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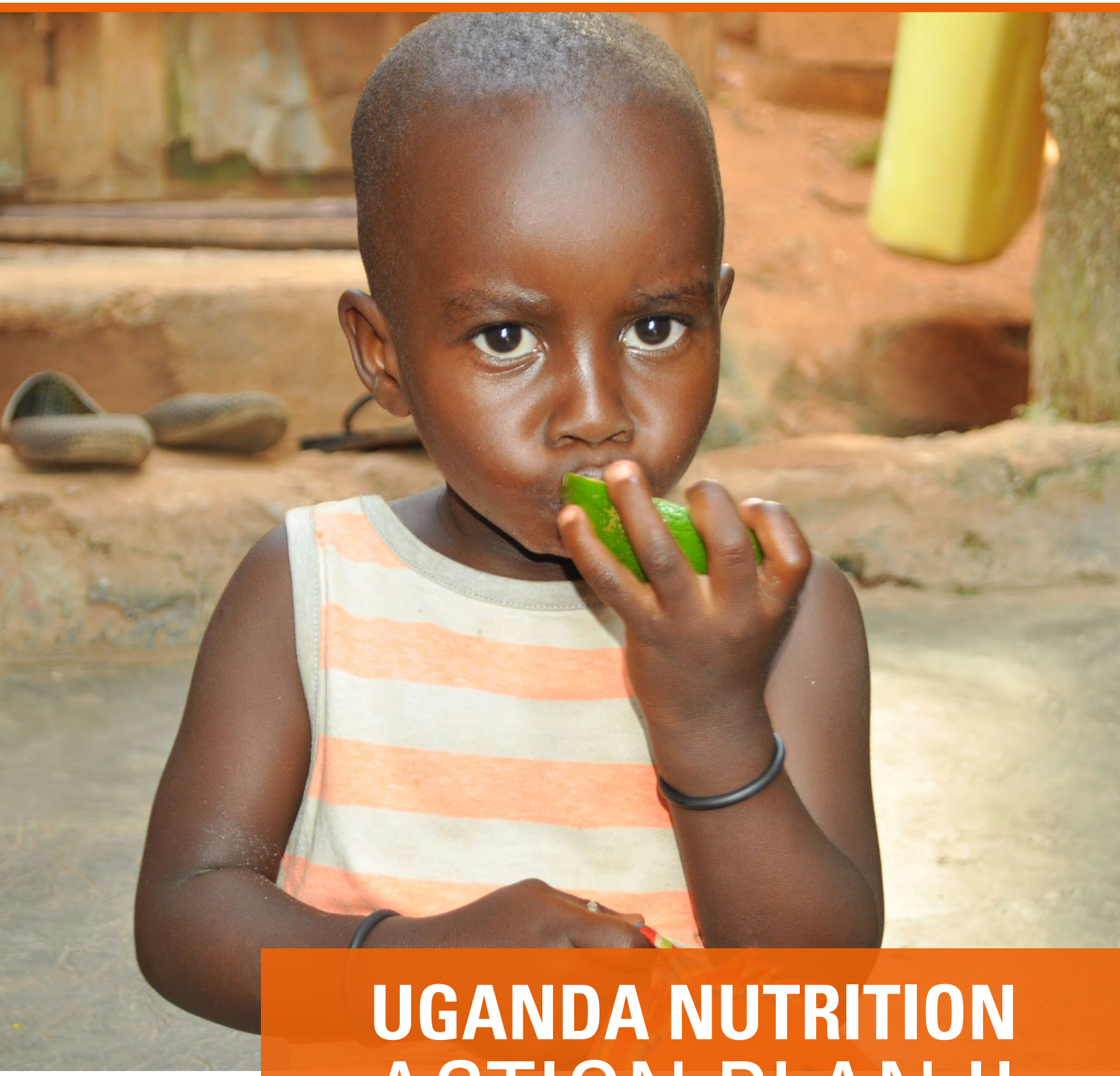

UGANDA NUTRITION ACTION PLAN II

2020/21 – 2024/25

RECOMMENDED CITATION: Office of the Prime Minister, 'Uganda Nutrition Action Plan (2020-2025): Leaving no-one behind in scaling up nutrition actions', Kampala, Uganda, 2020

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The second 'Uganda Nutrition Action Plan 2020-2025' was developed by the Office of the Prime Minister, Uganda. The European Union provided the funding for this plan. Additional information about it may be obtained from the Office of the Prime Minister.

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THE REPUBLIC OF UGANDA
OFFICE OF THE PRIME MINISTER

UGANDA NUTRITION ACTION PLAN II

2020/21-2024/25

VISION

‘A well-nourished, healthy and productive population effectively participating in the socio-economic transformation of Uganda.’

THEME

‘Leaving no-one behind in scaling up nutrition actions in Uganda.’

NATIONAL VISION STATEMENT

‘A transformed Ugandan society from a peasant to a modern and prosperous country within 30 years.’

THIRD ‘NATIONAL DEVELOPMENT PLAN’ (NDP III) GOAL

‘Increased household incomes and improved quality of life of Ugandans.’

SECOND ‘UGANDA NUTRITION ACTION PLAN’ GOAL

‘Improved nutrition status among children under five years, school-age children, adolescents, pregnant and lactating women and other vulnerable groups by 2025.’

Map of Uganda showing Uganda Demographic and Health Survey (UDHS) sub-regions in which Uganda Nutrition Action Plan (UNAP) programming is based

Source: UNICEF, 2020

This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers

Foreword

Right Honourable
Nabbanja Robinah (MP)

The second 'Uganda Nutrition Action Plan' ('UNAP II') comes when Uganda, like other countries, is in a season of disease management due to the coronavirus disease (COVID-19). The pandemic has highlighted the need to ensure adequate food security and nutrition through healthy, sustainable diets. Under guideline 13 of his communication on the measures against COVID-19, His Excellency, Yoweri Kaguta Museveni, the President of Uganda, emphasized good nutrition as 'immunization' against COVID-19. Earlier, in 2019, His Excellency launched the 'Presidential Initiative on Healthy Eating and Lifestyle.' Food security and adequate nutrition are of paramount importance for a healthy and productive life. Nutrition is a major factor in healthcare because it reduces the burden of preventable diseases and ultimately leads to increased and sustainable productivity. In order to improve nutrition, the Ugandan Government has been and will continue to implement programmes to ensure adequate nutrition for all Ugandans. The 'UNAP II' is, therefore, a welcome and timely development.

It is important to note that government commitment to address malnutrition remains high on the development agenda, as reflected in the third 'National Development Plan' ('NDP III'). The 'NDP III' includes the following targets: increase per capita income to US$1,361 by 2025, from US$864 in 2017/18; increase life expectancy at birth to 70 years from 63.3; reduce the poverty rate to 15.5 per cent from 21 per cent; increase the proportion of food secure households from 69 per cent (per baseline in 2017/18) to 89.84 per cent in 2025 and reduce the prevalence of children under-five stunting from 28.9 per cent to 19 per cent by 2025. These high-level results in the national planning framework will not be achieved unless good nutrition becomes a norm for the average Ugandan. This calls for a sustained, concerted effort by and with all key actors in promoting effective, equitable nutrition programming.

The second 'Uganda Nutrition Action Plan' ('UNAP II') has been developed to build upon the gains made under 'UNAP I' (2011-2016). For instance, the country registered a reduction in the prevalence of child stunting from 33 per cent in 2011 to 28.9 per cent in 2016. I extend my appreciation to government ministries, departments and agencies (MDAs), and all partners who worked together with the Office of the Prime Minister (OPM) in supporting the implementation of 'UNAP I' and subsequently the development of this second nutrition action plan.

Since the implementation of 'UNAP I', nutrition has been acknowledged as a development and human rights issue globally and nationally. It is a cross-cutting and multi-sectoral issue central to societal development and transformation. These are aspirations of the Uganda Vision 2040, 'NDP III' and the National Resistance Movement (NRM) Manifesto 2021-2026. The principles underpinning this paradigm on nutrition are embodied in this second 'Uganda Nutrition Action Plan', the country's strategic framework for Scaling up Nutrition (SUN) and overall planning framework for nutrition programming 2020/21-2024/25 in the country.

The momentum gathered so far in implementing strategies laid out in the 'Uganda Nutrition Action Plan' results from leveraging the synergies of multiple actors. These include government ministries, local governments (LGs), development partners and other non-state actors, including civil society organizations (CSOs), the private sector and the academia. This plan will be the vehicle in ensuring that Uganda achieves all the Sustainable Development Goal (SDG) targets relating to ending hunger, achieving food security, improving nutrition and promoting sustainable agriculture. Additionally, meeting these targets contributes to attaining others since nutrition is related to 12 SDGs. Furthermore, in 2016, at the global High-Level Political Forum in New York, nutrition was identified as a catalyst for the SDGs. Specifically, an effort is needed to address poor dietary diversity and meal frequency among children aged six months to two years, reduce anaemia in children and women, and decrease the prevalence of stunting among children in all the sub-regions of Uganda.

The 'UNAP II' goal, objectives, strategies and priority actions align with the 'NDP III' programme areas of Human Capital Development, Agro-Industrialization, Community Mobilization and Mindset Change, Regional Development and Development Plan Implementation. Therefore, the development and adoption of the 'UNAP II' are in line with the Ugandan Government's intent and national priorities. The 'UNAP II' provides a coordinated framework for inclusively and sustainably implementing, monitoring and reporting, resulting in improved multi-sectoral nutrition results.

Successful implementation of 'UNAP II' requires adequate financial and human resources, effective multi-sectoral coordination, a strengthened enabling environment for scaling up nutrition services and practical monitoring, evaluation, accountability and learning (MEAL). Therefore, the implementers of the 'UNAP II' should focus on delivering common results, enhancing synergies and strengthening the alignment of work plans and budgets for smooth implementation of its priority actions. I also call upon for involvement and practice of data management, research and evidence for nutrition for policy decisions and learning.

I call again upon all stakeholders, including government ministries, civil society organization, development partners, the private sector, academia and research institutions, to embrace this 'UNAP II' by supporting its implementation and being champions for nutrition in all your spheres.

For God and My Country.

Right Honourable Nabbanja Robinah (MP)
Prime Minister

ACKNOWLEDGEMENTS

The Government of Uganda acknowledges the contribution of State and non-state stakeholders towards the development of this five year 'Uganda Nutrition Action Plan' that will steadily and reasonably move Uganda towards a malnutrition-free society. I commend the strategic guidance and leadership provided by the Policy Coordination Committee on Nutrition chaired by the Prime Minister.

In a special way, I would like to acknowledge the financial and technical support from Nutrition International, formerly the Micronutrient Initiative, under the Technical Assistance for Nutrition project, funded through UK Aid from the British Government. Other key development partners who contributed, notably United Nations Children's Fund (UNICEF), are much appreciated. The oversight role by the Office of the Prime Minister (OPM) through the Strategic Coordination and Implementation (SCI) department cannot be underestimated.

Special recognition also goes to the Multi-sectoral Nutrition Technical Coordination Committee (MSNTCC) led by Joses Tegyeza (OPM); Maureen Tumusiime Bakunzi (OPM); Alex Bambona (Ministry of Agriculture, Animal Industry and Fisheries); Dr George Upenthu Upenytho (Ministry of Health); Susan Oketcho (Ministry of Education and Sports); Stanly Ahimbisibwe (Ministry of Trade, Industry and Cooperatives); Everist Tumwesigye (Ministry of Gender, Labour and Social Development); Andrew Musoke (Ministry of Local Government); Julia Kamara (Ministry of Water and Environment); Dr Sarah Nahalamba (National Planning Authority); Nelly Birungi (UNICEF); the resource persons who supported the drafting of this Nutrition Action Plan; Patrick Nganzi; Dr Dan Kajungu; Jacob Korir and Asiimwe Charles. Members of the Parliamentary Forum on Nutrition, District Nutrition Coordination Committees and all non-state actors who participated in the development of this action plan are highly appreciated. All members who made significant contributions to the development and finalization of this document are duly acknowledged and applauded for their valuable inputs. Recognition also goes to the local, regional and international data authorities, including the Uganda Bureau of Statistics (UBOS), whose publications were vital in informing the development of this action plan.

This second 'Uganda Nutrition Action Plan' will be of much help to all stakeholders at national, regional and international levels as a reference framework for guiding Uganda's multi-sectoral response towards attaining better nutrition for all.

Geoffrey Seremba
Ag. Permanent Secretary
Office of the Prime Minister

Statement of Commitment

We, the Honourable Ministers and Chairpersons of the UNAP-implementing ministries, departments and agencies which constitute the Policy Coordination Committee on nutrition are:

1. **Certain of** the fact that nutrition is central to national development through human capital development, increased productivity and ultimately the sustainable transformation of our country;
2. **Concerned** that the double burden of malnutrition is emerging with diet-related non-communicable diseases increasing at a fast pace alongside high levels of undernutrition;
3. **Mindful** of the negative consequences of all forms of malnutrition on the achievement of national social and economic development, and that the attainment of good nutritional status, especially among children and women of reproductive age, is both a marker and a maker of sustainable development;
4. **Confident** that interventions and priority actions outlined in the 'UNAP II' are informed by the 'NDP III' and the relevant programme implementation action plans.

Through our signatures attached hereto, we commit ourselves to the following:

1. We reaffirm that it is our joint responsibility at all levels and with all stakeholders to accelerate progress towards attaining better nutrition outcomes in Uganda.
2. We shall take practical steps to enhance our MDA policies, strategies, programmes, plans and budgets to integrate nutrition actions.
3. We will take the lead in enhancing the effective implementation of our MDA nutrition work plans actions and achievement of the 'UNAP II' outcomes.

MINISTERS AND CHAIRPERSONS

Minister for General Duties, Office of the Prime Minister	Minister of Public Service	Minister of Finance, Planning and Economic Development	Minister of Local Government
Minister of Education and Sports	Minister of Agriculture, Animal Industry and Fisheries	Minister of Health	Minister of Trade, Industry and Co-operatives
Minister of Gender, Labour and Social Development	Minister of Water and Environment	Minister, Office of the President in charge of Science, Technology and Innovation	Minister for Relief, Disaster Preparedness & Refugees
Minister for Karamoja Affairs	Minister of Information, Communications Technology and National Guidance	Minister for Kampala City and Metropolitan Affairs	Chairperson Uganda Bureau of Statistics
Chairperson National Planning Authority			

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Acronyms

ALN	African Leaders for Nutrition Initiative
AMIS	Agricultural Market Information System
ARIN	Academia and Research Institutions Network
ARNS	Africa Regional Nutrition Strategy
AU	African Union
BMI	Body mass index
CESCR	Committee on Economic, Social and Cultural Rights
CFS	Committee for World Food Security
COHA	Cost of hunger in Africa
COVID-19	Coronavirus disease
CBO	Community-based organization
CDO	Community development officer
CSOs	Civil society organizations
DD	Dietary diversity
DDPs	District development plans
DNCC	District Nutrition Coordination Committee
DLG	District local government
DPs	Development partners
DRNCDs	Diet-related non-communicable diseases
EAC	East Africa Community
EAPA FSN	Eastern African Parliamentary Alliance for Food Security and Nutrition
ECD	Early childhood development
FAL	Functional adult literacy
FAO	Food and Agriculture Organization
FEWSNET	Famine Early Warning Systems Network
GBV	Gender-based violence
GHI	Global Hunger Index
GDP	Gross domestic product
GLOPAN	Global Panel on Agriculture and Food Systems for Nutrition
GNR	Global Nutrition Report
HCDP	Human Capital Development Programme
HMIS	Health Management Information System
ICN	International Conference on Nutrition
ICSCN	Implementation Coordination Steering Committee on Nutrition
IECD	Integrated early childhood development
ITN	Insecticide-treated net
KCCA	Kampala Capital City Authority
KCCA-DNCC	Kampala Capital City Authority District Nutrition Coordination Committee
LBW	Low birth weight
LF	Lead farmer
LLG	Lower local government
LGs	Local governments
M&E	Monitoring and evaluation
MAAIF	Ministry of Agriculture, Animal Industry and Fisheries
MAD	Minimum acceptable diet
MDAs	Ministries, departments and agencies
MDA NCC	Ministries, department and agencies Nutrition Coordination Committee
MDD	Minimum diet diversity
MDNCC	Municipal Division Nutrition Coordination Committee
MEAL	Monitoring, evaluation, accountability and learning
MIYCAN	Maternal, infant, young child and adolescent nutrition
MNCC	Municipality Nutrition Coordination Committee
MoES	Ministry of Education and Sports
MoFPED	Ministry of Finance, Planning and Economic Development
MoGLSD	Ministry of Gender, Labour and Social Development
MoH	Ministry of Health
MoLG	Ministry of Local Government
MoPS	Ministry of Public Service

MoSTI	Ministry of Science, Technology and Innovation
MoTIC	Ministry of Trade Industry and Cooperatives
MoWE	Ministry of Water and Environment
MSMEs	Micro, small and medium enterprises
MSNTCC	Multi-Sectoral Nutrition Technical Coordination Committee
MTEF	Mid-Term Expenditure Framework
N4G	Nutrition for growth
NCC	Nutrition Coordination Committee
NCD	Non-communicable diseases
NDP III	National Development Plan (Third)
NDPG	Nutrition Development Partner Group
NEPAD	New Partnership for Africa's Development
NGO	Non-governmental organization
NIPN	National Information Platform for Nutrition
NNF	National Nutrition Forum
NNP	National Nutrition Policy
NPA	National Planning Authority
NRM	National Resistance Movement
OPM	Office of the Prime Minister
ORS	Oral rehydration salts
ORT	Oral rehydration therapy
PCC	Policy Coordination Committee
PCCN	Policy Coordination Committee on Nutrition
PDC	Parish Development Committee
PG	Parental group
PIAP	Programme implementation action plan
P/WNCC	Parish/Ward Nutrition Coordination Committee
RCNCC	Regional City Nutrition Coordination Committee
RCNFP	Regional City Nutrition Focal Person
RDI	Required dietary intake
RHF	Recommended homemade fluids
RI	Regional initiative
SBCC	Social behaviour change communication
SBN	SUN Business Network
SCI	Strategic coordination and implementation
SDG	Sustainable Development Goal
SDPs	Sector development plan
SNCC	Sub county Nutrition Coordination Committee
SOFA	State of food and agriculture
SUN	Scaling Up Nutrition
TNCC	Town Council Nutrition Coordination Committee
TPC	Technical Planning Committees
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UGX	Uganda Shilling
UNAP I	Uganda Nutrition Action Plan (First)
UNAP II	Uganda Nutrition Action Plan (Second)
UNECA	United Nations Economic Commission for Africa
UNICEF	United Nations Children's Fund
UNPS	Uganda National Planning Survey
UNSCN	United Nations System Standing Committee on Nutrition
UNREACH	United Nations Renewed Efforts Against Child Hunger and undernutrition
UWEP	Uganda Women Entrepreneurship Programme
USAID	United States Agency for International Development
VIP	Ventilated improved pit (latrines)
WASH	Water, sanitation and hygiene
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organization

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Executive Summary

This second 'Uganda Nutrition Action Plan' ('UNAP II') will guide the country in delivering the nutrition aspirations articulated in Uganda Vision 2040 and the third National Development Plan (2020/21-2024/25). The second 'Uganda Nutrition Action Plan' 2020/21-2024/25 is anchored on the progress made, challenges encountered, and lessons learnt from the implementation of 'UNAP I'. As Uganda faces the COVID-19 pandemic, the 'UNAP II' presents an inroad into 'immunizing' its people through accessible good nutrition and healthy lifestyles for all. The health, safety and well-being of all Ugandans remain a responsibility and top priority of the Ugandan Government. The 'UNAP II', alongside other relevant sector strategic plans, will spur on government commitment toward a Uganda that is free of all forms of malnutrition. In light of this, the 'UNAP II' defines the strategic direction for the country and sets critical objectives, strategies, priority actions and targets to achieve optimum nutrition for all Ugandans in a sustainable manner that is essential for a healthy and productive life.

HIGHLIGHTS OF 'UNAP II' VISION, GOAL AND OBJECTIVES

The vision of the 'UNAP II' is: 'A well-nourished, healthy and productive population effectively participating in the socio-economic transformation of Uganda.' The goal is: 'Improved nutrition status among children under five years, school-age children, adolescents, pregnant and lactating women and other vulnerable groups by 2025.' The three strategic objectives are:

OBJECTIVE 1

To increase access to and utilization of nutrition-specific services by children under five years of age, school-age children, adolescents, pregnant and lactating women and other vulnerable groups.

OBJECTIVE 2

To increase access to and utilization of nutrition-sensitive services by children under five years, school-age children, adolescents, pregnant and lactating women and other vulnerable groups.

OBJECTIVE 3

To strengthen the enabling environment for scaling up nutrition-specific and nutrition-sensitive services.

ACHIEVEMENTS AND CHALLENGES

Some significant achievements registered throughout 'UNAP I' implementation include:

Child stunting reduced from **33% to 29%**

Child wasting reduced from **5% to 4%**

Newborns put to the breast within one hour of birth increased from **53% to 66%**

Infants aged 0-5 months old who were exclusively breastfed increased from **63% to 66%**

Children aged 6-23 months who achieved minimum diet diversity (MDD) being 4+ food groups increased from **12.8% to 30.3%**

minimum acceptable diet (MAD) increased from **5.8% to 15%**

Children aged 6-59 months receiving vit. A supplementation increased from **56.8% to 62%**

Pregnant women receiving iron and folic acid supplementation increased from **75%to 88%**

Women of reproductive age who

took iron tablets or syrup for 90+ days increased from **4% to 23%**

consumed foods rich in vitamin A increased from **61% to 74%**

consumed foods rich in iron improved from **34% to 58%**

Women who took deworming medication during pregnancy increased from **50% to 60%**

Children aged 6-59 months given deworming medication increased from **50% to 71%**

Despite the above achievements, there are several significant challenges, including:

Meal frequency among children aged 6-23 months reduced from **45% to 42%**

The prevalence of anaemia in women increased from **49% to 53%**

The prevalence of anaemia in children increased from **23% to 32%**

The status of overweight in children under five years of age increased from **3%to 4%**

The status of overweight among adult women increased from **14.6% to 16.5%** while adult overweight increased from **4% to 7.2%**

Obesity among men increased from **0.2% to 1.2%** while adult obesity in women increased from **4.2% to 7.2%**

Coverage of nutrition-specific interventions and nutrition-sensitive interventions remained **below the expected level of 80%**

Inadequate functionality of nutrition coordination structures at all levels.

STRATEGIES THAT WILL DELIVER THE RESULTS

The following strategies will be implemented to realize OBJECTIVE 1

To increase access to and utilization of nutrition-specific services by children under five years of age, school-age children, adolescents, pregnant and lactating women and other vulnerable groups.

Strategy 1.1 Promote optimal maternal, infant, young child and adolescent nutrition (MIYCAN) practices in stable and emergency situations.

Strategy 1.2 Promote optimal micronutrient intake among children, adolescent girls and women of reproductive age in stable and emergency situations.

Strategy 1.3 Increase coverage of the management of acute malnutrition in stable and emergency situations.

Strategy 1.4 Integrate nutrition services in the prevention, control and management of infectious diseases and epidemics.

Strategy 1.5 Integrate nutrition services in the prevention, control and management of diet-related non-communicable diseases.

The following strategies will be implemented to realize OBJECTIVE 2

To increase access to and utilization of nutrition-sensitive services by children under five years, school-age children, adolescents, pregnant and lactating women and other vulnerable groups.

Strategy 2.1 Increase the production of diverse, safe and nutrient-dense food at the household level from plant, fisheries and animal sources.

Strategy 2.2 Increase access to diverse, safe and nutrient-dense food from plant, fisheries and animal sources.

Strategy 2.3 Increase the utilization of diverse, safe and nutrient-dense food from plant, fisheries and animal sources.

Strategy 2.4 Promote the integration of nutrition services in social protection programmes.

Strategy 2.5 Promote access to nutrition services through integrated early childhood development (ECD) services and quality education and sports.

Strategy 2.6 Increase access to nutrition-sensitive water, sanitation and hygiene (WASH) services.

Strategy 2.7 Increase the participation of trade, industry and investment actors in scaling up nutrition.

The following strategies will be implemented to realize OBJECTIVE 3

To strengthen the enabling environment for scaling up nutrition-specific and nutrition-sensitive services.

Strategy 3.1 Strengthen nutrition coordination and partnerships at all levels.

Strategy 3.2 Improve the planning, resource mobilization, financing and tracking of nutrition investments.

Strategy 3.3 Strengthen institutional and technical capacity for scaling up nutrition actions.

Strategy 3.4 Strengthen nutrition advocacy, communication and social mobilization for nutrition.

Strategy 3.5 Strengthen coherent policy, legal and institutional frameworks for nutrition.

Strategy 3.6 Strengthen and institutionalize nutrition evidence and knowledge management along with a multi-sectoral nutrition information system for effective decision making.

IMPLEMENTATION AND COORDINATION MODALITIES

The 'UNAP II' provides a framework for scaling up multi-sectoral implementation of nutrition-specific, nutrition-sensitive and nutrition-enabling environment interventions across state and non-state actors.

The coordination framework is at nine levels:

1. The National Nutrition Forum (NNF).
2. Policy Coordination Committee on Nutrition (PCCN).
3. Implementation Steering Coordination Committee (ISCC)
4. Multi-Sectoral Nutrition Technical Coordination Committee (MSNTCC).
5. MDA Nutrition Coordination Committee (NCC).
6. Regional city and district NCCs
7. City division NCCs, municipal NCCs and regional city division NCCs
8. Municipal division NCCs and sub county/town council NCCs
9. Parish and ward NCCs

Under Scaling Up Nutrition (SUN) arrangements, at the country level, the following networks exist:

- SUN Development Partner Group (DPG) Network
- SUN Civil Society Organization (CSO) Network
- SUN Business Network (SBN)
- SUN Academia and Research Institutions Network (ARIN)

TOTAL FINANCING REQUIREMENTS

The five-year 'UNAP II' total cost is **3.28 trillion Uganda Shillings (UGX)**. Financing will be a collaboration between the Government of Uganda, development partners, the private sector, communities, CSOs and households. Adequate financing is a crucial prerequisite for successfully implementing priority actions and achieving 'UNAP II' goals.

KEY EXPECTED PRIMARY OUTCOMES

The 14 key expected primary outcomes of implementing the plan are categorized into two groups with expected primary targets under each.

1. Reduced prevalence of undernutrition

The expected primary targets on undernutrition are:

Reduced prevalence of stunting in children aged 0-5 years from **29% to 19%**	Reduced prevalence of low birth weight (<2500 g) from **10% to 7%**	Reduced prevalence of wasting in children aged 0-5 years from **4% to 3%**	Reduced prevalence of anaemia in children aged 0-5 years from **53% to 35%**	Reduced prevalence of anaemia in women of reproductive age from **32% to 20%**

2. Reduced prevalence of overweight, obesity and diet-related non-communicable disease

The expected primary targets on overweight, obesity and diet-related non-communicable disease (NCD) are:

Reduced prevalence of overweight in children aged 0-5 years from **4% to 3%**	Reduced proportion of overweight adult women aged 18+ years from **16.5% to 12.5%**	Reduced proportion of overweight adult men aged 18+ years from **7.7% to 3.7%**	Reduced proportion of obesity in adult women aged 18+ years from **7.2% to 5.2%**	Reduced proportion of obesity in adult men aged 18+ years from **1.2% to 0.4%**
Reduced proportion of overweight in adolescents from **10% to 6%**	Proportion of obesity in adolescent girls maintained at **1%**	Reduced age-standardized prevalence of raised blood glucose/diabetes among persons aged 18+ years from **3.3% to 2.1%**	Reduced age-standardized prevalence of raised blood pressure among persons aged 18+ years from **24% to 20%**	

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CHAPTER ONE

Introduction

The second 'Uganda Nutrition Action Plan' ('UNAP II') (2020/21-2024/25) outlines strategies to address the nutrition needs of all population groups in Uganda with a particular focus on children under five years, school-age children, adolescents, pregnant and lactating women and other vulnerable groups. The plan has been developed in the context of existing nutrition legal and policy frameworks and initiatives at the global, regional and national level. The Constitution of the Republic of Uganda underscores an individual's right to health, food security, and nutrition to ensure a healthy and well-nourished Ugandan society. All relevant ministries, departments and agencies (MDAs) are required to set minimum standards and develop policies that ensure optimal nutrition. The 'UNAP II' provides guidance to all key stakeholders in fulfilling their responsibilities and commitments to ensuring a well-nourished population.

1.1 WHY INVEST IN NUTRITION

Good nutrition is a catalyst for social and economic transformation and human development. The United Nations System Standing Committee on Nutrition (UNSCN) (2017) states that since **good nutrition** (as opposed to malnutrition) is a human right, it is a **moral imperative** to work towards the elimination of malnutrition, considering current knowledge, techniques and means of mobilization and communication.

Good nutrition is a human right and the foundation of well-being

United Nations System Standing Committee on Nutrition (UNSCN), 2017

Every man, woman and child has the right to adequate food and nutrition

Committee on Economic, Social and Cultural Rights (CESCR) (1999)

One dollar invested in nutrition gives a rate of return of US$16

(GNR, 2015)

"NUTRITION IS ONE OF THE BEST DRIVERS OF DEVELOPMENT: IT SPARKS A VIRTUOUS CYCLE OF SOCIO-ECONOMIC IMPROVEMENTS, SUCH AS INCREASING ACCESS TO EDUCATION AND EMPLOYMENT."

Kofi Annan, former UN Secretary-General (2018)

Nutrition is essential, especially the first 1,000 days from conception to two years. Poor nutrition causes irreversible cognitive and physical damage, with consequences for individuals, households, communities and the nation. According to the 'Global Nutrition Report' (GNR) (2018), malnutrition is responsible for more ill-health than any other cause; therefore, good health is impossible without good nutrition. The same report highlights that undernutrition can be attributed to approximately 45 per cent of deaths among children under five, mainly in low and middle-income countries (including Uganda). Furthermore, the health consequences of overweight and obesity contribute to an estimated 4 million deaths (7.1 per cent of all deaths) and 120 million healthy years of life lost (disability-adjusted life years) across the global population.

The 'Cost of Hunger in Africa' (COHA) study in Uganda (2013) established that malnutrition is associated with 15 per cent of all under-five mortalities, which represented over 19,000 child deaths in 2009. The total losses in productivity attributed to childhood malnutrition were estimated at approximately UGX 1.9 trillion (US$899 million), which represented 5.7 per cent of the nation's gross domestic product (GDP). In terms of education, the report highlighted that 7 per cent of all grade repetitions in school are associated with a higher incidence experienced by stunted children.

According to the 'COHA' Uganda report, improved nutrition in Uganda from 2013 to 2025 would:

- Save more than 101,000 infants' lives by improving breastfeeding practices.
- Save more than 60,000 children's lives by decreasing vitamin A deficiency.
- Save approximately 119,000 children's lives by preventing stunting.
- Save approximately 26,000 infants' lives by reducing low birth weight.
- Save approximately 20,000 infants' and 7,000 mothers' lives by decreasing maternal anaemia.
- Prevent permanent brain damage in about 236,000 children and increase the average child's intelligence quotient by up to 13.5 points by preventing iodine deficiency.
- Result in earlier school enrolment, children staying in school longer, and better performance in school.

By 2025, this would total 19.8 million equivalent school years of learning gained, lead to economic gains through increased productivity exceeding UGX 4.3 trillion (US$1.7 billion) by 2025 and lead to improvement in the health and family planning sectors. Since health, family planning and nutrition are synergistic, investing in any one sector alone will not lead to the same return as investing in all of them.

The benefits of investing in nutrition far outweigh the costs, making it one of the 'smartest investments' for Uganda's economic development and prosperity. Therefore, reducing the causes and effects of malnutrition is requisite for achieving the nation's Sustainable Development Goals (SDGs) and Uganda's Vision 2040.

The figure below further illustrates how nutrition is essential for the success of all the SDGs *(see Figure 2)*.

FIGURE 2 NUTRITION AND THE SUSTAINABLE DEVELOPMENT GOALS

1.2 GLOBAL, CONTINENTAL AND NATIONAL FRAMEWORKS CONTEXT

1.2.1 Global nutrition commitments and initiatives

The 'UNAP II' has been designed with a global outlook. The critical international nutrition declarations, commitments and initiatives informing it include:

- Lancet Series on Maternal Child and Nutrition, 2013
- Scaling up Nutrition (SUN) Movement, 2010
- The 1,000 Days Initiative, 2010
- The United Nations General Assembly on Non-Communicable Diseases, 2011
- New Alliance for Food Security and Nutrition for sustained agriculture-led growth in Africa and Asia launched in G8 Summit, 2012
- World Health Assembly Resolution, 2012
- Nutrition for Growth Summit, 2013
- Committee on World Food Security (CFS), 2013
- The Global Panel on Agriculture and Food Systems for Nutrition (GLOPAN), 2013
- Global Nutrition Reports (GNR)
- 2nd International Conference on Nutrition (ICN), 2015
- Rome Declaration and Framework for Nutrition, 2014
- Sustainable Development Goals, 2015
- United Nations Decade of Action on Nutrition, 2016-2025

Annexe 1.1 attached provides the sequence and evolution of some of the key global commitments and initiatives.

1.2.2 Continental and regional frameworks context

The 'UNAP II' has also been designed with a continental and regional outlook. The key regional and continental nutrition declarations, commitments and initiatives informing the plan include:

- African Union (AU) Agenda, 2063.
- Maputo Declaration, 2003.
- Grow Africa Initiative (AU and New Partnership for Africa's Development (NEPAD)), 2011.
- Malabo Declaration, 2014.
- Malabo Declaration on Nutrition, 2015.
- Africa Regional Nutrition Strategy (ARNS), 2015-2025.
- Food and Agriculture Organization of the United Nations (FAO) Regional Initiative (RI) on Africa's Commitment to End Hunger by 2025.
- East and Southern Africa Regional Civil Society Nutrition Network, 2017.
- African Leaders for Nutrition Initiative (ALN), 2018.
- African Development Bank's Multi-Sectoral Nutrition Action Plan (2018-2025).
- East Africa Community (EAC) Food and Nutrition Security Strategy (2018-2022).
- EAC Food and Nutrition Security Action Plan (2018-2023).
- Eastern African Parliamentary Alliance for Food Security and Nutrition (EAPA FSN), 2019.

Annexe 1.2 attached provides detail of the Africa regional development agenda relevant to nutrition programming.

1.2.3 National legal, policy and planning frameworks context

The 'UNAP II' has been designed with a legal, policy and planning frameworks outlook. Nationally, the Constitution of the Republic of Uganda (1995) recognizes the right to food. Objective XXII of the Constitution requires the State to take appropriate steps to encourage people to grow and store adequate food. It also requires the State to establish national food reserves and to promote proper nutrition through mass education and other means to build a healthy state. In addition, the government has several sector policies and legal frameworks that guide the scaling up of nutrition. These include:

- The Education Act, 2008.
- National Trade Policy, 2007.
- Second National Health Policy, 2010.
- The National Community Development Policy for Uganda, 2015.
- The National Extension Policy, 2016.
- The National Integrated Early Childhood Development Policy, 2016.
- The Social Protection Policy, 2015.
- National Integrated Early Childhood Development Policy, 2016.
- The Uganda Vision 2040.
- Third 'National Development Plan' ('NDP III').

1.3 PROGRAMME ACHIEVEMENTS AND CHALLENGES

Some significant achievements registered throughout 'UNAP I' implementation include:

Child stunting reduced from **33% to 29%**

Child wasting reduced from **5% to 4%**

Newborns put to the breast within one hour of birth increased from **53% to 66%**

Infants aged 0-5 months old who were exclusively breastfed increased from **63% to 66%**

Children aged 6-23 months who achieved minimum diet diversity (MDD) being 4+ food groups increased from **12.8% to 30.3%**

minimum acceptable diet (MAD) increased from **5.8% to 15%**

Children aged 6-59 months receiving vit. A supplementation increased from **56.8% to 62%**

Pregnant women receiving iron and folic acid supplementation increased from **75%to 88%**

Women of reproductive age who

took iron tablets or syrup for 90+ days increased from **4% to 23%**

consumed foods rich in vitamin A increased from **61% to 74%**

consumed foods rich in iron improved from **34% to 58%**

Women who took deworming medication during pregnancy increased from **50% to 60%**

Children aged 6-59 months given deworming medication increased from **50% to 71%**

Despite the above achievements, there are several significant challenges, including:

Meal frequency among children aged 6-23 months reduced from **45% to 42%**

The prevalence of anaemia in women increased from **49% to 53%**

The prevalence of anaemia in children increased from **23% to 32%**

The status of overweight in children under five years of age increased from **3%to 4%**

The status of overweight among adult women increased from **14.6% to 16.5%** while adult overweight increased from **4% to 7.2%**

Obesity among men increased from **0.2% to 1.2%** while adult obesity in women increased from **4.2% to 7.2%**

Coverage of nutrition-specific interventions and nutrition-sensitive interventions remained **below the expected level of 80%**

Inadequate functionality of nutrition coordination structures at all levels.

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1.4 CONTEXTUAL CHALLENGES

There are societal and contextual issues that continue to inhibit good nutrition in Uganda. They include the following, among others:

- Entrenched cultural and social norm and economic conditions which negatively affect feeding practices and lifestyle choices.
- Low literacy levels and ignorance leading to low utilization of nutrition-specific and nutrition-sensitive services by communities.
- Inadequate participation of women in development and income-generating activities.
- Poverty, low household income and limited access to social protection programmes and support networks.
- Frequent climatic shocks in regions such as Karamoja limits agricultural productivity leading to low household income.
- The increasing trend of urbanization and change in diets and lifestyle is a risk factor for overweight and obesity.
- Infrastructural, technological, trade and marketing barriers that negatively affect the production and consumption of nutrient-dense foods.

There are also governance issues that affect the implementation of nutrition interventions in Uganda. These include:

Limited functional capacity among nutrition stakeholders to plan for and implement nutrition. The 'NDP II' identified the need for capacity strengthening for nutrition.

Planning, budgeting and resource mobilization challenges. The government has identified nutrition as a priority thematic cross-cutting issue impacting planning, budgeting and implementation.

Challenges of behaviour change, advocacy and social mobilization for nutrition. Whereas the Constitution of the Republic of Uganda, under the directive principle of state policy number XXII, emphasizes proper nutrition through mass education, changing mindsets is still a challenge.

Monitoring, evaluation, accountability and learning deficiencies: The national planning frameworks, including the NDP, provide indicators and targets for nutrition. However, tracking these indicators and linking them to nutrition programming is still a challenge at the sector and local government level. Analysis was carried out as part of developing 'UNAP II', which has informed its strategic direction, form, and content.

1.5 OPPORTUNITIES TO HARNESS

The 'UNAP II' presents an opportunity to:

- Fulfil government commitment to nutrition as stipulated in the National Constitution of 1995, Vision 2040 and 'NDP III'.
- Sustain political will to prioritize and scale up nutrition, with reference to H.E. the President's initiative on healthy eating and lifestyles.
- Continue promoting nutrition as a cross-cutting priority issue per the NDP planning circular call and the budget speech 19/20 and 20/21.
- Align with global trends, e.g. SDGs, Nutrition for Growth (N4G) and the SUN movement, as well as south to south cooperation and coordination.

1.6 THE PROCESS OF DEVELOPING THE 'UGANDA NUTRITION ACTION PLAN'

The process of developing the 'Uganda Nutrition Action Plan II' involved the following activities:

1. Identification of 'UNAP II' technical assistance needs.
2. Approval of terms of reference and recruitment of technical assistance provider.
3. Inception and consultations at the national and lower local government (LLG) level.
4. Consensus building on draft 'UNAP II'.
5. Stakeholder engagement and gathering of feedback on the 'UNAP II' draft.
6. Content finalization and validation workshop.
7. Detailed revision of 'UNAP II'.
8. Multi-sectoral Nutrition Technical Coordination Committee validation, incorporating final comments from MDAs and non-state actors.
9. Presentation to heads of departments at OPM.
10. Final approval by Policy Coordination Committee (PCC) on 22 September 2020.

CHAPTER TWO
Nutrition Situational Analysis

2.1 UNDERNUTRITION

The indicators of undernutrition of focus under the 'UNAP II' are:

2.1.1 Prevalence of stunting in children aged 0-5 years.
2.1.2 Prevalence of low birth weight (<2500 g).
2.1.3 Prevalence of wasting in children aged 0-5 years.
2.1.4 Prevalence of anaemia in children aged 0-5 years.
2.1.5 Prevalence of anaemia in women of reproductive age.

The following paragraphs describe the status, trends and patterns of the five indicators for undernutrition.

2.1.1 Prevalence of stunting in children under five years of age

The prevalence of stunting in children under five years of age reduced from 33 per cent in 2011 to 29 per cent in 2016. There was a reduction in the prevalence of child stunting from 45 per cent in 2000 to 29 per cent in 2016. According to the World Health Organization (WHO) classification, Uganda moved from very high to high severity of stunting by dropping below the 30 per cent prevalence threshold. Based on the Uganda National Panel Survey (UNPS) of 2020, Uganda achieved a National Development Plan (II) target of reducing the prevalence of child stunting from 29 per cent in 2016 to 25 per cent in 2020. Findings from the UDHS 2020/21 will further validate this result.

Despite the progress on stunting, more improvement is needed to achieve a classification of medium stunting severity (<20 per cent) and to meet the World Health Assembly (WHA) target of reducing the absolute number of stunted children by 40 per cent by 2025. There is substantial economic disparity, with the prevalence of stunting in each of the poorest three wealth quintiles nearly double that of the richest quintile. There is regional variability in stunting; the prevalence was generally highest in the areas that had the highest poverty *(see Figure 3)*.

It is important to note that out of 15 sub-regions, 13 have a prevalence of child stunting higher than acceptable levels. This calls for a national effect to scale actions to address stunting in all sub-regions. It is also important to note that four in every ten children born to mothers with no education are stunted, compared to one in every ten children born by educated mothers, per the Uganda Demographic and Health Survey (UDHS) 2016.

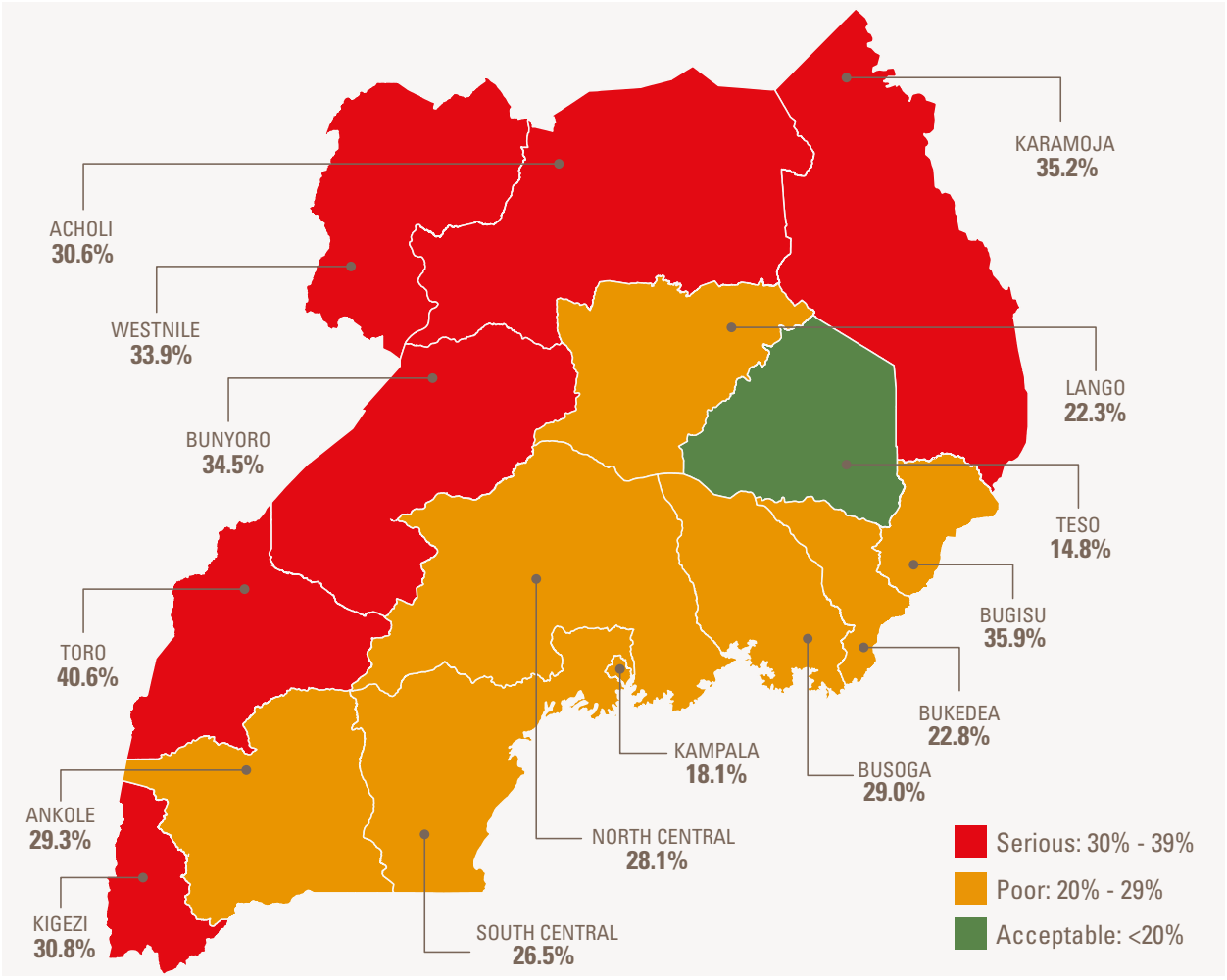
The prevalence of stunting among children increases in the first year of age and **peaks at 37% among children aged 18-35 months.**

Children in rural areas are more likely to be stunted than children in urban areas.

Children whose mothers are overweight or obese are less likely to be stunted than children whose mothers have a normal body mass index (BMI) or are thin.

The proportion of children who are stunted decreases with increasing mother's education.

FIGURE 3 DISTRIBUTION OF STUNTING IN CHILDREN UNDER FIVE YEARS OLD BY REGION IN UGANDA



Source: UNICEF, 2021
This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.

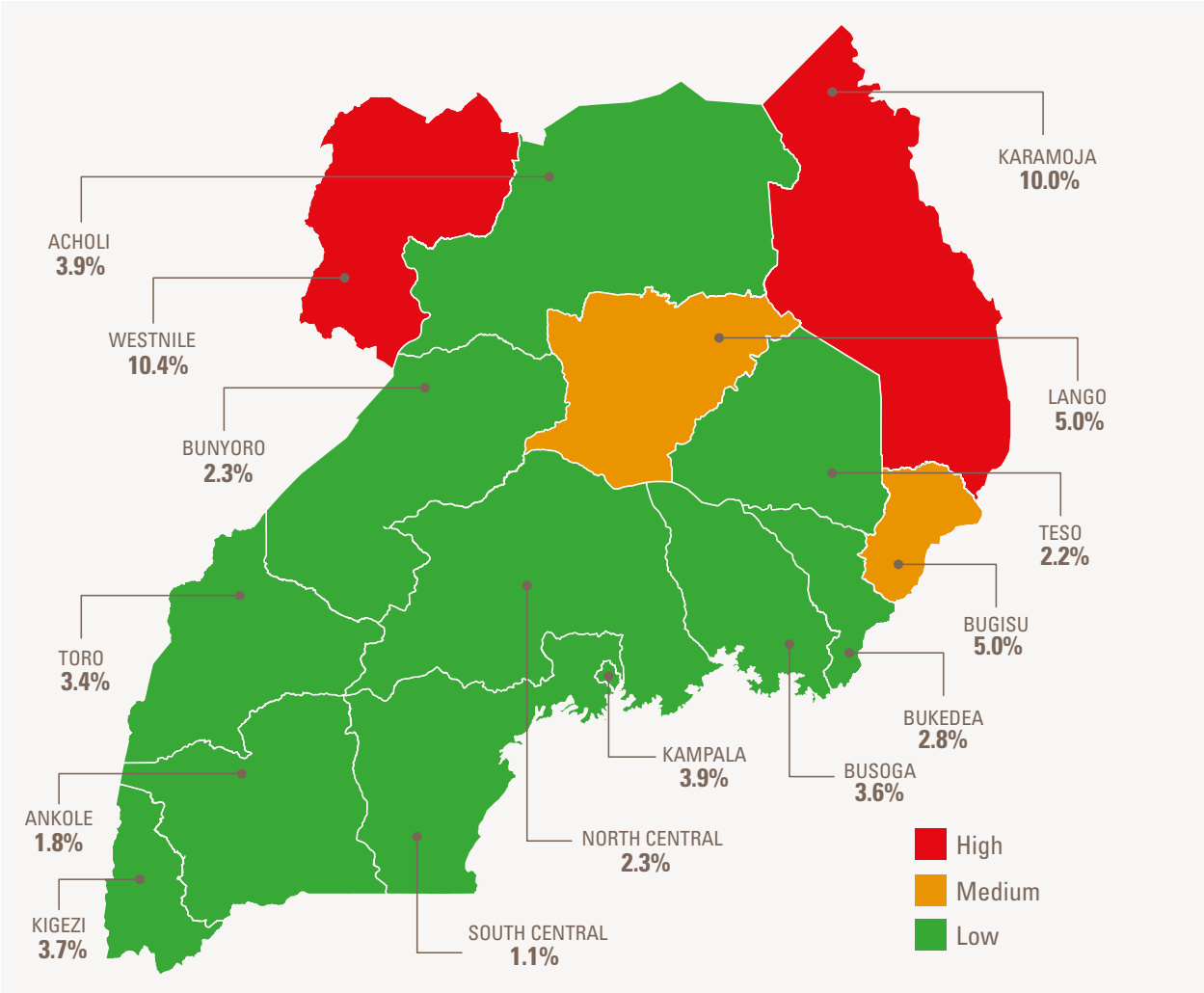
2.1.2 Prevalence of low birth weight (<2500g)

Prevalence of low birth weight (LBW) (<2500 g) remained at 10 per cent. Birth weight is an important indicator when assessing a child's health for early exposure to childhood morbidity and mortality. It is usually an outcome of intrauterine growth retardation and/or preterm birth. Low birth weight is not only strongly associated with increased risk of fetal and neonatal mortality and morbidity, but also with increased risk of inhibited growth, poor cognitive development, and chronic diseases later in life.

2.1.3 Prevalence of wasting in children aged 0-5 years

The prevalence of wasting among children aged 0-5 years remains an issue in two sub-regions of Karamoja and West Nile, where the prevalence of wasting increased over 10 per cent in 2016 (*see Figure 4*). The cause of the recent increase in acute malnutrition in the two regions is associated with poverty and frequent climatic shocks.

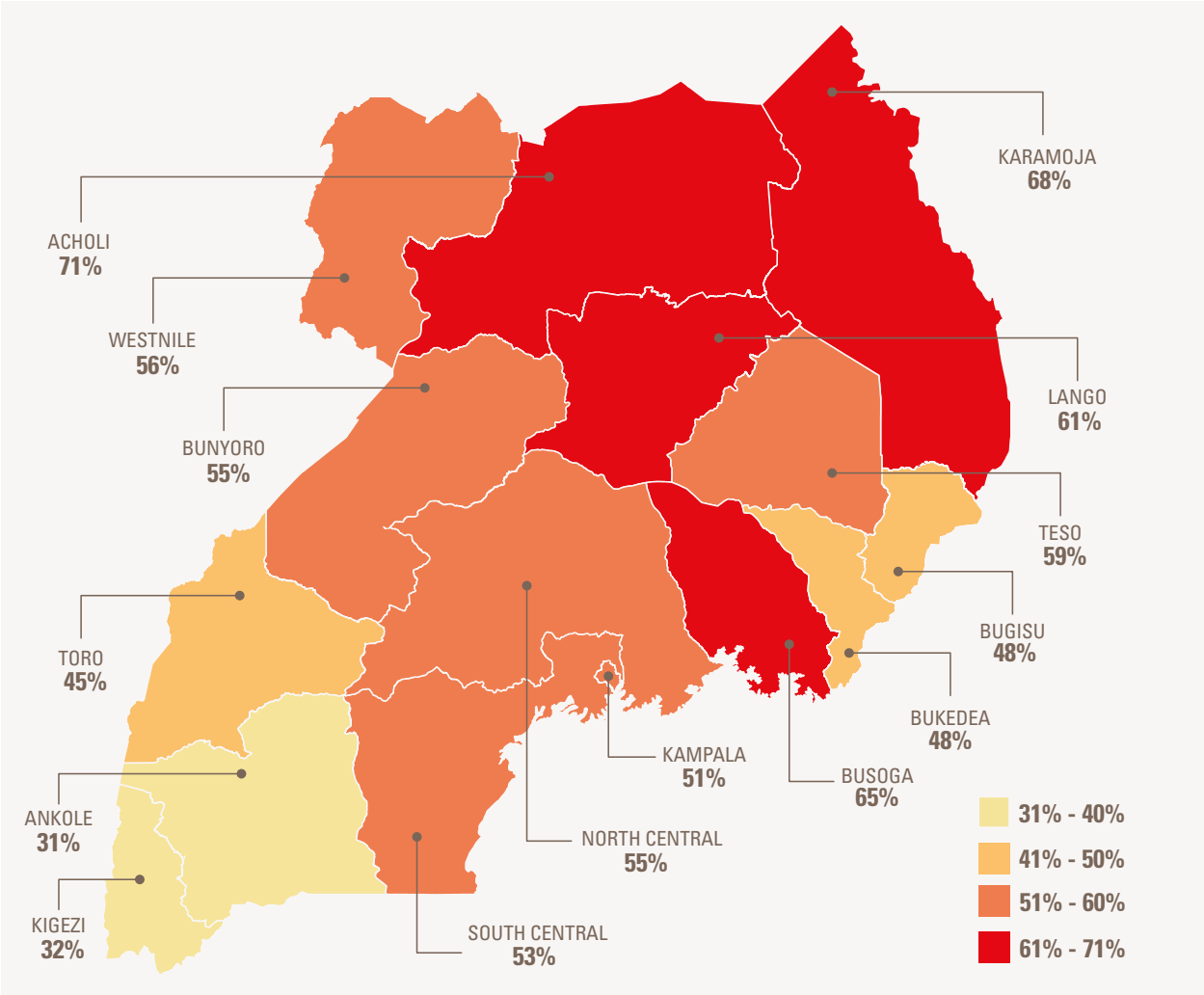
FIGURE 4 PERCENTAGE OF CHILDREN UNDER FIVE YEARS OLD WITH WASTING



Source: UNICEF, 2021
This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.

2.1.2 Prevalence of anaemia in children aged 0-5 years

FIGURE 5 PERCENTAGE OF CHILDREN UNDER FIVE YEARS OLD WITH ANY ANAEMIA

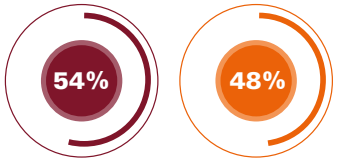


Source: UNICEF, 2021
This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.

The prevalence of anaemia among children aged 6-59 months dropped sharply from 73 per cent in 2006 to 49 per cent in 2011, before increasing again to 53 per cent in 2016. This prevalence is well above the WHO cut-off to define a serious public health problem (≥40 per cent). The prevalence of anaemia in Uganda is higher among younger children (aged 6-23 months) than older children (aged 24-59 months), with a peak prevalence of 78 per cent among children aged 9-11 months. This can be associated with poor complementary feeding practices. The prevalence of anaemia is higher in rural areas than in urban areas. There is regional variation in the prevalence of anaemia; 71 per cent of children in the Acholi region are anaemic, compared with 32 per cent of children in the Kigezi region and 31 per cent of children in the Ankole region. The prevalence of anaemia in children aged 6-59 months' decreases with an increase in the mother's education and household wealth.

Prevalence of anaemia aged 6-59 months

The prevalence of anaemia is higher in rural areas than in urban



It is important to note that all sub-regions have a prevalence of child anaemia higher than acceptable levels.

2.1.5 Prevalence of anaemia in women of reproductive age

One-third (32 per cent) of women aged 15-49 years have some degree of anaemia. The proportion of women aged 15-49 years with any degree of anaemia rose from 23 per cent in 2011 to 32 per cent in 2016. Of the 15 sub-regions, two sub-regions have a mild public health importance prevalence of anaemia of 17 per cent and 18 per cent in Kigezi and Bukedi, respectively. Eleven sub-regions are classified as having moderate public health importance of anaemia prevalence of 41 per cent and 47 per cent in Busoga and Acholi, respectively. Pregnant (38 per cent) and breastfeeding women (34 per cent) are more likely to be anaemic than women who are neither pregnant nor breastfeeding (30 per cent). Pregnant women have a lower prevalence of mild anaemia (19 per cent) than women who are breastfeeding (29 per cent) and those who are neither pregnant nor breastfeeding (25 per cent); however, they have a higher prevalence of moderate anaemia (18 per cent) than other women (4-5 per cent). The prevalence of anaemia decreases with increasing wealth, from 41 per cent among women in the lowest wealth quintile to 25 per cent among women in the highest quintile.

URGENT ACTION IS NEEDED TO ADDRESS ANAEMIA AND CHILD STUNTING.

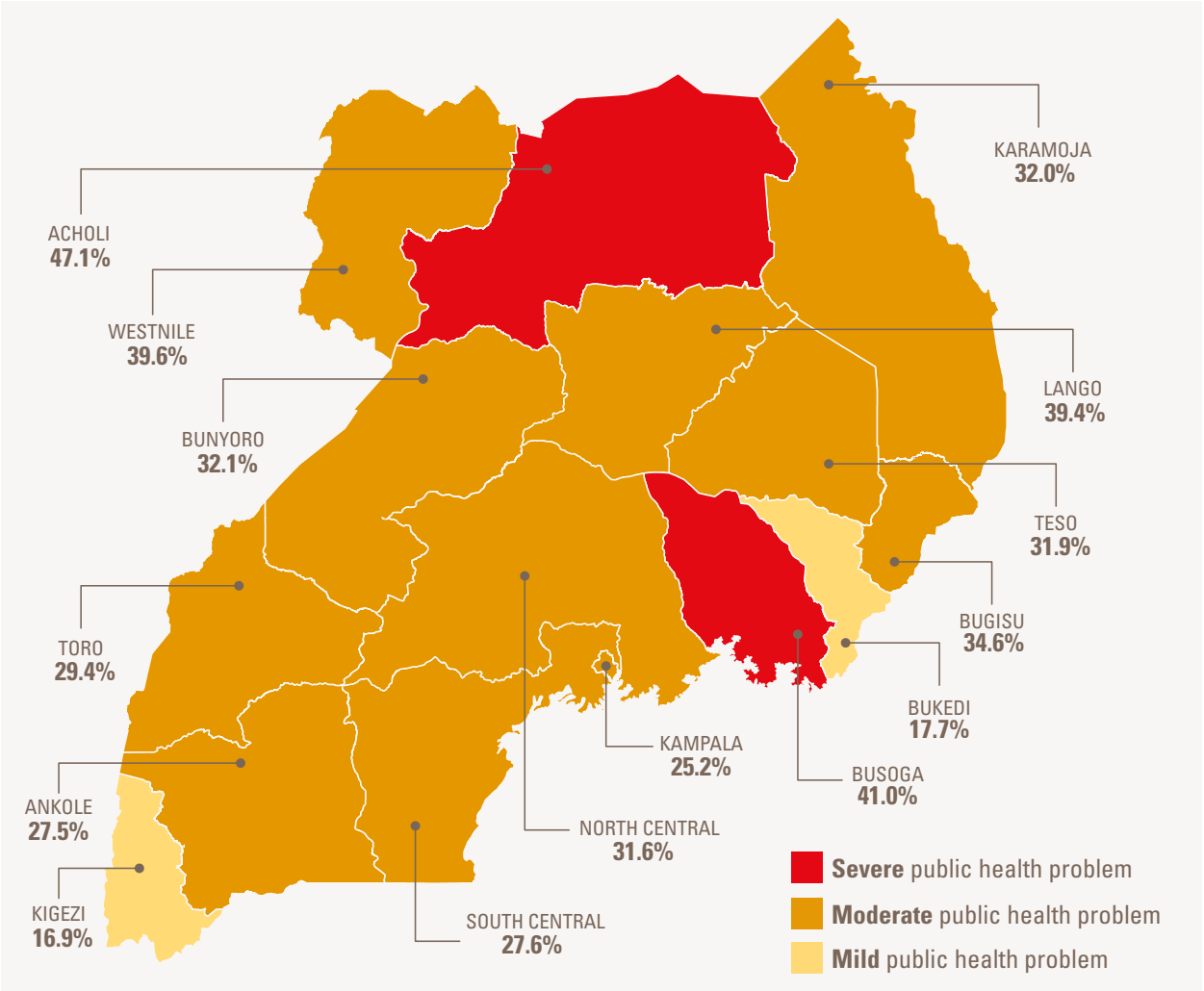
13 out of 15 sub-regions

have a prevalence of child stunting **higher than 20%**

All the 15 sub-regions

have a level of anaemia among children and women of reproductive age that are a public health concern.

FIGURE 6 PERCENTAGE OF WOMEN OF REPRODUCTIVE AGE WITH ANY ANAEMIA



Source: UNICEF, 2021
This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.

2.2 OVERWEIGHT, OBESITY AND DIET-RELATED NON-COMMUNICABLE DISEASES (NCD)

The indicators of concern under 'UNAP II' are:

2.2.1 Prevalence of overweight in children under five years of age.
2.2.2 Proportion of overweight women aged 18+ years.
2.2.3 Proportion of overweight men aged 18+ years.
2.2.4 Proportion of obesity in women aged 18+ years.
2.2.5 Proportion of obesity in men aged 18+ years.
2.2.6 Proportion of overweight in adolescents.
2.2.7 Proportion of obesity in adolescent girls.
2.2.8 Age-standardized prevalence of raised blood glucose/diabetes among persons aged 18+ years.
2.2.9 Age-standardized prevalence of blood pressure among persons aged 18+ years.

2.2.1 Prevalence of overweight in children under five years of age

At 3.7 per cent, the prevalence of child overweight is not a critical public health issue at the national level. However, there was a slight increase in child overweight from 2011 to 2016, which is a signal that it could escalate if unchecked.

2.2.2 and 2.2.4 Proportion of overweight and obesity in adult women aged 18+ years

The proportion of women who are overweight or obese has increased in the same period, from 17 per cent in 2006 to 19 per cent in 2011 and 24 per cent in 2016. The proportion of women of normal weight declines with age, from 76 per cent among those aged 15-19 years to 58 per cent among those aged 40-49 years. Women aged 15-19 years are more likely (13 per cent) to be thin compared to older women (7-8 per cent). The proportion of women who are overweight or obese increases with age, from 11 per cent among those aged 15-19 to 34 per cent among those aged 40-49 years. One in three (34 per cent) of urban women are overweight or obese compared with one in five (20 per cent) rural women. The proportion of women who are overweight or obese increases with increasing education and wealth. For example, 8 per cent of women in the lowest wealth quintile are overweight or obese, compared with 42 per cent of women in the highest wealth quintile.

2.2.3 and 2.2.5 Proportion in overweight and obesity among adult men aged 18+ years

Nine per cent of adult men aged 18+ years are overweight or obese. Similar proportions of urban (76 per cent) and rural (78 per cent) men have a normal BMI. However, more rural (16 per cent) than urban (7 per cent) men are thin and more urban (16 per cent) than rural (6 per cent) men are overweight or obese. One in five men who have more than secondary education (19 per cent) and who are in the highest wealth quintile (21 per cent) are overweight or obese.

2.2.6 and 2.2.7 Prevalence of overweight and obesity in adolescents and adolescent girls

The adolescence stage is the second-fastest development stage of the human body after infancy. The development during this stage requires increases the nutrient requirements of the body. However, over nutrition in adolescents has the same implication on non- communicable diseases in adolescence as in childhood. The Uganda National Panel Survey (UNPS) 2019/2020 provide information on the body mass index (BMI) for adolescents (10-19 years). BMI in adolescents helps in the assessment of the future risk of some poor health conditions such as high blood pressure, diabetes, and hypertension. Overall, the Survey revealed that 2.9% of adolescents are overweight. Among adolescent girls, obesity was at 0.5%. The UDHS 2021 will provide a clear picture once conducted

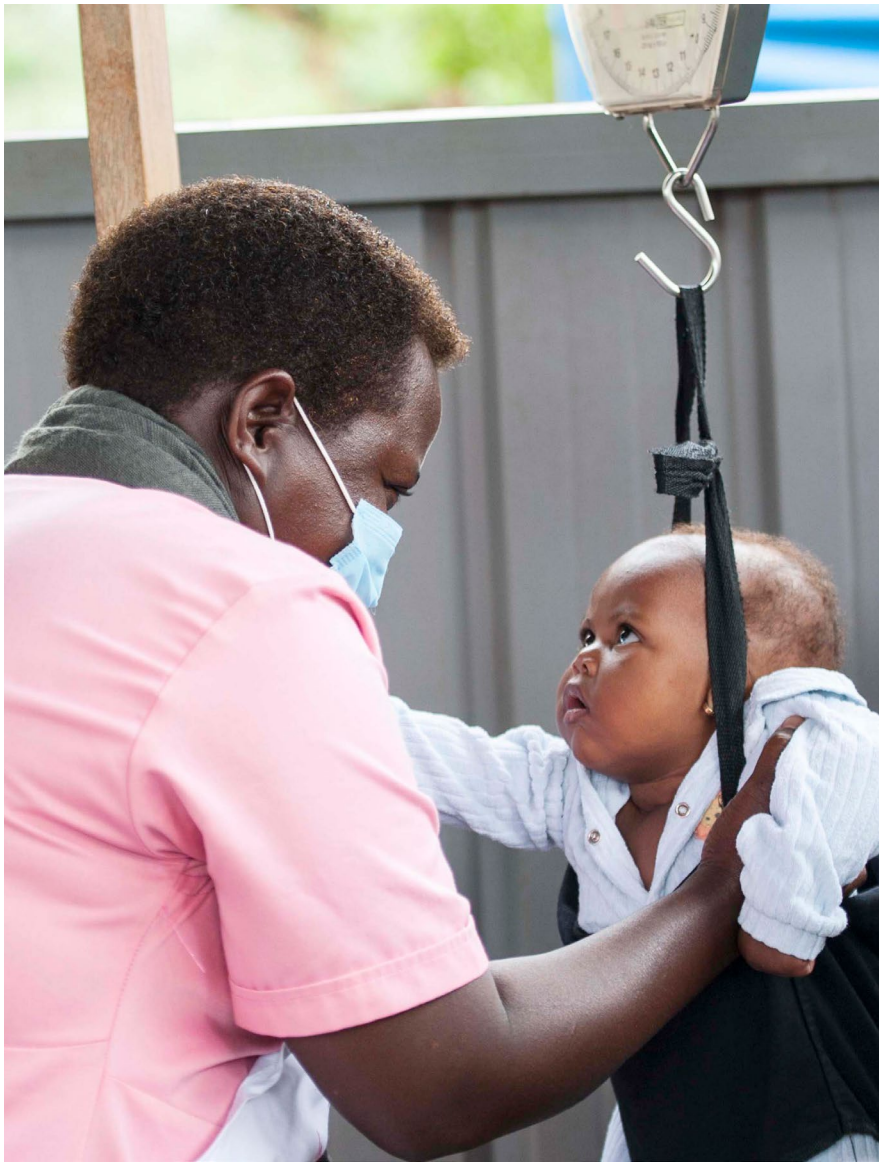
2.2.8 and 2.2.9 Age-standardized prevalence of raised blood glucose/diabetes and blood pressure among persons aged 18+ years

The age-standardized prevalence of raised blood glucose/diabetes among persons aged 18+ years was at 3.3 per cent in 2014. The age-standardized prevalence of raised blood pressure among persons aged 18+ years was 24 per cent in 2014. Obesity and excessive energy intake are known major causes of hypertension. Consequently, hypertension/raised blood pressure can partly be an indirect measure of the population's nutrition status or secondary consequences of malnutrition. The UNPS data showed that 6.5% of the adult women affecting all regions of the country. The proportion of women with a raised blood pressure in the central region was 7.2% while the northern region had the highest proportion of women with raised blood pressure despite having least proportion of women that were obese.

Available data from the UNPS 2020 indicate that raised blood pressure among men was at 8% with the northern region having the highest proportion of men with a raised blood pressure. The UNPS 2020 report indicated that the proportion of raised blood pressure was continently higher in men compared to women. This is despite the proportions of obesity and overweight being much higher among men than women. The proportion of men with raised blood pressure was higher than the national proportion of both men and women with raised blood pressure. Raised blood pressure was much higher in men aged 60 years and above.

There is a double burden of malnutrition.

Amidst the high prevalence of stunting and anaemia in children and women, there is also overweight in children under five years of age, overweight among adult women and men, and adult obesity among men and women are on the increase.



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2.3 DETERMINANTS OF NUTRITION STATUS

Nutrition status results from a complex set of multiple and interacting factors at different levels and across the various sectors. This challenge, therefore, calls for a multi-sectoral approach to address the causes of malnutrition at all levels. The 'UNAP II' categorizes determents of nutrition status outcomes into three broad categories:

1. **Immediate determinants,** namely inadequate dietary intake, disease burden and physical inactivity.
2. **Underlying determinants,** including poor water, sanitation, hygiene and food safety; inadequate access and utilization of health services; inadequate care and feeding practices and behaviour; insufficient supply and access to healthy, nutritious, safe foods and sedentary lifestyle and behaviours.
3. **Basic determinants** comprising of socio-cultural, economic, political and contextual factors which negatively influence communities and households to access adequate resources. These include legislation and regulatory factors, rapid urbanization, climate change and gender inequity, among others.

The following areas are significant in determining nutrition status.

2.3.1 Maternal, infant and young child feeding practices.

2.3.2 Childhood diseases.

2.3.3 Access to and utilization of maternal and child health services.

2.3.4 Early childhood development.

2.3.5 Food production, access and utilization.

2.3.6 Water, sanitation and hygiene.

2.3.1 Maternal, infant and young child feeding practices.

According to the UDHS, 2016, 66 per cent of newborns started breastfeeding within one hour. There was regional variation in breastfeeding initiation; 93 per cent of children in the Karamoja region start breastfeeding within one hour of birth, compared with 50 per cent of children in the Bukedi region. The percentage of children who start breastfeeding within one hour of birth decreases as the mother's education increases. This calls for appropriate messages to mothers, including the educated. The percentage of children under six months of age exclusively breastfed remained above 60 per cent from 2000 to 2016. Exclusive breastfeeding declines with age, from 83 per cent among children aged 0-1 months to 69 per cent among those aged 2-3 months and 43 per cent among those aged 4-5 months. The proportion of children who are breastfeeding and consuming complementary foods first increases with age (peaking at 87 per cent among children aged 9-11 months) and then falls among children aged 12-23 months (as older children stop breastfeeding).

The median duration of breastfeeding among children born in the three years before the 2016 UDHS is 19.8 months, and half of all children stopped breastfeeding before 20 months. Children in rural areas breastfeed for longer (20.4 months) than children in urban areas (17.8 months). Children in the lowest wealth quintile breastfeed for longer (21.2 months) than children in the highest wealth quintile (17.2 months). The findings above show that various contextual issues affect optimal breastfeeding practices, especially continued breastfeeding up to 2 years. Intervention is needed to make exclusive breastfeeding during the first six months of life the norm for infant feeding.

The proportion of children aged 6-23 months who received the minimum number of meals remained low in 2016, at 42 per cent. Similarly, only three in ten (30 per cent) of children aged 6-23 months were fed according to the required minimum dietary diversity. The proportion of children receiving the minimum acceptable diet (those achieving minimum meal frequency and minimum dietary diversity) was alarmingly low, at

15 per cent. There is regional variation in the proportion of children aged 6-23 months receiving the minimum acceptable diet, from 3 per cent in the Acholi region to 27 per cent in the Ankole region (UDHS, 2016). The proportion of children aged 6-23 months receiving the minimum acceptable diet rises with increasing mother's education, from 10 per cent among children whose mothers have no education to 26 per cent among children whose mothers have more than secondary education.

It is evident that minimum meal frequency and minimum dietary diversity are major contributors to sub-optimal infant and young child feeding practices and malnutrition in Uganda. 'NDP III', sector development plans (SDPs) and district development plans (DDPs) should prioritize support to interventions that target improving complementary feeding such as social behaviour communication and the promotion of region-specific recipes for complementary foods. 'UNAP II' has also created viable linkages and complementary actions so that diverse, safe and nutrient-dense food is sustainably produced, accessed and consumed.

Among last-born children aged 6-23 months, nearly 7 in 10 (67 per cent) ate foods rich in vitamin A, and 4 in 10 (40 per cent) ate foods rich in iron. Rural children are less likely (38 per cent) to have eaten iron-rich foods than urban children (47 per cent). While 86 per cent of women took iron supplements at least once during their most recent pregnancy, only 23 per cent took them for 90 days or more. One in 10 women (12 per cent) took no iron supplements. Six in 10 (60 per cent) women took deworming medication during their most recent pregnancy.

SUMMARY

During the period 2011-2016, there was an increase in the percentage of:

newborns put to the breast **within one hour of birth** from **53% to 66%**

infants aged 0-5 months old who were **exclusively breastfed** from **63% to 66%**

children aged 6-23 months who **received a minimum diet diversity** (MDD) of 4+ food groups from **12.8% to 30.3%**

children aged 6-23 months who **achieved minimum acceptable diet** (MAD) from **5.8% to 15%**

Despite this notable increase, this coverage is far below the **expected coverage of 80%**

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2.3.2 Childhood diseases

Frequent infections precipitate undernutrition by leading to loss of appetite, increased metabolic rate, increased nutrient requirements and loss of nutrients. On the other hand, undernutrition causes a reduction of the body's ability to fight infections, which worsens their severity. Consequently, infections can cause undernutrition and undernutrition can increase the severity of infections. Child health and survival services can help improve nutrition outcomes through appropriate interventions to prevent childhood illnesses. The burden of disease, especially among children under five, remains high in Uganda. The common childhood illnesses in Uganda are acute respiratory infection, fever, and diarrhoea.

Fever is a symptom of malaria but is also associated with other childhood illnesses that may contribute to high levels of malnutrition, morbidity, and mortality in young children. One-third (33 per cent) of children under five years had a fever in the two weeks preceding the UDHS 2016 survey. The prevalence of fever is highest among children in Busoga (66 per cent) and Teso (59 per cent) regions and lowest in the Bunyoro region (11 per cent). Twenty per cent of children under five years of age suffer from diarrhoea. The prevalence of diarrhoea rises after age six months, from 19 per cent among children under age six months to 39 per cent among those aged 6-11 months, when complementary foods and other liquids are introduced. The prevalence remains high (31 per cent) at age 12-23 months when children begin to walk and are at an increased risk of contamination from the environment, though declines thereafter. The percentage of children with diarrhoea is highest in Teso (29 per cent) and Busoga (27 per cent) regions and lowest in the Bunyoro region (10 per cent). Interventions to address the three common childhood illnesses in Uganda are expected to improve children's health in Uganda and, consequently, their nutrition status. Therefore, the integration of appropriate nutrition practices in the prevention, control and management of infectious has been prioritized in this action plan.

2.3.3 Access to and utilization of maternal and child health services

Pregnant women should increase their intake of iron and reduce parasites to prevent anaemia. In 2016, while 88 per cent of women took iron supplements at least once during their pregnancy, only 23 per cent took them for 90 days or more. Sixty per cent took intestinal parasite medication at least once. In Uganda, 78 per cent of women with a live birth in the two years before the UDHS survey reported taking one or more doses of fansidar during their last pregnancy, while 46 per cent reported taking two or more doses, and 17 per cent reported taking three or more doses. The proportion of women with a live birth in the two years before the survey who took three or more doses of fansidar during their last pregnancy increased from 6 per cent in 2006 to 17 per cent in 2009, reduced to 10 per cent in 2011, grew to 28 per cent in 2014-15, and decreased to 17 per cent in 2016.

In 2016, 62 per cent of children under five years slept underneath an insecticide-treated net (ITN) the night before the survey, and 75 per cent of children under five years in households with at least one ITN slept under an ITN. Similarly, 64 per cent of pregnant women aged 15-49 slept under an ITN, and close to 79 per cent in households with at least one ITN slept under an ITN. The proportion of children under five years who slept under an ITN was 43 per cent in 2011 and 62 per cent in 2016. A similar trend is observed among pregnant women, with an increase from 47 per cent in 2011 to 64 per cent in 2016.

The proportion of children aged 6-59 months receiving vitamin A supplementation increased from 56.8 per cent to 62 per cent. Fifty-five per cent of children aged 12-23 months received all basic vaccinations at any time before the survey. In comparison, 49 per cent received the basic vaccinations by the appropriate age of 12 months, and 1 per cent received no vaccinations at all. The percentage of children aged 12-23 months who have received all basic vaccinations ranges from 45 per cent in the Busoga region to 73 per cent in the Karamoja region.

As noted, fever is a symptom of malaria but is also associated with other childhood illnesses. About 20 per cent of children under five years had a diarrhoeal episode. Children with diarrhoea are given increased fluids or a fluid made from a packet of oral rehydration salts (ORS) or government-recommended homemade

fluids (RHF). Fifty-five per cent of children with diarrhoea received some form of oral rehydration therapy (ORT) such as ORS, recommended homemade fluids, or increased fluids. Nineteen per cent of children received antibiotics, and 40 per cent were given zinc, which can reduce the duration and severity of diarrhoea. Nearly one in five (19 per cent) children with diarrhoea did not receive any treatment. The proportion of children with diarrhoea who received no treatment increased from 14 per cent in 2011 to 19 per cent in 2016. Male children are more likely (58 per cent) to receive ORT than female children (52 per cent). The proportion of children receiving ORT is higher in urban areas (61 per cent) than in rural areas (54 per cent). Children in the Karamoja region are more likely to receive ORT (84 per cent) than children in other regions. Only about one-third of children in Teso (34 per cent) and Ankole (37 per cent) regions received ORT.

2.3.4 Early childhood development (ECD)

Organized early childhood education programmes are important to facilitate children's cognitive development and prepare them for formal primary education. In Uganda, 37 per cent of youngest children aged 36-59 months living with their mother attend organized early childhood education programmes. Children born to mothers with more than secondary education (80 per cent), those from households in the highest wealth quintile (66 per cent), those living in urban areas (55 per cent), and those aged 48-59 months (47 per cent) are more likely to attend early childhood education. Children from Karamoja (13 per cent) and Teso (17 per cent) regions are less likely to participate in early childhood education than children from other regions.

Inadequate care for children: Children under five years should be in the care and guidance of responsible adults. Nearly 37 per cent of youngest children under five years living with their mother received inadequate care for at least one hour in the week preceding the survey. Twenty-three per cent spent at least one hour entirely alone. Twenty-eight per cent spent at least one hour in the care of another child younger than ten years of age.

Early child development index: Sixty-three per cent of youngest children aged 36-59 months living with their mother are developmentally on track according to the early child development index. Ninety-one per cent of children are on track in the physical development domain, 86 per cent in the learning domain, 68 per cent in the social-emotional domain, though only 26 per cent in the literacy-numeracy domain. The proportion of children who are developmentally on track is highest in Ankole (84 per cent) and South Central (82 per cent) regions. The proportion is lowest in Lango (42 per cent), Teso (42 per cent), and Karamoja (43 per cent) regions. Children who are attending early childhood education are more likely to be developmentally on track (82 per cent) than those who are not attending (53 per cent). The percentage of children who are developmentally on track in at least three of the four domains rises with increasing mother's education, from 57 per cent among children whose mothers have no formal education to 87 per cent among children whose mothers have more than secondary education.

2.3.5 Food production, access and utilization

2.3.5.1 Factors affecting food security in Uganda

The following factors affect food production, access and utilization of food in Uganda.

Low agricultural production and productivity: Low productivity in agriculture is often the result of erratic weather patterns characterized by severe and frequent droughts and floods. Nearly 90 per cent of households reported reductions in food production due to weather-related shocks, with minimal variation across regions (Uganda National Panel Survey (UNPS) 2013/14). Other factors are low access to extension services, low adoption of agricultural enhancing technologies, poor quality inputs on the market, the prevalence of pests and disease epidemics, limited access to agricultural financing, insecure land tenure systems, inefficient output and a limited market. In addition, low productivity results from food losses and wastage along the value chain due to poor handling practices, inappropriate storage methods and low storage capacity.

Informal trade across borders: Uganda is the largest informal supplier of grains in the East Africa region, contributing to more than 70 per cent of regional consumption. It is recognized that the informal grain trade between Uganda and her neighbours is around five times higher than that of the formal grain trade. This, therefore, demonstrates the dominance of informal trade in the region, which in turn limits value addition and food income. In addition, the unregulated cross border food trade has encouraged the inflow of foreign traders who purchase food from the gardens exposing households to food insecurity as they are tempted to sell almost everything. The lack of food distribution and redistribution systems also fails to leverage food surplus in one region to cater for scarcity in another region.

Untapped potential for irrigation: Currently, Uganda's ratio of cultivated area under irrigation to the irrigation potential is only 0.5%. The comfort of receiving rains to sustain two cropping seasons in a year has provided little impetus to government to invest extensively in irrigation. Little attention has been accorded to technological and human capacity development in irrigation. Despite the advantages that the country holds in the ease of undertaking irrigation development, the potential has not been harnessed. Uganda's rain-fed agriculture has progressively been constrained by frequent threats of, and actual occurrence of, droughts and floods affecting efforts for increased production, fight against hunger and poverty. Uganda's vulnerability to climate change is exacerbated by a rapidly growing population, a factor that has increased pressure on natural resources (mainly wetlands and forest covers) leading to environmental degradation *(Ministry of Water and Environment, National Irrigation Policy, Republic of Uganda, Kampala, 2018*.

Limiting land tenure system: The constraints related to the land tenure system, such as insecurity of land tenure, unequal access to land, fragmented land and lack of mechanisms to transfer rights and consolidate plots, have resulted in under-developed agriculture, high landlessness and food insecurity, as well as degrading natural resources in most parts of the country.

Low household incomes, especially in rural areas: Low household incomes impact food security and exacerbate hunger in both rural and urban households, with a more significant impact on those classified as rural low-income. The lower the household income, the higher the proportion of household expenditure on food, implying higher vulnerability to food insecurity. The average share of food in total household expenditures was in the range of 55 per cent to 61 per cent over the 2009/10-2013/14 period, implying medium vulnerability to food insecurity (UNPS, 2013/14).

Low food safety: The enforcement of standards on food handling and hygiene is limited, leading to unsafe food production, processing, packaging, marketing, sale and consumption practices. At the production level, food is contaminated by chemicals and aflatoxins; at the processing level, by old machines and unhygienic processing practices; and, at the consumption level, through unhygienic food preparation practices. The household environment in which food is prepared must be clean, safe, and free from disease causative agents. However, most of the Ugandan population live in unhealthy environments with limited access to sanitation facilities and poor hygiene. In 2016, 22 per cent of households (9 per cent urban and 26 per cent

rural) still had an unimproved water source. Furthermore, only 19 per cent of households had an improved toilet facility, and 44 per cent had a handwashing facility with soap and water. (UDHS, 2016). These poor sanitation conditions affect food safety through contamination and food poisoning, leading to diarrhoeal diseases and other intestinal infections. This situation is compounded with a weak government health inspection function due to limited human, logistical and financial resources.

Food loss and waste: According to the State of Food and Agriculture (SOFA) report 'Food loss and wastage reduction' (Food and Agriculture Organization, 2019), globally, around 14 per cent of food produced is lost from the post-harvest stage. Roughly one-third of the edible parts of food produced for human consumption gets lost or wasted globally, which is about 1.3 billion tons per year. By category, this includes 45 per cent of all fruit and vegetables, 35 per cent of fish and seafood, 30 per cent of cereals, 20 per cent of dairy products and 20 per cent of meat. In Uganda, high food losses are a result of poor post-harvest handling practices (inadequate drying and high moisture content at time of storage), insufficient and inappropriate storage facilities, limited value-addition, filth and contamination, inadequate marketing systems, damage by insects, rodents and other pests and infestation by micro-organisms especially fungus that leads to aflatoxin. Food losses contribute to and exacerbate hunger situations, poverty and food insecurity. Currently, annual post-harvest loss stands at 17.6 per cent for about 2.8 million metric tons, 12.4 per cent for about 214,000 metric tons(MT) and 13.5 per cent for 230,000MT of maize, millet and rice produced in the country, respectively (FAO, 2020). If markets are not properly organized, the losses in mangoes, oranges and pawpaw crops could reach 80 per cent of total production.

Livestock post-harvest losses: These occur mainly in milk due to a lack of cold storage and primary processing equipment. Losses from beef and fish also happen due to a lack of cold storage facilities. Honey losses occur mainly due to poor harvesting technologies and skills, leading to 20 per cent of the would-be honey being left in combs.

Food storage and reserve infrastructure: Food reserve infrastructure is critical in minimizing food losses, wastage and enhancing safety. However, Uganda lacks a national food reserve system, further exposing the country to food and nutrition insecurity risks. The few available reserves[1] are small and are mainly private sector owned. At the household level, the traditional food reserve mechanisms are also non-existent.

2.3.5.2 Hunger

In Uganda, hunger is a national concern, with rural areas experiencing severe hunger more than urban areas. As of January 2017,[2] an estimated 10.9 million people were experiencing acute food insecurity, of which 1.6 million were in crisis, reflecting a high magnitude of hunger. Severely affected districts in 2017 were Isingiro, Butaleja and Kasese. A similar situation was experienced in Namutumba district in 2015, where children died of malnutrition following a prolonged drought. The situation of school feeding also portrays severe hunger, given that about 66 per cent of school-going children do not access school meals (UNPS, 2018). The 'Cost of Hunger in Africa' study in Uganda estimated an annual cost associated with childhood undernutrition and hunger at an equivalent of 5.6 per cent of the gross domestic product (World Food Programme (WFP), United Nations Economic Commission for Africa (UNECA) & African Union Commission, 2013).

Uganda's ranking on the Global Hunger Index (GHI) remains low and lags behind other sub-Saharan African countries. Nonetheless, the country registered progress in reducing its GHI score, from 38.9 in 2000 to 30.6 in 2019 (Concern Worldwide and Welt Hunger Hilfe, 2020). Despite the progress, the depth of hunger in Uganda remains serious, with 41.0 per cent of the population undernourished (Concern Worldwide and Welt Hunger Hilfe, 2020). The situation may be worse following the COVID-19 pandemic that reached Uganda in March 2020.

1 Those operated by Uganda Grain Council and those established with support from World Food Programme (WFP) in specific districts

2 Integrated Food Security Phase Classification (IPC) report, 2017

In the same way, nearly 1.4 million refugees and asylum-seekers, including 867,000 South Sudanese and 403,000 Congolese nationals, were sheltering in Uganda as of January 2020. It is worth noting that many refugee households in Uganda rely on food assistance to meet their daily food needs. According to the Famine Early Warning Systems Network (FEWS NET), without sustained assistance during the COVID-19 pandemic phase, refugees in Uganda were likely to face acute food insecurity crisis levels (USAID, 2020).

Hunger and nutrition insecurity among school-going children is high, especially in rural areas, with the northern and western regions being the most affected. Only 34 per cent of primary and secondary school children receive meals while at school. Urban children (41 per cent) are more likely to receive a school meal than their rural counterparts (32 per cent). The problem is more pronounced in northern (14.8 per cent) and western (14.4 per cent) regions. The Education Act vests the responsibility of school feeding to parents and guardians; however, the majority do not fulfil their obligations.

Estimates based on the Integrated Phase Classification (IPC) on food security by the Uganda IPC Technical Working Group (2017) show that the national food secure population declined from 83 per cent in July 2016 to 69 per cent in January 2017. The decreasing proportion of food secure Ugandans may be attributed to disease, disasters and erratic weather conditions. The rural areas, which are the food producers, are increasingly becoming food insecure and more hunger-stricken due to selling off most of the food produced. This is a reversing trend since in the period (2002/3-2005/6). Individual residents in urban areas had a higher prevalence of food insecurity and hunger than their rural counterparts (Ssewanyana and Kasirye, 2010).

Essentially, food security encompasses four dimensions: food availability, economic and physical access to food, food utilization and stability over time (FAO 1996). Analysis of country reports and food projections reveals that Uganda has significant gaps in its food requirements. Most gaps in food production relate to staples, including rice, millet, sorghum and wheat, with a gap of -1,017,142 metric tons. Milk and milk products have similar shortages. The most significant shortages are in fish and meat, with gaps of -547,317 and -544,504 metric tons, respectively.

High prevalence of undernourishment in the country: Overall, the prevalence of undernourishment (reflecting the share of the population with insufficient caloric intake below 2,200 kcal) remains high, with nearly 40 per cent of individuals in Uganda classified as undernourished, and 16 per cent of the households chronically undernourished, with only 4 per cent of the household's food secure for the period 2009/10-2015/2016. Over 64 per cent of Ugandans cannot afford the desired three meals per day (UBOS & ICF, 2018). This implies that Ugandans only consume 1,860 kcal a day and cannot consume the minimum required dietary intake for light physical activity, which is 2,200 kcal per day. The intake is lower in the rural areas with an average of 1,814 kcal in 2009/10 to 1,841 kcal in 2015/16 compared to the urban areas at 1,956 kcal in 2009/10 2,030 kcal in the same year. The prevalence of undernourishment is highest in the western region and lowest in the northern region. Specifically, there is a drastic decline in caloric intake per person per day in the eastern region, from 1,913 kcal in 2009/10 to 1,692 kcal in 2015/16, and caloric deficiency increased from 33.2 per cent in 2009/10 to 45.8 per cent in 2015/16. This may be attributed to the unguided commercialization of agriculture in the region, with an increased focus on cash crops at the cost of food production. The prevalence of undernourishment is highest among the poor. The wealthiest 20 per cent of the population can meet the required dietary intake, while the poorest 20 per cent have the highest levels of undernourishment. Overall, there is an urgent need to focus on the food intake of the poorest households if Uganda is to meet the required targets for ensuring access to food to all Ugandans all year round.

Low dietary diversity (DD) scores: The DD scores remain below the standard average of 9.2[3], although some improvements have been registered. However, households in the northern and eastern regions that are more food insecure have higher food diversification than the central and western, which are more food secure. This reflects cultural differences in food consumption and nutrition knowledge gaps.

3 Based on the USAID framework for household dietary diversity score (HDDS) for measurement of household food access, the *"average HDDS in the richest 33 percent of households can serve as a guide for setting the target level of HDDS"* (Swindale and Bilinsky, 2006); from the UNPS, the average HDDS for this group was estimated at 9.2.

Low nutritional quality of foods consumed in the country: The most consumed foods in Uganda are staples (cereals, roots, tubers and matooke), which are typically relatively cheap. However, generally, they are also low in nutritional density due to low protein and micronutrient deficiencies, except beans and ground nuts. The contribution of staples to caloric intake remains high at over 60 per cent of the daily caloric intake. Consequently, micronutrient deficiencies are common. According to UDHS 2016, it is estimated that the anaemia levels increased from 49 per cent to 53 per cent among children aged 6-59 months and 33 per cent of women of reproductive age (UBOS & ICF, 2018). vitamin A deficiency affects one out of five young children and women of reproductive age, resulting in impaired resistance to infection and consequently higher levels of illness and mortality, as well as potentially severe eye problems. The prevalence of zinc deficiency ranges from 20 per cent to 70 per cent in young children and 20 per cent to 30 per cent in adults. Zinc deficiency results in poor growth, reduced resistance to infectious diseases, and increased incidence of stillbirths. Therefore, both dietary quantity and quality remain critical challenges in ensuring that all Ugandans are hunger-free and nutrition secure. The essential protein foods such as meat, fish, poultry, eggs, milk and milk products constitute a low proportion of children's diets. There is notably low consumption of dairy products since 2006, with only 3 per cent of children aged 6-23 months consuming milk and milk products in 2016. The consumption of fortified foods was less than one per cent in 2016. Therefore, a lot needs to be done to improve children's diets, especially with nutrient-rich foods.

2.3.6 Water sanitation and hygiene (WASH)

2.3.6.1 Drinking water sources and treatment

Improved drinking water sources include piped water, public taps, standpipes, tube wells, boreholes, protected dug wells, springs, and rainwater. Households that use bottled water for drinking are classified as using an improved source only if the water they use for cooking and handwashing comes from an improved source. Just over three quarters (78 per cent) of households in Uganda have access to an improved source of drinking water. Access to improved water sources is more predominant in urban (91 per cent) than rural (74 per cent) households.

About half (52 per cent) of households use an appropriate water treatment method. The most commonly used method is boiling (47 per cent of households) and more urban households (70 per cent) than rural households (39 per cent) reported boiling their water. More than half of households in rural areas (54 per cent) do not treat their drinking water at all. More than half (55 per cent) of rural households spend at least 30 minutes (round trip) to fetch drinking water, as compared with 23 per cent of urban households. More than half of urban households (54 per cent) use piped water for drinking; 23 per cent have water piped into their dwelling/yard, 18 per cent use water piped to a neighbour, and 13 per cent use a public tap/standpipe. On the other hand, rural households rely mainly on tube wells or boreholes (45 per cent) or an unimproved source (26 per cent). Sixty-seven per cent of households in Uganda reported having water with no interruption of at least a single day. Urban households (50 per cent) are more likely than rural households (24 per cent) to report water as unavailable for at least one day. The proportion of households using an improved source of drinking water increased steadily from 2011 (70 per cent) to 2016 (78 per cent).

2.3.6.2 Sanitation

Improved toilet facilities include any non-shared toilet of the following types: flush/pour toilets to piped sewer systems, septic tanks, and pit latrines; ventilated improved pit (VIP) latrines; pit latrines with slabs and composting toilets. About two in ten households (19 per cent) in Uganda use improved toilet facilities. This is a slight improvement from 15 per cent in 2011. Urban households are more prone to use shared facilities (46 per cent) than rural households (11 per cent). More than half of households in Uganda (55 per cent) use unimproved toilet facilities, with nearly two-thirds (65 per cent) of rural households and one quarter (25 per cent) of urban households using such facilities.

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2.3.6.3 Handwashing

Fifty-nine per cent of household members most often wash their hands. Among households in which a place for handwashing exists, 44 per cent had soap and water, 32 per cent had water, but no soap, and 21 per cent had no water, no soap and no other cleansing agent.

2.3.7 Nutrition-enabling environment

There are governance issues that affect the implementation of nutrition interventions in Uganda. The functionality of Nutrition Coordination Committees (NCC) at UNAP-implementing MDAs not yet at optimal levels. The functionality status of 120 district local government (DLG) NCCs is unknown. For the 26 DLGs whose status has been determined, the functionality is not yet at an optimal level. Despite joining the SUN movement in 2011, which requires the establishment of country-level SUN networks, the Business Network, Academia and Research Institute Network and Civil Society Network s not yet established. Despite its establishment, the functionality index of the Nutrition Development Partners Groups Network has never been determined. The following measures of enabling environment for nutrition are general not yet optimal at all levels of UNAP implementation:

- Nutrition coordination and partnerships.
- Nutrition planning, resource mobilization, financing and tracking.
- Institutional and technical capacity for nutrition.
- Nutrition advocacy, communication and social mobilization.
- Legislation and policy and planning frameworks for nutrition.
- Nutrition evidence and knowledge management for effective decision-making.

2.4 GOVERNMENT COMMITMENT TO ADDRESS MALNUTRITION

Uganda was one of the 'early riser' Scaling up Nutrition (SUN) countries that declared its commitment to nutrition in response to the call to action when it joined the Movement in 2011. Uganda adopted the SUN Movement's multi-sectoral coordination mechanism and established a multi-sectoral coordination mechanism under the OPM. Being a member of the SUN Movement, Uganda galvanized other initiatives such as the United Nations Renewed Efforts Against Child Hunger and undernutrition (UN REACH) initiative at the country level. The 'UNAP II' further highlight the global SUN Movement aspirations.

Eliminating malnutrition in all its forms is critical in breaking the intergenerational cycle of poverty that propels underdevelopment. Uganda is a signatory of key global and regional initiatives aimed at addressing malnutrition in all its forms. The country has demonstrated commitment to alleviating malnutrition by:

1. Positioning nutrition in the Constitution of the Republic of Uganda 1995, Vision 2040, and 'NDP III' (2020/21-2024/25).
2. Developing and implementing 'Uganda Nutrition Action Plan' (UNAP) as the country's strategic and common results framework to enhance mainstreaming nutrition in sector policies, strategies and action for scaling up nutrition in Uganda.
3. Joining the Scaling Up Nutrition (SUN) Movement in 2011 and committing to SUN principles.
4. Committing to achieving World Health Assembly (WHA) nutrition targets, Sustainable Development Goals (SDGs) and the Second International Conference on Nutrition (ICN) Framework for Action, among others.
5. Embracing multi-sectoral and multi-stakeholder approaches to nutrition programming and coordination under OPM.
6. Rolling out the 'Presidential Initiative on Healthy Eating and Healthy Lifestyles' (July 2019). H.E President Yoweri Museveni launched the initiative with the following objectives:
    - Promote healthy eating and lifestyle practices in households and communities.
    - Raise public awareness about malnutrition and its consequences.
    - Advocate for engagement and involvement of public and private sectors, civil society and other stakeholders in promoting healthy diets and lifestyles.

CHAPTER THREE

'UNAP II' Strategic Direction

3.1 'UNAP II' THEORY OF CHANGE

The 'UNAP II' theory of change (*see Figure 7*) below has been informed by the Lancet framework for actions to achieve optimum foetal and child nutrition and development. In addition to nutrition-specific, nutrition-sensitive and enabling environment strategies, the 'UNAP II' theory of change acknowledges the current situation and assumptions that must hold true for its goal to be achieved. The 'UNAP II' builds on the gains attained under the 'UNAP I'. Its scope includes diet-related non-communicable diseases (overnutrition), undernutrition among women, children and all vulnerable groups of the population.

To effectively scale up nutrition actions and promote the wellbeing of Ugandans, particularly in light of the COVID-19 pandemic, a mix of nutrition-specific and nutrition-sensitive strategies is required. Additionally, further effort is needed to strengthen the enabling environment. It is important to note that enabling environment strategies play a catalytic role in promoting nutrition-specific and nutrition-sensitive actions. Such methods include enhancing nutrition governance, ensuring coherent policy, legal and institutional frameworks, and strengthening the use of nutrition information, data, and evidence for effective decision-making,

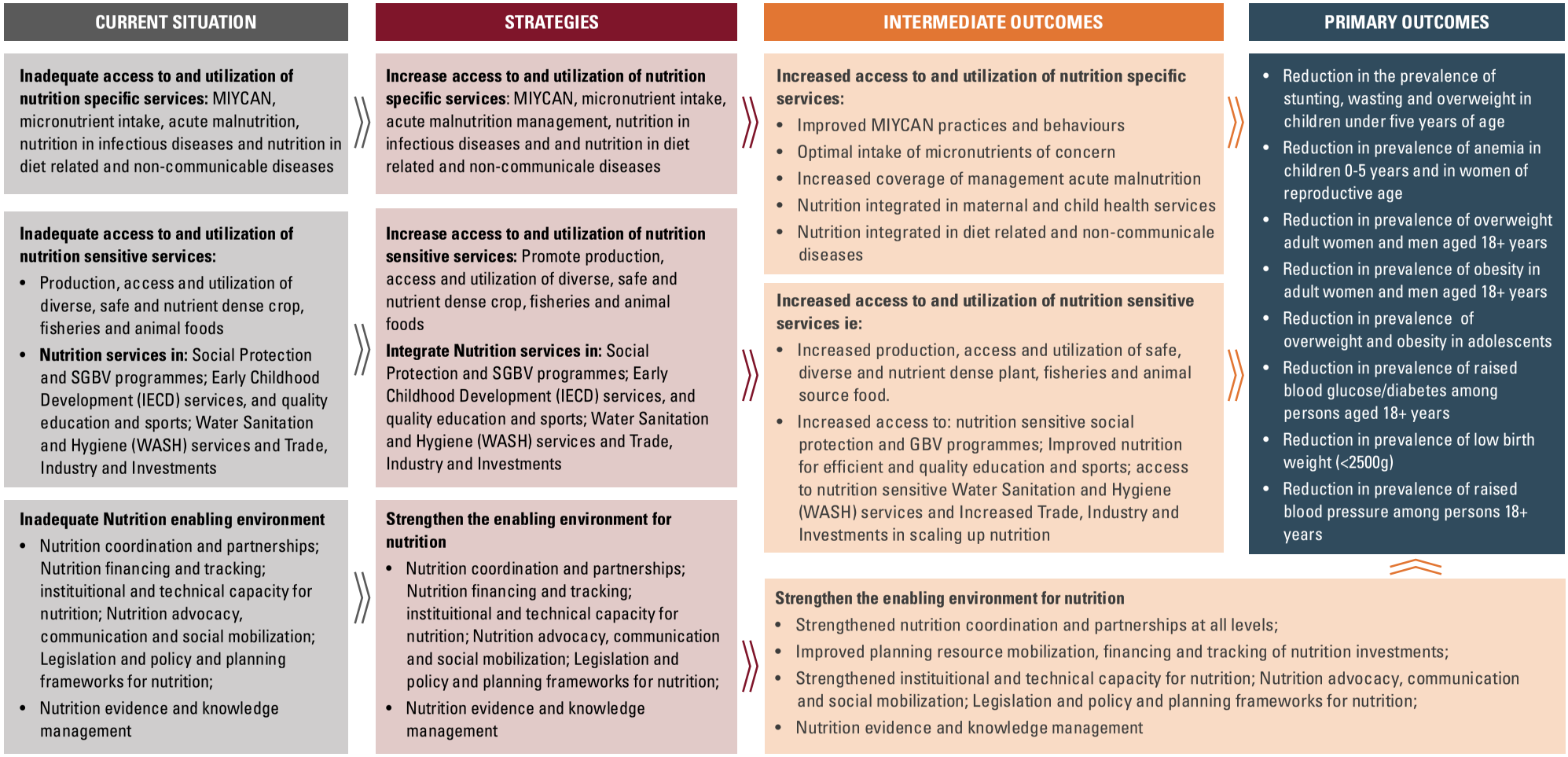
'UNAP II' will ensure that viable linkages between nutrition-specific and nutrition-sensitive strategies are established, since nutrition-sensitive approaches act as delivery platforms for increased coverage of nutrition-specific interventions. Promotion of the production of, access to and utilization of diverse, safe, nutrient-dense food through agricultural and social protection strategies, coupled with the advancement of MIYCAN practices, will lead to improved dietary diversity and micronutrient intake. Integration of essential nutrition actions in preventing and managing infectious and non-communicable diseases and increased access to WASH services will reduce disease burden.

'UNAP II' outputs will be achieved with the assumption that quality nutrition information, sufficient finances and an adequate, skilled human resource base will be available, leading to increased coverage of quality nutrition services. It is also assumed that adequate support for the target groups will lead to a change in behaviours and practices, resulting in the continued utilization of nutrition services. Sustained achievement of primary 'UNAP II' intermediate outcomes will lead to improved nutrition status among children under five years of age, school-age children, adolescents, pregnant and lactating women and other vulnerable groups by 2025 (*see Figure 7*).

FIGURE 7 'UNAP II' THEORY OF CHANGE

ASSUMPTIONS

- Quality nutrition information will contribute to design of impactful interventions
- Sufficient resources to scale up nutrition sensitive and nutrition specific actions will be available
- Enabling environment will lead to increased coverage of nutrition actions
- Target cimmunities demans, access and utilize interventions
- Adequate support to the target groups will lead to change in behaviours and practices
- The COVID-19 pandemic does not stop service delivery



3.2 VISION

A well-nourished, healthy and productive population effectively participating in the socio-economic transformation of Uganda.

3.3 GOAL

Improve nutrition status among children under 5 years, school age children, adolescents, pregnant and lactating women and other vulnerable groups by 2025;

3.4 OBJECTIVES

The 'UNAP II' objectives are based on a holistic approach to nutrition, taking into account all-encompassing global contemporary trends and demands. These include SUN, 2030 Agenda and SDGs, as well as the Vision 2040 aspirations operationalized in the 'NDP III'. The focus areas are nutrition specific, nutrition sensitive and enabling environment. The spirit of the objectives is to uphold a multi-sectoral approach to nutrition. Over the period 2020-2025, 'UNAP II' seeks:

OBJECTIVE 1

To increase access to and utilization of nutrition-specific services by children under five years of age, school-age children, adolescents, pregnant and lactating women and other vulnerable groups.

OBJECTIVE 2

To increase access to and utilization of nutrition-sensitive services by children under five years, school-age children, adolescents, pregnant and lactating women and other vulnerable groups.

OBJECTIVE 3

To strengthen the enabling environment for scaling up nutrition-specific and nutrition-sensitive services.

3.5 STRATEGIES AND PRIORITY ACTIONS

OBJECTIVE 1

To increase access to and utilization of nutrition-specific services by children under five years of age, adolescent girls, pregnant and lactating women and older persons.

STRATEGY	PRIORITY ACTIONS
Strategy 1.1: Promote optimal maternal, infant, young child and adolescent nutrition practices in emergencies and stable situations.	1. Promote exclusive breastfeeding for infants aged 0-5 months. 2. Promote complementary feeding for children aged 6-23 months. 3. Promote and support growth promotion and monitoring services at health facilities and in communities.
Strategy 1.2: Promote optimal micronutrient intake among children, adolescent girls and women of reproductive age in stable and emergency situations.	1. Provide routine vitamin A supplementation to all children aged 0-5 years during integrated child health days. 2. Educate and provide for all pregnant women attending antenatal care to uptake iron and folate supplementation. 3. Promote consumption of fortified foods especially in schools with focus on beans, rice, sweat potatoes, cooking oil, maize. 4. Promote and enforce mandatory consumption of safe and fortified foods in schools 5. Promote and support food fortification for specified foods
Strategy 1.3: Increase coverage of the management of acute malnutrition in stable and emergency situations.	1. Integrate routine screening and timely management of severe and moderate acute malnutrition into routine health and health services in refugee settlements, host communities and other areas.
Strategy 1.4: Integrate nutrition services in the prevention, control and management of infectious diseases and epidemics.	1. Increase access to immunization against childhood diseases. 2. Promote de-worming medications targeting children 1-14 years receiving at least two doses per year. 3. Reduce the burden of communicable diseases, focusing on high burden diseases (malaria and diarrhoea) related to malnutrition through the primary health care approach.
Strategy 1.5: Integrate nutrition services in the prevention, control and management of diet-related non-communicable diseases.	1. Have a national physical exercise day. 2. Conduct sensitization of employers and workers on workplace physical activities for staff. 3. Assess workers and employees for body mass index. 4. Assess workers and employees for diabetes and hypertension. 5. Procure nutrition assessment and health fitness equipment. 6. Develop social behaviour change communication on feeding habits and behaviours. 7. Sensitize households and communities on healthy eating and lifestyle. 8. Engage with public and private sectors, civil society and other stakeholders to promote healthy diets and lifestyles.

OBJECTIVE 2

To increase access to and utilization of nutrition-sensitive services by children under five years, school-age children, adolescent girls, pregnant and lactating women and other vulnerable groups.

STRATEGY	PRIORITY ACTIONS
Strategy 2.1: Increase the production of diverse, safe and nutrient-dense food at the household level from plant, fisheries and animal sources.	1. Support access to improved technologies, including climate-smart ones, to increase diverse, safe, nutrition enhancing crop and animal products. 2. Scale up research about the popularity and accessibility of indigenous and non-indigenous nutrition-enhancing seed and stock. 3. Design and streamline mechanisms for improved farmer access to indigenous and non-indigenous nutrition-enhancing seed and stock varieties. 4. Support the production of nutrient-dense indigenous and underutilized plant, fisheries and animal resources. 5. Increase the production of biofortified foods. 6. Establish community structures for delivering nutrition-sensitive agriculture services through the primary school system. 7. Strengthen linkages between community health worker's services and farming communities. 8. Enhance nutrition services delivered through primary schools, parental groups (PGs) and lead farmers (LFs). 9. Strengthen linkages between agricultural extension services and primary schools to deliver multi-sectoral food and nutrition-security actions. 10. Strengthen the capacity of health, agriculture and education ministries to deliver multi-sectoral food and nutrition-security actions.
Strategy 2.2: Increase access to diverse, safe and nutrient-dense food from plant, fisheries and animal sources	1. Support the scale-up of value addition, agro-processing and marketing of diverse, safe, nutrient-dense foods, including indigenous and underutilized food resources. 2. Build capacity of farmers on postharvest handling technologies and value addition. 3. Support on-farm agricultural enterprise mixes to ensure stable, diversified food access. 4. Provide timely early warnings systems to ensure stable access to food, including the Integrated Phase Classification System.
Strategy 2.3: Increase the utilization of diverse, safe and nutrient-dense food from plant, fisheries and animal sources.	1. Integrate nutrition and home economics in agricultural research and extension. 2. Support investment in technologies and infrastructure development for food safety along the agricultural value chain. 3. Intensify awareness on benefits of consuming safe and nutrition-dense foods, including fortified (bio and industrial), indigenous and underutilized food resources. 4. Develop national food-based dietary guidelines and food composition tables. 5. Establish and operationalize a functional food safety index-tracking system along the agricultural value chains..

STRATEGY	PRIORITY ACTIONS
Strategy 2.4: Promote the integration of nutrition services in social protection programmes.	1. Implement the 15-household model for social-economic empowerment. 2. Mainstream nutrition interventions into social protection programmes and humanitarian assistance safety net programmes. 3. Implement income-generating activities targeting poor and vulnerable households and communities. 4. Support initiatives that create an enabling environment for women to participate in development activities.
Strategy 2.5: Promote access to nutrition services through integrated early childhood development (ECD) services and quality education and sports.	1. Register all ECD centres in accordance with the Ugandan Basic Requirements and Minimum Standards (BRMS). 2. Sensitize private players to spread ECD centres to under-served areas. 3. Increase access to ECD services for children aged 0-8 years. 4. Promote and enforce mandatory consumption of safe and fortified foods in schools. 5. Mobilize parents to provide meals to school-going children. 6. Promote the establishment of school gardens
Strategy 2.6: Increase access to nutrition-sensitive water, sanitation and hygiene (WASH) services.	1. Increase access to inclusive, safe water supply in rural areas. 2. Increase access to inclusive sanitation and hygiene services in rural areas. 3. Increase access to inclusive, safe water supply in urban areas. 4. Increase access to inclusive sanitation and hygiene services in urban areas. 5. Provide support to improve WASH services in institutions. 6. Improve nutrition and food safety with emphasis on children under five years and school-going children.
Strategy 2.7: Increase the participation of trade, industry and investment actors in scaling up nutrition.	1. Build capacity of local industries to adopt appropriate technologies for industrial food fortification. 2. Support industrial uptake and value addition of bio-fortified plants. 3. Enforce surveillance for compliance with the mandatory food fortification regulation. 4. Build capacity of micro, small and medium enterprises (MSMEs) in the food sector with compliance to quality and standards. 5. Support traders and processors of foods to form viable cooperatives. 6. Mitigate non-tariff barriers that affect food and nutrition.

OBJECTIVE 3

To strengthen the enabling environment for scaling up nutrition-specific and nutrition-sensitive services.

STRATEGY	PRIORITY ACTIONS
Strategy 3.1: Strengthen nutrition coordination and partnerships at all levels.	1. Conduct comprehensive nutrition stakeholder and action mapping at MDA levels. 2. Conduct comprehensive nutrition stakeholder and action mapping at local government levels. 3. Establish and support the functionality of Nutrition Coordination Committees (NCCs) at the national and MDA level. 4. Establish and support the functionality of NCCs at local government levels. 5. Establish and support the functionality of all SUN networks with a focus on SUN business, academia and CSO networks. 6. Support joint annual SUN Movement assessments and other relevant joint nutrition programme reviews.
Strategy 3.2: Improve the planning, resource mobilization, financing and tracking of nutrition investments.	1. Develop nutrition action plans (districts, regional cities, municipalities, municipal divisions, and town councils) aligned to 'UNAP II' and 'NDP III' programme implementation action plans (PIAPs). 2. Develop joint annual nutrition work plans (districts, regional cities, municipalities, municipal divisions, and town councils) aligned to the 'UNAP II' implementation matrix. 3. Develop nutrition action plans for Kampala Capital City Authority (KCCA) and its five divisions aligned to 'UNAP II' and 'NDP III' PIAPs. 4. Develop joint annual nutrition work plans for KCCA and its five divisions aligned to the 'UNAP II' implementation matrix. 5. Develop joint annual nutrition work plans and action plans for UNAP-implementing MDAs aligned to the 'UNAP II' implementation matrix. 6. Undertake expenditure reviews for nutrition. 7. Develop an investment case for nutrition in Uganda. 8. Conduct detailed costing of 'UNAP II'. 9. Develop and implement resource mobilization and tracking plan for nutrition aligned to 'UNAP II'.
Strategy 3.3: Strengthen institutional and technical capacity for scaling up nutrition actions.	1. Conduct nutrition capacity assessments among UNAP-implementing MDAs. 2. Conduct nutrition capacity assessments among DLGs and regional cities. 3. Develop nutrition capacity development framework for UNAP-implementing MDAs. 4. Develop nutrition capacity development framework for DLGs and regional cities. 5. Implement the nutrition capacity development framework for UNAP-implementing MDAs. 6. Implement the nutrition capacity development framework for DLGs and regional cities.

STRATEGY	PRIORITY ACTIONS
Strategy 3.4: Strengthen nutrition advocacy, communication and social mobilization for nutrition.	1. Develop a nutrition advocacy communication strategy fully aligned with the 'UNAP II' strategic direction. 2. Develop and implement a regional-specific nutrition advocacy and communication campaign. 3. Mobilize and institute high-level nutrition advocates to actively advance the nutrition agenda at national and sub-national levels. 4. Develop nutrition advocacy briefs and technical briefs for use at national and sub-national levels. 5. Develop nutrition commitments scorecards at national and MDAs levels. 6. Develop nutrition commitments scorecards targeting districts and regional cities. 7. Build capacity of community-based structures such as functional adult literacy (FAL) groups, Parish Development Committees (PDCs), community resource persons, and community-based informal groups to trigger and deliver community-based advocacy, social mobilization and behavioural change communication on nutrition interventions. 8. Undertake campaigns to reduce teenage pregnancy, gender-based violence (GBV) and other harmful practices that result in malnutrition.
Strategy 3.5: Strengthen coherent policy, legal and institutional frameworks for nutrition.	1. Conduct regulatory impact assessment for the National Nutrition Policy. 2. Finalize the National Nutrition Policy (NNP). 3. Develop the national food fortification policy and law. 4. Develop standards and guidelines for child care facilities at formal workplaces 5. Develop and implement employment regulations related to breastfeeding and childcare facilities at workplaces. 6. Amend the Employment Act to provide for childcare facilities at workplaces. 7. Develop legislature and regulation to regulate the production and consumption of sweetened beverages 8. Develop the public food procurement policy for schools and institutions. 9. Strengthen and develop school feeding programmes policy. 10. Conduct a detailed review and revision of existing policies and pending legislation, regulations and standards across relevant sectors. 11. Advocate for coordinated enforcement of relevant legislation at all levels.
Strategy 3.6: Strengthen and institutionalize nutrition evidence and knowledge management along with a multi-sectoral nutrition information system for effective decision making.	1. Design and implement a monitoring, evaluation, accountability and learning (MEAL) plan for 'UNAP II'. 2. Strengthen and scale up early warning systems, survey and surveillance on food and nutrition from community to national levels. 3. Develop, disseminate and enhance the use of evidence-based nutrition knowledge products at all levels. 4. Implement sector-specific research and assessment plans for 'UNAP II'. 5. Create capacity within national institutions to operate and maintain the National Information Platform for Nutrition (NIPN). 6. Strengthen capacity to track progress in meeting national objectives to prevent malnutrition and monitor nutrition investments. 7. Build the capacity of government staff to make better use of evidence and data to design and implement nutrition-related policies and programmes.

3.6 'UNAP II' ALIGNMENT WITH 'NDP III'

TABLE 1 UNAP II ALIGNMENT WITH NDPII

'NDP III' PROGRAMME	'UNAP II'	MDA
01. Agro-Industrialisation	Strategy 2.1	Ministry of Agriculture, Animal Industry and Fisheries (MAAIF)
06. Natural Resource, Environment, Climate Change, Land and Water Resources Management	Strategy 2.6	Ministry of Water and Environment (MoWE)
12. Human Capital Development	Strategy 1.1-1.5; 2.7 Strategy 2.4; 2.5; 2.6	Ministry of Education and Sports (MoES) Ministry of Health (MoH)
13. Technology Transfer and Development	Strategy 2.1; 2.2; 2.7	Ministry of Science, Technology and Innovation (MoSTI)
14. Public Sector Transformation	Strategy 3.3	Ministry of Public Service (MoPS)
15. Community Mobilisation and Minuet Change	Strategy 2.4; 2.5; 3.4	Ministry of Gender, Labour and Social Development (MoGLSD)
17. Regional Balanced Development	Strategy 2.1; 2.2; 2.7	Ministry of Gender, Labour and Social Development
18. Development Plan Implementation	Strategy 3.1-3.6	Ministry of Finance, Planning and Economic Development (MoFPED)

3.7 IMPLEMENTATION PRINCIPLES

While espousing the implementation of 'UNAP II', the following principles will be applied by all actors.

Ensuring community participation: Community participation will be strengthened to address local nutrition challenges by including community members in assessing the extent of challenges, analysing causes and finding solutions. This principle is in line with the government's thinking of using parish development committees. The 'UNAP II' coordination structures have fully taken care of this arrangement by providing terms of reference for the Parish Nutrition Coordination Committee in all parishes.

Strengthening community-based nutrition programming: The 'UNAP II' will emphasise mainstreaming and strengthening nutrition actions through community-based nutrition programmes that reduce food insecurity and consumption of poorly diversified diets. The Parish Model approach will facilitate the implementation of the UNAP strategic direction at community levels.

Strengthening effective coordination mechanism in line with 'NDP III' planning framework: It is important to note that the 'UNAP II' has been developed at a time when the Ugandan Government has approved the 'NDP III' 2020/21-2014/25, which includes multi-sectoral and programme-based implementation. Like the 'UNAP' approach, the 'NDP III' programme approach focuses on the delivery of common results; strengthening the alignment of planning and budgeting frameworks; enhancing synergies among sectors and other actors to minimise silo approach to implementation and providing a coordinated framework for implementation, monitoring, reporting and evaluation of common results.

Deliberate targeting for vulnerable population groups and regions with the highest number and prevalence of malnutrition: Nutrition priority actions, especially for sustaining proper care for nutritionally vulnerable groups, shall be integrated with emergency response systems and addressed in a coordinated manner. Particular groups, especially farmers, typically sell off the most nutritious foods for cash and remain with less healthy foods for their children. Unfortunately, their earned income from the sale of nutritious foods is rarely used to buy a suitable variety of foods, and so ultimately, their children are exposed to undernutrition. Evidence from the UDHS 2016 indicates that regions such as Tooro with high food production per capita is the same region with the highest prevalence of child stunting.

Improving nutrition knowledge and skills: Training in community nutrition is to be provided to health workers, agriculture extension workers, community development workers and functional adult literacy workers using a standardized training manual developed by UNAP-implementing MDAs. Adequate technical and material support for carrying out nutrition interventions will be provided to all service providers. Attention shall also be given to strengthening higher learning institutions participating in pre-and in-service training in multi-sectoral nutrition relevant disciplines for high-level multi-sectoral nutrition programming training.

3.8 TARGETING

Although nutrition is important for all demographics, there are primary target groups upon which focus must be put during 'UNAP II' implementation. Critical among the target groups are:

Pregnant and lactating women: Malnutrition during pregnancy poses a high risk for both the mother and the unborn child. In particular, iodine deficiency in early pregnancy can cause stillbirth and other pregnancy-related complications. If a foetus is born malnourished, this can cause irreversible defects. Similarly, iron deficiency anaemia during pregnancy can increase the risk of maternal mortality and significantly contribute to low birth weight.

Infants and children under five years of age: In most low-income countries, including Uganda, growth faltering begins in the mother's womb. The damage caused by poor nutrition in the womb or the first years of life will be a burden that a child must bear for the rest of his/her life. Rarely does a child who is stunted at the age of two catch up with the mental and physical growth of his/her peers. The child becomes permanently stunted if malnutrition is not averted at this early age.

People living with HIV/AIDS: People living with HIV/AIDS are particularly vulnerable to malnutrition. Opportunistic infections reduce appetite and thus lower food intake, further exacerbating the illness and the progression towards AIDS. Therefore, sensitising and educating people living with HIV/AIDS on the importance of maintaining nutrition is vital.

Displaced population groups: Population groups who are displaced due to either natural or man-made calamities are usually at risk of being malnourished.

Food insecure households: Food insecure households are vulnerable to overt hidden malnutrition. In these conditions, children and mothers are the most vulnerable groups and should receive special attention.

Other population groups: The elderly, prisoners, students in boarding schools, children in orphanages and hospital in-patients, as well as other population groups who are exposed to malnutrition, must receive adequate attention during this action plan implementation.

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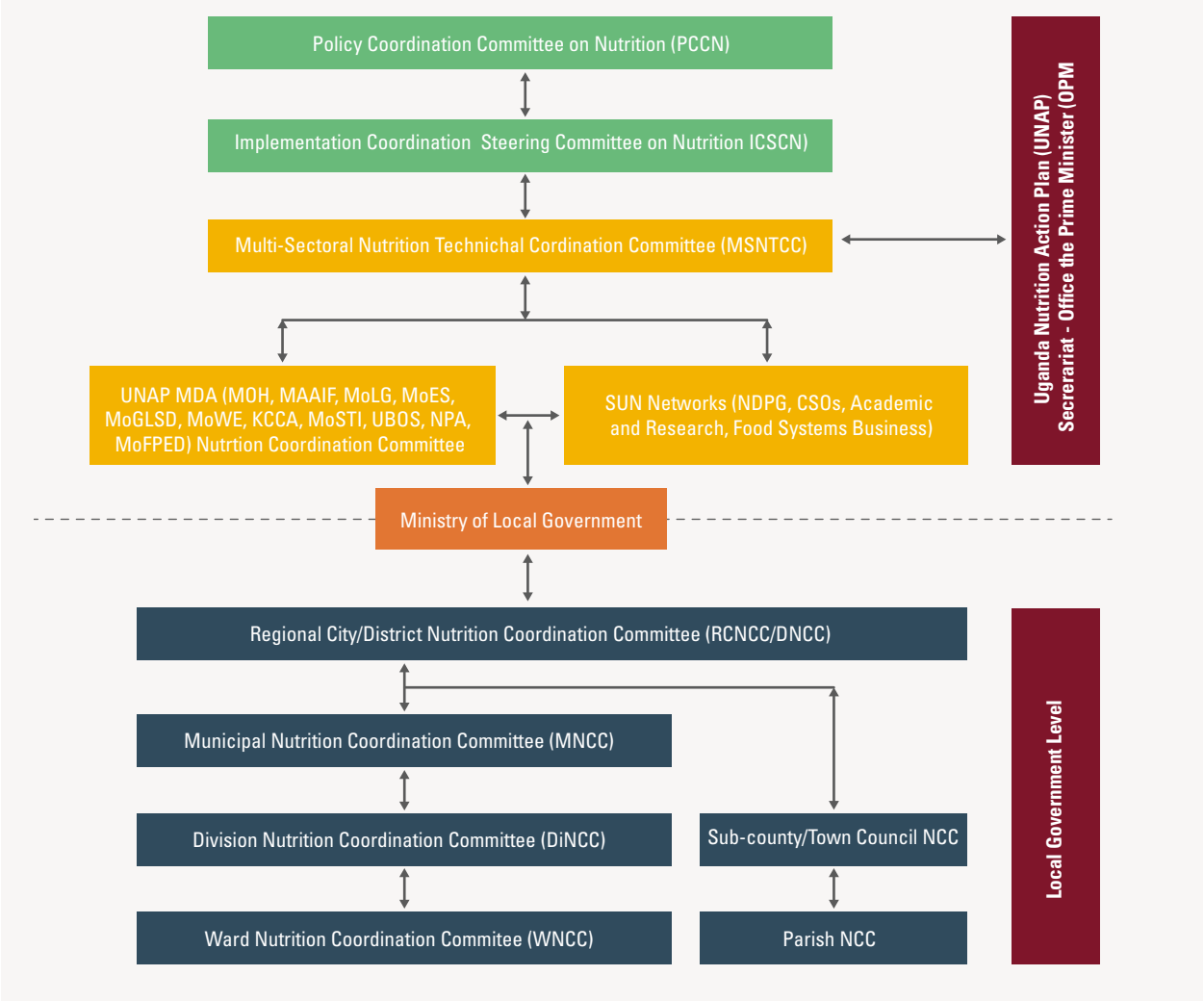
CHAPTER FOUR

‘UNAP II’ Implementation and Coordination Arrangements

The ‘UNAP II’ coordination structure is derived from the Institutional Framework for Coordination (National Coordination Policy, 2016). Figure 8 describes a schematic presentation of the ‘UNAP II’ multi-sectoral coordination framework at the national and sub-national levels. The ‘UNAP II’ remains the strategic framework for SUN in Uganda, based on a multi-sectoral approach and multi-stakeholder engagement as clarified in the implementation matrix. Line MDAs required to plan and budget for nutrition programming and implementation include OPM, MoH, MAAIF, Ministry of Trade Industry and Cooperatives (MoTIC), MoES, MoWE, MoLG, MoGLSD, MoFPED, National Planning Authority (NPA), UBOS, KCCA, LGs and MoSTI. Implementing actors include development partners, CSOs, those in academia and the private sector.

FIGURE 8 SCHEMATIC PRESENTATION OF 'UNAP II' MULTI-SECTORAL COORDINATION FRAMEWORK AT THE NATIONAL AND SUB-NATIONAL LEVELS



Effective coordination is a critical component of nutrition improvement as it creates the necessary enabling environment for harmonization, scale-up, mutual accountability and sustainability of nutrition actions.

The UNAP coordination framework is at nine levels:

i) The National Nutrition Forum convened by the RT Hon Prime Minister

ii) Policy Coordination Committee on Nutrition chaired by the Right Honourable Hon Prime Minister.

iii) iImplementation Coordination Steering Committee on Nutrition chaired by the Permanent Secretary Office the Prime Minister.

iv) Multi-Sectoral Nutrition Technical Coordination Committee chaired by the Permanent Secretary, Office of the Prime Minister.

v) MDA Nutrition Coordination Committees (NCC) each chaired by respective permanent secretaries or executive directors in MoH, MAAIF and KCCA.

vi) Regional city and district NCCs chaired by the City Clerk and Chief Administrative Officer (CAO), respectively.

vii) City division NCC; municipal NCCs and regional city division NCCs chaired by town clerks.

viii) Municipal division NCCs, sub county/town council NCCs chaired by Senior Assistant Town Clerk and Senior Assistant Secretary.

ix) Chairperson LCII chairs the PMC while the Parish Chief is the focal person.

Under Scaling Up Nutrition arrangements, NDPG, CSO, Academia, and Business and Research Networks are at the country level.

4.1 NATIONAL COORDINATION STRUCTURES AND PLATFORMS

The National Nutrition Forum: The National Nutrition Forum (NNF) is the apex tier of engagement on nutrition by all stakeholders. Every two and a half years, the NNF is covenanted by the Right Honourable Prime Minister to take stock of the implementation of the halfway period for the UNAP. The NNF brings together all heads of government departments and agencies, ambassadors, development partners, the private sector, civil society organizations and academia under the chairmanship of the Prime Minister. The NNF event is preceded by a technical review meeting that focuses on reviewing the progress in implementing the 'Uganda Nutrition Action Plan'. Terms of reference for networks detailing the membership, roles and responsibilities, chair, secretariat, frequency of meetings and manner of call, as well as a functionality assessment tool, have been developed as part of the supporting tools for 'UNAP II'.

The Policy Coordination Committee on Nutrition (PCCN): This is composed of Cabinet Ministers from MoH; MoES; MAAIF; MoGLSD; MoLG; MoWE; MoTIC; MoFPED; MoSTI; KCAA, and Chairpersons of UBOS and NPA. The Rt Hon. Prime Minister chairs the PCCN.

The Implementation Coordination Steering Committee on Nutrition (ICSCN): This is composed of Permanent Secretaries from MoH; MoES; MAAIF; MoGLSD; MoLG; MoWE; MoTIC; MoFPED; MoSTI and Executive Directors of KCCA, UBOS and NPA. The ICSCN is chaired by the Permanent Secretary, Office of the Prime Minister.

The Multi-Sectoral Nutrition Technical Coordination Committee (MSNTCC): This is composed of focal persons drawn from the UNAP implementing MDA of MoH; MoES; MAAIF; MoGLSD; MoLG; MoWE; MoTIC; MoFPED; MoSTI, and Executive Directors of KCCA, UBOS and NPA. Membership of MSNTCC also includes representatives of the SUN CSO Network, NDPG Network, SUN Business Network and SUN Academia and Research Institute. The MSNTCC is chaired by the Permanent Secretary, Office of the Prime Minister. The MSNTCC is held quarterly to mainly discuss the progress of UNAP quarterly and annual work plan implementation and reports to the ICSCN.

Department of Strategic Coordination and Implementation (SCI): This is composed of the secretary to the PCCN, ICSCN and the MSNTCC. The SCI performs the key function of overall policy analysis and day to day coordination for the UNAP on behalf of the Ugandan Government. The role of the SCI as the UNAP Secretariat is to:

- prepare reports on operations of the MSTNCC per the existing government of Uganda reporting arrangements/structures.
- provide supervision and mentorship in the area of nutrition governance to the MDAs.
- support the MDAs to prepare annual nutrition work plans derived from the 'UNAP II' five-year implementation matrix to facilitate its implementation at the MDA level.
- facilitate the committee to undertake regular support supervision visits to implementation sites for programmes to MDAs.
- prepare quarterly progress reports on UNAP implementation and contribute to the 'UNAP II' nutrition advocacy agenda, knowledge-sharing and learning events and visits.

Ministries Department and Agencies Nutrition Coordination Committee (MDA NCC): This consists of members from the MoH; MoES; MAAIF; MoGLSD; MoLG; MoWE; MoTIC; MoFPED; MoSTI: KCCA, UBOS and NPA. MDA NCC members are drawn from the directorates/departments/divisions/programmes within the MDA to reflect multi-sectoral programming. Nutrition implementing partners supporting relevant ministries are members of the MDA NCC. The MDA NCC is chaired by the Permanent Secretary and Executive Director for KCCA, UBOS and NPA. The committee meetings are held quarterly and report to the MSNTCC through the UNAP Secretariat.

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Kampala Capital City Authority Nutrition Coordination Committee (KCCA NCC): During the implementation of 'UNAP I', Kampala Capital City Authority was left behind in the coordination structures. However, UNAP interventions were being implemented in the city. It is important to note that despite being at the acceptable level of child stunting in 2016, KCCA registered an increase in child stunting from 14 per cent in 2011 to 18 per cent in 2016. In addition, problems of overweight, obesity, poor dietary and lifestyle behaviours are on the increase in Kampala City and its surrounding urban areas. Although KCCA operates as an MDA for which coordination structure is already provided (see organogram), the 'UNAP II' coordination structure deliberately provides for KCCA and its five divisions to facilitate and fast track the coordination and implementation of nutrition programming in the KCCA as a matter of urgency. The coordination of UNAP implementation in KCCA is cognizant of the KCCA Act 2010 with its amendments (2019). The KCCA NCC members are drawn from Directorates of Administration and Human Resources Management; Treasury Services; Engineering and Technical Services; Public Health and Environment; Education and Social Services; Legal Affairs; Revenue Collection; Gender, Community Services and Production and Internal Audit. The nutrition committee is chaired by Kampala City Authority Executive Director and reports to MSNTC through the UNAP Secretariat.

4.2 NATIONAL LEVEL SCALING UP NUTRITION (SUN) NETWORKS

SUN Development Partners Group (NDPG) Network: Members shall be drawn from development partners involved in financing and supporting nutrition-specific and nutrition-sensitive programmes in Uganda. The Network will meet quarterly and reports to MSNTC through the UNAP Secretariat.

SUN Business Network (SBN): Members shall be drawn from registered business associations, corporate bodies, public-sector agencies involved in the food trade, food transportation, food processing and food and nutrition advisory services for nutrition-specific and nutrition-sensitive actions. The SBN meets quarterly and reports to MSNTC through the UNAP Secretariat.

SUN Civil Society Organizations (CSO) Network: Members shall be drawn from the entire active member CSOs (including international CSOs) implementing nutrition actions. The CSO Network meets quarterly and reports to MSNTC through the UNAP Secretariat.

SUN Academia and Research Institutions Network (ARIN): Members shall be drawn from academic and research institutions working in Uganda that offer Bachelors or advanced degrees in human nutrition, health, food security and other relevant biological sciences in the field of nutrition. All such institutions must be accredited by the National Council of Higher Education, approved by the National Council of Science and Technology or should be registered as non-profit organisations and have ethical clearance from an accredited Ethics Committee or Ethical Review Board. The Network will meet quarterly and reports to MSNTC through the UNAP Secretariat.

4.3 ROLES OF MDAS IN THE COORDINATION OF THE IMPLEMENTATION OF 'UNAP II'

The 'UNAP II' implementation matrix (*see Annexe 2*) provides for MDA specific outputs and their respective indicators to facilitate regular monitoring and evaluation (M&E) of MDA progress of 'UNAP II' implementation (quarterly, bi-annually and annually). It is expected that individual UNAP-implementing MDAs will quality assure nutrition priority actions within their mandates as detailed in the 'UNAP II' implementation matrix. Implementation of enabling environment actions takes place at the following levels:

- Policy Coordination Committee.
- Implementation Coordination Steering Committee.
- Multi-Sectoral Nutrition Technical Coordination Committee.
- Kampala City Authority Nutrition Coordination Committee.
- MDA Nutrition Coordination Committee.
- SUN Networks (NDPG, CSOs, Academia, Business and Research).

OPM will mainly provide technical support in the coordination of national-level actions. In contrast, MoLG will particularly support the strengthening of enabling environment actions and implementation at LG levels of Regional City and District NCC; Municipal NCC; Division NCC; Sub-county/Town Council NCC and Parish NCC. Actual delivery of services will take place at household and community levels. The MDA Nutrition Coordination Committees will regularly undertake support supervision to these sub-national structures to strengthen nutrition governance and technical capacity for nutrition programming and subsequently provide updates to the MSNTC through established reporting arrangements.

Based on these implementation arrangements, the UNAP-implementing MDAs need to ensure that priority actions in the 'UNAP II' are implanted under respective strategies at regional cities, district municipal, division, sub county, town council wards, parish, village and household levels through existing established technical coordination committees. This will mean that technical capacity in nutrition programming at all levels is assured. It is important to note that the Nutrition Coordination Committee roles are specifically for implementing objective three of the 'UNAP II', that is, strengthening the enabling environment for scaling up nutrition-specific and nutrition-sensitive interventions. The UNAP established coordination structures are sub-committees of the Technical Planning Committees (TPCs), and it is expected that the technical quality assurance task is at the technical committee level.

4.4 SPECIFIC ROLES OF PARLIAMENT, CABINET AND UNAP-IMPLEMENTING MDAS

The Ugandan Parliament is the highest legislative body in Uganda. It is expected that Parliament will debate and enact relevant laws to create an enabling environment for nutrition programming. The parliament will also allocate appropriate resources to UNAP-implementing MDAs and ensure transparent and accountable spending of allocated funds. Engaging Members of Parliament about nutrition is important in ensuring that they champion and effectively legislate nutrition relevant bills for enactment into Acts of Parliament.

The Cabinet, as the highest policy-making organ of the Ugandan Government, will, in the context of nutrition programming, ensure that nutrition relevant policies and planning frameworks are in place to allow effective implementation of nutrition programmes.

The Ministry of Health will provide quality assurance in these strategies:

Strategy 1.1: Promote optimal maternal, infant, young child and adolescent nutrition (MIYCAN) practices in stable and emergency situations.

Strategy 1.2: Promote optimal micronutrient intake among children, adolescent girls and women of reproductive age in stable and emergency situations.

Strategy 1.3: Increase coverage of the management of acute malnutrition in stable and emergency situations.

Strategy 1.4: Integrate nutrition services in the prevention, control and management of infectious diseases and epidemics.

Strategy 1.5: Integrate nutrition services in the prevention, control and management of diet-related non-communicable diseases.

In addition, through the MDA NCC, MoH will support these strategies:

Strategy 3.1: Strengthen nutrition coordination and partnerships at all levels.

Strategy 3.3: Strengthen institutional and technical capacity for scaling up nutrition actions.

Strategy 3.4: Strengthen nutrition advocacy, communication and social mobilization for nutrition.

Strategy 3.5: Strengthen coherent policy, legal and institutional frameworks for nutrition.

Strategy 3.6: Strengthen and institutionalize nutrition evidence and knowledge management along with a multi-sectoral nutrition information system for effective decision making.

The Ministry of Agriculture, Animal Industry and Fisheries (MAAIF) will provide quality assurance in these strategies:

Strategy 2.1: Increase the production of diverse, safe and nutrient-dense food at the household level from plant, fisheries and animal sources.

Strategy 2.2: Increase access to diverse, safe and nutrient-dense food from plant, fisheries and animal sources.

Strategy 2.3: Increase the utilization of diverse, safe and nutrient-dense food from plant, fisheries and animal sources.

In addition, through the MDA NCC, MAAIF will support these strategies:

Strategy 3.1: Strengthen nutrition coordination and partnerships at all levels.

Strategy 3.2: Improve the planning, resource mobilization, financing and tracking of nutrition investments.

Strategy 3.3: Strengthen institutional and technical capacity for scaling up nutrition actions.

Strategy 3.4: Strengthen nutrition advocacy, communication and social mobilization for nutrition.

Strategy 3.5: Strengthen coherent policy, legal and institutional frameworks for nutrition.

Strategy 3.6: Strengthen and institutionalize nutrition evidence and knowledge management along with a multi-sectoral nutrition information system for effective decision making.

The Ministry of Gender, Labour and Social Development (MoGLSD) will provide quality assurance in this strategy:

Strategy 2.4: Promote the integration of nutrition services in social protection programmes.

In addition, through the MDA NCC, MoGLSD will support these strategies:

Strategy 3.1: Strengthen nutrition coordination and partnerships at all levels.

Strategy 3.2: Improve the planning, resource mobilization, financing and tracking of nutrition investments.

Strategy 3.3: Strengthen institutional and technical capacity for scaling up nutrition actions.

Strategy 3.4: Strengthen nutrition advocacy, communication and social mobilization for nutrition.

Strategy 3.5: Strengthen coherent policy, legal and institutional frameworks for nutrition.

Strategy 3.6: Strengthen and institutionalize nutrition evidence and knowledge management along with a multi-sectoral nutrition information system for effective decision making.

Ministry of Education and Sports (MoES) will provide quality assurance in this strategy:

Strategy 2.5: Promote access to nutrition services through integrated early childhood development (ECD) services and quality education and sports.

In addition, through the MDA NCC MoES will support these strategies:

Strategy 3.1: Strengthen nutrition coordination and partnerships at all levels.

Strategy 3.2: Improve the planning, resource mobilization, financing and tracking of nutrition investments.

Strategy 3.3: Strengthen institutional and technical capacity for scaling up nutrition actions.

Strategy 3.4: Strengthen nutrition advocacy, communication and social mobilization for nutrition.

Strategy 3.5: Strengthen coherent policy, legal and institutional frameworks for nutrition.

Strategy 3.6: Strengthen and institutionalize nutrition evidence and knowledge management along with a multi-sectoral nutrition information system for effective decision making.

Ministry of Water and the Environment (MoWE) will provide quality assurance in this strategy:

Strategy 2.6: Increase access to nutrition-sensitive water, sanitation and hygiene (WASH) services.

In addition, through the MDA NCC MoWE will support these strategies:

Strategy 3.1: Strengthen nutrition coordination and partnerships at all levels.

Strategy 3.2: Improve the planning, resource mobilization, financing and tracking of nutrition investments.

Strategy 3.3: Strengthen institutional and technical capacity for scaling up nutrition actions.

Strategy 3.4: Strengthen nutrition advocacy, communication and social mobilization for nutrition.

Strategy 3.5: Strengthen coherent policy, legal and institutional frameworks for nutrition.

Strategy 3.6: Strengthen and institutionalize nutrition evidence and knowledge management along with a multi-sectoral nutrition information system for effective decision making.

Ministry of Trade Industry and Cooperatives (MoTIC) will provide quality assurance in this strategy:

Strategy 2.7: Increase the participation of trade, industry and investment actors in scaling up nutrition.

In addition, through the MDA NCC MoTIC will support these strategies:

Strategy 3.1: Strengthen nutrition coordination and partnerships at all levels.

Strategy 3.3: Strengthen institutional and technical capacity for scaling up nutrition actions.

Strategy 3.4: Strengthen nutrition advocacy, communication and social mobilization for nutrition.

Strategy 3.5: Strengthen coherent policy, legal and institutional frameworks for nutrition.

Strategy 3.6: Strengthen and institutionalize nutrition evidence and knowledge management along with a multi-sectoral nutrition information system for effective decision making.

4.5 SUB-NATIONAL LEVEL COORDINATION

Coordination of nutrition programming at the sub-national level will be effected through the following government entities: regional cities; district local governments; Kampala City divisions; regional city divisions; municipalities; municipality divisions; town councils; sub counties; wards and parishes. The roles and responsibilities of these NCCs are:

- advocacy, planning, budgeting, and resource mobilisation
- coordination and partnerships
- nutrition behaviour change communication and social mobilisation
- system capacity building and strengthening of nutrition interventions
- policy implementation and dissemination
- monitoring, evaluation, accountability and learning about the implementation of the 'UNAP II' in the respective entity levels.

Terms of reference and a functionality assessment tool for each NCC have been developed as part of 'UNAP II'.

Regional City Nutrition Coordination Committee (RCNCC): RCNCC members shall be drawn from the following departments: Administration, Human Resources, Finance, Planning, Health Services, Production, Works, Natural Resources, Education, Community Based Services and Commercial Services Development. The City Clerk chairs the RCNCC. Of the RCNCC members from the Regional City Departments, the Technical Planning Committee (TPC) assigns/designates a Regional City Nutrition Focal Person (RCNFP). The committee meetings are held quarterly, and the RCNCC reports to the TPC.

District Nutrition Coordination Committee (DNCC): DNCC members shall be drawn from the following departments: Administration, Human Resources, Finance, Planning, Health Services, Production, Works, Natural Resources, Education, Community Based Services and Commercial Services Development. The Chief Administrative Officer (CAO) chairs the DNCC. The committee meetings are held quarterly, and the DNCC reports to the TPC. Under the Local Government Act, 1997, with its amendments, district local governments and the regional cities fall under the Ministry of Local Government implementation coordination arrangements.

Kampala Capital City Authority District Nutrition Coordination Committee (KCCA-DNCC): KCCA-NDCC m-embers shall be drawn from the following focus areas: Education services, Medical operations, Veterinary services, Revenue collection, Gender, Production and marketing, Physical planning, Law enforcement, Human Resource, Division clerk, Environmental and sanitation. The Town Clerk chairs the KCCA-DNCC. The committee meetings are held quarterly, and KCCA-DNCC reports to the TPC.

Municipality Nutrition Coordination Committee (MNCC): MNCC members shall be drawn from the following departments: Administration, Finance and Planning, Human Resource, Works, Environmental Management, Physical Planning, Education, Production Unit, Community-Based Services, Trade, Industry and Local Economic Development and Public Health. The Town Clerk chairs the MNCC. The committee meetings are held quarterly, and the MNCC reports to the TPC.

Municipal Division Nutrition Coordination Committee (MDNCC): MDNCC members are drawn from the following departments: Administration, Finance, Health, Production, and Community-Based Services like Senior Assistant Town Clerk, Assistant Town Clerk, Treasurer, Community Development Officer, Principal Town Agent, Assistant Treasurer and Law Enforcement Officer. The Senior Assistant Town Clerk chairs the MDNCC.

Town Council Nutrition Coordination Committee (TNCC): TNCC members are drawn from the following departments: Administration, Finance and Planning, Works, Production Unit, Community-Based Services, Trade, Industry, Local Economic Development and Public Health. The Principal Township Officer (who is head of the Town Council) chairs the TNCC. The committee meetings are held quarterly, and the TNCC reports to the TPC.

Sub county Nutrition Coordination Committee (SNCC): SNCC members are drawn from the following departments: Administration (including parish chiefs), Finance, Health, Production, Community-Based Services. In addition, the Health Centre III In-charge and the Health Assistant should be included as SNCC members. The Senior Assistant Secretary/Sub-county Chief chairs the SNCC. The committee meetings are held quarterly, and the SNCC reports to the TPC.

Parish/Ward Nutrition Coordination Committee (P/WNCC): Members of the Parish Development Committee established as per the MoLG Parish Development Committee (PDC) Guidelines (2020) will constitute the Parish Nutrition Coordination Committee. The PDC (which at the same time will work as the PNCC) is composed as follows: LCII Chairperson; Parish Chief; Members of the parish executives holding the following portfolios; Sec. Production, Sec. Information, Sec. Prodn & Env, Representatives of the special interest group in the executive (Youth, PWD, Women); CSOs, NGOs, CBOs; Opinion Leaders (Male and Female) such as retired civil servants; Business/Private Sector Representatives and Chairpersons LC1 in the Parish. PDCs will be strengthened to effectively oversee planning, implementation and monitoring of nutrition actions at the Parish level. 'UNAP II' will support actions aimed at re-activating dormant PDCs and establishment in areas where they are non-existent. The Parish Chief/Ward Administrator/Town Agent chairs the P/WNCC. The committee meetings are held quarterly, and the P/WNCC reports to the TPC.

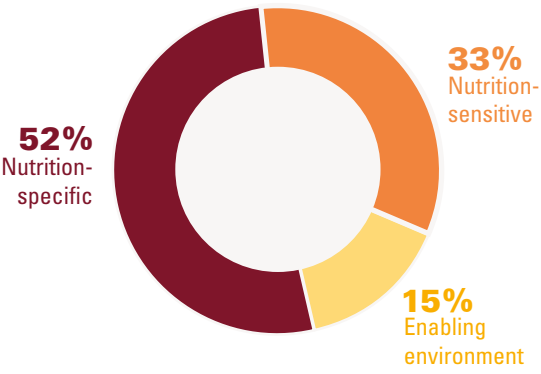
CHAPTER FIVE

Financing and Resource Mobilization

5.1 ESTIMATED FINANCIAL REQUIREMENTS FOR IMPLEMENTING 'UNAP II'

The total indicative financial resource requirement is UGX 3,287.315 billion (UGX 3.28 trillion) for the entire period of five years, distributed as follows:

- Nutrition-specific interventions: **UGX 1,721.08 billion**
- Nutrition-sensitive interventions: **UGX 1,072.4904 billion**
- Enabling environment interventions: **UGX 493.745 billion**



The 'UNAP II' Theory of Change recognizes the need for adequate financial resources as a key prerequisite for successfully implementing priority actions and achieving the 'UNAP II' goal. 'UNAP II' strategies and priority actions are spread across government ministries departments and agencies, namely, OPM, MoH; MoES; MAAIF; MoGLSD; MoLG; MoWE; MoTIC; MoFPED; MoSTI, KCCA, UBOS and NPA. This implies that each of the MDAs together with stakeholders supporting them, have a role in financing 'UNAP II'. The table below summarizes the estimated cost of implementing the 18 'UNAP II' strategies and achieving results over the 2020-2025 period (*see Table 2*).

TABLE 2 SUMMARY OF 'UNAP II' FIVE-YEAR INDICATIVE COSTS BY OBJECTIVE AND STRATEGY

OBJECTIVE 1

To increase access to and utilization of nutrition-specific services by children under five years of age, school-age children, adolescents, pregnant and lactating women and other vulnerable groups.

SN	STRATEGY	INDICATIVE COST (UGX BILLIONS)	LEAD MDA	PARTNERSHIPS
1	**Strategy 1.1:** Promote optimal maternal, infant, young child and adolescent nutrition (MIYCAN) practices in stable and emergency situations.	1,586.71	MoH	MAAIF, MoSTI MoTIC, development partners (DPs), CSOs
2	**Strategy 1.2:** Promote optimal micronutrient intake among children, adolescent girls and women of reproductive age in stable and emergency situations.	21.4	MoH	MAAIF, MoSTI MoTIC, DPs, CSOs
3	**Strategy 1.3:** Increase coverage of the management of acute malnutrition in stable and emergency situations.	106.47	MoH	MoSTI, DPs, CSOs, private sector
4	**Strategy 1.4:** Integrate nutrition services in the prevention, control and management of infectious diseases and epidemics.	-	MoH	MoWE, DPs, CSOs, private sector
5	**Strategy 1.5:** Integrate nutrition services in the prevention, control and management of diet-related non-communicable diseases.	6.5	MoH	MAAIF, MoTIC, DPs, CSOs, private sector
SUBTOTAL FOR OBJECTIVE 1				**1,721.08**

OBJECTIVE 2

To increase access to and utilization of nutrition-sensitive services by children under five years, school-age children, adolescents, pregnant and lactating women and other vulnerable groups.

SN	STRATEGY	INDICATIVE COST (UGX BILLIONS)	LEAD MDA	PARTNERSHIPS
6	**Strategy 2.1:** Increase the production of diverse, safe and nutrient-dense food at the household level from plant, fisheries and animal sources.	482.0664	MAAIF	MoWE, MoSTI, DPs, CSOs, private sector
7	**Strategy 2.2:** Increase access to diverse, safe and nutrient-dense food from plant, fisheries and animal sources.	115.8	MAAIF	MoTIC, MoSTI, DPs, CSOs, private sector
8	**Strategy 2.3:** Increase the utilization of diverse, safe and nutrient-dense food from plant, fisheries and animal sources.	111.889	MAAIF	MoH, MoSTI DPs, CSOs, private sector
9	**Strategy 2.4:** Promote the integration of nutrition services in social protection programmes.	220.55	MoGLSD	MoH, MoFPED, DPs, CSOs
10	**Strategy 2.5:** Promote access to nutrition services through integrated early childhood development (ECD) services and quality education and sports.	47.51	MoES, MoGLSD	MoH, MAAIF, DPs, CSOs
11	**Strategy 2.6:** Increase access to nutrition-sensitive water, sanitation and hygiene (WASH) services.	76.2	MoWE	MoH, DPs, CSOs, private sector
12	**Strategy 2.7:** Increase the participation of trade, industry and investment actors in scaling up nutrition.	18.475	MoTIC	MAAIF, MoH, MoFPED DPs, CSOs, private sector
SUBTOTAL FOR OBJECTIVE 2				**1,072.4904**

OBJECTIVE 3

To strengthen the enabling environment for scaling up nutrition-specific and nutrition-sensitive services.

SN	STRATEGY	INDICATIVE COST (UGX BILLIONS)	LEAD MDA	PARTNERSHIPS
13	**Strategy 3.1:** Strengthen nutrition coordination and partnerships at all levels.	24.462	All UNAP MDAs	All line ministries, DPs, CSOs
14	**Strategy 3.2:** Improve the planning, resource mobilization, financing and tracking of nutrition investments.	36.823	All UNAP MDAs	All line ministries, DPs, CSOs, private sector
15	**Strategy 3.3:** Strengthen institutional and technical capacity for scaling up nutrition actions.	44.69	All UNAP MDAs	All line ministries, DPs, CSOs, private sector
16	**Strategy 3.4:** Strengthen nutrition advocacy, communication and social mobilization for nutrition.	183.51	All UNAP MDAs	All line ministries, DPs, CSOs, private sector
17	**Strategy 3.5:** Strengthen coherent policy, legal and institutional frameworks for nutrition.	59.68	All UNAP MDAs	All line ministries, DPs, CSOs, private sector
18	**Strategy 3.6:** Strengthen and institutionalize nutrition evidence and knowledge management along with a multi-sectoral nutrition information system for effective decision making.	144.58	All UNAP MDAs	All line ministries, DPs, CSOs
SUBTOTAL FOR OBJECTIVE 3				**493.745**
GRAND TOTAL				**3,287.315**

The Uganda central and local governments, with support from development partners, civil society organizations, the private sector, academia and research institutions and other stakeholders supporting nutrition in Uganda, will finance 'UNAP II'. Effective coordination, clarity of accountabilities, capacity to complement and leverage resources is vital in ensuring that 'UNAP II' is adequately financed. The 'UNAP II' implementation matrix in Annexe 2 defines sector/ministry priority actions, outputs and performance indicators. The matrix is helpful in the process of estimating financial requirements to implement 'UNAP II'. It is important to note that the estimated figures summarized in Table 2 are only indicative of the resource requirements to implement 'UNAP II'. Also, most capital project costs already indicated in the various 'NDP III' PIAPs relevant to 'UNAP II' have been excluded in the indicative cost of 'UNAP II', but the activities under such costs have been maintained. Implementation of such activities, especially in the Ministry of Water and Environment, contribute to improved nutrition outcomes.

5.2 GENERATION OF INDICATIVE COSTS FOR 'UNAP II'

The indicative figures in Table 2 were arrived at based on existing budget provisions and extrapolated over the implementation period and the nutrition expenditure review. They will guide the costing of work plans for each of the strategies. The projected resources for 'UNAP II' include resources already available in the 'NDP III' PIAPs Mid-Term Expenditure Framework (MTEF) for line MDAs and ongoing projects and programmes. Implementation will be mainstreamed in relevant UNAP MDA work plans and budgets generated from the 'NDP III' Programme PIAPs for Agro-Industrialization, Human Capital Development, Community Mobilization and Mindset Change. 'UNAP II' strategies and priority actions fall into three categories from the cost estimation lens:

i) Nutrition actions that already have an indicative figure provided under the 'NDP III' PIAPs or MDA work plans.

ii) Existing nutrition actions of capital nature such as water and sanitation infrastructure costs under MoWE; infrastructure costs under MAAIF and MoTIC such as agro-processing industries construction; activities already at MDA level which are aggregated in nature, such as disease prevention costs under MoH that contribute to nutrition outcomes, without necessarily being included in the 'UNAP II' cost estimate

iii) New nutrition-specific, nutrition-sensitive and enabling environment actions that have not been costed given any cost in the existing government and non-Government plans and yet are a priority in realised of the desired 'UNAP II' targets.

Categorization of strategies and priority actions (as indicated above) helped conduct a targeted review of existing information sources and generate indicative costs. The following data sources were used to come up with 'UNAP II' cost estimates:

- **'NDP III' Programme Implementation Action Plans** for (1) Agro-industrialization (2) Human Capital Development and (3) Community Mobilization and Mindset Change guided the generation of indicative costs for strategies 2.4 to 2.7.
- **MIYCAN Action Plan 2020-2025** by MoH guided the generation of indicative cost for strategies 1.1 and 1.2.
- **Integrated Management of Acute Malnutrition** by MoH guided the indicative figure for strategy 1.3.
- **Mainstream MoH budgets** related to its core functions of disease prevention and control guided the generation of indicative costs for strategy 1.4.
- **MAAIF Strategic Plan for 2020/21-2024/25** guided the generation of indicative costs for strategy 2.1 to 2.3.
- **Uganda Multi-Sectoral Food Security and Nutrition Project Document** provided additional indicative costs for strategy 2.1.

Note: Accurate projections require comprehensive nutrition expenditure review and activity-based costing. In addition to the ongoing nutrition expenditure review, the development of investment case for detailed nutrition costing and consequent development of nutrition resource mobilization and tracking plan has been identified as a priority activity in the 'UNAP II' implementation roadmap.

5.3 RESOURCE MOBILIZATION

Developing a plan for resource mobilization and tracking has been included as a critical activity in the 'UNAP II' implementation roadmap. The estimated costs of implementing 'UNAP II' actions and the ongoing nutrition expenditure review will provide crucial information for the development of 'UNAP II' resource mobilization and tracking plan. The plan will ensure systematic and sustained financing of nutrition actions.

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CHAPTER SIX

Monitoring, Evaluation, Accountability and Learning (MEAL)

6.1 OVERVIEW OF THE 'UNAP II' MEAL FRAMEWORK

'UNAP II' recognizes the importance of tracking and evaluating the performance of various targets. In addition to tracking programme implementation and performance, 'UNAP II' will also track resources and build an evidence base for timely decision making, accountability and learning both at the national and sub-national level. The MEAL framework is also helpful in aligning stakeholders' commitments, enhancing evidence-based policy dialogue and retaining institutional memory. The 'UNAP II' MEAL framework is aligned with the 'NDP III' monitoring and evaluation framework, 'NDP III' PIAPs, SDGs, World Health Assembly targets and the SUN MEAL framework. The 'UNAP II' MEAL framework will be implemented through the MEAL plan. The framework captures the indicators to be monitored at impact and implementation levels as drawn from existing frameworks. The 'UNAP II' MEAL framework has been developed to focus on primary and intermediate outcomes while the outputs and their indicators are entailed in the implementation matrix (*see Annexe 2*).

6.2 PRIMARY AND INTERMEDIATE OUTCOMES OF THE 'UNAP II'

The expected primary targets on the **reduced prevalence of undernutrition** are:

Reduced prevalence of stunting in children aged 0-5 years from	Reduced prevalence of low birth weight (<2500 g) from	Reduced prevalence of wasting in children aged 0-5 years from	Reduced prevalence of anaemia in children aged 0-5 years from	Reduced prevalence of anaemia in women of reproductive age from
29% to 19%	**10% to 7%**	**4% to 3%**	**53% to 35%**	**32% to 20%**

The expected primary targets on the **reduced prevalence of overweight, obesity and diet-related non-communicable disease** are:

Reduced prevalence of overweight in children aged 0-5 years from	Reduced proportion of overweight adult women aged 18+ years from	Reduced proportion of overweight adult men aged 18+ years from	Reduced proportion of obesity in adult women aged 18+ years from	Reduced proportion of obesity in adult men aged 18+ years from
4% to 3%	**16.5% to 12.5%**	**7.7% to 3.7%**	**7.2% to 5.2%**	**1.2% to 0.4%**

Reduced proportion of overweight in adolescents from	Proportion of obesity in adolescent girls maintained at	Reduced age-standardized prevalence of raised blood glucose/diabetes among persons aged 18+ years from	Reduced age-standardized prevalence of raised blood pressure among persons aged 18+ years from
10% to 6%	**1%**	**3.3% to 2.1%**	**24% to 20%**

The nutrition-specific intermediate outcomes are:

Outcome 1.1: Improved maternal, infant, young child and adolescent nutrition (MIYCAN) practices in stable and emergency situations.

Outcome 1.2: Optimal uptake of micronutrients of concern among children, adolescent girls and women of reproductive age in stable and emergency situations.

Outcome 1.3: Increased coverage of the management of acute malnutrition in stable and emergency situations.

Outcome 1.4: Nutrition services fully integrated in the prevention, control and management of infectious diseases and epidemics.

Outcome 1.5: Nutrition services fully integrated in the prevention, control and management of diet-related non-communicable diseases.

The nutrition-sensitive intermediate outcomes are:

Outcome 2.1: Increased production of diverse, safe and nutrient-dense food at the household level from plant, fisheries and animal sources.

Outcome 2.2: Increased access to diverse, safe and nutrient-dense food from plant, fisheries and animal sources.

Outcome 2.3: Improved utilization of diverse, safe and nutrient-dense food from plant, fisheries and animal sources.

Outcome 2.4: Increased access to nutrition-sensitive services in social protection programmes.

Outcome 2.5: Increased access to nutrition services through integrated early childhood development (IECD) services and quality education and sports

Outcome 2.6: Increased access to nutrition-sensitive water, sanitation and hygiene (WASH) services.

Outcome 2.7: Increased participation of trade, industry and investment actors in scaling up nutrition.

The enabling environment intermediate outcomes are:

Outcome 3.1: Strengthened nutrition coordination and partnerships at all levels.

Outcome 3.2: Improved planning, resource mobilization, financing and tracking of nutrition investments.

Outcome 3.3: Strengthened institutional and technical capacity for scaling up nutrition actions.

Outcome 3.4: Strengthened nutrition advocacy, communication and social mobilization for nutrition.

Outcome 3.5: Coherent policy, legal and institutional frameworks for nutrition.

Outcome 3.6: Improved nutrition evidence and knowledge management along with multi-sectoral nutrition information system for effective decision making:

6.3 'UNAP II' MEAL ARRANGEMENTS

In collaboration with line ministries and relevant stakeholders, OPM will monitor and evaluate progress towards achievement of 'UNAP II' outcomes at output, objective and goal levels using the set indicators as detailed in the implementation matrix and MEAL framework (Annexe 2 and 3, respectively). In addition to routine monitoring, **a systematic mid-term review and summative evaluation** will be conducted. Uganda National Planning Survey (UNPS), Health Management Information System (HMIS), Agricultural Market Information System (AMIS) and other existing systems will be used to collect routine data. It will be collated in the national nutrition information platform/database to facilitate 'UNAP II' implementation monitoring.

Quarterly and annual monitoring, reporting and reviews

'UNAP II' implementation matrix in Annexe 2 will guide quarterly work planning, budgeting, implementation and reporting in each MDA through output indicators provided. The work plans will detail planned activities under each priority action, expected outputs, output indicator, annual target, timeframe, activity location and activity cost per strategy. It is important to note that the outputs provided in the implementation matrix are for priority actions at the strategic level. Therefore, lower level outputs may be included in the annual work plans related to the activity implementation under the respective priority action.

From the annual work plan, quarterly and annual reports will be generated to track 'UNAP II' implementation on a more regular basis. Quarterly reports will act as a key source of information for the annual nutrition review in each MDA. The annual reports will provide information on the following topics: achievement of relevant intermediate outcomes, achievement of commitments in line with nutrition scorecard, variance and remedial measures, lessons learned, risks analysis and mitigation measures, among others.

Mid-term review and summative evaluation

The mid-term review will assess progress and changes in the nutrition context and recommend amenable revisions to strategic objectives and priority actions in response to the changing context. End-term evaluation criteria will highlight the impact, effectiveness, efficiency, sustainability and relevance of nutrition actions and cross-cutting issues. SUN joint annual assessments, panel surveys, DHS surveys, nutrition surveys, sectoral administrative assessments, thematic research and other assessments will provide additional information.

6.4 LEARNING

'UNAP II' will encourage continuous improvement of processes and outcomes through learning. This will involve evidence-based contextual assessment and analysis of successes, challenges, and opportunities to pinpoint aspects that influence the achievement of results. Plans will be put in place to ensure systematic formal and informal learning, experience sharing and reflection involving all stakeholders. The MEAL plan will put in place systems for continuous documentation and dissemination of lessons learnt.

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6.5 RISKS AND MITIGATION MEASURES

'UNAP II' will strive to identify and manage risks that may affect smooth implementation and achievement of results. The aim is to maximize opportunities and reduce threats to the achievement of 'UNAP II' objectives. This involves identifying and analysing risks through the systematic use of available information to determine the likelihood of specified events. It also determines the magnitude and consequences of risks and prioritizes risks from the most critical to least critical. Risk mitigation consists of coming up with strategies to reduce the likelihood that a risk event will occur and reducing the effect of a risk event if it does occur. Various risks are anticipated during the course of 'UNAP II' implementation. Therefore, it is vital to prioritize risks based on the likelihood of occurrence and impact using the risk prioritization matrix below (*see Table 3*).

TABLE 3 RISK PRIORITIZATION MATRIX

LIKELIHOOD OF OCCURRENCE	CONSEQUENCE/IMPACT		
	High	Medium	Low
High	5	4	3
Medium	4	3	2
Low	3	2	1

TABLE 4 RISK IDENTIFICATION, PRIORITIZATION AND MITIGATION PLAN FOR 'UNAP II'

IDENTIFIED RISK EVENT	RISK CONSEQUENCE	LIKELIHOOD OF OCCURRENCE	RISK IMPACT / CONSEQUENCE	RISK MITIGATION STRATEGY	RESPONSIBILITY
Limited integration of nutrition into ongoing health, agriculture, education, social protection WASH, trade and industry and other programmes	Low coverage of nutrition programmes leading to low performance	Medium	High	• Continuously monitor and report on integration and implementation convergence for nutrition actions • Ensure effective nutrition multi-sectoral nutrition coordination and linkage	• OPM • Line ministries • LLGs • NDPGs • Implementing partners
Inadequate institutional and technical capacity to implement, monitor and evaluate 'UNAP II'	Poor performance in meeting 'UNAP II' objectives	Medium	High	• Conduct capacity assessment and use findings to develop and implement capacity development framework for 'UNAP II'	• OPM • Line ministries • NDPGs • Implementing partners
Inadequate funding of 'UNAP II' activities	Slow down or halt in implementation nutrition actions	High	High	• Develop and implement a robust resource mobilisation and tracking plan for nutrition • Champion integration of nutrition to relevant ongoing sector programmes	• OPM • MoFPED • LLGs • NDPGs • Line ministries • Implementing partners
Low enforcement of relevant nutrition regulations (e.g. mandatory food fortification, food safety, marketing of breast milk substitutes, maternity protection)	Limited compliance leading to missed opportunities in improving nutrition	High	High	• Include monitoring of enforcement and compliance as part of the M&E framework	• OPM • Line ministries
Occurrence of natural disasters, e.g. floods, drought, landslides, earthquakes and disease outbreaks such as Ebola	Disruption of service delivery and limited access by populations	Medium	High	• Develop contingency plans and integrate early warning and action monitoring in the M&E system	• OPM • Line ministries • LLGs • NDPGs • Implementing partners
Fading of the current political will and Government commitment to address malnutrition	Inadequate funding and support to effectively implement 'UNAP II'	Low	Medium	• Ensure sustained engagement of political leaders and key stakeholders • Use nutrition commitments scorecard to monitor commitments and advocate for sustained support	• OPM • Line ministries • Line ministries • LLGs • NDPGs • Implementing partners
The continued influx of refugees	Pressure on current nutrition interventions and programmes	High	High	• Collaborate with other sectors in monitoring the situation and developing contingency plans • Explore other mechanisms such as reserve funds which can be activated in case of emergencies	• OPM • Line ministries • LLGs • NDPGs • Implementing partners
COVID-19	The coronavirus pandemic has brought to the forefront the need to ensure adequate food security and nutrition	High	High	• To improve nutrition, the Ugandan Government will aggressively implement programmes to ensure adequate sensitization and awareness of all Ugandans on the benefits out of good nutrition for their health and wellbeing	• OPM • Line ministries • LLGs • NDPGs • Implementing partners

Annexes

Annexe 1

EVOLUTION OF GLOBAL AND AFRICAN NUTRITION COMMITMENTS AND INITIATIVES

Annexe 1.1: Global commitments and initiatives

Lancet Series on Maternal Child and Nutrition 2008 (later updated in 2013)

Scaling up Nutrition (SUN) Movement launched in 2010

1,000 Days Initiative (2010), which promotes targeting effective actions and investments to improve nutrition in the first 1,000 days of life (from a woman's pregnancy through her child's second birthday)

United Nations General Assembly on Non-Communicable Diseases (2011)

New Alliance for Food Security and Nutrition for sustained agriculture-led growth in Africa and Asia launched in G8 Summit (2012)

World Health Assembly Resolution (2012); 65.6 endorsed the WHO Comprehensive Implementation Plan for maternal, infant and young child nutrition and outlined global nutrition targets for 2025

Nutrition for Growth Summit (2013); which capitalized on the political engagement during the London Summer Olympics

Committee for World Food Security and Nutrition (CFS, 2013); which incorporated the United National System Standing Committee on Nutrition (UNSCN)

Launch of the **Global Panel on Agriculture and Food Systems for Nutrition** (GLOPAN) (2013)

Global Nutrition Reports; the first one was launched in 2014, and they are produced annually. They track commitments and progress, actions and accountability at the global and national level

Second International Conference on Nutrition (2015) Rome Declaration and Framework for Nutrition; underlined the need to address the impact of climate change and other environmental factors on food security and nutrition

Sustainable Development Goals (2015); these include 17 goals and 169 targets of which SDG 2 focuses on ending hunger, achieving food security and improved nutrition

UN Decade of Action on Nutrition (2016-2025); follow up of the second International Conference on Nutrition (ICN 2) and a powerful tool for achieving the WHA and NCD targets it serves as a major driving force for achieving the SDGs

As per Annexe 1.2 below, more recent initiatives offer a significant opportunity for Uganda to demonstrate nutrition leadership in the region by aligning its priorities with these plans. These include the African Development Bank's (AFDB) Africa Leaders for Nutrition (ALN) initiative, AFDB Multi-Sectoral Nutrition Action Plan, East Africa Community Food and Nutrition Security Strategy and Action Plan (2018).

Annexe 1.2: Evolution of regional (African) nutrition declarations, commitments and initiatives[4]

African Union (AU) Agenda, 2063 This is a strategic framework for the socio-economic transformation of the African continent over the next 50 years. It builds on and seeks to accelerate past and existing continental initiatives for growth and sustainable development. It prioritizes the goal of healthy and well-nourished citizens with the strategy of reducing maternal and child malnutrition.

Maputo Declaration, 2003 This contains a commitment to allocating at least 10 per cent of national budgetary resources to agriculture and rural development policy implementation within five years.

Grow Africa Initiative (AU & NEPAD), 2011 It works to increase private sector investment in agriculture and accelerate the execution

4 Adapted from the 'East African Food and Nutrition Security Strategy 2018-2022'

and impact of investment commitments. Opportunities to integrate nutrition into agricultural initiatives through this initiative are abounding.

Malabo Declaration, 2014 This aims to transform Africa's agriculture for shared prosperity and improved livelihoods through harnessing opportunities for inclusive growth and sustainable development opportunities.

Malabo Declaration on Nutrition, 2015 It includes a commitment to increased investment in nutrition to end all forms of malnutrition as articulated in the SDGs.

Africa Regional Nutrition Strategy (ARNS), 2015-2025 ARNS 2015-2025 is the extension of the ARNS 2005-2015. It is an update of the nutrition situation in Africa based on lessons learnt during the implementation of the ARNS 2005-2015. It outlines the specific role of the AU in the elimination of hunger and malnutrition. It is based on the AU 2014-2017 Strategic Plan and reflects the recently initiated AU Agenda 2063, which articulates the continent's longer-term vision.

FAO Regional Initiative (RI) on Africa's Commitment to End Hunger by 2025 This was established in 2014 as a response to the UN Secretary General's Zero Hunger Challenge. It assists countries, and regional economic communities, strengthen their systems and capacities to deliver programmes that contribute to eradicating hunger and malnutrition.

East and Southern Africa Regional Civil Society Nutrition Network, 2017 In June 2017, representatives of nine Civil Society Alliances (CSAs) on nutrition in East and Southern Africa, namely Kenya, Madagascar, Malawi, Mozambique, Rwanda, South Sudan, Tanzania, Zimbabwe and Zambia, resolved to establish this network. It exists to strengthen coordination for joint advocacy by the national CSAs, support regional advocacy and help meet the critical need for media engagement and communication support to position nutrition as a crucial development issue in the region.

Uganda's Civil Society for Nutrition Network was not involved at the time; however, through 'UNAP II', there will be greater emphasis on civil society engagement.

African Leaders for Nutrition Initiative (ALN), 2018 The ALN initiative was endorsed by the Assembly of Heads of State and Governments of the African Union (AU) at the 30th ordinary AU Summit, held in Addis Ababa, Ethiopia, on 31 January 2018. It is led by the President of the African Development Bank and Global Panel on Agriculture and Food Systems for Nutrition, Panel Member Dr Akinwunmi Adesina. ALN launched a 'Continental Nutrition Accountability Scorecard' in 2019 to support greater advocacy and accountability for nutrition investments in Africa.

African Development Bank's Multi-sectoral Nutrition Action Plan, 2018-2025 The Action Plan aims to catalyze nutrition-smart investments to support a 40 per cent stunting reduction in Africa by 2025.

East Africa Community (EAC) Food and Nutrition Security Strategy (FNSS), 2018-2022 This is hinged on the EAC Food and Nutrition Security Policy goal, which is 'to attain food and nutrition security for all the people of East African Community throughout their life cycle, for their health and social and economic wellbeing.' The EAC FNSS and FNSP aim to provide a unified approach to implementing, coordinating, and monitoring the food and nutrition security programs at the national and regional levels. A clear objective on nutrition has been included to improve access and utilization of nutritious, diverse and safe food by 2022.

EAC Food and Nutrition Security Action Plan (FNSP), 2018-2023

Eastern African Parliamentary Alliance for Food Security and Nutrition (EAPA FSN), 2019 During their First Annual Meeting from 15 to 17 April 2019 in Arusha, Tanzania, members of the newly-formed 'Eastern African Parliamentary Alliance for Food Security and Nutrition (EAPA FSN)' committed to leveraging their critical role as legislators to promote the right to food.

Annexe 2

'UNAP II' IMPLEMENTATION MATRIX 2020/21-2024/2025

The implementation matrix details the priority actions, outputs, output indicators, estimated cost, the lead MDA and the relevant 'NDP III' (2020/21-2024/25) PIAP alignment. From this matrix, each implementing entity, for example, MDA and local governments, will develop annual work plans implanted with activities to deliver the expected outputs.

'UNAP II' PRIORITY ACTIONS	OUTPUTS	OUTPUT INDICATORS	COST (UGX BILLION)	LEAD MDA	'NDP III' PIAP ALIGNMENT
OBJECTIVE 3 **To increase access to and utilization of nutrition-specific services by children under five years of age, school-age children, adolescents, pregnant and lactating women and other vulnerable groups**					
Strategy 1.1: Promote optimal maternal, infant, young child and adolescent nutrition (MIYCAN) practices in stable and emergency situations.			1,586.71	MoH	Human Capital Development Programme (HCDP) Objective 1
Outcome 1.1: Improved maternal, infant, young child and adolescent nutrition (MIYCAN) practices in stable and emergency situations.					
Promote exclusive breastfeeding for infants aged 0-5 months	Baby-friendly initiatives in health facilities, communities and workplaces scaled up	Proportion of health facilities certified as baby-friendly	706.44	MoH	HCDP Objective 1; Intervention 1.2
		Number of exclusive breastfeeding promotion activities		MoH	HCDP Objective 1; Intervention 1.2
	Increased number of breastfeeding corners in public and private institutions and workplaces established	Percentage of workplaces with breastfeeding corners		MoH	HCDP Objective 1; Intervention 1.2
	Increased number of commercial outlets and health facilities monitored conforming to the code of marketing	Percentage of commercial outlets and health facilities monitored conforming to the code of marketing		MoH	HCDP Objective 1; Intervention 1.2
	Increased number of breastfeeding mothers sensitized on optimal breastfeeding and complementary feeding practices by peer mothers	Proportion of breastfeeding mothers sensitized on exclusive breastfeeding practices by peer mothers		MoH	HCDP Objective 1; Intervention 1.2
Promote complementary feeding for children aged 6-23 months	Peer mothers trained to mobilize and sensitize breastfeeding mothers to adopt optimal breastfeeding and complementary feeding practices	Proportion of peer mothers trained to mobilize and sensitize breastfeeding mothers on optimal breastfeeding and complementary feeding practices	880.27	MoH	HCDP Objective 1; Intervention 1.2

'UNAP II' PRIORITY ACTIONS	OUTPUTS	OUTPUT INDICATORS	COST (UGX BILLION)	LEAD MDA	'NDP III' PIAP ALIGNMENT
Promote and support growth promotion and monitoring services at health facilities and in communities	Increased number of children aged 0-5 years reached with growth promotion and monitoring services at health facilities and community	Proportion of children aged 0-5 years reached with GMP services at health facilities		MoH	HCDP Objective 1; Intervention 1.2
		Proportion of children aged 0-5 years reached with GMP services at the community level		MoH	HCDP Objective 1; Intervention 1.2
Strategy 1.2: Promote optimal micronutrient intake among children, adolescent girls and women of reproductive age in stable and emergency situations.			21.4	MoH	HCDP Objective 1; Intervention 1.2
Outcome 1.2: Optimal uptake of micronutrients of concern among children, adolescent girls and women of reproductive age in stable and emergency situations.					
Provide routine vitamin A supplementation to children aged 0-5 years during integrated child health days	Increased number of children under five years receiving vitamin A second dose	vitamin A second dose coverage for children under five years (percentage)	11.4	MoH	HCDP Objective 1; Intervention 1.2
Educate and provide for all pregnant women attending antenatal care to uptake iron and folate supplementation	Increased number of pregnant women receiving iron and folate supplement	Percentage of pregnant women receiving iron and folate supplement	10.0	MoH	HCDP Objective 1; Intervention 1.2
Strategy 1.3: Increase coverage of the management of acute malnutrition in stable and emergency situations.			106.470	MoH	HCDP Objective 4
Outcome 1.3: Increased coverage of the management of acute malnutrition in stable and emergency situations.					
Integrate routine screening and timely management of severe and moderate acute malnutrition into routine health and health services in refugee settlements, host communities and other areas	Availability and supply of essential nutrition commodities and logistics for the management of acute malnutrition streamlined	Supply documents indicating availability and supply of essential nutrition commodities and logistics for the management of acute malnutrition	106.470	MoH	HCDP Objective 4; Intervention 4.1
	Nutrition assessment, counselling and support at health faculty and community levels scaled up	Proportion individuals (per age category) accessing nutrition assessment and screening services		MoH	HCDP Objective 4; Intervention 4.1
	Referral systems for the management of acute malnutrition strengthen	Percentage of individuals identified with malnutrition and referred for treatment		MoH	HCDP Objective 4; Intervention 4.1
	Increased number of health facilities providing IMAM services	Proportion of facilities providing IMAM services		MoH	HCDP Objective 4; Intervention 4.1
	Increased number of malnourished individuals receiving IMAM services	Percentage of malnourished individuals receiving IMAM services		MoH	HCDP Objective 4; Intervention 4.1
	Increased number of malnourished clients linked to support services at the community level	Proportion of malnourished clients linked to support services at the community level		MoH	HCDP Objective 4; Intervention 4.1

'UNAP II' PRIORITY ACTIONS	OUTPUTS	OUTPUT INDICATORS	COST (UGX BILLION)	LEAD MDA	'NDP III' PIAP ALIGNMENT
Strategy 1.4: Integrate nutrition services in the prevention, control and management of infectious diseases and epidemics.			Part of MoH budgets	MoH	HCDP Objective 4
Outcome 1.4: Nutrition services fully integrated in the prevention, control and management of infectious diseases and epidemics.					
Increase access to immunization against childhood diseases	Communities mobilized to increase uptake for child immunization services	Proportion of villages mobilized to increase uptake for child immunization services	Part of MoH budgets	MoH	HCDP Objective 4; Intervention 4.1
	Increased number of 1-year-old children who have received the appropriate doses of the recommended vaccines	Proportion of 1-year-old children who have received the appropriate doses of the recommended vaccines in the national schedule	Part of MoH budgets	MoH	HCDP Objective 4; Intervention 4.1
Promote de-worming medications targeting children above 1-14 years receiving at least two doses per year	Increased number of children above 1-4 years receiving at least two doses of deworming medication per year	Proportion of children aged 1-4 years receiving two doses of deworming medication per year	Part of MoH budgets	MoH	HCDP Objective 4; Intervention 4.1
	Increased number of children aged 5- 14 years receiving two doses of deworming medication per year	Proportion of children aged 5-14 years receiving two doses of deworming medication per year	Part of MoH budgets	MoH	HCDP Objective 4; Intervention 4.1
Reduce the burden of communicable diseases, focusing on high burden diseases (malaria and diarrhoea) related to malnutrition through the primary health care approach	Strengthened community-based behavioural change actions to harness and sustain positive malaria practices among children aged 0-5 years, pregnant and lactating women	Percentage of the population with knowledge, utilize and practice correct malaria prevention, control and management measures	Part of MoH budgets	MoH	HCDP Objective 4; Intervention 4.1
		Percentage of primary health care programmes integrating nutrition actions	Part of MoH budgets	MoH	HCDP Objective 4; Intervention 4.1
	Strengthened community-based behavioural change actions to harness and sustain positive diarrhoea practices among children aged 0-5 years	Percentage of the population with knowledge, utilize and practice correct diarrhoea prevention, control and management measures for children aged 0-5 years	Part of MoH budgets	MoH	HCDP Objective 4; Intervention 4.1

'UNAP II' PRIORITY ACTIONS	OUTPUTS	OUTPUT INDICATORS	COST (UGX BILLION)	LEAD MDA	'NDP III' PIAP ALIGNMENT
Strategy 1.5: Integrate nutrition services in the prevention, control and management of diet-related non-communicable diseases.			6.5 Part of MoH NCD activities	MoH	HCDP Objective 4.
Outcome 1.5: Nutrition services fully integrated in the prevention, control and management of diet-related non-communicable diseases.					
Have a national physical exercise day	National physical exercise day held	National physical exercise day in place	Part of MoH NCD activities	MoH	HCDP Objective 4; Intervention 4.12
Conduct sensitization of employers and workers on workplace physical activities for staff	Employers and workers sensitized on workplace physical activities	Number of workplaces with physical exercise initiatives	Part of MoH NCD activities	MoH	HCDP Objective 4; Intervention 4.12
		Physical fitness increased	Part of MoH NCD activities	MoH	HCDP Objective 4; Intervention 4.12
Assess workers and employees for body mass index	Workers assessed for body mass index (BMI)	Proportion of workers and employees assessed for BMI	Part of MoH NCD activities	MoH	HCDP Objective 4; Intervention 4.12
Assess workers and employees for diabetes and hypertension	Workers assessed for diabetes and hypertension	Proportion of workers assessed for diabetes	Part of MoH NCD activities	MoH	HCDP Objective 4; Intervention 4.12
		Proportion of workers assessed for hypertension	Part of MoH NCD activities	MoH	HCDP Objective 4; Intervention 4.12
Procure nutrition assessment and health fitness equipment	Nutrition assessment and health fitness equipment procured	Proportion of households and communities sensitized on healthy eating and lifestyle	Part of MoH NCD activities	MoH	HCDP Objective 4; Intervention 4.12
Develop social behaviour change communication on feeding habits and behaviours.	Social behaviour change communication on feeding habits and behaviours	Proportion of healthcare providers trained on diet-related non-communicable diseases (DRNCDs) at all levels	6.5	MoH	HCDP Objective 4; Intervention 4.10
Sensitize households and communities on healthy eating and lifestyle	Increased number of households and communities sensitized on healthy eating and lifestyle	Proportion of households and communities sensitized on healthy eating and lifestyle		MoH	
Engage with public and private sectors, civil society and other stakeholders in the promotion of healthy diets and lifestyles	Increased number of healthcare providers trained on healthy diets and lifestyles	Proportion of public and private sectors, civil society and other stakeholders engaged in promoting healthy diets and lifestyles		MoH	

'UNAP II' PRIORITY ACTIONS	OUTPUTS	OUTPUT INDICATORS	COST (UGX BILLION)	LEAD MDA	'NDP III' PIAP ALIGNMENT
OBJECTIVE 2 **To increase access to and utilization of nutrition-sensitive services by children under five years, school-age children, adolescent girls, pregnant and lactating women and other vulnerable groups.**					
Strategy 2.1: Increase the production of diverse, safe and nutrient-dense food at the household level from plant, fisheries and animal sources.			482.0664	MAAIF	Agro-industrialization Programme Objective 1
Outcome 2.1: Increased production of diverse, safe and nutrient-dense food at the household level from plant, fisheries and animal sources.					
Support access to improved technologies, including climate-smart ones, to increase diverse, safe, nutrition enhancing crop and animal products	Increase access to improved technologies	Percentage of the districts including urban centres in Uganda having access to a package of nutrition-sensitive technologies along the entire value chain	80.18	MAAIF	Agro-industrialization Programme Objective 1
Scale up research about the popularity of and access to indigenous and non-indigenous nutrition-enhancing seed and stock			100	MAAIF	Agro-industrialization Programme Objective 1
Design and streamline mechanisms for improved farmer access to indigenous and non-indigenous nutrition-enhancing seed and stock varieties	Increase access to indigenous and none indigenous nutrition enhancing seed and stock	Percentage of districts having established multiplication centres for biofortified and indigenous crop varieties	1.6	MAAIF	Agro-industrialization
Support the production of nutrient-dense indigenous and underutilized plant, fisheries and animal resources			20.15	MAAIF	Agro-industrialization Programme Objective 1
Increase the production of biofortified foods	Increased production of biofortified foods intensified	Proportion of farming households producing biofortified foods	203.85	MAAIF	Agro-industrialization Programme Objective 1
Establish community structures for delivering nutrition-sensitive agriculture services through the primary school system	Community structures for delivering nutrition-sensitive agriculture services established	Number of structures delivering nutrition services established at the community level	5.52	MoES	HCDP Objective 1
Strengthen linkages between community health worker's services and farming communities	Linkages between community health workers services and farming communities established	Proportion of village health teams participating in the delivery of nutrition-sensitive agriculture services	8.7216	MoES	HCDP Objective 1

'UNAP II' PRIORITY ACTIONS	OUTPUTS	OUTPUT INDICATORS	COST (UGX BILLION)	LEAD MDA	'NDP III' PIAP ALIGNMENT
Enhance nutrition services delivered through primary schools, parental groups (PGs) and lead farmers (LFs)	Nutrition services delivered through primary schools, PGs and LFs	Proportion of primary schools, PGs and LFs delivering nutrition services	47.84	MoES	HCDP Objective 1
Strengthen linkages between agricultural extension services and primary schools to deliver multi-sectoral food and nutrition-security actions	Linkages between agricultural extension services and primary schools strengthened to deliver multi-sectoral food and nutrition security actions	Proportion of primary school backstopped by agriculture extension officers staff to deliver multi-sectoral food and nutrition security actions	6.8448	MAAIF	HCDP Objective 1
Strengthen the capacity of health, agriculture and education ministries to deliver multi-sectoral food and nutrition-security actions	Increased number of health, agriculture and education personnel trained to deliver multi-sectoral food and nutrition security actions	Proportion of health, agriculture and education personnel trained to deliver multi-sectoral food and nutrition security actions	7.36	MAAIF	HCDP Objective 1
Strategy 2.2: Increase access to diverse, safe and nutrient-dense food from plant, fisheries and animal sources.			115.8	MAAIF	Agro-industrialization Programme Objective 2
Outcome 2.2: Increased access to diverse, safe and nutrient-dense food from plant, fisheries and animal sources.					
Support the scale-up of value addition, agro-processing and marketing of diverse, safe, nutrient-dense foods, including indigenous and underutilized food resources	Small scale cottage industries established	Percentage of districts with cottage industries following GMP	94.47	MAAIF	Agro-industrialization Programme Objective 3
Build capacity of farmers on postharvest handling technologies and value addition	Farmers trained on postharvest handling technologies and value addition	Number of farmers trained on postharvest handling and value addition	3.25	MAAIF	Agro-industrialization Programme Objective 2
Support on-farm agricultural enterprise mixes to ensure stable, diversified food access	On-farm agriculture enterprises supported for stable access to diversified foods	Percentage of districts supported with on-farm agriculture enterprises for stable access to diversified foods	5.03	MAAIF	Agro-industrialization Programme Objective 1
		Number of farmers supported with on-farm agriculture enterprises for stable access to diversified foods			Agro-industrialization Programme Objective 1
Provide timely early warnings systems to ensure stable access to food, including the Integrated Phase Classification System	Timely early warning systems for food security and nutrition established	E-based early warning system in place	13.05	MAAIF	Agro-industrialization Programme Objective 1

'UNAP II' PRIORITY ACTIONS	OUTPUTS	OUTPUT INDICATORS	COST (UGX BILLION)	LEAD MDA	'NDP III' PIAP ALIGNMENT
Strategy 2.3: Increase the utilization of diverse, safe and nutrient-dense food from plant, fisheries and animal sources.			111. 889	MAAIF	HCDP Objective 1; Intervention 1.2c
Outcome 2.3: Improved utilization of diverse, safe and nutrient-dense food from plant, fisheries and animal sources.					
Integrate nutrition and home economics in agricultural research and extension	Nutrition and home economics integrated into agriculture research and extension	Guidelines, handbooks and information, education and commmunication m materials on nutrition-sensitive extension services in place	3.6	MAAIF	Agro-industrialization Programme Objective 1
Support investment in technologies and infrastructure development for food safety along the agricultural value chain	Technologies and infrastructure for food safety along the value chain developed	Number and type of technologies developed /infrastructure in place	59.25	MAAIF	Agro-industrialization Programme Objective 1
		Number of technology implementation action plans	10	MoSTI	
Intensify awareness on benefits of consuming safe and nutrition-dense foods, including fortified (bio and industrial), indigenous and underutilized food resources	Communities sensitized on the benefits of consuming diverse, safe nutrient-dense crop, fish and animal products	Number of households sensitized on the benefits of consuming diverse, safe nutrient-dense crop, fish and animal product	13.02	MAAIF	HCDP Objective 1
	Extension officers sensitized trained on the benefits of consuming diverse, safe nutrient-dense crop, fish and animal products	Number of extension officers sensitized trained on the benefits of consuming diverse, safe nutrient-dense crop, fish and animal products			HCDP Objective 1
Develop national food-based dietary guidelines and food composition tables	National food composition tables developed	National food composition tables in place	15.919	MAAIF	HCDP Objective 1
	National food-based dietary guidelines developed	National food-based dietary guidelines in place			HCDP Objective 1
Establish and operationalize a functional food safety index-tracking system along the agricultural value chains	A functional food safety index-tracking system established	A functional food safety index-tracking system operational	10.1	MAAIF	HCDP Objective 1

'UNAP II' PRIORITY ACTIONS	OUTPUTS	OUTPUT INDICATORS	COST (UGX BILLION)	LEAD MDA	'NDP III' PIAP ALIGNMENT
Strategy 2.4: Promote the integration of nutrition services in social protection programmes.			220.55	MoGLSD	HCDP Objective 5
Outcome 2.4: Increased access to nutrition-sensitive services in social protection programmes.					
Mainstream nutrition interventions into social protection programmes and humanitarian assistance safety net programmes	A program aimed at promoting household engagement in improving household income implemented	Number of households benefiting from village savings and loan associations investment clubs	220.55	MoGLSD	Community Mobilization and Mindset Change Programme Objective 1
	The village cluster household model expanded to undertake five investments, e.g. (water point, agricultural inputs, livelihood support)	Proportion of households benefitting from one time investments		MoGLSD	
Mainstream nutrition interventions into social protection programmes and humanitarian assistance safety net programmes	Increased number of vulnerable populations covered by nutrition-sensitive social protection programmes and humanitarian assistance safety net programmes.	Proportion of vulnerable populations covered by nutrition-sensitive social protection programmes and humanitarian assistance safety net programmes.		MoGLSD	HCDP Objective 5
Implement income-generating activities targeting poor and vulnerable households and communities	Increased number of poor and vulnerable households and communities engaging in income-generating activities	Proportion of poor and vulnerable households and engaging in income-generating activities		MoGLSD	HCDP Objective 5
Support initiatives that create an enabling environment for women to participate in development activities	Increased number of women participating in development initiatives such as the Uganda Women Entrepreneurship Programme fund	Proportion of women of women participating in development initiatives such as the Uganda Women Entrepreneurship Programme fund		MoGLSD	HCDP Objective 5
Strategy 2.5: Promote access to nutrition services through integrated early childhood development (ECD) services and quality education and sports.			47.51	MoES and MoGLSD	HCDP objective 1
Outcome 2.5: Increased access to nutrition services through integrated early childhood development (ECD) services and quality education and sports.					
Register all ECD centres in accordance with the Ugandan Basic Requirements and Minimum Standards	ECD centres registered	Percentage of ECD centres registered	2	MoES	HCDP objective 1
Sensitize private players to spread ECD centres to under-served areas			0.15	MoES	HCDP Objective 1

'UNAP II' PRIORITY ACTIONS	OUTPUTS	OUTPUT INDICATORS	COST (UGX BILLION)	LEAD MDA	'NDP III' PIAP ALIGNMENT
Increase access to ECD services for children aged 0-8 years	Integrated ECD service delivery framework rolled out	Proportion of children aged 0-8 years accessing ECD services	14.1	MoGLSD	HCDP Objective 1
	The national integrated communication and advocacy strategy rolled out		14.1	MoGLSD	HCDP Objective 1
	Delivery of integrated ECD services in local governments monitored		1.16	MoGLSD	HCDP Objective 1
Promote and enforce mandatory consumption of safe and fortified foods in schools	Nutritious meals provided at schools	Number of schools (primary and secondary) providing safe and fortified foods to children	10	MoES	HCDP Objective 1; Intervention:1.2b
Mobilize parents to provide meals to school going children	Parents mobilized to provide a hot healthy meal to their school-going children during school days	Percentage of day school-going children having at least a healthy hot meal a day	2	MoES	HCDP Objective 1
Promote the establishment of schools gardens	Schools gardens established	Proportion of schools with school gardens established	4	MoES	HCDP Objective 4; Intervention 4.15
Strategy 2.6: Increase access to nutrition-sensitive water, sanitation and hygiene (WASH) services.			76.2 for social behaviour change communication on WASH; capital costs in MoWE budgets	MoWE	HCDP objective 4; Intervention 4.5
Outcome 2.6: Increased access to nutrition-sensitive water, sanitation and hygiene (WASH) services.					
Increase access to inclusive, safe water supply in rural areas	Piped water systems constructed in rural areas	Percentage of people accessing safe and clean water sources in rural areas	Imbedded in MoWE capital projects	MoWE	HCDP objective 4; Intervention 4.5
	Solar/wind-powered water supply systems constructed in rural areas		Imbedded in MoWE capital projects	MoWE	HCDP objective 4; Intervention 4.5
	New point water sources constructed in rural areas		Imbedded in MoWE capital projects	MoWE	HCDP objective 4; Intervention 4.5
	Improved water point per village constructed in rural areas	Percentage of villages with access to safe and clean water supply	Imbedded in MoWE capital projects	MoWE	HCDP objective 4; Intervention 4.5
	Communal or institutional rainwater harvesting systems provided in rural areas		Imbedded in MoWE capital projects	MoWE	HCDP objective 4; Intervention 4.5

'UNAP II' PRIORITY ACTIONS	OUTPUTS	OUTPUT INDICATORS	COST (UGX BILLION)	LEAD MDA	'NDP III' PIAP ALIGNMENT
Increase access to inclusive sanitation and hygiene services in rural areas	Increased number of villages reached with social behaviour change communication for construction and use of improved sanitation facilities	Percentage of population with access to basic sanitation	Imbedded in MoWE capital projects	MoWE	HCDP objective 4; Intervention 4.5
	Increased number of villages in districts promoting faecal sludge management in rural areas	Percentage of population using safely managed sanitation services	Imbedded in MoWE capital projects	MoWE	HCDP objective 4; Intervention 4.5
	Increased number of households reached with social behaviour change communication for the use of handwashing with water, investment in public handwashing facilities in rural areas	Percentage of population with handwashing facilities with soap and water at home	10	MoWE	HCDP objective 4; Intervention 4.5
Increase access to inclusive, safe water supply in urban areas	Increased number of new piped water supply systems using regional and integrated national approaches in small towns constructed	Percentage of the urban population within access of an improved water source (200 m)	Imbedded in MoWE capital projects	MoWE	HCDP objective 4; Intervention 4.5
	Increased number of pro-poor public stand posts in small towns	Number of people having access to pro-poor facilities	Imbedded in MoWE capital projects	MoWE	HCDP objective 4; Intervention 4.5
	Increased number of household connection in small towns (number)	Percentage of population using safely managed drinking water services located on-premises	Imbedded in MoWE capital projects	MoWE	HCDP objective 4; Intervention 4.5
Increase access to inclusive sanitation and hygiene services in urban areas	Increased number of urban centres reached with social behaviour change communication (SBCC) for construction and use of improved sanitation facilities	Percentage of population with access to basic sanitation in urban areas	10.8	MoWE	HCDP objective 4; Intervention 4.5
	Increased number of urban centres with faecal sludge management processes, transport and appropriate sewerage infrastructure constructed	Percentage of population using safely managed sanitation services	Imbedded in MoWE capital projects	MoWE	HCDP objective 4; Intervention 4.5
	Increased number of urban centres reached with SBCC for handwashing with water, investment in public handwashing facilities	Percentage of population with handwashing facilities with soap and water at home in urban areas	20.2	MoWE	HCDP objective 4; Intervention 4.5

'UNAP II' PRIORITY ACTIONS	OUTPUTS	OUTPUT INDICATORS	COST (UGX BILLION)	LEAD MDA	'NDP III' PIAP ALIGNMENT
Provide support to improve WASH services in institutions	Increased institutions (schools, prisons, barracks, religious establishment, health facilities, etc.) with water supply infrastructure constructed or extended	Percentage of institutions with an improved water source	Imbedded in MoWE capital projects	MoWE	HCDP objective 4; Intervention 4.5
	Increased number of schools reached with SBCC for the use of sanitation facilities and handwashing with water	Percentage of pupils enrolled in schools provided with basic sanitation and handwashing facilities	20.2	MoWE	HCDP objective 4; Intervention 4.5
Improve nutrition and food safety with emphasis on children under five years and school-going children	Increased number of household sensitized, monitor and evaluated for water usage and handwashing practices with particular focus on nutrition and food safety	Number of households use of safe water with a deliberate focus on nutrition and food safety	15	MoWE	HCDP objective 4; Intervention 4.5
Strategy 2.7: Increase the participation of trade, industry and investment actors in scaling up nutrition.			18.475	MoTIC and MoSTI	Agro-industrialization Programme Objective 2 and 3
Outcome 2.7: Increased trade, industry and investments in scaling up nutrition.					
Build capacity of local industries to adopt appropriate technologies for industrial food fortification.	Increased availability of fortified foods on the market	Proportion of industries supplying fortified foods on the market	14	MoTIC	Agro-industrialization Programme Objective 2 and 3
	Increased support to research and development to biofortified products	Types and number of new biofortified products supported through research and development		MoSTI	Agro-industrialization Programme Objective 2 and 3
	Increased awareness created on biofortification and its importance to human nutrition	Number of awareness campaigns created on biofortification and its importance to human nutrition		MoSTI	Agro-industrialization Programme Objective 2 and 3
Support industrial uptake and value addition of biofortified plants	Increased value addition of nutritious foods	Proportion of value-added nutritious foods	1.2	MoTIC	Agro-industrialization Programme Objective 2 and 3
Enforce surveillance for compliance with the mandatory food fortification regulation	Increased number of industries complying with the fortification of wheat flour, maize flour, edible oil enforcement	Proportion of industries complying with the fortification of wheat flour, maize flour, edible oil enforcement	0.75	MoTIC	Agro-industrialization Programme Objective 2 and 3

'UNAP II' PRIORITY ACTIONS	OUTPUTS	OUTPUT INDICATORS	COST (UGX BILLION)	LEAD MDA	'NDP III' PIAP ALIGNMENT
Build capacity of micro, small and medium enterprises (MSMEs) in the food sector with compliance to quality and standards	Increased number of MSMEs in the food system availing fortified foods on the market	Proportion of MSMEs in the food system availing fortified foods on the market	1.25	MoTIC	Agro-industrialization Programme Objective 2 and 3
Support traders and processors of foods to form viable cooperatives	Increased number of traders and processors of foods forming viable cooperatives for trading quality nutritious foods	Proportion of traders and processors of foods forming viable cooperatives for trading quality nutritious foods	0.675	MoTIC	Agro-industrialization Programme Objective 4
Mitigate non-tariff barriers that affect food and nutrition	Decreased non-tariff barriers that affect food and nutrition mitigated	Proportion of non-tariff barriers that affect food and nutrition that have been mitigated	0.6	MoTIC	Increase market access and competitiveness of agricultural products in domestic and international markets

'UNAP II' PRIORITY ACTIONS	OUTPUTS	OUTPUT INDICATORS	COST (UGX BILLION)	LEAD MDA	'NDP III' PIAP ALIGNMENT
OBJECTIVE 3 **To strengthen the enabling environment for scaling up nutrition-specific and nutrition-sensitive services**					
Strategy 3.1: Strengthen nutrition coordination and partnerships at all levels.			24.462	UNAP MDAs	HCDP Objective 1; Intervention 1.2a
Outcome 3.1: Strengthened nutrition coordination and partnerships at all levels.					
Conduct comprehensive nutrition stakeholder and action mapping at MDA levels	Comprehensive nutrition stakeholder and action mapping at national and MDA levels conducted	Nutrition stakeholder and action mapping at MDA levels	0.6	OPM	HCDP Objective 1; Intervention 1.2a
Conduct comprehensive nutrition stakeholder and action mapping at local government levels	Comprehensive nutrition stakeholder and action mapping at local government levels conducted regularly	Nutrition stakeholder and action mapping at local government levels	4.95	MoLG	HCDP Objective 1; Intervention 1.2a
Establish and support the functionality of Nutrition Coordination Committees (NCCs) at the national and MDA level	Multi-sectoral Nutrition Technical Coordination Committee (MSNTCC) is fully established and fully-functional	Overall functionality score of the MSNTCC	1.962	OPM	HCDP Objective 1; Intervention 1.2a
	Existence of nutrition coordination committees in all UNAP-implementing MDAs	Functionality index of individual MDAs NCCs		UNAP MDAs	HCDP Objective 1; Intervention 1.2a
Establish and support the functionality of NCCs at local government levels	Existence of nutrition coordination committees at all levels of local governments	Functionality index of local government level NCCs	16	MoLG	HCDP Objective 1; Intervention 1.2a
Establish and support the functionality of all SUN networks with a focus on SUN business, academia and CSO networks.	SUN Business Network is fully established and fully-functional	SUN Business Network functionality index	0.9	MoTIC	HCDP Objective 1; Intervention 1.2a
	SUN Civil Society Organisation Network (CSO) is fully established and fully-functional	SUN CSO network functionality index		MOGLSD	HCDP Objective 1; Intervention 1.2a
	SUN Academic and Research Institutions Network (ARIN) is fully established and fully-functional	SUN ARI network functionality index		MoES	HCDP Objective 1; Intervention 1.2a
	SUN Development Partners Group (DPG) is fully established and fully-functional	SUN DPG Network functionality index		OPM	HCDP Objective 1; Intervention 1.2a
Support joint annual SUN Movement assessments and other relevant joint nutrition programme reviews	Joint annual SUN Movement assessments (and other joint nutrition programme reviews) conducted	SUN Movement processes score	0.050	OPM	HCDP Objective 1; Intervention 1.2a

'UNAP II' PRIORITY ACTIONS	OUTPUTS	OUTPUT INDICATORS	COST (UGX BILLION)	LEAD MDA	'NDP III' PIAP ALIGNMENT
Strategy 3.2: Improve the planning, resource mobilization, financing and tracking of nutrition investments.			36.823	UNAP MDAs	HCDP Objective 1; Intervention 1.2a
Outcome 3.2: Improved planning, resource mobilization, financing and tracking of nutrition investments.					
Develop nutrition action plans (districts, regional cities, municipalities, municipal divisions, and town councils) aligned to 'UNAP II' and 'NDP III' programme implementation action plans (PIAPs).	Nutrition action plans (district, regional cities, municipalities, municipal divisions, and town councils) developed	Proportion of LGs with nutrition action plans (district, regional cities, municipalities, municipal divisions, and town councils) in place for implementation	24.45	MoLG	HCDP Objective 1; Intervention 1.2a
Develop joint annual nutrition work plans (districts, regional cities, municipalities, municipal divisions, and town councils) aligned to the 'UNAP II' implementation matrix	Joint annual nutrition work plans (district, regional cities, municipalities, municipal divisions, and town councils) developed	Proportion of LGs with approved joint annual nutrition work plans for implementation		MoLG	HCDP Objective 1; Intervention 1.2a
Develop nutrition action plans for Kampala Capital City Authority (KCCA) and its five divisions aligned to 'UNAP II' and 'NDP III' PIAPs	Nutrition action plans for KCCA and the five divisions developed	Nutrition action plans for KCCA and the five divisions in place for implementation		KCCA	HCDP Objective 1; Intervention 1.2a
Develop joint annual nutrition work plans for KCCA and its five divisions aligned to the 'UNAP II' implementation matrix	Joint annual nutrition work plans for KCCA and the five divisions developed	Joint annual nutrition work plans for KCCA and the five divisions in place for implementation		KCCA	HCDP Objective 1; Intervention 1.2a
Develop joint annual nutrition work plans for UNAP-implementing MDAs aligned to the 'UNAP II' implementation matrix	Joint annual nutrition work plans for UNAP-implementing MDAs developed	Proportion of MDAs with annual nutrition work plans (UNAP-implementing MDAs) in place for implementation		OPM, all UNAP MDAs	HCDP Objective 1; Intervention 1.2a
Undertake expenditure reviews for nutrition	Nutrition expenditure review finalized and report disseminated	Nutrition expenditure review report in place	2.298	OPM, all UNAP MDAs	HCDP Objective 1; Intervention 1.2a
Develop an investment case for nutrition in Uganda	Nutrition investment case developed and disseminated	Nutrition investment case in place for use in resource mobilization	1.880	OPM	HCDP Objective 1; Intervention 1.2a
Conduct detailed costing of 'UNAP II'	Finalize detailed costing of 'UNAP II'	Report indicating costs per priority action in the 'UNAP II'	2.45	OPM	HCDP Objective 1; Intervention 1.2a
Develop and implement resource mobilization and tracking plan for nutrition aligned to 'UNAP II'	Resource mobilization and tracking plan for nutrition developed	Resource mobilization and tracking plan in place	5.745	OPM, all UNAP MDAs	HCDP Objective 1; Intervention 1.2a

'UNAP II' PRIORITY ACTIONS	OUTPUTS	OUTPUT INDICATORS	COST (UGX BILLION)	LEAD MDA	'NDP III' PIAP ALIGNMENT
Strategy 3.3: Strengthen institutional and technical capacity for scaling up nutrition actions.			44.69	UNAP MDAs	HCDP Objective 1; Intervention 1.2a
Outcome 3.3: Strengthened institutional and technical capacity for scaling up nutrition actions.					
Conduct nutrition capacity assessments among UNAP-implementing MDAs	Nutrition capacity gaps identified and prioritized for action by UNAP-implementing MDAs	UNAP- implementing MDAs nutrition capacity assessment report	0.401	UNAP MDAs	HCDP Objective 1; Intervention 1.2a
Conduct nutrition capacity assessments among DLGs and regional cities	Nutrition capacity gaps identified and prioritized for action by DLGs and regional cities	DLGs and regional cities nutrition capacity assessment report	1.0	MoLG	HCDP Objective 1; Intervention 1.2a
Develop nutrition capacity development framework for UNAP-implementing MDAs	All UNAP-implementing MDAs and partners integrate nutrition capacity development activities in annual work plans and budgets	Nutrition capacity development framework for UNAP-implementing MDAs	0.9	All UNAP MDAs	HCDP Objective 1; Intervention 1.2a
Develop nutrition capacity development framework for DLGs and regional cities	All DLGs, regional cities and partners integrate nutrition capacity development activities in annual work plans and budgets	Nutrition capacity development framework for DLGs and regional cities	3	MoLG	HCDP Objective 1; Intervention 1.2a
Implement the nutrition capacity development framework for UNAP-implementing MDAs	The nutrition capacity development plan is fully implemented by all MDAs and implementing partners	Status of implementation of the nutrition capacity development framework for UNAP-implementing MDAs	9.389	All UNAP MDAs	HCDP Objective 1; Intervention 1.2a
Implement the nutrition capacity development framework for DLGs and regional cities	The nutrition capacity development plan is fully implemented by all DLGs and regional cities and their implementing partners	Status of implementation for the nutrition capacity development framework for DLGs and regional cities	30	MoLG	HCDP Objective 1; Intervention 1.2a
Strategy 3.4: Strengthen nutrition advocacy, communication and social mobilization for nutrition.			183.51	All UNAP MDAs	HCDP Objective 1; Intervention 1.2a
Outcome 3.4: Strengthened nutrition advocacy, communication and social mobilization for nutrition.					
Develop a nutrition advocacy communication strategy fully aligned with the 'UNAP II' strategic direction	Nutrition advocacy and communications strategy fully aligned with the 'UNAP II' strategic direction developed	Nutrition advocacy and communications strategy fully aligned with the 'UNAP II' strategic direction	0.6	OPM	HCDP Objective 1; Intervention 1.2a
	Training packages for the NACSII developed	Training packages for the NACSII strategy developed		OPM	HCDP Objective 1; Intervention 1.2a
Develop and implement a regional-specific nutrition advocacy and communication campaign	Sub-regional context NACSII implementation framework developed and implemented	Number of sub-regional context NACSII implementation framework in place	2.0	OPM/ all UNAP MDAs	HCDP Objective 1; Intervention 1.2a

'UNAP II' PRIORITY ACTIONS	OUTPUTS	OUTPUT INDICATORS	COST (UGX BILLION)	LEAD MDA	'NDP III' PIAP ALIGNMENT
Mobilize and institute high-level nutrition advocates to actively advance the nutrition agenda at national and sub-national levels	High-level nutrition advocates instituted at the national level and actively advancing the nutrition agenda	Number of high-level nutrition advocates instituted	1.05	OPM/ all UNAP MDAs	HCDP Objective 1; Intervention 1.2a
Develop nutrition advocacy briefs and technical briefs for use at national and sub-national levels	Nutrition advocacy briefs and technical briefs are harmonized and used.	Number of nutrition advocacy briefs/ technical briefs	0.9	MoLG	HCDP Objective 1; Intervention 1.2a
Develop nutrition commitments scorecards at national and MDAs levels	Advocacy and SBCC campaign systematically uses scorecards at national and MDAs levels	Number MDAs with scorecards for nutrition advocacy and SBCC campaigns	0.4	OPM/ all UNAP MDAs	HCDP Objective 1; Intervention 1.2a
Develop nutrition commitments scorecards targeting districts and regional cities	Advocacy and SBCC campaign systematically uses scorecards at national and MDAs levels at districts and regional cities level	Number of districts and regional cities with scorecards for nutrition advocacy and SBCC campaigns	0.6	MoLG	HCDP Objective 1; Intervention 1.2a
Build capacity of community-based structures such as functional adult literacy (FAL) groups, Parish Development Committees (PDCs), community resource persons, and community-based informal groups to trigger and deliver community-based advocacy, social mobilization and behavioural change communication on nutrition interventions	Capacity of community-based structures built to deliver advocacy, social mobilization and behavioural change communication for nutrition	Number of community engagement dialogues for advocacy, social mobilization and behavioural change communication for nutrition	175.46	MoGLSD	Community Mobilization and Mindset change Programme Objective 4.
Undertake campaigns to reduce teenage pregnancy, GBV and other harmful practices that result in malnutrition	Campaign to reduce teenage pregnancy, GBV and other harmful practices that result in malnutrition	Number of campaigns on teenage pregnancy, GBV, and other harmful practices that result in malnutrition conducted	2.5	MoGLSD	No objective?
Strategy 3.5: Strengthen coherent policy, legislation and institutional frameworks for scaling up nutrition.			59.68	UNAP MDAs	HCDP Objective 1; Intervention 1.2a
Outcome 3.5: Coherent policy, legal and institutional frameworks for nutrition.					
Conduct regulatory impact assessment for the National Nutrition Policy (NNP)	Regulatory impact assessment for the NNP developed	NNP	0.49	OPM	HCDP Objective 1; Intervention 1.2a
Finalize the NNP	NNP approved			OPM	HCDP Objective 1; Intervention 1.2a
Develop the national food fortification policy and law	National food fortification policy and law developed	National food fortification policy and law in place	0.45	MoH	HCDP Objective 1; Intervention 1.2d

'UNAP II' PRIORITY ACTIONS	OUTPUTS	OUTPUT INDICATORS	COST (UGX BILLION)	LEAD MDA	'NDP III' PIAP ALIGNMENT
Develop standards and guidelines for child care facilities at formal workplaces	Standards and guidelines for child care facilities at formal workplaces developed	Standards and guideline in place for child care facilities at formal workplaces	0.6	MoH	HCDP Objective 1; Intervention 1.2a
Develop and implement employment regulations related to breastfeeding and childcare facilities at workplaces	The employment breastfeeding and child care facilities at workplaces regulations developed	The employment breastfeeding and child care facilities at workplaces regulations in place	28.6	MoGLSD	HCDP Objective 1; Intervention 1.1
Amend the Employment Act to provide for child care facilities at workplaces	Employment Act amended to provide for child care facilities at workplaces	Presence of the amended Employment Act that provides for child care facilities at workplaces	1.2	MoGLSD	HCDP Objective 1; Intervention 1.2a
Develop legislature and regulation to regulate the production and consumption of sweetened beverages	Regulations on sweetened beverages and alcohol developed	Regulations on sweetened beverages and alcohol	5.86	MoH	HCDP Objective 4; Intervention 4.10
Develop the public food procurement policy for schools and institutions	Forum for the development of multi-sectoral teams to develop the schools and institutional policy established	Public food procurement policy for schools and institutions	0.3	MoES	HCDP Objective 4; Intervention 4.10
	Public food procurement policy for schools and institutions developed				
Strengthen and develop school feeding programmes policy	School feeding programmes policy developed	School feeding programmes policy in place	4.2	MoES	HCDP Objective 4; Intervention 4.10
	Community-based school feeding and nutrition guidelines developed	Community-based school feeding and nutrition guidelines		MoES	
	Standards and quality indicators for school feeding and nutrition developed	Standards and quality indicators for school feeding and nutrition		MoES	
	Guidelines for school feeding and nutrition in Ugandan institutions developed	Guidelines for school feeding and nutrition in Ugandan institutions		MoES	
	Teachers' guide on nutrition and comic book implemented	Status of implementation of the Teachers' guide and comic book		MoES	
Conduct a detailed review and revision of existing policies and pending legislation, regulations and standards across relevant sectors	Revised policies, legislations and frameworks covering relevant sectors at all levels	Proportion of sectors and actors aligning to relevant policies, legislations and frameworks	13.78	UNAP MDAs	HCDP Objective 1; Intervention 1.2a
Advocate for coordinated enforcement of relevant legislation at all levels	The legal, policy and planning provisions relevant to nutrition popularized at all levels	Implementation status of policies, legislation, regulations and standards across relevant sectors	4.2	UNAP MDAs	HCDP Objective 1; Intervention 1.2a

'UNAP II' PRIORITY ACTIONS	OUTPUTS	OUTPUT INDICATORS	COST (UGX BILLION)	LEAD MDA	'NDP III' PIAP ALIGNMENT
Strategy 3.6: Strengthen and institutionalize nutrition evidence and knowledge management along with a multi-sectoral nutrition information system for effective decision making.			144.58	UNAP MDAs	HCDP Objective 1; Intervention 1.2a
Outcome 3.6: Improved nutrition evidence and knowledge management along with multi-sectoral nutrition information system for effective decision making.					
Design and implement a monitoring, evaluation, accountability and learning (MEAL) plan for 'UNAP II'	Develop MEAL plan for 'UNAP II'	MEAL plan for 'UNAP II'	45.1	OPM	HCDP Objective 1; Intervention 1.2a
	Develop a MEAL training package for 'UNAP II'	MEAL training package for 'UNAP II'		OPM	HCDP Objective 1; Intervention 1.2a
	Conduct training of sectoral planning and M&E officers using MEAL training package	Proportion of sectoral planning and M&E officers trained using MEAL training package		OPM and UNAP MDAs	HCDP Objective 1; Intervention 1.2a
	Conduct periodic evaluative studies to provide evidence on the effectiveness of nutrition programmes and interventions	Number of evaluative studies to provide evidence on the effectiveness of nutrition programmes and interventions		OPM and UNAP MDAs	HCDP Objective 1; Intervention 1.2a
Strengthen and scale up early warning systems, survey and surveillance on food and nutrition from community to national levels	Nutrition-related surveys and analysis generated with action support	Number of Food Security and Nutrition Aseessments data available for programming	52.2	OPM and UNAP MDAs	HCDP Objective 1; Intervention 1.2a
	Early warning system for food and nutrition established	Number of early warning system for food and nutrition reports		OPM and UNAP MDAs	HCDP Objective 1; Intervention 1.2a
Develop, disseminate and enhance the use of evidence-based nutrition knowledge products at all levels	Knowledge products for nutrition developed	Number of knowledge products for nutrition developed and disseminated	14.46	OPM and UNAP MDAs	HCDP Objective 1; Intervention 1.2a
	Policy dialogue among policymakers for evidence-based decision making for nutrition enhanced	Number of policy dialogue among policymakers for evidence-based decision making for nutrition held		OPM and UNAP MDAs	HCDP Objective 1; Intervention 1.2a
	Learning and knowledge dissemination for nutrition at different multi-sectoral nutrition committees envisioned under the 'UNAP II' organized	Number of learning and knowledge dissemination for nutrition at different multi-sectoral nutrition committees envisioned under the 'UNAP II' organized		OPM and UNAP MDAs	HCDP Objective 1; Intervention 1.2a

'UNAP II' PRIORITY ACTIONS	OUTPUTS	OUTPUT INDICATORS	COST (UGX BILLION)	LEAD MDA	'NDP III' PIAP ALIGNMENT
Implement sector-specific research and assessment plans for 'UNAP II'	Partnerships with academic and research institutions for conducting research and publication on nutrition established	Number of partnerships with academic and research institutions for conducting research and publication on nutrition established	22.6	OPM and UNAP MDAs	HCDP Objective 1; Intervention 1.2a
	Conduct a joint annual nutrition review	Number of joint annual nutrition reviews conducted and results disseminated		OPM and UNAP MDAs	HCDP Objective 1; Intervention 1.2a
	Conduct an annual conference on nutrition research	Number of annual conferences on nutrition research conducted		OPM and UNAP MDAs	HCDP Objective 1; Intervention 1.2a
	Research on nutrition-agricultural linkages conducted	Number of research on nutrition-agricultural linkages conducted		OPM and UNAP MDAs	HCDP Objective 1; Intervention 1.2a
Create capacity within national institutions to operate and maintain the National Information Platform for Nutrition (NIPN)	Achievement of the implementation plans agreed with the NIPN policy advisory committee, according to the key performance indicators and their annual targets	Degree of achievement of the implementation plans agreed with the NIPN policy advisory committee, according to the key performance indicators and their annual targets	10.22	OPM and UBOS	HCDP Objective 1; Intervention 1.2a
Strengthen capacity to track progress in meeting national objectives to prevent malnutrition and monitor nutrition investments	Nutrition-specific and nutrition-sensitive data sets obtained by NIPN	Number and quality of nutrition-specific and nutrition-sensitive data sets obtained by NIPN		OPM and UBOS	HCDP Objective 1; Intervention 1.2a
	Policies that are informed or updated and reflect the needs for nutrition, notably for vulnerable groups, women, and children under five years	Number of policies that are informed or updated and reflect the needs for nutrition, notably for vulnerable groups, women, and children under five years		OPM and UBOS	HCDP Objective 1; Intervention 1.2a
Build the capacity of government staff to make better use of evidence and data to design and implement nutrition-related policies and programmes	Increase in the cost-effectiveness of nutrition-related programmes	Cost-effectiveness of nutrition-related programmes		OPM and UBOS	HCDP Objective 1; Intervention 1.2a
	Increase in nutrition-related data from nutrition-specific and nutrition-sensitive programmes and sectors	Number of nutrition-related data sets from nutrition-specific and nutrition-sensitive programmes and MDAs		OPM and UBOS	HCDP Objective 1; Intervention 1.2a
	Requests for data or information made to NIPN	Number of requests for data or information made to NIPN		OPM and UBOS	HCDP Objective 1; Intervention 1.2a
	Government staff trained in disciplines that support the work of the NIPN and their institutions	Proportion of government staff trained in disciplines that support the work of the NIPN and their institutions		OPM and UBOS	HCDP Objective 1; Intervention 1.2a

Annexe 3

'UNAP II' MEAL FRAMEWORK 2020/21-2024/25 ALIGNED WITH 'NDP III', SDGS AND SUN MEAL FRAMEWORKS

Annexe 3.1: Indicators for primary outcomes ('UNAP II' goal level)

INDICATOR	BASELINE (%)	TARGET 2024/2025 (%)	DATA SOURCE
Prevalence of stunting in children aged 0-5 years	29 (UDHS 2016)	19	UDHS/UBOS
Prevalence of low birth weight (<2500 g)	10 (UDHS 2016)	7	UDHS/UBOS
Prevalence of wasting in children aged 0-5 years	4 (UDHS 2016)	2	UDHS/UBOS
Prevalence of anaemia in children aged 0-5 years	53 (UDHS 2016)	35	UDHS/UBOS
Prevalence of anaemia in women of reproductive age	32 (UDHS 2016)	20	UDHS/UBOS
Prevalence of overweight in children aged 0-5 years	4 (UDHS 2016)	3	UDHS/UBOS
Proportion of overweight adult women aged 18+ years	16.5 (UDHS 2016)	125	UDHS/UBOS
Proportion of overweight adult men aged 18+ years	7.7 (UDHS 2016)	3.7	UDHS/UBOS
Proportion of obesity in adult women aged 18+ years	7.2 (UDHS 2016)	5.2	UDHS/UBOS
Proportion of obesity in adult men aged 18+ years	1.2 (UDHS 2016)	0.4	UDHS/UBOS
Proportion of overweight in adolescents	10 (UDHS 2016)	6	UDHS/UBOS
Proportion of obesity in adolescent girls	1 (UDHS 2016)	1	UDHS/UBOS
Age-standardized prevalence of raised blood glucose/diabetes among persons aged 18+ years	3.3 (MoH 2014)	2.1	UDHS/UBOS
Age-standardized prevalence of raised blood pressure among persons aged 18+ years	24 (MoH 2014)	20	UDHS/UBOS

Annexe 3.2: Indicators for intermediate outcomes ('UNAP II' objective level)

INTERMEDIATE OUTCOME INDICATORS	BASELINE	TARGET 2024/2025	DATA SOURCE	IMPLEMENTING MDA
Outcome 1.1: Improved maternal, infant, young child and adolescent nutrition (MIYCAN) practices in stable and emergency situations				
1.1.1 Proportion of health facilities that are baby-friendly hospital initiative certified.	No data	80	Health Management Information System (HMIS)	Ministry of Health (MoH)
1.1.2 Percentage of newborns put to the breast within one hour of birth.	66	80	Uganda National Panel Survey (UNPS)/Uganda Demographic and Health Survey (UDHS)	MoH
1.1.3 Percentage of infants aged 0-5 months old who were exclusively breastfed.	66	80	MoH	MoH
1.1.4 Proportion of mothers of children aged 0-23 months who have received counselling, support or messages on optimal breastfeeding at least once in the last year.	No data	80	UNPS/UDHS	MoH
1.1.5 Proportion of children aged 6-23 months who receive a minimum diet diversity (MDD).	30	40	UNPS/UDHS	MoH
1.1.6 Proportion of children aged 6-23 months who receive a minimum meal frequency (MMF).	42	60	UNPS/UDHS	MoH
1.1.7 Proportion of children aged 6-23 months who achieve minimum acceptable diet (MAD).	15	40	UNPS/UDHS	MoH
1.1.8 Prevalence of women of reproductive age (WRA) consuming a minimum diet diversity.	16 (UNPS 2019)	40	UNPS/UDHS	MoH
Outcome 1.2: Optimal uptake of micronutrients of concern among children, adolescent girls and women of reproductive age in stable and emergency situations.				
1.2.1 Proportion of children aged 6-59 months receiving vitamin A supplementation.	62	80	HMIS/UNPS/UDHS	MoH
1.2.2 Proportion of pregnant women receiving iron and folic acid supplementation.	23	80	HMIS/UNPS/UDHS	MoH
1.2.3 Proportion of schools (primary and secondary) providing safe and fortified foods to children.	No data	60	Education Management Information System/UNPS/UDHS	Ministry of Education and Sports (MoES)
Outcome 1.3: Increased coverage of the management of acute malnutrition in stable and emergency situations.				
1.3.1 Proportion of children aged 6-59 months with severe acute malnutrition admitted for treatment.	No data	60	HMIS/UNPS/UDHS	MoH
Outcome 1.4: Nutrition services fully integrated in the prevention, control and management of infectious diseases and epidemics.				
1.4.1 Proportion of children under five years old with diarrhoea (in last two weeks) receiving oral rehydration salts (ORS) and zinc.	30 (UDHS 2016)	80	UNPS/UDHS	MoH

INTERMEDIATE OUTCOME INDICATORS	BASELINE	TARGET 2024/2025	DATA SOURCE	IMPLEMENTING MDA
1.4.2 Proportion of children aged 12-59 months receiving at least one dose of deworming medication.	60	80	UNPS/UDHS	MoH
1.4.3 Percentage of children 0-5 years old who slept under an insecticide-treated mosquito net.	62 (UDHS 2016)		UNPS/UDHS	MoH
1.4.4 Prevalence of malaria in children under five years.	30	10	UNPS/UDHS	MoH
1.4.5 Proportion of 1-year-old children who have received the appropriate doses of the recommended vaccines in the national schedule.	55	80	UNPS/UDHS	MoH
1.4.6 Prevalence of diarrhoea in children under five years.	20	10	UNPS/UDHS	MoH
Outcome 1.5: Nutrition services fully integrated in the prevention, control and management of diet-related non-communicable diseases.				
1.5.1 Percentage of adults considered physically inactive.	4.3	0	UNPS/UDHS	MoH
1.5.2 Proportion of workplaces with health and wellness programme.	20	45	UNPS/UDHS	MoH
1.5.3 Age-standardized prevalence of persons (aged 18+ years) consuming less than five total servings (400 grams) of fruit and vegetables per day.	No data	20% increase from baseline	UNPS/UDHS	MoH
1.5.4 Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years.	No data	20% increase from baseline	UNPS/UDHS	MoH
Outcome 2.1: Increased production of diverse, safe and nutrient-dense food at the household level from plant, fisheries and animal sources.				
2.1.1 Percentage increase in the production volumes of priority food commodities.	3.8% annual increment	6% annual increment	MAAIF, Uganda Bureau of Statistics (UBOS)	Ministry of Agriculture, Animal Industry and Fisheries (MAAIF)
2.1.2 Proportion of households dependent on subsistence agriculture as a main source of livelihood.	68 (2017/18)	55	MAAIF, UBOS	MAAIF
2.1.3 Percentage increase in production volumes of biofortified staple food commodities.	-	30%	MAAIF, UBOS	MAAIF
2.1.4 Proportion of households chronically undernourished.	16	8	UNPS UDHS, Food and Agriculture Organization of the United Nations (FAO)	MAAIF
2.1.5 Population experiencing acute food insecurity (millions).	10.9 (2017)	5.5	Integrated Phase Classification, UNPS, Uganda National Household Survey (UNHS)	MAAIF
2.1.6 Proportion of households that are food secure.	69 (2017/18)	89.84	UNPS, UNHS	MAAIF
2.1.7 Post-harvest losses for priority commodities (percentage).	37 (2017/18)	15	UNPS, UNHS	MAAIF

INTERMEDIATE OUTCOME INDICATORS	BASELINE	TARGET 2024/2025	DATA SOURCE	IMPLEMENTING MDA
2.1.8 The total amount of fruit and vegetables and derived products (in grams) available for human consumption during the reference period. (expressed in per capita terms).	397 (2013)	400	UNPS, UNHS	MAAIF
2.1.9 Fortification status of fortifiable food vehicles (including salt, vegetable oil, wheat flour, maize flour, rice, sugar, fish/soy sauce) based on information about coverage and compliance.	Sustain salt, improve oil/wheat (2016)	Salt, vegetable oil, wheat flour, maize flour, rice, sugar, fish/soy sauce	UNPS, UNHS	Ministry of Trade Industry and Cooperatives (MoTIC)
2.1.10 Share of total household expenditure on food and non-alcoholic beverages.	43%	37%	UNHS 2016/17	MAAIF
2.1.11 Percentage of the population able to meet the required daily dietary intake.	60%	65%	UNPS, UDHS, UNHS	MAAIF
2.1.12 Percentage of calories from non-staples in the food supply.	60% (2016)	50%	UNPS	MAAIF
2.1.13 Percentage of undernourishment (share of the population with insufficient caloric intake below 2,200 kcal).	40% (2016)	30	UNPS UDHS, FAO	MAAIF
2.1.14 Percentage of households suffering a reduction in food production due to weather shocks.	90%	40%	UNPS, UNHS	MAAIF
2.1.15 Prevalence of persons aged 18+ years consuming less than 400 grams of fruit and vegetables per day.	14 (2016)	20	UDHS	MAAIF
2.1.16 Dietary diversity score.	4.1 (2014)	6.1	UNPS	MAAIF
2.1.17 Percentage of households that have suffered a reduction in food access due to major emergencies.	-	25%	IPS, UNPS, UNHS	MAAIF
Outcome 2.4: Increased access to nutrition-sensitive services in social protection programmes.				
2.4.1 Percentage of households participating in public development initiatives.	60 (2017/18)	90	Sector reports	Ministry of Gender, Labour and Social Development (MoGLSD)
2.4.2 Percentage of vulnerable and marginalized persons empowered.	1.5% (2017/18)	10%	Sector reports	MoGLSD
2.4.3 Proportion of households participating in saving schemes.	10 (2017/18)	60	Sector reports	MoGLSD
2.4.4 Percentage of smallholder farmers covered by social assistance and social protection programmes.	-	30%	Education Sector Strategic Plan reports	MoGLSD
Outcome 2.5: Increased access to nutrition services through integrated early childhood development (ECD) services and quality education and sports.				
2.5.1 Percentage of youngest children aged 36-59 months attending organised early childhood education programmes.	30% (UDHS 2016)	60%	UNPS/UDHS	MoES

INTERMEDIATE OUTCOME INDICATORS	BASELINE	TARGET 2024/2025	DATA SOURCE	IMPLEMENTING MDA
2.5.2 Proportion of children aged 36-59 months who are developmentally on track in at least three of the following domains: literacy-numeracy, physical development, social-emotional development and learning.	63	80	UNPS/UDHS	MoES
2.5.3 Percentage of school-going children having meals at schools.	34% (2016)	54%	UNPS/UDHS	MoES
Outcome 2.6: Increased access to nutrition-sensitive water, sanitation and hygiene (WASH) services.				
2.6.1 Proportion of rural households with access to a safe water supply.	73 (2017/18)	85	Sector/UNPS/UDHS	Ministry of Water and Environment (MoWE)
2.6.2 Proportion of urban households with access to a safe water supply.	74 (2017/18)	100	Sector/UNPS/UDHS	MoWE
2.6.3 Proportion of rural households with access to improved toilets.	19 (2017/18)	45	Sector/UNPS/UDHS	MoWE
2.6.4 Proportion of urban households with access to Improved handwashing facility.	34 (2017/18)	50	Sector/UNPS/UDHS	MoWE
Outcome 2.7: Increased trade, industry and investments in scaling up nutrition.				
2.7.1 Percentage increase in production volumes of industrial-fortified staple food commodities.	-	15%	MoTIC/UBOS	MoTIC
2.7.2 Percentage of food losses across the food value chain.	37%	15%	UBOS	MoTIC
2.7.3 Proportion of foods and feeds conforming to aflatoxin standards (percentage).	-	80	UBOS, UNBS, MAAIF	MoTIC
2.7.4 Percentage of certified food products on the market.	-	50%	NBS, MTIC	MoTIC
2.7.5 Percentage of food-based MSMEs in food processing and value addition.	-	30%	UBOS, MTIC	MoTIC
Outcome 3.1: Strengthened nutrition coordination and partnerships at all levels.				
3.1.1 Functionality score of the Multi-sectoral Nutrition Technical Coordination Committee.	No data	80	Nutrition governance assessment reports	Office of the Prime Minister (OPM)
3.1.2 Functionality score of SUN networks.	No data	80	Nutrition governance assessment reports	OPM
3.1.3 Functionality index of MDAs nutrition coordination committees.	No data	80	Nutrition governance assessment reports	OPM
3.1.4 Functionality index of local government nutrition coordination committees.	No data	80	Nutrition governance assessment reports	Ministry of Local Government (MoLG)
3.1.5 SUN business network functionality index.	No data	80	Nutrition governance assessment reports	MoTIC
3.1.6 SUN civil society network functionality index.	No data	80	Nutrition governance assessment reports	MoGLSD

INTERMEDIATE OUTCOME INDICATORS	BASELINE	TARGET 2024/2025	DATA SOURCE	IMPLEMENTING MDA
3.1.7 SUN academic and research institutions network functionality index.	No data	80	Nutrition governance assessment reports	MoES
3.1.8 NDPG functionality index.	No data	80	Nutrition governance assessment reports	OPM
Outcome 3.2: Improved planning, resource mobilization, financing and tracking of nutrition investments.				
3.2.1 Level of alignment between the annual budgets and the 'NDP III' at the national and programme level.	No data	80	Annual review reports	OPM
3.2.2 Level of alignment between the annual budgets and the nutrition action plans at the district level.	No data	80	Annual review reports	MoLG
3.2.3 National budget spending for nutrition-budget analysis completeness.	Report in place	Tracking tool updated annually	Annual review reports	OPM
3.2.4 Total nutrition expenditures.	UGX 2,218 billion (NER 2020)	UGX 3,284 billion	Annual review reports	OPM
3.2.5 Percentage of total government spending on essential services: education, health and social protection.	No data	3%	Annual review reports	OPM
Outcome 3.3: Strengthened institutional and technical capacity for scaling up nutrition actions.				
3.3.1 Status of implementation of the nutrition capacity development framework for UNAP-implementing MDAs.	No data	80	Annual review reports	UNAP MDAs
3.3.2 Status of implementation for the nutrition capacity development framework for DLGs and regional cities.	No data	80	Annual review reports	MoLG
3.3.3 Proportion of public service health professionals trained in nutrition services delivery.	No data	80	Annual review reports	MoH
3.3.4 Proportion of public non-health professionals trained in nutrition services delivery.	No data	80	Annual review reports	UNAP MDAs
Outcome 3.4: Strengthened nutrition advocacy, communication and social mobilization for nutrition.				
3.4.1 Level of alignment of the nutrition advocacy communication strategy with 'UNAP II'.	No data	80	Annual review reports	OPM
3.4.2 Level of implementation of sub regional context nutrition advocacy and communication strategy.	No data	80	Annual review reports	OPM
3.4.3 Implementation status of the nutrition advocacy and communication strategy for 'UNAP II'.	No data	80	Annual review reports	OPM
3.4.4 Mobilization of high-level advocates (champions, parliamentarians, media).	No data	80	Annual review reports	OPM

INTERMEDIATE OUTCOME INDICATORS	BASELINE	TARGET 2024/2025	DATA SOURCE	IMPLEMENTING MDA
3.4.5 Implementation of status scorecards for nutrition advocacy and social behaviour change communication (SBCC) campaigns at national/MDA levels.	No data	80	Annual review reports	All UNAP MDAs
3.4.6 Implementation status scorecards for nutrition advocacy and SBCC campaigns at district/regional cities level.	No data	80	Annual review reports	MoLG
Outcome 3.5: Coherent policy, legal and institutional frameworks for nutrition.				
3.5.1 Status of implementation of nutrition-relevant policies and legal frameworks.	No data	80	Annual review reports	All UNAP MDAs
3.5.2 Level of constitutional protection of the right to food (high, medium-high, medium, low).	High (2003)	High	Annual reports	OPM
3.5.3 Presence of legal documentation indicating standardized fortification levels of the food vehicle in question with one or more priority nutrients.	Yes	Yes	Annual reports	MoTIC
3.5.4 Presence of legal documentation that has the effect of mandating fortification of the food vehicle in question with one or more priority micronutrients.	Yes (Salt, wheat, maize, oil) (2016)	Yes (Salt, wheat, maize, oil)	Annual reports	MoTIC
3.5.5 Presence of legal documentation indicating standardized fortification levels of the food vehicle in question, but does not have legal documentation that has the effect of mandating fortification.	Yes (salt, wheat, maize, oil) (2016)	Yes (Salt, wheat, maize, oil)	Annual reports	MoTIC
3.5.6 Presence of policies to reduce the impact of marketing of foods and non-alcoholic beverages high in saturated fats, trans-fatty acids, free sugars, or salt on children.	No (2016)	Yes	Annual reports	MoH
3.5.7 Presence of maternity protection law/regulations in line with the International Labour Organization Maternity Protection Convention, 2000 (No. 183) and Recommendation No.191.	No (2011)	Yes	Annual reports	MoGLSD
3.5.8 Presence of legislation/regulation fully implementing the International Code of Marketing of Breastmilk Substitutes (resolution WHA34.22) and subsequent relevant resolutions adopted by the World Health Assembly.	Full	Full	Annual reports	MoH
3.5.9 Percentage of local governments with enacted by-laws and ordinances on nutrition.	No data	30%	Annual review reports	MoLG
Outcome 3.6: Improved nutrition evidence and knowledge management along with multi-sectoral nutrition information system for effective decision making.				
3.6.1 Level of achievement of 'UNAP II' targets.	No data	100	Annual reports	OPM
3.6.2 Proportion of 'UNAP II' baseline indicators up-to-date and updated.	No data	80	Annual reports	OPM

Annexe 4

'UNAP II' ROLLOUT AND IMPLEMENTATION ROAD MAP 2020/21-2024/2025

	ACTIVITY	TIME FRAME					OUTPUT	RESPONSIBILITY	POTENTIAL PARTNERSHIPS
		2020/21	2021/22	2022/23	2023/24	2024/25			
1	Production of a simplified reader-friendly version of 'UNAP II' and the Nutrition policy						2,000 copies printed and circulated	OPM UNAP Secretariat	UNICEF, USAID, DFID, EU, WHO, FAO and CSOs
2	High-level launch of 'UNAP II' at the national level						Government and non-governmental leaders are aware of 'UNAP II' and commit to supporting its implementation	OPM 'UNAP II' Secretariat	UNICEF, USAID, DFID, EU, WHO, FAO and CSOs
3	Finalise and disseminate standard operating procedures for nutrition coordination structures aligned to 'UNAP II'						National and LLG actors are sensitized on the standard operating procedures nutrition	OPM UNAP Secretariat	UNICEF, USAID, DFID, EU, WHO, FAO and CSOs
4	Conduct a stakeholders mapping and capacity assessment and design a capacity development framework						A catalogue of 'UNAP II' stakeholders, Geographic Information System maps, capacity gaps and a capacity development	OPM UNAP Secretariat and line ministries	UNICEF, EU and CSOs
5	Support the establishment and functionality of nutrition coordination structures at DLGs, and LLG level						Functional DNCCs and SNCCs in all districts	MoLG	NDPG and implementing CSO partners
6	Develop and roll out MEAL system for 'UNAP II'						Functional MEAL plan supported by stakeholders at all levels	OPM UNAP Secretariat and line ministries	NDPG and implementing CSO partners
7	Finalise nutrition expenditure review						Functional resource mobilization and tracking plan for 'UNAP II' with clear commitments and accountabilities	OPM UNAP Secretariat and line ministries	NDPG and implementing CSO partners
8	Conduct detailed costing of 'UNAP II' and resource mobilization, financing and tracking plan for 'UNAP II'						Costing of 'UNAP II' and resource mobilization, financing and tracking plan for 'UNAP II' developed	OPM UNAP Secretariat and line ministries	NDPG and implementing CSO partners

ACTIVITY		TIME FRAME					OUTPUT	RESPONSIBILITY	POTENTIAL PARTNERSHIPS
		2020/21	2021/22	2022/23	2023/24	2024/25			
9	Develop nutrition investment case						Nutrition investment case developed	OPM UNAP Secretariat and line ministries	NDPG and implementing CSO partners
10	Develop the NACS strategy for 'UNAP II' and disseminate it at the national and LLG level						Revised NACS	OPM UNAP Secretariat and line ministries	NDPG and implementing CSO partners
11	Training packages for NACSII developed						Training packages for NACSII developed	OPM UNAP Secretariat and line ministries	NDPG and implementing CSO partners
12	Provide technical support to LLGs to develop nutrition action plans aligned to 'UNAP II'						146 DNAPs produced	OPM and relevant line ministries	Implementing partner CSOs
13	Conduct sensitization/ orientation/dissemination workshops and 'UNAP II' at national the national level and in LLGs						Oriented and sensitized DNCCs	MoLG	NDPG and implementing CSO partners
14	Orient all district local councils (V and III) on 'UNAP II' and DNAPs						DNAPs are aligned to the DDPs and allocated funds in the district budget	MoLG	NDPG and implementing CSO partners
15	Provide technical and advisory support to SUN networks						SUN networks are established and are functional	OPM UNAP Secretariat	NDPGs, implementing partners/CSOs
16	Conduct annual national 'UNAP II' progress review fora						Progress reports on 'UNAP II' implementation	OPM UNAP Secretariat	NDPGs, implementing partners/CSOs
17	Conduct annual sub-regional 'UNAP II' progress review fora						Progress reports on 'UNAP II' implementation	MoLG	NDPGs, implementing partners/CSOs
18	Conduct annual national nutrition reviews						Progress reports and renewed stakeholder commitments	OPM and relevant line ministries	NDPGs, implementing partners/CSOs
19	Midterm evaluation and review of 'UNAP II'						Summative evaluation report	OPM UNAP Secretariat SUN Coordinator	NDPGs, implementing partners/CSOs
20	Summative evaluation for 'UNAP II'						Summative evaluation report	OPM UNAP Secretariat SUN Coordinator	NDPGs, implementing partners/CSOs

Annexe 5

INFORMATION ON OUTSTANDING 'UNAP II' IMPLEMENTATION COMPONENTS

Background

Nutrition stakeholders agreed in July 2019 to focus on clarifying the 'UNAP II' strategic direction, implementation and coordination framework and M&E framework, with other detailed components to be developed after the 'UNAP II' is validated. This was informed due to the fact that 'UNAP II' has delayed for more than two years, and there was a high risk of missing out on key developments such as integrating nutrition in the 'National Development Plan III'. Furthermore, mobilization of financial resources and technical support to cover the five components listed below would have taken more than 12 months. The table below describes the five components that are important in ensuring successful implementation of 'UNAP II', together with the indicative timelines it will take to develop each component[5]. These activities are already part of the 'UNAP II' implementation matrix and road map.

TABLE 5 FIVE ESSENTIAL COMPONENTS FOR THE SUCCESSFUL IMPLEMENTATION OF 'UNAP II'

	COMPONENT	ESTIMATED TIMELINE
1	Comprehensive nutrition expenditure review, costing of 'UNAP II', development of nutrition investment case and development of nutrition resource mobilization and tracking plan.	Ten months
2	Multi-sectoral MEAL system for 'UNAP II' (MEAL plan, MEAL tools, capacity building plan for MEAL, indicator dashboard, nutrition repository etc.).	Seven months
3	Institutional and technical capacity assessment and development of capacity development framework for nutrition.	Nine months
4	Development of multi-sectoral nutrition advocacy, communication and social mobilization plan.	Six months
5	Development of common results, accountability and coordination plan (including a nutrition commitments scorecard).	Five months

It is important to note that components one (supported by UNICEF) and two (supported by the EU under the NIPN project) already have partial financial and technical support, and have started. This will save a considerable amount of time, but it is essential to be mindful that a component will be implementable only when developed in full. For example, comprehensive expenditure review will be impactful if followed by costing and development of resource mobilization and tracking plan. This implies that fundraising should continue until funding to cover the entire component is secured.

Some components, such as components two and five, are interrelated, thus developing them at the same time will save time and resources. Coherence across the five components is also vital. OPM and key actors should therefore ensure effective coordination, information sharing and learning across the five components.

5 Covers period of time from recruitment of technical assistance to finalization of each component.

Below are general details indicative/rough costs estimates (in USD) for each of the five components.

COMPONENT	UNIT	UNIT COST	DAYS	TOTAL (USD)
1. Comprehensive nutrition expenditure review, costing of 'UNAP II', development of nutrition investment case and development of nutrition resource mobilization and tracking plan.[6]				
Lead consultant	1	550	40	22,000
Sub-consultants	3	400	30	36,000
Consultation, review and validation workshops	4	25,000		100,000
Travel, accommodation, communication, stationery and other costs	Lump sum	15,000		15,000
TOTAL				**163,000**
2. Multi-sectoral MEAL system for 'UNAP II' (MEAL plan, MEAL tools, capacity building plan for MEAL, indicator dashboard, nutrition repository etc.)[7]				
Lead consultant	1	500	40	20,000
Sub-consultant	1	350	40	14,000
Consultation, review and validation workshops	3	20,000		60,000
Travel, accommodation, communication, stationery and other costs	Lump sum	10,000		10,000
TOTAL				**104,000**
3. Institutional and technical capacity assessment and development of capacity development framework for nutrition				
Lead consultant	1	650	40	26,000
Sub-consultants	3	400	35	42,000
Consultation, review and validation workshops	3	25,000		75,000
Travel, accommodation, communication, stationery and other costs	Lump sum	20,000		20,000
TOTAL				**163,000**
4. Development of multi-sectoral nutrition advocacy, communication and social mobilization plan				
Lead consultant	1	450	35	15,750
Sub-consultant	1	350	35	12,250
Consultation, review and validation workshops including pre-testing	4	30,000		120,000
Communication, stationery, transportation and other costs	Lump sum	15,000		15,000
TOTAL				**163,000**
5. Development of common results, accountability and coordination plan (including a nutrition commitments scorecard)				
Lead consultant	1	500	25	20,000
Sub-consultant	1	350	25	
Consultation, review and validation workshops	1	350		80,000
Communication, stationery, transportation and other costs	Lump sum	2,500		2,500
TOTAL				**102,500**
GRAND TOTAL				**465,500**

6 Estimated costs are exclusive financial and technical support for nutrition expenditure review and development of investment case for nutrition by UNICEF.

7 Estimated costs are exclusive of exclusive ongoing financial and technical support by NIPN project.

References

1. Arimond, M. et al., 'Dietary Diversity as a Measure of the Micronutrient Adequacy of Women's Diets in Resource-Poor Areas, Summary of Results from Five Sites', FANTA-2 Bridg. 16-25, FHI 360, Durham, North Carolina, USA, 2011.
2. Development Initiatives Poverty Research Limited, *Global Nutrition Report: Actions and Accountability to Advance Nutrition and Sustainable Development,* Development Initiatives Poverty Research Limited, Bristol, United Kingdom, 2015.
3. Development Initiatives Poverty Research Limited, *Global Nutrition Report: Shining a light to spur action on nutrition,* Development Initiatives Poverty Research Ltd, Bristol, United Kingdom, 2018.
4. East African Community, 'East African Food and Nutrition Security Strategy 2018-2022', East African Community, Arusha, United Republic of Tanzania, 2018.
5. FANTA Uganda Profiles, 'Reducing Malnutrition in Uganda: Estimates to Support Nutrition Advocacy', FHI 360, Durham, North Carolina, USA, 2013.
6. FAO, IFAD, UNICEF, WFP and WHO, 'The State of Food Security and Nutrition in the World 2019: Safeguarding against economic slowdowns and downturns', United Nations Food and Agriculture Organization, Rome, Italy, 2019.
7. FAO, 'The Second International Conference on Nutrition: Comitting to a Future free of Malnutrition', United Nations Food and Agriculture Organization, Rome, Italy, 2014.
8. Government of Uganda, 'Uganda Vision 2040: A Transformed Ugandan Society from a Peasant to a Modern and Prosperous Country within 30 years', Government Of Uganda, Kampala, Uganda, 2007.
9. Turcan, L. and Bene, T, 'A review of policies for improving human nutrition in Uganda and the use of evidence for making policy', Agropolis International, Montpellier, France, 2018.
10. MAAIF, 'Agriculture Strategy and Investment Plan, 2010/11-2014/15', Ministry of Agriculture, Animal Industry & Fisheries, Entebbe, Uganda, 2010.
11. MAAIF, 'Agriculture Strategy and Investment Plan: 2015/16-2019/20', Ministry of Agriculture, Animal Industry & Fisheries, Entebbe, Uganda, 2015.
12. Meera Shekar, et-al., 'An Investment Framework for Nutrition in Uganda: Reducing Stunting and Other Forms of Child Malnutrition', World Bank, Washington DC, USA, 2016.
13. MoTIC, 'Sector Development Plan: 2015/16 – 2019/20', Ministry of Trade, Industry and Cooperatives, Kampala, Uganda, 2015.
14. MoES, 'Education and Sports Sector Strategic Plan: 2015/16-2019/20', Ministry of Education and Sports, Kampala, Uganda, 2015.
15. MoGLSD, 'National Integrated Early Childhood Development Policy Action Plan: 2016-2021', Ministry of Gender, Labour and Social Development, Kampala, Uganda, 2016.
16. MoGLSD, 'Social Development Sector Plan, 2015/16-2019/20', Ministry of Gender, Labour and Social Development, Kampala, Uganda, 2015.
17. MoH, 'Annual Health Sector Performance Report: Financial Year 2015/16', Ministry of Health, Kampala, Uganda, 2015.
18. MoH, 'Uganda Population-Based HIV Impact Assessment (UPHIA)', 2017, Ministry of Health, 2015, Kampala, Uganda.
19. MoH, 'Health Sector Development Plan: 2015/16-2019/20', Ministry of Health, , Kampala, Uganda, 2015.

20. MoH, 'Integrated Managment of Acute Malnutrition Guidlines, 2010', Ministry of Health, Kampala, Uganda, 2015.

21. MoWE, 'Water and Environment Sector Development Plan: 2015/16-2019/20' Ministry of Water and Environment, Kampala, Uganda, 2015.

22. National Planning Authority, 'National Nutrition Planning Guidelines for Uganda', Government of Uganda, Kampala, Uganda, 2015.

23. NPA and WFP, 'A Strategic Review of Sustainable Development Goal 2 in Uganda, 2017', Ministry of Finance, Planning and Economic Development, Kampala, Uganda, 2017.

24. Office of the Prime Minister, 'Multi-Sectoral Nutrition Coordination Comittee Orientation Guidlines for Facilitators', Office of the Prime Minister, Kampala, Uganda, 2017.

25. Pomeroy-Stevens A, et-al, 'Prioritizing and Funding the Uganda Nutrition Action Plan', Food and Nutrition Bulletin, Vol. 37 (4S) USAID SPRING, Kampala, Uganda, 2016.

26. Ruel, M. T., 'Operationalizing Dietary Diversity: A Review of Measurement Issues and Research Priorities, 133, 3911S–3926S', Journal of Nutrition, 2003.

27. Ssewanyana, S. N. & Kasirye, I., 'Food Security in Uganda: A Dilemma to achieving the Millennium Development Goals', Economic Policy Research Centre (EPRC), Kampala, Uganda, 2010.

28. SUN Movement, 'SUN Monitoring, Evaluation, Accountability and Learning (MEAL) Updated Version', Scaling Up Nutrition Movement, Geneva, Switzerland, 2018.

29. SUN Movement, 'Checklist on the Criteria and Characteristics of Good National Nutrition Plans', Scaling Up Nutrition Movement, Geneva, Switzerland, 2016.

30. SUN Movement, 'Guidelines for Using the Common Results Framework Planning Tool', Scaling Up Nutrition Movement, Geneva, Switzerland, 2015.

31. SUN Movement, 'SUN Self Assessment Report, Joint Assessment by Multi-Stakeholder Platforms', Scaling Up Nutrition Movement, Geneva, Switzerland, 2016.

32. SUN Movement, 'SUN Strategy and Roadmap 2016-2020', Scaling Up Nutrition Movement, Geneva, Switzerland, 2016.

33. UBOS and ICF Macro, 'Uganda Demographic and Health Survey 2016', Uganda Ministry of Finance, Planning and Economic Development, Kampala, Uganda, and Rockville, Maryland, USA, 2017.

34. UBOS and ICF Macro, 'Uganda Demographic and Health Survey 2006', Ministry of Finance, Planning and Economic Development Uganda, Kampala Uganda and Rockville, Maryland, USA, 2007.

35. United Nations, 'The Decade of Action: 2016-2025', United Nations, New York, USA.

36. WFP and NPA, 'The Cost Hunger in Uganda: Implications on National Development and Prosperity in Uganda', National Planning Authority, Kampala, Uganda, 2015.

37. WFP/ECA, 'The Cost of Hunger in Uganda Summary Report', United Nations World Food Programme, Rome, Italy, 2013.

38. WHO, 'World Health Assembly Resolution 65.6 Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition' World Health Organization, Geneva, Switzerland, 2012.

39. WHO, 'World Health Assembly Resolution 66.8. WHO Global Monitoring Framework for the Prevention and Control of Non-Communicable Diseases', World Health Organization, Geneva, Switzerland, 2013.

40. WHO, 'Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition', World Health Organization, Geneva, Switzerland, 2014.

41. World Bank, 'An Investment Framework for Nutrition in Uganda: Reducing Stunting and Other forms of Malnutrition', Washington DC, USA, 2016.

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Design and layout of this document was supported by EU/DINU/UNICEF

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