



AFRICA HEALTH  
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# AHO POLICY BRIEF ON MALNUTRITION IN UGANDA

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PREVENTING MALNUTRITION IN UGANDA

## Partners



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# Introduction

Uganda is among the 20 countries worldwide with the highest burden of malnutrition and threatens to destroy a generation of children in Uganda with more than one third of all young children (2.4 million) stunted. The damage caused by stunting is irreversible. Half of children under five and one quarter of child-bearing-age women are anemic. The burden of disease persists despite a drop in stunting and anemia rates in recent years. Between 2013 and 2015, it is estimated that more than 500,000 young Ugandan children died. Of these deaths, nearly half were associated with undernutrition. Undernutrition is responsible for 4 in 10 deaths of children under five. The 2012 study, Cost of Hunger in Uganda, estimated the health cost of children's undernutrition-related illnesses (for those under five) to be more than UGX 525 billion, most of which was used for treating undernutrition and associated illnesses. It is also estimated that undernutrition costs Uganda 1.8 trillion UGX, an equivalent of 5.6 per cent of its GDP annually (UNICEF, 2019).

The prevalence of stunting increases with decreasing levels of the mother's education. About 4 in 10 children born to mothers with no education (37 percent) are stunted compared with 1 in 10 children born to mothers with at least secondary level of education. In addition, stunting increases with decreasing wealth quintiles, from 17 percent among children in the highest wealth quintile to 32 percent of children in the lowest wealth quintile. Prevalence of wasting (low weight-for-height) nationally is 4 percent, however in the regions of Karamoja and West Nile, its higher compared to the rest of the regions (USAID, 2017).

## Analysis of the current situation

Uganda's population growth is at a rate of 3 percent a year and is facing one of the fastest growing refugee emergencies in the world. The country has received an average of 1,800 South Sudanese refugees daily since July 2016; with a total refugee population of more than 1.34 million, Uganda is currently hosting the largest number of refugees in Africa and the third-largest number in the world. In 2016, the country experienced an acute food shortage, with up to 1.6 million people food insecure and a further 9.3 million reported to be food stressed (World Bank 2017).

Fink et al. (2014) found out that Ugandan women on average give birth to 5 children, which puts pressure on the limited family resources. The fertility rates in Uganda are among the highest in East and southern Africa. Women in Uganda start childbearing at a young age; 58 percent of adolescent girls had begun childbearing in 2011 and 54 percent in 2016, which in turn poses a risk to the nutritional status of a child since children born to very young mothers are at increased risk of malnutrition, illness and death compared to those born to older mothers. The risk of stunting is 33 percent higher among first-born children of girls under 18 years and as such, early motherhood is a key driver of malnutrition.

The prevalence of anemia is high in children under 5 years; and 1 in 3 women are anemic, with regional anemia prevalence differences ranging from 17 percent in Kigezi sub-region to 47 percent in Acholi sub-region; which is a reflection of several micronutrient deficiencies, infections and, even genetic traits in malaria-endemic areas (UBOS and ICF 2018).

In addition, lack of access to clean water and sanitation, high disease burden, especially childhood diarrhea and malaria, and poor infant and young child feeding practices accelerate child malnutrition. Although 66 percent of children 0–5 months are exclusively breastfed, the percentage drops to 43 percent among children 4–5 months. Only 15 percent of breastfed children 6–23 months receive a minimum acceptable diet (UBOS and ICF 2018).

Child malnutrition remains largely a ‘hidden problem’ in Uganda. Most children affected are moderately malnourished, which is difficult to identify without regular assessment. Micronutrient deficiencies are similarly difficult to detect. Among women of reproductive age, more than 12 percent were found to be underweight in 2016, with a body mass index (BMI) of less than 18.5 kg/m<sup>2</sup>. Iron-deficiency anaemia remains the most serious micronutrient deficiency faced by Ugandan women. In addition, Uganda is faced with a double burden of malnutrition—the increasing co-existence of obesity and undernourishment in communities across the country. The 2016 UDHS showed high levels of overweight among women living in urban centres, as well as in many rural areas of Western and Central regions.

The causes of food insecurity in Uganda are multifaceted, often a result of poverty, landlessness, high fertility, natural disasters, high food prices, lack of education, and the fact that most Ugandans depend on agriculture as a main source of income. Gender inequality worsens food insecurity and poverty. Producing more staple food does not guarantee less stunted children, as seen in the southwest region, considered the “food basket” of Uganda, which has one of the highest rates of stunting among children under

5 years in the country. Pastoralists have been forced to settle in concentrated areas, leading to overgrazing and ecological degradation, which is undermining their livelihoods and their ability to cope with droughts and other climate-related disasters (FAO et al. 2017).

## Affected Population

Uganda has an enormous burden of nutrition with over 29% of children aged 6-59 months stunted (short for their age), 4% wasted (thin for their height), 11% underweight (low weight for their age) and another 4% over weight (high weight for their age), according to the 2016 Uganda Demographic Health Survey. The most vulnerable groups are infants, school children, adolescent girls, pregnant and lactating women, sick people, and older persons.

## Risk Factors

### Household food insecurity

Food insecurity is a significant underlying cause of malnutrition; agriculture in Uganda has been plagued by unreliable rainfall which affect agricultural production and food security, and these have become more frequent as a result of global climate change. In addition, the foods that households frequently consume are relatively deficient in micronutrients. Seasonality in food production, variable food prices, and seasonal earning patterns exacerbate the instability and the poor quality of the diet the household consumes through the year.

## High levels of poverty

Uganda is a Sub-Saharan African country with one of the highest rates of poverty reduction, but the country remains among the poorest in the world. According to a 2016 poverty assessment, poverty in Uganda reduced significantly from 31.1 percent in 2006 to 19.7 percent in 2013. Poor nutrition in childhood fuels the poverty cycle, in which underachievement, reduced opportunities, and increased morbidity and mortality ensue for that and subsequent generations.

The issue now is the sustainability of this poverty reduction, as Uganda is lacking important non-monetary resources. These include adequate sanitation, access to electricity, health and well-being, education and nutrition.

## Inadequate maternal and childcare.

Care-related constraints lead to both inadequate dietary intake and a high disease burden in young children. These constraints include the heavy workload that women as primary caregivers in the household must shoulder every day. Women do both farm and household chores and might engage in small business activities, while also being responsible for the continual care of the children and other dependents within the household. Frequent births limit a woman's ability to properly care for her infant and other young children, while simultaneously regaining her own health. In addition, social dislocation in many households and communities in Uganda has led to changes in traditional gender roles and increased family breakups. These changes tend to worsen the quality of the nutrition and health care women and young children receive.



Poor access to health care and a healthy environment.

Some households with young children do not live in a healthy environment with good access to toilets and other sanitation services, a reliable safe water supply, and effective health facilities and services, including nutrition services, such as micronutrient supplementation and nutrition education.

## Consequences of Malnutrition in Uganda

Malnutrition increases mortality.

Low birth weight is rampant in Uganda. Of the 2.4 million under-5 children in Uganda: 1 in 3 are stunted and 1 in 2 are anemic. Between 2013 and 2015, over 500,000 children below 5 years died, with malnutrition accounting for half of the mortality (UNICEF, 2019). Other forms of malnutrition were associated with more than 67,500 child deaths in 2018. Anaemia affects 49 percent of women. One in three of these deaths could be prevented if Uganda doubled its coverage of micronutrient supplementation among pregnant women.

Malnutrition significantly reduces agricultural productivity.

Uganda's main employer, the agriculture sector lost more than US\$34 million worth of productivity in 2009 alone due to iron-deficiency anaemia in the adult population. Other losses to agriculture occurred as a result of time lost due to illnesses associated with other types of malnutrition or time lost while dealing with family illnesses or deaths associated with malnutrition.

Malnutrition contributes to poverty.

Uganda loses US\$310 million worth of productivity per year due to the high levels of stunting, iodine-deficiency disorders, iron deficiency, and low birth weight, and malnutrition contributes to a loss of about 4.1 percent of the gross domestic product per year. Malnutrition is expensive to treat. For instance, treating severe acute malnutrition costs more than US\$120 per child.

Malnutrition affects the education and intellectual potential of schoolchildren.

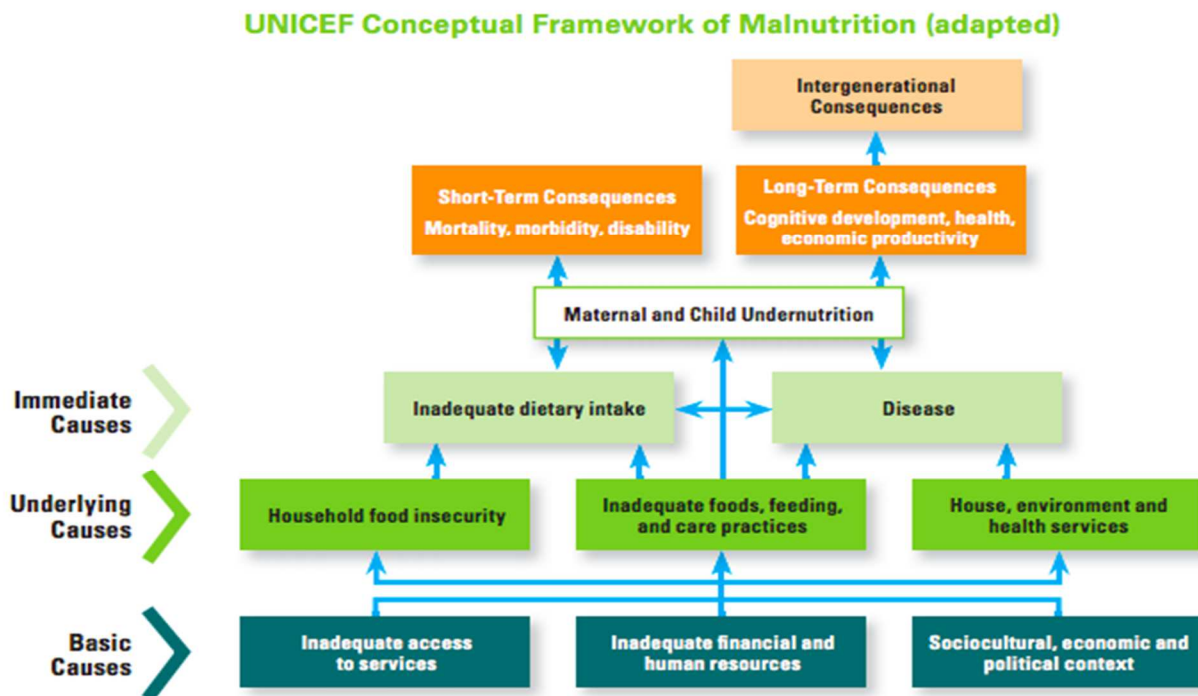
Between 2006 and 2015, iodine-deficiency disorder was responsible for cretinism in over 19,000 children and mental disabilities in 540,000 children. In addition, stunting causes children to start school late because they are too small for their age. In 2006, one in four 7-year-olds had not started school, even with the Universal Primary Education programme. Malnutrition is also a leading cause of absenteeism and repetition of school years in children from disadvantaged households.

Obesity and overweight increases the risk of noncommunicable diseases.

The prevalence of cardiovascular disease, type II diabetes, hypertension, musculoskeletal disorders, and cancer (endometrial, breast, and colon) increases with obesity and overweight. These comorbidities have high medical costs that result in cycles of debt and illness, exacerbating poverty and perpetuating health and economic inequalities. In addition, these affect worker productivity, resulting in loss of economic production and household earnings.

# Conceptual framework of Malnutrition in Uganda

The causes and consequences of malnutrition are multi-dimensional and interconnected. The causes range from policy issues and immediate household conditions to underlying community and cultural situations. The immediate causes of child malnutrition in Uganda are twofold: inadequate dietary intake resulting from suboptimal maternal and infant feeding practices and the high disease burden resulting from malaria, diarrheal diseases, acute respiratory infections, and worm infestations. The underlying causes range from traditions that influence food intake and health-seeking behaviour, care for women and women empowerment in decision making at the household level, teenage pregnancies and frequent short-spaced pregnancies, increasing alcoholism and related gender-based violence, and lack of livelihood options and skills to withstand the effects of national and community shocks.



Effectively addressing malnutrition requires an integrated approach with broad cross-sectoral political support. While cross-sectoral coordination increases the challenges in implementing effective programmes, these challenges are not insuperable, particularly if there is effective leadership at national and district levels.

## Priority actions to reduce malnutrition in Uganda.

The nutrition strategies and interventions to address malnutrition in Uganda should target children, women, elderly and sick people with the following objectives.

- Improving access to and utilisation of services related to maternal, infant, and young child nutrition.
- Strengthening the policy, legal, and institutional frameworks and the capacity to effectively plan, implement, monitor, and evaluate nutrition programmes.
- Creating awareness of and maintain national interest in and commitment to improving and supporting nutrition programmes in the country.
- Enhancing consumption of diverse diets, especially by using locally available foods.
- Protecting households from the impact of shocks and other vulnerabilities that affect their nutritional status, such as drought.

## Recommendations to reduce malnutrition in Uganda.

- Strengthening proper nutrition in the early years of life for lifelong growth and development in children. All stake holders should prioritize interventions to improve

children's nutrition. This may require providing caregivers with nutrition education and behavior change communication on proper infant and young child feeding practices; improving access to nutritious foods for pregnant women, mothers, and children; and improving healthcare services and the water, sanitation, and hygiene environment to reduce infections and infestation with parasites.

- Invest in the fight against malnutrition by prioritizing it through increased budgetary allocation for the agreed interventions within the sector.
- Initiate community-led programmes targeting interventions to promote diet diversity, backyard gardening, integrated farming, post-harvest food handling, school nutrition, water and sanitation, and child spacing. Agriculture extension needs to be strongly supported as the entry point for scaling up nutrition investment.
- Establish disaster preparedness and relief committees and prepare plans and strategies to reduce nutrition challenges associated with external shocks and disasters.
- Strengthen the intersectoral collaborations of all stakeholders and government agencies in addressing malnutrition and ensuring that sectors explicitly allocate direct resources towards addressing malnutrition.
- Employ and deploy nutritionists to participate and coordinate the implementation of nutrition activities at local levels.
- Increase the social mobilization through mass media campaigns about the basic nutrients for both the children and women of reproductive age.

- Establishing a multi -sectoral nutrition coordination committee to ensure effective planning and budgeting for nutrition programmes, coordination of the different related implementers at local levels, and monitoring of the agreed plans and activities. The local leaders should take the lead in convening nutrition coordination committees and ensuring that they are functional.
- Measures must be taken to increase the productivity and resilience of refugee populations. Such measures include improving tenure security; providing increased technical assistance in farming; increasing the availability of veterinary care to enhance the benefits of livestock keeping by refugees and minimize the risks of livestock disease; and improving the provision of basic services such as water, sanitation, hygiene, and healthcare for refugee and host communities.
- Preventing and controlling childhood obesity by involving parents to play a critical role in child's nutrition and physical activity choices. Educate parents about the physical activity standards about how much time children in day care should spend in moderate-vigorous physical activity; increase their risk perception of unhealthy foods to children; and encourage nutritious meals and snack options that consist of as many fresh produce items as possible, low-fat dairy, fruits, vegetables, whole grains, water and low-fat milk should be the preferred.

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