UGANDA

PARTIAL IPC ACUTE MALNUTRITION ANALYSIS IN REFUGEE SETTLEMENTS AND HOST DISTRICTS

IPC ACUTE MALNUTRITION ANALYSIS
FEBRUARY 2022 – JANUARY 2023

Published on November 24, 2022

KEY FIGURES	FEBRUARY 2022 - JANUARY 2023	
104,442 cases of children aged 6-59 months acutely malnourished IN NEED OF TREATMENT	Severe Acute Malnutrition (SAM)	**16,544**
	Moderate Acute Malnutrition (MAM)	**87,898**
12,847 cases of pregnant or lactating women acutely malnourished IN NEED OF TREATMENT		

Overview

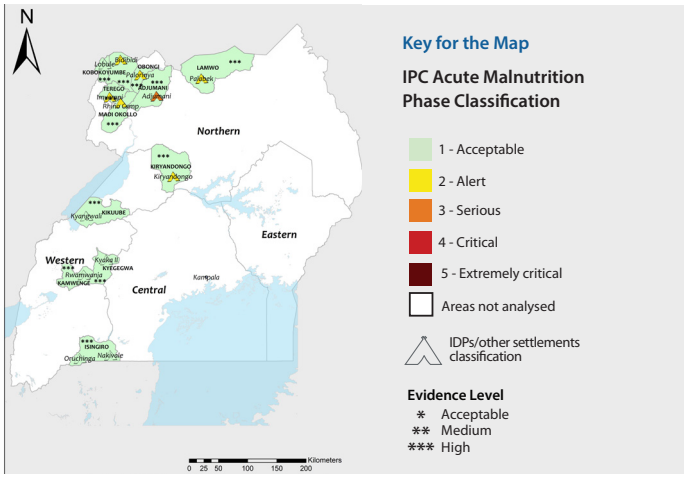
How Severe, How Many and When: This report describes the acute malnutrition situation of the refugee settlements and the host districts of Uganda included in the IPC Acute Malnutrition (IPC AMN) analysis. Over a hundred thousand cases of children aged 6-59 months, and twelve thousand cases of pregnant and lactating women are expected to suffer from acute malnutrition between February 2022 and January 2023. Of the thirteen refugee settlements (excluding Kampala urban settlement), one settlement was classified in a Serious situation (IPC AMN Phase 3), six in an Alert situation (IPC AMN Phase 2) and another six in an Acceptable situation (IPC AMN Phase 1) during the period of February – July 2022. In the projection period of August 2022 - January 2023, the AMN situation will likely improve in one settlement, while in the rest it is expected to remain the same.

As for the twelve host districts (excluding Kampala), the AMN situation was Acceptable (IPC AMN Phase 1) in all of them during the period of February to July 2022 and likely to remain the same during the projected period.

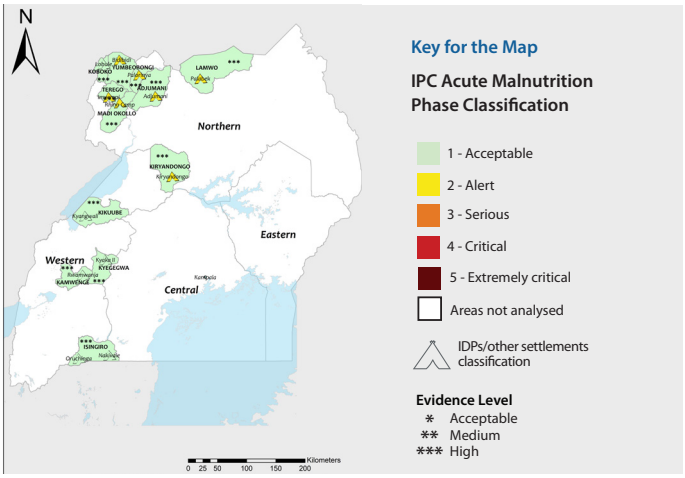
Where: For the period of February to July 2022, Adjumani refugee settlement was classified in a Serious situation (IPC AMN Phase 3), whereas Bidibidi, Imvepi, Palabek, Palorinya, Rhino Camp and Kiryandongo were classified in an Alert situation (IPC Phase 2) and the remaining settlements were classified in Acceptable situation (IPC AMN Phase 1). During the projection period, Adjumani is the only settlement where the situation is likely to improve. As for the host districts, all of them included in the analysis (Adjumani, Isingiro, Kamwenge, Kikuube, Kiryandongo, Koboko, Kyegegwa, Lamwo, Madi Okollo, Obongi, Terego and Yumbe) were classified in an Acceptable situation.

Why: The major factors contributing to acute malnutrition in the refugee settlements are inadequate food consumption, both in terms of quality and quantity; high malaria and Acute Respiratory Infection incidences and prevalence; inadequate Maternal, Infant, Young Child and Adolescent Nutrition (MIYCAN) practices / interventions; inadequate water access and the generally high levels of anaemia among children and pregnant mothers.

Acute Malnutrition | February - July 2022



Projected Acute Malnutrition | August 2022 - January 2023



Key Drivers

Poor Food Consumption
with only 8.5% of the children in refugee settlements able to attain a Minimum Acceptable Diet.

Disease
High disease burden, especially malaria and acute respiratory infections.

Inadequate childcare
Inadequate childcare and MIYCAN practices; with only about 60% of infants in refugee settlements exclusively breastfed. Continued breastfeeding at 2 years declines significantly in some settlements and host districts.

Acute Food Insecurity
High food insecurity among the population in the settlements (54%) and that in the host districts (21%).

Low CMAM
coverage in some settlements.

Anaemia
among children aged 6-59 months is of major public health concern in the refugee settlements (45%) as well as in the host communities (50%). Anaemia among pregnant women is also generally high and of public concern.

CURRENT SITUATION OVERVIEW AND CONTRIBUTING FACTORS (FEBRUARY – JULY 2022)

Situation Overview

Uganda hosts over 1.5 million refugees and asylum seekers, of whom 1.41 million are in the 13 rural-based refugee settlements, while the other 0.1 million are in Kampala. The rural based refugee settlements are Bidibidi, Adjumani, Palorinya, Nakivale, Kyaka II, Rhino Camp, Lobule, Oruchinga, Palabek, Kyangwali, Kiryandongo, Rwamwanja and Imvepi. Of all these settlements, Adjumani settlement is the largest, hosting 237,787 refugees, followed by Bidibidi, that hosts 227,996 refugees, while Lobule is the smallest, hosting 5,823 refugees. The unending civil conflicts in South Sudan, the Democratic Republic of Congo, Sudan, Burundi, Somalia and Ethiopia have been the main reason for citizens from those countries seeking asylum and to be hosted as refugees in Uganda. About 100 refugees of Kenyan origin are hosted in Kiryandongo settlement. The refugee policy in Uganda grants refugees the right to work, free access to primary health care, free access to education, among other privileges. General Food Assistance (GFA), both cash and in-kind, remains the main source of food and other livelihoods for refugees in rural settlements. Urban refugees in Kampala are in most cases deemed to be self-reliant, and not considered for regular programmed cash-based and in-kind assistance. Refugees in rural settlements also grow their own food, although this is increasingly affected by their limited access to agricultural land. Some refugees are engaged in provision of labour as a source of income to buy food and other essential non-food items. Kampala urban refugees were not included in this analysis.

GFA, in form of cash and in-kind, is provided by the United Nations World Food Programme (WFP), while the Office of the United Nations High Commissioner for Refugees (UNHCR) and other partners provide cash for non-GFA food schemes, like fresh food vouchers and vegetable growing, and for non-food items within the refugee response. Currently, the GFA contribution modality is 57% cash and 43% in-kind and the cash assistance provided to refugees by WFP is based on the Minimum Expenditure Basket (MEB). However, the current increase in market prices of the items included in the GFA commodity basket have eroded the effective purchasing power of the refugees, forcing them to only purchase a fraction of the MEB. This reduction in the ability to access food poses a risk of worsening the food security and nutrition situation among the refugees.

The refugees in Uganda are hosted in 13 districts i.e., Adjumani, Isingiro, Kampala, Kamwenge, Kikuube, Kiryandongo, Koboko, Kyegegwa, Lamwo, Madi Okollo, Obongi, Terego and Yumbe. Of these, only Isingiro hosts 2 settlements while the rest host 1 settlement each. Whereas refugees in the other districts are hosted in gazetted settlements, those in Kampala have spread across the refugee hotspots in the city that include Kabalagala, Kansanga, Kisenyi and Mengo. In Koboko district, the refugees have integrated into the host community and often share the same services without exclusion. Kampala host community has not been included in this analysis.

According to the IPC Acute Malnutrition scale, during the period of February to July 2022, Adjumani settlement was classified in a Serious situation (IPC AMN Phase 3), with a GAM rate of 10.5%. Bidibidi, Imvepi, Palorinya, Rhino Camp, Palabek and Kiryandongo settlements were classified in an Alert situation (IPC AMN Phase 2), with GAM prevalences of 6.5%, 5.5%, 6.8%, 6.8%, 6.3% and 9.7% respectively. All the other remaining 6 settlements, namely Lobule, Kyaka II, Kyangwali, Nakivale, Oruchinga and Rwamwanja, were classified in an Acceptable situation (IPC AMN Phase 1), with GAM prevalences of 3.2%, 0.7%, 1.4%, 2.0%, 0.6% and 1.8% respectively. Compared to same period of analysis last year, the acute malnutrition situation improved in Palabek and Kiryandongo settlements from a Serious situation to an Alert situation, and in Lobule settlement from an Alert to an Acceptable situation, whereas it remained the same in all the other settlements. It is estimated that 36,590 cases of children aged 6-59 months across all refugee settlements are expected to suffer from acute malnutrition and in need of treatment, of whom 28,000 are moderate acute malnutrition cases and 8,590 are severe acute malnutrition cases for the period of February 2022 to January 2023. Compared to the other settlements, Adjumani settlement has the highest number of cases of acutely malnourished children in need of treatment (10,527), of whom 8,850 are affected by moderate acute malnutrition and 1,677 are affected by severe acute malnutrition. Additionally, 4,186 pregnant and lactating women (PLW) among the refugee population are affected by acute malnutrition and in need of treatment, with the largest number found in Kyangwali settlement.

As for the refugee hosting districts included in the analysis, they were all classified in an Acceptable situation (IPC AMN Phase 1). Madi Okollo district with a GAM rate of 4.4% had the highest prevalence while Kyegegwa district had the lowest prevalence at 0.3%. With the exception of Koboko (0.8%) and Obongi (0.5%), all the other districts had a SAM rate of 0%, based on the weight-for-height Z-score (WHZ). Although all were classified in an Acceptable situation, it is estimated that 67,852 children across the 12 hosting districts are expected to suffer from acute malnutrition and in need of treatment, of whom 59,898 are moderate acute malnutrition cases and 7,954 are severe acute malnutrition cases between February 2022 to January 2023. Yumbe district has the highest number

of cases of moderate acute malnutrition (10,052), while Isingiro district has the highest number of cases of severe acute malnutrition (1,625). It is further estimated that 8,661 PLW among the host population are expected to suffer from acute malnutrition and in need of treatment, with the largest number found in Kiryandongo district.

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

Immediate factors

There are generally **poor food consumption** levels among children aged 6-23 months, with the Minimum Acceptable Diet (MAD) as low as 8.5% across the refugee settlements, based on results from the recent Food Security and Nutrition Assessment (FSNA). The highest MAD was observed in Kiryandongo at 26.9% and the lowest in Kyaka II, Palabek, Kyangwali, Rhino Camp and Palorinya settlements at 2.1%, 3.3%, 4.0%, 4.0% and 4.3% respectively. In terms of diversity in diet, about 21.3% of the children can attain a Minimum Dietary Diversify (MDD), with those most affected by low diversity in diet found in Kyaka II (7.4%), Kyangwali (13.3%) and Palorinya (15.8%) settlements. Over half of the children in the refugee settlements are fed more frequently (at least twice for children 6-8 months and at least thrice for children 9-23 months) with the Minimum Meal Frequency (MMF) among breastfed children across the settlements observed at 55.2%. Mother feeding practices are poor with only 28.2% of the women in refugee settlements able to consume 5 or more food groups in a day, and the most affected women are found in Nakivale (9.7%), Oruchinga (11.4%) and Palabek (11.6%) settlements.

Malaria and Acute Respiratory Infection (ARI) cases are high in refugee settlements as well as in host communities, which places a strenuous disease burden on the children but also strains the general health service provision, eventually leading to malnutrition. From the most recent FSNA, 76.3% of children in the settlements and 77.1% of those in the host communities were found to have tested positive for malaria in the 2 weeks preceding the survey. Refugee settlements with the highest malaria positivity rate were Lobule (86.4%), Palabek (84.5%), Imvepi (83.3%) and Adjumani (79.3%) with Oruchinga (48.7%) registering the lowest positivity rate. Equally affecting the children was ARI (mostly cough), with 24.4% of the children having suffered from cough in the 2 weeks preceding the survey, with those in Palabek (45.7%), Imvepi (36.7%) and Kyangwali (34%) most affected. Additionally, 69.8% of the children with cough and/or flu (running nose) were found to have suffered shortness in breath.

Underlying factors

Generally, and even with the GFA provided monthly to the refugee population, there is **food scarcity and food insecurity,** as most households do not have enough food from own production and the recent high prices in the local markets have significantly limited the ability to meet the Minimum Expenditure Basket (MEB). According to the Consolidated Approach for Reporting Indicators of Food Insecurity (CARI) indicator derived from the recent survey data, about 49% of the refugee population were moderately food insecure while another 6% were severely food insecure. The highest food insecure population was found in Kyaka II, Kyangwali, Nakivale and Adjumani settlements.

There are marked **inadequate childcare and IYCF practices**. Breast feeding practices, particularly exclusive breastfeeding, are inadequate across the refugee population. Although 95% of the children born to refugees were found to have ever been breastfed and 79% of these initiated on breastfeeding in the first 1 hour after birth, only 60% (a reduction from the 62% recorded in 2021) are exclusively breastfed during the first 6 months. The practice of exclusive breastfeeding was found to be poorest in Lobule (40%), Kyaka II (46%), Adjumani (54%) and Palorinya (54%), and only relatively better in Rwamwanja (81%) and Nakivale and Oruchinga where it stood at 71%, respectively. Proper breast-feeding practices help the child to get the nutrients necessary for protection against diarrhoea and other common illnesses such as ARI, with other longer-term health benefits. Generally, Maternal, Infant, Young child, and Adolescent Nutrition (MIYCAN) practices / interventions have been and continue to be inadequate in most of the settlements, which leads to inadequacy in feeding frequency and dietary intake. Mixed feeding practices for infants are still rampant among the refugee mothers with the introduction of solid, semi solid and soft foods being done at earlier stages of life than should be the correct practice. Continued breastfeeding at 12-23 months stood at 72% across all settlements with Adjumani (60%) registering the lowest rate and Bidibidi (86%) the highest.

There is **poor water access** but generally good, although seasonal, sanitation access among refugee populations. About 79% of the refugee households have access to improved sanitation facilities, with 14% using communal latrines and only 3% practicing open defecation. Open defecation is mostly practiced in Palabek (10%) and Kyaka II (6%) settlements. Although 94% of the households among the refugee population are able to access safe water sources, the *per capita* water use is still low, with only 33% of them able to use 20 or more litres of water per person per day. Households in Palorinya (45%) and Kiryandngo (43%) settlements tend to use more water than those in the other settlements. In almost 63% of the refugee households, water for drinking is not treated before use.

Structural / Basic Factors

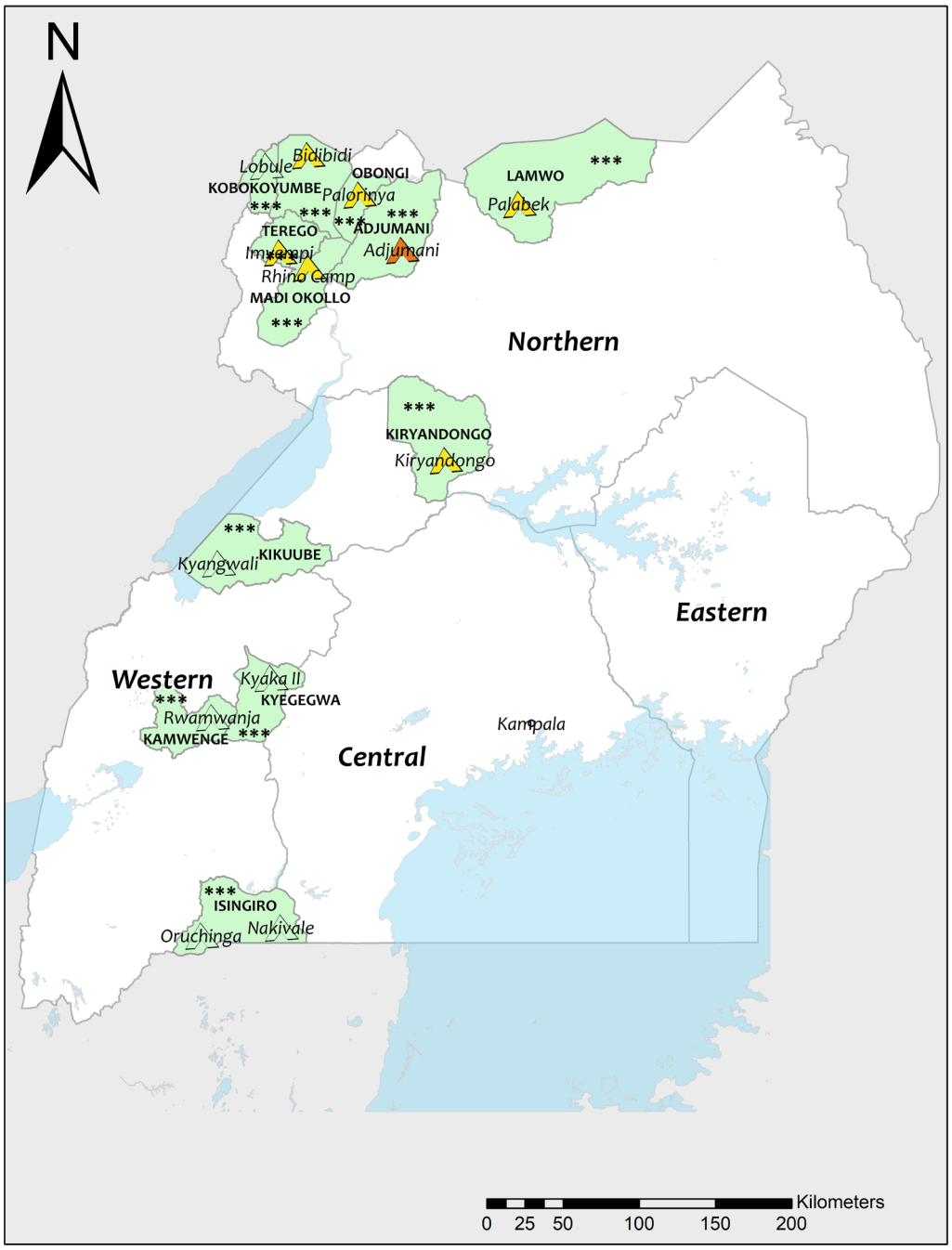
The Community-based Management of Acute Malnutrition (CMAM) coverage is suboptimal in some refugee settlements, implying that active case finding and referral for Integrated Management of Acute Malnutrition (IMAM) services is not reaching all children in need of care. The coverage is about 68% across the settlements, with Imvepi (44%) registering the lowest coverage and Oruchinga (98%) the highest.

High levels of anaemia among children aged 6-59 months are of major public health concern that calls for urgent attention in the refugee settlements (45%). Anaemia among children aged 6-59 months contributes to reduced immunity, loss of appetite and body weakness, which affects intake and absorption of nutrients, growth and development leading to acute malnutrition. The highest number of children suffering from anaemia were found in Palabek (70%), Kyangwali (57%), and Kiryandongo (54%), yet the lowest number was found in Oruchinga (23%). Iron deficiency anaemia resulting from poor quality of food and malarial anaemia are highly probable contributing factors for acute malnutrition among the children. Likewise, high levels of anaemia among pregnant women are of public concern that calls for attention and action in the refugee settlements (32%). The high anaemia prevalence among PLWs is a contributing factor to low birth weight infants that are usually prone to acute malnutrition. The low birth weight also greatly contributes to acute malnutrition indirectly due to the intergeneration cycle of malnutrition.

Trend analysis

Historical data on both acute malnutrition as well as contributing factors show improvement in the nutrition status of under 5 children in some settlements, yet there has been deterioration in others. In 2017, Palabek, Bidibidi and Adjumani settlements had the highest levels of acute malnutrition at 12.3%, 11.8% and 11.8% respectively. Even though there was no anthropometric study done in 2018 and 2019 in the refugee settlements, available mass screening data indicate worsening SAM and MAM admissions for some settlements, with the same data indicating an improvement in others, compared to the past years. In 2020, Kiryandongo, Adjumani and Palabek settlements had the highest GAM prevalence of 8.7%, 8.3% and 8.2% respectively, whereas in 2021, Kiryandongo (8.7%), Adjumani (8.3%) and Palabek (8.2%) had the highest GAM prevalence. In 2022, Adjumani, Kiryandongo, Palorinya and Rhino Camp have the highest GAM prevalence at 10.5%, 9.7%, 6.8% and 6.8% respectively.

IPC ACUTE MALNUTRITION SITUATION MAP (FEBRUARY – JULY 2022)



Key for the Map

IPC Acute Malnutrition Phase Classification

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

IDPs/other settlements classification

Evidence Level

- * Acceptable
- ** Medium
- *** High

PROJECTED SITUATION OVERVIEW (AUGUST 2022 – JANUARY 2023)

Overall, during the projection period of August 2022 to January 2023, the acute malnutrition situation in the refugee settlements is expected to remain similar and generally following historical trends, except for in one settlement. While the situation will remain the same in all other settlements as it was in the current period of analysis, Adjumani refugee settlement, which was classified in a Serious situation (IPC AMN Phase 3), is anticipated to improve to an Alert situation (IPC AMN Phase 2). Bidibidi, Imvepi, Palorinya, Rhino Camp, Palabek and Kiryandongo settlements, that were classified in an Alert situation (IPC AMN Phase 2), will likely remain in the same situation, while Lobule, Kyaka II, Kyangwali, Nakivale, Oruchinga and Rwamwanja, that were classified in an Acceptable situation (IPC AMN Phase 1), are also likely to remain in the same situation. On the other hand, all the 12 refugee hosting districts, namely, Adjumani, Isingiro, Kamwenge, Kikuube, Kiryandongo, Koboko, Kyegegwa, Lamwo, Madi Okollo, Obongi, Terego and Yumbe, that were classified in an Acceptable situation (IPC AMN Phase 1), will likely remain in the same acute malnutrition situation throughout the projection period.

In line with historical trends and the anticipated rains, the prevalence of malaria, ARI, diarrhoea and other preventable diseases affecting nutrition status could increase between August and October 2022, in refugee settlements as well as in hosting communities. This trend will, however, change in November through the rest of the projection period. The anticipated improved health service provision and the integrated child health days will likely reduce the impact of increased disease incidence. Due to its location and proximity to the Democratic Republic of Congo, there is most likely to be spontaneous outbreaks of Ebola, Cholera, and Crimean–Congo Hemorrhagic Fever (CCHF) in Kyangwali refugee settlement.

Food consumption will likely improve during the projection period as harvests are realized, but may gradually deteriorate for some households as they run out of food supplies with an expected replenishment of these stocks again in November as the seasonal green harvests start. Food availability is expected to improve owing to the anticipated average crop harvest complemented by good livestock production. There will be availability of imports as markets are fully functional and there are no movement restrictions in the districts and settlements included in the analysis. Since the 60% (40% in some settlements) food ration is not enough for the refugees to meet the MEB, it is anticipated that dietary diversity and meal frequency will not improve but may also not deteriorate to the levels realized in the current period of analysis. Overall, the food security situation is expected to improve in both settlements and host communities during the projection period, which will lead to improvement in the nutrition status of children and mothers.

Dependence on GFA by the refugee population, particularly cash assistance from WFP and UNHCR, both from routine distribution and the one-off safety net program will continue through the projection period, with the food rations anticipated to remain at 60% of the daily calorie requirement in some settlements and as low as 40% in others. Due to limited exposure to financial literacy for most refugee households, there may be continued extravagance and food security shocks, as households have a tendency to divert the cash to access other needs rather than purchase enough food.

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

Current MIYCAN practices are expected to be maintained, but will improve in some settlements where SBCC is being rigorously implemented. The tendency of caretakers to concentrate on crop field work as the agricultural season intensifies may negatively impact feeding practices of children in the host districts, which will also likely keep the practice of bottle feeding at the rates realized in the current analysis period. Sensitization that was done to the populations during the breastfeeding week will go a long way in improving breastfeeding practices in some communities.

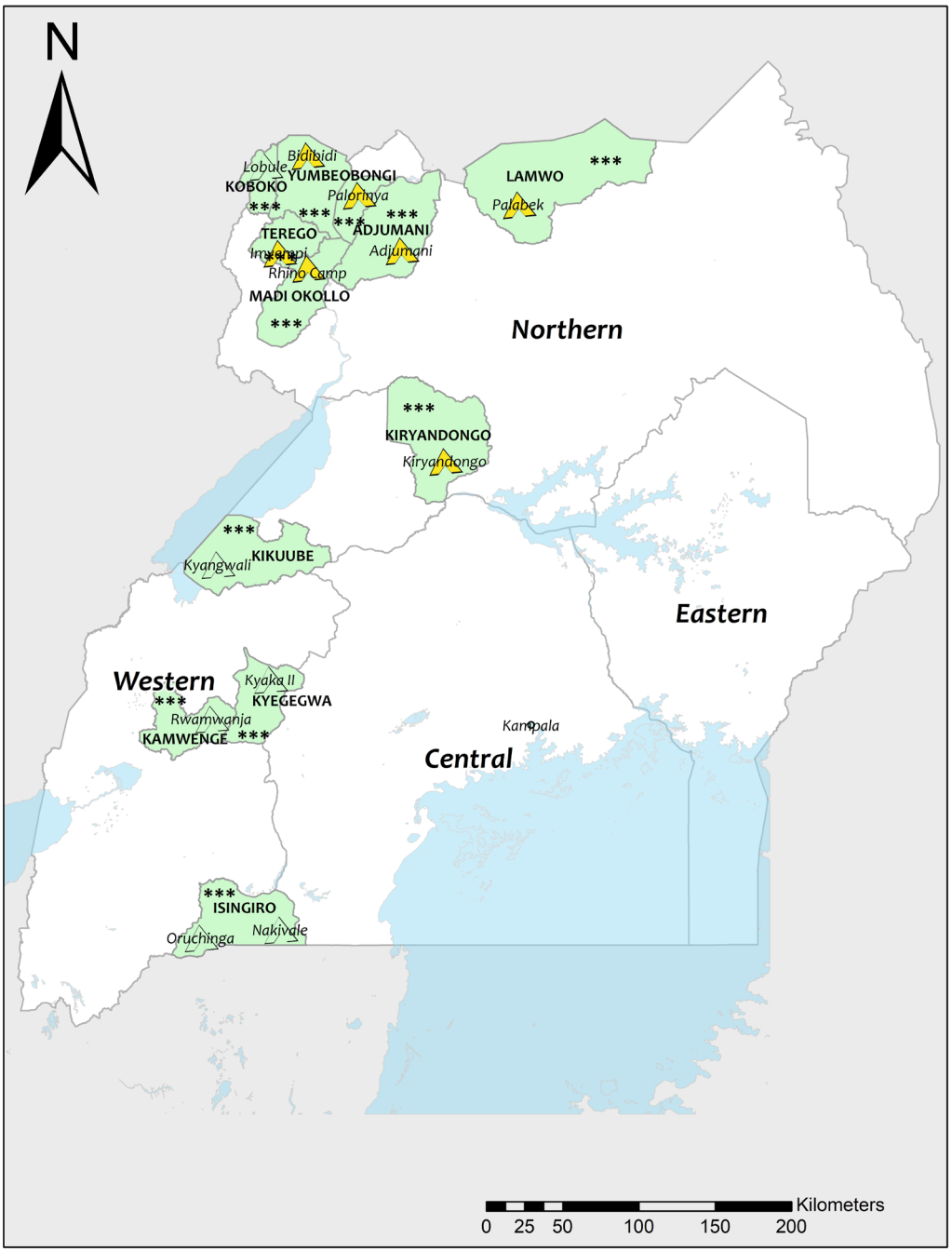
CMAM coverage will likely remain low across settlements and host communities, even though the recent FSNA results have triggered a response from Non-Governmental Organisations, Ministry of Health and other partners. Fuel price increases that generally affect transport mechanisms will continue to impact movement of teams that can readily identify malnutrition cases in the far communities. The ongoing Russia-Ukraine war and the general global logistical and supply challenges will continue affecting the supply of nutrition commodities like Ready to Use Therapeutic Foods (RUTF) and super cereals.

Humanitarian assistance will likely remain at the levels realised during the current analysis period but may deteriorate due to the current global challenges, mainly arising from the Russia-Ukraine war and slow recovery of donor countries from the Covid-19 crisis. Generally, even funding for nutrition programmes is anticipated to remain low.

The unending conflicts and civil war in the Democratic Republic of Congo, South Sudan and Ethiopia may lead to refugee influx in the country.

Anaemia is expected to remain high throughout the projection period but the situation will not deteriorate further. There are currently no planned activities intended to reverse the anaemia trend although it is highly anticipated that positive changes in food availability and consumption and the likely interventions in the identification and treatment of malaria cases will reduce anaemia both among children and mothers. The production and consumption of iron rich foods that may have naturally reversed the anaemia trend is expected to remain low.

IPC ACUTE MALNUTRITION PROJECTED SITUATION (AUGUST 2022 – JANUARY 2023)



Key for the Map

IPC Acute Malnutrition Phase Classification

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

IDPs/other settlements classification

Evidence Level

- * Acceptable
- ** Medium
- *** High

SUMMARY POPULATION TABLES (FEBRUARY 2022 – JANUARY 2023)

Refugee Settlements

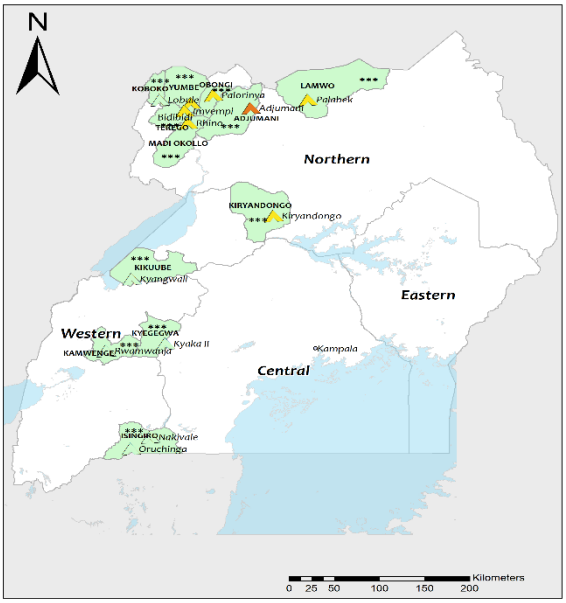
Refugee Settlement	Total No. of Cases of Children (6-59 Months) in Need of Treatment			Total No. of Cases of Pregnant and Lactating Women in Need of Treatment
	GAM Treatment	MAM Treatment	SAM Treatment	
Adjumani	10,527	8,850	1,677	404
Bidibidi	4,041	3,668	373	593
Imvepi	1,481	1,266	215	110
Kiryandongo	3,157	2,086	1,071	255
Kyaka II	2,083	1,141	942	499
Kyangwali	1,952	976	976	713
Lobule	129	129	0	32
Nakivale	2,866	1,552	1,314	481
Oruchinga	124	90	34	44
Palabek	1,796	1,679	117	227
Palorinya	3,322	2,345	977	314
Rhino Camp	3,478	2,993	485	370
Rwamwanja	1,635	1,226	409	145
All Settlements	**36,590**	**28,000**	**8,590**	**4,186**

Host Districts

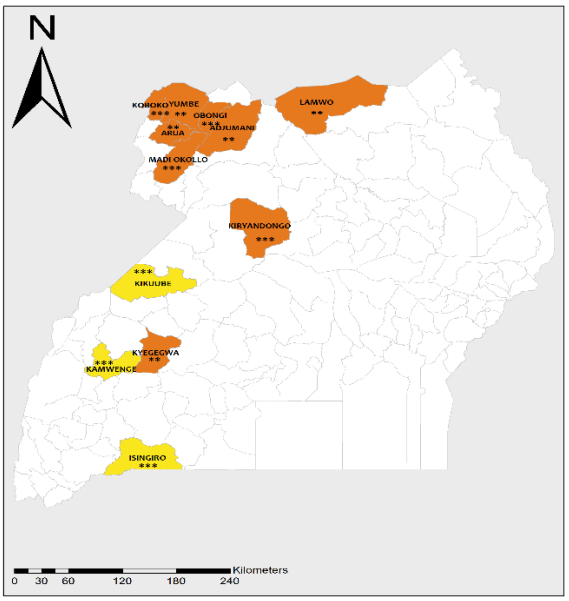
Host District	Total No. of Cases of Children (6-59 Months) in Need of Treatment			Total No. of Cases of Pregnant and Lactating Women in Need of Treatment
	GAM Treatment	MAM Treatment	SAM Treatment	
Adjumani	5,938	5,168	770	263
Isingiro	9,751	8,126	1,625	1,243
Kamwenge	5,042	4,538	504	881
Kikuube	6,042	4,761	1,282	929
Kiryandongo	5,852	5,434	418	1,621
Koboko	6,236	5,102	1,134	1,346
Kyegegwa	4,157	4,157	0	538
Lamwo	2,635	2,036	599	367
Madi Okollo	5,603	4,894	709	363
Obongi	1,476	1,312	164	92
Terego	4,522	4,317	206	135
Yumbe	10,596	10,052	543	884
All Districts	**67,852**	**59,898**	**7,954**	**8,661**

COMPARISON WITH AFI CLASSIFICATION – HOST DISTRICTS

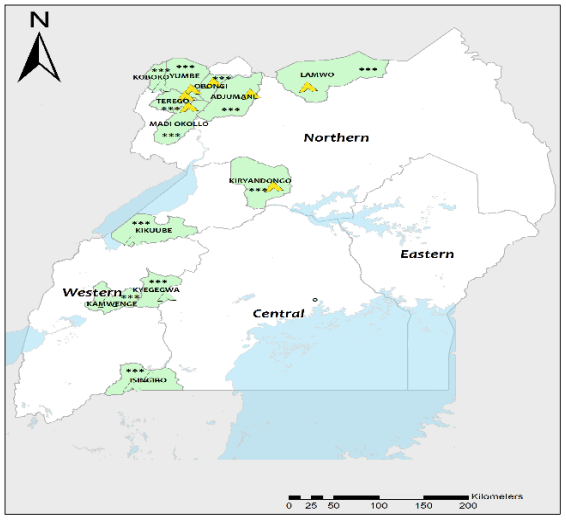
AMN Current (February – July 2022)



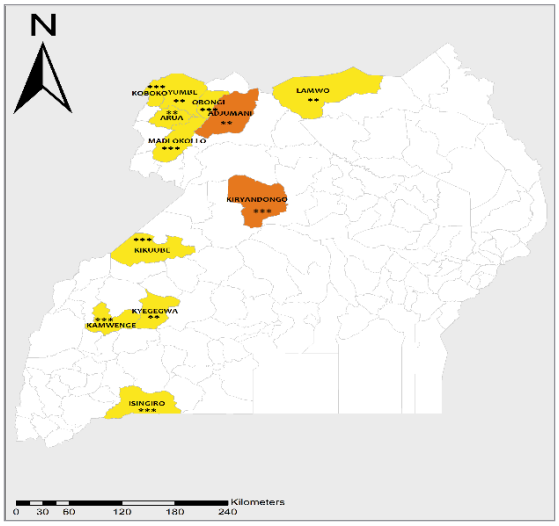
AFI Current (June – August 2022)



AMN Projection (August 2022 – January 2023)



AFI Projection (September 2022 – January 2023)



RECOMMENDATIONS FOR ACTION

Response Priorities

1. Scale up screening and treatment for SAM and MAM cases identified, particularly in settlements with low coverage. Early case identification needs to be scaled up for both children and pregnant and lactating women.
2. Conduct a coverage survey e.g., the Semi-Quantitative Evaluation of Access and Coverage (SQUEAK) for establishment of IMAM coverage, dive deeper into reasons for any low coverage. The FSNA is not a reliable source for IMAM coverage.
3. Improve coverage and access of IMAM services through stabilizing the commodity pipeline, strengthening the capacity of health workers in IMAM, having the right staffing levels, and strengthening the facility-community linkages.
4. Strengthen MIYCAN practices at both health facility and community levels through multisectoral collaboration, using available MIYCAN Social and Behaviour Change Communication (SBCC) materials, scaling up the care group model, and creating mother-baby friendly spaces at health facilities for breastfeeding, IYCF counseling etc.
5. 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.
6. Strengthen prevention, testing and treatment of malaria in settlements and host population through scale-up of interventions like ICCM, community mobilizations and outreach services, vector control mechanisms like distribution of mosquito nets, indoor residual spraying, and larviciding and other public health services.
7. Scale up iron supplementation in children and women including Iron-Folic acid supplementation during ANC. Additionally, scale up provision of multi-vitamin powders (MNPs), deworming, promotion of the production and consumption of Iron-rich and Vitamin C rich foods; and enhance investment in multisectoral actions to reduce anaemia among all vulnerable groups.
8. Intensify but also introduce (where they do not exist) food and cooking demonstration activities to increase knowledge on the dietary practices.
9. Improve on the current low levels of clean water for home use in host communities and, where needed, formulate by-laws to improve on the latrine coverage, including total elimination of open defecation.
10. Promote and strengthen agricultural and nutrition sensitive programs to address micronutrient deficiencies e.g., kitchen gardens; introduce and ensure sustainable production of bio-fortified sweet potatoes, Iron and Zinc rich beans, vitamin A rich fruits and vegetables and protein enriched maize.
11. Strengthen shock responsive social protection to improve resilience of households to shocks and vulnerabilities, which include promotion of livelihood activities that provide regular income to enable the purchase of micro-nutrient rich foods like iron-rich beans and vegetables.
12. Empower communities with life and vocational skills to improve their livelihoods through economic inclusion tools on financial literacy, access to micro-credit, and expansion of mobile money services.
13. Strengthen advocacy for refugees to access more land for own food production.
14. Promote improved farming techniques for the refugee population given their limited access to agricultural land. These include climate-smart agriculture, optimized land-use techniques like block farming.
15. Scale up Social Behaviour Change Communication (SBCC) on health and WASH.

Situation monitoring and update

1. Review the projected IPC AMN situation for both refugee settlements and host districts in November, when historically, the acute malnutrition admissions rise a bit before dropping in December.
2. Monitor the acute food insecurity in the most affected settlements and districts, during the projected period.
3. Monitor progress in dietary intake and diversity in the period October to December, when more food is available to host communities in the West Nile area.
4. Monitor trends in acute malnutrition admissions.

Risk factors to monitor

- Admission trends of acute malnutrition
- Coverage of CMAM programs, immunisation and vitamin A coverage
- Stock-out of nutrition supplies for treatment of acute malnutrition in affected settlements
- Increased seasonal human disease burden for measles, malaria and ARI
- Distribution and utilisation of long lasting Insecticide Treated Mosquito Nets in areas with high malaria incidence and prevalence
- Provision of cash and in-kind support to refugee communities by WFP, UNHCR and other humanitarian agencies, including the anticipated reduction in rations.
- Utilization of ANC, PNC and YCC services at health facilities
- Health seeking behaviours as most mothers will be engaged in agricultural activities
- Volatile market food and essential non-food prices
- Anticipated refugee influx which may also be linked with some disease epidemics making the refugees and host populations more vulnerable

PROCESS AND METHODOLOGY

A team of nutrition, health, food security, and statistics experts working at central as well as settlement and district levels in Uganda carried out the analysis using the standard IPC Acute Malnutrition version 3.1 protocols. Prior to the analysis, all analysts underwent a full Level 1 Training on the IPC Acute Malnutrition scale. This training was based on the IPC Technical Manual version 3.1, and most of the participants who took part in the training were involved in the analysis. The training and analysis were conducted between 20th-29th July, 2022, in Kampala and Jinja Cities.

The analysis was technically supported by the IPC Global Support Unit and 3 TWG Facilitators and carried out under the overall co-ordination and leadership of the IPC Technical Working Group in Uganda. Financial support was provided by the United Nations World Food Programme.

Sources

The data used in this analysis mainly came from the Food Security and Nutrition Assessment (FSNA) of 2022 conducted in 13 refugee settlements and 12 refugee hosting districts of Uganda by WFP and UNHCR. Data from mass screening exercises conducted on behalf of UNHCR by Action Against Hunger (ACF), Medical Teams International (MTI), International Rescue Committee (IRC) and Save the Children, and general health facility data from the Health Information System (HIS) was also used. Historical FSNA were used to compare the current situation with the past and conduct trend analysis.

Limitations of the analysis

- There was little readily available data on most of the outcome and contributing factor indicators with validation of the FSNA data being done alongside the IPC analysis.
- Even after the 3-day training, some host district analysts could not readily use the IPC tool.
- The 5-day period for the analysis workshop was too short to complete analysis and vetting of the 25 analysis areas, which undermined accuracy and the overall IPC analysis process.
- Failure to conduct the FSNA and the IPC analysis earlier in the current period of analysis (high acute malnutrition season) and failure to produce and release the IPC Report on time rendering the current analysis results obsolete and only the projection results can be used for decision making.

What is the IPC and IPC Acute Malnutrition?

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

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

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

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

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

IPC AMN Analysis Partners:

THE REPUBLIC OF UGANDA · WFP World Food Programme · UNHCR The UN Refugee Agency · unicef for every child · ACTION AGAINST HUNGER · Save the Children · MEDICAL TEAMS International · INTERNATIONAL RESCUE COMMITTEE

TOTAL NUMBER OF CASES OF CHILDREN AGED 6-59 MONTHS AND PREGNANT AND LACTATING WOMEN AFFECTED BY ACUTE MALNUTRITION AND IN NEED OF TREATMENT

Refugee Settlements

Refugee settlement	Settlement population	Children aged 6-59 months							Pregnant and Lactating women		
		Total #	GAM % (95% CI)	MAM % (95% CI)	SAM % (95% CI).	Estimated number of GAM cases	Estimated number of MAM cases	Estimated number of SAM cases	Total #	AMN % (95% CI)	# of cases AMN
Adjumani	237,787	35,831	11.3%	9.5%	1.8%	10,527	8,850	1,677	11,889	3.4%	404
Bidibidi	227,996	23,909	6.5%	5.9%	0.6%	4,041	3,668	373	11,400	5.2%	593
Imvepi	59,549	9,190	6.2%	5.3%	0.9%	1,481	1,266	215	2,977	3.7%	110
Kiryandongo	69,866	10,841	11.2%	7.4%	3.8%	3,157	2,086	1,071	3,493	7.3%	255
Kyaka II	117,450	19,073	4.2%	2.3%	1.9%	2,083	1,141	942	5,873	8.5%	499
Kyangwali	123,954	22,080	3.4%	1.7%	1.7%	1,952	976	976	6,198	11.5%	713
Lobule	5,823	1,052	4.7%	4.7%	0.0%	129	129	0	291	11.0%	32
Nakivale	145,613	22,965	4.8%	2.6%	2.2%	2,866	1,552	1,314	7,281	6.6%	481
Oruchinga	7,761	1,190	4.0%	2.9%	1.1%	124	90	34	388	11.4%	44
Palabek	69,702	8,970	7.7%	7.2%	0.5%	1,796	1,679	117	3,485	6.5%	227
Palorinya	125,687	15,032	8.5%	6.0%	2.5%	3,322	2,345	977	6,284	5.0%	314
Rhino Camp	136,909	15,555	8.6%	7.4%	1.2%	3,478	2,993	485	6,845	5.4%	370
Rwamwanja	82,926	15,723	4.0%	3.0%	1.0%	1,635	1,226	409	4,146	3.5%	145
Grand Total	**1,411,023**	**201,411**				**36,590**	**28,000**	**8,590**	**70,551**		**4,186**

The expected number of cases of acute malnutrition among children was calculated using the following formula: *npk*, where n is the number of children aged 6-59 months, p is the prevalence of acute malnutrition (based on combined GAM), and k is the incident correction factor of 2.6

The expected number of cases of acute malnutrition among pregnant and lactating women was calculated using the formula: *np,* where n is the number of PLWs and p is prevalence of acute malnutrition (based on MUAC, estimated at <23cm).

Host Districts

Refugee settlement	Settlement population	Children aged 6-59 months							Pregnant and Lactating women		
		Total #	GAM % (95% CI)	MAM % (95% CI)	SAM % (95% CI).	Estimated number of GAM cases	Estimated number of MAM cases	Estimated number of SAM cases	Total #	AMN % (95% CI)	# of cases AMN
Adjumani	238,800	42,295	5.4%	4.7%	0.7%	5,938	5,168	770	11,940	2.2%	263
Isingiro	637,300	104,180	3.6%	3.0%	0.6%	9,751	8,126	1,625	31,865	3.9%	1,243
Kamwenge	359,500	64,637	3.0%	2.7%	0.3%	5,042	4,538	504	17,975	4.9%	881
Kikuube	395,200	70,422	3.3%	2.6%	0.7%	6,042	4,761	1,282	19,760	4.7%	929
Kiryandongo	330,800	53,590	4.2%	3.9%	0.3%	5,852	5,434	418	16,540	9.8%	1,621
Koboko	277,500	43,609	5.5%	4.5%	1.0%	6,236	5,102	1,134	13,875	9.7%	1,346
Kyegegwa	512,400	94,061	1.7%	1.7%	0.0%	4,157	4,157	0	25,620	2.1%	538
Lamwo	146,800	23,036	4.4%	3.4%	1.0%	2,635	2,036	599	7,340	5.0%	367
Madi Okollo	172,800	27,280	7.9%	6.9%	1.0%	5,603	4,894	709	8,640	4.2%	363
Obongi	51,300	7,885	7.2%	6.4%	0.8%	1,476	1,312	164	2,565	3.6%	92
Terego	245,300	39,531	4.4%	4.2%	0.2%	4,522	4,317	206	12,265	1.1%	135
Yumbe	736,400	104,494	3.9%	3.7%	0.2%	10,596	10,052	543	36,820	2.4%	884
Grand Total	**4,104,100**	**675,020**				**67,852**	**59,898**	**7,954**	**205,205**		**8,661**

The expected number of cases of acute malnutrition among children was calculated using the following formula: *npk*, where n is the number of children aged 6-59 months, p is the prevalence of acute malnutrition (based on combined GAM), and k is the incident correction factor of 2.6

The expected number of cases of acute malnutrition among pregnant and lactating women was calculated using the formular *np*; where n is the number of PLWs and p is prevalence of acute malnutrition (based on MUAC, estimated at <23cm).