UGANDA

REFUGEE SETTLEMENTS

IPC ACUTE FOOD INSECURITY AND ACUTE MALNUTRITION ANALYSIS

JUNE 2025 – FEBRUARY 2026
Published 16 September 2025

CURRENT ACUTE FOOD INSECURITY JUNE - JULY 2025

920,000
48% of the population analysed

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

IN NEED OF URGENT ACTION

Phase 5	0 People in Catastrophe
Phase 4	76,000 People in Emergency
Phase 3	844,000 People in Crisis
Phase 2	669,000 People Stressed
Phase 1	339,000 People in food security

PROJECTION ACUTE FOOD INSECURITY AUGUST 2025 – FEBRUARY 2026

712,000
37% of the population analysed

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

IN NEED OF URGENT ACTION

Phase 5	0 People in Catastrophe
Phase 4	16,000 People in Emergency
Phase 3	696,000 People in Crisis
Phase 2	825,000 People Stressed
Phase 1	391,000 People in food security

ACUTE MALNUTRITION APRIL 2025 - MARCH 2026

56,627
the number of 6-59 months children acutely malnourished

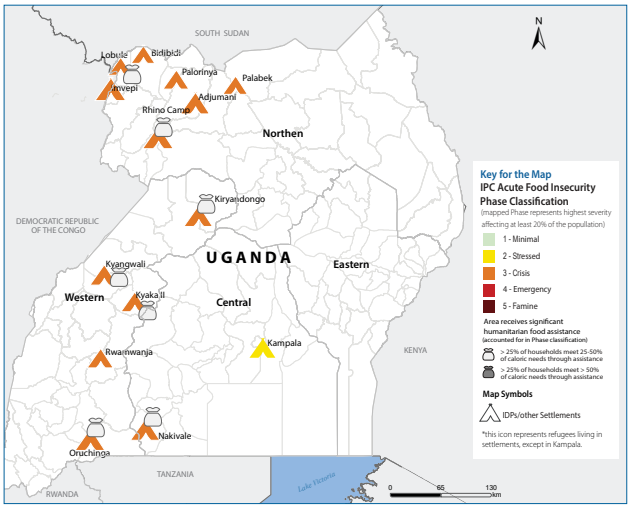
IN NEED OF TREATMENT

Severe Acute Malnutrition (SAM)	9,929
Moderate Acute Malnutrition (MAM)	46,698

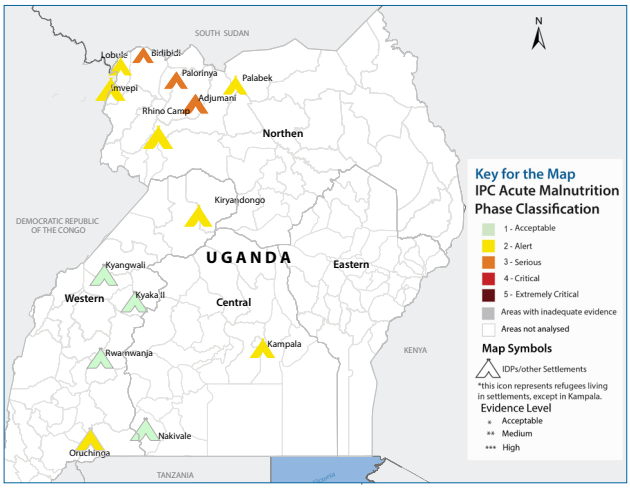
6,827
Pregnant or lactating women acutely malnourished

IN NEED OF TREATMENT

Current Acute Food Insecurity June - July 2025



Current Acute Malnutrition April - September 2025



Overview

Uganda is facing a significant refugee crisis, hosting over 1.9 million refugees—the largest number in Africa and the sixth largest globally. In the 13 refugee settlements analysed as well as Kampala, around 712,000 (37 percent of the population analysed) are experiencing high levels of acute food insecurity between August 2025 and February 2026, including 16,000 people experiencing IPC Phase 4 (Emergency) and 696,000 people in IPC Phase 3 (Crisis). This is a significant improvement from the current period (June - July 2025) where 920,000 people (48 percent of the population analysed) faced high levels of acute food insecurity. This anticipated improvement is largely due to expected increases in crop yields resulting from enhanced agricultural production. Additionally, food prices are forecast to decrease due to higher production, thereby improving household food availability and access.

The refugee crisis is primarily driven by conflicts and instability in neighbouring countries, particularly with 55 percent of refugees coming from South Sudan, 31 percent from Democratic Republic of the Congo, and 14 percent from other countries. Uganda's progressive policies—which grant refugees rights to land, education, and work—are facing strain due to the sheer number of new arrivals. The situation is exacerbated by lack of adequate funding, natural

hazards, epidemics, and climate change impacts, further challenging the country's ability to provide adequate support. A significant portion of refugees in Uganda live in settlements. Around 91 percent of them reside in the 13 settlements of Adjumani, Bidibidi, Imvepi, Kiryandongo, Kyaka II, Kyangwali, Lobule, Nakivale, Oruchinga, Palabek, Palorinya, Rhino Camp and Rwamwanja, while the remaining 9 percent reside in Kampala. For the first time, the IPC Acute Food Insecurity analysis covered the refugee population in all 13 settlements and in Kampala, providing a thorough overview of their food security situation to inform support responses by government and implementing partners targeting vulnerable refugee populations.

All 13 settlements were classified in IPC Phase 3 (Crisis) and Kampala in IPC Phase 2 (Stressed) during the current analysis period (June - July 2025) with 920,000 people (48 percent of the analysed population) who experienced Phase 3 or above. There were 844,000 people who experienced Phase 3 and 76,000 people who experienced Emergency conditions (Phase 4) in seven settlements (Adjumani, Bidibidi, Imvepi, Kiryandongo, Palabek, Palorinya and Rhino Camp), characterised by large food gaps and high levels of acute malnutrition. The situation was primarily driven by reduced food assistance due to inadequate funding, limited access to agricultural land and production, continuous arrivals of new refugees and limited sustainable income sources and reduced purchasing power, which particularly impacted refugees who mainly relied on food from the markets for survival. However, a small percentage of the population in most settlements and host districts benefited from the onset of the first season harvest which led to declining food prices. Among the settlements, Palabek and Palorinya, had the highest percentage of the population in Phase 3 or above (65 percent), while Kyaka II, Lobule and Rwamwanja settlements had the lowest percentage in Phase 3 or above. Kampala had the least amount of people in Phase 3 or above (10 percent).

With regards to the nutrition situation, among all 13 refugee settlements and Kampala's urban refugees, approximately 56,627 children aged 6-59 months and 6,827 Pregnant or Breastfeeding Women and Girls (PBWGs) are suffering or projected to suffer acute malnutrition between April 2025 and March 2026. The situation between April and September 2025 was significantly worse than the same period in 2024. Three refugee settlements – Adjumani, Bidibidi and Palorinya – were classified in IPC Acute Malnutrition (AMN) Phase 3 (Serious), while six settlements (Imvepi, Kiryandongo, Lobule, Oruchinga, Palabek and Rhino Camp) and Kampala urban refugees were classified in IPC AMN Phase 2 (Alert). The remaining four settlements (Kyaka II, Kyangwali, Nakivale and Rwamwanja) wereclassified in IPC AMN phase 1 (Acceptable). The reported acute malnutrition is attributed to high disease burden, suboptimal child consumption, influx of new arrival refugees that stretch the existing essential resources, limited access to food at household level and reduced humanitarian support that led to reduced coverage for food assistance, closure of nutrition sites and reduced outreach programs.

Acute malnutrition is expected to improve in the projection period (October 2025 to March 2026) across 11 of the refugee settlements, with the exception of Oruchinga and Nakivale (both in Isingiro District), where deterioration in acute malnutrition is expected. Three settlements (Adjumani, Bidibidi, and Palorinya) that are currently in Phase 3 (Serious), are expected to improve to Phase 2 (Alert). The expected improvement is in line with main harvests that will increase availability of food in the market at reduced prices.

Key drivers of acute food insecurity

Food production

While over 80 percent of refugee households across most settlements are engaged in agricultural production, most cultivate a very limited acreage. Although food availability from own production began to improve towards the end of the current period, it still contributes only marginally to refugee household stocks due to limited access to agricultural inputs and land for cultivation.

Reduced Humanitarian Food Security Assistance (HFSA)

The effect of donor assistance cuts has greatly affected the quantity of food assistance available for the refugees. Overall, only 32.4 percent of refugees across all settlements received HFSA, and the quantities provided were insufficient to meet daily caloric needs. The limited food assistance significantly undermined household food security in all settlements, except in Kampala, where refugees do not receive food assistance. This is because, unlike in settlements where refugees are organized under settlement authorities, those in Kampala are dispersed across various slums.

Price shocks

Although prices of major staples began to decline in June 2025 across most settlements due to the season A harvest, refugees' purchasing power remained very low as they lacked access to sustainable sources of income. Most rely on casual agricultural labour and the limited sale of food crops. Despite the decline in staple food prices, incomes for poor and very poor households remained below normal, resulting in a sharp reduction in purchasing power and a high incidence of food insecurity.

Contributing factors to acute malnutrition

Inadequate food consumption

In the current period of analysis a significant deterioration was reported in all food consumption indicators Minimum Dietary Diversity (MDD), Minimum Meal Frequency (MMF), and Minimum Acceptable Diet (MAD) compared to the same period in 2024 for children 6-23 month and women of reproductive age. This implies nutrient inadequacies contributing to acute malnutrition.

High disease burden

Despite registered reduction in disease burden in the current period of analysis (April-September 2025) compared to the same period in 2024, diseases prevalence remains elevated and poses a significant risk to acute malnutrition. Malaria is categorised as a medium to high risk factor to the current levels of acute malnutrition in six settlements.

Limited access to sufficient water and sanitation facilities

Insufficient quantity of water was reported to be a very high-risk factor in two settlements (Nakivale and Oruchinga), a high risk in eight settlements (Kyaka II, Kyangwali, Adjumani, Imvepi, Kiryandongo, Lobule, Palabek and Rhino Camp), a medium risk in two settlements (Palorinya and Kampala) and a low risk in two settlements (Rwamwanj and Bidibidi).

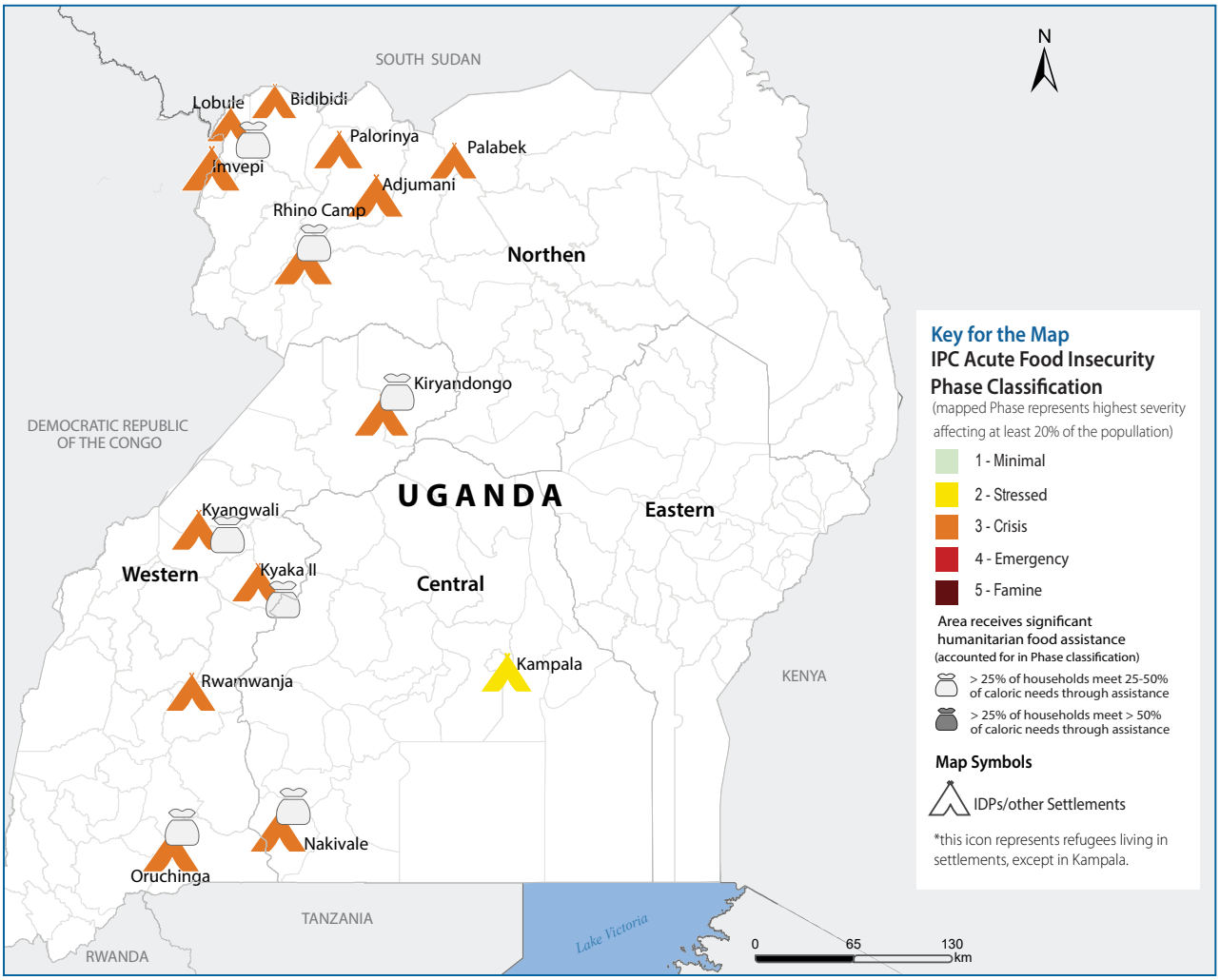
Food insecurity at household level

12 refugee settlements and Kampala are in Phase 3 (Crisis), meaning that households have food consumption gaps that are reflected by high or above-usual acute malnutrition and are not able to meet minimum food needs.

Influx of refugees

Despite reduced humanitarian support, Uganda continues to receive an influx of refugees from the Democratic Republic of Congo, South Sudan and Sudan, with the majority hosted in Kiryandongo, Adjumani, Palorinya, Kyangwali and Nakivale settlements. The influx of new arrivals led to additional pressure on the available social services in the settlements including access to sanitation, water, health services and markets. These service gaps increase the risk of acute malnutrition.

CURRENT ACUTE FOOD INSECURITY MAP AND POPULATION TABLE (JUNE – JULY 2025)



Current Population Table: June – July 2025

Settlement / 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 settlement	231,808	34,771	15	69,542	30	104,314	45	23,181	10	0	0	3	127,495	55
Bidibidi settlement	208,180	31,227	15	52,045	25	114,499	55	10,409	5	0	0	3	124,908	60
Imvepi settlement	73,893	7,389	10	22,168	30	40,641	55	3,695	5	0	0	3	44,336	60
Kampala	159,018	63,607	40	71,558	45	23,853	15	-	-	0	0	2	23,853	15
Kiryandongo settlement	158,224	31,645	20	47,467	30	71,201	45	7,911	5	0	0	3	79,112	50
Kyaka II settlement	135,681	27,136	20	67,841	50	40,704	30	-	-	0	0	3	40,704	30
Kyangwali settlement	151,806	30,361	20	68,313	45	53,132	35	-	-	0	0	3	53,132	35
Lobule settlement	6,363	1,591	25	2,545	40	2,227	35	-	-	0	0	3	2,227	35
Nakivale settlement	266,228	39,934	15	93,180	35	133,114	50	-	-	0	0	3	133,114	50
Oruchinga settlement	8,113	2,028	25	3,245	40	2,840	35	-	-	0	0	3	2,840	35
Palabek settlement	92,940	4,647	5	27,882	30	46,470	50	13,941	15	0	0	3	60,411	65
Palorinya settlement	141,256	14,126	10	35,314	25	84,754	60	7,063	5	0	0	3	91,817	65
Rhino Camp settlement	190,671	19,067	10	66,735	35	95,336	50	9,534	5	0	0	3	104,870	55
Rwamwanja settlement	103,412	31,024	30	41,365	40	31,024	30	-	-	0	0	3	31,024	30
Grand Total	**1,927,593**	**338,553**	**18**	**669,200**	**35**	**844,109**	**44**	**75,734**	**4**	**0**	**0**		**919,843**	**48**

Note: A population in Phase 3+ does not necessarily reflect the full population in need of urgent action. This is because some households may be in Phase 2 or even 1 but only because of receipt of assistance, therefore they may be in need of continued action.

CURRENT SITUATION OVERVIEW (JUNE – JULY 2025)

Parts of Uganda still grapple with high levels of acute food insecurity, particularly in the northern and eastern parts of the country and among refugee communities, despite having significant agricultural potential. For the refugees, the situation is compounded by challenges in access to legal protection, housing, land rights, and livelihood opportunities, impacting household access to food thus increasing the levels of food insecurity. Refugees are settled within refugee gazetted settlements that are integrated within local communities. There are a total of 13 refugee settlements found in 11 local government districts, where they are supported with relevant services. Some refugees have settled on their own onto urban centres that are outside the settlements, especially in Kampala. Each of the 13 settlements is coordinated by the Settlement Commandant (SC), who has semi-autonomous authority for managing and supervising the settlement matters.

All 13 refugee settlements assessed were classified in Phase 3, with Kampala being the only location classified in Phase 2. Out of the total population analysed, 48 percent (920,000 people) were in Phase 3 or above, 35 percent (669,200 people) were in Phase 2, and 18 percent (339,000 people) were in IPC Phase 1 (None/Minimal). Refugees in Kampala reside in slums spread across the city and engage in small-scale businesses, giving them relatively better financial capacity compared to those in other refugee settlements. In terms of severity, Palabek and Palorinya settlements recorded the highest percentage of the population in Phase 3 or above (65 percent), Kyaka II had 30 percent, Rwamwanja had 30 percent and Kampala had 15 percent. According to the magnitude of the affected population, Nakivale (133,000), Adjumani (127,000) and Bidibidi (125,000) had the highest population in need of immediate humanitarian assistance because of their high number of food insecure refugees, while Lobule and Oruchinga settlements had the lowest population in Phase 3 or above at 2,000 and 3,000 people respectively. Also, the majority (6 out of 7) of refugee settlements located in the West Nile/Northern region had populations in Phase 4. These include Palabek (15 percent), Adjumani (10 percent), Bidibidi (5 percent), Imvepi (5 percent), Palorinya (5 percent), and Rhino Camp (5 percent), while only one out of six settlements in the South West region – specifically Kiryandongo (5 percent) had populations in Phase 4.

According to the Food Security and Nutrition Assessment (FSNA) results, nearly all the 13 settlements except Kampala reported agriculture casual labour and sale of food crops as their main source of livelihood. Since agriculture casual labour and subsistence agriculture is a very unstable source of income, the food security situation for most of refugee population analysed were negatively affected by poor performance of both crops and livestock during the current cropping season A, mainly due to climate-related shocks and high incidences of crop and livestock diseases. The low level of food production as a result of the very small land holding (less than one acre for over 80 percent of households), together with high food prices, depleted food stocks, both among the refugee and host community and low purchasing power for most households have caused widespread food insecurity among most of the households in nearly all settlements and among Kampala refugees.

Household Food Consumption

According to the 2025 FSNA results for refugee settlements, only 38 percent of the households across all the refugee settlements except for Kampala had acceptable levels of Food Consumption Score (FCS), with up to 62 percent consuming inadequate diets. This indicates that the majority of the refugee households have high food consumption gaps. Across the settlements, South West had the highest percentage of the population with acceptable food consumption at 63 percent while West Nile had the lowest at 24 percent.

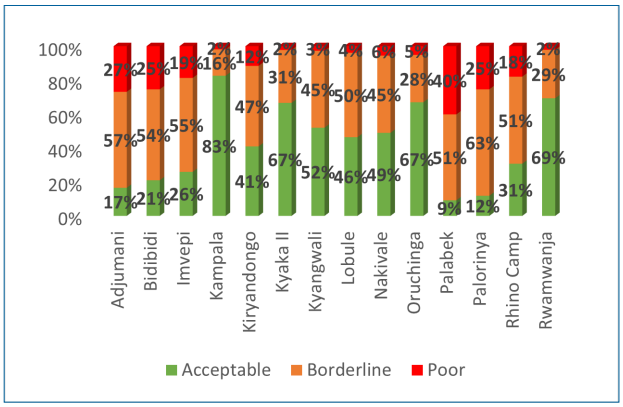


Figure 1: Food Consumption Score

The settlement disaggregated outlook indicated, Kampala (83 percent), Rwamwanja (69 percent) and Kyaka II (67 percent) had the highest percentage of the population with acceptable food consumption, while Palorinya settlement (12 percent) and Palabek settlement (9 percent) had the lowest population with acceptable food consumption. Also, Palabek, Adjumani, Bidibidi and Palorinya had the highest percentage of the population with poor food consumption. According to the Household Dietary Diversity Score, 46 percent of households reported consuming a diversified diet (eating 5-12 food groups) while 47 percent of the household reported having medium dietary diversity of 3-4 food groups. Only 7 percent of households had low dietary diversity across all settlements. Reduction of portion of meals was reported as the most frequently employed food coping strategy implemented by 74 percent of households - Adjumani recorded the highest prevalence (90 percent of households) while Kampala reported the lowest at 51 percent.

Livelihood Coping Strategies Index (LCSI)

Overall, only 29 percent of households reported not employing any livelihood coping strategy, with over 70 percent employing some form of coping mechanism to meet their household food needs. This reflects greater stress on the refugee households' ability to meet food needs, as they are depleting essential assets or employing unsustainable measures to cope. In addition, over 40 percent of the respondents were employing crisis and emergency coping strategies with Imvepi (54 percent) and Kiryandongo (56 percent) reporting the highest percentage of the population employing crisis and emergency coping strategies while Kyangwali (31 percent) and Rwamwanja (20 percent) settlements reporting the lowest percentages of the population employing crisis and emergency coping to meet household food needs. Comparing South West and West Nile settlements, South West recorded a higher percentage of the population not employing any coping strategy at 33 percent compared with 27 percent of West Nile.

Compared to their host community counterparts, refugees exhibited significantly higher levels of food insecurity. The direct evidence points to larger food consumption gaps, a more limited dietary diversity, and a heavier reliance on both food-based and livelihood-based coping strategies, underscoring their heightened vulnerability.

Food Availability

Unlike in the case of the host communities, food availability among the refugee communities is not driven by own production due to limited access to agriculture land. Even though own production has limited impact on food availability for refugees, production by the host communities positively impacts on refugees accessing food, as agricultural produce are frequently – and more easily than with cash - bartered against agriculture labour.

It is important to note that data on food availability that was collected during the FSNA for the refugee settlement was limited to only utilisation of agricultural land for production and the acreage of land accessible by households.

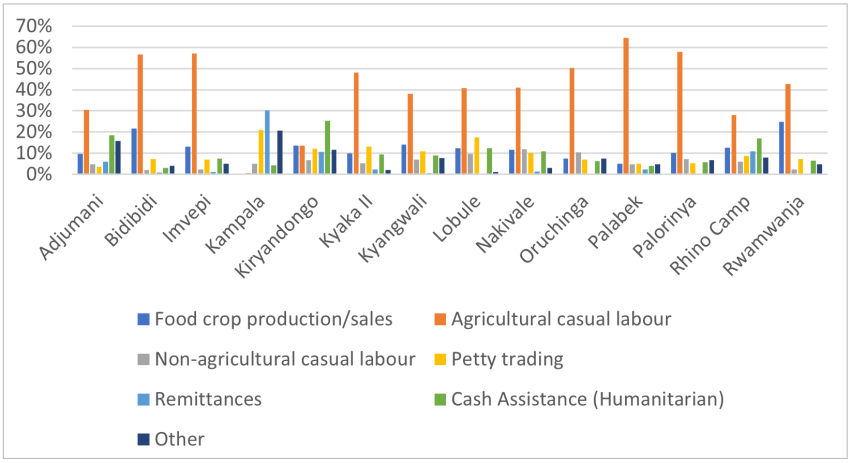
Across the settlements, 74 percent of households reported utilising land for agriculture production, with West Nile region having the highest percentage of households who utilised land for agriculture production (80 percent) compared to South West (64 percent). Imvepi settlement had the highest percentage of the households utilising land for agriculture production at 93 percent while Nakivale and Kampala had the lowest at 46 percent and 0.3 percent respectively. On access to land, all refugees are allocated a standard 30mx30m of land on arrival across all settlements by Office of the Prime Minister (OPM). However, some refugees rent agriculture land from the host communities while others are leased land for production.

Overall, 82 percent of refugees reported having access to land allocated by the OPM, 30 percent were leased land by the host community while 6.2 percent borrowed land from the host community. Nakivale settlement and Kampala reported the highest percentage of household who rented land from the host community (55 percent and 50 percent, respectively), while Kiryandongo had the lowest at 9 percent. Food availability was therefore a major limiting factor across all the refugee settlements.

Food Access

Food access is a major limiting factor to food security in all refugee settlements and Kampala. Although prices of most staple food commodities (cassava, maize, beans, Irish potatoes, cooking bananas) are generally reducing as a result of the first season harvest across all settlements and regional markets, the below average production during season B 2024 and average production of season A of 2025 somehow affected food availability in the markets, hence leading to an increase in prices for most staples, especially around April to June 2025. For example, prices of beans were on average at 4,000 Ugandan Shillings per kg from the usual average of 2,500 Ugandan shillings during the period of analysis.

Figure 2: Household Income Sources

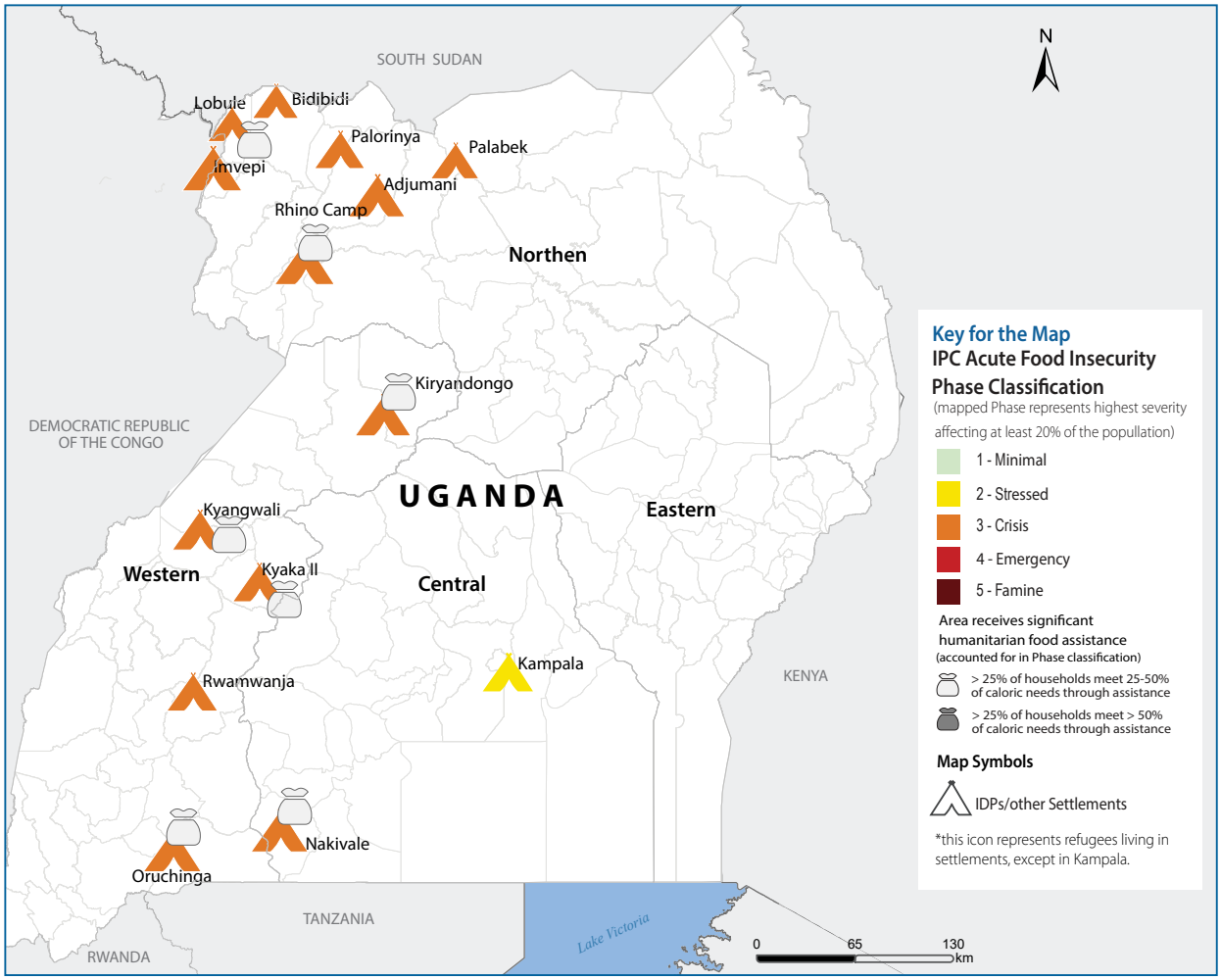


According to FSNA results, the main sources of income for most households across the refugee settlements were sale of food crops (13 percent) and agricultural casual labour (39 percent). The sale of crops was greatly affected by the below average harvest of season B 2024, which is the major season and average season A of 2025. In addition, poor rainfall distribution and limited access to land for agriculture production among the refugees, reduced opportunities for agricultural related casual labour which is the most important source of income. Also, debt burden and limited access to financial services for the refugees mean that their economic vulnerability levels negatively affect their ability to access food. In most settlements, food was available in the local markets but at high prices and most households were not able to purchase enough food due to low purchasing power, hence increased food consumption gaps. With over 50 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 had a direct impact on the income of the household's hence low purchasing power, making food access a major limiting factor across all settlements analysed.

Food Utilisation

According to the Wash Gap Analysis which was conducted in June 2025, the average per capita water use across all the 13 settlements was at 15.6 litres per person per day, less than the standard which is 20 litres per person per day, with Adjumani recording the highest per capita water use at 23 litres per person per day while Nakivale showed the lowest at 9 litres per person per day. On sanitation coverage, Palorinya had the highest coverage at 78 percent while Rhino Camp had the lowest at 60 percent, all falling less than the recommended standard of 85 percent.

PROJECTED ACUTE FOOD INSECURITY MAP AND POPULATION TABLE (AUGUST 2025 – FEBRUARY 2026)



Projected Population Table August 2025 – February 2026

Settlement / 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 settlement	231,808	46,362	20	104,314	45	69,542	30	11,590	5	0	0	3	81,132	35
Bidibidi settlement	208,180	41,636	20	62,454	30	104,090	50	-	-	0	0	3	104,090	50
Imvepi settlement	73,893	11,084	15	25,863	35	36,947	50	-	-	0	0	3	36,947	50
Kampala	159,018	63,607	40	79,509	50	15,902	10	-	-	0	0	2	15,902	10
Kiryandongo settlement	158,224	31,645	20	63,290	40	63,290	40	-	-	0	0	3	63,290	40
Kyaka II settlement	135,681	33,920	25	67,841	50	33,920	25	-	-	0	0	3	33,920	25
Kyangwali settlement	151,806	37,952	25	68,313	45	45,542	30	-	-	0	0	3	45,542	30
Lobule settlement	6,363	1,909	30	2,863	45	1,591	25	-	-	0	0	3	1,591	25
Nakivale settlement	266,228	39,934	15	106,491	40	119,803	45	-	-	0	0	3	119,803	45
Oruchinga settlement	8,113	2,434	30	3,245	40	2,434	30	-	-	0	0	3	2,434	30
Palabek settlement	92,940	13,941	15	37,176	40	37,176	40	4,647	5	0	0	3	41,823	45
Palorinya settlement	141,256	21,188	15	56,502	40	63,565	45	-	-	0	0	3	63,565	45
Rhino Camp settlement	190,671	19,067	10	95,336	50	76,268	40	-	-	0	0	3	76,268	40
Rwamwanja settlement	103,412	25,853	25	51,706	50	25,853	25	-	-	0	0	3	25,853	25
Grand Total	**1,927,593**	**390,532**	**20**	**824,903**	**43**	**695,923**	**36**	**16,237**	**1**	**0**	**0**		**712,160**	**37**

Note: A population in Phase 3+ does not necessarily reflect the full population in need of urgent action. This is because some households may be in Phase 2 or even 1 but only because of receipt of assistance, therefore they may be in need of continued action.

PROJECTION ACUTE FOOD INSECURITY SITUATION OVERVIEW (AUGUST 2025 – FEBRUARY 2026)

The food security situation in refugee settlements is projected to improve during the period from August 2025 to February 2026, as households shift to the 2025 SOND (September–October–November–December) season and harvest food sources of the succeeding wet season. The number of people facing high levels of acute food insecurity (IPC Phase 3 or above) and in need of food assistance and livelihood support is expected to decline from 920,000 (48 percent of the analysed population) to 712,000 (37 percent). This anticipated improvement is largely due to expected increases in crop yields resulting from enhanced agricultural production during the period. Additionally, food prices are forecast to decrease due to higher production, thereby improving household food availability and access. Settlements projected to have the highest populations in IPC Phase 3 or worse include Nakivale (120,000), Bidibidi (104,000), and Adjumani (81,000).

Although households are relying on the dwindling food stocks from the current harvest season and improvements expected during the SOND, most are expected to face food shortages as early as December 2025, leading to increased food consumption gaps and heightened vulnerability. The projected normal to above-normal rainfall in most districts, except Isingiro, which is forecasted to receive below-normal rainfall based on historical trends, is expected to support improved crop and livestock production across refugee settlements. The actual level of agricultural output will also depend on rainfall performance, with excessive rainfall potentially causing flooding and negatively impacting yields.

Compared to the current analysis period, food consumption and household incomes from own production and other livelihood sources are expected to increase during the 2025 projection period, largely due to reduced food prices. Although agricultural production may improve in some settlements, the overall gains are expected to be modest and insufficient to shift the majority of the population out of IPC Phase 3 or to a much better phase. Dietary diversity is unlikely to improve significantly, as limited purchasing power, food preferences, and low nutritional awareness among caregivers and mothers will continue to pose challenges. Additionally, sanitation and hygiene conditions are projected to remain largely unchanged across the settlements due to ongoing funding and capacity constraints.

Uganda's refugee settlements continue to face structural challenges that will drive acute food insecurity. Though seasonal rains may bring short-term improvements in food availability, they are not sufficient to offset the effects of reduced assistance, resource pressure, and weak livelihood systems. Long-term resilience will require targeted support, investment in sustainable livelihoods, and restored humanitarian funding.

Key Assumptions

Crop Production: The upcoming season 2025 SOND is expected to receive normal to above-average rainfall across most refugee communities creating favourable conditions for increasing casual labour opportunities as well as for direct crop growth, encouraging households to expand cultivation. More farmers will likely expand cultivations to additional land leading to higher production levels compared to the June-August period. Planting has begun and will continue through early October 2025, with harvests starting in late September 2025 for early planted crops and extending to the end of December 2025 for crops planted later. Food availability is therefore expected to improve during this period, and most households are likely to rely on their own food production and markets until early January 2026. Livestock productivity is also projected to improve between September and November 2025 due to sufficient pasture and water, although a gradual decline is expected from December 2025 through February. During the peak of the rainy season, incidents of crop destruction by stray animals will be minimal, further protecting household food sources. Despite the expected good harvests, food stock levels are anticipated to begin depleting from mid-January to February 2026, as this is a lean season. Production will be hindered by small land sizes, limited access to inputs, delayed rains in areas like Nakivale, and a lack of land for some households across the settlements.

Funding cuts impact on Humanitarian Food Security Assistance (HFSA): Due to ongoing funding constraints across the humanitarian sector, support to refugees in the settlements is expected to be further impacted. The general food assistance ration has already been reduced from 60 percent to 40 percent, during the projection period. Additionally, the continued influx of refugees mainly from Democratic Republic of Congo, South Sudan and Sudan is likely to place increased pressure on limited resources, further deteriorating food security conditions across the camps.

Rainfall: Based on historical trends, the SOND rainfall season is expected to peak in mid-September and end around early to mid-November 2025, with near-normal to above-normal rainfall prevailing. This will enhance water availability, boosting crop and livestock productivity from September to December 2025. However, excessive rains may lead to flooding, waterlogging, infrastructure damage, and increased outbreaks of pests and diseases, particularly blights in horticultural crops, which could reduce crop performance. Despite these challenges, overall productivity is anticipated to improve.

New arrivals/refugee influx: The deteriorating political situation in Democratic Republic of Congo, South Sudan and Sudan is expected to lead to new arrival of refugees in most of the settlements. The ongoing political instability in the Democratic Republic of Congo, South Sudan, and Sudan is driving a continuous influx of refugees into various settlements across Uganda, including Palabek, Kiryandongo, Palorinya, and Rhino Camp. This steady arrival of new refugees is placing additional pressure on already limited resources such as food, land, and humanitarian assistance, further straining both refugee and host communities. According to UNHCR, as of August 2025, Uganda hosts over 1.9 million forcibly displaced and stateless persons, primarily from South Sudan, the Democratic Republic of Congo, and Sudan, with 92 percent residing in 13 refugee settlements and the remaining 8 percent in Kampala. The refugee population is predominantly vulnerable, with women and children making up 78 percent, and over half under the age of 18. Despite a continued influx of over 120,000 new asylum seekers this year, humanitarian funding remains critically low.

Projection Situation By Refugee Settlement

Adjumani Settlement

Adjumani is projected to remain in IPC Phase 3 (Crisis) due to limited own production despite high dependence on farming, limited income sources, and rising food prices. While 86 percent of households engage in farming, 27 percent rent or borrow land to boost production, and only 10 percent cultivate up to five acres according to FSNA results. Harvests expected in August 2025 may increase food availability. On a positive note, water access exceeds the minimum standard, at 23 liters per person per day. Despite some improvements, underlying vulnerabilities like high dependence on farming, low income, and price fluctuations keep the settlement in Crisis (Phase 3).

Kampala

Food security is expected to improve slightly, with the proportion of households facing Crisis (IPC Phase 3) conditions projected to decline from 15 percent in the current period to 10 percent in the projection period. A large proportion (42 percent) of households have no income source, and many depend on borrowing to purchase food. Food availability is expected to improve with good rainfall between September and December 2025, leading to lower staple prices and better access. Water supply is above standard due to piped infrastructure, but flood-prone slum areas pose serious health risks like diarrhea, which affect food utilization. Many households continue to adopt negative coping strategies such as cutting and spending on health and education. Market supply improvements, as a result of season B 2025 are not enough to shift Kampala out of stress situation. Refugees are largely concentrated in informal settlements where overcrowding, poor sanitation, and flood risks are common, contributing to the spread of diseases like diarrhea that undermine food utilization and health. Despite being in an urban environment, 42 percent of refugee households in Kampala have no source of income and are highly dependent on markets for food, leaving them vulnerable to price fluctuations and inflation. The lack of humanitarian assistance in the city exacerbates this vulnerability, pushing many refugees to rely on negative coping strategies like engaging in informal and often exploitative labour. Although seasonal harvests may temporarily lower food price reductions, they do little to improve the food security of urban refugees who have limited purchasing power. The increasing refugee population also places pressure on public services and can lead to social tensions with host communities competing for the same limited resources. Without targeted support, livelihood opportunities and inclusive urban planning, refugees in Kampala will remain trapped in a cycle of stress level food insecurity.

Key Assumptions

Agriculture labour opportunity: The projection period coincides with the second season cultivation and harvest; agricultural labour is likely to increase, leading to improved cash availability across most settlements, hence improved purchasing power. However, daily wage rates for agricultural labour are likely to remain stable or slightly decline with improved labour opportunities. Based on historical trends in urban areas like Kampala, where refugees have limited access to agricultural labour it is likely to be a challenge to food access since a big percentage accesses food from markets but will not have incomes. Overall, these opportunities won't fully address food insecurity caused by limited land, funding cuts, and rising refugee numbers.

Crop pests and livestock diseases: An outbreak of Food and Mouth Disease (FMD) is likely to occur in most of the livestock keeping districts and settlements, in spite of the expected vaccination campaigns. FMD will continue affecting the income of households relying on the sale of livestock and livestock products, due to likely loss of animals and to quarantine restrictions. In case of high FMD prevalence and outbreaks, a livestock quarantine may be imposed, greatly affecting household as livestock markets will be closed for some time. A likely increase of outbreaks of crop pests and diseases could also reduce crop performance and yields, potentially limiting the positive effects of favourable rainfall on agricultural production.

Prices: Retail prices of staple food in most settlements and neighbouring districts will remain generally stable or decline further as a result of the peak season harvest, improving the purchasing power for the vast majority of households relying on markets for their food supply. Although food commodity prices have increased significantly compared to previous years maize rising from 1,150 to 2,300 Ugandan Shillings and sorghum from 1,000 to 1,500 Ugandan Shillings. Despite the favourable rainfall, limited production and rising refugee numbers may constrain the ability of the supply to meet growing demand.

National elections: The primary election campaign for presidential, parliamentary and local council members, which is ongoing though February 2026 may bring about disruptions during this period likely to affect agricultural activities. As many labourers may engage in campaign activities thereby delaying land preparation processes. Many agricultural labourers may shift their focus to election campaign related work, delaying essential farming operations such as land preparation and planting. This could negatively affect agricultural productivity, particularly in settlements heavily reliant on seasonal labor. Additionally, while the elections are likely to increase money circulation, which may contribute to access for staples like maize and beans in the short term, the overall impact on food production and market activity may reduce food availability and access, especially for household's dependent on markets and casual labour for their livelihoods.

Kiryandongo Settlement

There is a notable 10 percentage point reduction in the proportion of the population classified in Phase 3 and above from the current to the projected period (from 50 percent down to 40 percent). Specifically, the share of households in Phase 3 (Crisis) decreases from 45 percent to 40 percent, and those in Phase 4 (Emergency) decline from 5 percent to 0 percent. However, the settlement remains classified in Phase 3 (Crisis) due to persistent challenges such as high levels of debt, limited income, and restricted agricultural productivity. More than 50 percent of households have no income and depend on a single earner, a situation unlikely to improve given the continuous influx of refugees and low wages resulting from an oversupply of labor in the agricultural sector. Nearly half of the population is in debt. Although above-normal rainfall during the projection period may enhance maize and cassava yields, the risk of flooding could offset these gains. Land shortages further constrain agricultural output, even though 63 percent of households are engaged in farming. Additionally, reductions in food assistance following donor cuts exacerbate the crisis situation, despite anticipated declines in food prices.

Nakivale Settlement

Nakivale is likely to remain in Phase 3 (Crisis), with only a 5 percent reduction in the population facing crisis level food insecurity, down from 50 percent to 45 percent. This marginal shift is primarily attributed to expected normal to below normal rains leading to prolonged dry spells, reduced donor support, and poor access to essential services such as water and sanitation. Farming activities have been delayed due to the prolonged dry spell, negatively impacting food production. Water access remains critically low, at just 9 liters per person per day well below the minimum standard while sanitation coverage is only 61 percent. Food consumption continues to be a major concern. An increasing number of households are also resorting to severe coping strategies (rCSI) to manage food shortages. The combination of reduced humanitarian assistance, ongoing below average rains, and poor access to basic services, alongside the continuous daily influx of refugees, continues to sustain Nakivale's Crisis classification.

Palabek Settlement

In the projected period, the proportion of households in Crisis decreases to 40 percent, and those in Emergency fall to 5 percent from 10 percent in the current period, resulting in a total of 45 percent in IPC Phase 3 and above between the current and projected periods. Palabek remains in Phase 3 (Crisis) despite anticipated good harvests, mainly due to the ongoing influx of refugees and overstretched resources. New arrivals from South Sudan continue to strain access to land and essential services. While above-normal rainfall is expected to boost food production and lower market prices, improving access for market-dependent households, rising population density is putting additional pressure on water and sanitation systems. This increases the risk of disease outbreaks, which in turn affects food utilization. As a result, improved harvests alone are not enough to lift Palabek out of Crisis.

Palorinya Settlement

Palorinya is projected to remain in Phase 3 (Crisis), with 45 percent of households classified in Phase 3 or above due to low-income levels, high debt, and reduced humanitarian assistance. In the projection period, the proportion of households in Crisis drops to 45 percent, and those in Emergency fall to 0 percent, resulting in a total of 45 percent in Phase 3 and above a 20 percent point reduction from current levels. Though normal-to-above-normal rainfall is expected to improve food production and stocks between August and December 2025, supplies may not last through the lean season starting January 2026. Assistance reductions further compound vulnerabilities. Common coping mechanisms include school withdrawals, reduced health spending, and asset sales. While the harvest may bring short-term relief, long-term needs remain unmet.

Imvepi Settlement

Imvepi will remain in IPC Phase 3 (Crisis) with 50 percent of households in phase 3+ while households in Phase 4 are expected to decline from 5 percent to 0 percent affiliated to the expected harvest for the SOND season. Due to ongoing food assistance cuts, poor water access, and minimal livelihood improvements, access to food and basic services is inadequate, and despite expected stable food prices and seasonal harvests, the impact is insufficient to lift some households out of food insecurity. Water supply and sanitation services remain under standard, negatively affecting food utilization. Households continue to rely on crisis-level coping strategies, and livelihood recovery is stagnant. The food consumption situation may improve marginally with harvests, but structural issues keep Imvepi in a prolonged state of vulnerability.

Bidibidi Settlement

Bidibidi is projected to remain in Phase 3 (Crisis), with 50 percent of households still in Phase 3 or above, despite a 5 percent improvement from Phase 4 between current and projected periods. While the upcoming harvest and favorable rainfall are expected to slightly boost food stocks and lower staple prices, persistent challenges such as pest outbreaks, low wages, and rising refugee numbers continue to strain resources. Many households remain highly dependent on markets, yet lack sufficient income to access food. Although slight improvements may be seen in food consumption indicators like HDDS, FCS, and rCSI, ongoing reductions in assistance and limited land access will prevent any substantial improvement in overall food security during the projection period.

Kyaka II Settlement

In the projected period, Kyaka II Settlement is expected to remain in Phase 3 (Crisis), with only moderate improvement that will be observed. The proportion of households in Phase 3 is projected to decrease slightly from 30 percent to 25 percent, indicating a 5 percent point slight improvement from the current situation. Despite better production and expected price improvements, the overall food security situation will remain fragile. The majority of food consumption indicators will still align with Phase 3 classifications, and the proportion of households using crisis-level coping strategies will remain unchanged.

Kyangwali Settlement

Kyangwali Settlement is projected to remain in Phase 3 (Crisis), with an estimated 30 percent of households expected to face food insecurity at crisis levels. Light improvements in food consumption are expected, as more households will access food through a mix of their own production and markets. Households are also likely to consume a more diverse and nutritious diet, including pulses and green leafy vegetables, indicating a modest positive impact. However, 30 percent of the households will be in crisis requiring the support humanitarian assistance.

Lobule Settlement

Lobule Settlement is projected to remain in Phase 3 (Crisis), although food security is expected to improve moderately during the projection period. Currently, 35 percent of the population is in Phase 3 or above, but this is expected to decline to 25 percent, reflecting a 10 percent point improvement. The improvement is largely attributed to the main harvest season, which will positively impact food consumption indicators such as HDDS, FCS, and HHS. Households relying on their own production, casual labor, or market purchases are expected to benefit from better food availability and lower prices. Favorable factors such as above-normal rainfall, improved crop and livestock production, increased food stocks, and reduced incidence of crop pests and livestock diseases are expected to support food security. However, these gains remain fragile and could reverse if food rations by WFP are reduced or if partner support declines.

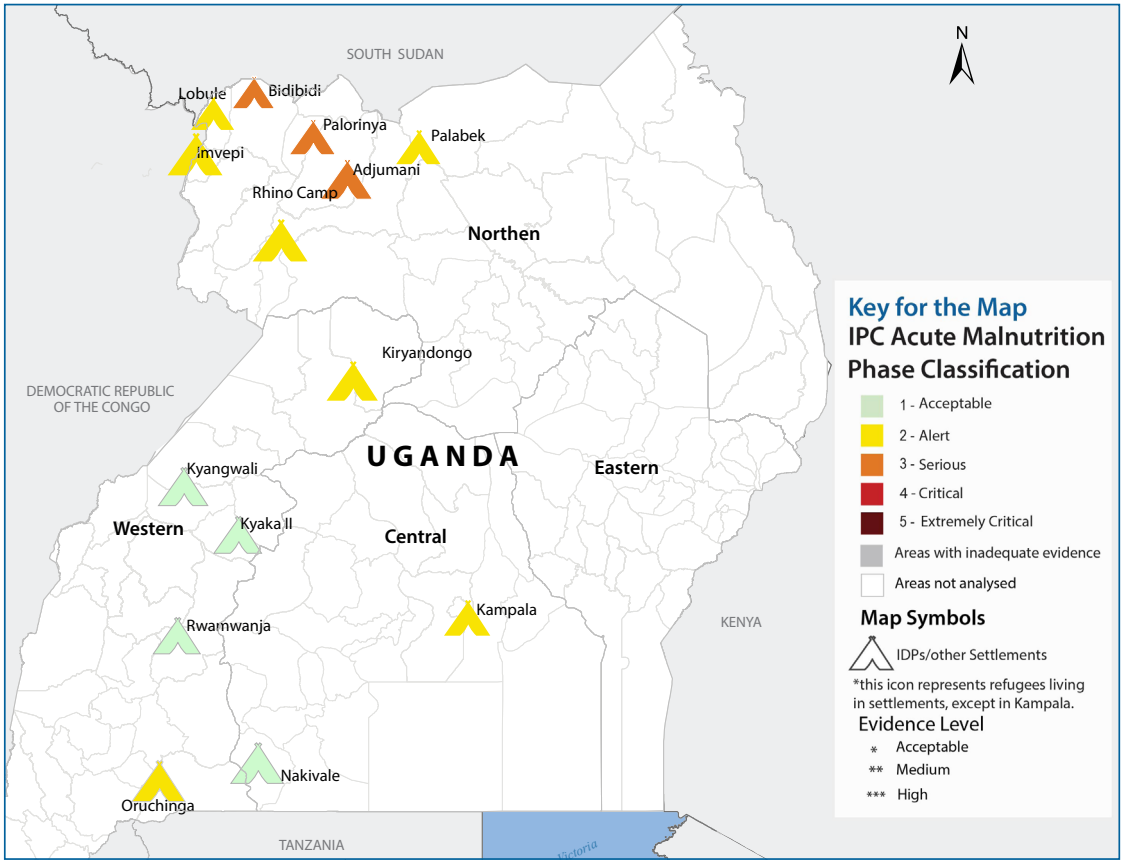
Oruchinga Settlement

Oruchinga Settlement is projected to remain in IPC Phase 3 (Crisis), with 30 percent of the population expected to be in Phase 3 or above during the projection period down slightly from 35 percent currently. However, this marginal change is not significant enough to shift the settlement out of Crisis. While projected normal to above-normal rainfall and declining food prices may improve food availability and household self-sufficiency for those with access to land, multiple risks threaten to offset these gains. These include crop pests, livestock disease outbreaks, election-related disruptions, and persistently low wages in the agricultural labor market, which is a key livelihood source for 50 percent of households according to FSNA results. Landless and debt-burdened households remain especially vulnerable. Additionally, excess rainfall could lead to waterlogging and crop damage, and limit labor opportunities due to poor accessibility.

Rwamwanja Settlement

Rwamwanja settlement is projected to remain in Phase 3 (Crisis) of IPC acute food insecurity, with 25 percent of the population expected to be in Phase 3 or above, down from the current 30 percent. This improvement is attributed to several factors: favorable near-normal rainfall during the SOND season supporting staple crop production, especially maize and beans; continued humanitarian assistance from key agencies such as WFP.

CURRENT ACUTE MALNUTRITION SITUATION OVERVIEW (APRIL – SEPTEMBER 2025)



During the current period of analysis (April to September 2025), general deterioration in acute malnutrition has been observed. Global acute malnutrition (GAM) increased in nine Refugee settlements (Adjumani, Bidibidi, Imvepi, Kyangwali, Lobule, Oruchinga, Palabek, Palorinya, Rhino Camp and Kampala urban refugees) compared to the same period in 2024. Only four settlements (Kiryandongo, Kyaka II, Nakivale and Rwamwanja) showed an improvement in the GAM prevalence.

Three settlements – Adjumani, Bidibidi and Palorinya were classified in AMN Phase 3 (Serious) with Bidibidi having the highest GAM prevalence of 11.4 percent. Six Refugee settlements (Imvepi, Kiryandongo, Lobule, Oruchinga, Palabek and Rhino Camp) and Kampala Urban refugees – were classified in IPC AMN Phase 2 (Alert) with GAM prevalence of 7.1, 5.3, 6.1, 5.1, 8.7. 8.2 and 4.8 percent, respectively. Only four settlements (Kyaka II, Kyangwali, Nakivale and Rwamwanja) were classified in IPC AMN Phase 1 (Acceptable) with GAM prevalence of 1.1, 2.6, 1.8, and 0.8 percent respectively.

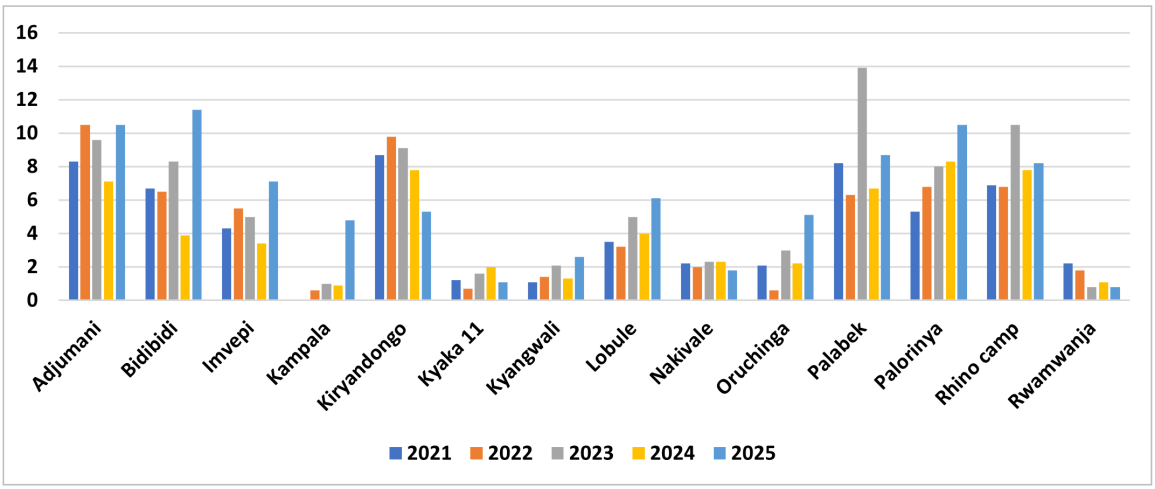


Figure3: Trend of acute malnutrition prevalence in refugee settlements and Kampala urban refugees (2021 – 2025)

Contributing factors to acute malnutrition

Immediate contributing factors

The key contributing factors to acute malnutrition in the refugee settlements and Kampala urban refuges are inadequate food consumption and high morbidity.

Inadequate food consumption

In the current period of analysis a significant deterioration was reported in all food consumption indicators Minimum Dietary Diversity (MDD), Minimum Meal Frequency (MMF), and Minimum Acceptable Diet (MAD) compared to the same period in 2024 for children 6-23 month and women.

Among children, Adjumani recorded the lowest MDD at only 4.1 percent, while Rhino Camp reported the highest at 30.6 percent. MAD was lowest in Kiryandongo (1.7 percent) and Bidibidi (4.3 percent). These results highlight serious nutrient inadequacies contributing to acute malnutrition.

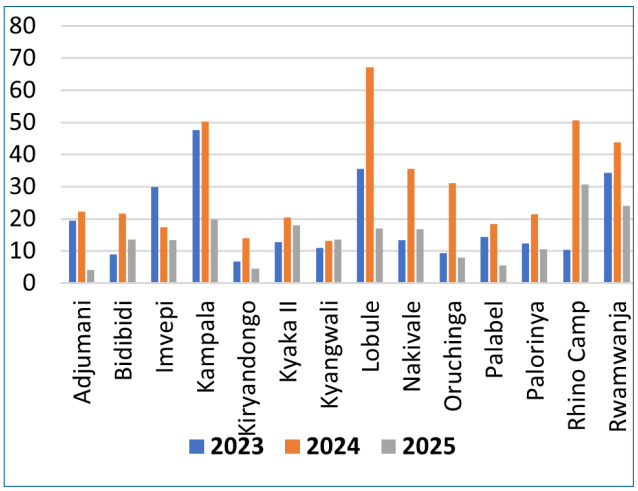


Figure 4: Trends of Minimum Dietary Diversity (2023-2025)

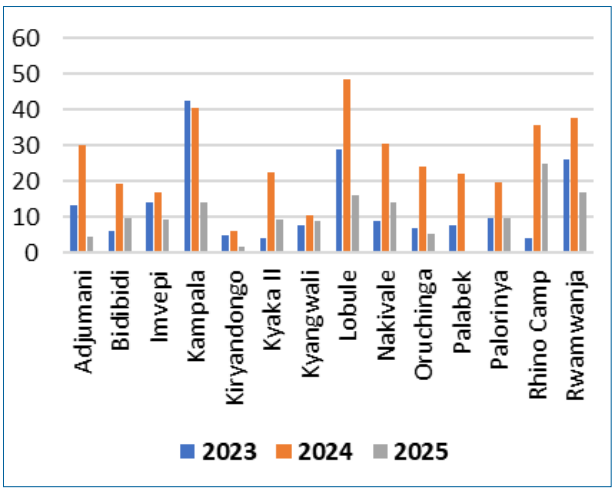


Figure 5: Trends of Minimal Acceptable Diet (2023-2025)

High morbidity

Despite registered reduction in disease burden in the current period of analysis (April-September 2025) compared to the same period in 2024, diseases prevalence remains elevated and poses a significant risk to acute malnutrition. Malaria is categorized as a medium to high risk factor to the current levels of acute malnutrition in six settlements. The highest proportion of malaria was recorded in Palabek (26.4 percent), Kyaka II (26.1 percent), and Kyangwali (18.5 percent). Repeated diarrhoea infections contribute to loss of nutrients and long-term gut damage that prevents nutrient absorption and immune system function, even when children eat healthy foods, resulting to acute malnutrition. Kyangwali Refugee Settlement reported the highest prevalence of diarrhoea at 16.6 percent followed by Palabek Settlement at 16.3 percent.

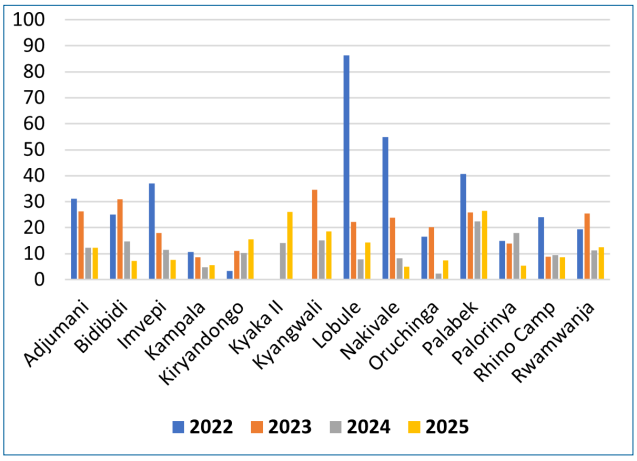


Figure 5: Trend of malaria prevalence over time among children aged 6-59 months (2022-2025)

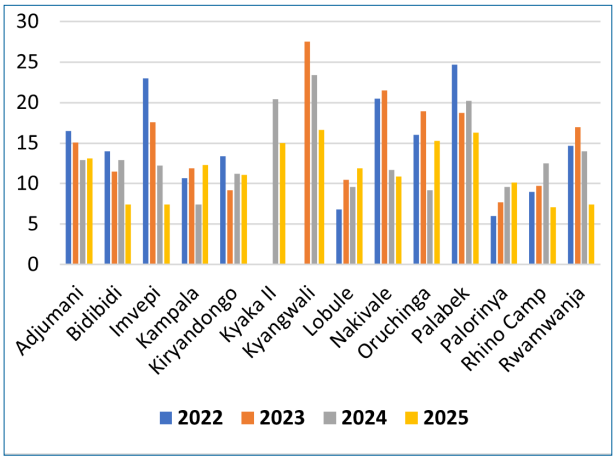


Figure 6: Trend of diarrhoea prevalence over time among children aged 6-59 months (2022-2025)

Evidence strongly suggests that a measles infection can trigger overt malnutrition due to a combination of factors: increased protein and energy requirements, reduced food intake caused by anorexia and direct or indirect effects on both the small and large intestines. Measles cases were also reported in five Refugee settlements (Kyangwali, Nakivale, Rwamwanja Adjumani and Rhino Camp) and among Kampala urban Refugees.

Underlying factors

Limited access to sufficient water

Limited access to sufficient water continues to be a risk factor to acute malnutrition levels observed in the refugee settlements. Insufficient quantity of water was reported to be a very high-risk factor in two settlements, a high risk in eight settlements, a medium risk in two settlements and a low risk in two settlements. The settlements in South-western region recorded lower access to sufficient quantities of water compared to the settlements in the West Nile Region. The lowest rates were recorded in Nakivale, Rwamwanja and Oruchinga at 23.3 percent, 26.9 percent and 27.6 percent respectively while Palorinya, Kampala and Kiryandongo had the higher rates at 58.2 percent, 50.8 percent and 41.7 percent respectively. Insufficient water in the households' compromises 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.

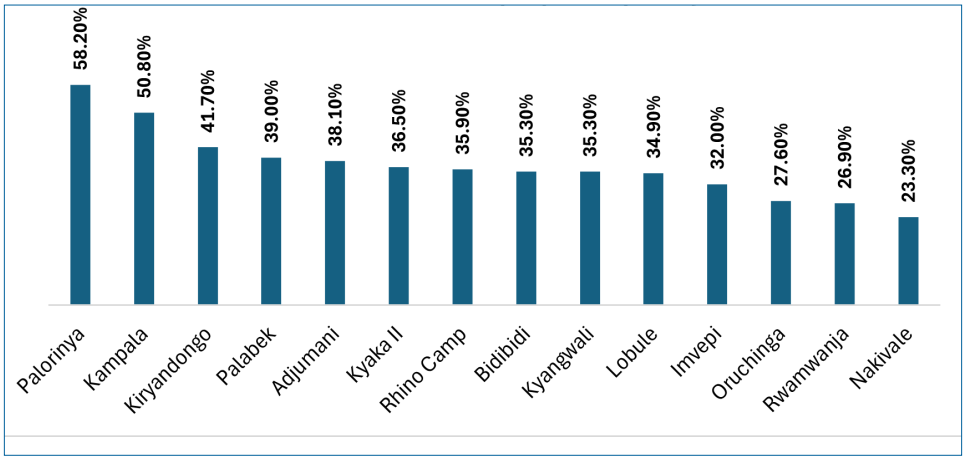


Figure 6: Proportion of households with access to sufficient water

Food insecurity

12 Refugee settlements and Kampala are in Phase 3 (Crisis), meaning that households have food consumption gaps that are reflected by high or above-usual acute malnutrition and are not able to meet minimum food needs. Households have to sell essential livelihood assets and resort to crisis-coping strategies to be able to meet their food needs. This can be attributed to the poor consumption indicators reported in most settlements and increased levels of acute malnutrition across settlements.

Poor access to sanitation facilities

Most of the settlements recorded a high coverage of improved sanitation facilities at household level with the lowest proportion of households at 72.6 percent in Lobule and 88 percent in Rhino Camp. Overall sanitation coverage was a low contributing factor to the current levels of acute malnutrition.

Basic factors

Shocks due to conflict

Despite reduced humanitarian support, Uganda continues to receive an influx of refugees from the Democratic Republic of Congo, South Sudan and Sudan, with the majority hosted in Kiryandongo, Adjumani, Palorinya, Kyangwali and Nakivale settlements. The influx of new arrivals led to additional pressure on the available social services in the settlements including access to sanitation, water, health services and markets. These service gaps increase the risk of acute malnutrition.

Other factors

High levels of anaemia

All the settlements recorded high anaemia levels among children aged 6-59 months exceeding the public health threshold of 20 percent. The highest prevalence was in Kyangwali (62.7 percent) followed by Rwamwanja (54.7 percent) while the lowest was recorded in Rhino Camp at 26.1 percent. Anaemia contributes to acute malnutrition by impairing protein synthesis and reducing appetite, leading to inadequate nutrient intake. This particularly affects children under two years, hindering growth and increasing health risks. Combined with disease, anaemia further raises the likelihood of malnutrition and mortality.

High levels of stunting

Eight refugee settlements recorded levels of stunting above 20 percent which is considered unacceptable. The highest prevalence was reported in Rwamwanja where more than half (50.5 percent) of children are stunted. The lowest prevalence was reported in Adjumani with 8.2 percent of children being stunted. Stunting is associated with inadequate dietary intake, repeated infections, and poor maternal health and nutrition status.

NUMBER OF PEOPLE IN NEED (PIN) OF TREATMENT FOR ACUTE MALNUTRITION (APRIL 2025 - MARCH 2026)

During the period of analysis (April 2025 to March 2026), it is estimated that 56,627 children 6-59 months across all refugee settlements and Kampala Urban Refugees will suffer from acute malnutrition and are in need of treatment. Of these 46,698 are considered moderate acute malnutrition cases, and 9,929 are considered severe acute malnutrition cases. Compared to the same period last year (April 2024 to March 2025) the current levels of acute malnutrition show 82 percent increase nearly doubling the burden of acute malnutrition in the refugee settlements and among Kampala urban Refugees.

Bidibidi settlement has the highest number of acutely malnourished children in need of treatment (9,479) of whom 7,232 are moderate acute malnutrition and 2,247 are severe acute malnutrition cases.

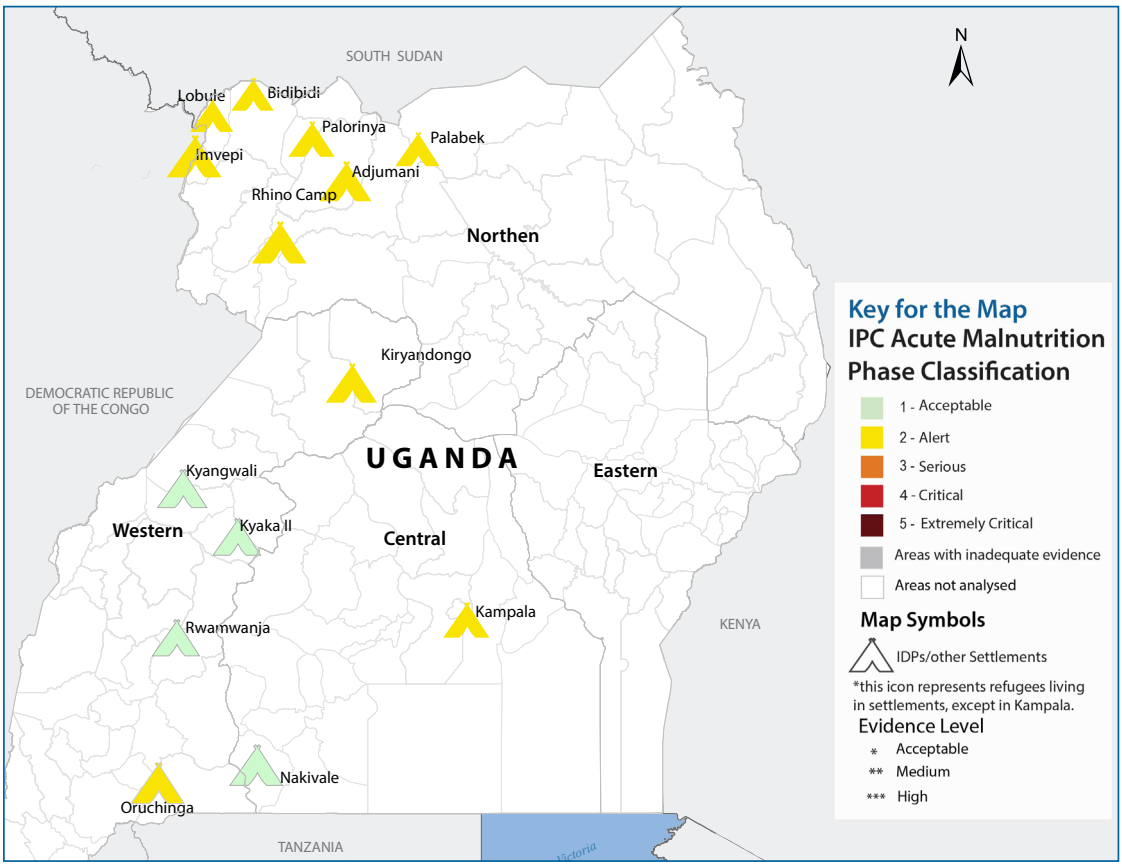
A total of 6,827 Pregnant or Breastfeeding Women and Girls (PBWGs) have or will suffer from acute malnutrition and in need of treatment, with the largest number reported in Rhino settlement (1,335). This results also show increased burden of acute malnutrition among women compared to similar period in 2024.

The estimated number of cases of children affected by acute malnutrition and in need of treatment was calculated using the formula NPK; where N is the total number of children aged 6-59 months in the refugee settlements, P is the prevalence of acute malnutrition based on combined GAM for the Refugee settlements and Prevalence of Acute malnutrition using MUAC (upper limit at 95% CI) and K is the incident correction factor of 2.6. The estimated number of cases of acute malnutrition among pregnant or Breastfeeding women (PBW) was calculated using the formula NP; where N is the number of PBWSs and p is prevalence of acute malnutrition (based on MUAC, estimated at less than 23.0 cm).

				Children aged 6-59 months						Pregnant and Breastfeeding Women and Girls (PBWGs)		
Sub-Region	District	Total Population	Total	Combined GAM	Combined MAM	Combined SAM	Estimated MAM Cases	Estimated SAM cases	Estimated GAM cases	Total #	GAM	Estimated number of GAM cases
Karamoja	Adjumani settlement	231,808	27,907	11.40%	10.20%	1.20%	7,401	871	8,272	11,590	6.9%	800
	Bidibidi settlement	208,180	27,005	13.50%	10.30%	3.20%	7,232	2,247	9,479	10,409	9.1%	947
	Imvepi settlement	73,893	9,476	7.50%	5.70%	1.80%	1,404	443	1,848	3,695	9.6%	355
	Kampala	159,018	16,601	9.10%	3.67%	5.43%	1,584	2,344	3,928	7,951	1.5%	119
	Kiryandongo settlement	158,224	20,889	5.60%	5.00%	0.60%	2,716	326	3,041	7,911	5.6%	443
	Kyaka II settlement	135,681	23,043	3.30%	2.20%	1.10%	1,318	659	1,977	6,784	2.9%	197
	Kyangwali settlement	151,806	27,165	6.30%	5.20%	1.10%	3,674	777	4,451	7,590	12.9%	979
	Lobule settlement	6,363	911	7.10%	5.30%	1.80%	126	43	168	318	8.3%	26
	Nakivale settlement	266,228	45,411	6.50%	6.30%	0.20%	7,438	236	7,674	13,311	2.8%	373
	Oruchinga settlement	8,113	1,187	6.90%	6.40%	0.50%	197	15	213	406	4.3%	17
	Palabek settlement	92,940	13,216	10.60%	8.90%	1.70%	3,058	584	3,642	4,647	7.4%	344
	Palorinya settlement	141,256	17,698	11.00%	10.50%	0.50%	4,832	230	5,062	7,063	10.5%	742
	Rhino Camp settlement	190,671	25,137	9.10%	7.90%	1.20%	5,163	784	5,947	9,534	14.0%	1,335
	Rwamwanja settlement	103,412	17,772	2.0%	1.20%	0.80%	554	370	924	5,171	2.9%	150
	Total	**1,927,593**	**273,428**				**46,698**	**9,929**	**56,627**	**96,380**		**6,827**

Table 1: Total AMN cases among refugee population (April 2025- March 2026)

PROJECTED ACUTE MALNUTRITION SITUATION OVERVIEW (OCTOBER 2025 – MARCH 2026)



Overview of projected period for acute malnutrition (October 2025 - March 2026)

The projection period, spanning from October 2025 to March 2026, is generally expected to be a season of low acute malnutrition across all refugee settlements except for Oruchinga and Nakivale (both in Isingiro district), where acute malnutrition is expected to deteriorate in the coming months.

During the projection period, the AMN Phase classification is expected to remain unchanged in 11 settlements of which four settlements (Kyaka II, Kyangwali, Nakivale and Rwamwanja) are expected to remain in AMN Phase 1 (acceptable) while seven settlements (Imvepi, Kampala, Kiryandongo, Lobule, Oruchinga, Palabek and Rhino Camp) are projected to remain in AMN Phase 2 (alert). However, Adjumani, Bidibidi, and Palorinya, that are currently in AMN Phase 3 (serious), are projected to improve to Phase 2 (alert) during the projection period. The improvement in acute malnutrition is attributed to the anticipated second-season harvest, better food security indicators, and improved food consumption among children and PBWGs, a decline in rain-related diseases and enhanced childcare practices, as caregivers will have more time to dedicate to their children in the post-harvest season. Meanwhile, Kyaka and Rwamwanja, also in AMN Phase 1 (acceptable) and Kampala in AMN phase 2 (alert) are expected to maintain similar levels of acute malnutrition since no significant change in contributing factors are foreseen.

Deterioration in acute malnutrition within the same phase is expected in Nakivale (AMN phase 1) and Oruchinga (AMN Phase 2). This deterioration is linked to the lean season, which coincides with second season planting and weeding. During this time, household food stocks are depleted, reducing food availability, while market food prices are expected to rise, limiting access to diverse and nutritious diets. In addition, as Nakivale settlement is receiving new arrivals, WASH conditions are likely to deteriorate further due to increased pressure on already limited water and sanitation services. Consequently, some households may resort to unsafe open water sources, such as stagnant waters and rivers, thereby increasing the risk of waterborne diseases like diarrhoea.

Projection assumptions:

Food security situation: During the months of October 2025– January 2026, the overall food security situation is expected to improve in the settlements of Lobule, Kyaka II, Palabek, Palorinya, Adjumani, Rhino Camp, Rwamwanja, Kiryandongo and Kyangwali. This improvement is attributed to the expected second season harvest in the first half of the projection period and this will result into, improved food availability and access especially from own production and in local markets. The improvement in the food security dimensions is expected to last until beginning of February 2026 when it will deteriorate due to households run low on food reserves. On other hand, the food security situation is expected to deteriorate in Nakivale and Oruchinga because from October - January 2026 to is typically characterised manly by second season planting and weeding while harvesting is realised in Mid-January to March 2026.

However, the food security for refugees will remain stable in Kampala during the projection period compared to the current season of the analysis. Compared with rural areas, where food security fluctuates with agricultural seasons, Kampala, as urban setting, experiences relatively stable food security dimension of food availability throughout the year. Food is continuously supplied from different regions across Uganda (central, western, northern, and eastern) and imported when needed. Food access in Kampala is also market-dependent and relatively stable, supported by income from formal employment, petty trade, transport, and other informal sector activities. These sources provide consistent cash flow, enabling households to continuously purchase food.

Food consumption: As a result of the anticipated improvements in food security dimensions following the second season harvest in the settlements of Lobule, Kyaka II, Palabek, Palorinya, Adjumani, Rhino Camp, Kiryandongo and Kyangwali, the food consumption indicators including Minimum Meal Frequency (MMF), Minimum Dietary Diversity for Children (MDD-C) and Minimum Dietary Diversity for Women (MDD-W) are expected to improve across these refugee settlements. The refugee settlements in Nakivale and Oruchinga, where the projection period will be a lean season, will experience a deterioration of these indicators. In Kampala and Rwamwanja settlements, food consumption indicators are expected to remain the same in the projection period as in the current period. However, the Minimum Acceptable Diet (MAD) is expected to remain unchanged across all settlements during the projection period due to the need for medium to long-term social and behavioral change initiatives.

Diseases: The prevalence of malaria, diarrhoea, and other preventable diseases that negatively impact nutritional status is expected to decline during the projection period across all the refugee settlements except Nakivale and Oruchinga. This anticipated improvement is based on historical disease trends and is attributed to below-normal rainfall, which limits mosquito breeding sites, as well as improved access to safe water sources and a cleaner environment resulting from enhanced sanitation practices. In Nakivale and Oruchinga projection period is expected to have more rainfall that creates a suitable environment for malaria from mosquitoes and diarrhoeal diseases.

Health services: In all the settlements, outreach health services are expected to remain at levels similar to the current period, as no major improvements are planned. However, the anticipated low rainfall is likely to support access and mobility to remote communities. Coverage of Community Management of Acute Malnutrition (CMAM) in both refugee settlements is likely to remain unchanged, given the absence of planned efforts to scale up community engagement for IMAM. On a positive note, the upcoming Integrated Child Health Days (ICHDs) scheduled for October and possibly extending into November are expected to boost coverage of Vitamin A supplementation, deworming, and routine vaccinations. These interventions are likely to have a positive impact on reducing disease incidence, particularly for malaria and vaccine-preventable illnesses. However, there is a higher risk of a measles outbreak in Palabek settlement and Lamwo district, driven by new refugee arrivals from South Sudan. Overall the health services and health environment are expected to remain the same as in the current period of analysis.

Health equipment: Access to sanitation facilities will remain in a similar situation as in the current period of analysis due to anticipated low rains. However, access to improved source of drinking water is expected to improve due to reduced contamination that is usually associated with low rain levels. On other hand, access to sufficient quantity of water is expected to remain the same across all settlements except Kyaka II where expansion of water distribution is planned.

Child Care practices: Overall child care practices will improve. In the refugee settlements of Lobule, Kyaka II, Palabek, Palorinya, Adjumani, Rhino Camp, Rwamwanja, Kiryandongo and Kyangwali, Infant and Young Child Feeding (IYCF) practices that include including exclusive breastfeeding, continued breastfeeding at 12-23 months and the timely introduction of solid, semi-solid, or soft foods are expected to remain largely unchanged during the first two months of the projection period, as caregivers will be engaged in the second-season harvest and spending most of their time in the field. However, in the latter larger part of the projection period, caregivers are anticipated to spend more time at home, which is expected to lead to improvements in IYCF practices such as exclusive breastfeeding, timely introduction of complementary foods and prompt health-seeking behaviours. Care practices are expected to reduce in Nakivale and Oruching since caretakers especially mothers will be away in crop planting and weeding. No changes are expected in Kampala from current period of analysis.

Humanitarian assistance: Refugees' dependence on General Food Assistance (GFA), particularly cash assistance from WFP and UNHCR—both through routine distributions and the one-off safety net program—is expected to continue throughout the projection period. Food rations are provided in 3 categories of 40 percent for refugees in Category 1 and 22 percent for refugees in Category 2. However, this has been revised downwards where only new arrivals receive 60 percent for a limited duration. Overall, funding cuts for nutrition programs observed in the current period are expected to continue into the projection period.

Others: Prevalence of anaemia is expected to register a slight reduction in settlements that will experience improvements in food availability, access and consumption and reduced incidences of malaria. However, it will remain elevated and continue to pose a significant public health concern across all settlements.

Humanitarian support and response

Of the USD 968 million required for the Uganda Country Refugee Response Plan, only 12 percent had been funded by the end of Q1 2025. This reflects significant global cuts in humanitarian funding and follows a trend of gradual reductions over the past five years.

In May 2025, the United Nations World Food Programme (WFP) began implementing new vulnerability-based food rations across all refugee settlements. This targeting approach, developed jointly by OPM, WFP, and UNHCR, prioritises food assistance to the most vulnerable, in line with dwindling resources. Refugees are grouped into four categories: Category 1: 40 percent food ration; Category 2: 22 percent food ration; Category 3: no food assistance; New arrivals: 60 percent food ration (for limited duration).

These are the most significant cuts to date, having removed more than 1 million refugees (63 percent) from food assistance, with some location-specific variations. The current food assistance structure is expected to remain unchanged unless new resources are secured. Even under current plans, available resources can only sustain assistance to 27 percent of refugees through December 2025, which is only halfway through the IPC projection period. Furthermore, Uganda has already received more refugees than initially projected for 2025. In the event of a major influx, further prioritization will be undertaken to address the most urgent needs. Given the already reduced rations WFP is providing, additional ration cuts are unlikely; instead, prioritization will focus on the most vulnerable categories for assistance.

Due to underfunding, key nutrition programmes have been scaled down or discontinued. WFP closed the Targeted Supplementary Feeding Programme (TSFP), a component of the Integrated Management of Acute Malnutrition (IMAM) for treating moderate acute malnutrition (MAM), in Oruchinga, Nakivale, Rwamwanja, Kyaka II, Bidibidi, Lobule, and Imvepi. During the same period, the Maternal Child Health and Nutrition (MCHN) programme, targeting stunting and improving access to maternal and child health services, was closed across all 13 refugee settlements. Coverage of key community health and nutrition interventions, particularly those supporting optimal maternal, infant, and young child feeding, has significantly declined. The reduction in funding has also led to a drop in human resources for health (HRH), including nutritionists, nurses, and health assistants. Despite the challenges, UNHCR and UNICEF continue to support MoH and the DLGs to sustain inpatient therapeutic care (ITC) and outpatient therapeutic care (OTC) for the treatment of severe acute malnutrition (SAM) across all 13 refugee settlements and Kampala.

Child Stunting and Child Anaemia have been observed to increase in 2025 across refugee hosting locations. Food insecurity, limited livelihood opportunities, and barriers to healthcare access continue to exacerbate the situation.

Multisectoral efforts will continue throughout the projection period to create an enabling environment for improved nutrition outcomes. These include hygiene promotion, expansion of household latrines and clean water, Integrated Community Case Management (ICCM), Child Health Days, Primary Health Care, food security and livelihoods interventions, and community health services. UNHCR, WFP, UNICEF, implementing partners, and other actors remain committed to supporting the Ministry of Health in strengthening the national nutrition commodity pipeline through forecasting, procurement, logistics, prepositioning, and distribution to sustain IMAM services.

During the analysis and projection period of the IPC analysis on refugees, the humanitarian and development funding for the Uganda refugee response is not expected to improve. An influx of asylum seekers fleeing conflict may place additional strain on already stretched resources, prompting further reprioritisation to support the most vulnerable. While there has been a strong focus on transitioning towards development-oriented livelihood interventions, this shift has not been fast enough to compensate for the increasing decline in humanitarian funding. Government and partners continue to advocate for increased humanitarian and development resources to support the Uganda Refugee Response.

LINKAGES BETWEEN ACUTE FOOD INSECURITY AND ACUTE MALNUTRITION

Out of the 14 analysed settlements, four areas (Kyaka II, Kyangwali, Nakivale and Rwamwanja) showed a two-phased divergence in the current classifications, with acute malnutrition (AMN) being classified at a lower phase than acute food insecurity (AFI) in each of these areas. Three areas (Adjumani, Bidibidi and Palorinya) presented phase 3 and above for both scales (AFI and AMN). Divergence is defined as a difference of at least 2 or more phases between AFI and AMN classifications. The low levels of acute malnutrition in these areas were attributed to significant food assistance to refugees, low disease burden, high functionality of health facilities, optimal childcare practices, coping strategies that prioritize children, and access to sanitation and safe drinking water.

Refugee settlements	AMN Classification				AFI Classification		Divergence	
	Current	Evidence Level	Projection	Likely Change	Current	Projection	Current	Projection
Kyaka II	1	***	1	→	3	3	-2	-2
Kyangwali	1	***	1	↑	3	3	-2	-2
Nakivale	1	***	1	↓	3	3	-2	-2
Rwamwanja	1	***	1	→	3	3	-2	-2

Kyaka II (Low acute malnutrition and high acute food insecurity) - Divergence

Acute malnutrition in Kyaka II consistently remained in phase 1 (acceptable) over the past 4 years. In 2025 GAM rate was reported at 1.1 percent retaining AMN phase 1 (acceptable) while AFI was in phase 3 (crisis). The low acute malnutrition has been attributed to:

- **Improved disease prevalence** where, there is marked reduction in Diarrhoea prevalence from 20.4 percent in 2024 to 15 percent in 2025 while upper respiratory tract infections (URTI) has always remained low below 5 percent with significant reduction in measles cases. The elevated malaria prevalence of 26 percent in 2025, up from 14.2 percent in the same season of 2024, has been effectively managed through the high functionality of health facilities in the settlements and strong health-seeking behavior. This has enabled timely treatment of childhood diseases, thereby reducing the impact on acute malnutrition. High immunization, vitamin A and deworming coverage is observed at above 90 percent that cushion the children against infection and disease severity and preventing acute malnutrition. Health facilities in the settlement have maintained 100 percent service availability and historically high coverage for Integrated Management of Acute Malnutrition (IMAM) services (>80 percent). This robust service provision serves as a critical safety net for managing malnutrition in the settlement. Above 80 percent of the households in Kyaka settlement have access to sufficient water, safer sources of drinking water and sanitation facilities. The favourable wash conditions further reduce the risk of infection, disease and acute malnutrition.
- **Strong childcare practices** with continued breast feeding above 80 percent not only increase child immunity but also supplement essential nutrients in the diet of the child preventing acute malnutrition. The majority of children (>80 percent) had timely introduction to solid and semi-solid foods thus high chances of meeting the daily caloric needs and reducing the risk to acute malnutrition. Despite the food gaps observed with the crisis level of acute food insecurity (AFI phase 3) the in the settlement about one third of the households prioritised children to eat over the adults at least 3 times in a week that cushions the children from hunger and acute malnutrition coupled with high coverage in the supplementary feeding program (SFP) at 88 percent in 2024.

Kyangwali (Low acute malnutrition and high acute food insecurity) - Divergence

Acute malnutrition in Kyangwali consistently remained in phase 1 (acceptable) over the past 4 years. In 2025 GAM rate was reported at 2.6 percent retaining AMN phase 1 (acceptable) while AFI was in phase 3 (crisis). The low acute malnutrition has been attributed to:

- **The disease burden** would have moderate risk to acute malnutrition with marked reduction in Diarrhoea prevalence progressively over the last 4 years, from 30.2 percent in 2022 to 16.3 percent in 2025. Malaria prevalence was at 18.5 percent that is a marginal increase from 15.1 percent reported in similar period in 2024. Measles outbreak has not been an issue with only 3 cases were reported in 2025. Optimum functionality of health systems with 100 percent service availability, ensures timely treatment of diseases and maximizes immunization coverage to prevent outbreaks. This includes 97.3 percent measles vaccination coverage, 91.6 percent Vitamin A supplementation, and 87.3 percent polio vaccination coverage, all of which contribute to reducing the risk of acute malnutrition. Access to safe drinking water has been poor over years, however significantly improved from 38 percent in 2022 to 82.3 percent in 2025 further reducing the risk to water borne diseases such as diarrhoea among children.
- Despite acute food security classification in Phase 3 (crisis), the children are cushioned with strong care practices where over 80 percent are timely introduced to solid and semi-solid foods increasing caloric intake. However, the diversity is still sub-optimal reducing consumption of nutritious foods that is partially met by the high (>70 percent) continued breastfeeding among children less than 2 years. Despite reduction in food assistance coverage form 90 percent in 2024 to 58 percent in 2025, there are strong coping strategies that favour chid consumption over adults and nutrition specific interventions at the health facilities targeting children with 88 percent IMAM coverage. These cushion the children reducing the risk to acute malnutrition.

Nakivale Settlement (Low acute malnutrition and high acute food insecurity) - Divergence

Acute malnutrition in Nakivale consistently remained in phase 1 (acceptable) over the past 4 years. In 2025 GAM rate was reported at 1.8 percent retaining AMN phase 1 (acceptable) while AFI was in phase 3 (crisis). The low acute malnutrition has been attributed to: :

- **Low disease burden** has been reported in Nakivale since 2024. In 2025, Malaria was at 5.0 percent, diarrhoea at 10.9 percent and URTI at 8.2 percent indicating lower risk to acute malnutrition from disease prevalence. Cases of measles were reported where the 123 cases were linked to the new arrivals to the settlement. Optimal health functionality is portrayed in the high coverage of measles, polio, Vitamin A supplementation, and basic vaccines all exceeding 95 percent in 2025 and previous years. This reflects strong community uptake, effective outreach, and sustained programme performance that cushion the children both from infection and severity of disease, reducing the risk to acute malnutrition. The strong health performance additionally neutralizes the effect of poor access to safe drinking water by about 50 percent of the households in Nakivale settlement.
- **Strong childcare practices** such as continued breastfeeding and timely introduction to solid and semi solid foods at above 90 percent not only supply additional nutrients and calories but also cushion the children against the possible food gaps in households in AFI phase 3 and above. High SFP coverage of 78 percent was reported in 2024. About 50 percent of the children meet the minimum meal frequency per day, however, diversity remains low at 16 percent indicating overconsumption of starchy staples that only meet daily caloric intake leaving gaps on diverse nutritious foods necessary for optimal growth. The food gaps are further cushioned by prioritization of children over adults when there is limited food at the household (34.5 percent) at least 3 times in a week reducing the risk to acute malnutrition.

Rwamwanja settlement (Low acute malnutrition and high acute food insecurity)- Divergence

Acute malnutrition in Rwamwanja, consistently remained in phase 1 (acceptable) over the past 4 years like all other settlements with divergence. In 2025 GAM rate was reported at 0.8 percent retaining AMN phase 1 (acceptable) while AFI was in phase 3 (crisis). The low acute malnutrition has been attributed to:

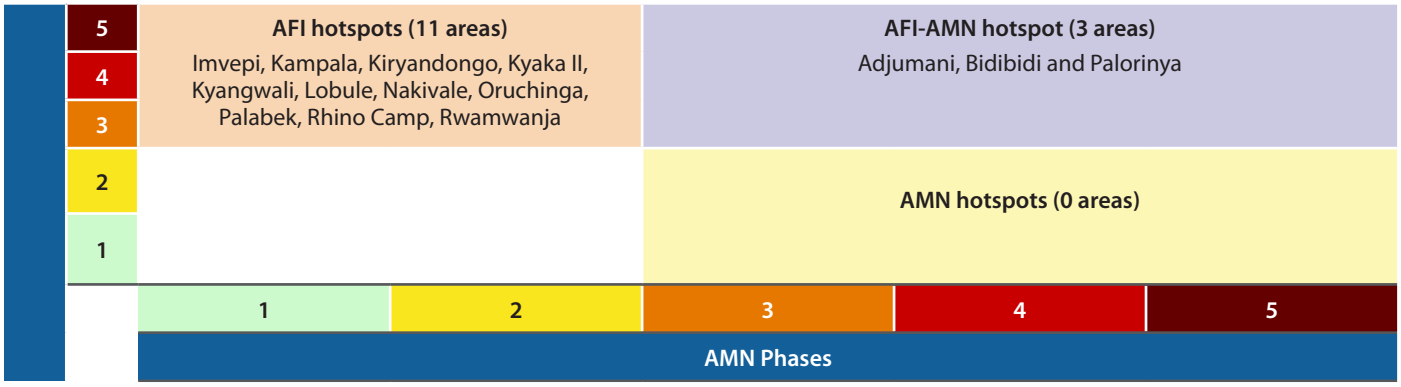
- **Low disease burden** versus the strong health functionality within the settlement. The disease prevalence was reported at 12 percent malaria, 7.4 percent Diarrhoea and 1.1 percent URTI, besides 5 cases of measles. The high functionality of the health facilities increase access to treatment of sick children while effectively managing the measles outbreak reducing the level of risk to acute malnutrition. High immunization and vitamin A supplementation coverage has been registered with measles at 98.6 percent, polio at 94.1 percent and vitamin A supplementation at 98.5 percent while

overall immunization for basic vaccinations was at 92.6 percent that further cushion the children from diseases reducing the risk to acute malnutrition. Low disease burden is further supported with the high access to safe drinking water and sanitation facilities at 94 percent and 86.4 percent respectively reducing vulnerability to water borne disease.

- Despite the food gaps portrayed by AFI phase 3 (crisis) in Rwamwanja refugee settlement, the impact is negated by high coverage for food assistance (72 percent), strong childcare practices that entail high continued breast feeding and timely introduction to solid and semisolid foods at 80.4 percent and 82.6 percent respectively. These in conjunction with favouring children over adults to eat at times of scarcity cushion the children against acute malnutrition. However, low variety of foods depicted by the low dietary diversity at 24 percent still put the children at risk to optimal growth and development.

Hot spots

The hot spots are those analysis areas that are classified in phase 3 and above for both acute food insecurity and acute malnutrition. There was no analysis area that was only hot spots for acute malnutrition while 11 areas were hot spots for acute food insecurity while 3 areas were hot spots for both acute malnutrition and acute food insecurity during the 2025 analysis for the refugees' settlements.



RECOMMENDATIONS FOR ACTION FOR ACUTE FOOD INSECURITY

Response Priorities

- **Strategic Planning for Projected Food Needs:** While some short-term improvements in food security are anticipated across all settlements, this will only be possible during the early months of the projection period, with the situation expected to deteriorate towards the end of the projection period. It is essential to develop robust contingency plans that ensure timely and adequate food support to vulnerable households who will be most affected during the expected downturn.
- **Humanitarian assistance:** There is an urgent need to provide food and livelihood assistance to populations classified under IPC Phase 3 and above. (Crisis to emergency). This intervention is critical to saving lives and protecting livelihoods in areas facing acute food insecurity.
- **Strengthen agricultural extension services:** Enhancing the delivery of agricultural extension services is vital. Farmers must be provided with timely early warning information, along with training in climate-smart agricultural practices. In addition, capacity building on post-harvest management is necessary to minimize losses and improve food storage outcomes.
- **Promote peacebuilding efforts:** Efforts should be made to facilitate peace agreements between host communities and refugees. This initiative aims to reduce ongoing conflicts over land and other essential resources, fostering harmony and more equitable resource sharing.
- **Support for dry season farming (December 2025 - February 2026):** To promote food availability during the dry season, farmers should be equipped with relevant skills and technologies, particularly in water harvesting and irrigation techniques. This support will enable them to engage in productive agricultural activities during the off-season, ensuring better resilience and food production.
- **Enhance social protection systems:** Reinforcing social protection systems is crucial to addressing the nutritional and food security needs of vulnerable populations. Targeted support through these systems will help cushion at risk groups from shocks and enhance overall resilience.
- **Strengthen pest and disease control mechanisms:** Given the anticipated rise in incidences of crop and livestock pests and diseases, it is important to strengthen management and control systems. Doing so will ensure better preparedness and enhance the capacity for rapid response to outbreaks, thereby protecting both food production and livelihoods.

Situation Monitoring and Update

Organize and conduct a Response Analysis with authorities managing refugee settlements to come up with more area/district-specific interventions to guide the designing of appropriate interventions to reduce food and nutrition insecurity.

Risk factors to monitor

- **Food Prices:** Food prices are expected to decline due to first season harvest which has started and expected favourable second season harvests for the September to November season. However, risks remain due to limited access to land and the cost of labour, together with the rising demand from a growing refugee population, which could strain supply. Market dependant households are particularly vulnerable to price fluctuations. Recent spikes in maize and sorghum prices highlight the potential for sudden increases if harvests fall short.
- **Flooding/waterlogging:** Given the forecast and based on historical trends, the normal to above normal rainfall expected for the upcoming season, monitoring flooding and waterlogging is essential, as increased rainfall heightens the risk of soil erosion, delayed planting or harvesting, and potential crop damage. These could lead to reduced agricultural productivity and food insecurity.
- **Household income/Debt Sources:** Households often resort to borrowing during times of crisis, but overreliance on

debt, especially from informal lenders, can lead to long-term vulnerability and asset depletion. Monitoring debt levels/sources of borrowing can provide insight into household coping capacity. Due to limited livelihood opportunities, households may resort to negative coping mechanisms such as theft, prostitution, charcoal burning, early child marriages, and child labour, which have long-term negative impacts on the well-being.

- **Refugee Influx:** A sudden increase in refugee population increases pressure on local resources, services, and livelihoods that rely heavily on humanitarian assistance, placing additional strain on host communities. While improved harvests may enhance food availability, a significant rise in refugee numbers can drive up demand for food, potentially offsetting the benefits of increased production and lower market prices. The increasing severe cuts in food assistance and continued removal of refugees from assistance under a new vulnerability-based targeting model, and current resources expected to last only through December 2025. This will result to widespread food insecurity. While multisectoral partners continue to promote resilience through livelihoods interventions, the humanitarian situation is expected to deteriorate further. Inter-communal violence within the settlements suggests further tensions are likely to arise, posing potential risks to community stability/livelihood.
- **Livestock Diseases and Vectors:** Livestock diseases and particularly Foot and Mouth Disease (FMD) in some districts like Kyegegwa, pose a serious threat to pastoral and agro-pastoral communities by reducing livestock productivity and undermining household income. Although government has put great effort to combat FMD through vaccinations, isolated FMD outbreaks often lead to government-imposed quarantines that restrict livestock movement, trade, and market access which affects livelihoods and local economies especially for households that depend on livestock sales. Management efforts lead to increase the cost of production in terms of expenditure on veterinary care and preventive measures which will raise the overall cost of livestock production.
- **Reduction in humanitarian assistance:** The reduction in humanitarian assistance, particularly food assistance from WFP and other partners, is critically affecting vulnerable refugee households, many of whom have minimal income opportunities. Continuous cutting of food rations will impact the population.
- **Dry spells:** Expected prolonged dry spell especially in Nakivale and Oruchinga settlements during the SOND period likely driven by climate change, is anticipated to negatively affect both crop and livestock productivity/yields in these settlements hence affecting household food security.

RECOMMENDATIONS FOR ACTION FOR ACUTE MALNUTRITION

Response Priorities

- 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.
- Scale up disease and Nutrition surveillance.
- 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.
- Monitor supply of nutrition supplies.
- Advocate for improved financing for refugee response.

Risk factors to monitor

- 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.
- Monitor supply chain of essential medicines and supplies
- Impact of reduction in humanitarian support especially food rations

PROCESS AND METHODOLOGY

An IPC analysis workshop was held from 28th July – 1st August, 2025. Due to resource limitations, no refresher training was conducted for the analyst prior to the analysis. For the first time in Uganda refugee analysis, IPC acute food insecurity analysis was conducted for the settlements and the newly developed Analysis Platform (AP) was used as opposed to the Information Support System (ISS) which had been used for the host communities to document the analysis. The approach draws together all available food security and nutrition information from reliable data sources. Classification is subsequently determined through convergence of evidence of current 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, UNHCR, WFP, UNICEF, FAO, and FEWSNET.

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 Malnutrition 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).

Contact for further Information

Alex Bambona
Ass. Commissioner, MAAIF
alexbambona@gmail.com

IPC Global Support Unit
www.ipcinfo.org

This analysis has been conducted under the patronage of the Food Security Information Systems in conjunction with the Food Security Technical Secretariat. It has benefited from the technical and financial support of the European Union.

Classification of food insecurity was conducted using the IPC protocols, which are developed and implemented worldwide by the IPC Global Partnership - Action Against Hunger, CARE, Catholic Relief Services (CRS), CILSS, EC-JRC, FAO, FEWSNET, Global Food Security Cluster, Global Nutrition Cluster, IFPRI, IGAD, IMPACT, Oxfam, SICA, SADC, Save the Children, UNDP, UNICEF, the World Bank, WFP and WHO.

IPC Analysis Partners:

Evidence on key outcome indicators was drawn from Food Security and Nutrition Assessment (FSNA) conducted by WFP, UNICEF and UNHCR in the 13 refugee settlements of Uganda plus Kampala, while various reports were used for evidence on contributing factors. The FSNA was conducted using the Standardized Expanded Nutrition Survey (SENS) guidelines and the SMART methodology; with a two-stage cluster sampling design. Training and data collection took place between June and July 2025. According to evidence drawn from the FSNA, the Evidence level for this analysis is High (E3).

Sources of information

1. WFP, UNICEF and UNHCR (2025) - Refugee and Refugee Host FSNA 2025
2. DLGs (2025), District food security update reports
3. MSNA (2025), Food security assessment
4. UNMA (2025) - Weather performance and forecast for MAM, JJA and SOND
5. UBOS (2024), National population census, 2024

Limitations of the analysis

- The number of days allocated for the analysis was so few (five days) as opposed to the recommended eight days hence affecting completion as linkages were not done during the analysis period.
- There was limited information on food availability across the settlements and this limited conclusion on food availability for the settlements.
- Data on Household Hunger Score (HHS) was not collected during FSNA
- The FSNA survey included robust information for the analysis but was the only source of data for outcome indicators, which limited triangulation of evidence.
- No refresher training was conducted for the analyst due to limited resources and this greatly affected the analysis as some analysts were attending for the first time.
- Some critical indicators such as levels of household food stocks were not collected during the FSNA.

ANNEX 1: SUMMARY OF FACTORS CONTRIBUTING TO ACUTE MALNUTRITION

Dimension	Indicator	South West settelements					West Nile settlements								Kampala
		Kyaka II	Kyangwali	Nakivale	Oruchinga	Rwamwanja	Adjumani	Bidibidi	Imvepi	Kiryandongo	Lobule	Palabek	Palorinya	Rhino Camp	
		Categories/Risk Contributing Factors													
Food consumption	Minimum Dietary Diversity (MDD)	High	High	High	Very High	Medium	Very High	High	High	Very High	High	Very High	High	Medium	High
	Minimum Meal Frequency (MMF)	Low	Medium	Low	Low	Low	Low	Low	Low	Medium	Low	Low	Low	Very Low	Low
	Minimum Acceptable Diet (MAD)	Very High	Very High	High	Very High	High	Very High	High	High	Very High	High	Very High	Very High	Medium	High
	Minimum Dietary Diversity – Women (MDD-W)	High	Medium	Very High	Very High	Medium	Very High	High	High	Very High	High	Very High	High	Medium	Medium
Diseases	Diarrhoea	High	High	Medium	High	Low	Medium	Low	Medium	Medium	Medium	High	Medium	Very Low	Medium
	Dysentery	No data	No data	Medium	No data	No data	Very Low	Very Low	Low	Very Low	Very High	No data	No data	Very Low	No data
	Fever	High	High	Low	High	Medium	High	Medium	Low	High	High	High	Medium	Medium	No data
	Malaria	High	High	Low	Low	Medium	Medium	Low	Low	High	Medium	High	Low	Low	Low
	Acute Respiratory Infection (ARI)	Low	Very Low	Low	Low	Very Low	Very Low	Very Low	Low	Very Low	Very Low	Very Low	Very Low	Very High	Very Low
	HIV/AIDS	No data	No data	Very Low	No data	No data	Very Low	Very Low	No data	Very Low	No data	No data	Very Low	Low	No data
	Cholera	Very Low	No data	No data	No data	No data	Low	No data	Very Low	Medium	No data	Very Low	No data	No data	Low
	Acute Watery Diarrhoea (AWD)	High	No data	High	Very Low	No data	No data	Very Low	No data	No data	No data	No data	No data	Medium	No data
	Measles	Low	High	Very High	Very High	Very High	Medium	Very Low	Very Low	Medium	Very Low	Very Low	No data	Very High	Medium
Food dimensions	Outcome of the IPC analysis	Medium	Medium	Medium	Medium	Medium	Medium	Medium	Medium	Medium	Medium	Medium	Medium	Medium	Medium
Caring and feeding practices	Exclusive breastfeeding under 6 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	Very Low	Very Low
	Continued breastfeeding at12-23 months	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	Very Low
	Introduction of solid, semi-solid or soft foods	Very Low	Very Low	Very Low	Very Low	Very Low	Low	Very Low	Very Low	Very Low	Very Low	Low	Very Low	Very Low	No data
	Restricted consumption by adults in order for small children to eat	Low	Low	Low	Low	Low	Low	Medium	Low	Low	Low	Low	Low	No data	Medium
Health services and health environment	Routine Measles vaccination coverage	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	High	Very Low	Low	Very Low	Low	Very Low	Very Low	Very High
	Routine Polio vaccination coverage	Low	Low	Very Low	Low	Very Low	Very Low	Low	Low	Low	Low	Medium	Very Low	Very Low	Medium
	Routine vitamin A supplementation coverage	Very Low	Very Low	Very Low	Very Low	Very Low	Very Low	Medium	Medium	Very High	No data	No data	No data	Low	Medium
	Vitamin A supplementation coverage from surveys	Very Low	No data	No data	No data	Very Low	Very Low	Very Low	Very Low	No data	Very Low	Very Low	No data	Very Low	No data
	Skilled birth attendance	Very Low	Very Low	No data	Very Low	Very Low	Very Low	Very Low	No data	Very Low	No data	Low	No data	Very Low	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	Low	No data
	Coverage of outreach programmes – CMAM programme coverage (SAM)	Low	Low	No data	No data	No data	Low	No data	No data	Low	No data	High	Low	No data	No data
	Coverage of outreach programmes – CMAM programme coverage (MAM)	Low	No data	No data	No data	No data	Low	No data	No data	Low	No data	High	Very Low	No data	No data
	Mean per capita water consumption	Low	Low	Medium	Low	Medium	Low	Low	Low	Low	Low	Very Low	Very Low	Low	Low
	Access to a sufficient quantity of water	High	High	Very High	Very High	Low	High	Low	High	High	High	High	Medium	High	Medium
	Access to Improved sanitation facilities	Very Low	Low	Low	Very Low	Very Low	Low	Very Low	Low	Low	Low	Low	Low	Low	Very Low
	Access to an improved source of drinking water	Very Low	Low	Low	Very Low	Very Low	Low	Very Low	Very Low	Medium	Very Low	Low	Low	Very Low	Very Low
	Refugee Influx	No data	Very Low	Very High	No data	No data	No data	No data	Low	Medium	No data	Medium	No data	No data	Medium
	Abrupt closure of programs	Medium	Medium	Medium	Medium	No data	Medium	Medium	Medium	Medium	Medium	Medium	Medium	Medium	No data
Basic Causes	Human capital	No data	Very Low	No data	No data	No data	No data	No data	No data	No data	No data	Very Low	No data	Very Low	No data
	Physical capital	No data	No data	Medium	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	Medium	No data	No data	No data	No data	No data	No data	No data	Medium	High	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	Low	No data	Very Low	No data
	Social capital	No data	Medium	Medium	No data	No data	No data	No data	No data	No data	High	High	Very Low	Very Low	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
Other issues	Anaemia among children 6-59 months	High	Very High	Medium	Medium	Very High	Very High	Medium	Medium	High	Medium	Very High	Medium	Medium	Medium
	Anaemia among pregnant women	Low	Very High	Medium	Low	Very High	Medium	High	High	Medium	High	Very High	Medium	Medium	Medium
	Anaemia among non-pregnant women	Medium	Very High	Medium	No data	Very High	Medium	High	Medium	Medium	Medium	Very High	Medium	Medium	Medium
	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	Very Low	Low	No data	Low	Low	Very Low	No data	Very Low	Very Low	No data	No data	No data	Low	Low
	Fertility rate	No data	No data	No data	Very Low	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