Noa Freed

East Chapel Hill High School

Chapel Hill, North Carolina, USA

Uganda: Population

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# Uganda: A Proposed Solution to Combat Skyrocketing Populations Causing Malnutrition

For a child in the Global North, dinner is a plate of chicken and mashed potatoes; for a child in Uganda, it's a survival game. While the Western diet is defined by variety and easy-to-grab foods, a day-to-day diet for a child in Uganda often consists of recycling the same three core foods- matooke, posho, and certain stews. Such nutritional monotony is not due to preference or cultural significance, but rather sheer affordability. As a Yemeni Israeli American, I have watched my own heritage be defined by malnutrition and starvation. In turn, it compelled me to look beyond my own borders, into a new perspective, and analyze the crisis of food insecurity in Uganda, where dinner isn't promised.

In Karamoja, a poverty-stricken sub-region, the youth bulge is a significant statistic, a dinner-time reality in which a single plate must be divided among seven, eight, or even ten siblings. Mealtime becomes a competition for basic nutrients, harming the next generation and those who follow. In this region, the total fertility rate exceeds 7.9 children per woman (Mercy Corps, 2024). Among these births, 1 in 5 women want to limit births but cannot access adequate contraception (Mercy Corps, 2024). This issue extends beyond Karamoja, or even Uganda—it is global. More than 220 million women in developing countries have an unmet need for family planning (Population Reference Bureau). In Karamoja, less than 10% of women use any form of contraception. These births are not just among grown, married women; children are affected, too. In Karamoja, approximately 24% of girls aged 15-19 have begun childbearing (Mercy Corps). So, a pregnant woman, aged just 15, could be one of the children splitting that very dinner plate. With Uganda's population growth rate of 2.9% annually, it seems impossible for food resources to remain plentiful (Uganda Bureau of Statistics). Additionally, the infant mortality rate has decreased significantly over the past decade, leading to nearly 70% of Uganda's population being under 30 (National Library of Medicine).

This constant cycle of early childbearing and high fertility rates both crowds the dinner table and creates a significant supply-and-demand imbalance that the Ugandan farmland cannot sustain. As populations boom, available land is divided into even smaller plots due to traditional inheritance practices. For example, when a single family's agricultural plot is divided to accommodate up to ten children rather than two, the land is never allowed to replenish. This leads to eventual soil degradation, revealing barren earth that cannot regenerate nutrients. A repeated pattern is created– a nation of farmers who can no longer sustain their own households because they simply cannot grow enough food sustainably. This significant youth bulge and towering fertility rate are transforming the Ugandan demographic from a once-stable society into a national problem.

Population growth plays a dominant role in Uganda's nutritional crisis, as rapid demographic expansion, 2.9% (UBOS), outpaces agricultural productivity growth, 2% (The World Bank). We cannot ignore the role of women in the household as well. Women in Uganda are simply caregivers and "household producers", but imagine the impact of having them as tools in farming, in addition to their contributions in

the household. The United Nations Development Programme organized a project to promote women-led agriculture in cereals, oilseeds, legumes, poultry, and more. After giving the women infinitely more opportunities to provide for their children by producing their own food, and even generating income for the family as a whole, H.E. Lulu Xingwana, the UNDP Uganda leader, believes that “the Karamoja sub-region has substantial opportunities” and “this empowerment will safeguard their children, particularly young girls, from being trafficked or experiencing teen pregnancy.”

However, the UNDP’s resources are limited. According to Action for Health Uganda, “As of the 2025/2026 Health Sector Budget, donor support for Family Planning commodities dropped from UGX 25.8 billion to UGX 10.7 billion.", meaning the donor support previously provided, amounting to about $7,000,000 USD, has dropped sharply to nearly $4,000,000 USD. This significant funding gap is actively depriving citizens across Uganda of the opportunities we can provide, and is therefore detrimental to their nutrition and food security.

Malnutrition goes beyond the struggle for nutrients and calories. It takes a heavy toll on the Ugandan population, especially the youth. Repeated starchy staples like matooke and posho dominate the diet, while nutrient-dense foods are lacking. As a result, children do not receive enough nutrients for neurological and physical growth. In Karamoja, 41% of children under five suffer from stunting (WFP). This stunting causes compromised immune and nervous systems. Uganda cannot afford such outcomes for the next generation, especially where healthcare is not easily accessible. Thousands of Ugandan children die each year from malnutrition complications and low-calorie intake. This is an unforgivable and irreversible statistic. Such a decline quickly escalates into a societal crisis and deepens the poverty trap. Currently, organizations such as the United Nations Development Programme, the World Food Programme, and Action for Health Uganda work with the Ministry of Health to improve Uganda’s nutrition.

## Proposed Solution

The immediate answer and treatment to population issues that drive malnutrition is family planning tools, directly bridging the gap between contraceptive supply and the health literacy surrounding it. There are various types of contraception or birth control, including single-use options and Long-Acting Reversible Contraceptives, or LARCs. Currently, many organizations are working to provide the delivery of contraceptives, but not the proper education surrounding them to ensure their effectiveness. This gap contributes to both the continued population growth rate and the spread of sexually transmitted infections. For instance, according to the Uganda AIDS Commission, 72% of men in Uganda lack the proper knowledge of how to use a condom correctly. Furthermore, lower levels of education, financial precarity, and inadequate access to food and water are linked to low self-efficacy in condom use (Moses Okumu, Professor of Social Work, UIUC). This underscores that a contraceptive is only as effective as the literacy supporting its use.

To maximize the impact of these interventions, a partnership must be forged among organizations that supply products. Most Ugandan women in limited, rural settings prefer birth control injectables and other LARCs, as they often need to walk long distances to a health center. Community health workers (CHWs) are already used to deliver injectable birth control, the same way they're used to encourage participation in vaccination programs, meaning this intervention requires a redirection of existing resources (Reproductive Health Uganda, DKT International, Pathfinder) rather than new infrastructure, a low-cost, high-leverage change. Beyond delivery, CHWs can provide door-to-door health literacy crash courses at every visit, transforming what was once a simple delivery into an educational message for all. This gives women the agency to manage their own fertility and gives men the confidence to regularly reach for contraceptives, without either group having to sacrifice access due to distance.

To enhance CHWs' influence within communities that carry certain stigmas or prejudices against sexual education, the recommended course of action would be to have the CHW be members of the same village or town they are instructing. Since other townsfolk will recognize and trust those representatives, it will create a more open, understanding environment–much better than a foreign, uncomfortable clinic visit. Keeping in mind that many communities in Uganda have traditional tribal values, this ensures the utmost ease and comfort throughout the entire process.

Next, we must coordinate funding. To reiterate, family planning support has experienced a steep drop– nearly four million USD. A union of organizations already working on the cause, like DKT International and Reproductive Health Uganda, could work together to bridge the funding gap to cover CHW training fees and stipends. Funding being directed towards this CHW education will increase the value of money being spent on supplies– it's not a need for a huge increase in funding, but rather a request for smarter, more intentional allocation of those funds.

The impact of this recommendation extends across every stakeholder group, not just those most visibly affected by early childbearing. For young girls, the effect is fewer early pregnancies driven not by access or supply alone, but by the CHWs delivering health literacy lessons, effectively giving girls the ability to distinguish between a wanted pregnancy and one they simply lack the means to support. As for men, the primary result is a decreased stigma around condom use, driven by literacy programs that reach men directly rather than treating family planning as a women-only issue. Women, as a whole, gain the ability to control the timing and spacing of pregnancies since birth control becomes available regardless of distance from a health center, through deliveries and instructional curriculum presented by CHWs. Institutions, such as the Ministry of Health and Reproductive Health Uganda, are now able to double the impact of their donor funds because of the literacy curriculum, essentially extending their reach and impact. And for every Ugandan, sexually transmitted infections are much less common, which lowers mortality rates nationwide. All in all, populations are able to grow at a pace in which families can control and sustain, which removes the added weight of another mouth to feed on top of existing nutritional strain.

Family planning addresses the root driver of malnutrition, but two existing efforts strengthen its impact. First, Moringa: a fast-growing, nutrient-dense tree already suited to Uganda's tropical climate. Moringa can be grown in small kitchen gardens, requiring minimal land and directly addressing micronutrient gaps in carb-heavy diets like matooke and posho without competing for the fragmented farmland families already struggling to divide among children. Ground into powder to offset its strong flavor, it integrates easily into everyday stews. Second, women-led cooperatives: organized groups focused around the restoration of communal or leased land rather than individual land. These secondary solutions are capable of turning household-level nutrition and reproductive health efforts into a shared community structure rather than isolated interventions.

## Conclusion

This recommendation treats population growth as the structural driver of Uganda's malnutrition crisis, not a background statistic. By pairing contraceptive access with CHW-delivered health literacy, piloted first in Karamoja where need is most acute, this model reduces the demand-side pressure that fragments farmland and strains household food supply–with Moringa cultivation and women-led cooperatives reinforcing the same goal at the community level. Short-term, this means fewer early pregnancies and reduced dependency ratios within households; long-term, it means slower land subdivision and a chance for degraded soil to recover. Rwanda's rise from roughly 4% to over 50% contraceptive prevalence in a decade shows this kind of change is achievable when supply is paired with literacy– Karamoja, with existing CHW infrastructure and committed organizational partners, has a credible path to the same result.

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