



UGANDA

REFUGEE SETTLEMENTS AND HOST DISTRICTS

IPC ACUTE MALNUTRITION ANALYSIS APRIL 2023 – MARCH 2024

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KEY FIGURES		APRIL 2023 – MARCH 2024	
114,202 cases of children aged 6-59 months acutely malnourished IN NEED OF TREATMENT	Severe Acute Malnutrition (SAM)	21,369	
	Moderate Acute Malnutrition (MAM)	92,833	
	13,218 cases of pregnant or lactating women acutely malnourished IN NEED OF TREATMENT		

Overview

How Severe, How Many and When:

Over 114,000 children aged 6-59 months and 13,000 pregnant or breastfeeding women are expected to suffer from acute malnutrition in the 13 refugee settlements and 12 host districts of Uganda between April 2023 and March 2024.

In the 13 refugee settlements (excluding Kampala urban settlement), 2 settlements were classified in IPC AMN Phase 3 (Serious), 6 in IPC AMN Phase 2 (Alert) and 5 in IPC AMN Phase 1 (Acceptable) during the period of April – September 2023. In the projection period of October 2023 – March 2024, the AMN situation is expected to deteriorate in 1 settlement, remain similar in 10 settlements and improve in 2 settlements. However, during the projection period, GAM levels will likely improve in all settlements located in West Nile, Acholi and Kiryandongo areas while they are expected to deteriorate in all settlements located in the midwest and southwest areas.

As for the 12 host districts included in the analysis, 1 district was classified in Phase 2 while the other 11 districts were classified in Phase 1. During the projection period, the IPC phase is expected to deteriorate in 1 district but remain similar in all other 11 districts. GAM levels will likely improve in all districts located in West Nile, Acholi and Kiryandongo areas while they are expected to deteriorate in all districts located in the midwest and southwest areas.

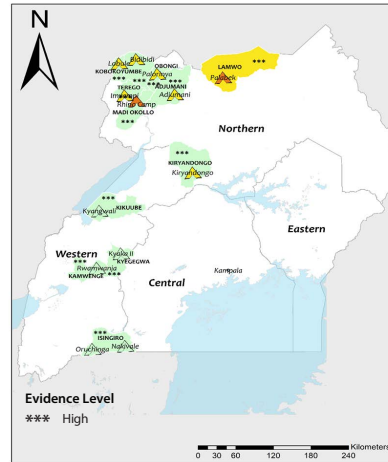
Where:

In the current analysis period (April – September 2023), Palabek and Rhino Camp refugee settlements were classified in Phase 3; Adjumani, Bidibidi, Imvepi, Lobule, Kiryandodngo and Palorinya settlements were classified in Phase 2; whereas Kyangwali, Kyak II, Rwamwanja, Oruchinga and Nakivale settlements were classified in Phase 1. In the host communities, Lamwo district was classified in Phase 2, whereas Adjumani, Isingiro, Kamwenge, Kikuube, Kiryandongo, Koboko, Kyegegwa, Madi Okollo, Obongi, Terego and Yumbe districts were classified in Phase 1.

Why:

The major risk factors contributing to acute malnutrition in refugee settlements and host communities are inadequate food consumption by children and women, both in terms of quality and quantity; high malaria, fever and diarrhoea incidences and prevalence; inadequate access to sufficient quantities of water and high levels of anaemia among children and pregnant/non-pregnant women.

Current Acute Malnutrition | April – September 2023



Key for the Map
IPC Acute Malnutrition Phase Classification

- 1 - Acceptable
- 2 - Alert
- 3 - Serious
- 4 - Critical
- 5 - Extremely critical

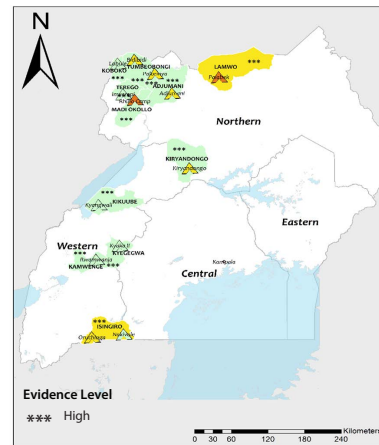
Phase classification based on MUAC

- Areas with inadequate evidence
- Areas not analysed

Map Symbols

- Urban settlement classification
- IDPs/other settlements classification

Projected Acute Malnutrition | October 2023 – March 2024



Key for the Map
IPC Acute Malnutrition Phase Classification

- 1 - Acceptable
- 2 - Alert
- 3 - Serious
- 4 - Critical
- 5 - Extremely critical

Phase classification based on MUAC

- Areas with inadequate evidence
- Areas not analysed

Map Symbols

- Urban settlement classification
- IDPs/other settlements classification

Key Drivers



Poor Food Consumption

Inadequate food consumption with only 11 percent of the children in refugee settlements and 18 percent in host communities able to attain a Minimum Acceptable Diet.



Water and Sanitation

Inadequate access to sufficient quantities of safe water, with only 34 percent of households in refugee settlements and 41 percent in host communities able to use 20 litres per person per day.



Disease

High disease burden, especially malaria and diarrhoea.

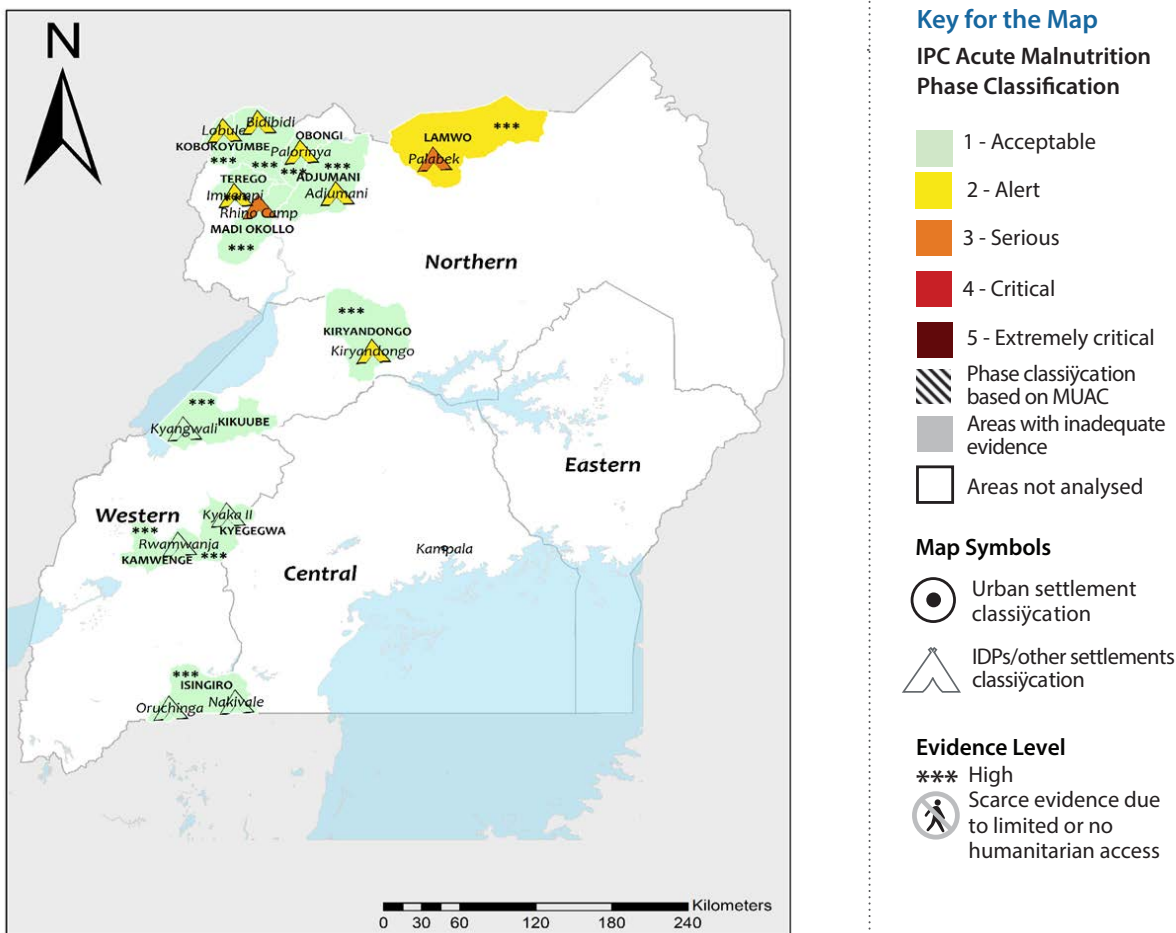


Anaemia

Anaemia among children 6-59 months is of major public health concern in the refugee settlements (41 percent) as well as in the host communities (45%). Anaemia among pregnant / non-pregnant women is also generally high and of public concern.



ACUTE MALNUTRITION CURRENT SITUATION MAP IN REFUGEE SETTLEMENTS AND HOST DISTRICTS (APRIL – SEPTEMBER 2023)



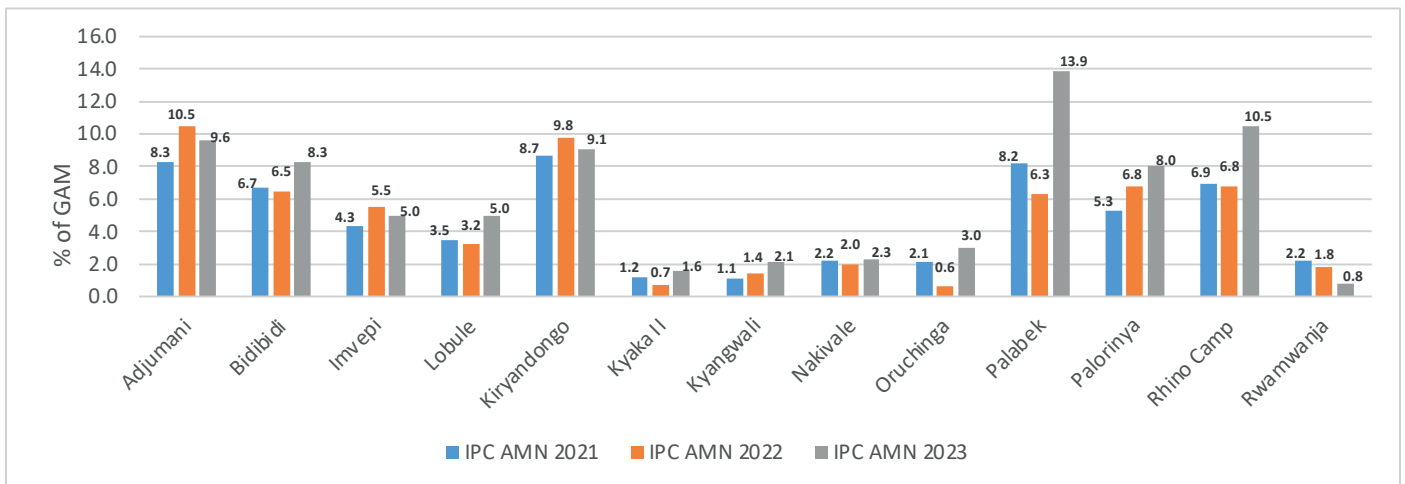
In most of the districts, the settlements showed higher vulnerability to acute malnutrition and were a phase higher than the host communities. All the host districts except Lamwo were in Phase 1 while the settlements were in Phase 2 and 3. Palabek and Rhino camp settlements were classified in Phase 3 that was the highest registered in the period of April – September 2023.

CURRENT SITUATION OVERVIEW

Uganda hosts over 1.5 million refugees and asylum seekers of whom 1.42 million are in the 13 rural-based refugee settlements while the other 80,000 are in Kampala. The rural based refugee settlements are Bidibidi, Adjumani, Palorinya, Nakivale, Kyaka II, Rhino Camp, Lobule, Oruchinga, Palabek, Kyangwali, Kiryandongo, Rwamwanja and Imvepi. The refugees in Uganda are hosted in 13 districts i.e., Adjumani, Isingiro, Kampala, Kamwenge, Kikuube, Kiryandongo, Koboko, Kyegegwa, Lamwo, Madi Okollo, Obongi, Terego and Yumbe. General Food Assistance (GFA) both cash and in-kind remains the main source of food and other livelihood for refugees in rural settlements. Urban refugees in Kampala are in most cases deemed to be self-reliant, and not considered for regular programmed cash-based and in-kind assistance. This IPC Acute Malnutrition analysis excluded Kampala refugees and Kampala host community, that had not been included in the Food Security and Nutrition Assessment.

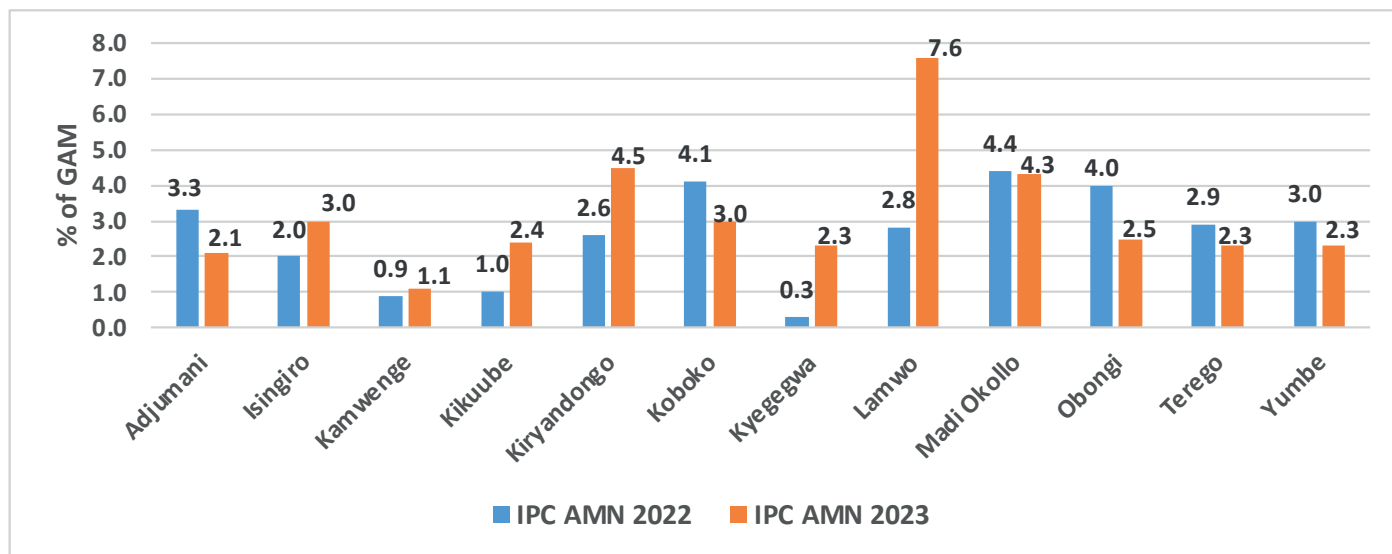
Refugee Settlements: During the current period of April to September 2023, Rhino camp and Palabek settlements were classified in Phase 3 with a GAM rate of 10.5 and 13.9 percent respectively. Adjumani Bidibidi, Imvepi, Kiryandongo, Lobule and Palorinya settlements were classified in Phase 2 with GAM prevalence of 9.6, 8.3, 5.0, 9.1, 5.0 and 8.0 percent respectively. All the other remaining 5 settlements, namely Kyaka II, Kyangwali, Nakivale, Oruchinga and Rwamwanja were classified in Phase 1 with GAM prevalence of 1.6, 2.1, 2.3, 3.0 and 0.8 percent respectively. Compared to the February – July 2022 analysis period, the acute malnutrition situation deteriorated in Rhino Camp from Phase 2 to Phase 3 and Lobule settlement from Phase 1 to Phase 2; whereas the situation improved in Adjumani settlement from Phase 3 to Phase 2 due to improvement in preventive measures for malaria, food consumption for children and care practices, particularly breastfeeding. The acute malnutrition situation remained similar in all the other settlements, although with slight variations in the GAM prevalence.

Figure 1: Comparison of IPC AMN in refugee settlements for the years 2021, 2022 and 2023



Host districts: During the current period of April to September 2023, all refugee hosting districts were classified in Phase 1, except Lamwo district which was classified in Phase 2 with a GAM prevalence of 7.6 percent. Adjumani, Isingiro, Kamwenge, Kikuube, Kiryandongo, Koboko, Kyegegwa, Madi Okollo, Obongi, Terego and Yumbe districts were classified in Acceptable situation with GAM prevalence of 2.1, 3.0, 1.1, 2.4, 4.5, 3.0, 2.3, 4.3, 2.5, 2.3 and 2.3 percent respectively. Compared to the February – July 2022 analysis period, the acute malnutrition situation deteriorated in Lamwo district with the GAM increasing by 5 percent.

Figure 2: Comparison of IPC AMN in refugee hosting districts for the years 2022 and 2023



In settlements and host communities where acute malnutrition is above the acceptable levels, the major risk factors contributing to this situation, grouped into immediate, underlying and structural key drivers, are the following:

Immediate factors

Poor food consumption levels among children aged 6-23 months across all settlements and host communities, with only 11 percent and 18 percent of children, respectively, able to attain a Minimum Acceptable Diet (MAD). In the current period of analysis, MAD was lowest in Rhino Camp and Kyaka II settlements, each at 4.1 percent followed by Kiryandongo settlement at 4.7 percent. In the host districts, low MAD was reported in Lamwo (8.1 percent), Isingiro (10.7 percent) and Kyegegwa (12.9 percent). Additionally, only 44 percent of the children in the refugee settlements are fed at recommended frequency per day (at least twice for children 6-8 months and at least thrice for children 9-23 months) but the proportion is slightly higher for children in the host communities at 58 percent despite the sub-optimal performance. Inadequate nutrient intake among children leads to acute malnutrition and requires both preventive and management interventions to prevent further deterioration.

High morbidity, especially malaria and diarrhoea, with the recent assessment indicating prevalence of 20 and 15 percent, respectively, among children in refugee settlements. The burden of malaria was highest in Bidibidi (34.5 percent), followed by Adjumani (26.2 percent) and lowest in Kiryandongo (9.6 percent) settlements. On the other hand, diarrhoea cases were most pronounced in Kyangwali (27.5 percent) followed by Nakivale (21.5 percent) and least pronounced in Palorinya (7.7 percent) settlements. In the host communities, malaria burden was highest in Adjumani (40.2 percent) and Lamwo (36.8 percent) districts, and similarly, diarrhoea burden was highest in Adjumani (27.5 percent) and Lamwo (25.1 percent) districts. High disease burden such as diarrhoea leads to nutrient losses while malaria and fever cause increased demands for more food intake thus increasing the risk to acute malnutrition as well as increasing severity and deterioration in child health. Where disease burden is high, both food access and health multidimensional approaches are required to reduce acute malnutrition to acceptable levels and save lives.



Underlying factors

Poor water access among refugee and host populations. About 93 percent of the households in refugee settlements have access to safe water sources although 75 percent can access water from such sources within the recommended 30 minutes. Hand pumps / boreholes (34 percent) and public stand pipes (54 percent) are the main sources of water for the refugee population, and, similarly, hand pumps / boreholes (55 percent) are the main source for the host population. However, even with such availability of safe water sources, the per capita water use is still low with only 34 percent of refugee households and 41 percent of host community households able to access sufficient water for use per day (20 or more litres of water per person per day). Households in Oruchinga (22.9 percent), Kyaka II (24.3 percent), Rwamwanja (25.6 percent) and Nakivale (26.8 percent) settlements, and those in Isingiro (28.4 percent), Kamwenge (28.6 percent) and Yumbe (30.2 percent) districts have more insufficient water for use per day compared to those in the other settlements / districts. Poor access to sufficient water and safe drinking water leads to poor hygiene practices that increase risk to disease especially diarrhoea that are associated to acute malnutrition.

Inadequate childcare and Infant & Young Child Feeding (IYCF) practices across the refugee and host population. Although 97 percent of the children born to refugees and 96 percent of those born to host population were found to have ever been breastfed, only 67 and 63 percent, respectively, are exclusively breastfed. The practice of exclusive breastfeeding was found to be lowest in Palabek (46.7 percent), followed by Imvepi (58.5 percent), Lobule (58.8 percent) and Rhino Camp (58.8 percent) settlements. Vitamin A supplementation, Measles vaccination and Deworming practices are generally optimal across settlements and host districts, except in Kiryandongo settlement, Kiryandongo district and Kikuube district where deworming is at 57.8, 54.5 and 58.2 percent, respectively.

There are generally **high levels of food scarcity and food insecurity** among the refugee and host populations. An IPC Acute Food Insecurity analysis conducted concurrently with this Acute malnutrition analysis indicates that 20 percent of the host community population are facing high levels of acute food insecurity (IPC Phase 3 or above). Populations most affected by acute food insecurity are found in Lamwo (40 percent), Yumbe (30 percent), Adjumani (25 percent) Kyegegwa (20 percent) and Kiryandongo (20 percent) districts. Food insecurity compounded with other non-food factors increase the risk to acute malnutrition.

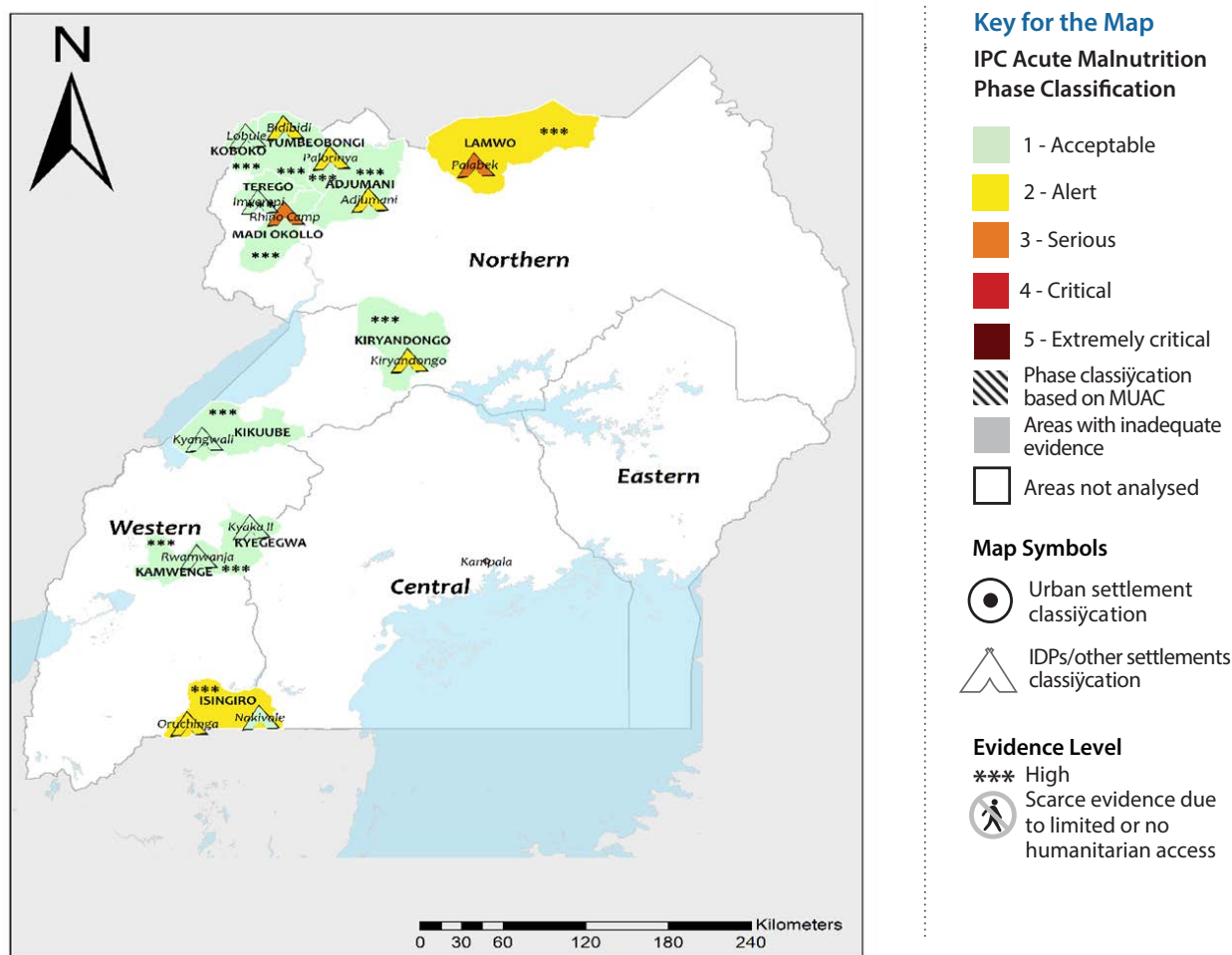
Other factors

The **high levels of anaemia** among the vulnerable populations is of major public health concern that calls for urgent attention in both the refugee settlements (41 percent) and host communities (45 percent). All the refugee settlements have anaemia prevalence above the acceptable threshold of less than 20 percent. The refugee settlements with highest burden are Kyangwali (58.1 percent), Palabek (55.1 percent), Kiryandongo (48 percent) and Imvepi (42.8 percent); whereas the host districts with the highest anaemia burden are Kiryandongo (58.8 percent), Obongi (53.5 percent), Kikuube (53.2 percent), Madi Okollo (49.7 percent), Terego (45.6 percent) and Yumbe (45 percent). Consumption of iron deficient foods and high malaria incidences are probable causes of anemia among children and women. Anaemia in pregnant and lactating women is associated with low birth weight that compromises normal growth and achievements of milestones of a child compared to non-anaemic children of same age. Anaemia in children prevents optimal development especially among children less than 2 years and also increases health risk that when compounded with disease increases risk to malnutrition and mortality.

Shift in the GFA policy by the Humanitarian Agencies from 100% support to lower levels (60, 30, and 0 percent), due to limited resources has rendered an increasing number of refugees more vulnerable, consequently negatively impacting food consumption among children and pregnant and lactating women. Currently, Category 1 individuals (highly vulnerable 13.4% of the refugee population) receive 60 percent assistance of their food needs, Category 2 individuals (vulnerable 82.2 percent of the refugee population) receive 30 percent assistance, while the remaining 4.4 percent of the refugee population no longer receive any assistance. The increasing inability of the refugee population to meet the daily food intake requirements has a direct impact on nutrition status of children and pregnant/lactating women.



ACUTE MALNUTRITION PROJECTED SITUATION MAP FOR REFUGEE SETTLEMENTS AND HOST DISTRICTS (OCTOBER 2023 – MARCH 2024)



Number of cases in Refugee Settlements: It is estimated that 39,402 cases of children aged 6-59 months across all refugee settlements are expected to suffer from acute malnutrition and in need of treatment, of whom 32,742 are moderate acute malnutrition cases and 6,660 are severe acute malnutrition cases, for the period of April 2023 to March 2024. Compared to the other settlements, Adjumani settlement has the highest number of cases of acutely malnourished children in need of treatment (8,512) of whom 6,995 are affected by moderate acute malnutrition and 1,517 are affected by severe acute malnutrition. Additionally, 3,732 Pregnant or Lactating Women (PLW) among the refugee population are affected by acute malnutrition and in need of treatment, with the largest number found in Nakivale settlement (624).

The expected number of cases of children affected by acute malnutrition was calculated using the formula $n \cdot p \cdot k$; where n is the number of children aged 6-59 months, p is the prevalence of acute malnutrition (based on combined GAM), and k is the incident correction factor of 2.6. The expected number of cases of acute malnutrition among pregnant or lactating women was calculated using the formula $n \cdot p$; where n is the number of PLWs and p is prevalence of acute malnutrition (based on MUAC, estimated at <23cm).



Refugee settlement	Settlement population	Children aged 6-59 months							Pregnant and Lactating women		
		Total #	GAM % (95% CI)	MAM % (95% CI)	SAM % (95% CI)	Estimated number of GAM cases	Estimated number of MAM cases	Estimated number of SAM cases	Total #	AMN % (95% CI)	Number of cases AMN
Adjumani	212,648	32,414	10.1%	8.3%	1.8%	8,512	6,995	1,517	10,632	3.6%	383
Bidibidi	193,841	24,373	10.0%	7.3%	2.7%	6,337	4,626	1,711	9,692	4.5%	436
Imvepi	66,135	9,788	5.4%	4.4%	1.0%	1,374	1,120	254	3,307	8.2%	271
Kiryandongo	65,455	8,168	9.7%	7.3%	2.4%	2,060	1,550	510	3,273	3.4%	111
Kyaka II	121,934	20,213	2.9%	2.6%	0.3%	1,524	1,366	158	6,097	4.0%	244
Kyangwali	131,800	23,428	2.6%	2.1%	0.5%	1,584	1,279	305	6,590	6.5%	428
Lobule	6,017	1,125	6.3%	5.5%	0.8%	184	161	23	301	6.7%	20
Nakivale	178,270	28,785	4.1%	3.9%	0.2%	3,068	2,919	150	8,914	7.0%	624
Oruchinga	7,995	1,329	5.4%	4.9%	0.5%	187	169	17	400	4.3%	17
Palabek	79,021	12,984	13.5%	11.2%	2.3%	4,557	3,781	776	3,951	4.6%	182
Palorinya	126,058	15,750	8.6%	7.3%	1.3%	3,522	2,989	532	6,303	8.8%	555
Rhino Camp	148,073	20,521	10.3%	9.4%	0.9%	5,496	5,015	480	7,404	4.6%	341
Rwamwanja	92,566	17,433	2.2%	1.7%	0.5%	997	771	227	4,628	2.6%	120
Grand Total	1,429,813	216,311				39,402	32,742	6,660	71,491		3,732

Number of cases in Host districts: It is estimated that 74,800 children across the 12 hosting districts are expected to suffer from acute malnutrition and in need of treatment, of whom 60,092 are moderate acute malnutrition cases and 14,708 are severe acute malnutrition cases, between April 2023 and March 2024. Compared to other districts, Yumbe district has the highest number of cases of acutely malnourished children in need of treatment (14,405) of whom 8,474 are affected by moderate acute malnutrition and 5,931 are affected by severe acute malnutrition. It is further estimated that 9,486 PLW among the host population are expected to suffer from acute malnutrition and in need of treatment.

Host District	Total District #	Children aged 6-59 months							Pregnant and Lactating women		
		Total #	GAM % (95% CI)	MAM % (95% CI)	SAM % (95% CI)	Estimated number of GAM cases	Estimated number of MAM cases	Estimated number of SAM cases	Total #	AMN % (95% CI)	Number of cases PLW
Adjumani	240,000	42,506	3.3%	3.3%	0.0%	3,647	3,647	0	12,000	4.2%	504
Isingiro	658,100	107,588	4.1%	3.3%	0.8%	11,469	9,231	2,238	32,905	8.2%	2,698
Kamwenge	372,000	66,889	1.8%	1.8%	0.0%	3,130	3,130	0	18,600	2.7%	502
Kikuube	414,400	73,841	2.3%	2.3%	0.0%	4,416	4,416	0	20,720	4.2%	870
Kiryandongo	339,200	54,301	6.4%	3.9%	2.5%	9,036	5,506	3,530	16,960	3.7%	628
Koboko	287,500	44,615	4.4%	3.9%	0.5%	5,104	4,524	580	14,375	0.0%	0
Kyegegwa	551,900	101,319	3.5%	3.5%	0.0%	9,220	9,220	0	27,595	6.7%	1,849
Lamwo	148,100	22,955	8.6%	6.9%	1.7%	5,133	4,118	1,015	7,405	5.7%	422
Madi Okollo	176,800	27,913	6.4%	5.0%	1.4%	4,645	3,629	1,016	8,840	4.2%	371
Obongi	52,300	7,961	4.9%	4.5%	0.4%	1,014	931	83	2,615	3.4%	89
Terego	251,500	40,517	3.4%	3.1%	0.3%	3,582	3,266	316	12,575	3.1%	390
Yumbe	775,000	108,635	5.1%	3.0%	2.1%	14,405	8,474	5,931	38,750	3.0%	1,163
Grand Total	4,266,800	699,040				74,800	60,092	14,708	213,340		9,486



ACUTE MALNUTRITION PROJECTION OVERVIEW

Overall, during the projection period of October 2023 to March 2024, the acute malnutrition phase classification is expected to remain similar in all refugee settlements, except in Oruchinga settlement where it will likely deteriorate from Phase 1 to Phase 2 and in Imvepi and Lobule settlements where it will likely improve from Phase 2 situation to Phase 1. It is anticipated that GAM prevalence will likely improve in all settlements located in West Nile, Acholi and Kiryandongo sub-regions while the prevalence is expected to deteriorate in all settlements located in the midwest and southwest, but these changes will not necessarily lead to changes in the IPC acute malnutrition phases. Similarly, 11 of the 12 refugee hosting districts will likely remain in the same acute malnutrition phases through the projection period, with the situation only projected to change in Isingiro district where it will likely deteriorate from Phase 1 to Phase 2. It is anticipated that GAM prevalence will likely improve in all districts located in West Nile, Acholi and Kiryandongo sub-regions while it is expected to deteriorate in all districts located in midwest and southwest, but again these changes will not necessarily lead to changes in the IPC acute malnutrition phases.

The prevalence of malaria, ARI, diarrhoea and other preventable diseases affecting nutrition status are expected to increase between October – November 2023, in both the refugee settlements and hosting communities. This trend will, however, change after November through the rest of the projection period. The anticipated integrated child health days and distribution of ITNs will likely reduce the impact of increased disease incidence, particularly malaria. Measles outbreak is expected in Palabek settlement and Lamwo district due to new refugee arrivals from South Sudan. Disease trends should be monitored closely and prevented or managed to reduce possible impact on acute malnutrition.

Food consumption will likely improve during the projection period as harvests are realized, especially for refugees and host communities in West Nile and Kiryandongo areas but may gradually deteriorate in February and March 2024 as households run out of food stock from the second season harvest. Since the 60 percent (30 percent in some settlements) food ration is not enough for the refugees to meet the Minimum Expenditure Basket (MEB), it is anticipated that dietary diversity and meal frequency will not improve for the refugee population. Overall, the food security situation is expected to improve in both settlements and host communities during the months of October 2023 – January 2024 and gradually deteriorate after that.

Current access to sanitation facilities will remain in a similar situation but may deteriorate for some low-lying areas as the forecasted rains intensify. Adequacy in water use is not expected to improve even with the current availability of safe water sources although it is unlikely it will deteriorate.

Care practices are expected remain similar in the projection period. Although in the second half of the projection caretakers will not be involved in garden work, they be involved in other livelihood activities that will reduce time available for optimal childcare.

CMAM coverage will likely remain sub-optimal across settlements and host communities even though the recent FSNA results may trigger response from Non-Governmental Organisations, Ministry of Health and other partners. The current high fuel prices, and general global logistical and supply challenges will continue affecting the supply of nutrition commodities like Ready to Use Therapeutic Foods (RUTF) and super cereals. This may make the situation worse than the projected if no deliberate measures are put in place to avert the impact.

Prevalence of anaemia and low birth weight are expected to remain high throughout the projection period although a slight reduction in anaemia is anticipated due to improvement in food consumption and the likely interventions in the prevention and treatment of malaria both among children and mothers.

Key Assumptions

Disease prevalence: Malaria, diarrhoea and respiratory infection prevalence will increase between October – November 2023 due to weather / climate related changes but start declining in December 2023.

Humanitarian and social protection programs: Refugees will continue depending on cash assistance from WFP and UNHCR for purchase of food. Due to limited resources, cash assistance for food will be maintained at 60% for Category 1, 30% for Category 2 and 0% for Category 3 refugees. No programmed assistance is anticipated for the host population.

Food consumption: Is expected to improve for the host population but may gradually deteriorate in late February 2024.

Water access: Water use is expected to remain at sub-optimal levels even with the improved availability of safe water sources.

Care practices: Breast feeding practices will continue to improve due to sensitization. Vaccination and deworming will remain at the current optimal levels for most settlements and host districts.

Anaemia: Prevalence will remain high although improvement in food consumption and other interventions may trigger a slight reduction.

Refugee influx: Unending wars in DRC, South Sudan and Sudan may trigger influx.



RECOMMENDATIONS FOR ACTION

Response Priorities

- Scale up case identification and treatment of Acute malnutrition (both SAM and MAM cases) for both children and women
- Improve coverage and access of IMAM services through stabilizing the commodity pipeline, strengthening the capacity of health workers in IMAM, having the right staffing levels, and strengthening the facility-community linkages.
- Strengthen MIYCAN practices at both health facility and community levels.
- Strengthen the Integrated Community Case Management (ICCM) within the settlements and host communities to bring health services closer to households, addressing leading child morbidities and reducing burden on health facilities.
- Strengthen prevention, testing and treatment of common childhood illnesses (malaria, fever, diarrhoea).
- Scale up Anaemia prevention and treatment interventions among children and women of reproductive age.
- Improve coverage of WASH practices.
- Strengthen shock responsive social protection to improve resilience of households to shocks and vulnerabilities.
- Scale up Social Behavior Change Communication (SBCC) on health and WASH.

Situation monitoring and update

1. Monitor progress in dietary intake and diversity in the period October to December when more food is available to host communities in the West Nile area.
2. Monitor trends in acute malnutrition admissions.

Risk factors to monitor

- GAM prevalence
- CMAM program Admission trends
- Disease prevalence such as malaria, diarrhoea, and anaemia in health facilities
- Preventive and treatment health services
- Stock-out of nutrition supplies for treatment of acute malnutrition in affected settlements
- Water use and sanitation access
- Anticipated refugee influx from Sudan and South Sudan which may also be linked with some disease epidemics making the refugees and host populations more vulnerable.
- Impact of reduction in humanitarian support especially food ration
- Anaemia among children, pregnant and lactating women



PROCESS AND METHODOLOGY

An IPC analysis workshop was held from 4 – 11 September, 2023, and was preceded by an IPC Acute Malnutrition level 1 refresher training (4 - 5 September). This was followed by the IPC Analysis workshop (6 – 11 September 2023) using protocols of the IPC Manual version 3.1. This approach draws together all available food security and nutrition information from reliable data sources. The key participating agencies included Government line ministries, District Local Governments, WFP, IRC, ACF, MTI and Save the Children. The IPC Global Support Unit (GSU) played a co-facilitation role throughout the analysis process.

Evidence on key outcome indicators was drawn from Food Security and Nutrition Assessment (FSNA) conducted by WFP and UNHCR in all 12 refugee hosting districts and 13 refugee settlements of Uganda. The FSNA was conducted using the Standardized Expanded Nutrition Survey (SENS) guidelines and the SMART methodology; with a two-stage cluster sampling design. Training and data collection took place between mid-July and mid-August 2023.

The analysis was technically supported by the IPC Global Support Unit and carried out under the overall co-ordination and leadership of the IPC Technical Working Group in Uganda.

Evidence Sources

WFP & UNHCR (2023), Refugee and Refugee Host FSNA 2023
 WFP & UNHCR (various years), Refugee and Host FSNA Reports
 ACF, MTI, IRC and SCI (2022, 2023), Mass Screening Reports
 Ministry of Health (2023), Health Information System (HIS) data
 UBOS (2022), Mid-year district population projections

Limitations Of The Analysis

1. Failure to conduct the FSNA and the IPC analysis earlier in the current period of analysis (peak of high acute malnutrition season).
2. There limited historical data for the projection period for trend analysis.
3. Most of the analysts had not attended a full level one training but only received a two days' refresher training.

What is the IPC and IPC Acute Malnutrition?

The IPC is a set of tools and procedures to classify the severity and characteristics of acute food insecurity and acute malnutrition crises as well as chronic food insecurity based on international standards. The IPC consists of four mutually reinforcing functions, each with a set of specific protocols (tools and procedures).

The core IPC parameters include consensus building, convergence of evidence, accountability, transparency and comparability. The IPC analysis aims at informing emergency response as well as medium and long-term food security policy and programming.

The IPC Acute Malnutrition Classification provides information on the severity of acute malnutrition, highlights the major contributing factors to acute malnutrition, and provides actionable knowledge by consolidating wide-ranging evidence on acute malnutrition and contributing factors.

Contact for further Information

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www.ipcinfo.org

This analysis has been conducted under the patronage of the IPC Technical Working Group of Uganda. It has benefited from the technical support of IPC GSU and financial support of the United Nations World Food Programme and the Food and Agriculture Organisation of the United Nations.

Classification of food insecurity and malnutrition was conducted using the IPC protocols, which are developed and implemented worldwide by the IPC Global Partnership - Action Against Hunger, CARE, CILSS, EC-JRC, FAO, FEWSNET, Global Food Security Cluster, Global Nutrition Cluster, IGAD, Oxfam, PROGRESAN-SICA, SADC, Save the Children, UNICEF and WFP.

IPC AMN Analysis Partners:

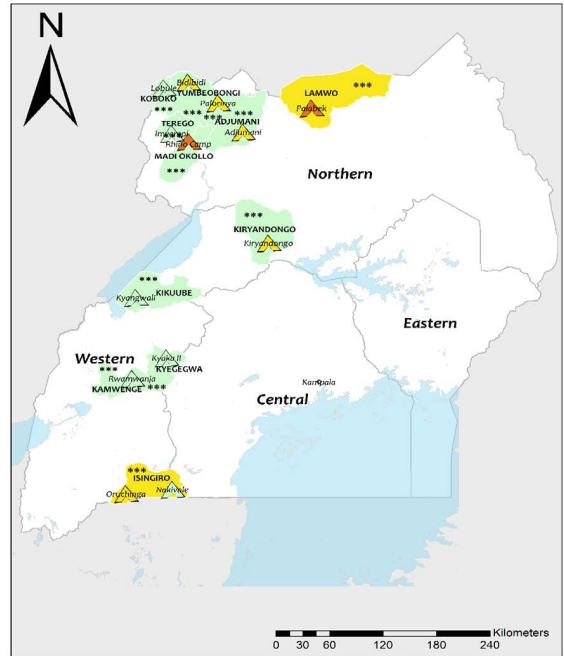
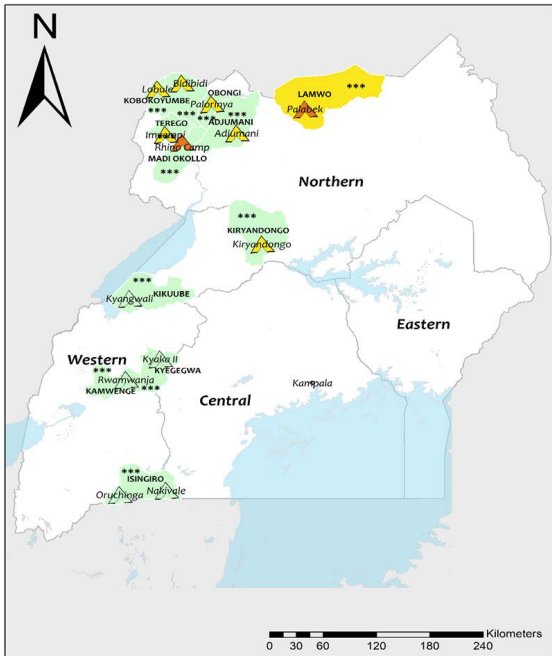




ANNEX 1: SNAPSHOT

ACUTE MALNUTRITION CURRENT SITUATION: April – September 2023

ACUTE MALNUTRITION PROJECTED SITUATION: Oct. 2023 – March 2024



0 Settlements Extremely Critical	0 Settlements Critical	2 Settlements Serious
PREVALENCE OF ACUTE MALNUTRITION	6 Settlements Alert	5 Settlements Acceptable

Locality	Adjumani	Bidibidi	Inveni	Kiryandongo	Kyaka II	Kyangwali	Lobule	Nakivale	Oruchinga	Palabek	Palorinya	Rhino camp	Rwamwanja
GAM*	9.6%	8.3%	5.0%	9.1%	1.6%	2.1%	5%	2.3%	3%	13.9%	8%	10.5%	0.8%
MAM*	7.8%	6.8%	4.2%	7.8%	1.6%	1.9%	4.2%	2.3%	3%	11.8%	6.9%	9.5%	0.8%
SAM*	1.9%	1.6%	0.7%	1.3%	0%	0.3%	0.8%	0%	0%	2.1%	1.1%	1%	0%

*Severe, Moderate and Global Acute Malnutrition

MAJOR CONTRIBUTING FACTORS		EXPECTED CHANGE IN AMN – PROJECTION PERIOD (October 2023 - March 2024)				
	Poor quality and quantity of food	Of the 13 Refugee Settlements	Acute malnutrition is expected to		Deteriorate	1 Settlement
	High disease burden (malaria and diarrhoea)				Remain Stable	10 Settlement
	High food insecurity				Improve	2 Settlement
	High anaemia					
	High prevalence of low birth weight					

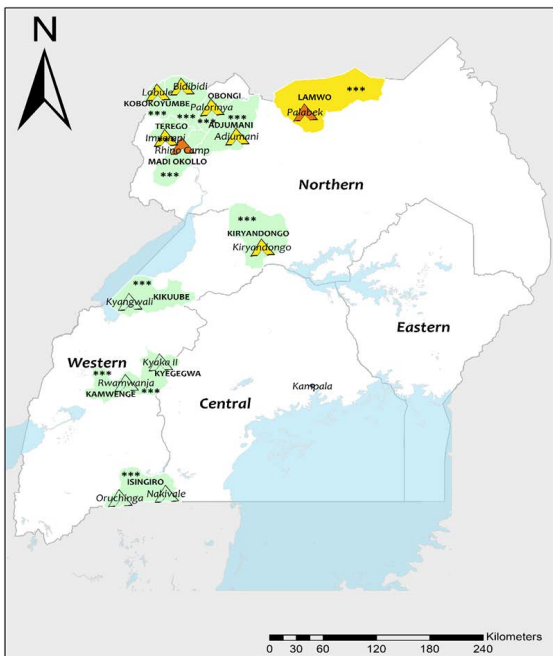
SEVERE, MODERATE AND GLOBAL ACUTE MALNUTRITION (April 2023-March 2024)

		IN NEED OF URGENT ACTION	
39,402	3,732	6,660 SAM* 6-59 months caseload	216,311
Cases of children aged 6-59 months acutely malnourished	Cases of pregnant or lactating women malnourished	32,742 MAM* 6-59 months caseload	Total population of children 6-59 months



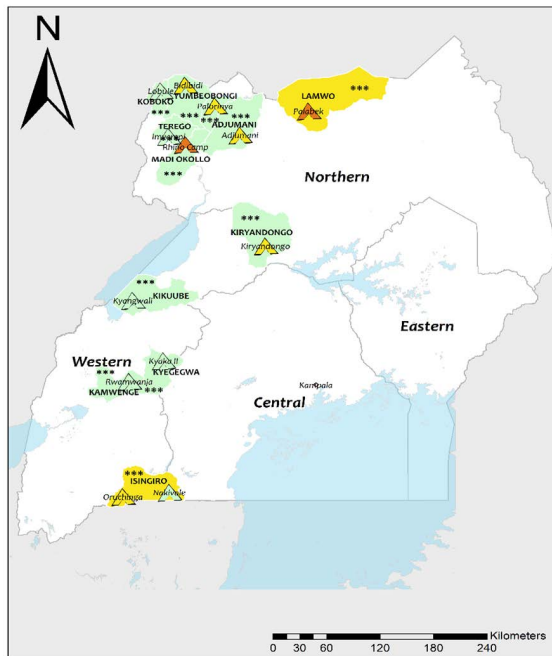
ACUTE MALNUTRITION CURRENT SITUATION: April – September 2023

HOST DISTRICTS



ACUTE MALNUTRITION PROJECTED SITUATION: Oct. 2023 – March 2024

HOST DISTRICTS



0 District Extremely Critical	0 District Critical	0 District Serious
PREVALENCE OF ACUTE MALNUTRITION		
1 District Alert		11 Districts Acceptable

District	Adjumani	Isingiro	Kamwenge	Kikuube	Kiryandongo	Koboko	Kyegegwa	Lamwo	Madi Okollo	Obongi	Terego	Yumbe
GAM*	2.1%	3.0%	1.1%	2.4%	4.5%	3.0%	2.3%	7.6%	4.3%	2.5%	2.3%	2.3%
MAM*	2.1%	3.0%	1.1%	2.4%	3.7%	3.0%	2.3%	7.1%	3.9%	2.5%	2.3%	2.3%
SAM*	0.0%	0.0%	0.0%	0.0%	0.8%	0.0%	0.0%	0.5%	0.4%	0.0%	0.0%	0.0%

*Severe, Moderate and Global Acute Malnutrition

MAJOR CONTRIBUTING FACTORS		EXPECTED CHANGE IN AMN – PROJECTION PERIOD (October 2023 - March 2024)				
	Poor quality and quantity of food	Of the 12 Host Districts	Acute malnutrition is expected to		Deteriorate	1 District
	High disease burden (malaria and diarrhoea)				Remain Stable	11 Districts
	High food insecurity				Improve	0 District
	High anaemia					
	High prevalence of low birth weight					

SEVERE, MODERATE AND GLOBAL ACUTE MALNUTRITION (April 2023 - March 2024)

		IN NEED OF URGENT ACTION	
74,800	9,486	14,708 SAM* 6-59 months caseload	699,040
Cases of children aged 6-59 months acutely malnourished	Cases of pregnant or lactating women malnourished	60,092 MAM* 6-59 months caseload	Total population of children 6-59 months

ANNEX 2: SUMMARY OF FACTORS CONTRIBUTING TO ACUTE MALNUTRITION

Refugee Settlements		Adjumani	Bidibidi	Imvepi	Kiryandongo	Kyangwali	Kyaka II	Lobule	Nakivale	Oruchinga	Palabek	Palorinya	Rhino Camp	Rwamwanja
 Food Consumption	Minimum Dietary Diversity (MDD)	High	Very High	Medium	Very High	High	High	Medium	High	Very High	High	High	High	High
	Minimum Meal Frequency (MMF)	Low	Low	Low	Low	Medium	Medium	Low	Medium	Low	Medium	Low	Medium	Low
	Minimum Acceptable Diet (MAD)	High	Very High	High	High	Very High	High	Medium	High	Very High	High	High	High	High
	Minimum Dietary Diversity – Women (MDD-W)	High	Very High	Medium	High	Very High	High	Low	High	High	High	High	Medium	Low
 Diseases	Diarrhoea	Medium	Low	Medium	Medium	High	Medium	Medium	High	Medium	Low	Low	Low	Medium
	Dysentery	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Acute Respiratory Infection (ARI)	Very Low	Very Low	Very Low	Low	Very Low	Low	Very Low	Low	Very Low	Very Low	Very Low	Low	Low
	HIV/AIDS	No data	No data	No data	No data	No data	No data	No data	No data	No data	Low	No data	No data	No data
	Cholera or Acute Watery Diarrhoea (AWD)	No data	No data	No data	No data	Medium	No data	No data	No data	No data	Very Low	Very Low	No data	Low
	Measles	No data	No data	No data	High	Very Low	No data	No data	No data	Very Low	High	Very Low	No data	High
	Malaria	Low	Very High	Medium	Medium	Very High	Low	Medium	Low	Low	Medium	Medium	Medium	High
	Fever	Very High	Very High	Medium	Low	Very High	High	Medium	Low	Low	High	High	Low	Medium
Food dimensions Outcome of IPC analysis														
 Caring and feeding practices	Exclusive breastfeeding under 6 months	Low	Low	Low	Low	Medium	High	Very Low	High	Medium	High	Low	High	Very High
	Continued breastfeeding at 1 year	Very Low	Very Low	Very Low	Low	Low	Low	Low	Low	Low	Low	Low	Low	Very Low
	Continued breastfeeding at 2 years	No data	No data	No data	No data	No data	No data	Low	Very Low	Very Low	Low	Very Low	Low	Medium
	Introduction of solid, semi-solid or soft foods	Low	Very Low	Very Low	Low	Low	Low	Medium	Low	Low	Low	Medium	High	Medium
 Health services and health environment	Measles vaccination	Very Low	Very Low	Very Low	Low	Very Low	Very Low	Very Low	Low	Very Low	Medium	No data	Very Low	Very Low
	Polio vaccination	Very Low	No data	Very Low	No data	Very Low	Very Low	Very Low	Very Low	Very Low	Low	No data	Medium	Very Low
	Vitamin A supplementation	Very Low	Very Low	Very Low	Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	No data	No data	Very Low
	Skilled birth attendance	No data	No data	No data	No data	Very Low	No data	No data	No data	No data	No data	No data	No data	Very Low
	Health seeking behaviour	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	Very Low
	Coverage of outreach programmes – CMAM programme coverage (SAM, MAM, or both)	No data	No data	No data	No data	No data	No data	No data	Very Low	No data	No data	No data	No data	Very Low
	Access to a sufficient quantity of water	Low	High	Low	Very High	High	High	High	Low	Low	Low	Low	Low	High
	Access to sanitation facilities	Low	Low	Very Low	Medium	Low	Very Low	Very Low	Very Low	Very Low	Medium	Very Low	Low	Very Low
	Access to an improved source of drinking water	Low	Low	Very Low	Medium	Medium	Very Low	Very Low	Low	Very Low	Low	Very Low	Low	Medium
	Access to piped water	Very Low	Very Low	Very Low	No data	No data	Medium	High	No data	Low	No data	No data	No data	High
 Basic causes	Human capital	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Physical capital	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Financial capital	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Natural capital	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Social capital	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Policies, Institutions and Processes	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Usual/Normal Shocks	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Recurrent crises due to unusual shocks	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
 Other nutrition issues	Anaemia among children 6-59 months	Medium	Medium	High	High	Very High	Medium	Very High	High	High	Very High	Medium	Very High	High
	Anaemia among pregnant women	No data	No data	High	Medium	Very High	No data	Very High	High	High	Very High	High	Medium	High
	Anaemia among non-pregnant women	No data	No data	Medium	Medium	Very High	No data	Medium	High	High	Medium	Medium	Medium	High
	Vitamin A deficiency among pre-school children (6 – 71 months)	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Vitamin A deficiency among non-pregnant women (15 – 49 years)	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Low birth weight	Very Low	Low	No data	No data	No data	No data	No data	No data	No data	No data	No data	Low	Very Low
	Fertility rate	Low	No data	No data	No data	No data	No data	No data	Low	No data	Low	No data	No data	No data

Legend
Risk Factor

Very Low

Low

Medium

High

Very High

No data



Host Settlements		Adjumani	Isingiro	Kamwenge	Kikuube	Kiryandongo	Koboko	Kyegegwa	Lamwo	Madi-Okollo	Obongi	Terego	Yumbe
 Food Consumption	Minimum Dietary Diversity (MDD)	High	High	Low	High	High	Low	High	High	High	High	High	No data
	Minimum Meal Frequency (MMF)	Low	Low	Very Low	Low	Low	Low	Low	Low	Low	Low	Low	Low
	Minimum Acceptable Diet (MAD)	High	High	High	High	High	High	High	Very High	High	High	High	Very High
	Minimum Dietary Diversity – Women (MDD-W)	No data	No data	Low	No data	High	No data	High	High	No data	No data	No data	No data
 Diseases	Diarrhoea	High	High	High	No data	High	High	High	High	High	High	High	High
	Dysentery	No data	No data	No data	High	No data	No data	No data	No data	No data	No data	No data	No data
	Acute Respiratory Infection (ARI)	Very Low	No data	Low	No data	Very Low	Very Low	Very Low	Low	Low	Very Low	Low	Very Low
	HIV/AIDS	No data	No data	No data	No data	No data	No data	No data	High	No data	No data	No data	No data
	Cholera or Acute Watery Diarrhoea (AWD)	Very Low	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Measles	Very Low	No data	High	Low	Very Low	High	No data	High	High	High	High	High
	Malaria	Very High	Low	High	High	High	High	Very Low	High	High	High	High	High
	Fever	High	High	High	Very High	High	High	No data	High	High	High	High	High
Food dimensions Outcome of IPC analysis		High	Low	Low	Low	High	Low	High	High	Low	Low	Low	High
 Caring and feeding practices	Exclusive breastfeeding under 6 months	Low	Very Low	Low	Low	Low	High	Very Low	Low	High	Low	Low	Low
	Continued breastfeeding at 1 year	Low	Low	Low	Low	No data	Very Low	Low	No data	Low	Very Low	No data	Very Low
	Continued breastfeeding at 2 years	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Introduction of solid, semi-solid or soft foods	Very Low	Very Low	Very Low	Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low
 Health services and health environment	Measles vaccination	Very Low	Very Low	High	Low	Very Low	Low	Very Low	Very High	Low	Very Low	Very Low	Very Low
	Polio vaccination	No data	No data	Very High	No data	No data	No data	No data	High	No data	No data	No data	No data
	Vitamin A supplementation	Very Low	Very Low	Low	Very High	No data	High	Very Low	High	Low	Very Low	Very Low	Very Low
	Skilled birth attendance	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Health seeking behaviour	No data	No data	No data	No data	No data	High	No data	No data	No data	No data	No data	No data
	Coverage of outreach programmes – CMAM programme coverage (SAM, MAM, or both)	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Access to a sufficient quantity of water	No data	No data	High	No data	No data	Very Low	No data	No data	High	Low	No data	High
	Access to sanitation facilities	No data	Low	Very Low	Low	Low	No data	Very Low	No data	Low	Very Low	Very Low	Very Low
	Access to an improved source of drinking water	No data	High	Low	High	High	Very Low	Very Low	No data	Low	Low	Low	Low
	Access to piped water	No data	No data	High	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Routine deworming coverage	No data	No data	Very Low	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Deworming coverage from surveys	No data	No data	Low	No data	No data	No data	No data	No data	Low	No data	No data	No data
 Basic causes	Human capital	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Physical capital	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Financial capital	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Natural capital	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Social capital	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Policies, Institutions and Processes	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Usual/Normal Shocks	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Recurrent crises due to unusual shocks	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
 Other nutrition issues	Anaemia among children 6-59 months	High	High	High	Very High	High	High	High	High	High	High	High	Very High
	Anaemia among pregnant women	No data	No data	Low	No data	High	No data	No data	High	No data	No data	High	High
	Anaemia among non-pregnant women	No data	No data	High	No data	High	No data	High	High	No data	No data	High	High
	Vitamin A deficiency among pre-school children (6 – 71 months)	No data	No data	No data	Very High	No data	No data	No data	No data	No data	No data	No data	No data
	Vitamin A deficiency among non-pregnant women (15 – 49 years)	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Low birth weight	No data	No data	No data	No data	No data	High	Very Low	No data	No data	No data	Very High	No data
	Fertility rate	No data	No data	No data	No data	No data	No data	No data	High	No data	No data	No data	No data

Legend Risk Factor ■ Very Low ■ Low ■ Medium ■ High ■ Very High ■ No data