UGANDA

IPC ACUTE FOOD INSECURITY AND ACUTE MALNUTRITION SITUATION FOR THE REFUGEES HOST DISTRICTS

IPC ACUTE FOOD INSECURITY AND ACUTE MALNUTRITION ANALYSIS

JULY 2024 – JUNE 2025

Published on XX December 2024

CURRENT ACUTE FOOD INSECURITY JULY 2024 – JANUARY 2025

797,000

17% of the population analysed

People facing high acute food insecurity (IPC Phase 3 or above)

IN NEED OF URGENT ACTION

Phase 5	0 People in Catastrophe
Phase 4	0 People in Emergency
Phase 3	797,000 People in Crisis
Phase 2	1,858,000 People Stressed
Phase 1	1,971,000 People in food security

PROJECTION ACUTE FOOD INSECURITY FEBRUARY – JUNE 2025

953,000

21% of the population analysed

People facing high acute food insecurity (IPC Phase 3 or above)

IN NEED OF URGENT ACTION

Phase 5	0 People in Catastrophe
Phase 4	0 People in Emergency
Phase 3	953,000 People in Crisis
Phase 2	1,863,000 People Stressed
Phase 1	1,690,000 People in food security

CURRENT ACUTE MALNUTRITION APRIL 2024 – MARCH 2025

54,000

the number of 6-59 months children acutely malnourished

IN NEED OF TREATMENT

Severe Acute Malnutrition (SAM)	6,600
Moderate Acute Malnutrition (MAM)	47,400

9,800

Pregnant or lactating women acutely malnourished

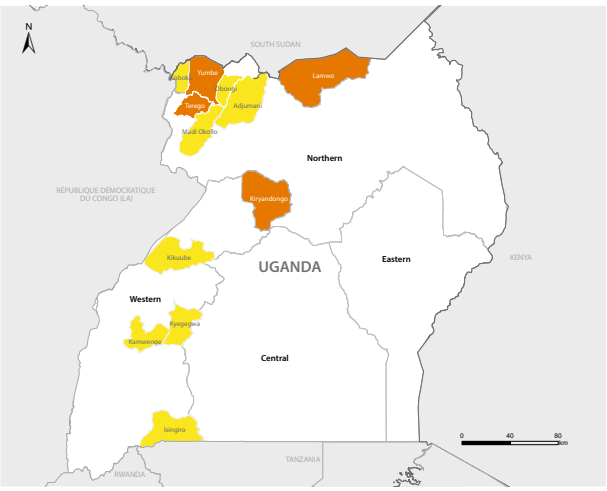
IN NEED OF TREATMENT

Overview

Approximately 797,000 people in refugee-hosting districts in Uganda are facing high levels of acute food insecurity (IPC Phase 3 or above), representing 17 percent of the population analysed. Of the 12 districts analysed, four were classified in IPC Phase 3 (Crisis), while the remaining eight were classified in IPC Phase 2 (Stressed).

The situation shows improvement compared to the same period in the previous year (August 2023 – January 2024), when six districts were classified in Phase 3, and the total number of food-insecure individuals decreased from 846,000 to 797,000. Adjumani and Kyegegwa districts transitioned from Phase 3 to Phase 2, reflecting better conditions. However, challenges

Current Acute Food Insecurity | July 2024 - January 2025



Key for the Map

IPC Acute Food Insecurity Phase Classification

- 1 - Minimal
- 2 - Stressed
- 3 - Crisis
- 4 - Emergency
- 5 - Famine

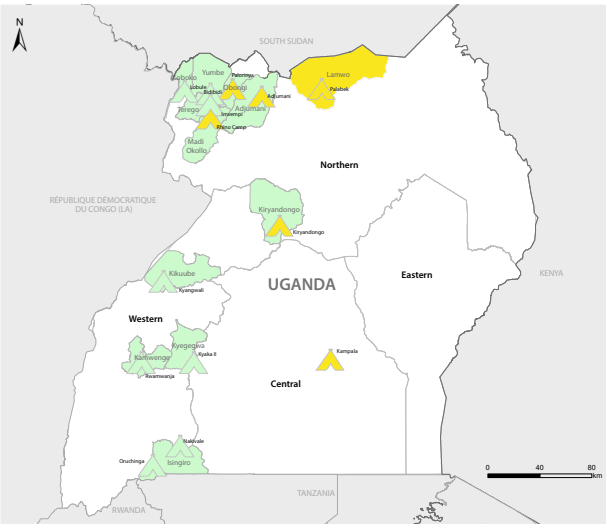
Areas with inadequate evidence

Areas not analysed

Evidence Level

*** High

Current Acute Malnutrition | April - September 2024



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

Evidence Level

*** High

Scarce evidence due to limited or no humanitarian access

persist due to poor rainfall performance, prolonged dry spells, rising food prices, low purchasing power, crop and livestock pests and diseases, and conflicts between host communities and refugees. These factors have driven many refugee-hosting communities into high levels of acute food insecurity.

Households in Kiryandongo, Lamwo, Terego, and Yumbe—classified in Phase 3—are particularly vulnerable. Poor first-season harvests, and reduced purchasing power are widening food consumption gaps, forcing affected households that have already exhausted their food reserves to rely on crisis and emergency coping strategies. Refugees, poor host households, and urban households dependent on markets are among the hardest hit.

It is important to note that the current analysis period coincides with two agricultural harvest seasons: the March–May and September–December rains, during which harvests of major staple crops are expected to be favourable in most districts, according to field reports. According to UNHCR, as of 31 October 2024, Uganda hosts over 1.7 million refugees and asylum-seekers in 13 districts. Approximately 8 percent of these refugees are in the Capital city Kampala and 92 percent are in 13 settlements spread across the 12 districts of Adjumani, Isingiro, Kamwenge, Kikuube, Kiryandongo, Koboko, Kyegegwa, Lamwo, Madi Okollo, Obongi, Terego and Yumbe. For these poor households, it is essential to implement activities aimed at saving lives, reducing food consumption deficits and protecting livelihoods.

The projection period (February to June 2025) will coincide with the dry season and lean period in all 12 districts analysed. Without timely interventions, the acute food insecurity situation is expected to gradually deteriorate from March 2025 to the end of the projection period, with the number of people in Phase 3 or above increasing from 797,000 people (17 percent of the analysed population) to 953,000 people (21 percent of the analysed population). Adjumani, Isingiro, Koboko, Madi Okollo and Obongi are anticipated to worsen from Phase 2 to Phase 3. The increase in food-insecure individuals includes 156,000 new cases, most of whom are in districts experiencing phase changes in addition to those already in Phase 3.

Between April 2024 and March 2025, approximately 54,000 children aged 6-59 months and 9,800 pregnant or breastfeeding women (PBW) are suffering or projected to suffer acute malnutrition in the 13 refugee settlements and urban refugee populations. This corresponds to a 53 and 26 percent reduction for children and PBW, respectively, compared to the same period last year. The significant improvement is attributed to the strengthened nutrition specific and sensitive interventions among the refugees and host communities. During the projection period, the only area in IPC AMN Phase 2 (Alert) is expected to improve to IPC AMN Phase 1 (Acceptable), while the rest are expected to remain in Phase 1.

Key Drivers for Acute Food Insecurity

Climatic shocks: Most districts experienced prolonged dry spells that reached drought levels in some areas, causing significant crop losses during the growing season A of 2024 in the months of May and June.

High food prices: The increase in food prices against low purchasing power of most households limit their food access.

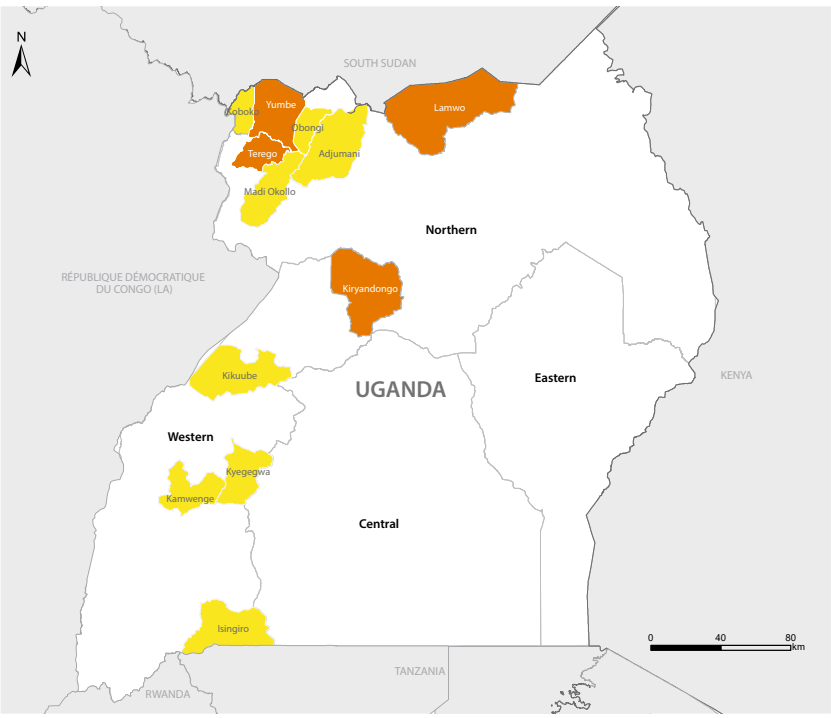
Seasonal pests and diseases: Seasonal crop pests, diseases and livestock diseases and vectors negatively affect food security.

Contibuting factors to Acute Malnutrition

Inadequate food consumption: The minimum Dietary Diversity among children and women is inadequate.

Inadequate access to water and sanitation: Access to water (20 litres per person per day) is insufficient and access to improved sanitation is limited.

ACUTE FOOD INSECURITY CURRENT SITUATION MAP AND POPULATION TABLE FOR REFUGEE HOSTING DISTRICTS (JULY 2024 – JANUARY 2025)



Key for the Map

IPC Acute Food Insecurity Phase Classification

- 1 - Minimal
- 2 - Stressed
- 3 - Crisis
- 4 - Emergency
- 5 - Famine
- Areas with inadequate evidence
- Areas not analysed

Area receives significant humanitarian food assistance
(accounted for in Phase classification)

> 25% of households meet 25-50% of caloric needs through assistance

> 25% of households meet > 50% of caloric needs through assistance

Evidence level:

*** High

Current Population Table: July 2024 – January 2025

District	Total population analysed	Phase 1		Phase 2		Phase 3		Phase 4		Phase 5		Area Phase	Phase 3+	
		#people	%	#people	%	#people	%	#people	%	#people	%		#people	%
Adjumani	300,380	150,190	50	105,133	35	45,057	15	0	0	0	0	2	45,057	15
Isingiro	633,844	253,538	40	285,230	45	95,077	15	0	0	0	0	2	95,077	15
Kamwenge	336,738	269,390	80	50,511	15	16,837	5	0	0	0	0	2	16,837	5
Kikuube	380,097	190,049	50	133,034	35	57,015	15	0	0	0	0	2	57,015	15
Kiryandongo	364,878	164,195	45	127,707	35	72,976	20	0	0	0	0	3	72,976	20
Koboko	271,655	149,410	55	81,497	30	40,748	15	0	0	0	0	2	40,748	15
Kyegegwa	501,535	200,614	40	225,691	45	75,230	15	0	0	0	0	2	75,230	15
Lamwo	213,799	85,520	40	74,830	35	53,450	25	0	0	0	0	3	53,450	25
Madi okollo	184,341	55,302	30	101,388	55	27,651	15	0	0	0	0	2	27,651	15
Obongi	143,492	64,571	45	57,397	40	21,524	15	0	0	0	0	2	21,524	15
Terego	322,893	96,868	30	129,157	40	96,868	30	0	0	0	0	3	96,868	30
Yumbe	972,351	291,705	30	486,176	50	194,470	20	0	0	0	0	3	194,470	20
Grand Total	**4,626,003**	**1,971,352**	**43**	**1,857,749**	**40**	**796,902**	**17**	**0**	**0**	**0**	**0**		**796,902**	**17**

Note: A population in Phase 3+ does not necessarily reflect the total population needing urgent action. This is because some households may be in Phase 2 or even one but only because of receipt of assistance; therefore, they may need continued action. Marginal inconsistencies that may arise in the overall percentages of totals and grand totals are attributable to rounding.

CURRENT ACUTE FOOD INSECURITY SITUATION OVERVIEW (JULY 2024 – JANUARY 2025)

Uganda currently hosts slightly over 1.7 million refugees (UBOS Census 2024) across 13 districts. Six of these are in West Nile (Adjumani, Koboko, Madi Okollo, Obongi, Terego, and Yumbe), one in Mid-North (Lamwo), four in Western (Kamwenge, Kikuube, Kiryandongo, and Kyegegwa), one in Southwestern (Isingiro), and one in Central (Kampala). All refugee-hosting districts, except Kampala, are included in this analysis.

Between July 2024 and January 2025, four districts were classified in IPC Phase 3 (Crisis) and eight districts in IPC Phase 2 (Stressed). Kiryandongo, Lamwo, Terego, and Yumbe were classified in Phase 3, whereas Adjumani, Isingiro, Kamwenge, Kikuube, Koboko, Kyegegwa, Madi Okollo, and Obongi were in Phase 2. Of the total population analysed, 17 percent (797,000 people) are classified in IPC Phase 3 or above (Crisis or worse). Unlike in 2023, when 1 percent (58,000 people) of the population were classified in IPC Phase 4 (Emergency), no population has been classified in Phase 4 during this analysis.

In terms of severity, Terego (30 percent), Lamwo (25 percent), Yumbe (20 percent), and Kiryandongo (20 percent) have the highest percentages of their populations classified in IPC Phase 3 (Crisis) or worse. Conversely, Kamwenge (5 percent) continues to have the lowest percentage in Phase 3 or above, as in the previous year. In terms of magnitude, the districts with the most affected population (IPC Phase 3 or above) remain Yumbe (194,000 people) because of its high population, Terego (96,000 people) and Isingiro (95,000 people). Kamwenge district has the lowest number of people (16,000 people) in Phase 3 or above. Compared to the analysis of 2023 (August 2023–January 2024), the acute food insecurity situation has generally improved across all the twelve districts, with the total number of people in Phase 3 and above declining from 846,000 to 797,000. Additionally, the population in Phase 4 has dropped from 1 percent (58,000) to none during the current analysis.

The primary livelihood for households in these refugee-hosting districts is crop and livestock farming. Field reports indicate that the food security situation in these districts has been negatively affected by poor crop and livestock performance during the last two consecutive rainy seasons, primarily due to poor rainfall, prolonged dry spells, and high incidences of crop and livestock pests and diseases. The reduction in food production, coupled with high prices for food and essential non-food commodities and the low purchasing power of most households, has resulted in widespread food insecurity across the districts.

Overview of outcome indicators

Food consumption and dietary diversity: According to the Food Security and Nutrition Assessment (FSNA) conducted by the Government and its technical partners (WFP, FAO, UNHCR) between July and August 2024, most districts had no people with poor food consumption. Exceptions were noted in Kamwenge, Kiryandongo, Kyegegwa, and Obongi, where the people with a poor consumption score ranged from 1 to 3 percent, and Lamwo, which recorded the highest rate at 7 percent. This shows a significant improvement compared to last year where all refugee-hosting districts had some people with poor food consumption. On average, according to the Household Dietary Diversity Score (HDDS), 0 to 3 percent of people were consuming 0 to 2 food groups which is a significant improvement compared to last year.

Coping mechanisms: The FSNA data highlights a significant improvement in both food-based and livelihoods coping strategies across most districts in 2024 compared to 2023. Adjumani, Obongi, and Kamwenge show notable progress, with higher proportions of households not employing food-based coping strategies. Adjumani increased from 46 percent to 78 percent, and Obongi from 49 percent to 85 percent, according to the Reduced Coping Strategies Index (rCSI). Similarly, Livelihood Coping Strategies (LCS) reflect positive trends, with more households not adopting any coping mechanisms, particularly in Kamwenge (85 percent), Obongi (80 percent), and Adjumani (75 percent). These improvements indicate a reduction in food insecurity levels and reliance on less severe coping strategies. However, challenges persist in some areas, particularly in districts like Lamwo and Yumbe, where a considerable proportion of households continue to rely on crisis or emergency coping strategies. For instance, Yumbe reported 25 percent of households using crisis strategies under LCS, while Lamwo reported 27 percent.

Similarly, Madi Okollo and Kiryandongo still report a significant proportion of stressed households under rCSI, at 58 percent and 49 percent, respectively. These figures demonstrate the need for targeted interventions in these districts to address lingering vulnerabilities and enhance resilience among affected households.

Acute malnutrition: There was a general improvement in the level of acute malnutrition across all 12 districts analysed

compared to 2023. The Global Acute Malnutrition (GAM) prevalence in the host districts stands at 2.4 percent, with 2.0 percent of children under five years classified as moderately malnourished, and no children found to be severely malnourished. This represents an improvement from the 3.4 percent recorded in June 2023. Lamwo recorded the highest GAM at 5.1 percent, while Kamwenge reported the lowest GAM at 0 percent, consistent with the 2023 findings.

Overview of key drivers of Acute Food Insecurity

Rainfall: During the first rainy season of 2024 (MAM), most districts received inadequate rainfall with prolonged dry spells which significantly reduced crop performance, especially in Terego and Isingiro districts. The general outlook of the second season 2024 (JJA and SOND) rains, over the current analysis period as provided by Uganda National Meteorological Authority (UNMA) has enhanced crop and livestock production in the refugee hosting districts. However, excessive rains received caused flooding and waterlogging mostly in the flood prone areas along the River Nile, causing water destruction of road infrastructure. It also led to increase in crop disease incidences especially blights in horticultural crops resulting in reduced crop performance. On the other hand, good long rains of JJA and SOND motivated farmers to open more land for crops hence increased production by 20 percent compared to 2024 first season.

Conflicts: Frequent conflicts have been reported between the host population and refugees over the struggle to occupy additional farmland, which has affected crop production in Palorinya, Itula, and Gimara sub-counties in Obongi district. Continuing disputes over land cultivation rights between the Madi and Acholi communities in the Apaa area, located on the border of Adjumani and Amuru districts, have displaced people from fertile areas to less productive regions, resulting in reduced crop production. In addition, isolated incidents of food theft in Kyegegwa district were a source of endless conflict between the refugees and host populations, especially for communities around Katonga game reserve in Ruyonza and Rwentuha sub-counties.

Crop pests and diseases: Crop production was affected by a range of crop pests and diseases that included maize streak, groundnut rosette and cassava brown streak disease, Fall Army Worm (FAW), African Army Worm (AAW), cassava mosaic virus, white flies (especially in cassava), aphids, pod sucking bugs and weevils, smuts in sorghum, rusts, powdery mildews in simsim, Anthracnose, variegated grasshoppers and bacterial blight in vegetables and legumes. The Coffee Twig Borer was also rampant in Isingiro district, due to erratic changes in weather characterized by high temperatures and prolonged dry spells. This is lowering the good production perspectives.

Livestock diseases: Livestock production was affected by a wide range of diseases. Foot and Mouth Disease (FMD) was reported in most of the districts which led to quarantine restrictions and closure of livestock markets. This reduced household income and food access. Other diseases included New Castle Disease (NCD), East Coast Fever (ECF), Babesiosis, Anaplasmosis, Trypanosomiasis, Helminthiasis, Mange, Contagious bovine pleuro-pneumonia (CBPP), Contagious caprine pleuropneumonia (CCPP), Peste des petits ruminants (PPR), Foot and Mouth Disease (FMD), lumpy skin disease, swine fever and Bacillary White Diarrhoea.

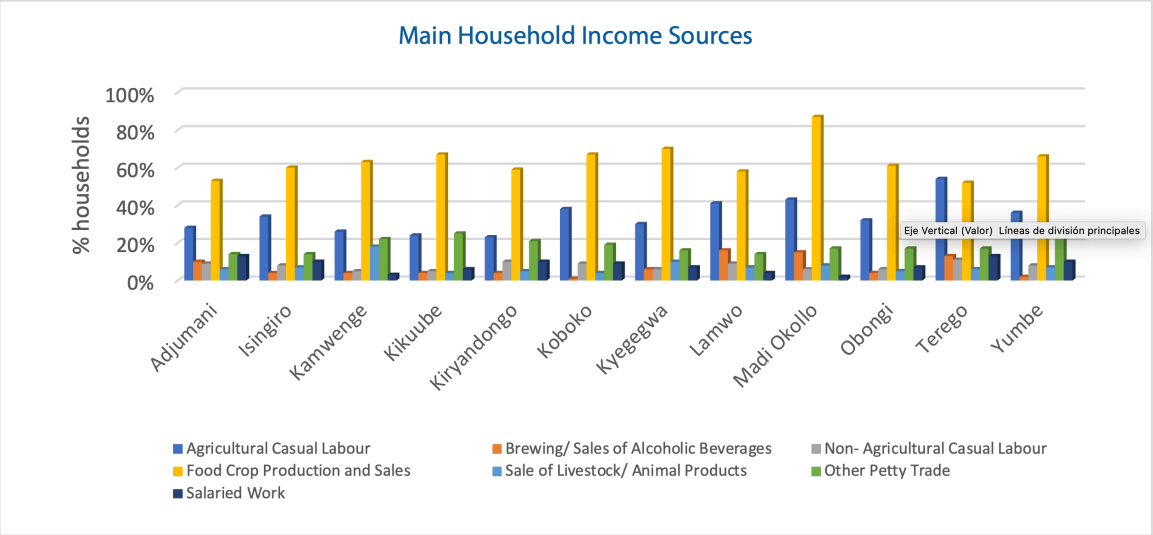
Market price and trends: The prices of most staple food crops such as maize, millet, cassava, beans, cow peas, sesame and groundnuts marginally increased in the first season (2024A). This was attributed to the low supply levels of these crops in the market due to reduced harvests realised in the first season. Consequently, household reliance on the market to meet food needs increased between July and September 2024. Reports from District Commercial Officers indicate that prices of staple foods and essential non-food commodities slightly increased during this period due to low market supply and relatively high external demand from South Sudan, Kenya, and the Democratic Republic of Congo. In the regional market of Arua district, the price of cassava flour increased from an average of Uganda Shillings 700 to Uganda Shillings 2,165, while a medium-sized fish cost Uganda Shillings 12,000. In Kyegegwa district, the price of maize grain and maize flour rose to Uganda Shillings 1,720 and Uganda Shillings 2,920 per kilogram, respectively, by July 2024, up from Uganda Shillings 800 and Uganda Shillings 2,000. Unfortunately, through the current period of analysis, incomes of poor and very poor households remained lower than normal causing a drastic drop in the purchasing power of this category of households.

District reports also indicated that high agro-inputs prices made production too costly for the poor farmers as these households were facing difficulties meeting demand for most of the major crop inputs. For instance, in Kiryandongo district, a 50 Kg bag of urea fertilizers cost Uganda Shillings 270,000 up from Uganda Shillings 110,000 in 2021, with the improved maize seed costs also following suit with at least a 17 percent increase.

Current state of food security dimensions

Food availability: Food availability is a minor limiting factor to food security in all districts, because food is generally available either in most households or local and regional markets. According to the crop yield data obtained from the agricultural production departments, there was generally average performance of most crops in the districts in season 2024A compared to season 2023B. The data revealed that, the yield per unit area cultivated in 2023B is higher than that of 2024A. Similarly, about 70 percent of the crops grown in most districts are for household consumption, implying that, most of the households depend on own production for their daily food requirements. According to the production data, the average amount of food stocks per household in most districts were very low lasting between 1 -3 months due to the poor harvest from season 2024A. Household's food stocks will improve by good harvests from second season which will continue up to the end of January 2025. This therefore implies that most households have available food for the current analysis period.

Food acces: Food access was found to be a major limiting factor to food security in all refugee hosting districts. Although prices of most staple food commodities (cassava, maize, beans, Irish potatoes, cooking banana) were generally lower from May to August 2024 than the same period last year in most districts and regional markets, the below average production during season 2024A somehow affected food availability in the markets hence leading to an increase in prices in September for most staples. For example, September prices of beans were on average at Uganda Shillings 4,000 per kg from the usual average of Uganda Shillings 3,500. With over 60 percent of households deriving their income from sale of agricultural produce and agriculture related labour as shown in the figure below, the below average harvest experienced and livestock diseases had a direct impact on the income of the household's hence low purchasing power, making food access a major limiting factor in all the districts analysed.



The main sources of income for most households across the refugee hosting districts are the sale of food crops (64 percent) and agricultural casual labour (34 percent). The sale of crops was greatly affected by the below average harvest of season 2024A. In addition, poor rainfall distribution and less land opened for agricultural activities, reduced opportunities for agricultural related casual labour which is the second most important source of income. As a result, the purchasing power of the poor and very poor population remained significantly low pushing many of them into Crisis levels of food insecurity as they were increasingly unable to meet their minimum food consumption needs. In most districts, food was available in the local markets but at high prices and most households were not able to purchase enough food to reduce consumption gaps.

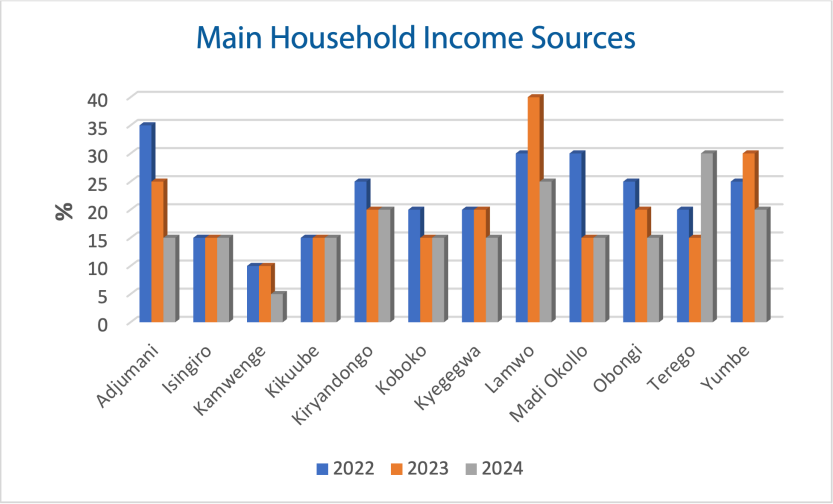
Food utilization: Food utilization is a major limiting factor in districts of Kiryandongo, Kyegegwa, Koboko, Madi Okollo, Terego and Yumbe. According to the Food Security and Nutrition Assessment (FSNA), 74 percent of households have access to improved water sources, with the highest proportion found in Adjumani and Yumbe both at 96 percent. Even though Yumbe district has high access to improved water source, it has a high level of water contamination during the rainy season due to low access to and use of latrine coverage (55 percent). This exposes most households to a high risk of water borne diseases. Districts with lowest access to water sources are Kyegegwa (51 percent) and Isingiro (36 percent), the per capita water usage was found to be very low in these districts averaging at 39.9 percent. Across the refugee-hosting districts, the primary source of safe, usable water is boreholes, accessed by 48 percent of households. However, there is very limited availability of boreholes in Isingiro district (13 percent), where 20 percent of households rely on piped water and 29 percent use surface water sources, including lakes, rivers, and unprotected streams. The consumption of leafy vegetables also improved

during the period of assessment especially during the rainy periods when vegetables are abundant. There is low dietary diversity due to lack of financial resources to purchase other food items as well as a historical preference for cassava in West Nile, maize and cassava in mid-West, and banana and millet in Southwestern districts. Access to and use of toilet facilities stands at 78 percent across the host districts with Kamwenge and Isingiro having the highest at 92 percent and 91 percent respectively while Yumbe had the lowest at 55 percent. All these factors greatly affect food utilization in these districts.

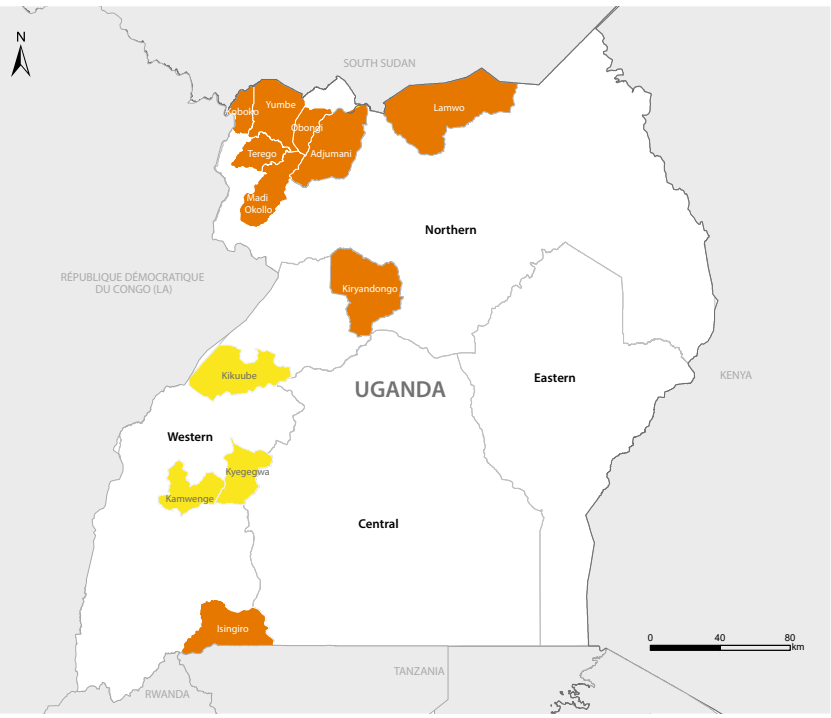
COMPARISON TO PREVIOUS ANALYSES

Compared to the last two years, the current food security situation (July 2024 to January 2025) shows a slight improvement across all refugee hosting districts analysed apart from Terego. The proportion of the population facing high levels of acute food insecurity in the refugee hosting districts decreased from 21 percent in 2022 to 20 percent in 2023 and 17 percent in 2024. This has been possible due to the improved agricultural production due to favourable rainfall performance in the past three consecutive years compared to previous years. No households have been classified in IPC AFI Phase 4 (Emergency) in 2024, compared to 3 percent in 2022 and 1 percent in September 2023. Eleven districts either recorded improvements in food security (Adjumani, Kamwenge, Kyegegwa, Lamwo, Obongi, and Yumbe) or remained stable (Isingiro, Kikuube, Kiryandongo, Koboko, and Madi Okollo) compared to 2023. On the contrary, Terego district showed serious decline with the percentage of food insecure households increasing from 15 percent in 2023 to 30 percent due to poor rainfall characterized with late onset and prolonged dry spells that drastically affected first season (2024A) planting. Due to limited food stocks, some households in Terego consumed seed stocks which reduced acreage planted for second season. All these factors greatly affected both availability and access to food for most households in Terego district, hence the observed decline in the food security situation as compared to 2023.

Refugee hosting distrcit populations in IPC Phase 3 or above (Crisis or worse)



ACUTE FOOD INSECURITY PROJECTION MAP AND POPULATION TABLE FOR REFUGEE HOSTING DISTRICTS (FEBRUARY – JUNE 2025)



Key for the Map

IPC Acute Food Insecurity Phase Classification

- 1 - Minimal
- 2 - Stressed
- 3 - Crisis
- 4 - Emergency
- 5 - Famine
- Areas with inadequate evidence
- Areas not analysed

Area receives significant humanitarian food assistance
(accounted for in Phase classification)

> 25% of households meet 25-50% of caloric needs through assistance

> 25% of households meet > 50% of caloric needs through assistance

Evidence level:

*** High

Population Table for Projection: February – June 2025

District	Total population analysed	Phase 1		Phase 2		Phase 3		Phase 4		Phase 5		Area Phase	Phase 3+	
		#people	%	#people	%	#people	%	#people	%	#people	%		#people	%
Adjumani	387,377	135,582	35	174,320	45	77,475	20	0	0	0	0	3	77,475	20
Isingiro	658,100	197,430	30	329,050	50	131,620	20	0	0	0	0	3	131,620	20
Kamwenge	372,000	260,400	70	74,400	20	37,200	10	0	0	0	0	2	37,200	10
Kikuube	414,400	186,480	45	165,760	40	62,160	15	0	0	0	0	2	62,160	15
Kiryandongo	339,200	135,680	40	118,720	35	84,800	25	0	0	0	0	3	84,800	25
Koboko	287,500	129,375	45	100,625	35	57,500	20	0	0	0	0	3	57,500	20
Kyegegwa	551,900	193,165	35	275,950	50	82,785	15	0	0	0	0	2	82,785	15
Lamwo	148,100	44,430	30	51,835	35	51,835	35	0	0	0	0	3	51,835	35
Madi okollo	176,800	35,360	20	97,240	55	44,200	25	0	0	0	0	3	44,200	25
Obongi	143,492	50,222	35	64,571	45	28,698	20	0	0	0	0	3	28,698	20
Terego	251,500	50,300	20	100,600	40	100,600	40	0	0	0	0	3	100,600	40
Yumbe	775,000	271,250	35	310,000	40	193,750	25	0	0	0	0	3	193,750	25
Grand Total	**4,505,369**	**1,689,674**	**38**	**1,863,071**	**41**	**952,624**	**21**	**0**	**0**	**0**	**0**		**952,624**	**21**

Note: A population in Phase 3+ does not necessarily reflect the total population needing urgent action. This is because some households may be in Phase 2 or even one but only because of receipt of assistance; therefore, they may need continued action. Marginal inconsistencies that may arise in the overall percentages of totals and grand totals are attributable to rounding.

ACUTE FOOD INSECURITY PROJECTION OVERVIEW (FEBRUARY – JUNE 2025)

The food security situation in refugee-hosting districts is projected to gradually deteriorate during the projection period (February–June 2025) as communities deplete stocks from the 2024 second season harvest during the lean period of April–June 2025. It is projected that the estimated number of people facing high levels of acute food insecurity (IPC Phase 3 or above) and requiring food assistance and livelihood improvement interventions will most likely increase from 797,000 which is 17 percent of the population analysed to 953,000 which is 21 percent of the population analysed. This is because of the expected decline in stock levels because of no production during that period. Food prices are also expected to increase due to scarcity around that period, hence affecting household food availability and access. Apart from Kikuube, Kamwenge and Kyegegwa, all other districts are expected to be classified in IPC Phase 3 (Crisis) with the districts of Adjumani, Isingiro, Koboko, Madi Okollo and Obongi deteriorating from IPC Phase 2 (Stressed) during the current analysis to Phase 3. In terms of severity, the districts expected to have the highest percentage in Phase 3 are Terego (40 percent), Lamwo (35 percent), Kiryandongo (25 percent), Madi Okollo (25) and Yumbe (25 percent). Kamwenge is instead projected to have the least population (10 percent), just like in 2023. In terms of magnitude, the districts projected to have the highest populations in Phase 3 are Yumbe (193,750), Isingiro (131,620), and Terego (100,600). The population in Phase 3 during the projection period has decreased in most districts, except for Isingiro and Terego, which have shown an increase compared to the figures from 2023.

During the months of February and March 2025, food is expected to be available both at household level and in the market from harvests of second season 2024. Most households are expected to run short of food stocks by April 2025, rendering them vulnerable to food shortage and increasing food consumption gaps. Compared to the current analysis period, food consumption and incomes from own production and other livelihood opportunities will tend to decrease in the projection period owing to declining stock levels and seasonal price changes. On the other hand, dietary diversity may not improve in the projection period due to food preferences, limited financial capacity to purchase other dietary foods from the markets, and general lack of knowledge among mothers and care givers. Likewise, sanitation and hygiene are likely to remain the same during the projection period.

Key Assumptions:

The projected situation during the period of February 2025 to June 2025, is based on the following assumptions:

Crop and livestock production: The good harvests from Season 2024 are expected to be available and easily accessible to most households until April 2025 when the stocks are expected to be depleted as the lean period reaches the peak. Livestock production and productivity is expected to be affected by the long dry period which starts end of December 2024 to mid-March 2025.The food availability will further reduce towards the end as people start planting for MAM season.

Rainfall: The projected La Niña event, as forecasted by UNMA, is expected to end in March 2025 and is likely to result in an intensified dry season in February and March 2025. This could have a significant impact on crops, particularly root crops such as cassava and sweet potatoes, plantation crops such as bananas, as well as water and pasture availability for livestock. High temperatures are also likely to lead to outbreaks of crop pests and livestock diseases, further affecting food availability in April, May, and June 2025.

Land conflicts: The on-going land conflicts in some areas will most likely continue curtailing any further land opening. Conflicts between cattle keepers and crop farmers in Kiryandongo district (Masindi Port, Mutunda and Kiryandongo sub-counties) are expected to continue as unattended cattle stray and destroy food crops. The major conflict in Obongi district that has been attributed to the new case load of refugee influx from South Sudan and also the existing high refugee population has put more pressure on land which is the primary factor of production. The usual conflicts between refugees and host communities regarding the use of natural resources such as fuel wood, water sources and mined sand will likely continue in most of the host districts. Small pockets of conflicts expected in Adjumani to occur due to increasing population, urbanization and demand of rental land for cultivation by refugees. Land wrangles and cattle rustling are expected in Lamwo.

Livestock vectors and diseases: The outbreak of FMD is likely to continue in most of the livestock keeping districts. CBPP, CCPP, PPR, Anaplasmosis, Babesiosis, ECF and NCD are expected to continue affecting livestock and poultry, even with the expected vaccination drives. This continued disease infestation and the ongoing quarantine restrictions are likely to affect income generation for households that depend on selling livestock and livestock products to access food. Further FMD outbreaks, are likely, imposing livestock quarantine, which will greatly affect household incomes due to likely closure of more livestock markets.

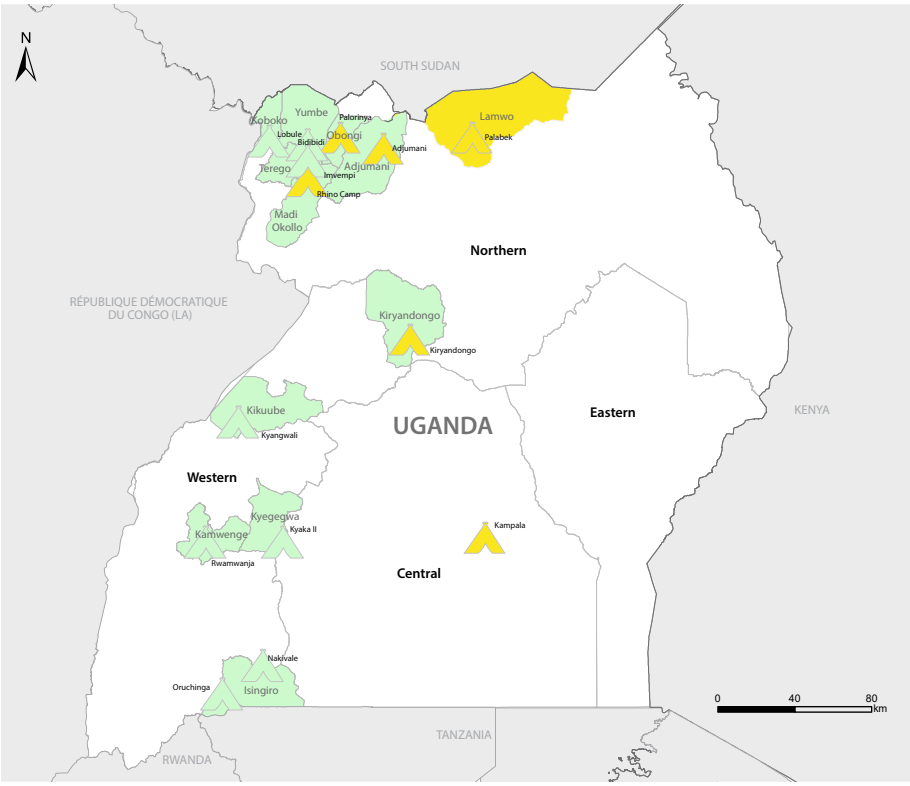
Income from typical livelihood strategies: Households engaged in low-value economic activities like charcoal burning, firewood collection and selling local brew trade and other petty trade will likely get improved incomes during the early projection period. The demand for agricultural labour likely to improve as the first season of 2025 starts and this will likely continue through

May 2025. The involvement of youths in sand mining, especially around lakes and rivers, will most likely continue if there are no negative restrictive measures put in place.

Prices trends: Prices of food crops are expected to increase between March and June 2025 as food stocks get exhausted and ahead of first season of 2025 harvests. Prices of livestock are likely to reduce because of the high costs associated with livestock management during the dry spell, and inadequate water and pasture availability due to the likely intense dry season. This is likely to trigger most farmers to sell off some animals.

Karuma Bridge reopening: The continued closure of Karuma Bridge is likely to affect transportation of food and non-food items during the projected period from other districts and Kampala. This will likely add to an increase in prices for food and non-food items in the host districts in West Nile region.

ACUTE MALNUTRITION CURRENT SITUATION MAP AND OVERVIEW IN REFUGEE SETTLEMENTS AND HOST DISTRICTS (APRIL - SEPTEMBER 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
- Refugee settlements

Evidence level:

*** High

OVERVIEW OF THE CURRENT PERIOD FOR ACUTE MALNUTRITION (APRIL – SEPTEMBER 2024):

During the current period of analysis (April to September 2024), the refugee settlements demonstrated a relatively higher vulnerability to acute malnutrition compared to the host districts. Six refugee settlements were classified in IPC AMN Phase 2 (Alert), while only one of the 12 host districts (Lamwo) was classified in Phase 2, with the remaining 11 districts classified in IPC AMN Phase 1 (Acceptable).

Refugee Settlements:

During the current period (April to September 2024), six settlements – Adjuman, Kamapla Urban, Kiryandongo, Rhinocamp, Palorinya and Palabek – were classified in Phase 2 with a GAM prevalence of 7.1, 6.2, 7.8, 7.8, 8.3 and 6.7 percent, respectively. The remaining eight settlements – Rwamwanja, Kyaka II, Nakivale, Oruchinga, Bidibidi, Lobule, Imvepi, and Kyangwali – were classified in Phase 1 with a GAM prevalence of 1.1, 2.0, 2.3, 2.2, 3.9, 4.0, 3.4, 1.3 percent, respectively.

Compared to the same period last year, the acute malnutrition situation improved in nine refugee settlements and Kampala Urban. Notably, Palabek and Rhino Camp improved from IPC AMN Phase 3 (Serious) to Phase 2, while Bidibidi, Imvepi, and Lobule moved from Phase 2 to Phase 1. However, Rwamwanja, Kyaka II, and Palorinya registered slight increases in GAM prevalence, while conditions in Nakivale remained unchanged.

The overall improvement in GAM prevalence can be attributed to comprehensive interventions addressing food security, health, and nutrition. Key factors include:

- Stable food prices and improved food production supported by favourable rains.
- Expanded vaccination coverage and disease prevention measures.
- A shift toward livelihood programming in refugee settlements.
- Provision of additional land for cultivation.
- Prompt treatment of acute malnutrition cases, supported by an enhanced supply chain and cash assistance (NUTRI CASH).

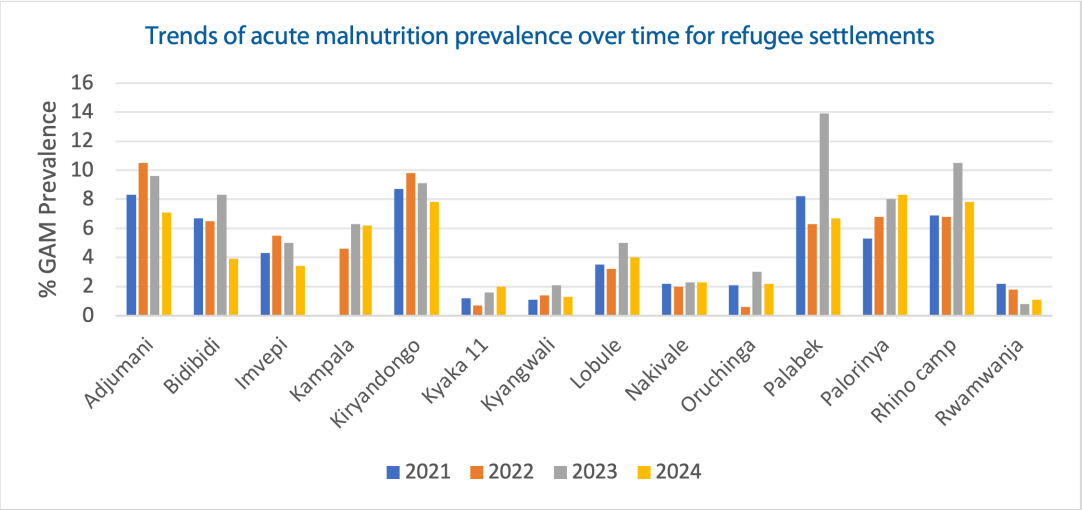


Figure 1: Trend of acute malnutrition prevalence over time

Host districts:

Only Lamwo district was classified in Phase 2 with a GAM prevalence of 5.1 percent. The rest of refugee hosting districts were classified in Phase 1. Compared to the same period of last year, the acute malnutrition situation has generally improved in the Host communities but deteriorated in Adjumani district with the GAM prevalence increasing by two times (from 2.1 percent in 2023 to 4.7 percent in 2024), although still within Phase 1. The World Health Organization (WHO) has set a target to reduce acute malnutrition in children under five years of age to less than 5 percent by 2025 and less than 3 percent by 2030. This underscores the need to sustain and enhance interventions aimed at further reducing acute malnutrition in the affected populations.

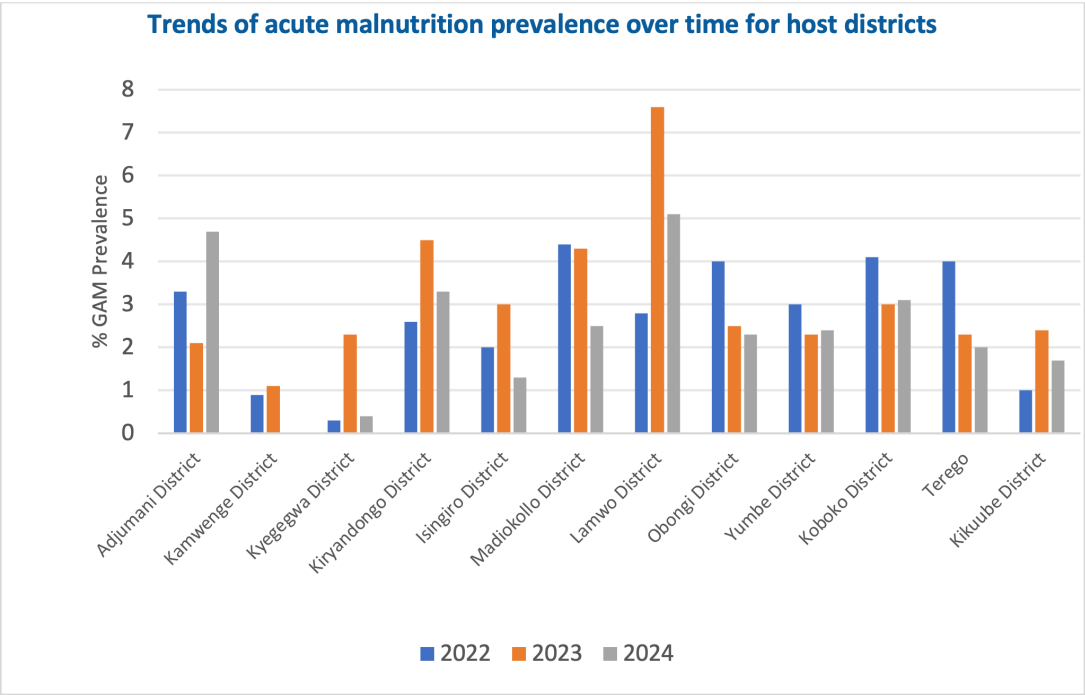


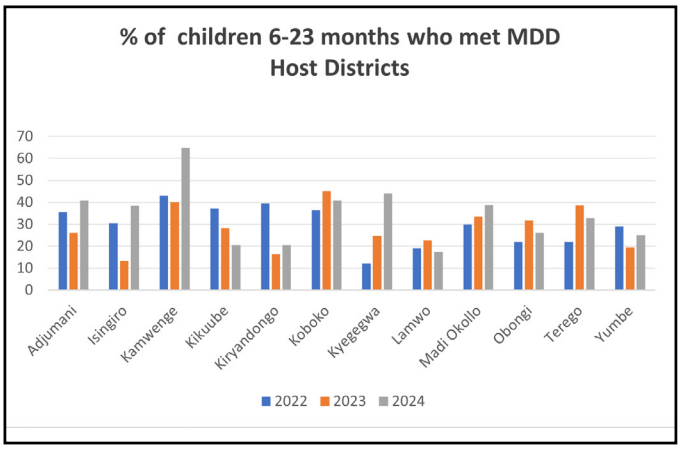
Figure 2: Trend of acute malnutrition prevalence over time

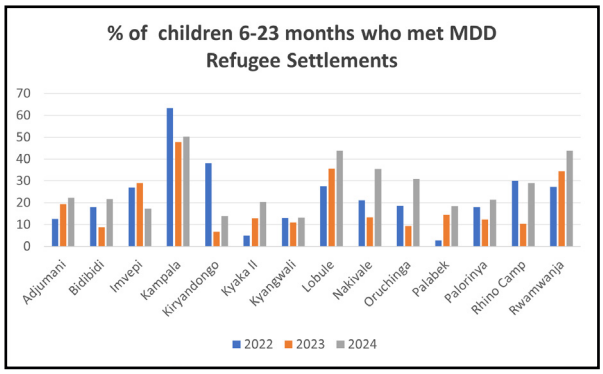
CONTRIBUTING FACTORS TO ACUTE MALNUTRITION

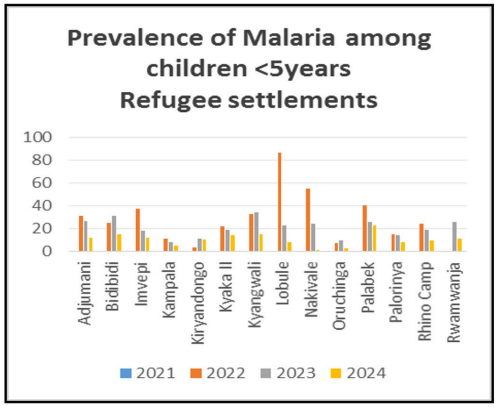
In settlements and host communities the major risk factors contributing to acute malnutrition, grouped into immediate, underlying and structural key drivers, are the following:

Immediate factors

Inadequate food consumption: Despite improvements observed during the period from April to September 2024 compared to the same period in 2023, food consumption, as referenced by Minimum Dietary Diversity (MDD) and Minimum Acceptable Diet (MAD), remained low among children aged 6–23 months and even lower among women across all settlements and host communities. While meal frequency improved, the quality of diets remained poor, particularly in the settlements. This was evident in the lowest MAD recorded at Kiryandongo settlement (6.0 percent), followed by Kyaka (8.2 percent) and Adjumani (10.2 percent) settlements. Similar trends were observed in the host communities, which performed better than refugee settlements in food consumption but remained at high risk of acute malnutrition in most areas. The MAD ranged from 11.3 percent in Lamwo district to a high of 48.6 percent in Kamwenge district. Poor food consumption contributes to nutrient inadequacies and acute malnutrition.

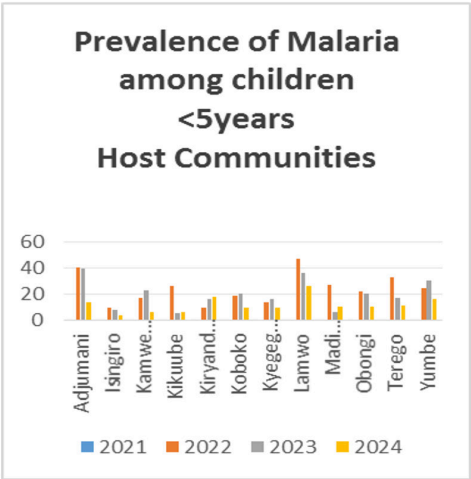


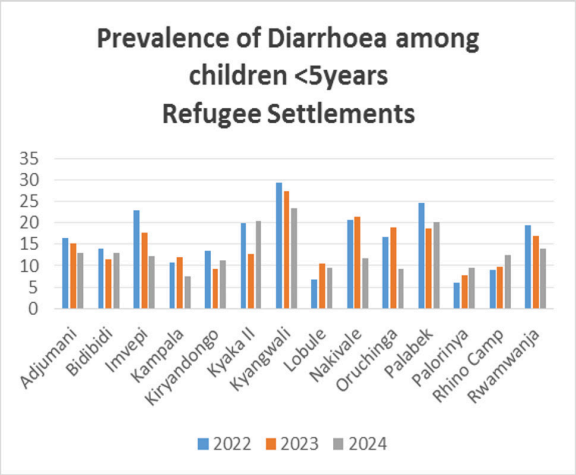




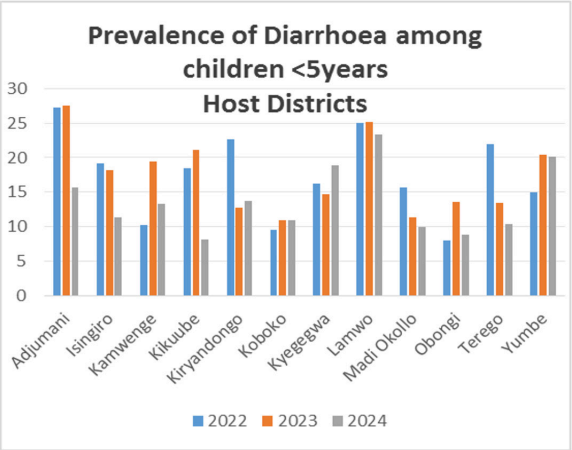
High morbidity:

The burden of disease has remained high despite reduction in prevalences registered in the period of analysis in 2024 compared to the same period in 2023. In the Refugee settlements a high burden of malaria was recorded in Kyangwali, Bidibidi and Kyaka II at 22.5 percent, 14.7 percent and 14.2 percent respectively. Malaria was rated as significant risk factor to malnutrition in 9 of the 13 Refugee settlements. Diarrhea was rated as medium risk in 6 refugee settlements (Adjumani, Bidibidi, Imvepi, Kiryandongo, Nakivale and Rwamwanja) and High risk in 3 settlements (Kyaka II, Kyangwali and Palabek)





In the host communities, the malaria burden was highest in the districts of Lamwo (26.9 percent), Yumbe (16.8 percent), and Adjumani (14.0 percent). Similarly, diarrhoea was identified as a risk factor in 8 of the 12 districts and was rated as a high-risk factor for acute malnutrition in Adjumani, Kyegegwa, Lamwo, and Yumbe districts. Measles cases were also reported in three districts of Kamwenge, Kikuube and Koboko. High disease burden disrupts normal nutrition in reference to intake, availability and metabolism while increasing nutrient needs that if not treated in a timely manner is likely to contribute to acute malnutrition.



UNDERLYING FACTORS

Limited access to sufficient water was reported to be of medium to high risk factor in all the twelve refugee settlements, with the lowest being in Oruchiga and Palabek where only 17.8 percent of the household accessed sufficient water (20 litres per person per day). The host districts presented similar trends where 7 of the 12 districts reported limited access to enough water. In the host districts, the lowest access to sufficient quantities of water were registered in Lamwo and Kikuube where 25.6 percent and 33.1 percent of households respectively accessed sufficient water. The communities have relatively better access to sufficient quantities of water than the refugee settlements, however, remain sub-optimal. Insufficient water in the households lead to compromised hygiene practices that increase vulnerability to infection, disease and acute malnutrition. There is a need to scale up access to sufficient water at the household level, considering water per capita as well as the proportion of households with access.

Food insecurity: compared to the period of April to September 2023, the food security situation improved in most Host districts. However, food gaps existed in Kiryandongo, Lamwo, Yumbe and Terego districts that were classified in IPC AFI Phase 3 (Crisis) while the rest of the districts were classified as IPC AFI Phase 2 (Stressed). Food insecurity leads to less diversified diets fed at sub-optimal frequencies resulting to nutrient inadequacies and acute malnutrition.

Poor access to sanitation facilities was registered in three refugee settlements (Kyangwali, Palabek and Rhino camp) and five Host districts of Isingiro, Kamwenge, Koboko, Kyegegwa and Madi increasing the risk of diseases related to poor environmental hygiene and infection to children that results in acute malnutrition.

Care practices: Most of the refugee settlements and host districts recorded desirable childcare practices, except for Adjumani settlement, which registered a relatively low prevalence of exclusive breastfeeding (EBF) at 65.4 percent. Continued breastfeeding for children aged 12 to 23 months was slightly low in Rhino Camp at 73.9 percent, while the practice of timely introduction of solid, semi-solid, or soft foods was relatively low in Kiryandongo settlement at 76 percent. Most of the refugee settlements and host districts recorded desirable childcare practices, except for Adjumani settlement, which registered a relatively low prevalence of exclusive breastfeeding (EBF) at 65.4 percent. Continued breastfeeding for children aged 12 to 23 months was slightly low in Rhino Camp at 73.9 percent, while the practice of timely introduction of solid, semi-solid, or soft foods was relatively low in Kiryandongo settlement at 76 percent.

BASICS FACTORS

Shocks due to the conflicts in Democratic Republic of Congo and Sudan meant there was influx of refugees in the Kiryandongo, Adjumani, Palorinya, kyangwali and Nakivale settlements. This influx of refugees led to additional pressure on the social services in the settlements including access to sanitation, water, health services and markets. Gaps created by additional pressure from refugees for various services increase the risk of acute malnutrition.

OTHER FACTORS

The high level of anaemia among children 6-59 months is a major public health concern that calls for urgent attention in both the refugee settlements and the host districts with exception of Kampala Urban and Oruchiga settlements. The highest burden was registered in Kiryandongo at 55.7 percent and others Kyangwali at 53.7 percent, Palabek (42.1 percent) Imvepi (35.2 percent), Kyaka II (33.8 percent), Palorinya 31.5 percent and Adjumain (29.6 percent).

Among the host districts, the highest prevalence of anaemia was in Kiryandongo (52.2 percent), followed by Kikuube, Koboko, Kegegwa and Adjumani at 36.4, 34.5, 33.0 and 30.0 percents, respectively.

Anaemia in children prevents optimal development, especially among children less than 2 years, and increases health risks that when compounded with disease, increases risk to malnutrition and mortality.

NUMBER OF PEOPLE IN NEED (PIN) OF TREATMENT FOR ACUTE MALNUTRITION (APRIL 2024 TO MARCH 2025)

Number of cases in Refugee Settlements: For the period of April 2024 to March 2025, it is estimated that **30,293** cases of children aged 6-59 months across all refugee settlements suffer acute malnutrition and need treatment, **25,139** of which are moderate acute malnutrition cases, and **5,153** of which are severe acute malnutrition cases. Compared to the other settlements, Adjumani settlement has the highest number of cases of acutely malnourished children in need of treatment (5,059) of whom 4,061 are suffer moderate acute malnutrition and 998 are suffer severe acute malnutrition. Additionally, **4,899** 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 Adjumani settlement (998).

Number of cases in Host districts: It is estimated that 23,666 children across the 12 refugee-hosting districts will suffer acute malnutrition and require treatment between April 2024 and March 2025. Of these, 22,227 are expected to be cases of moderate acute malnutrition, while 1,439 are projected to be cases of severe acute malnutrition. Compared to other districts, Yumbe district has the highest number of cases of acutely malnourished children in need of treatment (4,626) all affected by moderate acute malnutrition. It is further estimated that 4,886 PLW among the host population are expected to suffer acute malnutrition and in need of treatment.

The expected number of cases of children affected by acute malnutrition was calculated using the formula NPK; where N is the total number of children aged 6-59 months in the refugee settlements and host districts, 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 NP; where N is the number of PLWs and p is prevalence of acute malnutrition (based on MUAC, estimated at <23 cm).

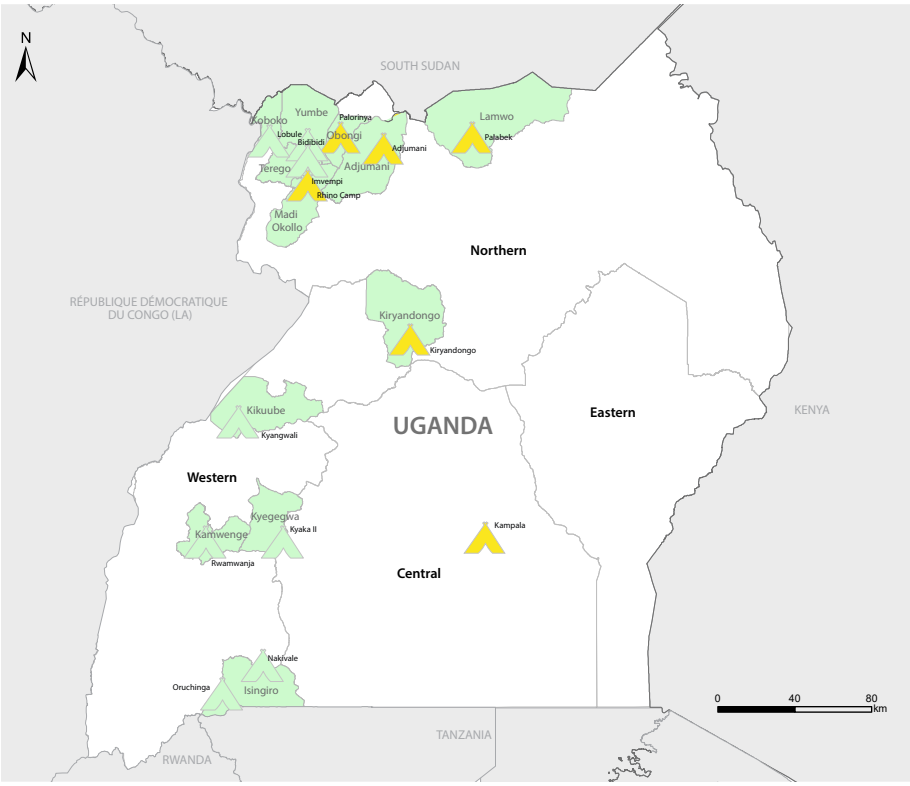
Population in need of Treatment: Refugee settlements

Refugee Settlements	Settlement Population	Children aged 6-59 months							Pregnant and Lactanting		
		Total #	Combined GAM	Combined MAM	Combined SAM	GAM cases	MAM cases	SAM cases	Total #	AMN %	Estimated number of AMN cases
Adjumani	225,571	27,404	7.1%	5.7%	1.4%	5,059	4,061	998	17,204	5.8%	998
Bidibidi	202,102	21,288	4.6%	3.3%	1.3%	2,546	1,826	720	18,949	2.2%	417
Imvepi	69,453	21,288	4.1%	3.5%	0.6%	2,269	1,937	332	5,632	5.0%	282
Kampala	154,070	9,941	6.8%	5.9%	0.9%	1,757	1,525	233	7,374	2.7%	199
Kiryandongo	128,415	13,578	8.9%	8.0%	0.9%	3,142	2,824	318	10,468	2.2%	230
Kyaka II	131,708	19,597	2.8%	2.0%	0.8%	1,427	1,019	408	13,443	5.2%	699
Kyangwali	142,553	21,912	2.9%	2.3%	0.6%	1,652	1,310	342	12,874	5.0%	644
Lobule	6,197	1,009	4.3%	4.3%	0.0%	113	113	0	582	9.5%	55
Nakivale	202,283	27,677	2.8%	2.8%	0.0%	2,015	2,015	0	16,556	2.0%	331
Oruchinga	8,039	1,132	2.5%	2.5%	0.0%	74	74	0	507	7.4%	38
Palabek	84,936	10,932	6.8%	6.3%	0.5%	1,933	1,791	142	8,604	2.9%	250
Palorinya	136,063	14,079	8.8%	6.9%	1.9%	3,221	2,526	695	7,595	5.7%	433
Rhino Camp	166,331	18,732	8.1%	6.7%	1.4%	3,945	3,263	682	8,294	3.1%	257
Rwamwanja	99,072	15,662	2.8%	2.1%	0.7%	1,140	855	285	6,732	1.0%	67
Total	**1,756,793**	**224,230**				**30,293**	**25,139**	**5,153**	**134,814**		**4,899**

Population in need of Treatment: Host Districts

Disctrict	District Population	Children aged 6-59 months							Pregnant and Lactanting		
		Total #	Combined GAM	Combined MAM	Combined SAM	Estimated GAM cases	Estimated MAM cases	Estimated SAM cases	Total #	AMN %	Estimated AMN cases
Adjumani	300,386	54,971	4.6%	4.2%	0.4%	2,529	2,309	220	15,019	0.0%	0
Isingiro	633,844	115,993	2.6%	2.3%	0.3%	3,016	2,668	348	31,692	0.0%	0
Kamwenge	336,738	61,623	1.0%	1.0%	0.0%	616	616	0	16,837	0.0%	0
Kikuube	380,097	69,558	2.8%	2.8%	0.0%	1,948	1,948	0	19,005	2.7%	513
Kiryandongo	364,878	66,773	4.0%	3.7%	0.3%	2,671	2,471	200	18,244	1.8%	328
Koboko	271,655	49,713	3.6%	3.3%	0.3%	1,790	1,641	149	13,583	4.8%	652
Kyegegwa	501,535	91,781	1.1%	1.1%	0.0%	1,010	1,010	0	25,077	2.1%	527
Lamwo	213,799	39,125	6.5%	5.8%	0.7%	2,543	2,269	274	10,690	5.3%	567
Madi Okollo	184,341	33,734	3.2%	2.7%	0.5%	1,080	911	169	9,217	0.0%	0
Obongi	143,492	26,259	2.5%	2.2%	0.3%	656	578	79	7,175	2.7%	194
Terego	322,893	59,089	2.0%	2.0%	0.0%	1,182	1,182	0	16,145	1.6%	258
Yumbe	972,351	177,940	2.6%	2.6%	0.0%	4,626	4,626	0	48,618	3.8%	1,847
Total	**4,626,009**	**846,560**				**23,666**	**22,227**	**1,439**	**231,300**		**4,886**

ACUTE MALNUTRITION PROJECTED SITUATION MAP AND OVERVIEW IN REFUGEE SETTLEMENTS AND HOST DISTRICTS (OCTOBER 2024 - MARCH 2025)



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Map Symbols

- Urban settlement classification
- Refugee settlements

Evidence level:

*** High

OVERVIEW OF THE PROJECTED PERIOD FOR ACUTE MALNUTRITION (OCTOBER 2024 – MARCH 2025):

The projection period, described as a season of low acute malnutrition, runs from October 2024 to March 2025. Based on the cited assumptions, the IPC Phase classification for all settlements is expected to remain consistent during the projection period with the current period of analysis. Consequently, the eight settlements classified in IPC AMN Phase 1 (Acceptable) during the current analysis period—Rwamwanja, Kyaka II, Nakivale, Oruchinga, Bidibidi, Lobule, Imvepi, and Kyangwali—are anticipated to remain in the same phase during the projection period. Similarly, the remaining six settlements—Adjumani, Kampala, Kiryandongo, Rhino Camp, Palorinya, and Palabek—classified in IPC Phase 2 (Alert) during the current analysis period are expected to remain in Phase 2 during the projection period.

While the IPC Phase classification is projected to remain unchanged across all settlements, the acute malnutrition situation, as indicated by GAM prevalence, is expected to deteriorate in the refugee settlements of Rwamwanja, Nakivale, and Oruchinga within IPC AMN Phase 1. Conversely, improvements in levels of acute malnutrition are anticipated in Bidibidi, Imvepi, and Lobule settlements, which are also classified in IPC Phase 1. In Kyaka II and Kyangwali settlements, levels of acute malnutrition during the projection period are expected to remain similar to those in the current period of analysis.

Eleven out of the 12 refugee-hosting districts are likely to remain in IPC AMN Phase 1 during the projection period, consistent with the current period of analysis. GAM levels are expected to improve in the districts of Adjumani, Kamwenge, Kiryandongo, Madi-Okollo, Obongi, Yumbe, and Koboko. However, these changes are not expected to result in a change in IPC AMN Phases. Conversely, the acute malnutrition situation (GAM) is projected to deteriorate in Isingiro district during the projection period, but it will remain within the same phase. In Lamwo district, acute malnutrition is anticipated to improve sufficiently to result in a phase change from IPC AMN Phase 2 to Phase 1.

Key Assumptions:

Food dimensions: Overall, the food security situation is expected to improve in both settlements and host communities during the months of October 2024 to January 2025 and gradually deteriorate in the last two months of February and March in the projection period.

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

Disease prevalence: The prevalence of malaria, diarrhoea and other preventable diseases affecting nutrition status are expected to decrease between in the projection period in both the refugee settlements and hosting communities

Humanitarian and social protection programs: Due to the prioritization exercise, the Self Reliance Model (SRM) will continue to be implemented in Bidi bidi, Lobule and Rhino Camp with a focus to promoting self-reliance, sustainable livelihoods, and incomes among refugee communities. GFA will be complemented by interventions in Food Security and livelihoods, WASH, market development activities as well as health and nutrition interventions.

WASH: Current access to sanitation facilities will remain in a similar situation due to anticipated low rains. On other hand, access to improved source of drinking water is expected to improve. Access to sufficient water is expected to deteriorate as more than half of the projection period is expected to be dry season.

Care practices: Breast feeding practices are expected to improve or remain similar as mothers will be at home with their children in most settlements and host districts.

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

Health services: Immunization Coverage is expected to improve as there is a planned catch up immunization throughout the country in November 2024.

EVOLUTION OF CONTRIBUTING FACTORS IN THE PROJECTION PERIOD

Food dimensions: Overall, the food security situation is expected to improve in both settlements and host communities during the months of October 2024 to January 2025 and gradually deteriorate in the last two months of February and March in the projection period. It is anticipated that the first half of the projection period will involve second harvest, hence all settlements and host communities will have improved food availability and access especially from own production and in local markets. However, the food security situation is expected to gradually deteriorate towards the end of February and March 2025 when households are low on food reserves from the second season harvest. The Isingiro host communities as well as the corresponding refugee settlements of Oruchinga and Nakivale will be affected most towards the end of the projection period leading to deterioration in acute malnutrition levels.

Food consumption: Owing to the anticipated improvements in food security dimensions following the second harvest, food consumption indicators—such as Minimum Meal Frequency (MMF), Minimum Dietary Diversity for Children (MDD-C), and Minimum Dietary Diversity for Women (MDD-W)—are also expected to improve in both host communities and refugee settlements. However, the Minimum Acceptable Diet (MAD), which requires mid- to long-term social behavioural change, is expected to remain unchanged across all settlements and host districts.

Diseases: The prevalence of malaria, diarrhoea, and other preventable diseases affecting nutritional status is expected to decrease during the projection period in both refugee settlements and host communities, based on historical trends. This is attributed to below-normal rainfall, which reduces water and breeding grounds for mosquitoes, increases access to safe water sources, and results in a less contaminated environment.

Health services: Outreach health services will remain similar to the current period due to anticipated low rains that usually affect mobility to communities. Community Management of Acute Malnutrition (CMAM) coverage is likely to remain unchanged across settlements and host communities, as no activities are currently planned to scale up community action for Integrated Management of Acute Malnutrition (IMAM). However, the anticipated Integrated Child Health Days in October, potentially extending into November, are expected to increase Vitamin A supplementation, deworming coverage, and vaccination coverage. This is likely to positively impact the incidence of diseases, particularly malaria and vaccine-preventable diseases. Measles outbreaks are likely to occur in Palabek settlement and Lamwo district due to new refugee arrivals from South Sudan underpinning the anticipatory actions for both prevention and management of any outbreaks.

WASH: Current access to sanitation facilities will remain in a similar situation due to anticipated low rains. On other hand, access to improved source of drinking water is expected to improve due reduced contamination that is usually associated with low rain levels. Access to enough water is expected to remain the same across all settlements and host communities unless expansion water distribution is done.

Child care practices: Infant and Young child feeding (IYCF) practices are expected to remain similar in the early months of the projection period because care takers will be involved in second season harvest and care takers will spend most of the time in their gardens. Although care takers will not be involved in garden work but in other livelihood activities in second half of the projection period it is anticipated that IYCF practices such exclusive breastfeeding, timely introduction of complementary foods and health care seeking practices will improve.

Humanitarian assistance: Dependence on General Food Assistance (GFA) by the refugee population, particularly cash assistance from WFP and UNHCR through both routine distribution and the one-off safety net programme, is expected to continue throughout the projection period. Food rations are anticipated to remain at 60 percent and 30 percent, respectively, for Category 1 and Category 2 individuals. However, funding for nutrition programmes in refugee settlements and benefitting host districts is projected to decline due to reduced resources from donors.

Others: Prevalence of anaemia is expected to register a slight reduction due to the anticipated improvement in food consumption and reduced incidences of malaria but will remain high as a public health issue in all settlements and host communities.

Influx of the Refugees

Due the recurrent conflicts in the Democratic republic of Congo and Sudan, an influx of new refugees is expected in the projection period especially the settlements already experiencing new arrivals; Kiryadongo, Adjumani, Palorinya, kyangwali and Nakivale settlements. This influx shall constrain the existing services hence affecting the quality of services provided. Disease outbreaks like Measles and Mpox are expected then due to the cross-border movements.

HUMANITARIAN SUPPORT AND RESPONSE

Uganda hosts 1,707,473 refugees and asylum seekers, of whom 1,553,403 reside in 13 rural-based refugee settlements, while 154,070 are based in Kampala (UNHCR, September 2024). The rural-based refugee settlements include Bidibidi, Adjumani, Palorinya, Nakivale, Kyaka II, Rhino Camp, Lobule, Oruchinga, Palabek, Kyangwali, Kiryandongo, Rwamwanja, and Imvepi. Refugees in Uganda are hosted across 13 districts: Adjumani, Isingiro, Kampala, Kamwenge, Kikuube, Kiryandongo, Koboko, Kyegegwa, Lamwo, Madi Okollo, Obongi, Terego, and Yumbe.

As of August 2024, World Food Programme continued to provide humanitarian assistance to eligible refugees; new arrivals (100 percent), category 1 (60 percent), category 2 (30 percent) and category 3 (no assistance), reaching 1,388,780 refugees through General Food Assistance (Cash assistance or In-kind assistance). Due to the prioritisation exercise, the Self Reliance Model (SRM) was rolled out in September 2023 in target settlements of Bidibidi, Lobule and Rhino Camp with a focus to promoting self-reliance, sustainable livelihoods, and incomes among refugee communities. The SRM constitutes four pillars including Livelihoods, Digital Financial Literacy, Social Protection and Social Empowerment and Mindset change. In all settlements, GFA was complemented by interventions in Food Security and livelihoods, WASH, market development activities as well as health and nutrition interventions.

In response to the high prevalence of malnutrition in refugee settlements, activities were intensified at both community and health facility levels in target locations, such as Palabek refugee settlement. These interventions included multisector coordination through UNHCR and OPM, Social and Behaviour Change initiatives via the scale-up of Care Groups and Family-Led MUAC, nutrition-sensitive interventions promoting biofortified crops, and enhanced community surveillance through the institutionalisation of community structures like Village Health Teams. Additionally, efforts were made to promote WASH interventions to further address malnutrition. Nutrition-specific interventions such as IMAM (through strengthening a steady supply chain for therapeutic food for acute malnutrition management), IYCF and Maternal, Child Health and Nutrition (MCHN) were strengthened for the prevention of malnutrition at community level and among new arrivals. These interventions were extended to other settlements to ensure access to and consumption of nutritious diets.

During the projection period, humanitarian support is expected to remain consistent with current levels due to donor funding cuts. The anticipated influx of refugees into some settlements may further strain the already limited donor support. There will be a greater focus on shifting towards livelihood interventions (development-oriented initiatives) rather than solely relying on humanitarian support.

LINKAGES BETWEEN ACUTE FOOD INSECURITY AND ACUTE MALNUTRITION

Divergence is defined as a difference of at least two phases between Acute Food Insecurity (AFI) and Acute Malnutrition (AMN) Phase classifications. Out of the 12 areas analysed for both acute food insecurity and acute malnutrition, three districts—Kiryandongo, Yumbe, and Terego—showed a divergence of two phases in the current classifications, with acute malnutrition generally classified in a lower phase compared to acute food insecurity.

County	GAM Prevalence	AMN Current (July-September 2024)	AMN Projection 1 (October 2024-March 2025)	AMN Likely change	AFI Current (July 2024-January 2025)	AFI Projection (February-June 2025)
Kiryandongo District	3.30%	1	1	↑	3	3
Yumbe District	2.40%	1	1	↑	3	3
Terego	2.00%	1	1	→	3	3

The observed low levels of acute malnutrition have been attributed to improved infant and young child feeding practices, optimal health services, and a reduction in disease prevalence. In contrast, high levels of food insecurity have been linked to suboptimal household food consumption, poor harvests, livestock diseases, and high food prices in the market.

LOW AMN AND HIGH AFI ANALYSIS AREAS WITH DIVERGENCE

Kiryandongo District

Acute malnutrition was classified in IPC AMN Phase 1, while acute food insecurity was classified in IPC AFI Phase 3, a pattern that has been historically observed. The main livelihood of the Kiryandongo population is crop farming, both for subsistence—focusing on crops such as cassava, sweet potatoes, maize, beans, bananas, groundnuts, rice, and vegetables—and for cash crops, including coffee, sunflower, soya beans, and tobacco. In addition, some residents engage in livestock rearing and fishing. Failed rainfall was experienced in the month of May 2024, which affected the normal planting season and later significantly reduced the performance of crops especially maize and beans. This situation was exacerbated by the crop pests and diseases such as Fall Army Worm in maize, cassava mosaic in cassava, and rosette virus in groundnuts. This was eminent in the low food stocks that were available in the first harvest season of July and August 2024. Despite the majority of households reporting acceptable to stressed levels in Household Food Consumption Score (FCS), Household Dietary Diversity (HDD), and Household Hunger Scale (HHS), one in three households recorded crisis levels in the same household consumption indicators, according to FSNA. Most of the food consumed was starch based that reflected in the low dietary diversity in women at 16.7 percent depicting nutrient inadequacies at the household level. Approximately 40 percent of households were headed by women, reflecting low access to resources and food. Food consumption gaps were also observed among children, with Minimum Dietary Diversity (MDD) at 20.6 percent and Minimum Meal Frequency (MMF) at 49.3 percent. Despite improvements in MDD, which increased from 16.1 percent during the same period in 2023, the frequency of meals declined from 69 percent in 2023. However, nutrient inadequacies were somewhat mitigated by favourable childcare practices, including a high prevalence of continued breastfeeding (70.8 percent) among children aged 12–23 months and timely introduction of solid and semi-solid foods for 94.9 percent of children aged 6–8 months. There is a pressing need to improve nutrient intake among children to ensure adequacy in both macro- and micronutrients, essential for optimal growth and development.

The disease burden remains a medium risk factor for acute malnutrition in Kiryandongo District, with malaria prevalence at 18.3 percent, diarrhoea at 13.7 percent, and fever at 28.1 percent—figures that are consistent with those reported during the same period in 2023. High access to health services as exhibited by measles and polio vaccination at 96.1 and 89.1 percent respectively, while vitamin A supplementation is at 92.9 percent has positive effect on reduced severity of diseases thus cushioning the children from acute malnutrition. Deworming remains low at 63 percent that could contribute to low nutrient availability to children that do not receive deworming and influencing acute malnutrition. Anaemia among children remains of public health concern at 52.2 percent.

Water and sanitation remain sub-optimal in Kiryandongo district where about 60 percent of the households use less than 20 litres per person per day with mean water per capita at 19.3 litres per person per day and only 39.8 percent of the households access sufficient water. This translates to compromised hygiene practices such as hand washing practice that is at 52.4

percent where 40 percent of hand washing facilities remained dry due to lack of water, increasing the risk to diseases and acute malnutrition. There is need to address access to sufficient water in the district.

Yumbe District

In Yumbe district, acute malnutrition was classified in IPC AMN Phase 1 while acute food insecurity was classified in IPC AFI Phase 3, and this has been reflected historically. Food gaps were observed and attributed to below-normal rains were received in the first season of March to May 2024 leading to low crop performance. The occurrence of crop pests, such as variegated grasshoppers, Fall Armyworm (FAW), and whiteflies, along with diseases like Cassava Brown Streak Disease (CBSD), cassava mosaic, and groundnut rosette, resulted in low crop yields and reduced income. Poor rainfall further impacted the quality of livestock pastures, leading to decreased milk yields in the sub-counties of Kululu and Ariwa. Additionally, reduced water levels in ponds lowered fish yields, further affecting household incomes. Livestock and poultry deaths from Black Quarter and Newcastle disease outbreaks respectively were reported besides increased food prices in local markets. The food gaps are eminent in the low household outcome indicators such as HDDS and FCS at 29 and 24 percent respectively, that further translated to low dietary diversity among women at 26.5 percent. Improvements in infant and young child feeding were observed in 2024, with Minimum Dietary Diversity (MDD) and Minimum Meal Frequency (MMF) reported at 25.0 percent and 68.1 percent, respectively, compared to 19.5 percent (MDD) and 60.4 percent (MMF) during the same period in 2023. High rates of continued breastfeeding among children aged 12–23 months (91.4 percent) supplemented nutrient intake, providing a protective effect against acute malnutrition. Additionally, the majority of children aged 6–8 months (96.3 percent) had been introduced to solid and semi-solid foods, increasing nutrient intake and reducing the risk of acute malnutrition.

Disease burden remains a risk to acute malnutrition especially Diarrhoea, malaria and fever at 20.1, 16.8 and 23 percent respectively despite registered reduction by 50 percent in malaria and fever in 2024 compared to similar period in 2023. Optimal health services such as measles and polio vaccinations at 98.4 and 98.3 percent respectively, vitamin A supplementation at 88.2 percent improve child immunity while reducing disease incidence and severity thus cushioning the children from acute malnutrition. Further, high deworming at 96.5 percent also increases nutrient availability and reducing risk to acute malnutrition.

Low access to sufficient water was reported, with findings from the FNSA (2024) showing that 75.2 percent of dwelling places (churches, mosques, and schools) lack water and 53.8 percent do not have handwashing facilities. Additionally, only 38.9 percent of households meet the recommended 20 litres of water per person per day. This poses a significant risk to hygiene and increases the likelihood of diseases such as cholera—evidenced by one confirmed case in the district—and other waterborne diseases like diarrhoea, which heighten the risk of acute malnutrition. There is an urgent need to improve access to sufficient water in the district to ensure the effectiveness of other health and nutrition interventions aimed at enhancing child health, growth, and development.

Terego District

In Terego district, acute malnutrition was classified in IPC AMN Phase 1 while acute food insecurity was classified in IPC AFI Phase 3, and this has been reflected historically. High food insecurity is attributed to below normal rainfall from March to May 2024 and some households ended up not planting during this period while those which planted got below normal harvest for first season and significantly lower food stocks in July to August 2024 while 60 percent of food grown is still sold in the markets (FSNA, 2024). Reduced agricultural casual labour to about 54 percent of the households also contributed to lower income for families and purchasing power reducing access to food in the markets. Food gaps is reflected in the household consumption outcomes such as HDDS (34 percent), FCS (32 percent), HHS (30 percent) and maternal dietary diversity at 35.3 percent that depicts high consumption of starchy staples at low frequency supported by a reported 20, 60 and 20 of households eating 3, 2 and 1 meal per day respectively. Contrary to the observed insufficient nutrient intake at household level, child frequency of consumption has improved significantly in 2024 where MMF at 90.8 percent compared to 63 present in 2023. Despite improvements in Meal frequency Dietary diversity has remained similar depicting over consumption of less diversified diets leading to Nutrient inadequacies and acute malnutrition. This is further exhibited by low MAD in 2024 at 31.6percent that has remained similar to that of 2023.. The marked improvement in child meal frequency contributed to improved GAM prevalence from 3.4 percent in 2023 to 2 percent in 2024. However, there are gaps in Optimal nutrient intake that affect growth and development. The children were further cushioned by favorable infant and young child feeding practices such as exclusive breastfeeding (86.2 percent), continued breast feeding (93.4 percent) and timely introduction to solid and semisolid foods at 95 percent supported nutrient adequacy while reducing the risk to acute malnutrition.

The disease burden in 2024 has remained improved compared to 2023, with a medium risk observed. Malaria prevalence was reported at 11.9 percent, and Acute Respiratory Infections (ARI) at a low 0.3 percent, compared to 17.2 percent and 24 percent, respectively, during the same period in 2023. However, fever continues to pose a high risk to acute malnutrition,

with a prevalence of 21 percent in 2024. The likely impact of disease burden is counteracted with the strong health services observed in child vaccination and micronutrient supplementation where, Measles and polio vaccination was at 97.6 and 97.4 percent respectively while Vitamin A supplementation was reported at 97 percent which keeps child immunity strong and cushioning from disease incidence and severity resulting to low risk to acute malnutrition. Deworming however remains at 61.2 percent of the children and needs to be strengthened to improve nutrient access further reduce the risk to acute malnutrition.

Low access to sufficient water remains a significant challenge to hygiene and sanitation in Terego district. The mean water per capita is at 20 litres per person per day, with only 50.3 percent of households accessing adequate water. This poses a risk to compromised hygiene and increases the likelihood of waterborne diseases. Improving access to sufficient water is crucial as a mitigating factor for reducing the risk of acute malnutrition.

RECOMMENDATIONS FOR ACTION

Response priorities for Acute Food Insecurity

- There is need to urgently provide food and livelihood assistance to the populations in IPC AFI Phase 3 (Crisis) to save lives and livelihoods.
- Since the projection period is expected to worsen, there is need to adequately plan for food support to households who will be in direct need of food during that period.
- Provide farmers with relevant skills and technologies in water harvesting and irrigation to be able to do dry season farming.
- Strengthen agricultural extension service delivery to be able to equip farmers with timely early warning information and knowledge on climate smart agriculture practices.
- Strengthen social protection systems for nutrition and food security.
- The Uganda Wildlife Authority (UWA), the Ministry of Agriculture, Animal Industry and Fisheries (MAAIF), and local governments should enforce acts and byelaws regulating wildlife and livestock movement to mitigate conflicts arising from crop losses caused by wild animals from national parks and livestock from farmers.
- Creation of peace agreement between the host communities and the refugees to reduce on the conflicts over land and other resources.
- Strengthen the livestock and crop pests and disease surveillance, control and management mechanisms to manage the high incidences expected.

Response priorities for Acute Malnutrition

- Scale up case identification and treatment of Acute malnutrition (both SAM and MAM cases) for both children and women.
- 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 anticipatory actions for potential disease outbreaks.
- 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 such as access to sufficient water and sanitation facilities in affected areas.

Situation Monitoring and Update

- Organize and conduct a Response Analysis with authorities managing refugee settlements and those in host districts to come up with more district specific information to guide designing of appropriate livelihood interventions to reduce food and nutrition insecurity.

Situation Monitoring and Update for Acute Malnutrition

- 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.
- Monitor trends in acute malnutrition admissions.
- Monitor diseases such as measles and cholera and M-pox.

Risk factors to monitor for Acute Food Insecurity

- **Food Prices:** Market prices of staple crops are likely to increase between March to June 2025 because of high demand from both refugees and cross border communities.
- **Household Food Stocks:** The projection period is characterised with consumption of stocks only with minimal production. It will therefore be necessary to monitor household food stocks by local government officials during the projection period.
- **Conflicts:** conflicts between host communities and refugees over land and other resources are likely to continue and more refugees are expected to come into the settlements due to the ongoing insecurity in DRC and Sudan, increasing stress on the livelihood of host communities.
- **Livestock Diseases and Vectors:** Risk of livestock disease outbreaks such as FMD which usually leads to prolonged periods of quarantine which greatly affects household incomes needs to be monitored. Equally, lifting of quarantine in districts that have been under quarantine is expected to improve household incomes as livestock markets will be opened hence affecting the livelihood of communities.

Risk factors to monitor for Acute Malnutrition

- Food consumption levels by children and women especially dietary diversity.
- Disease prevalence and cases such as malaria, diarrhoea, and anaemia in health facilities.
- Access to sufficient quantities of Water and sanitation.
- Disease outbreaks especially measles, Cholera and Dysentery.
- 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 at Kontik Hotel, Hoima from 14 to 21 October 2024, and was preceded by an IPC level 1 refresher training (14 and 15 October 2024). This was followed by the IPC Analysis workshop (16 to 21 October 2024) using the protocols of the IPC Manual version 3.1. This approach draws together all available food security and nutrition information from reliable data sources. The analysis was conducted and documented in ISS by assigned analysts per district. The classification was subsequently determined through convergence of current evidence or projected most likely scenario, considering the impact of humanitarian assistance to arrive at a 'big picture' analysis of the overall food security situation. The key participating agencies included Government line ministries, District Local Governments, WFP, FAO, and FEWSNET. Throughout the analysis, a team of three from the IPC GSU provided continuous technical support.

Evidence on key outcome indicators was drawn from Food Security and Nutrition Assessment (FSNA) conducted by WFP and UNHCR in the 12 refugee hosting districts of Uganda, while various reports were used for evidence on contributing factors. The FSNA was conducted using the Standardized

Acute Food Insecurity Phase name and description

Phase 1 None/Minimal	Phase 2 Stressed	Phase 3 Crisis	Phase 4 Emergency	Phase 5 Catastrophe/ Famine
Households are able to meet essential food and non-food needs without engaging in atypical and unsustainable strategies to access food and income.	Households have minimally adequate food consumption but are unable to afford some essential non-food expenditures without engaging in stress-coping strategies.	Households either: • have food consumption gaps that are reflected by high or above-usual acute malnutrition; **or** • are marginally able to meet minimum food needs but only by depleting essential livelihood assets or through crisis-coping strategies.	Households either: • have large food consumption gaps that are reflected in very high acute malnutrition and excess mortality; **or** • are able to mitigate large food consumption gaps but only by employing emergency livelihood strategies and asset liquidation	Households have an extreme lack of food and/or other basic needs even after full employment of coping strategies. Starvation, death, destitution and extremely critical acute malnutrition levels are evident. For famine classification, area needs to have extreme critical levels of acute malnutrition and mortality.)

Acute Mainutrition Phase name and description

Phase 1 Acceptable	Phase 2 Alert	Phase 3 Serious	Phase 4 Critical	Phase 5 Extremely Critical
Less than 5% of children are acutely malnourished.	**5–9.9%** of children are acutely malnourished.	**10–14.9%** of children are acutely malnourished.	**15–29.9%** of children are acutely malnourished. The mortality and morbidity levels are elevated or increasing. Individual food consumption is likely to be compromised.	**30% or more** children are acutely malnourished. Widespread morbidity and/or very large individual food consumption gaps are likely evident.

What are the IPC, IPC Acute Food Insecurity and IPC Acute Malnutrition?

The IPC is a set of tools and procedures to classify the severity and characteristics of acute food and nutrition 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.

For the IPC, Acute Food Insecurity and Acute Malnutrition are defined as any manifestation of food insecurity or malnutrition found in a specified area at a specific point in time of a severity that threatens lives or livelihoods, or both, regardless of the causes, context or duration. The IPC Acute Food Insecurity Classification is highly susceptible to change and can occur and manifest in a population within a short amount of time, as a result of sudden changes or shocks that negatively impact the determinants of food insecurity. The IPC Acute Malnutrition Classification's focus is on identifying areas with a large proportion of children acutely malnourished preferably by measurement of Weight for Height Z-Score (WHZ) but also by Mid-Upper Arm Circumference (MUAC).

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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, FEWS NET, Global Food Security Cluster, Global Nutrition Cluster, IFPRI, IGAD, Oxfam, SICA, SADC, Save the Children, UNDP, UNICEF, WFP, WHO and the World Bank.

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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 2024. According to evidence drawn from the FSNA, the Evidence level for this analysis is High (***). IPC self-assessment was conducted in plenary through discussions to ascertain adherence to IPC protocols, identify challenges experienced, and provide feedback for future improvements.

Sources

1. WFP & UNHCR (2024) - Refugee and Refugee Host FSNA 2024
2. DLGs (2024), District food security update reports
3. MSNA (2024), Food security assessment
4. UNMA (2024) - Weather performance and forecast for MAM, JJA and SOND
5. UBOS (2024), National population census, 2024

Limitations of the Analysis

- The FSNA survey included robust information for the analysis but was the only main source of data for outcome indicators, which limited triangulation of evidence.
- It is recommended to conduct the IPC acute food insecurity analysis for the Refugee Settlements, incorporating the significance of the humanitarian food assistance, to assess the food security situation of the refugees.
- Some critical indicators such as levels of household food stocks were not collected during the FSNA.
- Time allocated for IPC AMN analysis was limited and made it impossible to find time for linkages discussions between the AMN and AFI teams for those areas with divergence.

ANNEX 1: SUMMARY OF FACTORS CONTRIBUTING TO ACUTE MALNUTRITION

	Refugee settlements	Adjumani	Bidibidi	Imvepi	Kampala	Kiryandongo	Kyaka II	Kyangwali	Lobule	Nakivale	Oruchinga	Palabek	Palorinya	Rhino Camp	Rwamwanja
Food Consumption	Minimum Dietary Diversity (MDD)	Medium	Low	Low	Low	Medium	Low	Medium	Low	Low	Low	Medium	Low	Low	Low
	Minimum Meal Frequency (MMF)	Low	Low	Low	Low	Medium	Low	Low	Very Low	Very Low	Low	Low	Very Low	Low	Low
	Minimum Acceptable Diet (MAD)	Medium	Medium	Low	Low	Very High	Medium	Medium	Low	Low	Medium	Medium	Medium	Medium	Low
	Minimum Dietary Diversity – Women (MDD-W)	High	High	Medium	Low	High	High	Very High	Medium	High	Medium	High	High	Medium	Medium
Diseases	Diarrhoea	Medium	Medium	Medium	Low	Medium	High	High	Low	Medium	Low	High	Low	Low	Medium
	Dysentery	No data	Low	Very High	No data	No data	No data	Very Low	Low	No data	No data	No data	No data	No data	Low
	Malaria	Medium	High	Medium	Low	Medium	High	High	Low	Very Low	Very Low	Medium	Medium	Low	Medium
	Acute Respiratory Infection (ARI)	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low
	HIV/AIDS	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	No data
	Cholera or Acute Watery Diarrhoea (AWD)	Very Low	Very Low	Very Low	Very Low	Low	Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low
	Measles	No data	Very Low	No data	No data	Very Low	High	High	High	Very High	No data	Very Low	No data	Medium	High
	Measles outbreak	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	No data
Food dimensions outcome of IPC analysis		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	No data
Caring and feeding practices	Exclusive breastfeeding under 6 months	Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low
	Continued breastfeeding at 12-23 months	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Low	Very Low
	Restricted consumption by adults in order for small children to eat	Low	No data	Medium	Very Low	Very Low	Very Low	Low	Very Low	Very Low	Very Low	Very Low	Very Low	Low	Very Low
	Introduction of solid, semi-solid or soft foods	Very Low	Very Low	Very Low	Very Low	Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low
Health services and health environment	Measles vaccination	Low	Very Low	Very Low	Very Low	Medium	Low	Very Low	Low	Very Low	Low	Very Low	Low	Very Low	Very Low
	Polio vaccination	Low	Very Low	Very Low	Very Low	Very Low	Very Low	Low	Very Low	Very Low	Very Low	Medium	Low	Very Low	Very Low
	Vitamin A supplementation	Low	Very Low	Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very 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	No data	No data
	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	No data	No data
	Coverage of outreach programmes – CMAM programme coverage (SAM, MAM, or both)	Low	Very Low	Very Low	Very Low	Medium	Very Low	Low	No data	Very Low	Low	No data	Very Low	Very Low	Very Low
	Mean water consumption per capita	Low	Medium	Low	Low	Low	Medium	Low	Low	Medium	Medium	High	Very Low	Medium	Medium
	Access to a sufficient quantity of water	High	Very High	High	Low	High	Very High	Medium	High	Very High	Very High	Very High	Medium	Very High	Very High
	Access to sanitation facilities	Low	Low	Low	Very Low	Low	Low	Medium	Low	Very Low	Very Low	High	Low	Medium	Low
	Access to a protected source of drinking water	Very Low	No data	Very Low	Very Low	Very Low		Medium	Very Low	Low	Very Low	Medium	Very Low	Low	Very Low
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	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	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	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	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	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	No data
	Refugee influx from Sudan	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Medium	No data	Medium	Very Low	No data	Very Low	Medium	Very Low
Other nutrition issues	Anaemia among children 6-59 months	Medium	Medium	Medium	Low	Very High	Medium	Very High	Low	No data	Low	No data	Medium	Medium	Medium
	Anaemia among pregnant women	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	No data
	Anaemia among non-pregnant women	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	No data
	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	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	No data
	Low birth weight	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	No data
	Fertility rate	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	No data

Legend **Risk Factor** Very Low | Low | Medium | High | Very High | No data

	Host districts	Adjumani	Isingiro	Kamwenge	Kikuube	Kiryandongo	Koboko	Kyegegwa	Lamwo	Madi Okollo	Obongi	Terego	Yumbe
Food Consumption	Minimum Dietary Diversity (MDD)	Low	Low	Very Low	Medium	Medium	Low	Low	Medium	Low	Low	Very Low	Low
	Minimum Meal Frequency (MMF)	Very Low	Very Low	Very Low	Low	Low	Very Low	Low	Low	Very Low	Very Low	Very Low	Low
	Minimum Acceptable Diet (MAD)	Low	Medium	Low	Medium	High	Low	Medium	Medium	Low	Low	Low	Low
	Minimum Dietary Diversity – Women (MDD-W)	Medium	Medium	Low	High	High	Medium	Medium	High	Low	Medium	Medium	Medium
Diseases	Diarrhoea	High	Medium	Medium	Low	Medium	Medium	High	High	Low	Low	Medium	High
	Dysentery	Very Low	Very Low	Low	High	Very Low	Low	Very Low	Very Low	Very Low	High	Low	Very Low
	Malaria	Low	Very Low	Low	Medium	High	Low	Low	Very High	Medium	Medium	Medium	Medium
	Acute Respiratory Infection (ARI)	Very Low	Very Low	Very Low	Very Low	Very Low	Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low
	HIV/AIDS	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Cholera or Acute Watery Diarrhoea (AWD)	Very Low	Very Low	Very Low	Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Medium
	Measles	Very Low	Very Low	High	High	Very Low	High	Very Low	Very Low	Very Low	Low	Very Low	Very Low
Food dimensions outcome of IPC analysis		Low	Low	Low	Low	Medium	Low	Low	Medium	Low	Low	Medium	Medium
Caring and feeding practices	Exclusive breastfeeding under 6 months	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Low	Very Low	Very Low	Very Low	Very Low	Very Low
	Continued breastfeeding at 12-23 months	Very Low	Very Low	Medium	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low
	Restricted consumption by adults in order for small children to eat	Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low
	Introduction of solid, semi-solid or soft foods	Very Low	Very Low	Very Low	Very 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	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low
	Polio vaccination	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low
	Vitamin A supplementation	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very 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	No data	No data	No data	No data	No data	No data	No data
	Mean water consumption per capita	Low	Low	Low	Low	Low	Low	Medium	Medium	Low	Low	Low	Low
	Access to a sufficient quantity of water	Medium	High	Low	High	Low	Medium	High	Very High	Medium	Medium	High	High
	Access to sanitation facilities	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Low	Medium	Very Low	Low	Low
	Access to an improved source of drinking water	Low	High	Medium	Medium	Very Low	Low	Medium	Low	Medium	Very Low	Low	Very Low
Basic causes	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
Other nutrition issues	Anaemia among children 6-59 months	Medium	Low	No data	Medium	Very High	No data	Medium	Very High	Medium	Medium	Medium	No data
	Anaemia among pregnant women	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Anaemia among non-pregnant women	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Programme admission trends (SAM, MAM, or GAM)	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 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
	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	No data	No data	No data	No data	No data	No data	No data
	Fertility rate	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data

Legend **Risk Factor** Very Low | Low | Medium | High | Very High | No data