-cultural vulnerability.

Figure 3: The conceptual model of social care and support system in Uganda



The Conceptual Model for SCSS outlines the target groups and the enabling factors for the system to function effectively. The target groups are those individuals within a society who may require assistance due to factors such as age, disability, illness, and other vulnerabilities. The targeted include but are not limited to vulnerable children, distressed youth, victims of abuse or violence, substance abusers, caregivers, refugees and asylum seekers, homeless individuals, the mentally ill, the chronically/terminally ill, frail Older persons among others.

The system takes cognisance of the fact that in Uganda, the family is the first line of care and support for vulnerable individuals. It emphasises the need to strengthen the capacity of families to provide SCSS to individuals who are at risk of social exclusion, neglect and abuse within the context of the traditional support mechanism. The system adopts Case Management as the main approach.

In consideration of the moral responsibility of society to take care of and support vulnerable individuals who may lack or receive inadequate assistance from their families, the community is expected to play a critical role in complementing household efforts. At the institutional level, the system envisages provision of specialised SCSS packages to vulnerable and marginalised individuals by Government agencies and non-state actors. Ultimately, the SCS system is expected to function through a well-defined structural arrangement that guarantees an effective referral system.

The functionality of the SCS system will be enhanced by enabling factors which include: i) Strong policy and legal framework; ii) Holistic and integrated package of services which meet the needs of vulnerable individuals; iii) Adequate institutional capacity for delivery of SCSS; iv) Effective coordination of service providers; i) Quality assurance to ensure compliance with service delivery standards; vi) Functional M&E system as well as MIS for collecting, processing, analysing and disseminating information on SCSS; and vii) Adequate financing of SCSS.

4.2 Guiding Principles

The operationalisation of this framework shall be guided by the principles outlined below:

Table 4: Guiding principles

Principle	Narrative
Person-centred services	The provision of SCSS should focus on the needs and unique circumstances of the individual and endeavour to empower them to achieve their aspirations.
Dignity and respect	Promoting and protecting the rights of individual to privacy, expression, entitlement and independence.
Responsive services	Ensure the provision of appropriate and consistent SCSS at the right time, which is adaptable to the changing needs and circumstances of individuals.
Family as the first line of response	The family shall be the basic unit of care and support.
Equity and equality	Every eligible individual will be accorded fair and equalopportunity to access SCSS based on objective criteria.
Quality and safety	The clients should have access to quality services in a safe and friendly environment.
Transparency and accountability	Reliable, complete and timely information should be provided to the public to enable them to appreciate, demand, access and assess SCSS.
Partnership, networking and collaboration	Commitment to working together across Government MDAs, private sector organisations,CSOs and communities to deliver SCSS.
Community participation and empowerment	Strengthen community capacity and initiatives to effectively playtheir role in the provision of social care and support services to vulnerable groups.
Strengthening referrals	Referrals shall be coordinated to ensure that vulnerable individuals access holistic, integrated and comprehensive SCSS.
Beneficiary participation	Emphasises involvement of the individual receiving care and support in the decision-making and delivery of services.

4.3 Vision, Mission, Goal and Specific Objectives

4.3.1 Vision

A society where all individuals live a dignified and productive life.

4.3.2 Mission

Provision of holistic and integrated SCSS to socio-culturally vulnerable individuals.

4.3.3 Goal

To enhance the dignity and productivity of socio-culturally vulnerable individuals.

4.3.4 Specific objectives

The specific objectives are to:

i) Scale up the provision of holistic, integrated and quality SCSS to vulnerable individuals.

ii) Enhance access to complementary services by vulnerable individuals and caregivers.

iii) Strengthen the regulatory framework for the delivery of holistic, integrated and quality SCSS to vulnerable individuals.

iv) Strengthen institutional capacity and systems for delivery of holistic SCSS

4.4 Strategies for achieving objectives

4.4.1 Objective 1: To scale up provision of holistic, integrated and quality SCSS to vulnerable individuals

4.4.1.1 Strengthening personal care services to vulnerable groups

Strengthening personal care services for vulnerable individuals is an important endeavour to support vulnerable individuals. By bolstering these essential services, the government will be extending the much-needed lifeline to those who are most in need of care. This entails a multi-faceted approach, encompassing comprehensive capacity building tailored for caregivers and vulnerable individuals. Through education, training, and empowerment, and home care services, caregivers will be equipped with the necessary skills to provide compassionate and effective care. Besides, appropriate living conditions are necessary for vulnerable individuals to ensure a safe and conducive environment that promotes their well-being and dignity. To strengthen personal care services the following actions will be undertaken taken:

i. Capacity building for caregivers and vulnerable individuals;

ii. Provision of appropriate habitation;

iii. Establish home -based care services for vulnerable individuals;

iv. Develop a care and support system for care givers;

4.4.1.2 Strengthening family and community capacity to provide care for vulnerable individuals

The need to strengthen family and community capacity to provide care for vulnerable individuals is rooted in the understanding that a supportive social network is pivotal for the well-being and holistic development of those in need. Families and communities can offer a unique blend of understanding of the individual, emotional connection, and cultural understanding that institutional care settings often lack. Improving the ability ofthe family and community to provide care, creates a more sustainable and inclusive support system which encourages a collaborative approach, where collective responsibility and compassion converge to create a nurturing environment for the vulnerable members within their communities. To strengthen the capacity of families and communities, the following actions will be implemented:

i. Build the capacity of the family to provide SCSS;

ii. Revitalise traditional and community support mechanisms for vulnerable individuals;

iii. Strengthen the system for early identification and intervention for vulnerable individual;

iv. Establish Sports and recreation centers, facilities and spaces at the community level;

v. Establish community and peer support mechanisms;

vi. Strengthen parenting mechanisms;

vii. Create awareness about SCSS;

viii. Conduct advocacy at the local, district, national and international levels to promote social care and support;

4.4.1.3 Enhancing access to specialised care for vulnerable individuals

Specialised care for vulnerable individuals is essential to ensure their well-being, dignity, and quality of life. Vulnerable persons face unique and complex needs that demand tailored approaches. Generic care models may not adequately address their specific requirements, potentially leading to neglect, inadequate support, or

worsening of their conditions. Specialised care recognises and respects the uniqueness of each person, considering their physical, emotional, and psychological needs. This strategy aims to remove barriers and ensure equitable access to vital services. This can be achieved through collaborative partnerships, targeted interventions, and informed decision-making. The following actions will be implemented:

i. Establish and strengthen access to habilitation services for PWDs;
ii. Enhance and expand rehabilitation services for PWDs including community-based rehabilitation;
iii. Deliver comprehensive geriatric services that address the medical, social, and emotional needs of older persons, promoting dignity and quality of life;
iv. Develop and implement transitional care services for homeless persons, providing pathways for reintegration into society;
v. Improve and expand access to mental health and psychosocial support services for vulnerable individuals;
vi. Establish and provide palliative care services for terminally ill individuals, ensuring comfort, dignity, and support for both patients and their families;
vii. Provide assistive devices and auxiliary services to individuals with disabilities to promote greater independence and accessibility in their daily lives;
viii. Improve access to formal and informal special needs education for children with disabilities;
ix. Establish and strengthen community outreach activities for various vulnerable groups;
x. Strengthen reintegration services;
xi. Provide specialised care and support services to victims and survivors of GBV;
xii. Establish public-private partnerships to enhance the delivery and scope of social care services through collaborative efforts and resource sharing;

4.4.1.3.1 Improving access to mental health and psychosocial support services to vulnerable individuals.

Mental health services are critical for fostering well-being, resilience, and recovery for individuals facing emotional, psychological, or behavioral challenges. These range from addressing everyday stress to more complex health conditions and aim at creating a safe, inclusive, and supportive environment that prioritizes the unique needs of each person. To strengthen access to mental health services, the following actions will be implemented:

i. Expand access to health and psychosocial support services for individuals in need;
ii. Provide home based mental health care services;
iii. Build capacity of community structures to support persons with mental health challenges;
iv. Provide rehabilitation services for victims of substance abuse;
v. Develop social reintegration mechanisms and after care for victims of substance abuse, people who have recovered, forensic patients, children with mental challenges;
vi. Provide alternative care for abandoned children with mental illness;
vii. Provide stress management services at work places;
viii. Create awareness on mental health issues;

4.4.1.4 Strengthening the referral system for the provision of SCSS

Due to the diverse needs of the communities and the vulnerable individuals which the framework targets to serve, one single organisation cannot provide a comprehensive package that caters for the needs of vulnerable individuals. Hence, the development of an effective referral and networking system is crucial to ensure timely access to multiple services required and ensuring smooth transitions between various service providers. This approach seeks to streamline communication, improve information sharing, and enhance collaboration among different service providers, ultimately contributing to more efficient, responsive, and comprehensive SCSS. Key actions to be undertaken include:

i. Develop and clarify referral pathways for SSCSS;

ii. Establish a functional case management mechanism for care and support at national and sub- national level;

4.4.1.5 Enhancing the provision of protection services for vulnerable individuals

The provision of protection services to vulnerable groups is key for addressing systemic barriers to accessing their rights, promoting human dignity, equity, and social justice. This involves a collaborative approach that integrates legal, social, and psychological support, underpinned by inclusive policies and practices. To ensure provision of protection services, the following actions done:

i. Build the capacity of vulnerable individuals on their rights and obligations;

ii. Strengthen alternative care for vulnerable children;

iii. Provide day care services and breast-feeding facilities at work places for working mothers;

iv. Provide and improve residential care in approved institutions for persons who do not have or cannot live with family- this will be done as a last resort;

v. Provide temporary shelters for victims of abuse and neglect;

vi. Strengthen the juvenile justice system;

vii. Expand and refurbish remand home facilities;

viii. Improve access to legal support and representation services for vulnerable individuals;

ix. Ensure expeditious administration of justice for vulnerable children;

x. Conduct advocacy and awareness creation for the protection of vulnerable individuals;

xi. Build capacity of duty bearers at national and sub national levels;

xii. Strengthen interventions for prevention and response to rights violation;

4.4.1.6 Safeguarding of vulnerable individuals while accessing SCSS

The social care and support framework recognises that the welfare and interests of children and vulnerable individuals are paramount. The framework aims to ensure thatregardless of age, gender, religion or beliefs, ethnicity, disability, or socio-economic background, all children and vulnerable people are protected from abuse or harm while in care. To ensure the safety and well-being of children and vulnerable people the following will be prioritised:

i. Review of relevant laws to provide for the safeguarding of vulnerable individuals;

ii. Enforce existing SCSS laws and regulations on safeguarding;

iii. Develop guidelines on safeguarding vulnerable individuals;

iv. Build capacity of duty bearers on safeguarding;

4.4.2 Objective 2: To enhance access to complementary services by vulnerable individuals and caregivers

4.4.2.1 Empowering vulnerable individuals and caregivers for effective uptake and delivery of SCSS

Empowering vulnerable individuals and their caregivers ensures a more inclusive and supportive community and improves uptake and delivery of quality SCS service. It ensures that those who need assistance and those who provide it are equipped with the necessary tools and knowledge to navigate the complex landscape of social care. The following are the key actions to be undertaken:

i. Support access to reproductive and life skills training for adolescents and youth;

ii. Provide tools and equipment for vulnerable individuals and their caretakers;

iii. Provide livelihood and employable skills training to vulnerable individuals and caregivers;

iv. Enhance access to financial services for vulnerable individuals;

v. Create awareness on existing complementary interventions;

vi. Establish a system for linking vulnerable individuals to other services, like social assistance, social security and other livelihood, food and nutrition;

vii. Provide start-up kits and apprenticeships to care leavers, caregivers and other vulnerable individuals;

viii. Awareness creation among care givers on laws that protect rights and property of vulnerable individuals;

4.4.2.2 Mainstreaming needs of SCSS beneficiaries in policies, programmes and guidelines of key MDAs

To uphold the principles of equity and holistic well-being, it is important to mainstream the needs of SCSS. This holistic approach not only acknowledges the multi-faceted requirements of individuals seeking social care and support but also envision a comprehensive framework that transcends traditional boundaries, ensuring that beneficiaries receive some form of assistance that addresses their diverse challenges. It is therefore important that these needs are integrated into policies, programmes and guidelines of key MDAs. The following key actions will be undertaken:

i. Ensure affirmative action for inclusive access to social services;

ii. Provide auxiliary services for vulnerable individuals;

iii. Develop guidelines for provision of courtesy services to vulnerable individuals like PWDs, frail and chronically ill individuals, pregnant and mothers with children among others;

iv. Integrate SCS services and needs to existing government programmes.

4.4.3 Objective 3: To Strengthen the policy and regulatory framework for the delivery of holistic, integrated and quality SCSS to vulnerable individuals

4.4.3.1 Regulating the provision of SCSS

Policy and legislation are key in guiding the delivery of services to vulnerable groups as standards are set for all implementers to follow. The policy and legal framework will focus on integrated and quality SCS services to be provided to vulnerable individuals. To strengthen the regulatory framework for the delivery of holistic, integrated and quality SCSS, the following actions will be implemented:

i) Enact a law to regulate the provision of SCS services and the social service workforce;

ii) Establish a body/unit to regulate the SCS services and the SSW;

iii) Institutionalise accreditation and quality assurance of the social service workforce;

iv) Support Professional Associations of the SSW;

4.4.3.2 Harmonising existing policies with the operational framework for SCSS

The operational framework for SCSS has been developed to ensure the comprehensiveness of the services and focus on the system. The existing policy and legislation will therefore need to be reviewed to address aspects in the operational framework. The action to be undertaken is to enhance the capacity for integration of SCS in MDA programmes, projects plans and activities.

i) Review existing policy and legal frameworks to align with the operational framework;

4.4.4 Objective 4: Strengthening institutional capacity and systems for delivery of holistic and quality SCS Services

4.4.4.1 Enhancing the capacity of the SSW and other duty-bearers to provide SCSS

In best practice for SCSS, human resource capacity is very critical. There is need to train social care professionals, regulate practitioners through licensing or certification procedures, promote professional standards of practice through curricula and programmes, and promote quality of service and quality workforce through professional associations in SCSS. To build the capacity of the SSW, the following actions will be implemented:

i) Institutionalise SCS in university and tertiary training curriculum.

ii) Develop and implement Continuous Professional Development programmes for the SSW.

iii) Develop and implement a capacity building plan for all cadres of the SSW at all levels including pre and in-service training.

iv) Develop quality assurance standards and guidelines for the entire SSW including state and non-state actors.

v) Strengthen the logistical capacity of actors

at national and local levels for delivery of SCS services.

vi) Recruit Social service workforce at national and sub national level (MDAs), local governments and institutions providing SCSS.

vii) Design tailor made training for other duty bearers (Judiciary, Police, NGO staff)

viii) Institutionalise the role of para social workers to support provision of care and protection services at family and community levels

ix) Establish a social service workforce cadre structure domiciled in the MGLSD

4.4.4.2 Strengthening coordination, partnership and collaboration in the delivery of SCSS at all levels

This framework underscores the importance of fostering synergies among relevant stakeholders, organisations, and institutions to create a unified and integrated network for the delivery of SCSS. To achieve this strategy, the following actions will be implemented:

i) Establish and operationalise governance, coordination and implementation structures for SCS at all levels;

ii) Formalize public-private partnerships in the delivery of SCS services;

iii) Map existing Social Care and Support Services

iv) Develop and disseminate quality assurance standards for social care and support services

4.4.4.4 Enhancing availability and utilisation of empirical information for quality assurance of SCSS programme implementation and evidence-based decision making

To ensure effectiveness within the SCSS implementation, it is fundamental that a shift towards evidence-based practice is used as a cornerstone. At the heart of this transformation lies the need to enhance the availability and utilisation of empirical information, a vital resource that empowers stakeholders to ensure the quality assurance of these programmes and make informed decisions. This reflects a commitment towards transparency, accountability, and continuous improvement, where data-driven insights illuminate the path towards optimal programme outcomes. To ensure that SCSS implementation is not just a process but a well-informed endeavour that resonates with the needs and aspirations of the individuals it serves, the following actions will be prioritised:

i) Establish and implement the M&E system for SCS;

ii) Establish and implement a dynamic MIS for SCS;

iii) Scale up operational research, learning and knowledge management for SCSS;

iv) Link SCSS MIS with the National Single Registry (NSR);

4.4.4.5 Enhancing resource mobilisation for delivery of SCSS •

The implementation of this operational framework for SCSS will require logistical, human and financial resources for effective service delivery. The following actions will be implemented:

i. Develop and operationalise a resource mobilisation strategy.

ii. Establish a transparency, accountability and anti-corruption mechanism.

iii. Develop and implement an Advocacy and Communication plan for the framework.

4.5 Expected Outcomes

The implementation of the Operational Framework is expected to result in:

i) Empowered vulnerable individuals for increased involvement and participation in national development.

ii) Improved quality of life for vulnerable individuals.

iii) Improved SCSS targeting individuals.

iv) Enhanced capacity of the social care and support service institutions to implement the SCSS Framework at national and local government level

5.0 PACKAGE OF SOCIAL CARE AND SUPPORT SERVICES

The SCSS Operational Framework provides for the progressive development of a strong preventive, protective, responsive, and sustainable system for providing services to vulnerable individuals, families, and communities. This section outlines the services that need to be put in place so that those in need may access them as and when they may require them based on the vulnerability.

5.1 Package of Social Care and Support Services

In identifying a package of SCSS under this Operational Framework, three typologies/ classifications are used; (i) Category according to demographic characteristics of vulnerable individuals, namely: children, young people, adults and Older persons; (ii) Category according to nature and cause of vulnerability, namely: PWDs, victims and survivors of GBV, and IDPs and refugees; (iii) Services cutting across age groups and vulnerabilities. The prioritised intervention packages for each of the categories mentioned are outlined in the Table 5 below.

Table 5: Continuum of social care and support services

Categories	Package of Social Care and Support Services according to the life cycle	Description
Children	1. Home Based Care	• Persons with health and other needs because of disabilities or other conditions will be provided care and support at home. • They will be assessed, and appropriate care and support provided. The care service provided will meet the practical needs of daily living, mobility needs, educational needs, and changes to the home such as constructing a ramp. • Siblings of the sick or a child with a disability will also be assessed to establish the impact of disability on them. • Parents will also be assessed to find out how caring for their ill or children with disability is impacting their well-being.

Categories	Package of Social Care and Support Services according to the life cycle	Description
		• Appropriate care and support will be provided to the parents. This may include: Helping them take breaks from care, provision of training, provision of equipment, and other material support. • It is assumed that childcare and support at home will be provided informally by the family but in some cases, there may be a need for formal regulated care services in the home.
	2. Foster care / Fostering / Foster family	• This is the full-time care of a child or adolescent within a non-blood related family that agrees to meet the developmental, psychosocial, medical, educational and spiritual needs of a child who is not able to live with his/her parents or extended family. • Foster care will be arranged as a short-term measure while a long-term plan is underway
	3. Adoption	• Adoption is the permanent placement of a child into a family whereby the rights and responsibilities of the biological parents (or legal guardians) are legally transferred to the adoptive parent(s). • Under this arrangement, the child enjoys all the rights a biological child does including inheritance
	4. Safe spaces for children and child rights clubs	• Children's safe places like children's parks should be established in every town. • Every school should have child rights clubs to create awareness and advocate for children's rights.
	5. Residential care	• This is care provided in any non-family-based group setting. It is type of care for a group of children looked after by paid staff in a specially designated facility which is not their own home
	6. Children (Approved) home	• A regulated arrangement where children live together as a group with professional staff looking after them. • A children's home is for children who cannot live in their family home, kinship care, or foster home for various reasons. • An approved home provides substitute family care for a child until such a time as the parents of the child or relatives of the child can provide adequate care to meet his or her basic needs or the child completes three years in the home or attains the age of eighteen years, whichever is earlier. • The homes are required to provide food, shelter, and space for physical, psychological, and social development as well as opportunities to get education and to succeed.

Categories	Package of Social Care and Support Services according to the life cycle	Description
	7. Nursing homes	• A regulated facility which provides accommodation and personal care. • In addition to providing care and support, a nursing home provides nursing and general basic health services. • There will be at least one nurse on duty supporting caregivers to provide care for children.
	8. Supervised independent living	• Settings where children and young persons, accommodated in the community and living alone or in a small group, are encouraged and enabled to acquire the necessary competencies for autonomy in society through appropriate contact with, and access to, support workers. • Such arrangements and support may be provided for individuals or small groups.
	9. Remand homes	• A place declared by the Minister to be a remand home under section 91 of the Children (Amendment) Act 2016 or any other place declared to be a remand home under any enactment. • It is a facility that provides custody to children in conflict with the law (Juvenile offenders). • Juvenile offenders are not supposed to mix with adult offenders in adult prisons
	10. Daycare and breast-feeding centres	• Working mothers require safe spaces for their children while at work like daycare centres, breastfeeding facilities, among others. • Organisations should provide facilities for breast feeding employees
	11. Family support	• Services are provided to families in the community to prevent family disintegration, child abandonment and neglect.
	12. Reintegration	• The process of facilitating a separated child to make a permanent transition back to his or her immediate or extended family and community.
Youth	1. Transition care and support services for young care leavers	• Intended especially for young care leavers who have been in the care system but have now become adults. • It is intended to support them in transitioning out of childcare. The transition process will start when the child is 16 years and by age 18, the child will no longer be under adult care. • Support provided will include health and development, education and training, employment and contact with the family. A multi-disciplinary team of professionals (i.e. health workers, social workers, psychotherapists, housing, and education) will be involved in planning and supporting the transition

Categories	Package of Social Care and Support Services according to the life cycle	Description
	2. Rehabilitation and reintegration	• Support to rehabilitate, especially the youth addicted to drugs and alcohol will be provided; it will also be provided to those with an addiction behaviour such as addiction to gambling, gaming, pornography, or sex. • Rehabilitation aims to support the person with drug-related challenges to overcome their addiction and can be residential or community-based. • Rehabilitation will be provided by professionals including health workers, counsellors, and nutritionists
	3. Youth centres	• A social and recreation centre to support youth considered to be vulnerable or at risk. • It provides an opportunity for social interaction, psychosocial support to and life skills to the youth of different sex, education, age and background.
Older persons	1. Group community daycare	• This is a service provided within the community where people with related challenges or similar conditions will form groups and periodically meet within their locality to receive psychosocial and other forms of support to enhance their resilience and access to basic services.
	2. Domiciliary care	• This is a regulated care service provided in the client's home for clients with significant needs that require care. Domiciliary care providers will be specialists in dementia care, mental health conditions, personal care, physical disabilities, sensory impairments and caring for adults.
	3. Older persons residential care	• A multi-residence housing facility for Older persons. This arrangement is intended for Older persons either unable to live alone or who cannot afford the cost of living alone. In residential accommodation, Older persons are provided with common services such as meals and personal care. • Some homes also provide nursing and medical care. Residential care for the. • Older persons is considered only as a last resort where community care is not available.
Persons with disabilities (PWDs)	1. Specialised rehabilitation services	• A set of interventions designed to optimise functioning and reduce disability in individuals with long-term health conditions. • It is designed to help a child, adult or Older person to be as independent as possible in everyday activities and enables participation in education, work, recreation, social inclusion and meaningful life roles such as taking care of family. • It does so by addressing underlying conditions (such as pain) and improving the way an individual function in everyday life, supporting him/her to overcome difficulties with thinking, seeing, hearing, communicating, eating, self-care or moving around.

Categories	Package of Social Care and Support Services according to the life cycle	Description
		• Parents of children with disabilities require social support to overcome the social stigma and stress of looking after a child with a disability. • They require training and psychosocial support to enable them to take care of children with disabilities.
	2. Formal and informal special needs education	• This type of service is for persons with disabilities (PWDs) that may require specific, learning support to be arranged in special schools and special classes, units or annexes integrated in the ordinary schools. • Specialised services will include the provision of sign language interpreters and braille transcribers; access to resource teachers and resource rooms and use of specialised technologies to access curriculum materials. • Progressively, emphasis will be on promoting an approach of inclusive education which focuses beyond both the traditional and transitional practices of special education and integration.
GBV victims and survivors	Care and support to GBV victims and survivors	• Care and support services will be made available for people who experience sexual and gender-based violence (SGBV). • SGBV care and support services will be provided to persons who experienced controlling, coercive or threatening behaviours, violence, or abuse by those aged 18 years or over who are, or have been, intimate partners or family members regardless of gender. • The abuse may be psychological, physical, sexual, financial, or emotional. Persons who experience SGBV will be supported with counselling services, legal services, social support/psychosocial services, other forms of practical support and accommodation (shelters). • A key service for this group is regulated and safe temporary accommodation (shelters) which is provided by professionals who support clients. • Temporary accommodation will be set up at district and LLG levels for all vulnerable persons assessed as needing emergency accommodation (shelters). • It is also important to make sure a secure secret location is used for providing shelters, so the perpetrators of SGBV cannot track down their victims once they have sought refuge.
IDPs and refugees	1. Shelter and clothing for IDPs and refugees	• Working with disaster and relief agencies, and the mandated sector of Government, support will be extended to IDPs and refugees in the form of shelter, clothing and other basic care requirements. • As with all other vulnerable individuals, IDPs will also require support with social inclusion, skills development, and employment support, among other services.

Categories	Package of Social Care and Support Services according to the life cycle	Description
Crosscutting	1. Skills development	• This will constitute a package of services designed to empower particularly the vulnerable youth, caregivers of vulnerable individuals, and survivors of GBV with skills, start-up kits, and financial resources to sustainably enable their households to provide adequate care and support services to members who are ill, old and/or severely disabled.
	2. Food and nutrition security	• A set of actions will be undertaken to support linkages between agencies providing socio-economic and food security; to identify and promote interventions that seek to prevent the risks that undermine socio-economic and food security in addition to laying down specific measures to mitigate the consequences of shocks that devastate or weaken the capabilities of households to cope.
	2. Mental health services	• These will be regulated services provided to individuals with alcohol addiction, drug addiction or other psychological problems such as depression, anxiety, obsessive-compulsive disorders, postpartum psychosis and other forms of psychosis (i.e. schizophrenia, personality or conduct disorders, and eating disorders). • Mental health services will be provided by psychiatrists, psychologists, social workers, nurses, support workers, occupational therapists, psychological therapists – this may include child psychotherapists, family psychotherapists, play therapists and creative art therapists, primary mental health workers, education mental health practitioners – who work in mental health support teams in schools and colleges, children's well-being practitioners, and specialist in substance misuse workers. • Individuals to be taken care of will be assessed with care and support provided
	4. Psychosocial support services	• Psychosocial support is an assistance that helps individuals and communities heal the psychological wounds and rebuild social structures after an emergency or traumatic or critical event. • Psychosocial services entail all actions that enable vulnerable persons including children, young and old persons to foster resilience and reach their full potential. The services will be extended to those facing (and those likely to be in) a risky situation, or suffering significant physical, emotional or mental harm that may result in their human rights not being fulfilled. • The support will be provided by social workers, counsellors, psychiatrists, nurses, or other psychotherapists. Psychosocial support can help people become active survivors rather than passive victims.

Categories	Package of Social Care and Support Services according to the life cycle	Description
	5. Rehabilitation care	• A set of interventions designed to optimise functioning and reduce disabilities in individuals with health conditions; to help a child, adult or Older person to be as independent as possible in everyday activities and enable participation in education, work, recreation and meaningful life roles such as taking care of family. • This will address underlying conditions (such as pain) and improve the way an individual function in everyday life, supporting them to overcome difficulties with thinking, seeing, hearing, communicating, eating, or moving around.
	6. Palliative care	• Regulated holistic care to be provided to patients with terminal illnesses to relieve the symptoms/pain and reduce the suffering caused by life-threatening diseases. • Palliative care will address physical needs like pain and vomiting; practical needs like finance, work, and accommodation; spiritual needs, emotional needs like depression, anxiety, and fear; and care needs. • Besides the hospital, palliative care will be provided at home and in designated palliative care facilities by a multi-disciplinary team of specialists that may include doctors, nurses, registered dieticians, pharmacists, chaplains, psychologists, and social workers.
	7. Referral services	• A referral is a process of recognising a risk or concern about a child or household, deciding that action needs to be taken and providing information about or referring the child or family to the identified service provider to address the known need. • Referrals include self-referral (e.g. calling a helpline) or a referral from a service provider (e.g. a case worker referring a family to the health clinic). • Referral arrangements will be made for social care and support services rendered by professional agencies, units or departments approved as the primary providers or contractors. • Referrals will need to be made for a variety of services including health, care, nutrition, psychosocial support and safeguarding vulnerable persons.
	1. Legal support	• Vulnerable persons/groups that come into conflict with the law or experience human rights violations require legal support/aid including representation in Courts of Law, mediation, and reconciliation among others.
	2. Nutrition support	• Some vulnerable persons and families require support in the form of essential foods which they may be unable to afford. This can be through direct Government support in the form of foodstuff, cash or by NGOs, FBOs and the private sector (under Corporate Social Responsibility).

5.2 Priority System Strengthening Activities

To deliver a package of SCSS under the Operational Framework, numerous priority activities for the different intervention areas are laid out. Some are tailored towards specific populations of vulnerable individuals, while others respond to nature and causes of vulnerability in general although others more broadly cut across populations and vulnerabilities. To enable efficient and effective delivery of service packages, the Operational Framework also lays out priority activities that serve as enablers. These include Mechanisms to strengthen the provision of SCS at family andcommunity levels; support towards the regulation of services, profession, standards, and training; advocacy; and *pro-bono* legal service mechanisms to support vulnerable groups. Others are: Strengthening coordination, monitoring and supervision of service systems; policy guidelines for mainstreaming of SCSS and expansion of resource base for service delivery through public-private partnerships (PPP) and an endowment fund. A detailed SCSS implementation log frame, which outlines priority activities, performance indicators, timelines for activity implementation and responsible agency/partners is presented in Annex 1 of the Framework.

5.3 Delivery Mechanism for SCSS

Assessment will be undertaken as part of the process of establishing the care needs of a person in need of care or carer. The provision of care and support will depend on the assessment of the needs of the vulnerable person. Assessment will be carried out for the vulnerable person, their carer, their siblings, parents and members of the household.

Client Needs Assessment: This will entail establishing the care needs a person has and how to help them. Assessment will be done by a social worker or jointly with other social service workforce or professionals such as Health workers, occupational therapists, nutritionists, housing officers or police officers as the case may be. It may be done in a single joint visit or independently. Assessment will establish and recommend services to meet health needs, emotional and psychological needs, material needs, social needs, among others. It could also recommend whether the person can be taken care of at home, in a care home or in a nursing home. Any out-of-home care should be considered as a temporary measure. Assessment may also provide information on how the person can get help to solvetheir problem.

Home or living environment Assessment: Assessment will also take place in the home or other location of the person with care needs.In the case of PWDs, or persons with health complications, home assessment may be carried out by an occupational therapist or other appropriate professional to identify the difficulties a person has in going about normal duties in the home. Home assessment aims at making it safer and easier for the vulnerable person with care needs to move easily and do everyday tasks. However, if the person is admitted to hospital, assessment may be done before they are discharged. Assessment in the hospital is to prepare for a patient's care in the community. Assessment may be further done in the office of the Social Worker.

Care giver's Needs Assessment: A carer needs assessment will be carried out for the person who seeks to find out their needs while taking care and how they can be met. Carer assessment may come up with needs such as training, help with caregivers of children, need for breaks, or tools and equipment for taking care.

Child and Family Needs Assessment: The needs of taking care of the child, and the parents of a child with an illness or disability will need to be assessed to determine what the parents need to provide proper care for their child. Assessment of the child will include: Speaking to them directly to ascertain their wishes and feelings. Children eligible for assessment will notonly be for families affected by disability, but also for violence and cases of abuse, or in need of alternative care, or other interventions.

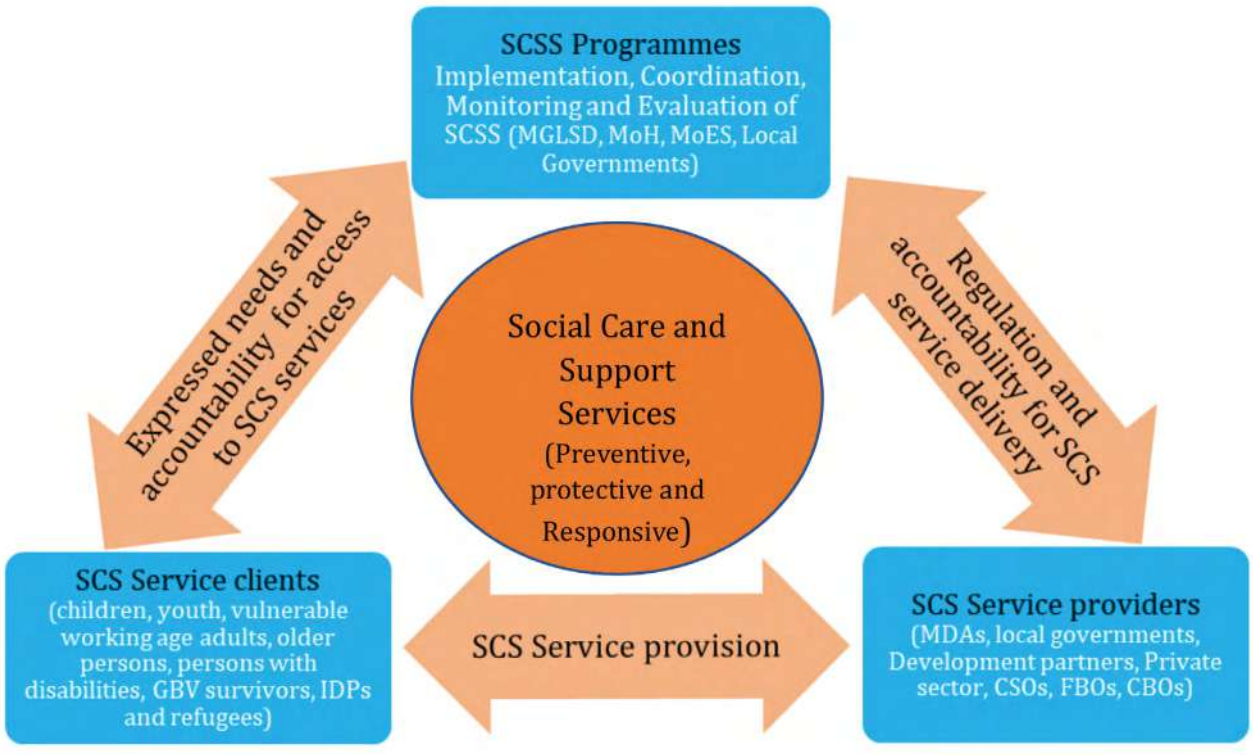
A care and support plan will be prepared for persons with care needs, caregivers, siblings of children in care or parents of children in care who will be supported through public finances.The plan will detail the goals to be achieved, the resources required, and the roles of different stakeholders in implementing the plan. A sample package of services for individuals is indicated in the Annex 1

6.0 IMPLEMENTATION ARRANGEMENTS

6.1 Institutional Framework

The SCSS framework is intended to organise and bring together all actors in the social care and support field to ensure systematic, coordinated and effective execution of social care and support services. Implementation of the SCSS Framework shall be multi-sectoral, multi-agency and multi-disciplinary. The Framework shall be implemented in a partnership arrangement between the Government, the private sector, CSOs and other relevant regional and international organisations. The Constitutional obligations of each level of Government, national and local governments on the provision of social care and support services shall be considered. The functional relationships between the various levels are in Figure 3.

Figure 4: Stakeholders, their function and relevance in SCS implementation



The key institutions in the delivery of SCSS as well as collaborating organisations have been identified as indicated in table 6 and mechanisms for inter-linkages for efficient and effective delivery of services have been articulated.

6.1.1 National level leadership and coordination

The MGLSD will be the lead coordinating agency in the implementation of this framework. The MGLSD, through its relevant departments, shall coordinate both public and private sector actors in SCS across relevant sectors of Health; Education and Sports; Justice and Constitutional Affairs; Internal Affairs; Agriculture, Animal Industry and Fisheries; Public Service; Local Government and local governments. Implementation of the Operational Framework will be integrated into and supported by the existing national-level committees including:

a) **The Policy Steering Committee of the Human Capital Development Programme -** will provide the overall policy and strategic oversight.

b) **The Technical Committee of the Human Capital Development Programme- this Committee will be enhanced with** Heads of agencies of the Government with the mandate to implement social protection and social care (see table 6). This committee provides technical support to the Policy Steering Committee Cabinet Sub-committee.

c) **Social Care and Support Services Coordination Desk -** shall also be establishedwithin the Directorate of Social Protection to coordinate the day-to-day activities of the SCS. The Coordination Desk shall be responsible for planning, budgeting, provision of technical support, resource mobilisation, setting standards, monitoring and coordination**.**

d) **Social Protection Sub-committee of the Social Development Sector Working Group (Programme Working Group) -** comprises MGLSD, other MDAs, Local Governments, CSOs, Development Partners, and the Private Sector under the headship of the Permanent Secretary, MGLSD.

e) **Technical Committee on SCSS -** comprises of MDAs and CSOs providing SCSS. This committee will be responsible for the development, implementation and monitoring and evaluation of SCSS.

f) **National SCSS M&E Technical Working Group -** comprises of M&E specialists from across the social protection and care line MDAs. This committee will be responsible for the collection and utilisation of social care and support information. National-level implementation will be supported by various technical staff in programming, M&E, and finance.

6.1.2 District-level leadership and coordination

The mandate of MGLSD is operationalised at the district level by the Community-based Services Department (CBSD). CBSD is staffed by CDOs and PWOs. However, given the capacity gaps and work overload in the CBSD, and in line with NSPP, the scope of work for the current District Community Development Officer (DCDO) will need to be expanded to comprehensively cater for SCSS. This will require more personnel, other resources and logistical support for the DCDO. To enhance efficiency in the provision of SCS services, probation and welfare functions will be separated. CBSD should have the positions of Probation Officer and Social Welfare Officer.

Coordination of social care work at the district level will be integrated into the existing District Social Protection Committee. Support for the work of the committee should be sourced from existing public resources to local governments and also leveraging local government development partners. Extra roles for social care and support will be added to the Local Government Social Protection Coordination Committee.

6.1.3 Lower local government level leadership and coordination

The MGLSD mandate is executed by the CDO at LLGs level. To strengthen capacity and overcome current gaps and challenges, the staffing levels for CDOs will be increased at the sub-county level to at least two positions (depending on the population), one for overall CDO focusing on, improving the local community economy, infrastructure, and livelihoods, and the second(Social Welfare Officer) focused on identifying, assessing, and coordinating support for individuals, children and families in

need of support and care services, as well as those at risk or in need of protection. The second officer will therefore plan, budget and support lower-level social protection and care staff.

Coordination of social care work at the district level will be integrated into the existing Lower Local Government Social Protection Coordination Committee. Support for the work of the committee should be sourced from existing public resources to local governments and also leveraging local government development partners. Extra roles for social care and support will be added to the Lower Local Government Social Protection Coordination Committee.

6.1.4 Parish-level leadership and coordination

Social protection and care work will be operationalised further at the Parish in line with the new Government policy operationalised under the Parish Development Model (PDM). To strengthen capacity at the Parish, the social care and support function will be embedded at the community level, in a clear Government role, preferably that of the Parish Chief, by including some social work tasks into their job description and making sure these tasks and skills are reflected in their recruitment and training. The long-term goal is to have a Social Welfare Officer at the Parish level responsible for SCS activities. This would also serve to strengthen linkages to the para social workers, and the wider community volunteer system up to the village level. Using the case management approach, in the medium term, the Parish Chiefs will be responsible for registering vulnerable individuals, assessing their needs, coordinating services to meet their social care, support and protection needs, referring clients to other service providers and coordinating these services as well as following up referrals. Parishes will be core structures where prevention efforts will be heavily implemented.

Coordination of social care and protection will be done through the multi-sectoral Parish committee which provides technical guidance and comprises Local Council II (LCII) executives, CSOs, religious institutions and organisations, cultural and traditional leaders, Representatives of interest groups not already represented in the Parish executive. The chairpersons of Local Council I (LCI) of the Parish are members of the Parish Development Committee (PDC) where they bring local issues from their localities.

6.2 Regulation of SCSS

To enhance the effective and efficient delivery of SCSS in the Country, an Act of Parliament to enforce SCSS shall be enacted. The envisaged Act shall, among others, regulate the availability, access, use and sustainability of SCSS while ensuring comprehensiveness of the services. The Act will also regulate the SSW.

6.3 Partnership and Strategic Alliances for SCSS

To implement the Operational Framework, a regulator – the Social Care and Support Council shall be established to regulate the actors. The MGLSD shall also harness partnerships with numerous stakeholders/organisations at different levels across the country, within the East African Community (EAC), Inter-governmental Authority on Development (IGAD), Common Market for Eastern and Southern Africa (COMESA), Southern African Development Community (SADAC), African Union and globally. MGLSD will foster bi-lateral partnerships with various institutions and organisations, such as the World Bank and African Development Bank to mobilise the technical, financial and political support necessary for implementation of the Framework.

6.4 Roles and Responsibilities of Stakeholders in SCSS

The Operational Framework shall be implemented under a multi-sectoral arrangement and the various stakeholders shall perform roles and responsibilities under their mandates as indicated in Table 6.

Table 6: Roles and responsibilities of key institutions

Institution	Role and responsibilities
Cabinet Committee onSocial Protection	• Provide the overall policy and strategic oversight SCSS provision in the country. • Budgetary appropriation. • Monitor resource utilisation and ensure value for money.
Office of the Prime Minister	• Integrate SCSS indicators in the National M&E Framework • Coordinate provision of SCSS for refugees and IDPs, survivors of human and natural disasters. • Preside over monitoring
Ministry of Gender, Labourand Social Development	• Shall provide leadership, guidance, and direction in implementing the strategy. • Popularise SCSS in the country. • Initiate and/or review policies and laws on delivery of SCSS in the country. • Develop guidelines and standards for SCS • Initiate programmes and projects for the delivery of SCSS. • Build the capacity of stakeholders to effectively deliver SCSS. • Monitor and coordinate delivery of SCSS. • Establish and maintain SCSS Information Management System. • Identify and register SCSS implementing partners
Ministry of Health	• Handle referral cases from the community with mental health, chronic or long-term health conditions. • Provide emergency medico-legal assessments in cases of child physical or sexual abuse. • Engage in prevention campaigns for child immunisations, reproductive health, adolescent and Older persons' health needs. • Engage other agencies to facilitate rehabilitative services for PWDs. • mainstream issues of social care and support in their plans ans fund them within their MTEF budget. • Liaise and coordinate with social workers in the community providing care and support, to meet the care needs of their patients, families and communities. • Train community health workers such as VHTs in identifying people with health needs and meeting these needs.
Ministry of Education and Sports	• Ensure the safety, health, and well-being of children and young people while in education. • Liaise and coordinate with social workers to meet the social care, support, and protection needs of the young people. • Identify children/learners with social care and support, address them as much as possible and or refer them to service providers • Guide the establishment of institutions of higher learning as well as ensure delivery of quality and relevant education to all qualified persons. • Regulate the training of social care workers. • Develop programmes for delivery of social protection service and supply specialised teaching materials, and assistive devices. • Sensitise parents and communities to avoid the negative attitude on children with disabilities. • Employ support providers - people with specialised skills like sign language interpreters, and guides for the blind, among others.

Institution	Role and responsibilities
Ministry of Internal Affairs	• Ensure safe custody, humane treatment, and rehabilitation of offenders, and regulation of NGOs. • Collaborate with Probation and Welfare Officers to oversee community and rehabilitation of offenders. • Ensure enforcement of laws following the Constitution of Uganda 1995 as amended, Children Act 2016 as amended and other laws relating to social care and child protection. • Handle cases involving juvenile offenders, witnesses and victims in a manner that respects, protects and upholds their rights and other services.
Ministry of Justice and Constitutional Affairs	• Provide legal services, promote protection of children, including OVC and children with disabilities, handle juvenile offenders and create awareness on children's rights and their welfare. • Provide psychosocial and moral support and build spiritual guidance and provide necessities to vulnerable groups such as food, clothing shelter and education. • Engage in advocacy, conduct research, and build capacity of stakeholders they engage with. • Set and guide cultural norms for holistic development, may initiate and manage community-led programmes.
Ministry of Agriculture, Animal Industry and Fisheries	• Review agricultural policies, appropriate regulations, standards guidelines and plans to mainstream vulnerable groups' issues. • Provide technical guidance, education and training of vulnerable groups in best agronomic practices and backstopping of their initiatives. • Promote marketing, trade, and value addition of vulnerable groups' products. • Support systematic demonstration and promotion of agricultural technologies that are efficient, cost effective and affordable. • Conduct capacity development of various stakeholders engaged in agricultural production, processing and marketing. • Disseminate information on agricultural development. • Promote market access and market information for agricultural products.
Ministry of Local Government	• Coordinate and support Local Governments to provide efficient and effective social care and support services. • Build capacity of Local Governments for planning, budgeting, implementation and monitoring of SCSS activities. • Advocate for a dedicated fund for SCSS development in Local Governments
Local Governments	• Responsible for actual implementation of most of the interventions meant for the beneficiaries and communities • Allocate funds for implementation • Participate in planning and development of SCSS activities. • Provide auxiliary extension services, technical assistance to farmers and other stakeholders. • Support implementation, backstopping, monitoring and evaluation of SCSS activities. • Mobilise and allocate resources for implementation of SCSS activities. • Support the formation and training of groups of vulnerable individuals to promote effective delivery of SCSS. • Support human resource development for implementation of SCSS activities.

Institution	Role and responsibilities
Ministry of Public Service	• Review the roles of social care workers at different levels. • Recruit and deploy social sector workers including teachers, community mobilisers, and health workers. • Remunerate and motivate the social care workforce
Development Partners	• Share global experiences and good practices and alternative approaches to social care and support services provision. • Provide financial and technical support for SCSS provision. • Conduct advocacy and promote research, policy promulgations, evaluations and monitoring of programmes. • Build and strengthen linkages, collaborations and partnerships at international, national, and local government levels
Ministry of Finance, Planning and Economic Development	• Mobilise and allocate financial resources for implementation of the SCSS Framework. • Coordinate foreign direct investments including aid to SCSS Framework. • Create an enabling environment for the PPPs in support of efficient delivery of SCSS. • Monitor resource utilisation and ensure value for money.
Civil Society, NGOs, FBOs and CBOs	• Build partnerships and networks with the Government, other agencies and communities in implementing the framework. • Advocate for effective and efficient SCSS policies and legislations. • Mobilise resources and advocate for increased funding for SCSS programmes. • Participate in the planning, implementation, and monitoring of SCSS programmes. • Monitor compliance with regional and international instruments on SCSS. • Sensitise the communities on SCSS management. • Develop and implement SCSS programmes in accordance with this framework. • Promote and facilitate Social Welfare and Social Development in Uganda. • Promote professional practice, national development, and social transformation.
Private Sector	• Partner with Government in financing and implementing SCSS programmes. • Provide infrastructure and human resource for delivery of SCSS. • Mainstream SCSS issues in Private Sector policies and legislation. • Provide alternative livelihood support for SCSS beneficiaries. • Mobilise funding for management and delivery of SCSS as part of their corporate social responsibility.
Social Care and Support Council	• Regulate social care by registering, monitoring, inspecting, and reviewing the operations of service providers.
Community	• Provide community care for the vulnerable groups, • Mobilise resources both in cash and in-kind to improve care and support to the groups, • Support community engagements and outreaches • identify positive and negative cultural and religious norms and practices that affect vulnerable individuals and address them accordingly.
Beneficiaries	• Participate in identifying and planning initiatives that improve their welfare, • Participate in identifying factors that cause and reinforce their vulnerability. • Participate in monitoring the implementation of the strategy.

6.5 Communication Strategy for SCSS

Provision of reliable information and effective communication is of essence to successful operationalisation of the framework. To improve information flow and management, the MGLSD in collaboration with key actors shall build capacity in policy analysis, and policy brief preparation and invest in information and communication technologies to effectively manage the knowledge generated. MGLSD shall strengthen information sharing with key stakeholders and partners and promote synergies while avoiding duplication.

A Coordination Desk to the Multi-Sectoral Committee established within the Directorate of Social Protection shall work with District CDOs/ Probation Officers to create awareness on the relevance of SCSS among the communities and other actors as well as solicit views/feedback to inform national review and decision-making on the Operational Framework for SCSS. Popular versions and policy briefs in major local languages shall be produced and disseminated. Various communication strategies shall be deployed to reach all stakeholders; technical and non-technical audiences including the private sector, civil society, faith-based and cultural organisations, and the entire public. Key strategies shall include workshops; seminars; media mainly radio, talk shows, television and social media. Others shall include public hearings, “Barazas” and Information, Education and Communication (IEC) materials. Information and knowledge resulting from this communication strategy shall be used to inform planning, SCSS framework reviews and decision-making to improve SCSS delivery in the country.

7.0 FINANCING ARRANGEMENTS

7.1 Overview of Costing and Financing for SCSS

The SCSS have been conceived within the planning and implementation framework of the NSPP. The social protection thrusts have been comprehensively anchored in the Social Development Sector Strategic Plan (SDSSP), the National Development Plan (NDP) and the Uganda Vision 2040. Some aspects of this Operational Framework are also embedded in the Strategic Plans of the various MDAs with mandates to implement this framework. The SDSP takes cognisance of the fact that the high and stable economic growth rates achieved by the Government over the last three decades needs to be matched with the corresponding human progress and development to be manifested through improvement in the quality of life for every person. This human progress and development can be achieved through elimination of all forms of inequality, protection against vulnerability as well as ensuring equal opportunities for all the disadvantaged sections of the population.

7.2 SCSS Costing Plan and Financing Framework

Various sector financing assessments conducted over the past decade indicate that the SDS has been traditionally underfunded, despite having a broad mandate of addressing the concerns of vulnerable and marginalised groups. It is anticipated that the MGLSD will mobilise sufficient funding through the Medium-Term Expenditure Framework (MTEF) and from Development Partners to sustain its lead role in coordinating SDS partners as they espouse the interventions to alleviate the socio-cultural vulnerability of individuals who suffer or are likely to face neglect, abuse, exploitation and social exclusion. The SCSS financing framework is premised on the fact that a large proportion of the resources will be allocated for implementing direct interventions using the service delivery mechanisms of partners in the sector. However, some resources will be devoted towards coordination, monitoring, evaluation, and accountability.

Table 7: Summary of the costs of priority areas of intervention (Ugx 000's)

SN	Objective	Year 1	Year 2	Year 3	Year 4	Year 5	Total	Share
1	Scale up the provision ofholistic, integrated and quality SCSS to vulnerable individuals.	103,415,000	138,186,000	141,869,000	145,590,000	145,925,000	**674,985,000**	**78.0%**
2	Enhance access to complementary services by vulnerable individuals and caregivers.	6,395,000	12,150,000	14,910,000	16,595,000	16,485,000	**66,535,000**	**7.7%**
3	Strengthen the regulatory framework for the delivery of holistic, integrated andquality SCSS to vulnerable individuals.	90,000	120,000	540,000	100,000	80,000	**930,000**	**0.1%**
4	Strengthen institutional capacity and systems for delivery of holistic SCSS.	870,000	17,674,000	28,939,000	36,919,000	38,402,000	**122,804,000**	**14.2%**
	TOTAL	**110,770,000**	**168,130,000**	**186,258,000**	**199,204,000**	**200,892,000**	**865,254,000**	**100.0%**

7.3 Key Assumptions

A Financial Planning Framework has been developed as an integral part of the Operational Framework for SCSS to provide a basis for mobilisation of resources as well as continuous monitoring and evaluation of the budget. In this way, the MGLSD and other actors in the SDS can ensure that the resources are spent most effectively and are reaching the populations of interest. In the preliminary analysis, many of the key parameters in the Financial Planning Framework are constant over the life of the analysis. Depending on the available resources and prevailing socio-economic conditions in the country, the key parameters may vary over time.

Reference year for the unit costs: 2023

Currency: Uganda Shillings.

Expected annual inflation rate for Uganda Shillings: Five (5**)** percent over the life of the analysis. We assume that this remains constant over the life of the analysis.

Expected annual real increases in the unit costs: For simplicity, we have assumed thatthe expected annual real increases in the unit cost over time are zero.

Average number of years for graduation from the interventions: Three (3**)** years. Except for some PWDs, some Older persons, and people with chronic illness, it is assumed that, on average, the beneficiaries of the interventions will need at least two years to become independent of assistance and transition to complete graduation in the third year.

The number of Parishes is 10,595. It is assumed that the number of Parishes will remain constant over the life of the analysis and can be recalculated using estimated increases in this number as needed. The Parish is the locus for community awareness creation on SCSS.

Average number of orphans including other vulnerable children in orphan households: It is assumed that this number remains constant over the life of the analysis. The number of children in orphan households is approximately 2,100,000.

Average number of youth aged (18 - 30) years in Uganda: About 78 percent of Uganda's population is below the age of 30 years. However, the percentage of children below the age of 18 years is 55 percent. It is assumed that this percentage remains constant over the life of the analysis. Therefore, the percentage of youth above 18 and below 30 years is approximately 23 percent (78 percent - 55 per cent = 23 percent) (23 percent × 45.741 million = 10,520,000). Only 10 percent of the youth (vulnerable youth) shall be supported under this framework.

In Table 7, the costs for each of the priority areas of intervention are summarised. A spreadsheet indicating a detailed breakdown of costs is attached to the Operational Framework in Annex 4.

1.4 Sources of Financing for the SCSS Framework

The Operational Framework for SCSS for Uganda will be financed by a variety of revenue streams from within the GOU through the MGLSD Annual Budgets and Medium-Term Expenditure financing arrangements and other MDAs that closely work with the SDS. These external resources will be mobilised from a wide spectrum of mechanisms through bilateral and multi-lateral Development Partners as well as through large global and bilateral mechanisms such as the Global Fund for HIV/AIDS, Malaria and Tuberculosis (GFAMT). In addition, the Private Sector, Local and International NGOs, and CBOs shall play a big role in financing the SCSS since many of themhave a strong relationship with the rural communities where the target groups for the SCSS framework live.

Collaboration and partnerships with Development Partners shall be strengthened to mobilise funding for the implementation of the Operational Framework. Development Partners will be key in providing technical assistance as well as funds for building the capacity for delivery of SCSS. At the same time, MGLSD will require financial support from Development Partners to support its work of coordination, networking, supervision, and capacity building of the community-level CSOs.

1.5 Meeting the Cost for SCSS

Care and support needs will be satisfied and paid for in several ways, including: Free informal care services, free public services, and private services.

7.5.1 Informal, public and CSO services

Identified care needs will be met first by informal service providers, especially social networks of vulnerable persons. The social networks include family, friends, neighbours, workmates, peer support groups, and organisations. These services are normally informal. Beyond the care and support of the informal social network, free care and support will be sought in public institutions such as hospitals, schools, NGOs and CBOs that are not-for-profit.

7.5.2 Public-private partnership

The government will partner with the private sector to support the expansion or improvement of SCSS. Some of the services earmarked for provision through public-private partnerships include:

- Home-based care of chronically ill persons;
- Palliative care of terminally ill persons;
- Institutional care for abandoned children;
- Institutional care for homeless Older persons;
- Mental healthcare and rehabilitation of PWDs.

7.5.3 Private social care and support services

Private SCSS provided by profit-making organisations will be paid for by users through out-of-pocket payment. However, individuals whose needs cannot be satisfied by free services and who are assessed to be eligible for publicly funded care and support will be paid for by the Government.

7.6 Resource Mobilisation Approach

A multi-sectoral approach will be adopted in resource mobilisation for the implementation of the Framework.

a) MGLSD - shall provide leadership, guidance, and direction in implementing the strategy.

b) Other Government MDAs - will be responsible for mainstreaming issues of social protection in their sectors and funding them from their respective sector budgets.

c) Local governments – will implement, fund, co-ordinate, supervise, monitor, mobilise and disseminate the resource mobilization strategy at district and lower local government levels.

d) Development partners – shall provide both financial and technical assistance for the implementation of this strategy as well as share global experiences in the mobilisation of resources for the implementation of social care and support services programmes.

e) Private sector – shall contribute resources, design and implement workplace policies that protect vulnerable groups from exploitation and abuse, and work with MGLSD and other actors to implement the strategy.

f) CSOs – will be responsible for building partnerships and networks with the Government, other agencies, and communities in implementing the strategy.

g) Communities – will be responsible for providing community care for the vulnerable groups, mobilising resources both in cash and in-kind to improve care and support to the groups, and encouraging community discussions to identify cultural and religious norms and practices that negatively affect these groups.

h) Vulnerable individuals - will participate in identifying and planning initiatives that improve their welfare, participate in identifying factors that cause and reinforce their vulnerability and participate in monitoring the implementation of the strategy.

7.7 Key Resource Mobilisation Strategies

Following the current reality of operating in an environment of uncertain resource base, MGLSD will use a five-pronged strategy to increase both internal and external resource mobilisation - which combines incomes from the Government under the Medium-Term Expenditure financing arrangements, funds from interest groups, donations, and sustainable funding from an endowment fund that is to be established. The resources will be employed to provide SCSS to target groups, capacity building and institutional development.

The five-pronged resource mobilisation strategy shall pursue the following thrusts:

a) Raising awareness about SCS through mobilisation, advocacy and lobbying for a supportive environment.
b) Strategic mainstreaming of vulnerable groups issues in Government policies, programmes, and projects.
c) Strengthen private sector partnerships development and management.
d) Strengthen development partners' engagement (grants).
e) Establishing and building an Endowment/ Corpus Fund.

i) Awareness creation

MGLSD will set up and train a Resource Mobilisation Committee (RMC) whose major task will be to coordinate and implement the strategy. The RMC shall also develop a comprehensive Stakeholder Communication Strategy to create awareness and advocate for the rights of vulnerable groups at every level of society, and to inform evidence-based decision-making and programming. Key activities to be espoused under this strategy include:

i) Consolidate relationships with existing donors, seek and establish new ones, and profile a database of existing and prospective Development Partners.
ii) Design and develop appropriate publicity materials to support the work of RMC.
iii) Set up a simple but efficient reporting system to track success in the whole framework implementation.
iv) Build the capacity of duty bearers and other actors in awareness creation and resource mobilisation.

ii) Strategic mainstreaming of vulnerable groups issues

Through influencing policy and legislation, national programmes, and projects and by active participation in the national and programme budget processes, other sectors and actors shall be encouraged to address issues of vulnerable groups in the design, implementation, monitoring and evaluation of their respective interventions at all levels.

iii) Strengthen private sector partnerships

The MGLSD will establish and strengthen relationships with media organisations that will act as its mouthpiece to promote the strategy. Focus will also be given to the Telecom Companies and special Radio and Television programmes will be designed and aired in prime time. The partnership development shall, among other things, include: raising awareness in the private sector institutions and mobilising resources at the same time.

Key activities to be implemented under this sub-strategy will be:

i) Establishing platforms and conducting focus meetings with the private sector and lobbying them to appreciate the importance of investing in the youth, women and children, and other vulnerable groups in the development of Uganda.
ii) Development of funding concept papers and proposals for the private sector to support and engage in vulnerable groups' activities.
iii) Development of MoUs for implementation of joint special programmes between MGLSD and private sector organisations.

iv) Strengthen development engagement with partners

The Ministry will conduct in-depth research on all possible funders to identify those whose mandate and interest are in working with and supporting programmes of vulnerable groups. The Ministry will also profile all the prospective donors and generate a 'Prospect' list of funders who have general interests in the subject area. The target donors shall include:

i) Any interested Governments
ii) Bi-lateral and multi-lateral organisations
iii) Financial institutions
iv) International NGOs
v) Charitable organisations
vi) Grant-making bodies
vii) Development partners
viii) Specialised institutions

The Ministry will further develop funding concepts and project proposals and share them with the prospective Development Partners. Round table conferences and breakfast meetings shall also be organised to engage the Development Partners on the possibilities of funding vulnerable groups' activities.

8.0 MONITORING, EVALUATION, RESEARCH AND LEARNING

8.1 Process and Role of Monitoring and Evaluation of SCSS

Actualisation of the Operational Framework shall be effectively guided through close monitoring and evaluation at management and operational levels. M&E will ensure prudent utilisation of resources, documentation of useful information, and good practices for planning and decision-making purposes. Monitoring will involve the continuous data collection, analysis and reporting on SCS. It will entail tracking performance and compliance with regulations and standards for SCS. Monitoring will focus on tracking activities, processes, and resources.

8.1.1 Performance monitoring

Will focus on tracking interventions/ activities to ensure SCS adequate and good quality services are provided as planned. The purpose is to detect early when interventions/activities are not being delivered as planned.There are two strands of performance monitoring: (i) Routine Monitoring and (ii) PeriodicMonitoring.

(i) ***Routine monitoring****:* This will entail continuous recording, analysing and reporting on the progress of SCS interventions/activities and inputs using a shared database across service providers. It will focus on tracking activities, processes, and events. It will also involve a catalogue of methods comprising: (i) Recording administrative data/information, (ii) Field spot checks/inspections, and (iii) maintaining a diary. A brief description of each is as follows:

Recording Administrative data/ information*:* This will involve capturing data in real-time as the activity happens. The data will comprise qualitative and quantitative biodata of beneficiaries and caregivers, services/support provided, complaints/grievances, payments, visits, training, etc. Administrative data/ information is critical for tracking efficiency and accountability. Tools will include (i) Standardised forms for recording/ capturing data; (ii) Daily logs/diaries; (iii) Registers; (iv)Automated data collection tools (i.e., Open Data Kit for monitoring and evaluation (ODK), Field Task).

Field spot checks, inspections, or follow-up*:* This will involve visits by designated staff inGovernment MDAs and partner CSOs to the vulnerable persons. The purpose is to assess the condition of the progress of vulnerable persons and verify the support provided. Field visits will involve interactions with beneficiaries, caregivers, service providers and community leaders. It will involve capturing primary data through interviews, meetings, informal discussions, observations and reviewing

records. Tools will include (i) Checklists, (ii) Interview/discussion guides, (iii) Monitoring forms, and (iv) automated data collection tools (ODK, Field Task).

Vulnerable person diary: Each vulnerable person will be provided with a diary to record services received, changes felt/ observed, grievances/complaints, visitors received, etc. The diary will be a primary source of data/information about the vulnerable person. It will be filled by the vulnerable person, caregivers, and service providers.

(ii) ***Periodic monitoring:*** This will focus on tracking outputs and immediate outcomes at regular intervals (i.e., monthly, quarterly, bi-annually, or annually). A family of methods will be used, including (i) Progress reporting, (ii) Reviews, (iii) Focus Group Discussions, and (iv) Supervision missions. A brief description of each is as follows:

Progress reporting: This will involve tracking SCS services through periodic reporting. Reporting will be required at all levels, including LLGs and national levels. Reports will be compiled monthly, quarterly, and annually by social care and support officers at all levels. The reports will provide information on services delivered, achievement of targets, resource utilisation, grievances/complaints, and constraints/challenges. The reports will provide an analysis of performance, including trends and behaviour patterns. The tools will include (i) Reporting templates and (ii) MIS/Database.

Periodic reviews: These will be conducted monthly, quarterly, and annually at different levels. The purpose of the reviews will be to bring together the relevant stakeholders to take stock of the progress in providing social care and support to vulnerable persons. At LLG levels, these reviews will be conducted monthly or quarterly at the district level and annually at national level. The tool to be used will be a Review Guide.

Supporting supervision: This is meant for staff and will take place at all levels by supervisors to track the performance of their staff and address weaknesses/gaps. Support supervision should also ensure support in professional development and overcoming burnout, among others. It is recommended that support supervision should be carried out through group supervision sessions by a multi-disciplinary team every quarter. Feedback should be given to the staff and the beneficiaries. The tool to be used will be a Checklist.

8.1.2 Compliance monitoring tools and methods

Will focus on tracking compliance with policies, laws, regulations, standards and guidelines regarding social care and support. The purpose is to detect cases of non-compliance to avoid compromising the quality of services and breaking the laws. This will be done through periodic inspections and compliance audits.

(i) ***Compliance inspections:*** Periodic compliance inspections will be undertaken bythe Social Care Council to assess the level of compliance with standards, guidelines, regulations, policies, laws, or contractual provisions. Some of the inspections will be impromptu and others planned. The tool to be used will be a Checklist.

(ii) ***Compliance audits:*** This will involve assessing whether the SCS service providers are conforming to regulatory requirements and performance standards. The purpose is to ensure compliance with SCS regulations and standards. Compliance audits will be undertaken by the regulator using internal or external auditors. The tool to be used will be a Checklist.

1.1.3 Evaluation

Will entail periodic and objective assessment of the progress towards the goal and objectives of SCSS. It will focus on outcomes, impacts and lessons learned. The primary objective of the M&E system will be to foster programme and financial accountability and enhance learning on what works and what does not in implementing the Framework. The Framework takes into consideration the existing M&E initiatives and addresses some of the gaps. Based on the Theory of Change (TOC) for SCS, it presents the

M&E component including objectives, key performance indicators, methods and roles of the different actors.

Evaluation will involve periodic and objective assessment of the effectiveness, impact and sustainability of social care and support services. Evaluations will comprise: (i) Baseline;

(ii) Annual surveys, (iii) Mid-term evaluation, (iv) Thematic, and (iv) Impact evaluation. Among key stakeholders during the landmark moments of implementing the framework, the input of beneficiaries will be sought.

1.2 Management Information System (MIS)

Data/information is a critical resource in SCSS delivery. This will involve establishing a functional MIS at the national level to maintain data on SCS. A centralised web-based database will be established and managed by the MGLSD. Data collection will be automated using data collection software like ODK, Field Task and others uploaded on Android phones. This will reduce time and errors in data capture and entry. Data to be captured will include Biodata of the vulnerable persons, caregivers and support services, training, community engagements, grievances, and human resources information, including details about the number and qualifications of the SSW and vacancy rates, among others.

There is need for integration of the MIS with other MDAs like MGLSD, MoH, Uganda Police, MES, among others, for ease of sharing data and reducing duplications and conflicting data. The National Information Technology Authority of Uganda (NITA-U) should guide the development of the integrated MIS for SCS.

1.3 Quality Assurance

Quality Assurance will involve a structured assessment of compliance with standards/ specifications at the different stages of SCS service delivery. This will also involve developing quality standards and/or specifications for the different SCS services. The standards/specifications will provide benchmarks for quality assurance.

As part of the initial activities for operationalising this SCS framework, MGLSD will develop a quality assurance plan detailing the activities, stages, and timing of the quality assurance for the different SCSS. Tools, including checklists and templates, will be developed to guide the quality assurance process. The SCSS duty bearers and service providers will be trained on quality standards and how they will be assessed. Quality management will be integrated into all SCSS. Quality audits will be conducted annually by the MGLSD. Supervision of service staff will also be prioritised as an additional quality assurance mechanism.

Operationalisation of the Operational Framework shall be effectively guided through close monitoring and evaluation at management and operational levels. M&E will ensure prudent utilisation of resources, documentation of useful information, and good practices for planning and decision-making purposes. Monitoring will involve the continuous data collection, analysis and reporting on SCS. It will entail tracking performance and compliance with regulations and standards for SCS. Monitoring will focus on tracking activities, processes, and resources. On the other hand, evaluation will entail periodic and objective assessment of the progress towards the desired goal and objectives of SCSS. It will focus on outcomes, impacts and lessons learned. The primary objective of the M&E system will be to foster accountability for results and enhance learning on what works and what does not in implementing the Framework. The Operational Framework takes into consideration the existing M&E initiatives and addresses some of the gaps/ weaknesses. Based on the TOC for SCS, it presents the M&E mechanisms including objectives, key performance indicators, methods and tools, and roles of the different actors.

1.4 Priority Areas and Key Performance Indicators

A list of priorities, key result areas, service areas and key performance indicators (KPIs) for assessing outcomes and impacts across all priority interventions of SCSS are presented in Tables 9 and 10, as shown below:

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Annex 1: Minimum Package of Category – specific and cross-cutting SCS services

No	Vulnerable Individual	• Minimum Package of Services
1.	Neglected child	• Assessment • Psychological support • Family tracing • Foster care • Legal support to ensure that one or both parentscarry out their responsibility • Access to basic needs (i.e. food, clothing and shelter) • Referral for social services
2.	Abandoned child	• Assessment • Psychosocial support • Family tracing • Foster care • Guardianship or adoption • Access to basic needs (i.e. food, clothing and shelter) • Referral for social services • Institutional care (as a last resort)
3.	Child in conflict with thelaw	• Social inquiry • Legal representation • Psychosocial support • Rehabilitation • Family tracing • Diversion • Reintegration or placement in a fit family • Access to basic needs (i.e. food, clothing and shelter) • Referral for social services
4.	Child in contact with thelaw	• Assessment • Psychosocial support • Access to basic needs (i.e. food, clothing and shelter) • Relevant legal support
5.	Child with disability	• Assessment • Psychosocial support for the child • Psychosocial support for caregivers • Provision of assistive devices • Rehabilitation • Habilitation • Therapy • Personal care services • Building family capacity to support CWDs • Recreation services • Auxiliary aids and services • Access to basic needs (i.e. food, clothing and shelter) • Referral for social services
6.	Chronically ill child	• Assessment • Psychosocial support • Palliative care • Personal care services • Access to basic needs (i.e. food, clothing and shelter) • Specialised health care

No	Vulnerable Individual	• Minimum Package of Services
7.	Child in worst forms of labour	• Assessment • Psychosocial support • Rehabilitation • Provision of basic needs (i.e. food, clothing and shelter) • Referral for social services
8.	Child living and workingon the streets	• Assessment • Psychosocial support • Rehabilitation • Provision of basic needs (i.e. food, clothing and shelter) • Family tracing • Reintegration • Referral for social services
9.	Child engaged in drug and substance abuse	• Psychosocial support • Rehabilitation • Reintegration • Referral for social services
10.	Child mother	• Assessment • Psychosocial support • Legal representation • Rehabilitation • Reintegration • Provision of basic needs (i.e. food, clothing and shelter) • Referral for social services (i.e. health, education)
11.	Youth with disability	• Assessment • Psychosocial support for the youth and the caregivers • Provision of assistive devices • Rehabilitation • Habilitation • Therapy • Personal care services • Capacity building for the family in care andsupport • Recreation services • Auxiliary aids and services • Provision of basic needs (i.e. food, clothing and shelter) • Referral for social services
12.	Youth engaged in drug and substance abuse	• Assessment • Psychosocial support • Rehabilitation • Reintegration • Referral for social services
13.	Young mother	• Assessment • Psychosocial support • Rehabilitation • Reintegration • Legal representation • Provision of basic needs (i.e. food, clothing and shelter) • Referral for social services (i.e. health, education)

No	Vulnerable Individual	• Minimum Package of Services
14.	GBV victim and survivor	• Assessment • GBV Shelter • Psychosocial support • Rehabilitation • Legal representation • Life skills training • Referral for social services
15.	Unemployed youth	• Assessment • Psychosocial support • Life skills training • Referral for social services • Referral for socio-economic services (i.e. skilling, training and apprenticeship)
16.	Adult engaged in drugand substance abuse	• Assessment • Psychosocial support • Rehabilitation • Reintegration • Referral for social services
17.	Adult with disability	• Assessment • Psychosocial support • Psychosocial support for caregivers • Provision of assistive devices • Rehabilitation • Habilitation • Personal care services • Building family capacity to provide care andsupport • Recreation services • Auxiliary aids and services • Access to basic needs (i.e. food, clothing and shelter) • Referral for social services
18.	Stressed working adult	• Assessment • Psychosocial support • Wellness check • Health and wellness services • Vacation or sabbatical leave
19.	Older person with disability	• Assessment • Psychosocial support • Psychosocial support for caregivers • Provision of assistive devices • Rehabilitation • Habilitation • Personal care services • Capacity building for the family on care andsupport • Recreation services • Auxiliary aids and services • Provision of basic needs (i.e. food, clothing and shelter) • Referral for social services
20.	Abandoned or neglectedOlder person	• Assessment • Psychosocial support • Provision of basic needs (i.e. food, clothing and shelter) • Referral for social services • Institutional care (as a last resort)

No	Vulnerable Individual	• Minimum Package of Services
21.	Person s with mental illness	• Assessment • Psychosocial support • Emotional and spiritual support • Personal care • Rehabilitation • Health and wellness services • Reintegration • Referral for social services

Annex 2: Social Care and Support Service Implementation Log-Frame

Key Strategy	Priority Actions	Activities	Indicators	Period	Lead Agency	Other partners
Objective 1: Scale up the provision of holistic, integrated and quality SCSS to vulnerable individuals						
Strategy 4.4.1.1 Strengthen personal care services to vulnerable groups	i. Capacity building capacity for personal care givers	Develop personal care guidelines	Number of personal care guidelines developed	2024-2030	MGLSD	MoH, MFPED, CSOs, Dev't Partners, LGs
		Develop training guidelines and train caregivers on personal care for vulnerable individuals	Number of care givers trained in the provision of personal care	2024-2030	MGLSD	MoH, MFPED, CSOs, Dev't Partners
			Number of care givers receiving care and support services	2025-2030		
	ii. Provision of appropriate habitation	Improve housing conditions for vulnerable individuals	Number of decent housing units for vulnerable persons	2024-2030	MLHUD, MGLSD	MoH, MFPED, CSOs, Dev't Partners, LGs, MLHUD, MW&T, Private Sector,
		Carry out assessment of available habitation mechanisms for vulnerable individuals	Number of assessments on available habitation mechanisms for vulnerable individuals	2024-2030	MLHUD	
	iii. Establish home based-care services for vulnerable individuals	Design home-based care services system	Number of home care visits	2025-2030	MOH	MGLSD, MOLG, LGs, OPM, Dev't Partners, Private Sector
4.4.1.2 Strengthening family and community capacity to provide care for vulnerable individuals	i. Build the capacity of family and community institutions to provide SCSS	Develop guidelines for social care and support	Number of guidelines on social care and support developed	2024-2025	MGLSD	MoH, JLOS, CSOs, Dev't Partners, LGs, Private Sector,

Key Strategy	Priority Actions	Activities	Indicators	Period	Lead Agency	Other partners
		Print and disseminate the guidelines for alternative care	Number of guidelines printed and disseminated	2024 -2025	MGLSD	
		Develop a care and support mechanism for care givers	Number of care and support system for care givers	2025-2026	MGLSD	MoH, MOLG, LGs
			Number of service care givers trained and supported	2026- 2030	MGLSD	
	Revitalise traditional and community support mechanisms for vulnerable individuals	Develop gate-keeping guidelines	Number of gate-keeping guidelines developed	2025	MGLSD	MOLG, LGs, OPM, Traditional & Cultural leaders Dev't Partners, Private Sector
		Print and disseminate the gate-keeping guidelines	Number of guidelines printed and disseminated	2024-2030	MGLSD	
		Establish gate-keeping committees	Number of committees established and trained	2024-2030	MGLSD	MOLG, LGs, OPM, Traditional & Cultural leaders Dev't Partners, Private Sector
		Create awareness about SCSS to various community stakeholders (traditional & Cultural leaders, etc.)	Number of the different categories of community leaders trained on SCSS	2024-2030	MGLSD	
		Establish community and peer support mechanisms.	Number of peer support groups established	2025-2030	MGLSD	MOH, MoES, LG, OPM, Dev't Partners, Private Sector
	Establish safe places, sports and recreation centers at the community level	Assessment of the availability of recreation facilities in urban and rural areas	Guidelines for assessment and design of safe spaces and recreation centres	2027-2030	MoES, MLHUD, MGLSD	MGLSD, MOH, MoLG, LG, MoW&T, OPM, Dev't Partners, Private Sector, MoFPED
		Develop guidelines for designing safe places	Number of urban center physical plans with clearly demarcated safe spaces, sports & recreation centers			

Key Strategy	Priority Actions	Activities	Indicators	Period	Lead Agency	Other partners
			Number of safe places, sports and recreation centres established at community/city/town level			
	Strengthen the system for early identification and intervention for vulnerable individual.	Develop early identification and response framework	Number of early identification and intervention framework in place	2027-2030	MoH, MGLSD	MGLSD, LGs, MoJCA, MoES
		Train professionals and SSW and other stakeholders early intervention and response	Number of professionals and SSW trained			
		Create awareness on early identification and interventions	Number of awareness creation events			
	Strengthen parenting mechanisms	Develop a curriculum for Parenting Education and Training	Number of curricula developed	2025-2030	MGLSD	MoH, MoES, MoLG, LGs, CSOs, Dev't Partners, LGs, Private Sector,
		Train parents on various tenets of parenting	Number of parents trained			
		Provide emergency parenting support	Number of parents supported with emergency support			
4.4.1.3 Enhancing access to specialised care for vulnerable individuals	Establish and strengthen access to habilitation services for PWDs.	Map and publish existing specialised care services for PWDs	Number of mapping report produced	2025-2030	MGLSD, MoH,	MoES, MoH, MFPED, CSOs, Dev't Partners, LGs, Private sector
		Deploy habilitation services	Number of vulnerable individuals accessing habilitation services			
		Provide assistive devices for the vulnerable in need	Number of assistive devices provided to vulnerable individuals			

Key Strategy	Priority Actions	Activities	Indicators	Period	Lead Agency	Other partners
	Enhance and expand rehabilitation services for PWDs including community-based rehabilitation.	Provide rehabilitation services for the various categories of vulnerable individuals	Number of PWDs accessing rehabilitation services	2025-2030	MoH, MGLSD, MoES	MoFPED, OPM, MoLG, Dev't Partners,
			Number of people with various vulnerabilities accessing rehabilitation services	2025-2030	MoH, MGLSD, MoES	MoES, OPM, MoLG, Dev't Partners, LG, Private Sector, CSOs
		Institutional care for children with neither family nor alternative support	Number of abandoned children cared for	2025-2030	MGLSD	
			Number of children in remand homes		MGLSD	
			Number of children in rehabilitation homes		MGLSD	
	Provide comprehensive geriatric services that address the medical, social, and emotional needs of older persons.	Review guidelines for geriatric services	Number of guideline reports	2025-2030	MOH, MGLSD,	MoLG, Dev't Partners, Private Sector, CSOs
		Train caregivers and actors on geriatrics	Number of caregivers and actors trained		MoH	MGLSD, LGs, Dev't Partners, Private Sector, CSOs
		Mainstream geriatric services in the minimum health package	Number of geriatric services mainstreamed in the minimum health package			
		Provide geriatric services	Number of older persons accessing geriatric services			

Key Strategy	Priority Actions	Activities	Indicators	Period	Lead Agency	Other partners
	Strengthen reintegration services	Develop and disseminate reintegration guidelines for various categories of vulnerable individuals	Number of reintegration guideline reports developed	2025-2030	MGLSD, MoIA	MOH, MoES, MoLG, JLOS DPs, Private Sector
		Trace and reintegrate vulnerable individuals to families	Number of vulnerable individuals traced and reintegrated in communities and families			
		Resettle vulnerable individuals into communities	Number of vulnerable individuals resettled in communities			
	Develop and implement transitional care services for homeless persons, providing pathways for reintegration into society.	Establish transitional care services at the sub-county level	Guidelines for establishment of Transitional Care	2028-2030	MGLSD, LGs, MoIA	OPM, MoES, MoH, MoLG, MOFPED, OPM, Dev't Partners, Private Sector, HAs, MoW&T, MLHUD
			Number of shelters to accommodate homeless persons constructed			
			Number of vulnerable individuals supported in transitional care homes			
			Number of professional staff facilitated to provide care and support services in transitional homes			
	Strengthen access to mental health and psychosocial support services to	Create public awareness on mental health	Number of advocacy and communication strategy on mental health developed	2025-2030	MOH	MGLSD, LGs, MoES, Private Sector, Dev't Partners, CSOs, LGs

Key Strategy	Priority Actions	Activities	Indicators	Period	Lead Agency	Other partners
			Number of communication materials produced and disseminated			
			Number of radio talk shows			
			Number of television talk shows			
		Provide professional counselling services to the individuals and the caregivers	Number of persons with mental health challenges accessing counselling	2025-2030	MOH, RRH	MGLSD, LGs, MoES, Private Sector, Dev't Partners, CSOs, LGs
			Number of care givers of persons with mental illness accessing counselling			
		Provide specialised care for persons with mental illness	Number of persons with mental illness provided with specialised care	2025-2030	MOH	MGLSD, LGs, MoES, Private Sector, Dev't Partners, CSOs, LGs
			Number of hospitals with psychiatric units			
		Engage persons with mental health challenges in recreation activities	Number of recreation equipment provided	2025-2030	LGs, MOH	MGLSD, LGs, MoES, Private Sector, Dev't Partners, CSOs, LGs
		Organise community outreaches to sensitise households on mental health challenges	Number of community sensitisation events organised	2025-2030	MOH	MGLSD, LGs, MoES, Private Sector, Dev't Partners, CSOs, LGs
	Enhance rehabilitation Services for victims of drug and substance abuse and other addictions	Provide rehabilitation services for victims of substance abuse	Number of drug and substance abusers rehabilitated	2026-2030	MOH	MGLSD, LGs, MoI,A, Dev't Partners, Private Sector

Key Strategy	Priority Actions	Activities	Indicators	Period	Lead Agency	Other partners
		Develop social reintegration mechanisms and post rehabilitation services for drug and substance abuse, forensic patients	Number of rehabilitated drug and substance abusers fully reintegrated and provided with post rehabilitation services	2027-2030	MGLSD	MoH, LGs, MoI,A, Dev't OPM Partners, Private Sector,
	Scale up Provision of Psychosocial Support	Establish mechanisms for stress management at the work place	Guidelines for stress management at workplace developed	2024-2025	MOH	MoPS, MGLSD, LGs, All MDAs
			Number of guidelines for stress management at workplace printed and disseminated	2025-2030	MOH, MGLSD, MoPS	MoPS, MGLSD, LGs, All MDAs
			Number of workplaces with facilities for stress management (Counselling rooms, sports and recreation, breast feeding spaces)			
		Establish spaces for physical exercise in the work places	Number of workplaces with spaces for physical exercise	2025-2030	MOH, MGLSD	OP, MoPS, MoLG, LGs, OPM, All MDAs, Dev't Partners, Private Sector, CSOs
		Provide for a position of counsellors in the workplace including schools	Number of staff trained to provide professional counselling at the workplace	2028-2030	MOPS/MOH	OP, MoPS, MoH, MoLG, LGs, OPM, All MDAs, Dev't Partners, Private Sector, CSOs
		Provide community members access to available sports and recreation facilities	Guidelines for promotion of sports and recreation at the community level developed	2025-2027	MGLSD, MoES, MOH	MoLG, LGs, OPM, Dev't Partners, Private Sector, CSOs

Key Strategy	Priority Actions	Activities	Indicators	Period	Lead Agency	Other partners
			Number of guidelines for promotion of sports and recreation at the community level printed and disseminated	2025-2027		
			Number of sports and recreation clubs established in the communities	2027-2030		
			Number of sports and recreation equipment provided to communities	2025-2030		
		Provide counselling services to community members	Number of community members trained to provide counselling	2025-2030	MOH	MGLSD, MoLG, Dev't Partners, Private Sector, LGs, CSOs
	Expand specialised care to severely and terminally ill persons	Provide palliative and respite care to the people in need	Guidelines for provision of palliative and respite care developed	2025-2025		
			Number of palliative care guidelines printed and disseminated	2025-2027		
			Number of health facilities providing palliative and respite care	2025-2030		
	Improve access to assistive devices and auxiliary services	Establish an effective mechanism for provision of assistive devices to PWDs	Documentation of the number of PWDs who require assistive devices by category	2025-2026	MGLSD	MoH, LGs, Dev't Partners, Private Sector, CSOs
			Number of assistive devices provided to rehabilitated vulnerable individuals	2025-2030	MOH	MGLSD, LGs, Dev't Partners, Private Sector, CSOs

Key Strategy	Priority Actions	Activities	Indicators	Period	Lead Agency	Other partners
			Number of service providers engaged to make assistive devices using appropriate technology		MOH	
			Guidelines for provision of auxiliary services for PWDs developed	2024-2025	MGLSD	MoH, MoES, MoLG, Dev't Partners, Private Sector, CSOs
			Number of guidelines for provision of auxiliary services for PWDs printed and disseminated			
			Number of educational institutions providing auxiliary services	2026-2024	MoES	MGLSD, MoH, LG, CSOs, Dev't Partners< Private
			Number of school children with disabilities accessing auxiliary devices		MoES	
Strategy 1.4: Enhance provision of services for protection of the vulnerable individuals	Build capacity of vulnerable individuals on their rights and obligations	Sensitise the vulnerable individuals and their care givers on their rights	Information material on rights and obligations of the vulnerable individuals developed	2025- 2030	MGLSD	MOIA, MoJCA, JLOS, CSOs, Dev't Partners, Private Sector, LGs
			Number of information material on rights and obligations of the vulnerable individuals printed and disseminated			
	Strengthen alternative care for vulnerable individuals	Establish a mechanism for alternative care for children (Kinship care, foster care, fit for purpose care, guardianship, adoption)	Alternative care framework approved	2025- 2026	MGLSD	MOIA, MoJCA, JLOS, CSOs, Dev't Partners, Private Sector, LGs
			Number of frameworks printed and disseminated			

Key Strategy	Priority Actions	Activities	Indicators	Period	Lead Agency	Other partners
		Place individuals in alternative care, based on their circumstances	Number of vulnerable individuals placed in alternative care	2025- 2026	MGLSD	
			Number of individuals in alternative care followed up			
		Provide residential care for homeless individuals (as a last resort)	Number of homeless individuals in residential care	2025- 2030	MGLSD	JLOS, CSOs, MoW&T, MLHUD, Dev't Partners, Private Sector, LGs
			Number of individuals in residential care followed up			
		Establish day care centres and breast -feeding spaces in the workplace	Number of work places with breast feeding centres	2027-2030	MGLSD	OP, MoPS, MoH, MoLG, LGs, OPM, All MDAs, Dev't Partners, Private Sector, CSOs
	Improve access to legal support services for vulnerable individuals	Collaborate with the Uganda Law Council to strengthen the mechanism for provision of pro bono services to vulnerable individuals by licensed law firms	Guidelines for provision of pro bono services by licensed legal firms developed	2025-2026	JLOS	MOIA, MoJCA, JLOS, CSOs, Dev't Partners, Private Sector, OPM
			Number of guidelines printed and disseminated	2025-2030	MGLSD, JLOS	CSOs, Dev't Partners, Private Sector, OPM
			Number of vulnerable individuals linked to available pro-bono services			
	Expedite administration of justice to children in conflict with the law	Provide probation services to children in conflict with the law	Number of cases involving children in conflict with the law having complete pre-sentence reports	2025-2030	MGLSD, JLOS	CSOs, Dev't Partners, Private Sector, LGs

Key Strategy	Priority Actions	Activities	Indicators	Period	Lead Agency	Other partners
			Number of cases involving children in conflict with the law resolved within the stipulated timeframe		JLOS	
		Strengthen the capacity of JLOS to expedite administration of justice to children in conflict with the law	Number of Judicial officers trained on administration of justice to children	2025-2030	JLOS, MGLSD	CSOs, Dev't Partners, Private Sector, LGs
			Number of prosecutors trained on administration of justice to children			
			Number of courts of law which have assigned specific judicial officers to handle cases of children	2025-2030	JLOS	MGLSD, CSOs, Dev't Partners Private Sector
			Number of police stations which have assigned specific officers to handle cases of children	2025-2030	JLOS	CSOs, Dev't Partners Private Sector
		Expand access to quality rehabilitation services for children in contact with the law.	Number of children in contact with the law accessing quality rehabilitation services	2025-2030	JLOS, MGLSD	
		Collaborate with the Uganda Law Council to secure commitment of lawyers to represent children who have committed capital offences in every region.	Number of lawyers committed to represent children in the various regions	2025-2030	JLOS	MGLSD, CSOs, Dev't Partners Private Sector
	Awareness creation for protection of vulnerable individuals	Raise awareness for protection of vulnerable individuals among duty bearers	Number of awareness activities conducted	2025-2030	MGLSD	JLOS, CSOs, Dev't Partners, Private Sector, LGs

Key Strategy	Priority Actions	Activities	Indicators	Period	Lead Agency	Other partners
			Number of Information, Education and Communication (IEC) material developed			
			Number of IEC materials designed and printed			
			Number of events to sensitise vulnerable individuals organised			
Strategy 1.5: Enhance safeguarding of vulnerable individuals while accessing SCSS	Strengthen safeguarding practices in provision of SCSS	Develop guidelines on safeguarding	Guidelines for safeguarding developed	2024 - 2030	MGLSD	JLOS, MoH, MoES, Private sector, All MDAs, LGs
			Number of guidelines printed and disseminated			
		Support institutions to develop safeguarding policies	Number of duty bearers trained on safeguarding for vulnerable individuals	2026-2030	MGLSD	JLOS, MoH, MoES, Private sector, All MDAs, LGs
			Number of institutions supported to develop safeguarding policies			
	Enforce laws and regulations on safeguarding	Build the capacity for enforcement of laws and regulations on safeguarding	Number of Judicial officers trained on safeguarding for vulnerable individuals	2024 - 2030	JLOS, MGLSD	MoH, MoES, Private sector, All MDAs, LGs
			Number of prosecutors trained on safeguarding for vulnerable individuals			

Key Strategy	Priority Actions	Activities	Indicators	Period	Lead Agency	Other partners
Objective 2: Enhance access to complementary services by vulnerable individuals and care givers						
Strategy 2.1: Empower vulnerable individuals and care givers	Enhance reproductive health of adolescents and youth	Provide reproductive health education and information to adolescents & teenagers	Materials on reproductive health and life skills developed	2025 - 2030	MoH, MGLSD	MOH, MOES, MOLG, LGs, OPM, Dev't Partners, Private Sector
			Number of materials on reproductive health and life printed and disseminated	2025 - 2030	MOH	MGLSD, CSOs, Dev't Partners, Private Sector
			Number of health facilities with adolescents and youth friendly corners			
			Number of adolescents and youth accessing services at the adolescents and youth friendly corners			
			Number of adolescents and youth peer educators trained in adolescent and life skills	2026-2030	MOH, MGLSD	MoES, CSOs, Dev't Partners, Private Sector, CSOs
			Guidelines for integrating reproductive health and life skills in the education system developed	2025-2030	MoES, MoH, MGLSD	LGs, Dev't Partners, Private Sector CSOs,
			Number of guidelines for integrating reproductive health and life skills in the education system printed and disseminated			

Key Strategy	Priority Actions	Activities	Indicators	Period	Lead Agency	Other partners
			Number of schools with teachers who are trained to provide reproductive health and life skills education to pupils and students			
	Enhance access to both formal and informal special needs education for CWDs and PWDs	Take affirmative action to increase enrolment of CWDs in special needs education schools	Number of schools equipped to provide special needs education to CWDs	2025-2030	MoES	MGLSD, MoH, LGs, Dev't Partners, Private Sector, All MDAs running institutions of learning
			Number of school children with disabilities accessing appropriate learning materials			
			Number of teachers recruited and deployed to provide special needs education to CWDs			
			Number of teachers in inclusive education schools oriented to support CWDs			
			Number of PWDs enrolled in formal special needs education schools			
		Provide alternative or non-formal basic education for children	Number of PWDs enrolled in alternative or non-formal basic education	2025-2030	MGLSD	MoES, LGs CSOs, Devt partners, Private Sector
	Enhance access to economic and livelihoods opportunities for vulnerable individuals and care givers	Provide livelihoods support to vulnerable individuals and caregivers	Number of vulnerable individuals and care givers provided with livelihoods skills	2025-2030	MGLSD	MFPED, OPM, MoLG, MoWT, MAAIF, CSOs, Devt partners, Private Sector

Key Strategy	Priority Actions	Activities	Indicators	Period	Lead Agency	Other partners
			Number of vulnerable individuals and care givers supported with start-up packages to engage in IGAs			
			Number of vulnerable individuals and care givers linked to extension services			
			Number of vulnerable individuals and care givers linked to livelihoods support programmes			
			Number of vulnerable individuals and care givers supported to benefit from existing social security programmes			
		Provide employable skills to vulnerable individuals and caregivers	Number of vulnerable individuals and care givers enrolled in apprenticeship programmes	2025-2030	MGLSD	MFPED, MoES, MoLG, LGs, MAAIF, Dev't Partners, CSOs, Private Sector
			Number of vulnerable individuals and care givers enrolled in vocational programmes			
			Number of vulnerable individuals and care givers supported to engage in paid employment			

Key Strategy	Priority Actions	Activities	Indicators	Period	Lead Agency	Other partners
Strategy 2.2: Mainstream complementary needs of SCSS beneficiaries in the policies, programmes and guidelines of key MDAs	Take affirmative action for inclusion of SCSS beneficiaries in programmes of key MDAs	Engage key MDAs to target SCSS beneficiaries through their programmes	Guidelines for mainstreaming complementary needs of SCSS beneficiaries developed	2026-2027	MGLSD	MoH, MoES, MoW&T, MoW&E, MoEMD, other MDAs, Private Sector
			Number of guidelines for mainstreaming complementary needs of SCSS beneficiaries printed and disseminated	2027-2030	MGLSD	
			Number of MDAs with programmes targeting SCSS beneficiaries			
			Guidelines for courtesy in provision of social services	2025-2026	MGLSD	MoWT, MoH, Private Sector, Dev't Sectors,
			Number of guidelines for courtesy in provision of social services printed and disseminated			
			Number of service providers with policies for courtesy in the provision of social services	2026-2030		
Objective 3: Strengthen the policy and regulatory framework for the delivery of holistic, integrated and quality SCSS to vulnerable individuals						
Strategy 3.1: Regulate the provision of SCSS	Enact a law to regulate the provision of SCSS	Review the regulatory framework for provision of SCSS	Regulatory Impact Assessment report	2025-2026	MGLSD	OP, LGs, MoJCA, Parliament, Dev't Partners, Private Sector, CSOs, MoLG, MoFPED
			Principles for a law to regulate the provision of SCSS drafted			

Key Strategy	Priority Actions	Activities	Indicators	Period	Lead Agency	Other partners
			A Bill to regulate the provision of SCSS drafted	2026-2027	MGLSD	MoES, Academia, MoLG, LGs, Private Sector, Dev't Sector
			Regulations for provision of SCSS drafted	2028-2030	MGLSD	
			A functional institutional mechanism for accreditation and quality assurance of the SSW social service workforce	2027 - 2030	MGLSD	
			Guidelines on norms and standards for provision of SCSS developed	2025-2027	MGLSD	MoH, MoES, MoLG,
			Number of guidelines on norms and standards for provision of SCSS printed and disseminated			All MDAs
Strategy 3.2: Harmonise existing policies with the operational framework for SCSS	Mainstream appropriate SCSS interventions in relevant policies	Review existing SCSS related policies of key MDAs	Guidelines for mainstreaming appropriate SCSS interventions in relevant policies developed	2028- 2030	MGLSD	OP, MoLG, LGs, Dev't Partners, Private Sector, CSOs
			Number of policies reviewed	2028- 2030	MGLSD	
			Number of MDAs for mainstreaming appropriate SCSS interventions in relevant policies printed and disseminated	2028- 2030	MGLSD	EOC, UHRC, MoFPED, MoJCA, JLOS

Key Strategy	Priority Actions	Activities	Indicators	Period	Lead Agency	Other partners
Objective 4: Strengthen institutional capacity and systems for delivery of holistic and quality SCSS.						
Strategy 4.1: Enhance capacity of the social service workforce (SSW) and other duty bearers to provide social care and support services	Provide adequate, competent human resource for delivery of SCSS at all levels	Review the human resource capacity for delivery of SCSS	Report of the comprehensive mapping of the SSW	2025-2026	MGLSD, MoPS	MoFPED, OPM, MoES, MoH, MoJCA, MoLG MoIA, LGs Dev't Partners, Private Sector, CSOs
			Number of vacant positions for SSW filled at national and district levels	2025-2030	MGLSD, MoPS, MoH, MoES	
			Number of social service workers dedicated to provision of SCSS in lower local government	2025-2030		
		Develop and implement a capacity building plan for the SSW at all levels	Number of social service workers who have undergone orientation in provision of SCSS	2026-2030	MGLSD, MoPS	MoH, MoES, MoLG, LGs, Dev't Partners, Private Sector, CSOs
			Number of social service workers who have received refresher training in provision of SCSS	2026-2030		
		Review the job descriptions of the SSW	Job descriptions and supervision guidelines for SSW developed	2024-2025	MoPS, MGLSD	
			Number of job description and supervision guidelines for SSW printed and disseminated	2025-2030		
		Align the CBSD to the MGLSD for support supervision	Number of LGs provided with mentoring and support supervision	2025-2030	MGLSD	MoH, MoES, JLOS,
	Institutionalize SCSS in Tertiary training curriculum	Engage tertiary institutions to review their curriculum	Report on the SCSS training gaps in curriculum of tertiary institutions	2028-2030	MGLSD	Academia, MoES, MoH, MoPS
			Number of tertiary institutions that have reviewed their curriculums	2029-2030	MGLSD	Academia, MoES, MoH, MoPS

Key Strategy	Priority Actions	Activities	Indicators	Period	Lead Agency	Other partners
	Enhance professional competency of the SSW	Establish a mechanism for continuous professional development for SSW	Strategy for continuous professional development for SSW developed	2025-2030	MGLSD	Academia, MoES, MoH, MoPS, LGs
			Number of copies of the strategy for continuous professional development for SSW printed and disseminated			
			Number of social service workers with relevant skills acquired after receiving professional training	2026-2030	MGLSD	Academia, MoES, MoH, JLOS
	Improve the logistical capacity for delivery of SCSS	Assess the logistical requirements for CBSD	Report of logistical requirements for the CBSD	2025-2026	MGLSD	MoPS, MoH, JLOS, MoES, MoFPED
		Provide required logistics for delivery of SCSS at all levels	Number of local governments with adequate logistics for delivery of SCSS	2026- 2030	MGLSD	MoFPED, MoPS, MoH, JLOS, MoES
	Recruit the required SSW at national and sub national level (MDAs), local governments and institutions	Conduct a comprehensive mapping of the SSW at all levels including for other MDAs providing SCSS	Report of the SSW	2025-2026	MGLSD, MoPS	MoFPED, Academia, MoES, MoH, MoLG, LGs, Dev't Partners, Private Sector,
		Fill the vacant positions at all levels	Number of positions of the SSW filled across MDAs	2026-2030	MoPS, MGLSD, MoLG, LGs	MoFPED, Respective MDAs
	Develop a common cadre structure for SSW in Government domiciled in the MGLSD	Engage the MoPS and other MDAs to centralise recruitment, deployment and supervision of SSW under the MGLSD	Guidelines for recruitment, deployment and supervision of SSW under the MGLSD developed	2028-2029	MGLSD, MoPS	MoFPED, MoES, MoH, JLOS, MoLG, LGs, Dev't Partners, Private Sector,

Key Strategy	Priority Actions	Activities	Indicators	Period	Lead Agency	Other partners
			Number of guidelines for recruitment, deployment and supervision of SSW under the MGLSD printed and disseminated	2029-2030		
			Cadre management unit established	2029-2030	MGLSD	MoPS, MoFPED, OP
			Number of SSW from other sectors oriented			
	Institutionalise para-social work	Conduct a mapping of existing para-social workers	Mapping Report of Para social workers	2026-2027	MGLSD, MoH	MoPS, MoLG, LGs, Humanitarian Actors, Dev't Partners, CSOs, Private Sector
		Build consensus with institutions with para social workers	Consensus report	2026-2027	MGLSD, MoH	
		Register, train and deploy para-social workers	Number of para-social workers registered, trained and deployed	2028-2030	MGLSD, MOH	
Strategy 4.2: Strengthen coordination, partnership and collaboration in delivery of SCSS at all levels.	Support the functionality of coordination structures for effective delivery of SCSS at all levels	Mapping of key SCSS providers in different sub-regions	SCSS providers mapping reports	2025-2026	MGLSD	MoH, MoES, LGs, MoLG, JLOS, Dev't Partners, CSOs
			Number of copies of the SCSS providers mapping report printed and disseminated			
			Number of SCSS service providers committed to collaborate with Government in delivery of SCSS	2027-2028	MGLSD	MoH, MoES, JLOS, MTIC,
		Proactively engage key stakeholders in joint planning for and implementation of SCSS programmes	Number of local governments with functional coordination structures	2025-2030	MGLSD	MoH, MoES, Dev't Partners, Private sector, Traditional Institutions, CSOs

Key Strategy	Priority Actions	Activities	Indicators	Period	Lead Agency	Other partners
			Number of SCSS stakeholders actively participating in established coordination structures at different levels	2026-2027	MGLSD, JLOS, MTIC	MoFPED, Dev't Partners, Private Sector, MoH, MoES
	Formalise partnership with non-state actors for enhancing the scope, coverage and quality of SCSS	Develop and operationalise Public-Private Partnership (PPP) policy for effective delivery of SCSS	PPP policy for effective delivery of SCSS developed			
			Number of copies of PPP policy for effective delivery of SCSS printed and disseminated			
			Number of PPP for delivery of SCSS established	2027-2030	MGLSD	All stakeholders
		Support the platforms for CSOs, Academia, Private and development partners for effective coordination	Number of platforms for various stakeholders established and supported	2025-2030	MGLSD	
	Develop quality assurance standards and guidelines for the entire SSW including state and non-state actors.	Prepare standards and guidelines for delivery of quality SCSS	Quality assurance standards and guidelines in place	2025-2027	MGLSD	Academia, MoES, MoH, MoPS, JLOS, MoLG, LGs
		Provide technical support	Number of MDAs, institutions following the quality standards			
Strategy 4.3: Strengthen the referral system for provision of SCSS	Clarify and simplify the referral pathways for SCSS	Establish a system for early identification, referral and intervention in the process of provision of SCSS	Referral pathways developed	2025- 2030	MGLSD	MoH, MFPED, MGLSD, MOIA, MAAIF, MoW&E, MoW&T, MLHUD, CSOs, Dev't Partners
			Number of guidelines referral printed and disseminated			

Key Strategy	Priority Actions	Activities	Indicators	Period	Lead Agency	Other partners
			Number of vulnerable individuals who have accessed services through a referral pathway			
	Establish a functional case management mechanism for care and support at national and sub- national level	Design a case management system for SCSS	Case management system in place	2025- 2030	MGLSD	MOH, MoES LGs, CSOs, Dev't Partners, Private Sector, CSOs,
			Number of cases handled			
Strategy 4.4: Enhance the availability and utilisation of empirical information for quality assurance of SCSS programme implementation and evidence-based decision making	Establish and implement an effective M&E system for SCSS	Develop a robust system for collecting, processing, analysing and reporting of information on SCSS delivery in Uganda	Baseline report on social care and support needs and services in Uganda	2025-2030	MGLSD	Academia, MoES, MoH, MoPS, JLOS, MoLG, LGs, Dev't Partners, Research Institutions, MoPED, UBOS, NPA
		Carry out baseline annual, mid-term and end line evaluation of the operational framework	Data collection tools and reporting format for SCSS delivery developed	2026-2030		
			Number of officers at national and local government levels trained on SCSS M&E			
			Periodic M&E report on performance of SCSS programmes produced			
			M&E report on performance of SCSS programmes printed and disseminated			

Key Strategy	Priority Actions	Activities	Indicators	Period	Lead Agency	Other partners
		Develop, deploy and operationalise a dynamic MIS for SCSS;	SCSS MIS requirements scoping report	2026-2030	MGLSD, NITA-U	Academia, MoES, MoH, MoPS, JLOS, MoLG, LGs, Dev't Partners, CSOs, NPA
			The first version of the SCSS MIS developed	2026		
			Report on the functionality of the piloted first version of the SCSS MIS	2026-2027		
			A fully functional MIS for SCSS developed	2027-2030		
			Number of SCSS MIS users trained			
			Number of service providers who have deployed the SCSS MIS			
			Number of SCSS MIS users provided with technical support			
			Number of SCSS MIS reports generated, printed and disseminated			
	Scale up operational research, learning and knowledge management for SCSS	Link SCSS MIS with the National Single Registry (NSR) and other GOU data bases	Number of SCSS programmes linked to the NSR	2027-2030	MGLSD	Academia, MoES, MoH, MoPS, JLOS, MoLG, LGs, CSOs, UBoS, NPA
		Commission research studies to inform evidence-based policy formulation and programming	SCSS research agenda developed	2025-2030		
			Number of research studies on SCSS conducted			
			Number of SCSS research reports printed and disseminated			
			Number of officers trained on learning and knowledge management			

Key Strategy	Priority Actions	Activities	Indicators	Period	Lead Agency	Other partners
			Number of collaborations and partnerships for SCSS research			
Strategy 4.5: Enhance resource mobilization for delivery of SCSS	Mobilise the required resources for implementation of the operational framework for SCSS at all levels	Develop and operationalize a resource mobilization strategy;	SCSS resource mobilisation strategy developed	2025-2026	MGLSD, MoFPED	Academia, MoES, MoH, MoPS, JLOS, MoLG, LGs, NPA, CSOs, UBoS
			Cost benefit analysis on social care and support systems conducted	2026-2027	MoFPED, MGLSD	UBOS,
			Number of partnerships for financing SCSS established	2025-2030	MoFPED, MGLSD	MoJCAs, Dev't Partners, CSOs
			SCSS communication and advocacy strategy developed	2026-2030	MGLSD	MoING, MoH, MoES,
	Establish a transparency, accountability and anti-corruption mechanism.	Prepare Transparency, accountability and anti-corruption plan	Transparency, accountability and anti -corruption plan in place	2026-2027	IGG, MGLSD	MoFPED, JLOS, OPM, MoLG, LGs

Annex 3: Key performance indicators at impact and outcome level

Narrative Summary		Indicators	Means of Verification	Assumptions
Goal		**Impact Indicators**		
	To enhance the dignity and productivity of socio-culturally vulnerable individuals.	% of vulnerable groups receiving integrated and quality SCSS.	Survey reports	Vulnerable persons/ families will be responsive toSCS services. Institutions willbe responsive.
		% of vulnerable groups and households accessing complementary services and empowered for sustained survival, participation and development		
		% of regulatory framework reviewed or formulated for the delivery of integrated and quality SCSS.		
		% of institutions, and systems enhanced for the delivery of integrated and quality SCSS.		
Objectives		**Outcome Indicators**		
	To Scale up the provision of holistic, integrated and quality SCSS to vulnerable individuals.	% of caregivers with the capacity to provide personal care services to vulnerable individuals.	Survey reports	There will the political will. Resources willbe availed. Cost of quality SCS services is affordable
		% of communities and/or institutions providing personal care services to vulnerable individuals.		
		% of traditional and community support mechanisms revitalised for provision of SCSS to vulnerable individuals.		
		% of Older persons receiving geriatric services.		
		% of drug and substance abuse and other addictions victims rehabilitated.		
		% vulnerable individuals who received psychosocial support services	Inspection reports	

Narrative Summary		Indicators	Means of Verification	Assumptions
		% of severely and terminally ill persons receiving specialised palliative care services.	Survey reports and inspection reports	There will the political will. Resources willbe availed. Cost of quality SCS services is affordable
		% of vulnerable children and individuals receiving appropriate alternative care services.		
		% of vulnerable individuals aware of their rights to SCSS and obligations.		
		% of vulnerable individuals accessing legal support services.		
		% of children in conflict with the law accessing justice.		
	Enhance access to complementary services by vulnerable individuals and caregivers.	% of vulnerable individuals aware of SCSS and receiving protection services.		
		% of adolescents and youth receiving sexual and reproductive health services.		
		% of CWDs and PWDs accessing both formal and informal special needs education.		
		% of vulnerable individuals and caregivers accessing economic and livelihood opportunities.		
		% of SCSS beneficiaries included in programmes of key MDAs on grounds of affirmative action.		
	Strengthen the regulatory framework for SCSS.	No of regulatory frameworks reviewed and or enacted to regulate the provision of SCSS.	Survey reports and Inspection reports	There will besupport and cooperation from MDAs.
		No of policies, laws, programmes, projects, BFPs, MPS that have integrated social care and support issues for vulnerableindividuals.		

Narrative Summary		Indicators	Means of Verification	Assumptions
	Enhance the capacity of institutions and systems for the provision of quality SCSS.	% of human resources with capacity for effective delivery of SCSS at all levels.	Reports	There will be cooperation from stakeholders. Community structures willbe responsive.
		% of Tertiary Training Institutions that have institutionalised SCSS in their training curriculum.		
		% of SSW with professional competency for provision of SCSS.		
		Number of logistical support mobilised for delivery of SCSS.		
		Common cadre structure for SSW established in Government domiciled in the MGLSD for the delivery of SCSS.		
		% of Institutionalisation of para-social work for effective delivery of SCSS.		
		Level of functionality of coordination structures for effective delivery of SCSS at all levels.		
		Level of formalisation of partnership with non-state actors for enhancing the scope, coverage and quality of SCSS.		
		% of referral pathways for SCSS that are functional.		
		Level of operational research, learning and knowledge management conducted for SCSS.		
		An effective M&E system for SCSS established and functional.		
		Amount of resources mobilised for implementation of the Operational Framework for SCSS at all levels.		

Annex 4: Detailed Costing of the Operational Framework

					QUANTITIES PER YEAR					VALUES (000's UGX) PER YEAR					
Key Strategy	**Priority Actions**	**Activities**	**Indicators**	**Unit Cost 000's UGX**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**Total**
Objective 1: Scale up the provision of holistic, integrated and quality SCSS to vulnerable individuals															
Strategy 1.1. Strengthen personal care services to vulnerable groups	Capacity building capacity for personal care givers	Develop personal care guidelines	Number of personal care guidelines developed	50,000	1	0	1	0	0	50,000	0	50,000	0	0	**100,000**
		Develop training guidelines and Train caregivers on personal care for vulnerable individuals	Number of care givers trained in the provision of personal care	200	40,000	40,000	40,000	40,000	40,000	8,000,000	8,000,000	8,000,000	8,000,000	8,000,000	**40,000,000**
		provide home based personal care services	Number of vulnerable individuals receiving personal care services	200	40,000	40,000	40,000	40,000	40,000	8,000,000	8,000,000	8,000,000	8,000,000	8,000,000	**40,000,000**
	Appropriate habitation for vulnerable individuals	Improve housing conditions for vulnerable individuals	Number of decent housing units for vulnerable persons	30,000	2,000	2,000	2,000	2,000	2,000	60,000,000	60,000,000	60,000,000	60,000,000	60,000,000	**300,000,000**
		Carry out assessment of available habitation mechanisms for vulnerable individuals	Number of assessments on available habitation mechanisms for vulnerable individuals	50,000	0	1	0	0	1	0	50,000	0	0	50,000	**100,000**
Strategy 1.2. Strengthen family and community capacity to provide care for vulnerable individuals	Capacity building for family and community institutions to provide SCSS	Develop guidelines for alternative care options	Number of guidelines on alternative care developed (Kinship care, foster care, fit for purpose care and adoption)	50,000	0	1	0	0	0	0	50,000	0	0	0	**50,000**
		Print and disseminate the guidelines for alternative care	Number of guidelines printed and disseminated	10	0	0	1,000		1,000	0	0	10,000	0	10,000	**20,000**
		Develop a care and support mechanism for care givers	Number of service care givers trained	800	0	0	3,000	3,000	3,000	0	0	2,400,000	2,400,000	2,400,000	**7,200,000**
	Revitalisation of traditional and community support mechanisms for vulnerable individuals	Develop gate-keeping guidelines	Number of gate-keeping guidelines developed	50,000	0	0	1		0	0	0	50,000	0	0	**50,000**
		Print and disseminate the gate-keeping guidelines	Number of guidelines printed and disseminated	10	0	0	0	1,000	1,000	0	0	0	10,000	10,000	**20,000**
		Establish gate-keeping committees	Number of committees established and trained	800	0	0	0	2,000	2,000	0	0	0	1,600,000	1,600,000	**3,200,000**
		Establish safe places and recreation centers at the community level	Assessment of the availability of recreation facilities in urban and rural areas	50,000	0	1	0	0	0	0	50,000	0	0	0	**50,000**
			Number of urban center physical plans with clearly demarcated recreation centers	5,000	0	20	20	20	20	0	100,000	100,000	100,000	100,000	**400,000**
			Number of recreation centres established at community level	5,000	20	50	70	80	80	100,000	250,000	350,000	400,000	400,000	**1,500,000**

					QUANTITIES PER YEAR					VALUES (000's UGX) PER YEAR					
Key Strategy	**Priority Actions**	**Activities**	**Indicators**	**Unit Cost 000's UGX**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**Total**
Strategy 1.3. Enhance access to specialized care for vulnerable individuals	Habilitation of PWDs	Map and publish existing specialised care services for PWDs	Number of mapping report produced	50,000	1	0	0	1	0	50,000	0	0	50,000	0	**100,000**
		Deploy habilitation services	Number of vulnerable individuals accessing habilitation services	500	0	2,500	2,500	2,500	2,500	0	1,250,000	1,250,000	1,250,000	1,250,000	**5,000,000**
		Provide assistive devices for the vulnerable in need	Number of assistive devices provided to vulnerable individuals	350	9,600	9,600	9,600	9,600	9,600	3,360,000	3,360,000	3,360,000	3,360,000	3,360,000	**16,800,000**
	Rehabilitation services for vulnerable individuals	Provide rehabilitation services for the various categories of vulnerable individuals	Number of PWDs accessing rehabilitation services	350	9,600	9,600	9,600	9,600	9,600	3,360,000	3,360,000	3,360,000	3,360,000	3,360,000	**16,800,000**
			Number of people accessing mental health rehabilitation services	500	1,600	1,600	1,600	1,600	1,600	800,000	800,000	800,000	800,000	800,000	**4,000,000**
			Number of people with substance abuse challenges accessing rehabilitation services	500	12,800	12,800	12,800	12,800	12,800	6,400,000	6,400,000	6,400,000	6,400,000	6,400,000	**32,000,000**
			Number of GBV survivors accessing rehabilitation services	500	2,000	2,000	2,000	2,000	2,000	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	**5,000,000**
			Number of children receiving rehabilitation services	350	18,000	18,000	18,000	18,000	18,000	6,300,000	6,300,000	6,300,000	6,300,000	6,300,000	**31,500,000**
		Institutional care for children with neither family nor alternative support	Number of abandoned children	350	3,000	3,000	3,000	3,000	3,000	1,050,000	1,050,000	1,050,000	1,050,000	1,050,000	**5,250,000**
			Number of children in remand homes	350	2,000	2,000	2,000	2,000	2,000	700,000	700,000	700,000	700,000	700,000	**3,500,000**
			Number of children in rehabilitation homes	350	1,000	1,000	1,000	1,000	1,000	350,000	350,000	350,000	350,000	350,000	**1,750,000**
	Geriatric services for older persons	Review guidelines for geriatric services	Number of guideline reports	50,000	0	1	0	1	0	0	50,000	0	50,000	0	**100,000**
		Train caregivers and actors on geriatrics	Number of caregivers and actors trained	800	0	7,800	7,800	7,800	7,800	0	6,240,000	6,240,000	6,240,000	6,240,000	**24,960,000**
		Mainstream geriatric services in the minimum health package	Number of geriatric services mainstreamed in the minimum health package	5,000	1	1	1	1	1	5,000	5,000	5,000	5,000	5,000	**25,000**
		Provide geriatric services	Number of older persons accessing geriatric services	500	0	34,000	34,000	34,000	34,000	0	17,000,000	17,000,000	17,000,000	17,000,000	**68,000,000**
	Reintegration services	Develop and disseminate reintegration guidelines for various categories of vulnerable individuals	Number of reintegration guideline reports developed	10	0	1,000	0	1,000	0	0	10,000	0	10,000	0	**20,000**
		Trace and reintegrate vulnerable individuals to families	Number of vulnerable individuals traced and reintegrated in communities and families	700	500	500	500	500	500	350,000	350,000	350,000	350,000	350,000	**1,750,000**

					QUANTITIES PER YEAR					VALUES (000's UGX) PER YEAR					
Key Strategy	**Priority Actions**	**Activities**	**Indicators**	**Unit Cost 000's UGX**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**Total**
		Resettle vulnerable individuals into communities	Number of vulnerable individuals resettled in communities	700	0	0	100	100	100	0	0	70,000	70,000	70,000	**210,000**
	Transitional care for homeless persons	Establish transitional care services at the sub-county level	Number of shelters to accommodate homeless persons constructed	30,000	0	100	100	100	100	0	3,000,000	3,000,000	3,000,000	3,000,000	**12,000,000**
			Number of vulnerable individuals supported in transitional care homes	200	0	600	1,200	1,200	1,200	0	120,000	240,000	240,000	240,000	**840,000**
			Number of professional staff facilitated to provide care and support services in transitional homes	1,600	0	150	300	300	300	0	240,000	480,000	480,000	480,000	**1,680,000**
	Mental Health Services	Create public awareness on mental health	Number of advocacy and communication strategy on mental health developed	50,000	1	0	0	0	0	50,000	0	0	0	0	**50,000**
			Number of communication materials produced and disseminated	10	0	1,000	1,000	1,000	1,000		10,000	10,000	10,000	10,000	**40,000**
			Number of radio talk shows	3,000	0	20	20	20	20		60,000	60,000	60,000	60,000	**240,000**
			Number of television talk shows	10,000	0	40	40	40	40		400,000	400,000	400,000	400,000	**1,600,000**
		Provide professional counselling services to the individuals and the caregivers	Number of persons with mental health challenges accessing counselling	400	500	500	500	500	500	200,000	200,000	200,000	200,000	200,000	**1,000,000**
			Number of care givers of persons with mental illness accessing counselling	200	2,500	2,500	2,500	2,500	2,500	500,000	500,000	500,000	500,000	500,000	**2,500,000**
		Provide specialised care for persons with mental illness	Number of persons with mental illness provided with specialised care	200	300	300	300	300	300	60,000	60,000	60,000	60,000	60,000	**300,000**
		Engage persons with mental health challenges in recreation activities	Number of recreation equipment provided	900	700	700	700	700	700	630,000	630,000	630,000	630,000	630,000	**3,150,000**
		Organise community outreaches to sensitise households on mental health challenges	Number of community sensitisation events organised	300	0	0	400	800	1,200	0	0	120,000	240,000	360,000	**720,000**
	Services for victims of drug and substance abuse and other addictions	Provide rehabilitation services for victims of substance abuse	Number of drug and substance abusers rehabilitated	800	1,000	1,000	1,000	1,000	1,000	800,000	800,000	800,000	800,000	800,000	**4,000,000**
		Develop social reintegration mechanisms and post rehabilitation services for drug and substance abuse, forensic patients,	Number of rehabilitated drug and substance abusers fully reintegrated and provided with post rehabilitation services	300	1,000	1,000	1,000	1,000	1,000	300,000	300,000	300,000	300,000	300,000	**1,500,000**

					QUANTITIES PER YEAR					VALUES (000's UGX) PER YEAR					
Key Strategy	**Priority Actions**	**Activities**	**Indicators**	**Unit Cost 000's UGX**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**Total**
	Scale up the Provision of Psychosocial Support	Establish mechanisms for stress management at the work place	Guidelines for stress management at workplace developed	50,000	0	1	0	0	0	0	50,000	0	0	0	**50,000**
			Number of guidelines for stress management at workplace printed and disseminated	10	0	0	1,000	1,000	1,000	0	0	10,000	10,000	10,000	**30,000**
			Number of workplaces with facilities for stress management (Couselling room, sports and recreation, breast feeding spaces)	1,000	0	0	500	1,200	1,300	0	0	500,000	1,200,000	1,300,000	**3,000,000**
			Number of staff trained to provide professional counselling at the workplace	1,500	0	0	0	500	500	0	0	0	750,000	750,000	**1,500,000**
		Provide community members access to available sports and recreation facilities	Guidelines for promotion of sports and recreation at the community level developed	50,000	0	1	0	0	0	0	50,000	0	0	0	**50,000**
			Number of guidelines for promotion of sports and recreation at the community level printed and disseminated	10	0	0	1,000	0	1,000		0	10,000	0	10,000	**20,000**
			Number of sports and recreation clubs established in the communities	250	0	1,000	1,000	1,000	1,000		250,000	250,000	250,000	250,000	**1,000,000**
			Number of sports and recreation equipment provided to communities	300	0	1,000	1,000	1,000	1,000		300,000	300,000	300,000	300,000	**1,200,000**
		Provide counselling services to community members	Number of community members trained to provide counselling	100	0	0	1,000	1,000	1,000	0	0	100,000	100,000	100,000	**300,000**
	Expand specialised care to severely and terminally ill persons	Provide palliative and respite care to the people in need	Guidelines for provision of palliative and respite care developed	50,000	1	0	0	0	0	50,000	0	0	0	0	**50,000**
			Number of palliative care guidelines printed and disseminated	10	0	1,000	0	1,000	0	0	10,000	0	10,000	0	**20,000**
			Number of health facilities providing palliative and respite care	1,000	0	300	300	400	400	0	300,000	300,000	400,000	400,000	**1,400,000**
	Improve access to assistive devices and auxiliary services	Establish an effective mechanism for provision of assistive devices to PWDs	Documentation of the number of PWDs who require assistive devices by category	50,000	0	1	0	1	0	0	50,000	0	50,000	0	**100,000**
			Number of assistive devices provided to rehabilitated vulnerable individuals	300	0	5,000	5,000	5,000	5,000	0	1,500,000	1,500,000	1,500,000	1,500,000	**6,000,000**

					QUANTITIES PER YEAR					VALUES (000's UGX) PER YEAR					
Key Strategy	**Priority Actions**	**Activities**	**Indicators**	**Unit Cost 000's UGX**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**Total**
			Number of service providers engaged to make assistive devices using appropriate technology	500	100	100	100	100	100	50,000	50,000	50,000	50,000	50,000	**250,000**
			Guidelines for provision of auxiliary services for PWDs developed	50,000	1	0	0	0	0	50,000	0	0	0	0	**50,000**
			Number of guidelines for provision of auxiliary services for PWDs printed and disseminated	10	0	500	0	500	0	0	5,000	0	5,000	0	**10,000**
			Number of educational institutions providing auxiliary services	100	0	300	300	400	400	0	30,000	30,000	40,000	40,000	**140,000**
			Number of school children with disabilities accessing auxiliary devices	50	0	1,000	1,000	1,000	1,000	0	50,000	50,000	50,000	50,000	**200,000**
Strategy 1.4: Enhance provision of services for protection of the vulnerable individuals	Build capacity of vulnerable individuals on their rights and obligations	Sensitise the vulnerable individuals and their care givers on their rights	Information material on rights and obligations of the vulnerable individuals developed	50,000	1	0	0	0	0	50,000	0	0	0	0	**50,000**
			Number of information material on rights and obligations of the vulnerable individuals printed and disseminated	10	0	1,000	0	1,000	0	0	10,000	0	10,000	0	**20,000**
	Strengthen alternative care for vulnerable individuals	Establish a mechanism for alternative care for children (Kinship care, foster care, fit for purpose care, guardianship, adoption)	Alternative care framework developed	50,000	1	0	0	0	0	50,000	0	0	0	0	**50,000**
			Number of frameworks printed and disseminated	10	0	1,000	0	1,000	0	0	10,000	0	10,000	0	**20,000**
		Place individuals in alternative care, based on their circumstances	Number of vulnerable individuals placed in alternative care	700	0	2,500	2,500	2,500	2,500	0	1,750,000	1,750,000	1,750,000	1,750,000	**7,000,000**
			Number of individuals in alternative care followed up	200	0	2,500	2,500	2,500	2,500	0	500,000	500,000	500,000	500,000	**2,000,000**
		Provide residential care for homeless individuals (as a last resort)	Number of homeless individuals in residential care	1,800	0	500	500	500	500	0	900,000	900,000	900,000	900,000	**3,600,000**

					QUANTITIES PER YEAR					VALUES (000's UGX) PER YEAR					
Key Strategy	**Priority Actions**	**Activities**	**Indicators**	**Unit Cost 000's UGX**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**Total**
			Number of individuals in residential care followed up	200	0	500	500	500	500	0	100,000	100,000	100,000	100,000	**400,000**
	Improve access to legal support services for vulnerable individuals	Collaborate with the Uganda Law Council to strengthen the mechanism for provision of pro bono services to vulnerable individuals by licenced law firms	Guidelines for provision of pro bono services by licenced legal firms developed	50,000	1	0	0	0	0	50,000	0	0	0	0	**50,000**
			Number of guidelines printed and disseminated	10	0	1,000	0	1,000	0	0	10,000	0	10,000	0	**20,000**
			Number of vulnerable individuals linked to available probono services	500	0	500	1,000	1,500	2,000	0	250,000	500,000	750,000	1,000,000	**2,500,000**
	Expedite administration of justice to children in conflict with the law	Provide probation services to children in conflict with the law	Number of cases involving children in conflict with the law having complete pre-sentence reports	200	500	500	500	500	500	100,000	100,000	100,000	100,000	100,000	**500,000**
			Number of cases involving children in conflict with the law resolved within the stipulated timeframe	100	500	500	500	500	500	50,000	50,000	50,000	50,000	50,000	**250,000**
		Strengthen the capacity of JLOS to expedite administration of justice to children in conflict with the law	Number of Judicial officers trained on administration of justice to children	800	30	30	30	30	30	24,000	24,000	24,000	24,000	24,000	**120,000**
			Number of prosecutors trained on administration of justice to children	800	30	30	30	30	30	24,000	24,000	24,000	24,000	24,000	**120,000**
			Number of courts of law which have assigned specific judicial officers to handle cases of children	200	10	20	30	30	30	2,000	4,000	6,000	6,000	6,000	**24,000**
			Number of police stations which have assigned specific officers to handle cases of children	200	10	20	30	30	30	2,000	4,000	6,000	6,000	6,000	**24,000**
		Expand access to quality rehabilitation services for children in contact with the law	Number of children in contact with the law accessing quality rehabilitation services	300	1,000	1,000	1,000	1,000	1,000	300,000	300,000	300,000	300,000	300,000	**1,500,000**
		Collaborate with the Uganda Law Council to secure commitment of lawyers to represent children who have committed capital offences in every region	Number of lawyers committed to represent children in the various regions	800	10	10	20	20	20	8,000	8,000	16,000	16,000	16,000	**64,000**

					QUANTITIES PER YEAR					VALUES (000's UGX) PER YEAR					
Key Strategy	**Priority Actions**	**Activities**	**Indicators**	**Unit Cost 000's UGX**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**Total**
	Awareness creation for protection of vulnerable individuals	Raise awareness for protection of vulnerable individuals among duty bearers	Number of awareness activities conducted	300	400	400	400	400	400	120,000	120,000	120,000	120,000	120,000	**600,000**
			Number of Information, Education and Communication (IEC) material developed	5,000	4	0	4	0	4	20,000	0	20,000	0	20,000	**60,000**
			Number of IEC materials designed and printed	10	0	1,000	0	1,000	0	0	10,000	0	10,000	0	**20,000**
			Number of events to sensitise vulnerable individuals organised	3,000	40	40	40	40	40		120,000	120,000	120,000	120,000	**480,000**
Strategy 1.5: Enhance safeguarding of vulnerable individuals while accessing SCSS	Strengthen safeguarding practices in provision of SCSS	Support institutions to develop safeguarding policies	Guidelines for safeguarding developed	50,000	1	0	0	0	0	50,000	0	0	0	0	**50,000**
			Number of guidelines printed and disseminated	10	0	1,000	0	1,000	0		10,000	0	10,000	0	**20,000**
			Number of duty bearers trained on safeguarding for vulnerable individuals	500	0	200	200	200	200		100,000	100,000	100,000	100,000	**400,000**
			Number of institutions supported to develop safeguarding policies	300	0	200	300	400	400		60,000	90,000	120,000	120,000	**390,000**
	Enforce laws and regulations on safeguarding	Build the capacity for enforcement of laws and regulations on safeguarding	Number of Judicial officers trained on safeguarding for vulnerable individuals	800	0	20	30	40	40	0	16,000	24,000	32,000	32,000	**104,000**
			Number of prosecutors trained on safeguarding for vulnerable individuals	800	0	20	30	40	40	0	16,000	24,000	32,000	32,000	**104,000**
Objective 2: Enhance access to complementary services by vulnerable individuals and care givers															
Strategy 2.1: Empower vulnerable individuals and care givers	Enhance reproductive health of adolescents and youth	Provide reproductive health education and information to adolescents & teenagers	Materials on reproductive health and life developed	5,000	4	0	4	0	4	20,000	0	20,000	0	20,000	**60,000**
			Number of materials on reproductive health and life printed and disseminated	10	0	10,000	0	10,000	0	0	100,000	0	100,000	0	**200,000**

					QUANTITIES PER YEAR					VALUES (000's UGX) PER YEAR					
Key Strategy	**Priority Actions**	**Activities**	**Indicators**	**Unit Cost 000's UGX**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**Total**
			Number of health facilities with adolescents and youth friendly corners	1,000	20	30	40	40	40	20,000	30,000	40,000	40,000	40,000	**170,000**
			Number of adolescents and youth accessing services at the adolescents and youth friendly corners	50	10,000	30,000	50,000	70,000	70,000	500,000	1,500,000	2,500,000	3,500,000	3,500,000	**11,500,000**
			Number of adolescents and youth peer educators trained in adolescent and life skills	700	50	100	200	300	300	35,000	70,000	140,000	210,000	210,000	**665,000**
			Guidelines for integrating reproductive health and life skills in the education system developed	50,000	1	0	0	0	0	50,000	-	-	-	-	**50,000**
			Number of guidelines for integrating reproductive health and life skills in the education system printed and disseminated	10	0	1,000	0	1,000	0	-	10,000	-	10,000	-	**20,000**
			Number of schools with teachers who are trained to provide reproductive health and life skills education to pupils and students	500	0	200	400	400	400	-	100,000	200,000	200,000	200,000	**700,000**
	Enhance access to both formal and informal special needs education for CWDs and PWDs	Take affirmative action to increase enrolment of CWDs in special needs education schools	Number of schools equiped to provide special needs education to CWDs	50,000	10	20	30	40	40	500,000	1,000,000	1,500,000	2,000,000	2,000,000	**7,000,000**
			Number of school children with disabilities accessing appropriate learning materials	200	0	500	500	500	500	0	100,000	100,000	100,000	100,000	**400,000**
			Number of teachers recruited and deployed to provide special needs education to CWDs	5,000	500	1,000	1,000	1,000	1,000	2,500,000	5,000,000	5,000,000	5,000,000	5,000,000	**22,500,000**
			Number of teachers in inclusive education schools oriented to support CWDs	500	200	300	400	400	400	100,000	150,000	200,000	200,000	200,000	**850,000**
			Number of PWDs enrolled in formal special needs education schools	300	2,000	3,000	4,000	4,000	4,000	600,000	900,000	1,200,000	1,200,000	1,200,000	**5,100,000**
		Provide alternative or non-formal basic education for children	Number of PWDs enrolled in alternative or non-formal basic education	200	3,000	5,000	6,000	6,000	6,000	600,000	1,000,000	1,200,000	1,200,000	1,200,000	**5,200,000**
	Enhance access to economic and livelihoods opportunities for vulnerable individuals and care givers	Provide livelihoods support to vulnerable individuals and caregivers	Number of vulnerable individuals and care givers provided with livelihoods skills	200	500	800	1,200	1,200	1,200	100,000	160,000	240,000	240,000	240,000	**980,000**

					QUANTITIES PER YEAR					VALUES (000's UGX) PER YEAR					
Key Strategy	**Priority Actions**	**Activities**	**Indicators**	**Unit Cost 000's UGX**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**Total**
			Number of vulnerable individuals and care givers supported with start up packages to engage in IGAs	300	500	800	1,200	1,200	1,200	150,000	240,000	360,000	360,000	360,000	**1,470,000**
			Number of vulnerable individuals and care givers linked to extension services	100	500	800	1,200	1,200	1,200	50,000	80,000	120,000	120,000	120,000	**490,000**
			Number of vulnerable individuals and care givers linked to livelihoods support programmes	100	3,000	5,000	7,000	7,000	7,000	300,000	500,000	700,000	700,000	700,000	**2,900,000**
			Number of vulnerable individuals and care givers supported to benefit from existing social security programmes	100	2,000	3,000	5,000	5,000	5,000	200,000	300,000	500,000	500,000	500,000	**2,000,000**
		Provide employable skills to vulnerable individuals and caregivers	Number of vulnerable individuals and care givers enrolled in apprenticeship programmes	200	1,000	1,000	1,000	1,000	1,000	200,000	200,000	200,000	200,000	200,000	**1,000,000**
			Number of vulnerable individuals and care givers enrolled in vocational programmes	500	500	500	500	500	500	250,000	250,000	250,000	250,000	250,000	**1,250,000**
			Number of vulnerable individuals and care givers supported to engage in paid employment	100	1,200	1,200	1,200	1,200	1,200	120,000	120,000	120,000	120,000	120,000	**600,000**
Strategy 2.2: Mainstream complementary needs of SCSS beneficiaries in the policies, programmes and guidelines of key MDAs	Take affirmative action for inclusion of SCSS beneficiaries in programmes of key MDAs	Engage key MDAs to target SCSS beneficiaries through their programmes	Guidelines for mainstreaming complementary needs of SCSS beneficiaries developed	50,000	1	0	0	0	0	50,000	0	0	0	0	**50,000**
			Number of guidelines for mainstreaming complementary needs of SCSS beneficiaries printed and disseminated	10	0	1,000	0	1,000	0	0	10,000	0	10,000	0	**20,000**
			Number of MDAs with programmes targeting SCSS beneficiaries	5,000	0	4	4	5	5	0	20,000	20,000	25,000	25,000	**90,000**
			Guidelines for courtesy in provision of social services	50,000	1	0	0	0	0	50,000	0	0	0	0	**50,000**
			Number of guidelines for courtesy in provision of social services printed and disseminated	10	0	1,000	0	1,000	0	0	10,000	0	10,000	0	**20,000**
			Number of service providers with policies for courtesy in the provision of social services	1,000	0	300	300	300	300	0	300,000	300,000	300,000	300,000	**1,200,000**

					QUANTITIES PER YEAR					VALUES (000's UGX) PER YEAR					
Key Strategy	**Priority Actions**	**Activities**	**Indicators**	**Unit Cost 000's UGX**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**Total**
Objective 3: Strengthen the policy and regulatory framework for the delivery of holistic, integrated and quality SCSS to vulnerable individuals															
Strategy 3.1: Regulate the provision of SCSS	Enact a law to regulate the provision of SCSS	Review the regulatory framework for provision of SCSS	Regulatory Impact Asessment report	50,000	1	0	0	0	0	50,000	0	0	0	0	**50,000**
			Principles for a law to regulate the provision of SCSS drafted	30,000	0	1	0	0	0	0	30,000	0	0	0	**30,000**
			A Bill to regulate the provision of SCSS drafted	30,000	0	1	0	0	0	0	30,000	0	0	0	**30,000**
			Regulations for provision of SCSS drafted	30,000	0	0	10	0	0	0	0	300,000	0	0	**300,000**
			A functional institutional mechanism for accreditation and quality assurance of the SSW social service workforce	80,000	0	0	1	1	1	0	0	80,000	80,000	80,000	**240,000**
			Gudelines on norms and standards for provision of SCSS developed	50,000	0	0	1	0	0	0	0	50,000	0	0	**50,000**
			Number of guidelines on norms and standards for provision of SCSS printed and disseminated	10	0	0	0	1,000	0	0	0	0	10,000	0	**10,000**
Strategy 3.2: Harmonise existing policies with the operational framework for SCSS	Mainstream appropriate SCSS interventions in relevant policies	Review existing SCSS related policies of key MDAs	Number of policies reviewed	20,000	2	3	3	0	0	40,000	60,000	60,000	0	0	**160,000**
			Guidelines for mainstreaming appropriate SCSS interventions in relevant policies developed	50,000	0	0	1	0	0	0	0	50,000	0	0	**50,000**
			Number of guidelines for mainstreaming appropriate SCSS interventions in relevant policies printed and disseminated	10	0	0	0	1,000	0	0	0	0	10,000	0	**10,000**
Objective 4: Strengthen institutional capacity and systems for delivery of holistic and quality SCSS.															
Strategy 4.1: Enhance capacity of the social service workforce (SSW) and other duty bearers to provide social care and support services	Provide adequate, competent human resource for delivery of SCSS at all levels	Review the human resource capacity for delivery of SCSS	Number of vacant positions for SSW filled at national and district levels	10,800	0	80	80	120	160	0	864,000	864,000	1,296,000	1,728,000	**4,752,000**
			Number of social service workers dedicated to provision of SCSS in lower local government	9,600	0	120	120	180	240	0	1,152,000	1,152,000	1,728,000	2,304,000	**6,336,000**
			Number of social service workers who have undergone orientation in provision of SCSS	1,400	0	100	100	150	200	0	140,000	140,000	210,000	280,000	**770,000**
			Number of social service workers who have received refresher training in provision of SCSS	2,800	0	200	400	400	400	0	560,000	1,120,000	1,120,000	1,120,000	**3,920,000**

					QUANTITIES PER YEAR					VALUES (000's UGX) PER YEAR					
Key Strategy	**Priority Actions**	**Activities**	**Indicators**	**Unit Cost 000's UGX**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**Total**
			Job descriptions and supervision guidelines for SSW developed	50,000	1	0	0	0	0	50,000	0	0	0	0	**50,000**
			Number of job description and supervision guidelines for SSW printed and disseminated	10	0	500	0	0	0	0	5,000	0	0	0	**5,000**
			Number of districts provided with mentoring and support supervision	1,800	0	800	800	800	800	0	1,440,000	1,440,000	1,440,000	1,440,000	**5,760,000**
	Institutionalize SCSS in Tertiary training curriculum	Engage tertiary institutions to review their curriculum	Report on the SCSS training gaps in curriculum of tertiary institutions	100,000	1	0	0	0	0	100,000	0	0	0	0	**100,000**
			Number of tertiary institutions that have reviewed their curriculums	30,000	0	2	2	2	2	0	60,000	60,000	60,000	60,000	**240,000**
	Enhance professional competency of the SSW	Establish a mechanism for continuous professional development for SSW	Strategy for continous professional development for SSW developed	50,000	1	0	0	0	0	50,000	0	0	0	0	**50,000**
			Number of copies of the strategy for continous professional development for SSW printed and disseminated	10	0	5,000	0	5,000	0	0	50,000	0	50,000	0	**100,000**
			Number of social service workers with relevant skills acquired after receiving professional training	1,200	0	400	400	400	400	0	480,000	480,000	480,000	480,000	**1,920,000**
	Improve the logistical capacity for delivery of SCSS	Provide required logistics for delivery of SCSS at all levels	Number of local governments with adequate logistics for delivery of SCSS	50,000	0	200	400	500	500	0	10,000,000	20,000,000	25,000,000	25,000,000	**80,000,000**
	Develop a common cadre structure for SSW in Government domiciled in the MGLSD Institutionalise para-social work	Engage the MoPS and other MDAs to centralise recruitment, deployment and supervision of SSW under the MGLSD Register, train and deploy para-social workers	Guidelines for recruitment, deployment and supervision of SSW under the MGLSD developed	50,000	1	0	0	0	0	50,000	0	0	0	0	**50,000**
			Number of guidelines for recruitment, deployment and supervision of SSW under the MGLSD printed and disseminated	10	0	500	0	500	0	0	5,000	0	5,000	0	**10,000**
			Number of SSW from other sectors oriented	1,200	0	200	200	200	200	0	240,000	240,000	240,000	240,000	**960,000**
			Number of para-social workers registered, trained and deployed	800	0	1,000	1,000	1,000	1,000	0	800,000	800,000	800,000	800,000	**3,200,000**

					QUANTITIES PER YEAR					VALUES (000's UGX) PER YEAR					
Key Strategy	**Priority Actions**	**Activities**	**Indicators**	**Unit Cost 000's UGX**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**Total**
Strategy 4.2: Strengthen coordination, partnership and collaboration in delivery of SCSS at all levels.	Support the functionality of coordination structures for effective delivery of SCSS at all levels	Mapping of key SCSS providers in different sub-regions	SCSS providers mapping reports	50,000	2	4	4	0	0	100,000	200,000	200,000	0	0	**500,000**
			Number of copies of the SCSS providers mapping report printed and disseminated	10	0	1,000	2,000	2,000	0	0	10,000	20,000	20,000	0	**50,000**
			Number of SCSS service providers commited to collaborate with Government in delivery of SCSS	500	0	100	200	200	0	0	50,000	100,000	100,000	0	**250,000**
		Proactively engage key stakeholders in joint planning for and implementation of SCSS programmes	Number of local governments with functional coordination structures	1,000	0	100	200	400	600	0	100,000	200,000	400,000	600,000	**1,300,000**
			Number of SCSS stakeholders actively participating in established coordination structures at different levels	200	0	2,000	4,000	6,000	8,000	0	400,000	800,000	1,200,000	1,600,000	**4,000,000**
	Formalise partnership with non-state actors for enhancing the scope, coverage and quality of SCSS	Develop and operationalise public-private partnership policy for effective delivery of SCSS	PPP policy for effective delivery of SCSS developed	50,000	1	0	0	0	0	50,000	0	0	0	0	**50,000**
			Number of copies of PPP policy for effective delivery of SCSS printed and disseminated	10	0	1,000	0	1,000	0	0	10,000	0	10,000	0	**20,000**
			Number of PPP for delivery of SCSS established	50,000	0	0	2	2	2	0	0	100,000	100,000	100,000	**300,000**
Strategy 4.3: Strengthen the referral system for provision of SCSS	Clarify and simplify the referral pathways for SCSS	Establish a system for early identification, referral and intervention in the process of provision of SCSS	Guidelines on early identification, referral and intervention developed	50,000	1	0	0	0	0	50,000	0	0	0	0	**50,000**
			Number of guidelines on early identification, referral and interventions printed and disseminated	10	0	1,000	0	1,000	0	0	10,000	0	10,000	0	**20,000**
			Number of vulnerable individuals who have accessed services through a referral pathway	100	0	2,000	4,000	4,000	4,000	0	200,000	400,000	400,000	400,000	**1,400,000**
Strategy 4.4: Enhance the availability and utilisation of empirical information for quality assurance of SCSS programme implementation and evidence based decision making	Establish and implement an effective M&E system for SCSS	Develop a robust system for collection, processing, analysis and reporting of information on SCSS delivery in Uganda	Baseline report on social care and support needs and services in Uganda	50,000	1	0	0	0	0	50,000	0	0	0	0	**50,000**
			Data collection tools and reporting format for SCSS delivery developed	20,000	1	0	0	0	0	20,000	0	0	0	0	**20,000**

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Key Strategy	**Priority Actions**	**Activities**	**Indicators**	**Unit Cost 000's UGX**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**Total**
			Number of officers at national and local government levels trained on SCSS M&E	1,200	0	40	40	40	40	0	48,000	48,000	48,000	48,000	**192,000**
			Periodic M&E report on performance of SCSS programmes produced	30,000	0	2	2	2	2	0	60,000	60,000	60,000	60,000	**240,000**
			M&E report on performance of SCSS programmes printed and disseminated	10	0	500	500	500	500	0	5,000	5,000	5,000	5,000	**20,000**
		Develop, deploy and operationalise a dynamic MIS for SCSS;	SCSS MIS requirements scoping report	50,000	0	1	0	0	0	0	50,000	0	0	0	**50,000**
			The first version of the SCSS MIS developed	100,000	0	1	1	0	0	0	100,000	100,000	0	0	**200,000**
			Report on the functionality of the piloted first version of the SCSS MIS	25,000	0	0	1	0	0	0	0	25,000	0	0	**25,000**
			A fully functional MIS for SCSS developed	50,000	0	0	1	0	0	0	0	50,000	0	0	**50,000**
			Number of SCSS MIS users trained	1,200	0	0	0	400	400	0	0	0	480,000	480,000	**960,000**
			Number of service providers who have deployed the SCSS MIS	1,000	0	0	0	400	400	0	0	0	400,000	400,000	**800,000**
			Number of SCSS MIS users provided with technical support	1,800	0	0	0	400	400	0	0	0	720,000	720,000	**1,440,000**
			Number of SCSS MIS reports generated, printed and disseminated	10	0	0	0	200	200	0	0	0	2,000	2,000	**4,000**
	Scale up operational research, learning and knowledge management for SCSS	Commission research studies to inform evidence based policy formulation and programming	SCSS research agenda developed	30,000	10	0	0	0	0	300,000	0	0	0	0	**300,000**
			Number of research studies on SCSS conducted	50,000	0	2	2	2	2	0	100,000	100,000	100,000	100,000	**400,000**
			Number of SCSS research reports printed and disseminated	10	0	500	500	500	500	0	5,000	5,000	5,000	5,000	**20,000**
			Number of officers trained on learning and knowledge management	1,800	0	200	200	200	200	0	360,000	360,000	360,000	360,000	**1,440,000**
			Number of collaborations and partnerships for SCSS research	1,000	0	20	20	20	20	0	20,000	20,000	20,000	20,000	**80,000**

					QUANTITIES PER YEAR					VALUES (000's UGX) PER YEAR					
Key Strategy	**Priority Actions**	**Activities**	**Indicators**	**Unit Cost 000's UGX**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**Total**
Strategy 4.5: Enhance resource mobilization for delivery of SCSS	Mobilise the required resources for implementation of the operational framework for SCSS at all levels	Develop and operationalize a resource mobilization strategy;	SCSS resource mobilisation strategy developed	50,000	1	0	0	0	0	50,000	0	0	0	0	**50,000**
			Cost benefit analysis on social care and support systems conducted	50,000	0	1	0	0	0	0	50,000	0	0	0	**50,000**
			Number of partnerships for financing SCSS established	1,000	0	50	50	50	50	0	50,000	50,000	50,000	50,000	**200,000**
			SCSS communication and advocacy strategy developed	50,000	0	1	0	0	0	0	50,000	0	0	0	**50,000**
Grand Total										**110,770,000**	**168,130,000**	**186,258,000**	**199,204,000**	**200,892,000**	**865,254,000**

THE REPUBLIC OF UGANDA

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ISBN 978-9913-600-31-6