



UGANDA

KARAMOJA IPC ACUTE MALNUTRITION SITUATION

IPC ACUTE MALNUTRITION ANALYSIS FEBRUARY 2022 – JANUARY 2023

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KEY FIGURES	FEBRUARY 2022 - JANUARY 2023	
91,600 cases of children aged 6-59 months acutely malnourished IN NEED OF TREATMENT	Severe Acute Malnutrition (SAM)	23,000
	Moderate Acute Malnutrition (MAM)	69,000
	9,500 cases of pregnant or lactating women acutely malnourished IN NEED OF TREATMENT	

Key Drivers



Diseases

Malaria (17%) and diarrhoea (14%) cases are still high in the region, which places a strenuous disease burden on children, eventually leading to malnutrition.



Poor Food Consumption

Very poor levels of food consumption among children 6-23 months, with the minimum acceptable diet close to 0% in some districts.



Acute Food Insecurity

Very high and recurrent food insecurity, with a continuous increase in the percentage of households in AFI Phase 3 or above.

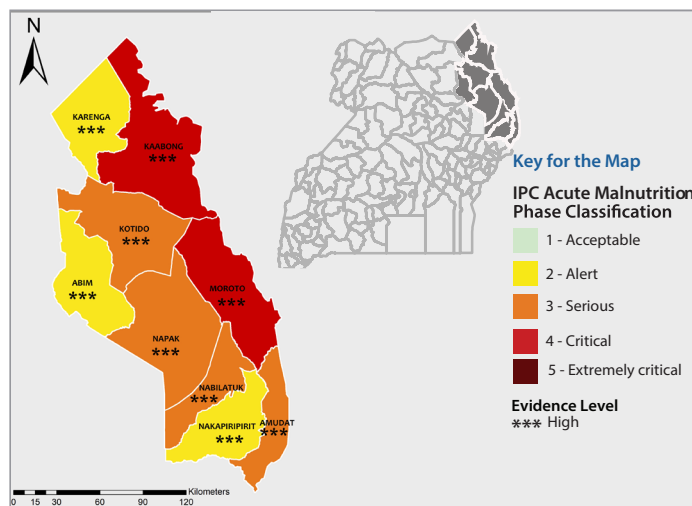
Overview

How Severe, How Many and When: Of the nine districts in Karamoja region, during the lean season of 2022 (February – July, 2022), acute malnutrition is at Critical situation (IPC AMN Phase 4) in 2 districts, a Serious situation (IPC AMN Phase 3) in four districts and at an Alert situation (IPC AMN Phase 2) in three districts. In the projection period of August 2022 to January 2023, acute malnutrition is expected to improve in two districts - in one district from Alert to Acceptable (IPC AMN Phase 1), and in the other from Serious to Alert - while in the other districts, the situation is expected to remain the same. About 91,600 children aged 6 to 59 months and 9,500 pregnant or lactating women (PLW) in the nine districts included in the analysis are affected by acute malnutrition and are in need of treatment.

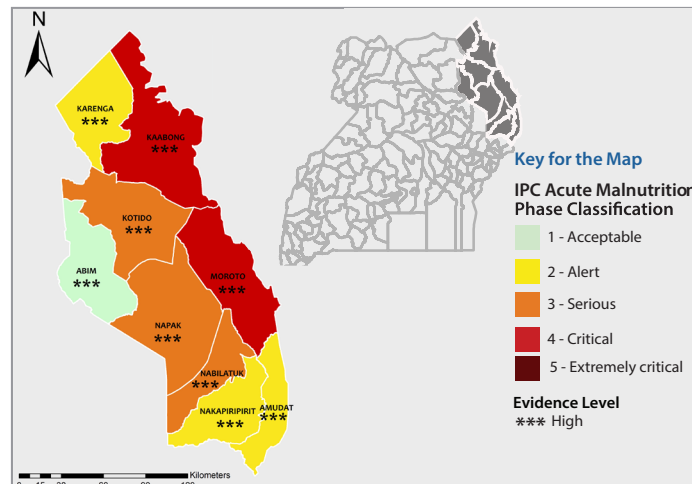
Where: For the period of February to July, Kaabong and Moroto are the two districts classified in a Critical situation (IPC AMN Phase 4). Amudat, Kotido, Nabilatuk and Napak are the districts classified in a Serious situation (IPC AMN Phase 3), whereas Abim, Karenga and Nakapiripirit are the three districts in an Alert situation (IPC AMN Phase 2). Except for the Abim and Karenga districts that have registered a slight improvement, acute malnutrition has worsened in all the other seven districts compared to 2021 levels. During the projection period, Amudat and Abim are the two districts where the situation is likely to improve, while in the rest of the districts, the situation is likely to remain similar compared to that observed in the current period (February to July 2022) and likely to continue worsening as shown by historical evidence.

Why: The inadequate response to the most urgent needs of the affected population over time is leading to recurrent and worsening of the malnutrition situation. Other factors contributing to acute malnutrition are very high and recurrent food insecurity, with a continuous increase in the percentage of households in IPC Acute Food Insecurity (AFI) Phase 3 or above, in line with the generally very poor levels of food consumption among children aged 6-23 months, with the minimum acceptable diet close to 0.0% in some districts. There are also inadequate child care and infant and young child feeding (IYCF) practices mostly related with high mother workload and alcoholism, as well as poor access to improved sanitation facilities and low per capita water use. Anaemia among <5 years and pregnant women (in some districts) is of public health concern.

Current Acute Malnutrition | February - July 2022



Projected Acute Malnutrition | August 2022 - January 2023



KARAMOJA CURRENT SITUATION OVERVIEW AND MAP (FEBRUARY – JULY 2022)

As per the survey data collected during the lean season of 2022 (February / March 2022) from the nine districts in the Karamoja region, all the nine districts have over 5 percent of children affected by acute malnutrition. According to the IPC Acute Malnutrition scale, Kaabong and Moroto districts have been classified in a Critical situation (IPC AMN Phase 4) with a Global Acute Malnutrition (GAM) prevalence of 19.8% and 22%, respectively. On the other hand, Amudat, Kotido, Nabilatuk and Napak districts have been classified in a Serious situation (IPC AMN Phase 3), with a GAM prevalence of 14.3%, 14.0%, 11.7% and 13.8%, respectively. The remaining three districts, namely Abim, Karenga and Nakapiripirit, have been classified in an Alert situation (IPC AMN Phase 2) with a GAM prevalence of 5.7%, 7.3% and 9.4%, respectively. Except for the Abim and Karenga districts that have registered a slight improvement, acute malnutrition has worsened in all the other seven districts compared to 2021 levels. Compared to the lean season analysis of 2021, one district was classified in a Critical situation, four districts in a Serious situation and four districts in an Alert situation of acute malnutrition.

Moroto district has the highest absolute number of children severely malnourished (4,791) whereas Kotido district has the highest number of moderately malnourished children (15,172). Kotido, Kaabong and Moroto districts account for almost 55% of children under 5 years of age in need of treatment in Karamoja region. Overall, 2.4% of the children in Karamoja region are severely malnourished (an increase from 1.9% in 2021) and another 10.7% are moderately malnourished (an increase from 8.8% in 2021), based on the weight-for-height (WHZ) index. Across the region, an estimated 91,610 children are acutely malnourished and in need of treatment, of whom 68,870 are moderately malnourished and 22,740 are severely malnourished. Additionally, 9,453 Pregnant and Lactating Women (PLW) are acutely malnourished and in need of treatment.

The major factors contributing to acute malnutrition in the region, 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 1.8% across the region, and as low as 0.0% in Napak and Nakapiripirit districts, based on results from the recent Food Security and Nutrition Assessment (FSNA). The highest Moderate Acute Malnutrition (MAM) was observed in Amudat and Nabilatuk districts, with 8.6% and 4.5% respectively, and the rest of the districts having far less than 5% of children being able to meet the minimum dietary requirements for a quality life. In terms of diversity in diet, all children are affected across the region, but those in Abim, Kaabong, Karenga, Moroto, and Napak are most affected by inadequacy in diet, with only 5.0%, 4.2%, 7.2%, 8.5% and 5.6% of children respectively consuming foods that are considered minimally acceptable in terms of diversity. Mother feeding practices are also still poor, with only about 19% of the women being able to consume foods considered adequate in terms of dietary diversity. The most affected districts in this regard are Napak (3.2%), Moroto (15.4%), Abim (11.5%) and Karenga (15%).

Malaria (16.9%) and **diarrhoea** (14.0%) cases are still high in the region, with the prevalence far higher in some districts than others, which places a strenuous disease burden on the children, eventually leading to malnutrition. For instance, in Kotido, Nabilatuk and Moroto districts, the prevalence of diarrhoea is 19.0%, 17.6% and 16.2%, respectively. Malaria prevalence is highest in Nakapiripirit, Kotido, Abim and Moroto districts, with prevalence of 23.6%, 22.7%, 18.7% and 17.2%, respectively. The acute respiratory infection prevalence is low at 4.4%, with Kotido (8.2%) and Abim (8.0%) being the most-affected districts. The immunosuppressive effects of malaria and diarrhoea increase the child's susceptibility to infection with other pathogens, which leads to recurrent nutritional deterioration.

Underlying factors

Very high and recurrent food insecurity with a continuous increase in the percentage of households in IPC Acute Food Insecurity Phase 3 or above.

Poor water and sanitation access, with access to enough water low and decreasing, whereas access to improved sanitation facilities, although increasing, is still at low levels. Although the availability of safe water sources stands at about 92% (FSNA, 2022), the per capita water use is below the recommended WHO standard of 20 litres per person per day. From the recent assessment, only 19% of the households (30% in 2021) meet this minimum water use standard with average per capita use being 13.2 litres per person per day, most likely due to long distances and high queuing time, coupled with heavy female workload (women are ideally charged with the duty of fetching water). It is only in Nabilatuk district where households are able to meet the minimum water use requirement, with the per capita use at 21.7 litres per person, per day. Access to improved sanitation facilities, particularly toilet availability and use, is still

very low across the region. Open bush / air defecation stands at 56% (an improvement from the 60% recorded in 2021) with only 9% able to use a pit latrine with slab, 22% are using latrines without slab while another 12% use open pits. The worst performing districts are Amudat, Moroto, Napak and Kotido where open defecation stands at 80%, 78%, 66% and 66%, respectively. Low water availability at household level and poor access to improved sanitation facilities have bred poor hygiene practices that expose the children to diarrhoea, dysentery and skin infections resulting into malnutrition.

Inadequate childcare and IYCF practices, mostly related with high mother workload and alcoholism. Breastfeeding practices (particularly, exclusive breastfeeding) and inadequate care practices are of concern in a number of districts. Exclusive breastfeeding across the region is at 61%, a reduction from the 74% recorded in 2021 and about 67% of children are predominantly breastfed. Kaabong (44%), Karenga (51%) and Kotido (61%) are performing poorest in regard to exclusive breastfeeding. High workloads for mothers and economic stress, as women are the main breadwinners in Karamoja, have been leading causes of inadequacy in breastfeeding and other care practices. Additionally, increased alcoholism among the mothers and trading in the same has been a major factor affecting child care practices in the region. Inadequate breastfeeding deprives children of essential nutrients, leading to reduced immunity that then exposes them to infections. Continued breastfeeding at 1 year in the Karamoja region stands at 91% but only 64% of the mothers continue breastfeeding at 2 years.

Structural factors

The **inadequate response to the most urgent needs** of the affected population over time is of more concern, and this is likely playing a key role in the recurrent and worsening of the situation in all districts, especially in Amudat, Kotido, Moroto, Kaabong, Nabilatuk and Napak.

Other outcomes

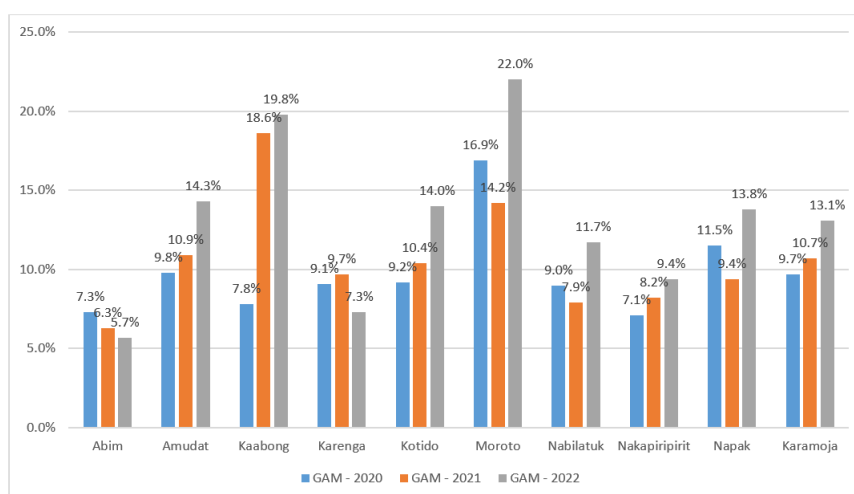
Evidence from the recent FSNA shows high levels of anaemia, which is a major public health concern that calls for urgent attention in all districts. Across the entire region, 37% (a reduction from the 59% recorded in 2021) of the children under five are estimated to be anaemic, with the highest number of children suffering from anaemia found in Napak (52.5%), Amudat (51.5%) and Nakapiripirit (45.7%) districts, whilst the lowest number is found in Abim (22.3%) and Karenga (26.8%). Iron deficiency anaemia resulting from poor quality of food and malarial anaemia are highly probable contributing factors for acute malnutrition in this region. Anaemia among pregnant women stands at 22.5%, while that among non-pregnant women stands at 29%.

Trend analysis

Available data show no long-term improvement in the nutrition status of children under 5 in the last eight years. The acute malnutrition prevalence for the region during the lean season slightly improved in 2016, having reduced from 14.1% in 2015 to 11% in 2016, and then deteriorated to 13.8% in 2017. The situation improved in 2018 to 10.5%, increased to 11.5% in 2019 and then showed signs of improvement after reducing to 9.7% in 2020. Since then, the GAM rates have moved upwards, having increased to 10.7% in 2021 and then 13.1% in 2022. The lean season under-5 acute malnutrition in Kaabong district unusually increased from 7.8% in 2020 to 18.6% in 2021 and then to 19.8% in 2022, and that in Moroto increased from 14.2% in 2021 to 22% in 2022, most likely because of increased inadequacy in food consumption both in terms of quantity and quality.

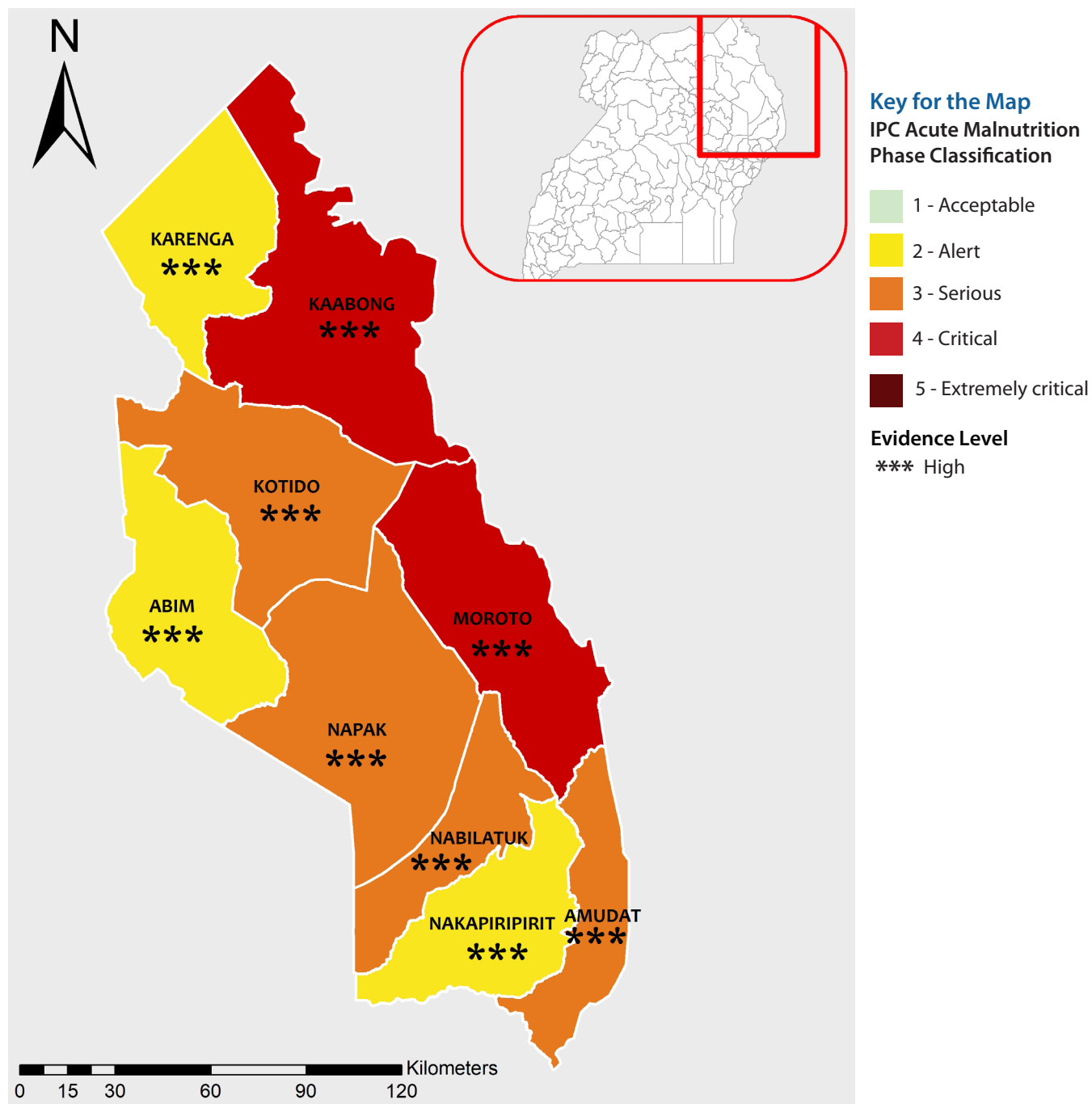
With the exception of access to safe water sources; the food security situation, water use and sanitation and toilet facility coverage have not improved much during the last five years, even with the ongoing livelihood improvement programmes in the region.

The continuously deteriorating situation, alongside the contributing factors, calls for urgent need to act with an appropriate, relevant and feasible response. See the comparative analysis on page 7 for more details.





IPC CURRENT ACUTE MALNUTRITION IN KARAMOJA (FEBRUARY – JULY 2022)



KARAMOJA PROJECTED SITUATION OVERVIEW AND MAP (AUGUST 2022 – JANUARY 2023)

Overall, during the projection period (August 2022 - January 2023), the acute malnutrition situation is expected to continue deteriorating as shown by the historical evidence, although likely to remain within the same IPC AMN Phase compared to the current, except in two districts. Kaabong and Moroto districts, currently in a Critical situation (IPC AMN Phase 4), are projected to remain in the same phase; Kotido, Napak and Nabilatuk districts, that are currently in a Serious situation (IPC AMN Phase 3), will also likely remain in the same phase; however, the acute malnutrition situation in Amudat will improve, from Serious to Alert (IPC AMN Phase 2). Likewise, whereas Karenga and Nakapiripirit districts that are currently in Alert will likely remain in the same situation, Abim district is projected to improve from Alert to an Acceptable situation (IPC AMN Phase 1). The situation is projected to remain similar in most districts due to the contributing factors that are likely to remain similar as per historical evidence, as well as the fact that there are no major or intensified humanitarian programs planned during the projected period that could prevent a further worsening compared to what the historical evidence has shown. In Amudat, particularly, although historical evidence has shown a continuous worsening of the situation, the situation is expected to improve due to expected improvement in milk production as well as milk consumption.

In line with historical trends and the anticipated normal to above normal rains, the prevalence of diarrhoea and other preventable diseases affecting nutrition status is expected to increase between August and October 2022, except in Amudat, where incidence in these months has historically been low. The forecasted rains will likely negatively impact the general hygiene conditions, as most districts have poor sanitation and toilet facility coverage.

Even though the rains will increase mosquito breeding and malaria infections, this impact will most likely be mitigated by the existing community-level interventions that include general distribution of Insecticide Treated Nets (ITNs) and the ongoing prophylactic malaria treatment that is being carried out across the whole Karamoja region. Facility-level interventions, including Vitamin A supplementation, may also mitigate the negative effects that could have arisen from increasing malaria, diarrhoea and other disease incidences.

The current unimproved sanitation facilities will also likely be washed away by the upcoming rains, which will worsen access to toilet facilities and increase household risk to faecal pathogens that may increase acute watery diarrhoea and dysentery cases within the communities. On the other hand, with the current water provision enhancement programmes, availability of safe water sources will improve in the projection period. However, the expected rains will aid increased availability of water in nearby unsafe water sources, tempting households to increase the use of unsafe water, which may increase risk to waterborne diseases.

Breastfeeding and other care practices will most likely remain the same or even deteriorate, as mothers may devote more time to harvesting crops from the gardens, where they usually spend the whole day.

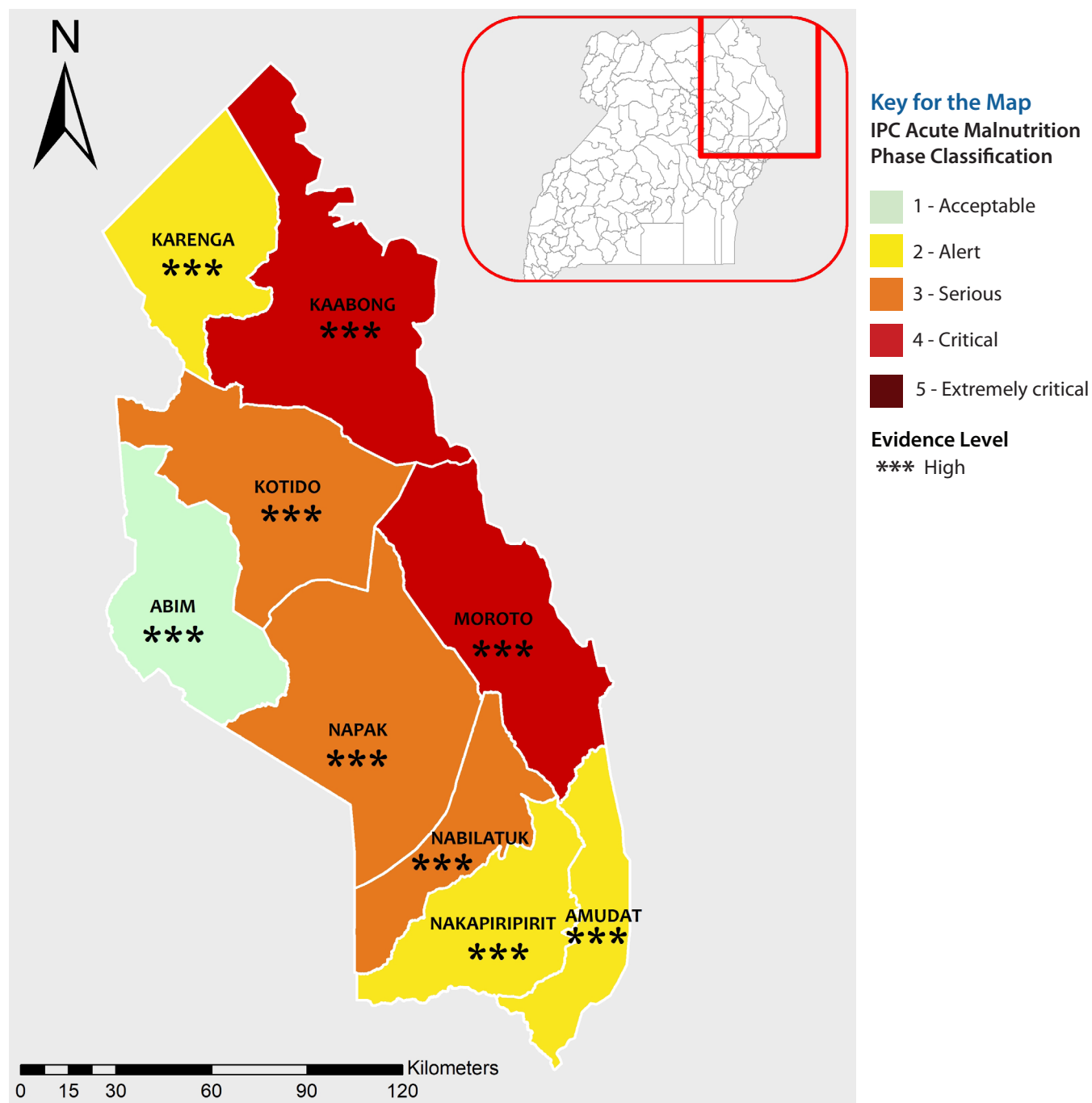
The reopening of schools since January 2022 has allowed and will continue to allow school going children access food through the School Feeding Programme provided by the United Nations World Food Programme (WFP) across the region. This is then anticipated to leave more food available to those remaining at home, including the under 5 children and lactating women, which will in turn improve the nutrition status.

The Andre Foods International (AFI) will resume providing food assistance to vulnerable households, through the Blanket Supplementary Feeding Programme (BSFP), although this is only likely for the months of August and September 2022. BSFP will help in mitigating any malnutrition that arises out of inadequate food consumption among those vulnerable households.

According to the projected IPC acute food insecurity situation, food availability and access at household level is likely to improve at the start of the projection period, though this may not be sustained throughout the projection period due to the projected average to below-average overall food production in the region. In this regard, some food consumption indicators like meal frequency may improve, although dietary diversity may not improve due to limits in the produced foods, historical food preferences and limited access to market purchase.

The fragile security situation arising from the increased incidents of livestock theft / raiding poses a big challenge to household access to food, livestock products and income generating activities. The current efforts by the Uganda People's Defence Forces (UPDF) and sister security agencies will most likely reduce or even end this insecurity during the projection period.

IPC PROJECTED ACUTE MALNUTRITION IN KARAMOJA (FEBRUARY – JULY 2022)



SUMMARY POPULATION TABLE (FEBRUARY 2022 - JANUARY 2023)

Unit of analysis	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	
Abim	5,829	4,663	1,166	395
Amudat	8,542	7,042	1,501	1,145
Kaabong	14,414	10,570	3,844	1,426
Karenga	3,001	2,230	771	349
Kotido	19,071	15,172	3,899	1,609
Moroto	15,300	10,509	4,791	1,565
Nabilatuk	6,385	4,721	1,664	594
Nakapiripirit	7,255	4,933	2,322	1,096
Napak	11,812	9,028	2,783	1,274
Karamoja	91,610	68,870	22,740	9,453

The expected number of cases of acute malnutrition among children was calculated using the following formula: $n \times p \times k$, where n is the number of children aged 6-59 months, p is the prevalence of acute malnutrition (based on the Combined GAM prevalence), 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 $n \times p$; where n is the number of PLWs and p is prevalence of acute malnutrition (based on MUAC, estimated at <23cm).

Comparative analysis of the IPC Acute Food Insecurity and IPC Acute Malnutrition

Of the nine districts analyzed, six are of concern in terms of both acute food insecurity (AFI) and acute malnutrition (AMN), namely Amudat, Kaabong, Kotido, Moroto, Nabilatuk and Napak. In terms of AFI and AMN reaching at least a classification of IPC Phase 3 (Crisis) for the AFI and IPC Phase 2 (Alert) for the AMN. Overall, there is a good consistency and convergence between results from the AFI and the AMN.

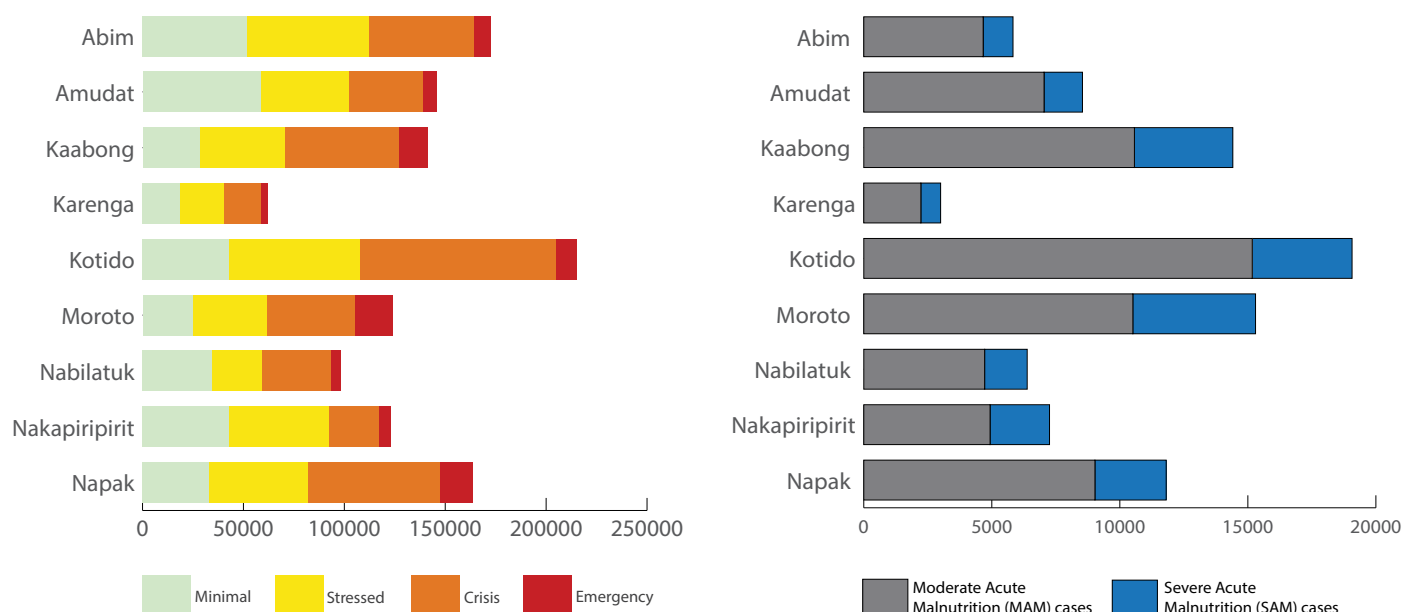
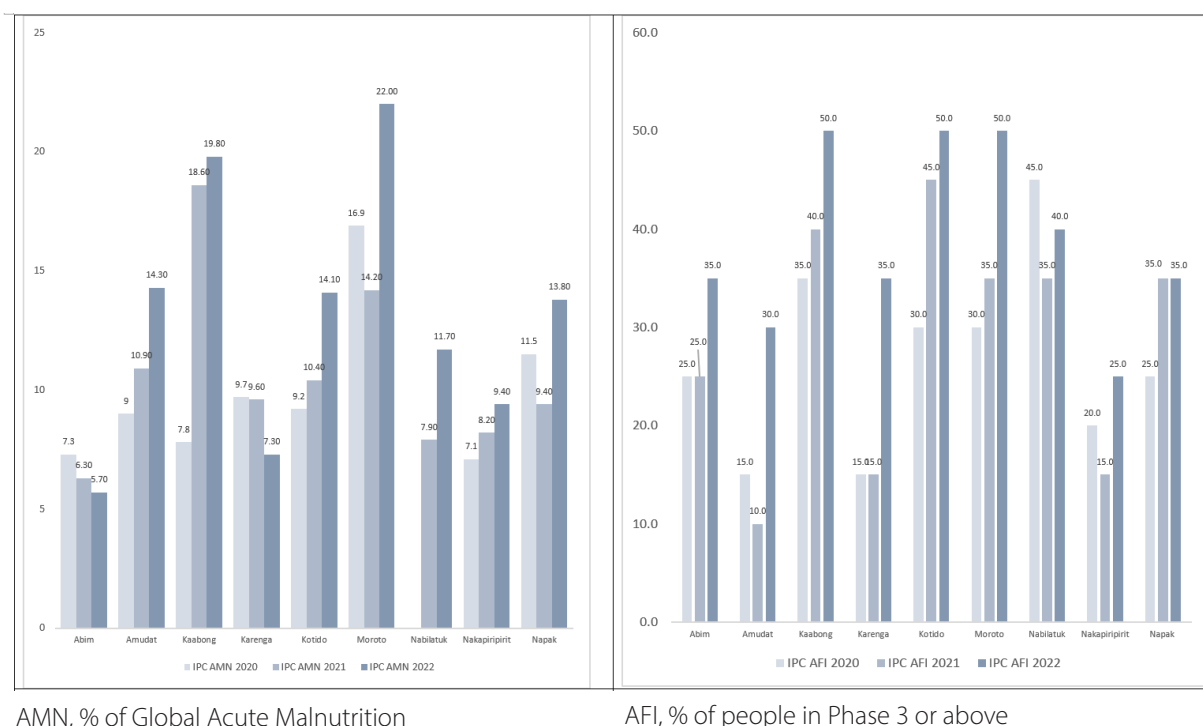


Figure 1: Comparative analysis of AFI (March - July 2022) and AMN (February - 2022 - January 2023) situation by district



AMN, % of Global Acute Malnutrition

AFI, % of people in Phase 3 or above

Figure 2: Comparative analysis of GAM prevalence and percentage of households in IPC AFI Phase 3+

Amudat

The severity of acute malnutrition and acute food insecurity are similar and equally high in Amudat district i.e. the district is in Phase 3 according to both IPC AFI and IPC AMN classifications, indicating Crisis levels of AFI and Serious levels of AMN, respectively. The acute malnutrition situation in the district, which was classified in Phase 2 in 2020, deteriorated significantly, and the district was classified in Phase 3 in 2021. Although the district remains in Phase 3 in 2022, the prevalence of GAM has increased from 10.9% to 14.3%. Acute food insecurity has been increasing since 2020, with an increase of 20% in population in Phase 3 or above in 2022 compared to 2021. Extremely poor food consumption among children 6-23 months and poor water and sanitation conditions are likely contributing to high levels of acute malnutrition in this district.

The acute food insecurity situation has deteriorated further, especially from 2021 to 2022, where the number of households in Phase 3 or above increased about three times (from 10% to 30%). Analysis of food security dimensions shows a deterioration in the Food Consumption Score (FCS) between 2021 and 2022, with about 3.4 times more households with a Borderline FCS in 2022 compared to 2021 (7.6% to 25.8%). This is in line with the Household Hunger Scale (HHS), where there was an increase of about 2.6 times higher in percentage of households in a Crisis situation (22.4% to 57.8%). There are an additional 2.3% of households in Emergency (IPC AFI Phase 4) compared to 0.7% last year. A deterioration in Livelihood Coping was observed as well, with an estimated increase of 2.2 times higher in percentage of households in Crisis coping than last year (6.8% to 14.7%).

The deterioration in acute food security is largely attributable to drought conditions and endemic livestock vectors / diseases that affected crop production in 2021 and livestock production in 2022. The low household incomes set against high commodity (food and non-food) prices have greatly affected household purchasing power over time.

Both acute food insecurity and acute malnutrition conditions are expected to improve slightly in the projection period of August 2022 to February 2023. This is mainly because of the improvement in milk production as well as milk consumption.

Kotido

In Kotido, acute malnutrition has been continuously deteriorating. In 2020, GAM prevalence was 9.2%, which corresponds with a classification in IPC AMN Phase 2, in 2021 GAM was 10.4% (IPC AMN Phase 3) and in 2022 GAM is 14.1% (IPC AMN Phase 3). Between last and this year, GAM prevalence has increased in about 1.4 times higher in percentage.



Analysis of contributing factors has shown that food consumption among children 6-23 months is deteriorating to even further low levels: 4.9% of Minimum Acceptable Diet (MAD) in 2020 to 6.2% in 2021 and 1.2% in 2022. Access to sufficient quantity of water is decreasing from 33% in 2020 to 29% in 2021 and 5.7% in 2022.

As for AFI, the situation has also been deteriorating just like GAM. The IPC AFI Phase has been Phase 3 since 2019 and has remained the same until now. The overall percentage of households in IPC Phase 3 or above has increased from 30% in 2020 to 45% in 2021 and 50% in 2022. Analysis on the food security dimensions has shown a deterioration in Reduced Coping Strategies Index (rCSI) and HHS mostly. Between last year and current, there was an increase of about 1.8 times higher in the percentage of households in Crisis rCSI (18.6% to 33.3%); while for HHS, the percentage of households in Crisis has increased in about 3.8 times higher (30.1% to 75.4%). There are an additional 3.8% households in Emergency and 1.3% in Catastrophe compared to 1.4% and 0.0% in 2021, respectively.

The deterioration in acute food security is largely attributable to drought conditions and the insecurity / conflicts that have negatively impacted crop and livestock production. The low household incomes set against high commodity (food and non-food) prices have greatly affected household purchasing power over time.

While for AFI the situation is expected to improve slightly over the projected period of August 2022 to February 2023, with the percentage in Phase 3 or above reducing from 50% to 30%, acute malnutrition is expected to remain similar over the same period. This is mainly due to the contributing factors that are likely to remain similar as historical evidence has shown, as well as the fact that there are no major or intensified humanitarian programs planned during the projected period that could prevent a further worsening of the malnutrition situation.

Kaabong

In Kaabong district, the AMN situation has been continuously deteriorating since 2020. In 2020, GAM prevalence was 7.8% (IPC AMN Phase 2), in 2021 GAM prevalence was 18.6% (IPC AMN Phase 4) and in 2022 GAM prevalence is 19.8% (IPC AMN Phase 4). Between 2020 to 2021, there has been an increase of about 2.4 times more, and between 2021 and 2022, an increase of about 1.0 times.

Analysis of the contributing factors shows that food consumption among children 6-23 months, according to the MAD indicator, deteriorated from 14.1% in 2020 to 3.0% in 2021, and slightly improved to 3.9% in 2022. Diarrhoea prevalence has been above ten percent in the last three years, having been 12.6% in 2020, 11.5% in 2021 and 13.8% in 2022. The above-described factors, coupled with other factors, such as WASH, might have played a key role in the deterioration of the acute malnutrition situation.

The AFI situation has been in Phase 3 since 2019, with the percentage of households in IPC Phase 3 or above being high at 45% in 2019 and continuously increasing from 35% (2020) to 40% (2021) and 50% (2022). This corresponds to almost 1.2 times higher AbimAmudatKaabongKarengaKotidoMorotoNabilatukNakapiripiritNapakIPC AMN August 2022 - February 2023IPC AFI August 2022 - February 20234321sis (from 44.5% in 2021 to 79.7% in 2022). The HHS has worsened in Nabilatuk mainly due to poor production, leading to households having less food stocks compared to last year during the same period. The data shows that one in every three households surveyed slept hungry, while 22% of households responded spending day and night hungry, showing linkages with limited food stocks. Linking to livelihood change, 30% of households in Nabilatuk responded having consumed their seed stocks, indicating a very serious food insecurity situation.

At individual level factors, food consumption among children has remained almost similar between 2021 and 2022 with MAD at 5.7% and 5.9%, respectively. On the other hand, disease prevalence has reduced considerably: Diarrhoea (from 21.8% in 2021 to 18.2% in 2022), fever (from 30.8% in 2021 to 15.0% in 2022) and acute respiratory infections (from 27.0% in 2022 to 2.8% in 2022).

For both AMN and AFI, the situation is expected to remain similar over the projected period. This is mainly due to the contributing factors that are likely to remain similar, especially acute food insecurity, as well as the fact that there are no major or intensified humanitarian programs planned during the projected period that could prevent a further worsening.

Napak

In 2020, GAM prevalence was 11.5% (IPC AMN Phase 3), and it slightly decreased in 2021 to 9.4% (IPC AMN Phase 2), while this year it deteriorated to 13.8% (IPC AMN Phase 3), an increase estimated in about 1.5 times higher than last year.

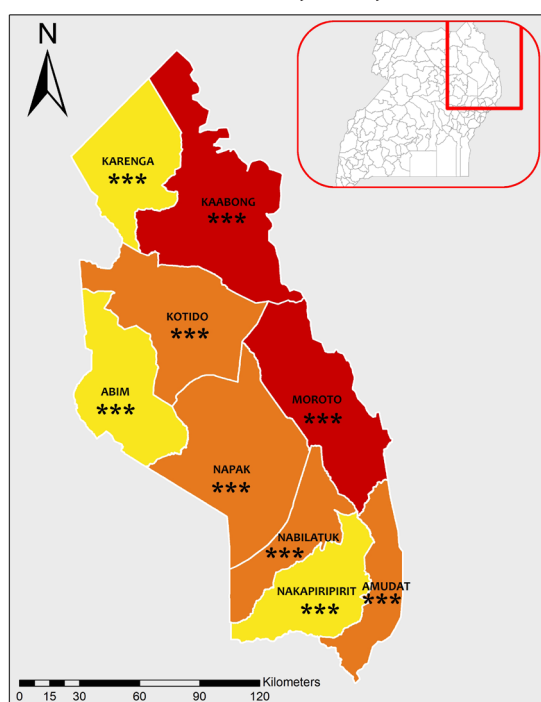
Analysis of contributing factors has shown that food consumption among children 6-23 months is deteriorating to even lower levels: 21% of MAD in 2020, to 2.5% in 2021 and 0.0% in 2022. Access to sufficient quantity of water decreased from 46.1% in 2021 to 16.4% in 2022 and access to improved sanitation facilities, although increasing, is still in low levels.

As for AFI, the situation has also been deteriorating. The IPC AFI Phase has consistently been Phase 3 since 2019. The overall percentage of households in Phases 3 or above was 45% in 2019, and has been continuously rising from 25% (2020) to 35% (2021) and 35% (2022). Analysis on the food security dimensions has shown that FCS, HDDS, rCSI and Livelihood coping remained within the same levels compared to last year, while a considerable deterioration is observed in HHS. The percentage of households in Crisis HHS increased by 1.7 times higher than last year (47.6% to 78.9%). The deterioration in acute food security is largely attributable to drought conditions and insecurity / conflicts that have negatively impacted crop and livestock production.

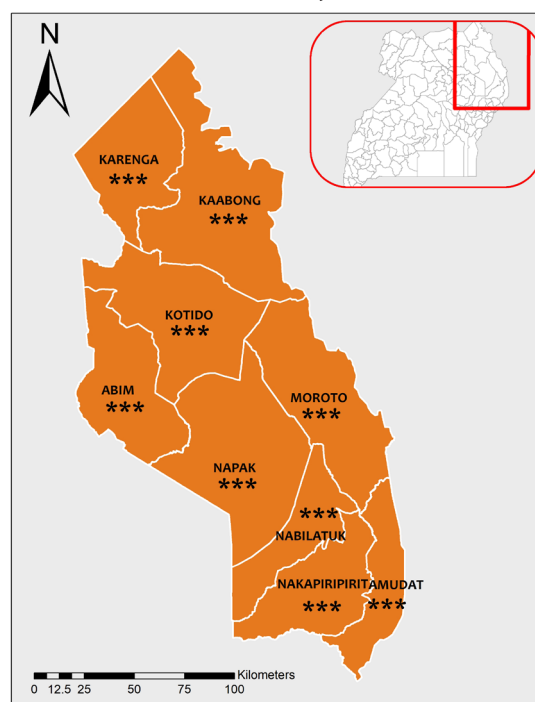
While for AFI the situation is expected to improve slightly over the projected period of August 2022 to February 2023, with the percentage in Phase 3 reducing from 50% to 35%, acute malnutrition is expected to remain similar over the same period. This is mainly due to the contributing factors that are likely to remain similar as historical evidence has shown, as well as the fact that there are no major or intensified humanitarian programs planned during the projected period that could prevent a further worsening of the malnutrition situation.

Comparison with AFI classification

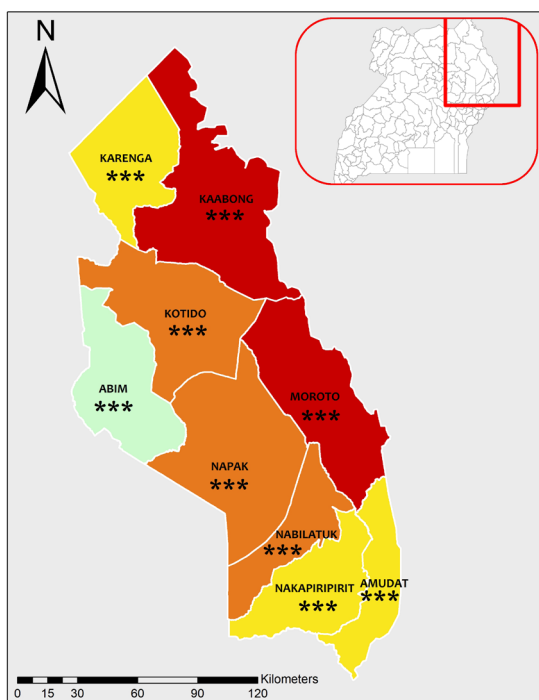
AMN Current (February - July 2022)



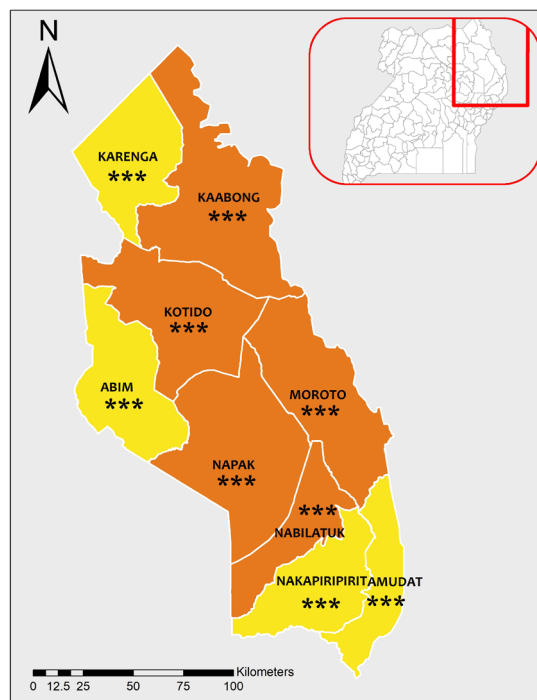
AFI Current (March - July 2022)



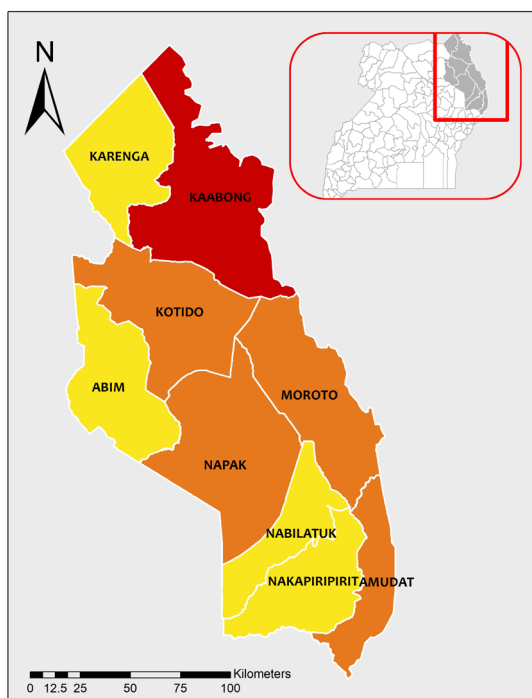
AMN Projection (August 2022- January 2023)



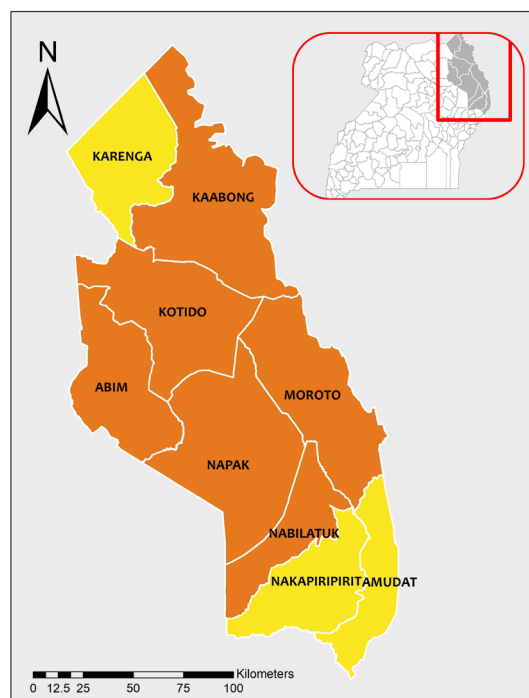
AFI Projection (August 2022 - February 2023)



AMN (February - July 2021)



AFI (March - July 2021)



Conclusion

Overall, there is a good consistency and convergence between results from the AFI and the AMN. Alongside morbidity, the low levels of Minimum acceptable diet of children in all districts and especially those with high malnutrition shows that food insecurity is likely playing a pivotal role on acute malnutrition. The situation is clearly showing that acute food insecurity has not been addressed. The evidence also strongly shows that acute malnutrition is likely to continue following the same trends, with many more other children likely becoming malnourished and possibly dying from this preventable cause. Appropriate, relevant and feasible actions are needed urgently to find and treat those already malnourished and prevent the situation from further worsening.

RECOMMENDATIONS FOR ACTION

Response Priorities

To avert further deterioration in the nutrition status among children and PLWs in the region, appropriate, relevant and feasible actions are urgently needed to break the continuous worsening of the situation and prevent acute malnutrition in future.

The following priority responses have been identified:

1. Intensify and scale up response to treat the existing cases of acute malnutrition among children as well as PLW in all the affected districts. This should ideally be done in a coordinated manner, through an appropriate, relevant, and feasible humanitarian response, in line with the needs of the affected population.
2. Promote and intensify awareness-raising actions on good practices for adequate Maternal, Infant, Young Child and Adolescent nutrition at community level.
3. Conduct an Integrated Management of Acute Malnutrition (IMAM) bottleneck or barrier analysis or Semi-Quantitative Evaluation of Access and Coverage (SQUEAC) study to understand the reasons why the situation is continuously deteriorating over time.
4. Organize and conduct a Response Analysis involving all nutrition, health, food security, as well as water and sanitation stakeholders in the region to identify appropriate interventions to improve the contributing factors and address acute malnutrition.
5. Strengthen early childhood development by improving the capacity of caregivers and infrastructure at the community centres, as well as creating greater awareness at community level about the benefits of nurturing care for children during the first five years of life.
6. Use nutrition surveillance systems to identify pockets of malnutrition and specifically target the areas in need of intervention programmes.
7. Scale up Nutrition Sensitive Agriculture in affected areas i.e., growing and consumption of early maturing, disease and drought resistant nutrient dense crops and biofortified foods such as orange-fleshed sweet potatoes, iron/zinc rich beans, vitamin rich oranges, etc.
8. Integrate WASH in nutrition and health education at health facility level and during community outreaches. Conducting home improvement campaigns on nutrition, WASH and Community-Led Total Sanitation (CLTS) will in turn increase access to safe water, improved sanitation and improved hygiene practices
9. Enact and implement by-laws on alcoholism and other unnecessary behaviours to improve childcare practices.
10. Scale up maternal and child friendly environments for improved breast feeding and optimal nutrition status. The continued support of existing programmes related to food, health, water and sanitation may be critical in ensuring a more optimal environment for mothers so they have more time to breastfeed their children.
11. Enhance and widen routine community-based micronutrient powder provision through the VHTs.
12. Social and Behaviour Change Communication (SBCC) using Information Education and communication materials in the local languages can be enhanced to dispel myths and misconceptions on nutrition taboos for good nutrition. Enhance community dialogues and awareness creation campaigns on the importance of good nutrition especially for children, pregnant and lactating mothers.

Situation monitoring and update

- Review the projected IPC AMN situation in November when most of the harvest has been done, and also when, historically, the acute malnutrition rates start dropping in the region. Usually, the months of August to October are high acute malnutrition months yet November to December are low acute malnutrition months.
- Monitor disease incidence, which historically is higher in the months of August to October.
- Monitor acute food insecurity and acute malnutrition in the most affected districts, during the projected period.

- Monitor progress in dietary intake and diversity when harvesting starts and more food is available to households.
- Monitor evolution of the security situation.
- Monitor trends in acute malnutrition admissions.

Risk factors to monitor

- Lack of an appropriate, relevant and feasible humanitarian response that addresses the most urgent needs of the affected population.
- Stock-out of nutrition supplies for treatment of acute malnutrition in each district.
- Unusual shocks such as long mid-season dry spells / drought, floods and rainfall patterns
- Seasonal human diseases like diarrhoea, measles, malaria and ARI
- Utilisation of mosquito nets and redistribution of nets in areas lacking nets and community sensitization in areas with low utilization. Additionally, monitor subsequent impact of the on-going prophylactic malaria treatment
- Distribution of relief food by Office of the Prime Minister, WFP and Andre Foods International
- Insecurity and organised cattle raids / thefts

PROCESS AND METHODOLOGY

A team of nutrition, health, food security, and statistics experts working at central as well as 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 refresher training on the IPC Acute Malnutrition scale. This training was based on the IPC Technical Manual version 3.1, and all participants who took part in the training were involved in the analysis.

The training and analysis were conducted between 6th-12th April, 2022, in Soroti district.

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

Sources

The data used in this analysis mainly came from the Food Security and Nutrition Assessment (FSNA) of 2022 conducted in all nine districts of the Karamoja region, that was conducted by WFP. District Health Information System (DHIS) data was also used. Historical FSNA were used to compare the current situation with the past and conduct trend analysis.

Limitations of the analysis

- Lack of district-specific data on some of the indicators, like disease outbreak.
- 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.
- Some analysts were new to the IPC, which took them time to adapt vis-à-vis understand the IPC tool and how it is applied.

What is the IPC and IPC Acute Malnutrition?

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

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

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

Contact for further Information

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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 Analysis Partners:






ANNEX 1: FACTORS CONTRIBUTING TO ACUTE MALNUTRITION

CONTRIBUTING FACTORS			Amudat	Kaabong	Kotido	Moroto	Nabilatuk	Napak
	Food consumption	Minimum Dietary Diversity (MDD)						
		Minimum Meal Frequency (MMF)						
		Minimum Acceptable Diet (MAD)						
		Minimum Dietary Diversity – Women (MDD-W)						
	Health status	Diarrhoea						
		Dysentery						
		Malaria						
		HIV/AIDS prevalence						
		Acute Respiratory Infection						
		Disease outbreak						
	Food security	Outcome of the IPC for Acute Food Insecurity analysis						
	Caring and feeding practices	Exclusive breastfeeding under 6 months						
		Continued breastfeeding at 1 year						
		Continued breastfeeding at 2 years						
		Introduction of solid, semi-solid or soft foods						
	Health services & environmental health	Measles vaccination						
		Polio vaccination						
		Vitamin A supplementation						
		Skilled birth attendance						

Legend	Major Contributing Factor	Minor Contributing Factor	No Contributing Factor	No data
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CONTRIBUTING FACTORS			Amudat	Kaabong	Kotido	Moroto	Nabilatuk	Napak
	Health services & environmental health	Health seeking behaviour						
		Coverage of outreach programmes						
		Access to a sufficient quantity of water						
		Access to sanitation facilities						
		Access to an improved source of drinking water						
	Structural causes and shocks	Human capital						
		Physical capital						
		Financial capital						
		Natural capital						
		Social capital						
		Policies, Institutions and Processes						
		Usual/Normal Shocks						
		Recurrent Crises due to Unusual Shocks						
	Other nutrition issues	Anaemia among children 6-59 months						
		Anaemia among pregnant women						
		Anaemia among non-pregnant women						
		Vitamin A deficiency among children 6-59 months						
		Low birth weight						
		Fertility rate						
Legend								
	Major Contributing Factor		Minor Contributing Factor		No Contributing Factor		No data	



ANNEX 2: SUMMARY FACTORS CONTRIBUTING TO ACUTE MALNUTRITION

District	District #	Children under 5							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
Abim	172,600	26,376	8.50%	6.80%	1.70%	5,829	4,663	1,166	8,630	4.60%	395
Amudat	146,100	22,199	14.80%	12.20%	2.60%	8,542	7,042	1,501	7,305	15.70%	1,145
Kaabong	141,200	20,533	27.00%	19.80%	7.20%	14,414	10,570	3,844	7,060	20.20%	1,426
Karenga	61,800	10,591	10.90%	8.10%	2.80%	3,001	2,230	771	3,090	11.30%	349
Kotido	215,300	32,600	22.50%	17.90%	4.60%	19,071	15,172	3,899	10,765	15.00%	1,609
Moroto	123,800	19,814	29.70%	20.40%	9.30%	15,300	10,509	4,791	6,190	25.30%	1,565
Nabilatuk	98,200	14,883	16.50%	12.20%	4.30%	6,385	4,721	1,664	4,910	12.10%	594
Nakapiripirit	123,000	18,602	15.00%	10.20%	4.80%	7,255	4,933	2,322	6,150	17.80%	1,096
Napak	163,600	26,109	17.40%	13.30%	4.10%	11,812	9,028	2,783	8,180	15.60%	1,274
Karamoja	1,245,600	191,707	18.00%	13.40%	4.60%	91,610	68,870	22,740	62,280		9,453

The expected number of cases of acute malnutrition among children was calculated using the following formula: $n \times p \times k$, where n is the number of children aged 6-59 months, p is the prevalence of acute malnutrition (based on the Combined GAM prevalence), 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: $n \times p$; where n is the number of PLWs and p is prevalence of acute malnutrition (based on MUAC, estimated at <23cm).