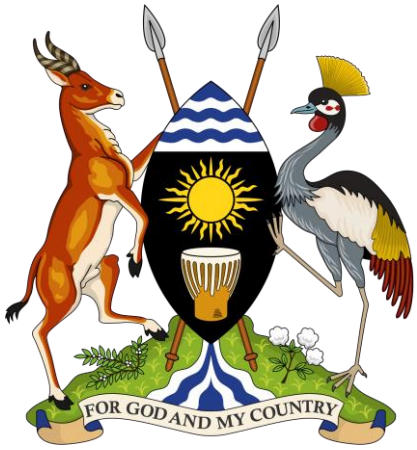

Uganda Nutrition Action Plan 2018-2025

Vision

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

Mission

To end hunger, achieve food security, and improve nutrition by 2030

August 2018

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Government commitment

Map of Uganda

Acronyms

ACDP	Agriculture Cluster Development Project
AfDB	Africa Development Bank
ANC	Antenatal Care
ASSP	Agriculture Sector Strategic Plan
AU	African Union
CAADP	Comprehensive Africa Agriculture Development Programme
CLTS	Community Led Total Sanitation
CRF	Common Results Framework
CSA	Climate Smart Agriculture
DNCC	District Nutrition Coordination Committees
DOA	Decade of Action
EAC	East African Community
ECD	Early Childhood Development
ESSP	Education Sector Strategic Plan
FANTA	Food and Nutrition Technical Assistance
FAO	Food and Agriculture Organisation
FFD	Financing for Development
FSN	Food Security and Nutrition
GDP	Gross Domestic Product
GOU	Government of Uganda
HIRB	High Iron Rich Beans
HSDP	Health Sector Development Plan
ICN2	Second International Conference on Nutrition
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IPC	Integrated Food Security Phase Classification
ISC	Implementing Steering Committee
IYCF	Infant and Young Child Feeding
LG	Local Government
LLG	Lower Local Government
MAAIF	Ministry of Agriculture, Animal Industry and Fisheries
MDA	Ministries, Departments and Agencies
MEAL	Monitoring, Evaluation, Accountability and Learning
MOESTS	Ministry of Education, Science, Technology and Sports
MOH	Ministry of Health
MSN	Multi sectoral Nutrition
MSP	Multi-sectoral Platform
NAADS	National Agriculture Advisory Services
NBCC	Nutrition Behavior Change and Communication
NDP II	Second National Development Plan
NDPG	Nutrition Development and Donor Partner Group
NNF	National Nutrition Forum
NPA	National Planning Authority
NRM	National Resistance Movement
NUFLIP	Northern Uganda Food Security and Livelihood Improvement Project
OFSP	Orange Fleshed Sweet Potato
OPM	Office of the Prime Minister
OWC	Operation Wealth Creation
PBS	Programme Based Budgeting System

PCC	Policy Coordination Committee
PDC	Parish Development Committee
RHITES	Regional Health Integration to Enhance Services
SDG	Sustainable Development Goal
SDP	Sector Development Plan
SNCC	Sub-county Nutrition Coordination Committee
SUN	Scaling Up Nutrition
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic Health Survey
UMFSNP	Uganda Multi-sectoral Food Security and Nutrition Project
UN	United Nations
UNAP	Uganda Nutrition Action Plan
UNBS	Uganda National Bureau of Standards
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WB	World Bank
WFP	World Food Programme
WHA	World Health Assembly

Glossary of Terms

Calorie	Unit of heat, measurement of energy. In general, foods are made up of carbohydrates, proteins, and fats, each of which provide different number of calories
Diet	The use of specific intake of nutrition for health or weight-management reasons (with the two often being related).
Evaluation	A systematic determination of the merit, worth and significance, of nutrition programmes using criteria governed by a set of assessment standards and indicators
Food	Any substance consumed to provide nutritional support for the human body. It is usually of plant or animal origin, and contains essential nutrients, such as carbohydrates, fats, proteins, vitamins, or minerals.
Monitoring	The systematic process of collecting, analyzing and using information to track nutrition programmes' progress toward reaching set objectives and to guide management decisions.
Multi-sectoral Approach	Deliberate collaboration among various nutrition stakeholder groups (e.g., government, civil society, and private sector) and sectors (e.g., health, agriculture, education, and environment) to jointly achieve nutrition policy and programme outcomes
Nutrients	Substances obtained from food and used in the body to provide energy and structural materials and to regulate growth, maintenance and repair of the body's tissue.
Nutrition surveillance	A systematic approach used to detect malnutrition and identify populations at risk of suffering from it.
Obesity	A chronic disease characterized by excessively high body fat in relation to lean body tissue.
Overweight	An excess of body weight that includes fat, bone and muscle.
Stakeholder	A party (organization/Institution) that has an interest in nutrition and can either affect or be affected by the nutrition work in Uganda
Stunted	The impaired growth and development that children (0-5years) experience from poor nutrition, repeated infection, and inadequate psychosocial stimulation. Height-for-age is more than two standard deviations below the WHO Child Growth Standards median
Vitamins	Organic compounds, essential nutrients or micronutrient that an organism needs in small amounts.

Chapter One

1 Introduction

1.1 Policy Context

The Nutrition action plan addresses the nutritional needs of all population groups in Uganda and therefore was developed in the context of the available set of policy and legal frameworks. The Republic of Uganda Constitution mandates the state to promote and encourage nutrition in order to ensure a healthy Ugandan society. The various ministries, departments and agencies are required to set minimum standards, guidelines and develop policies that ensure provision of quality foods and nutrition services for Ugandans.

1.1.1 Global Framework

Eliminating malnutrition in all its form is critical in breaking the intergenerational cycle of poverty that propels underdevelopment. In 2010, the Scaling Up Nutrition (SUN) a global movement to unite governments, civil society, businesses and citizens in a worldwide effort to end under- nutrition. The SUN adopted Strategy 2012- 2015 with four processes[1].

In May, 2012 the World Health Assembly adopted the Comprehensive Implementation Plan on Maternal Infant and Young Children Nutrition (CIP-MIYCN) and endorsed 6 Global Nutrition Targets[2]. In 2014, at the Second International Conference on Nutrition (ICN2), a Framework of Action with sixty policy recommendations for improving nutrition was adopted. In 2015, the 2030

[1]Process one: Bringing people together in the same space for action; Process two: Ensuring a coherent policy and legal framework; Process three: Aligning actions around common results and Process four: Tracking finance and mobilising resources

[2]40% reduction in the number of children under-5 who are stunted;50% reduction of anaemia in women of reproductive age;30% reduction in low birth weight;No increase in childhood overweight; Increase the rate of exclusive breastfeeding in the first 6 months up to at least 50% and reduce and maintain childhood wasting to less than 5% by 2025.

Agenda for Sustainable Development Goals was adopted. According to the Global Nutrition Report 2015, for every 1 USD invested in nutrition a country can get 16 USD in returns, therefore improving nutrition outcomes impacts on realization of the other SDGs.

In 2016, the United Nations in 2016 declared a Decade of Action on Nutrition (2016-2025) to galvanize further action towards improving nutrition. The 60 recommendations of the Framework of action were coined into six core programme areas for action[3]. Each programme area has recommended actions[4] for which this nutrition action plan will be aligned to.

In 2017, the 2030 nutrition targets were calculated based on a similar approach used for the 2025 targets, the six global nutrition targets were extended to 2030 for SDGs with adjustments in some targets while keeping others the same as for 2025; 50% reduction in the number of children under-5 who are stunted;50% reduction of anaemia in women of reproductive age;30% reduction in low birth weight;reduce and maintain childhood overweight to less than 3%;Increase the rate of exclusive breastfeeding in the first 6 months up to at least 50% and reduce and maintain childhood wasting to less than 3% by 2030.

1.1.2 Regional Frameworks

At the Africa level, Heads of State and Government declared at Maputo in 2003 to commit at least 10% of their national budgets towards agriculture and food security within the Comprehensive Africa Agriculture Development Programme

[3]Sustainable, resilient food systems for healthy diets; Aligned health systems providing universal coverage of essential nutrition actions; Social protection and nutrition education, behavior change communication, Trade and investment for improved nutrition; Safe and supportive environments for nutrition at all ages and Strengthened governance and accountability for nutrition.

[4]Actions to create an enabling environment for effective action; for sustainable food systems promoting healthy diet; for trade and investment; for nutrition education and information; on social protection; for strong and resilient health systems; to promote protect and support breastfeeding; to address wasting; to address stunting; to address childhood overweight and obesity; to address anaemia in women of reproductive age; in the health services to improve nutrition; on water, sanitation and hygiene ; on food safety and antimicrobial resistance and for accountability

(CAADP). Subsequently, at Malabo in 2014, the African Union (AU) made a declaration on Accelerated Agriculture Growth and Transformation and re-affirmed the CAADP commitment to end hunger and reduce stunting on the continent to 10% by 2025.

1.1.3 National Frameworks

The 1995 Constitution of the Republic of Uganda, expresses Government commitment to food security and nutrition and stipulates that "Uganda shall take appropriate steps to encourage people to grow and store adequate food; establish national food reserves; and encourage and promote proper nutrition through mass education and other appropriate means in order to build a healthy state" (Objective XXII).

The National Water Policy (1999), whose main objective is to manage and develop the water resources in an integrated and sustainable manner, covers all aspects of water resource management and water infrastructure development. Of the seven strategic objectives of the Water and Environment Strategic plan 2015-2020 two objectives cover provision of safe water and improved sanitation for both rural and urban areas (MOWE, 2015-2020).

In 2003, The Food and Nutrition Policy was approved with a goal of ensuring food security and adequate nutrition for all the people in Uganda, for their health as well as their social and economic well-being. Since then, a number of legal, policy and planning frameworks relating to nutrition and food security have emerged at international, regional and national landscape, rendering the programming, coordination, financing, implementation and monitoring and evaluation frameworks of the Food and Nutrition Policy (2003) not sufficient in responding to the multi-sectoral approach to the fight against malnutrition in all its forms.

The Education and Sports Sector's role in nutrition programming is reinforced among others, by the Education Act (2008) and the current Education Sector Strategic Plan (ESSP 20017-2020). Under this ESSP, the Education sector has prioritized development and implementation of a strategy to address school feeding and nutrition for school-going children that include continuous sensitization of parents about their role in feeding children and providing school uniforms. Implementation of this strategy was to contribute to the provision of equitable access for all eligible children at the primary level and post-primary levels (MOES, 2017).

In 2010, the Government approved the national Development plan (2010-2015) and subsequently sector development plan (2010-2025). To demonstrate commitment in the fight against malnutrition however, the government approved in 2011 the Uganda Nutrition Action Plan (UNAP) as the country`s strategic framework for scaling up nutrition. The goal of the UNAP was to reduce malnutrition levels among women of reproductive age, infants, and young children during the period 2011- 2016 and beyond the period.

The second Ministry of Health Policy (NHPII) goal is "to attain a good standard of health for all people in Uganda in order to promote healthy and productive lives". The priority areas are: Strengthening health system in line with decentralization; re-conceptualizing and organizing supervision and monitoring of health systems at all levels; establishing a functional integration within the public and private sector; and addressing the human resource crisis. The NHP II (2010) aims at universal access to the Uganda National Minimum Health Care Package.

The National Standards and Quality Policy (2012) was developed in order to expand regional and international trade, there is need to adopt and implement the internationally recognized and accepted Standards, Conformity Assessment and Accreditation (SMCA) practices. The policy vision is 'to have an effective and

efficient national quality infrastructure that delivers goods and services that are internationally competitive' with a mission 'to develop SMCA infrastructure that supports the production and consumption of quality goods and services'.

In 2013, Ministry of Agriculture, Animal Industry and Fisheries (MAAIF) developed The National Agriculture Policy (NAP) of 2013. The overall objective of the agriculture policy is to achieve food and nutrition security and improve household incomes through coordinated interventions that focus on enhancing sustainable agricultural productivity and value addition; providing employment opportunities, and promoting domestic and international trade (MAAIF, 2013). Through the Agriculture Sector Strategic Plan (2015-2020) MAAIF aims at improving food and nutrition security by enhancing consumption of diverse diets at household level (MAAIF, 2015).

Under the Ministry of Gender, Labour and Social Development the following policies that are sensitive to nutrition programming exist; The National Social Protection Policy, (2015); The Integrated Early Childhood Development Policy, (2016); The National Adult Literacy Policy, (2014) and The National Community Development Policy for Uganda, (2015). All these frameworks have elements of nutrition sensitive interventions for which this plan has taken advantage of.

Government took steps to tackle the problem of malnutrition by setting high targets in the Uganda Vision 2040 and NDPII, the overarching planning frameworks for the country. Uganda's Vision 2040 describes long term policy objectives for the country and envisions a transformed society from a predominantly peasant and low-income country to a competitive upper middle-income country. The 2nd National Development Plan 2015/16 – 2019/20 is the overarching planning guide for Uganda and provides strategic direction to the sectors so that they can contribute to "propel the country towards middle income

status by 2020". The NDP II has human capital development as one of the four development objectives and has set child stunting as percent of under-5s as one of the Development Indicators. The target is to reduce prevalence of child stunting from 33% in 2011 to 25%and 0% by 2020 and 2040 respectively.

The National Integrated Early Childhood Development (NIECD) Policy (2016) advocates for 'supporting nutritious food production and uptake, nutrition care within the household, and community mobilization to promote the adoption of healthy behaviors and increased public awareness of the centrality of improved nutrition to community and national development to reduce prevalence of malnutrition among infants and young children, expectant and lactating mothers'. The National Integrated Early Childhood Development (NIECD) Policy (2016) stresses the importance of good nutrition alongside health care and stimulation for holistic development.

The Social Protection Policy (2015) also recognizes the provision of social assistance and social security to vulnerable populations. In identifying the different necessities of Society, the social development sector ranks vulnerable groups such as children, women, orphans and older persons as being more prone to deprivation from food as well as other social services. Consequently, the Social Development Sector Strategic Investment Plan (2010/11-2015/16) focused on different social groups as a basis for interventions. The Social Sector Development Plan (2015/16-2019/20) builds on the earlier plan by prioritizing social protection (for example, the Social Assistance Grants for Empowerment (SAGE), which target the elderly) and improvement in food and nutritional security for women, children and older persons. Other initiatives in the social development sector are the Male Involvement Strategy (2015), which calls for the involvement of men to be part of healthy feeding and good sanitation.

The government in 2016 developed the National Coordination Policy (NCP) for public service delivery. This NCP provides a clear framework for coordination in the management of service delivery in the public sector. This was on the basis of the sitting Governments election pledges, the National Development Plan (NDP), Medium Term Expenditure Frameworks (MTEF), Sectoral Development Plans and Annual Budget Framework Papers. The NCP 2016 provided the institutional framework for coordination of policies and government programmes. The coordination framework for this action plan has been designed taking into account the established institutional Framework for Coordination of Policy and Programme Implementation in Government (GOU, 2016).

The NRM manifesto 2016-2021 proposes a cost-effective approach integrating the three pillars (Health, Education and training, while the community components (social protection, family and socialization and water and sanitation) of Human Capital Development to tracing the human capital development along the life cycle to be followed during manifesto implementation. The stages of this cycle are: pregnancy to birth, Education and Training (Early Childhood Development, Primary school age (6 – 12), Lower secondary school age (13-16), Upper secondary school age (17-18 and Tertiary and University (19-24) and Young adulthood – Community Component. Nutrition is particularly important during conception and early childhood, influencing an individual's health, cognitive development and economic outcomes that are carried into later life.

In 2017, Government of Uganda undertook a Strategic Review of SDG2 "End hunger, achieve food security and improved nutrition; and promote sustainable agriculture by 2030". The review provide the following; the situation of hunger, food and nutrition security; the policy, legal and institutional frameworks related to food and nutrition security; the existing programmes and the extent to which they address food and nutrition security; existing financing for food and nutrition

programmes. The report provided the policy actions and recommendations and this action plan has used some of the report findings as a foundation for proposing its strategic direction for 2018-2020 and beyond.

In 2017, government undertook the development of the Nutrition Policy. This UNAP II will work as the implementation strategy for the National Nutrition policy. The plan has been developed taking into consideration of the achievements, challenges, opportunities, potentials and lessons leant during the implementation period of UNAP 2011-2017. The objectives, strategies and priority actions of the UNAP (2018-2025) are therefore aligned with the Nutrition Policy 2018.

1.2 Situation Analysis

1.2.1 Nutrition Outcomes

The situation analysis presents nutrition outcome trends, the determinants and causes of malnutrition and their impact on existing factors of the context with the appropriate level of disaggregation (e.g. by age, sex, location, ethnicity, socio-economic status and disability) within the epidemiological, political, socioeconomic and organizational context prevailing in the country.

1.2.2 Child Nutrition Status

Between 2011 and 2016, stunting decreased from 33% to 29%, while wasting decreased from 5% to 4% between 2011 and 2016, a period when the first UNAP was implemented. While progress has been made, these figures, particularly the 29% stunting level, are still poor (UDHS, 2016).

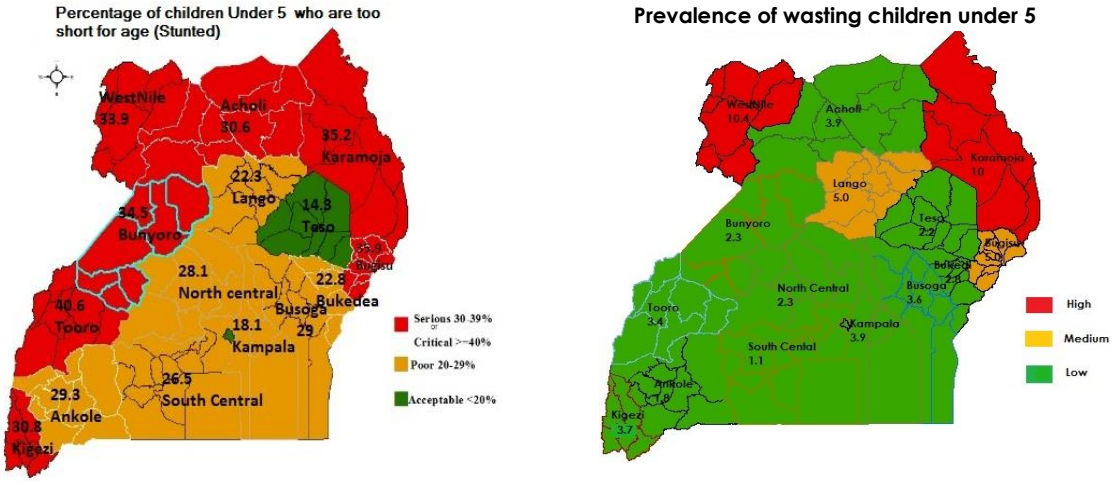

Figure 1: Partial distribution of stunting (left) and wasting (right) by regions of Uganda (UDHS, 2016)

The prevalence of anemia among children age 6-59 months increased slightly from 49% in 2011 to 53% in 2016 as shown in Table 1. It tends to be higher among younger age (6-23 months) than older age (24-59 months) children, with a peak prevalence of 78% among children age 9-11 months.

Table 1: Comparing child nutrition outcomes in 2011 and 2016

Child Nutrition Outcomes (Objectively Verifiable Indicators)	2011	2016
Prevalence of stunting among children under five (%)	33.4	29.3
Prevalence of wasting among children under five (%)	4.7	4.0
Prevalence of low birth weight (%)	10.2	14.2
Prevalence of Under-five Overweight (%)	3.4	
Prevalence of child Anemia 0-5 years (%)	49	53

The efforts by government and partners have not reduced the prevalence of anemia in the country except in two sub-regions of Kigezi and Ankole with the best statistics on water, sanitation and hygiene coverage as shown in Figure 2.

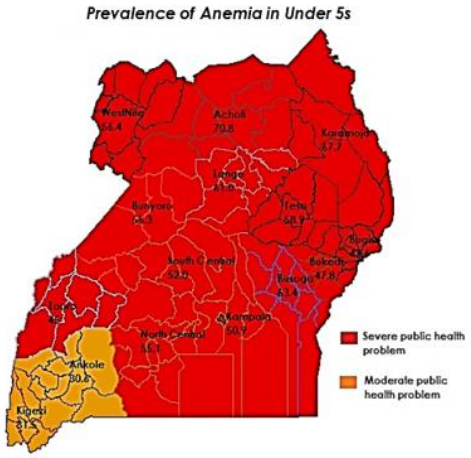

Figure 2: Anemia prevalence in Under-five years of age across the country (UDHS, 2016)

Further analysis indicates that children in rural areas are more likely to be anemic than those in urban areas (54% and 48% respectively). Vulnerability to anemia in children varies from region to region. For example, prevalence of anemia among children is lowest in Ankole sub region at 31%, and highest in Acholi sub region at 71% (UDHS, 2016).

Child stunting and anemia occur across all wealth quintiles not only in low income households. Rates are high even in the two highest wealth quintiles with 32% of children in the lowest wealth quintile compared to 17% in the highest wealth quintile (UDHS 2016). Four in every 10 children born to mothers with no education are stunted compared with 1 in every 10 children born from educated mothers. Karamoja no longer has the highest prevalence of stunting. The most food secure regions have very high prevalence of stunting. Overall, there has been a reduction in stunting over time between 2012 and 2017 according to the Uganda trends, projection and targets for stunting prevalence presented in Figure 3.

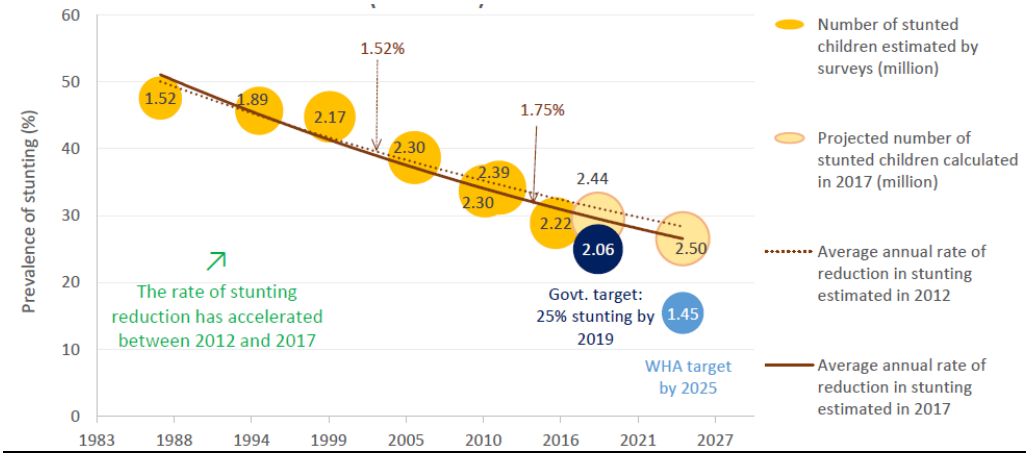

Figure 3: Uganda: Trend, projection and targets in the prevalence and number of children (under five) stunted

Source: International Cooperation and Development, European Commission (http://ec.europa.eu/europeaid/uganda-nutrition-country-fiche-and-child-stunting-trends_en)

The rates of wasting and overweight have remained stable since 2011. However, the prevalence of acute malnutrition in Uganda is at high levels in Karamoja, West Nile and camps in Northern Uganda.

1.2.3 Adult Nutrition Status

Anaemia in women of reproductive age increased from 23% in 2011 to 32% in 2016 as shown in Table 2. The proportion of women with anaemia is higher in rural areas than in urban areas (33% and 27% respectively).

Table 2: Adult Nutrition Outcomes (2011-2016)

Adult Nutrition Outcomes (Objectively Verifiable Indicators)	2011	Actual 2016
Prevalence of Women Anemia 15-49 years (%)	23	32
Prevalence of Adult overweight (%) women	14.6	17
Prevalence of Adult obesity (%)women	4.2	7
Prevalence of Adult overweight (%)men	4.0	7
Prevalence of obesity in adults aged 15-49 years men	0.6	1
Prevalence of Diabetes among adults 15-49 years of age		

Regional prevalence of anaemia among women ranges from 17% in Kigezi sub region to 47% in Acholi sub region as shown in Figure 4. In Uganda, anaemia is currently a moderate public health problem for women of reproductive age and a severe public health problem for children under five years (UDHS, 2016).

The proportion of women who are overweight or obese has increased from 19% in 2011 to 24% in 2016. This has tended to increase with age, from 11% among that age 15- 19 to 34% among that age 40-49. One-third (34%) of urban women are overweight or obese, as compared to one-fifth (20%) of rural women. The proportion also increases with education and wealth; for example, 8% of women in the lowest wealth quintile are overweight or obese, compared to 42% of women in the highest wealth quintile (UDHS, 2016).

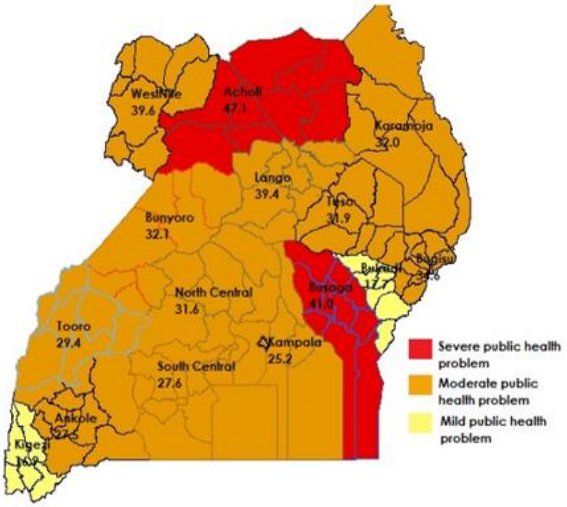

Figure 4: Anemia prevalence among women in reproductive age across the country (UDHS, 2016)

One in five (5) men who have more than a secondary education (19%) and who are in the highest wealth quintile (21%) is overweight or obese. It's noted too that the proportion of women age 15-49 with any degree of anemia rose slightly from 23% in 2011 to 32% in 2016. Pregnant (38%) and breastfeeding women (34%) are more likely to be anemic than women who are neither pregnant nor breastfeeding (30%).

1.2.4 Causes of malnutrition

To achieve improvement in nutrition outcomes, the various causes of malnutrition must be tackled. There are three levels of causes of malnutrition: basic causes at the societal level, underlying causes at the household and family level, and immediate causes at the individual level. This is illustrated in the conceptual framework for addressing malnutrition in all its forms in Figure 5.

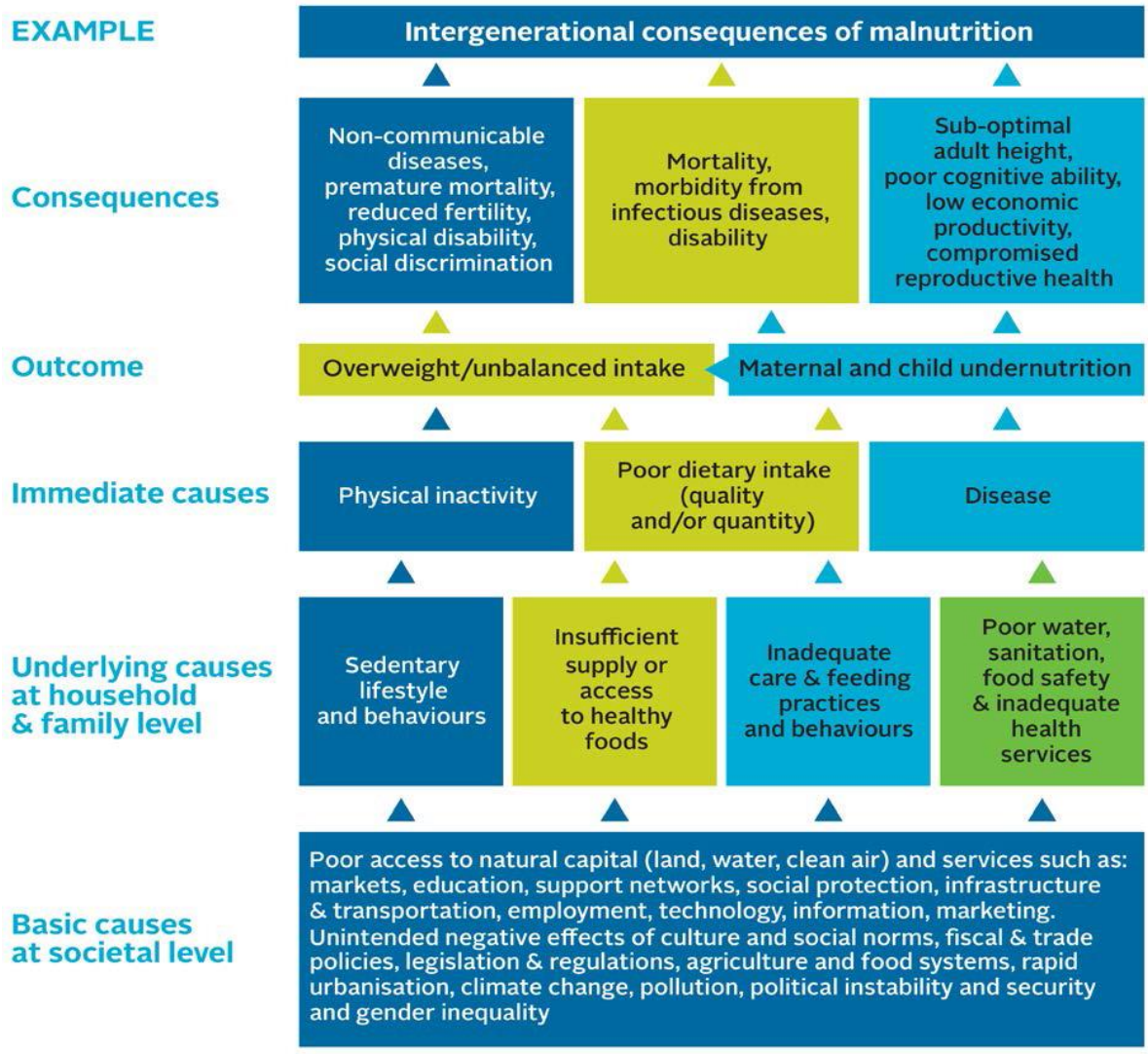

Figure 5: Frameworks for addressing malnutrition in all its forms

Immediate causes lead directly to direct outcomes of malnutrition. The most obvious immediate cause is poor dietary intake. A person may not be getting enough required daily calories, or may be consuming food that does not have the necessary micronutrients, which can lead to chronic malnutrition (stunting) and acute malnutrition (wasting) in children or specific micronutrient deficiency such as iron deficiency which contributes to anemia in women and children. Extended and frequent illness/disease can also have an impact on the body's ability to absorb required nutrients. An example of this is a young child who has frequent diarrhea, which can result into acute malnutrition due to poor nutrient

absorption. In addition, consumption of unhealthy foods (e.g., fatty or high calorie and nutrient poor food) and physical inactivity can also lead to malnutrition in the form of overweight or obesity, which can lead to diet-related non-communicable diseases such as diabetes and heart disease.

Immediate causes are exacerbated or caused by underlying causes of malnutrition. Inadequate dietary intake could be due to household food insecurity or poor child feeding practices, such as inadequate dietary diversity or early cessation of breastfeeding. Other inadequate care practices, such as failing to provide stimulation and other good early child development practices, can have negative impacts on cognitive development, which are further compounded by poor diet. Poor nutrition that may results into reduced immunity to infection, while infection results into the loss of appetite and reduces nutrient absorption, which can produce further weight loss and continued or increased levels of malnutrition. As this cycle repeats itself in a child, growth is compromised, the nutritional status worsens, and the risk of mortality continues to rise. Diseases can also be caused by poor food hygiene, (e.g., diarrhea is often caused by exposure to faeces through poor hand washing practices). This, in turn, is linked to the environment, including issues of access to water and sanitation infrastructure. Poor water and sanitation infrastructure can contaminate food, leading to an increase in disease. Lack of access to health services, such as vaccinations, also contributes to disease. Lifestyle choices, such as sedentary behaviour, can lead to overweight and obesity, particularly if there is an imbalance in the number of calories consumed versus used.

Finally, basic causes influence the underlying causes, and so can lead to malnutrition. At this level, all sectors are involved. Household food insecurity can be due to a lack of income, which can be the result of low levels of education, which restrict job opportunities and other income-generating opportunities. Educational disparity can lead to increases in gender-based violence, which can

have an impact on a mother's ability to properly care for her children; this may result lead to inadequate feeding practices or the inability to take children for health services. Educational disparity and limited household resources also contribute to individuals making poor dietary choices. This may lead to consuming a diet that is low in diversity, high in fat and sugar, and low in micronutrient content (e.g., soda, chips, and biscuits). Political will can have an impact on the availability of services, including health, education, community development and agricultural extension services. It also has an impact on the enabling environment for pro-nutrition policies, which can help expand service coverage and provide funding for necessary services. As you unpack this framework, it becomes apparent that every sector has a role to play in improving nutrition.

The causes of malnutrition within the household can be further explained using the factors identified as influencing infant and young child nutrition (IYCN) practices in Northern Uganda. These include women's workload and time, teenage pregnancies and frequent pregnancies. Alcoholism and gender-based violence have also been identified among them. Negative traditional practices, polygamy, the lack of livelihoods and food insecurity are among them. These require concerted efforts from various groups within the communities to improve nutrition outcomes.

According to the UDHS 2016, 66% of infants under age 6 months are exclusively breastfed. This is contrary to the recommendation that children under age 6 months be exclusively breastfed, 7% of infants consume plain water, 6% consume non-milk liquids, 8% consume other milk and 11% consume complementary foods in addition to breast milk before they reach 6 months of age. In addition, 2% of infants under age 6 months are not breastfed at all. The percentage of children exclusively breastfed decreases sharply with age from 83% of infants age 0-1 month being exclusively breastfed to 69% of infants age 2-3 months and more to

43% of infants age 4-5 months. 11% of infants under age 6 months are fed using a bottle with a nipple, a practice that is discouraged because of the risk of illness to the child. Breastfeeding a child until age 2, with proper complementary feeding practices beginning after the age of 6 months, is recommended (Uganda Bureau of Statistics (UBOS): Uganda Demographic and Health Survey Report, 2016

The root causes of and factors contributing to malnutrition in Uganda are complex and multidimensional and this include:

a. poverty, underdevelopment, unemployment and low socio-economic status in both rural and urban areas, often aggravated by the impact of conflict, post conflict and humanitarian emergencies and protracted crises, including natural disasters;

b. inequity and inequality, poor infant and young child feeding and care practices, poor sanitation and hygiene, lack of access to education, quality health systems and safe drinking water, foodborne infections and parasitic infestations, ingestion of harmful contaminants due to unsafe food production or preparation practices;

c. New and emerging challenges and trends such as climate change, pressures from population growth, urbanization, changing lifestyles and consumption patterns.

The minimum standards with respect to infant and young child feeding (IYCF) practices among children aged 6-23 months are measured through the Minimum Acceptable Diet (MAD) indicator. The UDHS 2016 indicates that 14% of children aged 6-23 months meet the criteria for MAD. The percentage of children meeting

MAD requirements varies by age group: 6-8 months (15%), 9-11 months (13%), 12-17 months (15%) and 18-23 months (13%).

1.2.5 Consequences of malnutrition

Malnutrition contributes to death and illness of many Ugandans each year. It also significantly reduces agricultural productivity because of productive time lost due to illnesses associated with malnutrition and time spent dealing with family illnesses or deaths associated with malnutrition. As discussed in previous earlier, it also has a disproportionate effect on children under 2, during which their cognitive development can be harmed, leading to lower levels of educational achievement.

Anaemia has negative effects on productivity and the social and economic development of a nation. Women of reproductive age who are anaemic are at more risk of maternal death, having premature births, and giving birth to babies with low birth weight (< 2.5 kg). In turn babies who are premature or born with low birth weight are at high risk of death before their first birthday.

Children who suffer from underweight and/or wasting are at increased risk of mortality from illnesses such as diarrhoea and pneumonia. The effects of undernutrition on the immune system are wide ranging and tend to be more frequent and severe in wasted children. Stunting in childhood has short-term and long-term consequences that affect health and human capital development. In addition to poor physical growth, stunting increases childhood risk of infection and mortality, and affects development, learning capacity and school performance. Later it affects productivity, wages and reproductive health.

It can also lead to excessive weight gain later in life, which contributes to higher levels of overweight and obesity. These conditions lead to increased risk of nutrition-related chronic diseases such as diabetes and heart disease. Overweight and obese children are likely to stay obese into adulthood and are

more likely to develop non-communicable diseases like diabetes and cardiovascular diseases at a younger age. Prevention of childhood obesity therefore, needs to be given high priority to support improvement in adult nutrition outcomes as well.

Chapter Two

2 Review of UNAP I (2011-2016)

2.1 UNAP I Implementation, Gaps and Opportunities for UNAPII

In March, 2011 Uganda joined the global Scaling Up Movement in nutrition (SUN). During the same year, 2011, Cabinet under Minute 293 (CT 2011) approved the Uganda Nutrition Action Plan (UNAP) as the Government Strategic Plan for Scaling up Nutrition in Uganda until 2016. The UNAP1 specifically aimed at scaling-up multi-sectoral efforts to establish a strong nutrition foundation for Uganda's development. The goal of the UNAP 1 was to reduce malnutrition levels among women of reproductive age, infants and young children from 2011 through 2016 and beyond with five objectives[5]:

During the implementation of UNAP, various frameworks emerged at the global, regional and national landscape for nutrition programming. The key framework that commit to improving nutrition by 2025 is the Framework for Action on Nutrition, adopted at the Second International Conference on Nutrition (ICN2), commit to improving nutrition by 2025. The framework has 60 recommendations.

Furthermore, a number of nutrition actors increased, an opportunity that required coherent and harmonized efforts to coordinate the use of resources, getting more partners aligned with national priorities and translating these efforts towards common nutrition goals and objectives into comprehensive nutrition plans.

[5]Improve access and utilization of Maternal, Infant and Young Child Nutrition health related services; Enhance consumption of diverse diets; Protect households from the impact of shocks & other vulnerabilities that affect nutritional status; Strengthen the policy, institutional framework & capacity to effectively plan, implement & monitor nutrition; and Create awareness, maintain interest & commitment to improve support for nutrition

While at the inception of the first UNAP in 2011, no standard guidance for generation of a good nutrition action plan was available to define what constitutes quality nutrition plans, in 2016, the SUN movement developed a checklist on the criteria and characteristics of "a good" national nutrition plans. The checklist recognizes the universality of malnutrition and the need for actions that address malnutrition in all its forms. It also recognizes the attainment of good nutritional status especially among children and women of reproductive age, as both a marker and a maker of sustainable development, with 12 out of 17 Sustainable Development Goals (SDGs) relevant to nutrition (IFPRI, 2015).

Overall, Uganda under UNAP-1 made substantial progress in most of the nutrition indicators used in tracking achievements especially stunting, wasting and exclusive breast feeding. However, the country performed poorly on other nutrition indicators such as anemia among children and women of reproductive age and low birth weight. Nevertheless the country is on a positive trend of reducing prevalence of stunting and has indeed achieved the UNAP-1 target of reducing stunting levels down to 29%.

Despite the achievements, holistic implementation of nutrition intervention remains weak concentrating in most food insecure and vulnerable areas of the country. Nutrition stakeholder interventions are not well coordinated and often do not align with what is articulated in the national frameworks for nutrition and other related policies. Systems for material, financial and human resources tracking for UNAP-1 implementation were not sufficeinttherefore, financing for nutrition was not well appreciated and thus was never well established. In general, the budget transparency for nutrition interventions across sectors during the UNAP mplementation was low due to high levels of aggregation of budgets making information on nutrition sensitive and specific expenditure scarce and difficult to track.

The UNAP 2 therefore is informed by the review findings of UNAP-1, SDGs, Agenda 2030 and the outcome documents of the Second International Conference on Nutrition (ICN2) held in 2014 that constitute the Framework for Action on Nutrition. The plan is further informed by the six pillars[6]of the Decade of Action on Nutrition (2016-2025), the Principles of Engagement[7] of the Scaling Up Nutrition (SUN) Movement and the need for a multi-sectoral, multi-stakeholder approach – from national to community levels and the SUN checklist, that sets out the essential 'ingredients' for sound national plans[8];

The second Uganda Nutrition Action Plan 2018-2025 is built on the Lancet 2013 and prepared in line with the Lancet guide as shown in Figure 6. The content scope is cognizant of the global, regional and national commitments. It is multi-sectoral in nature and so linked to the coordination and implementation of nutrition related intervention to end hunger to achieve food security and improve nutrition by 2025 and beyond.

[6]Aligned health systems providing universal coverage of essential nutrition actions, sustainable, resilient food systems for healthy diets, Social protection and nutrition education, behavior change communication; Safe and supportive environments for nutrition at all ages; Strengthened governance and accountability for nutrition

[7]Transparency about intentions and impact, inclusiveness, Rights based, willingness to negotiate, predictability and mutual accountability, cost-effectiveness, continuous communication, integrity and ethical, mutual respect and do non-harm

[8]Situation analysis and policy and programming review; Stakeholders' engagement and political commitment process; Costs and budgetary framework; implementation and management arrangements and Monitoring, evaluation, operational research and review arrangements.

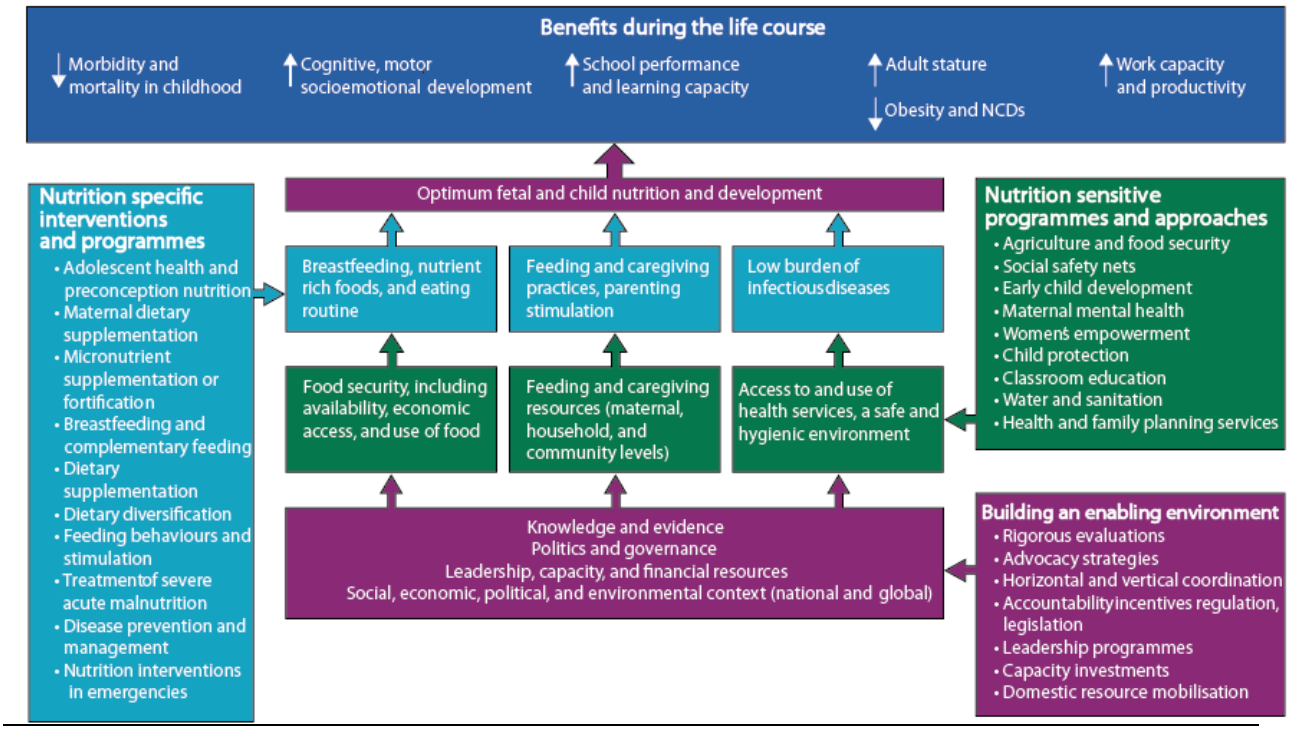

Figure 6: Framework for actions to achieve optimum foetal and child nutrition development (Lancet, 2013)

There are three categories of program areas and interventions required to address the immediate, basic, and underlying causes of malnutrition. The program areas fall under three main headings: Nutrition-specific interventions programmes that address the immediate determinants of foetal and child nutrition and development – adequate food and nutrient intake (Lancet, 2013). It also considers the feeding, caregiving and parenting practices including low burden of infectious diseases.

Nutrition-sensitive interventions and programmes address the underlying determinants of foetal and child nutrition and development – food security; adequate care giving resources at the maternal, household and community levels. Access to health services safe and hygienic environment equally considered. It incorporates specific nutrition goals and actions. Nutrition governance that addresses the basic causes of malnutrition is provided for in the guideline.

2.2 UNAP II 2018-2025 Theory of Change

The Theory of Change (ToC) that underpins UNAP-II is grounded on the six steps[9] of the SUN movement strategy monitoring, evaluation, accountability and learning (MEAL) results framework and the SUN road map 2016-2020 (SUN March 2018) and the nutrition decade of action. Figure 7 presents the proposed UNAP-II theory of change.

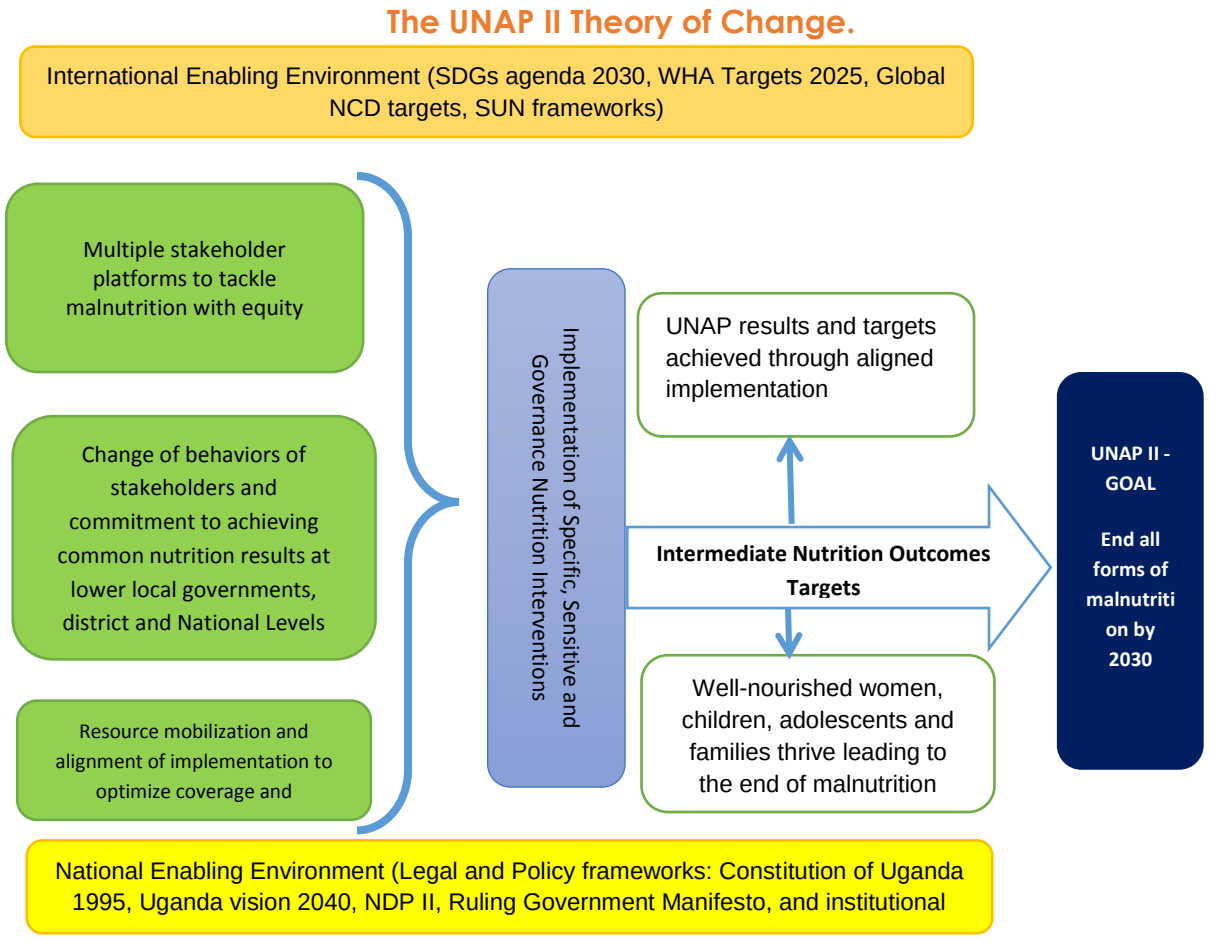

Figure 7: UNAP-II Theory of Change

[9]STEP 1: Multiple stakeholders from different sectors come together to tackle malnutrition and build an enabling environment for improving nutrition with equity;
STEP 2: Multiple stakeholders from different sectors change their behaviors and commit to achieving common nutrition results for everyone, everywhere;
STEP 3: Multiple- stakeholders mobilize resources and align implementation to optimize coverage and effectiveness of their actions;
STEP 4: Results are achieved through aligned implementation in a far greater way than what could have been achieved by each stakeholder on its own;
STEP 5: Women, children, adolescents and families thrive leading to the end of malnutrition by 2030 (SDG 2.2);
STEP 6: Better nutrition contributes to the achievement of SDGs

2.2.1 Critical success factors for UNAP-II implementation linked to the ToC

- Designing and implementation of the standard mechanisms for reporting, monitoring and surveillance of the food security situation on a regular basis to ensure proactive responses nationally and in respective regions.

- Ensuring that the programme Based Budgeting System (PBS) reports generated by Local Governments clearly state the targets achieved under nutrition service delivery programmes; through integrating nutrition indicators in the PBS.

- Developing a functional resource mobilization strategy for nutrition to address nutrition financing gaps and enforce mutual accountability mechanisms in monitoring multi-sectoral nutrition programme financing and link investments to nutrition outcomes

- Enforcing regulations on quality assurance of agricultural inputs including fertilizers, seeds, seedlings and stocking materials and agricultural chemical

- Establishment and operationalization of a comprehensive National food reserve system; through promoting mass production and fortification of major staples such as maize, beans, millet and rice as food security crops by facilitating their production at regional level.

- Enforcing consumption of nutrient rich foods through mandatory industrial food fortification and bio-fortification for major staples.

- Developing an integrated management programmes for antenatal micronutrient supplementation, intermittent preventive treatment for malaria in pregnancy, iron and folic acid supplementation for non-pregnant women,

- Designing and undertaking popular behavioral change campaigns to promote all-inclusive good nutrition and hygiene practices for infants,

children, pregnant mothers, people living with disabilities and the elderly. This should be complemented by targeted interventions like iron, zinc and vitamin A supplementation.

- Conducting operations research aimed at enhancing staple food fortification, and popularizing locally available complementary foods to boost the treatment of severe/acute and other forms of malnutrition.

- Undertaking nutrition policy reviews, institutional reforms, streamlining coordination structures down-to the parish level, delivery linkages with stakeholders highlighting implementation mandates and milestones.

2.3 Priority Investment Areas for UNAP-II

The investment areas for UNAP II are aligned with the Uganda Vision 2040, NDP II, and the ruling government manifesto. Globally, UNAP-II is fully aligned to the six cross cutting areas of the United Nations Decade of Action on Nutrition (2016-2025) that are integrative areas for impact, derived from the ICN2 FfA recommendations and relevant to related SDGs. Figure 8 shows the investment areas while Table 3 illustrates the alignment.

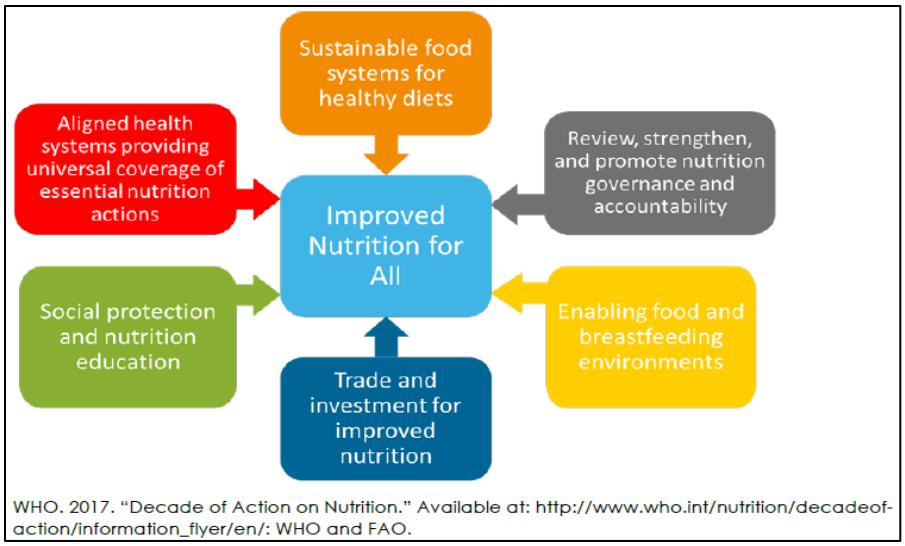

Figure 8: Six Pillars of investment areas for Nutrition Action

The investment areas are aligned with the Uganda vision 2040, the National Development Plan II as well as the manifesto of the governing party and the SDG Agenda 2030.

Table 3: Alignment of UNAP II strategies to the priority Action area for investment

Priority Action Area for investment in the decade of action	UNAP-II Strategies	Vision 2040 & NDP II	SDG Agenda 2030
Aligned health systems providing universal coverage of essential nutrition actions	• Promote Optimal maternal, infant, young child and adolescent nutrition practices	√	√
	• Promote micronutrient intake in children and women of reproductive age	√	√
	• Increase coverage of management for acute malnutrition in stable and in emergency situations	√	√
	• Integrate Nutrition services in prevention, control and management of infectious diseases.	√	√
	• Integrate Nutrition services in prevention, control and management of non-communicable diseases.	√	√
Sustainable, resilient food systems for healthy diets	• Promote production and consumption of bio-fortified and industrial fortified foods	√	√
	• Promote and increase production, access and consumption of diverse high nutrient value and safe foods	√	√
Social protection and nutrition education, behavior change communication	• Promote access to integrated early childhood development and child protection services for improved nutrition	√	√
Trade and investment for improved nutrition	• Promote trade and investment for improved nutrition through involving the business community in scaling up nutrition actions	√	√
Safe and supportive environments for nutrition at all ages	• Promote access to classroom education through school food and nutrition programmes as guided by the 2013 school feeding and nutrition guidelines	√	√
	• Promote integration of food and nutrition programming into water, sanitation and hygiene (WASH) services	√	√
Strengthened governance and accountability for nutrition	• Strengthen nutrition governance at central and local government levels	√	√
	• Institutionalize nutrition research and knowledge management for decision making	√	√

Chapter Three

3 Results Chain

3.1 The strategic direction

The UNAP-II is guided by the Uganda Vision 2040 (Uganda Vision, 2014) and the NDP II (2015) priorities and seeks to address 12 out of the 17 SDGs but with specific consideration of SDG-2. It sets out priorities, strategic results and targets in three thematic programme areas of nutrition specific, nutrition sensitive and nutrition governance. This UNAP-II is the strategic implementation plan for the Nutrition Policy 2018. Nutrition is one of the contributing factors to the attainment of NDP-II aspirations of graduating to middle -Income status. The strategic direction of the plan is presented in this chapter.

3.2 The Goal, Vision and Mission of UNAP II 2018-2025

Goal

To end food insecurity and all forms of malnutrition in children under 5 years of age, adolescent girls, pregnant and lactating women including older persons by 2030

Vision

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

Mission

To end hunger, achieve food security, and improve nutrition by 2030.

3.3 Objectives and Primary outcomes

Over the planned period 2018-2025, the UNAP II seeks to:

(1) Increase access to and utilization of nutrition-specific services by children under 5 years of age, adolescent girls, pregnant and lactating women and other vulnerable groups
(2) Increase availability and utilization of nutrition sensitive service by children under 5 years of age, adolescent girls, pregnant and lactating women and other vulnerable groups
(3) Strengthen the enabling environment for scaling up nutrition specific and nutrition sensitive interventions.

3.3.1 Key Primary Outcomes

Achievement of the Uganda Nutrition Action Plan (2018-2025) targets will be measured through a set of primary, intermediate, process and policy/capacity indicators. The key primary outcomes and targets based on UNAP-1, Second National Development Plan, National Standards Indicator Framework, and World Health Assembly 2025 targets as per the Comprehensive Implementation Plan on maternal, infant and young child framework (WHO, 2012) and the Comprehensive Global Monitoring Framework (GMF) for the prevention and control of non-communicable diseases nutrition targets. Details of the individual indicators have been provided in the Monitoring and Evaluation Framework (Annex).

Below are the ten (10) primary targets from the above frameworks;

I. A 40% reduction in the number of children under-5 who are stunted by 2025 and 50reduction in the number of children under-5 who are stunted by 2030;

II. A 50% reduction of anemia in women of reproductive age by 2025 and 2030;
III. A 30% reduction in low birth weight;
IV. Reduce and maintain childhood overweight to less than 3%
V. Achieve an Increase the rate of exclusive breastfeeding in the first 6 months up to at least 70%
VI. Reduce and maintain childhood wasting to less than 3%;
VII. A 30% relative reduction in mean population intake of salt/sodium
VIII. A 25% relative reduction in the prevalence of raised blood pressure
IX. A 10% reduction in prevalence of insufficient physical activity
X. No increase in the prevalence of obesity and diabetes

3.3.2 Intermediate Outcomes, Strategies and Priority Actions

Objective 1: Increase access to and utilization of nutrition-specific services by children under 5 years of age, adolescent girls, pregnant and lactating women and older persons;

Intermediate outcomes

- Improved maternal, infant, young child and adolescent nutrition practices
- Increased micronutrient intake in children and women of reproductive age
- Increased coverage of management for acute malnutrition in stable and in emergence situations
- Increased coverage of nutrition services in disease prevention, control and management of infectious diseases
- Increased coverage of nutrition services in disease prevention, control and management of diet related non-communicable disease

Strategy 1.1: *Promote optimal maternal, infant, young child and adolescent nutrition practices*

Priority actions

I. Promote and support health and nutrition education to increase the level of awareness of good nutrition.
II. Promote integration of nutrition services in all routine and outreach

health services and programmes targeting children and mothers.

III. Manage nutrition for sick children, pregnant and lactating mothers, and other women of reproductive age.
IV. Integrate the management of severe and moderate acute malnutrition into routine health services.
V. Promote utilization of antenatal and postnatal care services among all pregnant and lactating mothers to monitor child growth, and the health and nutrition status of both the mother and the child.
VI. Promote and support breastfeeding policies, programmes, and initiatives.
VII. Promote and support appropriate complementary feeding practices.
VIII. Promote proper food handling, hygiene, and sanitation through increased knowledge, use of safe water, and hand washing practices at household level.
IX. Promote infant and young child nutrition practices
X. Promote community based and health facility-based growth promotion and monitoring.

Strategy 1.2: *Promote* micronutrient intake in children and women of reproductive age

Priority actions

I. Provision of Vitamin A supplementation for children
II. Promote deworming in Children
III. Avail Iron folic acid supplementation for pregnant women
IV. Promote storage and consumption of iodized salt
V. Encourage the utilization of therapeutic zinc supplementation with ORS
VI. Promote the consumption iron fortified staple foods
I. Promote consumption of home-based fortified foods

Strategy1.3: Increase coverage of management for acute malnutrition in stable and in emergency situations

Priority actions

i. Implement integrated management of acute malnutrition targeting refugee children and women.
ii. Implement integrated management of acute malnutrition targeting children and women from refugee host communities and other areas in the country.

iii. Implement integrated management of acute malnutrition targeting food insecure communities such as Karamoja.

Strategy 1.4: Integrate Nutrition services in prevention, control and management of infectious diseases.

Priority actions

i. Integrate diet therapy into routine disease management
ii. Promote actions that prevent and improve management of childhood diarrhoea and gastro intestinal infestations
iii. Ensure universal access to and use of insecticide-treated nets
iv. Prevent and treat malaria for pregnant women, children and other vulnerable groups
v. Promote and sustain universal and age-appropriate immunization services
vi. Prevent and treat diarrhea children
vii. Prevent and treat Acute Respiratory infections (ARIs) for children
viii. Prevent and treat childhood fevers

Strategy 1.5*:* Integrate Nutrition services in prevention, control and management of non-communicable diseases.

Priority actions

I. Promote actions that prevent and improve management nutrition-related non-communicable diseases
II. Train Health Care Providers on Diet and Nutrition Related Non-Communicable Diseases at all levels
III. Sensitizing communities on The Tips for a Healthy Life Style; Eating Healthy and exercising regularly

Objective 2: Increase availability and utilization of nutrition sensitive service by children under 5 years of age, adolescent girls, pregnant and lactating women, older persons and other vulnerable groups

Intermediate Outcomes

- Increased production, access and consumption of diverse diets
- Increased production and consumption of fortified foods
- Improved access to Social protection programmes with a food and nutrition security objective

- Improved coverage water, sanitation and hygiene (WASH)
- Increased access to classroom education
- Increased access to integrated early childhood development and child protection services
- Increased participation of the business sector in scaling up nutrition.

Strategy 2. 1: Promote and increase production, access and consumption of diverse high nutrient value and safe foods.

Priority actions

I. Promote indigenous food production and processing of diversified nutritious foods at household and community levels.
II. Promote the production, accessibility and consumption of a variety of cereals, legumes, fruits, animal–source foods, including fish, meat eggs and dairy products
III. Promote the diversification of crops including underutilized traditional crops, appropriate production of animal-source products as needed.
IV. Strengthen local food production and processing, especially by smallholder
V. Promote food safety interventions at different levels
VI. Promote post-harvest handling and value addition technologies along the food value chain
VII. Promote the uptake and use of the adapted small-scale irrigation technologies/options
VIII. Scale up nutrition sensitive and climate smart agriculture projects that build resilience to climate change and other shocks to the food supply system.
IX. Strengthen monitoring and surveillance for compliance to food control systems.
X. Improve storage, preservation, transport and distribution technologies and infrastructure to reduce seasonal food insecurity, food and nutrient loss and waste.

Strategy 2. 2: Promote production and consumption of bio-fortified and industrial fortified foods

Priority actions

I. Promote industrial food fortification and consumption of fortified maize flour, wheat in households and institutions
II. Promote bio fortification of orange flesh sweet potatoes, and iron rich beans, especially in all high production zones
III. Generate foundation seed for bio-fortified crops and promote production of bio-fortified foods

Strategy 2.3: Promote integration of food and nutrition security services in social protection programmes.

Priority actions

I. Mainstream nutrition interventions into social protection programmes and into humanitarian assistance safety net programmes
II. Promote social transfers to support livelihoods for the most vulnerable households and communities.
III. Develop and implement programmes for special social assistance and for livelihood promotion and protection in areas with high levels of malnutrition.
IV. Implement the school feeding and nutrition programme in humanitarian situations and refugee
V. Promote energy saving technologies targeting women
VI. Mainstream nutrition in the youth livelihood programme implementation
VII. Strengthen and scale up early warning systems on food and nutrition information from community to national levels.

Strategy 2.4: Promote integration of food and nutrition programming into water, sanitation and hygiene (WASH) services.

Priority actions

I. Promote access and utilization of safe water at household level
II. Scale up Community Led Total Sanitation (CLTS) practices
III. Promote food safety and hygiene education at household level and in schools
IV. Promote safe water supply in rural and urban areas

Strategy2.5: Promote access to classroom education through school food and nutrition programmes as guided by the 2013 school feeding and nutrition guidelines.

Priority actions

i. Mobilize school going children to access nutrition education during Integrated Child Health Days.
ii. Implement the parent led School feeding and Nutrition using sustainable school feeding models
iii. Link OWC to school garden projects
iv. Expand and improve provision of safe water Supply and sanitation infrastructure to Schools within the mandate of the education sector
v. Mainstream nutrition education in key development programmes.
vi. Strengthen nutrition education in pre-primary, primary school, health and agriculture training institutions.

Strategy 2.6*: Promote access to* integrated early childhood development and child protection services for improved nutrition.

Priority actions

i. Promote early childhood care education
ii. Promote food security and nutrition for ECD
iii. Promote child protection services
iv. Promote primary Health care, WASH and environment hygiene for ECD

Strategy 2.7*:* Promote trade and investment for improved nutrition through involving the business community in scaling up nutrition actions.

Priority actions

I. Conduct a mapping exercise for the business community actors in food and nutrition.
II. Develop and implement strategy for business community actors' participation in scaling up nutrition as per the SUN guidelines.
III. Strengthen the capacity of the business in agricultural inputs production, processing and marketing.
IV. Support and facilitate Village Saving and Loan Associations and SACCOs for improved access to incomes, food and nutrition security.

Objective 3: Strengthen the enabling environment for scaling up nutrition specific and nutrition sensitive interventions.

Intermediate Outcomes

- Functional Nutrition governance structures
- Improved political commitment for nutrition
- Improved behaviors to advocate, partner and commitment towards common results improved functional and institutional capacity
- Coherent policy implementation of multi-sectoral nutrition programmes
- Improved knowledge and evidence for nutrition programming

Strategy 3.1: Strengthen nutrition governance at central and local government levels.

Priority actions

i. Enhance capacities of nutrition coordination structures at local government to coordinate, plan, implement and monitor the implementation of UNAP-II.
ii. Enhance capacities of nutrition coordination structures in MDAs to coordinate, plan, implement and monitor the implementation of the nutrition Policy and UNAP-II.
iii. Support the implementation of the nutrition advocacy and communication strategy for UNAP-2at national and local government level.
iv. Implement the National Family Policy to promote the rights of the family members and foster nutrition and wealth creation.
v. Mainstream nutrition in the Uganda Women empowerment programme implementation.
vi. Implement Nutrition Behavior Change Communication and Advocacy Strategy (BCC strategy) 2015.

Strategy 3. 2: Institutionalize nutrition research and knowledge management for decision making.

Priority actions

I. Create capacity within national institutions to operate and maintain a National Information Platform for Food and Nutrition;
II. Strengthen capacity to track progress in meeting UNAP-II objectives to

prevent malnutrition and monitor nutrition investments;

III. Build the capacity of national policy makers and nutrition programme planners and implementers to make better use of evidence in designing and implementing nutrition-related policies, programmes and projects.

IV. Establish the academic and research institutions network for scaling nutrition research in the country.

V. Establish and implement systems for mobilizing and tracking finances for nutrition in the public, private and civil society sectors

VI. Design and implement a Monitoring, Evaluation, Reporting and Learning plan for UNAP-II.

Chapter Four

4 UNAPII Implementation Arrangements

4.1 Coordination Structure

The coordination structure for the UNAP is derived from the institutional Framework for Coordination of Policy and Program implementation in Government (IFCPPI) under Minute No 257 (CT 2003 (NCP, 2016). Effective coordination is a critical component of nutrition improvement as it creates the necessary enabling environment for scale-up, empowerment and sustainability of interventions. Although in nutrition we understand what works and in many ways how it should work, the challenge is to ensure interventions are delivered across sectors through an efficient, cost-effective and coherent adherence to the principles of good governance.

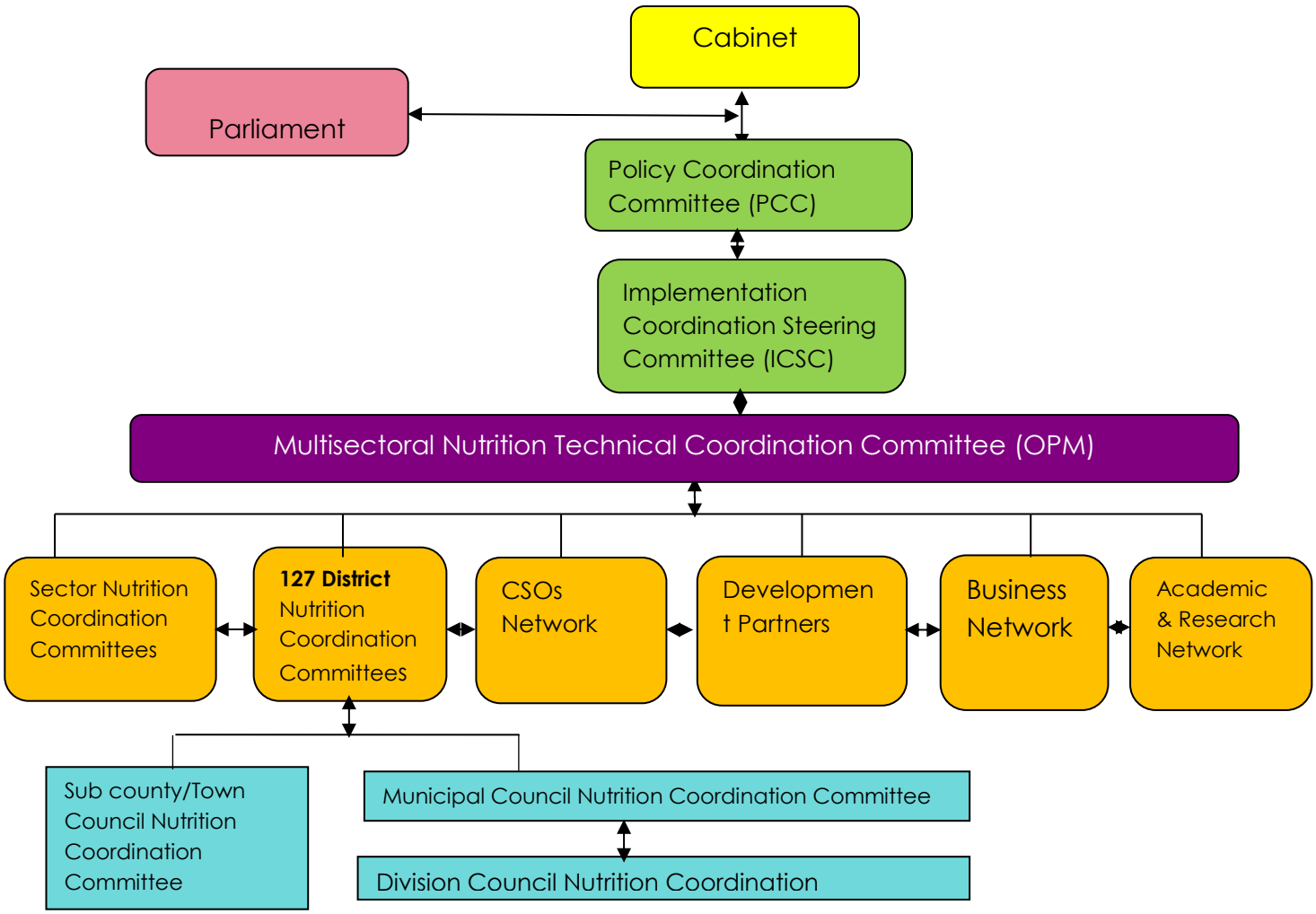

Figure 9: The UNAP coordination and implementation structure with stakeholder inter and intra coordination and multiplicity.

In order to effectively implement this action plan, partners are encouraged to adhere to the SUN Movement Principles of Engagement and act according to their commitments, including mobilizing resources and aligning implementation to optimize coverage and effectiveness of their actions. As a result, we will notice improvements in feeding and dietary practices, increased access to required services among families especially those most at risk of malnutrition. The nutrition status of Ugandans will improve and the country will be able to show how nutrition has contributed to the achievement of the 2030 Agenda for Sustainable Development and the accompanying Global Goals (SDGs).

4.1.1 National Nutrition Forum

National Nutrition Forum (NNF) will be the Apex tier of engagement on nutrition by all stakeholders. The NNF will bring together Government Ministries, Departments and Agencies, representatives from Local Governments, Development Partners, Private Sector, Civil Society Organisations, Academia and Research Institutions. Hosted and Chaired by the Prime Minister, the Nutrition Forum will meet annually to review the implementation of the nutrition policy and provide policy advice and advocacy for nutrition programming.

Prior to the Forum event, a technical review meeting of Permanent Secretaries; Heads of Corporation and Agency and representatives from Local Governments, Civil Society Organizations, Private Sector, Academic and Research Institutions will be held annually to provide input to the deliberations for the NNF.

4.1.2 Policy Co-ordination

Policy co-ordination will be done through three entities: A Policy Coordination Committee, the Implementation Steering Committee (ISC) and the Parliamentary Sub-Committee on Nutrition. The Policy Coordination Committee will meet annually to review progress on key nutrition indicators in the country and to provide policy direction. The Policy Coordination Committee (PCC) will

be chaired by the Prime Minister.

The Implementation Steering Committee (ISC), which will include key line Permanent Secretaries, will meet annually to review progress on performance of key nutrition indicators, analyze budget performance of nutrition programmes, analyze the constraints to implementation and provide strategic direction. Recommendations from the Policy Coordination Committee (PCC) and the Implementation Steering Committee (ISC) will be fed into the Parliamentary Sub-Committee on Nutrition, which will approve the key policy and financial decisions and then forwarded to the Nutrition Multi-Sectoral Technical Committee for implementation.

4.1.3 Technical Coordination

Technical co-ordination of nutrition will be done through the Nutrition Multi-Sectoral Technical Committee, which will comprise key technical experts from government, development partners, the private sector, academia, and civil society. The committee will be chaired by the Permanent Secretary, Office of the Prime Minister.

The Nutrition Multi-Sectoral Technical Committee will be supported by the department of Strategic Coordination and Implementation (SCI) which will be responsible for supporting the coordination of joint planning and review with departments as well as development partners, civil society, the private sector and academia; they will Monitor and evaluate the national nutrition response in the country; Mobilizing resources and support for nutrition response; Providing national standards and norms for nutrition; advocate for the development of nutrition structures and adequate resource allocation; Lobbying for the establishment of a consolidated nutrition fund by development partners and facilitating cross-sector collaboration, higher-level committees notwithstanding.

4.1.4 Nutrition Development Partners Committee

The Nutrition Development Partners Committee will be responsible for promoting and identifying funding resources for the nutrition agenda in Uganda. It will also promote joint resource mobilization, allocation and support; responding to the proposed development partners' consolidated nutrition fund. Beyond that the committee will provide policy guidance on the alignment of nutrition programs to the Sustainable Development Goals and the nutrition commitments of the United Nations Development Agency Fund and other international organizations. This committee will be composed of representatives of nutrition development partners and will feed into the policy and technical co-ordination committees.

4.1.5 The SUN Movement Networks

The SUN Movement provides the platform to enable stakeholders work together to define shared objectives, mobilize resources and deliver solutions. While the Development Partners SUN Network and the Government has been active during UNAP 1 implementation, the Civil Society Network, Business Network, academic and Research Network will be established/strengthened during the first year of the second UNAP implementation. Each Network will have its terms of reference developed in line with the Global SUN Movement taking into consideration the Uganda Legal and policy context.

The SUN Monitoring, Evaluation, Accountability and Learning (MEAL) system will be used to measure the extent to which the SUN Networks adhere to the SUN Movement Principles of Engagement, commitments and alignment of implementation to optimize coverage and effectiveness of actions proposed in the UNAP. Annually a Joint-Assessment will be held to measure progress towards (I) Bringing people together in the same space for action (ii) Ensuring a coherent policy and legal framework (iii) Aligning actions around the Integrated Common Results Framework (ICRF) for this UNAP and (iv) Tracking finance and mobilizing resources towards achieving results and impacts.

4.1.6 Sector Nutrition Co-ordination Committees

During the first UNAP, Ministries, Departments and Agencies formed nutrition Coordination Committees to oversee the co-ordination of nutrition programmes and support implementation by central government departments, local governments, the private sector, academia and civil society. During UNAP II, the capacities of sector nutrition coordination committees will be strengthened to be able to plan, budget, implement and monitor nutrition specific, nutrition sensitive and governance interventions. Sector coordination Committees will prepare and share annual work plan with the UNAP Secretariat, Office of the Prime Minister. This annual work plan will work as a tool to facilitate the coordination of implementation of the UNAP within and across sectors. Nutrition focal persons in each sector will facilitate the co-ordination of nutrition programming within the sector.

Under the UNAP II, effort will be taken for Kampala Capital City Authority to come on board in the coordination of implementation of the UNAP through established legal and policy framework.

4.1.7 Decentralized Coordination

In order to scale up the nutrition governance for creating an enabling environment to implement the nutrition interventions at household level, UNAP II, will cascade the decentralized coordination of nutrition programming. This will be through the district nutrition coordination committees that were established in UNAP I to the community level through established lower local government structures i.e. municipality, town council, division and sub-county levels.

Actual implementation of development programmes happen at household and community level and this require capacities of various actors at the community level to be strengthened. Through the parish chiefs, capacities of the existing parish development committees (PDCs) will be strengthened to coordinate the implementation of multi-sectoral nutrition interventions under the UNAP at

household and community levels. Local Council executive committee members will be mobilized to support the implementation of the plan at village and house levels across the over 60,000 villages in the country. Terms of reference and standard operation procedures to guide the various actors from the district to the parish levels will be developed for technical guidance.

Chapter Five

5 Financing and Resource Mobilisation

Uganda's central and local governments, with support from other agencies and development partners, will finance UNAP-II through resource mobilization and alignment of implementation to optimize coverage and effectiveness of multi-sectoral nutrition interventions. Development partners will complement the government strategies, plans and budgets to implement the UNAP.

Existing and available resources for nutrition within the national budget, private sector and development partners must be coordinated effectively to maximize impact.

Financing the UNAP has to take into consideration the changing global context that has resulted into a more complex aid architecture: the emergence of new actors in the nutrition programming beyond one sector, development of new financing instruments e.g. programme base budgeting system and new forms of dialogues that require improved coordination, harmonization and alignment with national priorities.

5.1 Financial requirements of UNAP II

Using the 3-Step approach to track budget resources on nutrition, the costing available resources has been identified and the funding gap generated for use to finalise the cost that is required to fund the other interventions in the UNAP 2018-2025. The 2013 Lancet Series was used to categorize existing interventions as nutrition-specific and nutrition-sensitive.

The identified funding gap will be used to develop a resource mobilization plan. The review of government national budgets of 2018-2023 helped to understand the level of detail easily accessible in government investment on nutrition level of aggregation of budget to support the nutrition specific and sensitive interventions

will be determined. On alignment of activities from the existing frameworks some vital activities will be left unfunded and these unfunded activities will be used to generate the resource mobilization plan that will be shared with development partners, civil society and private sector for support.

The formulation of the UNAP costing framework has been based on the existing sector plans and budgets. The process involved identification of existing budgets for nutrition sensitive and specific interventions in sector budget framework papers and plans.

For effective costing of the UNAP II and the Nutrition Policy, an analysis of budgets as per sector Budget Framework Papers of 2018-2023 and previous expenditures to interventions was undertaken ans it provides a basis for generating the financing and implementation of the 2nd UNAP. The scope of this financing plan is therefore limited to interventions already available in the medium term budget frameworks with some areas already budgeted whille others fall under unfunded priorities. Ongoing and already identified funded programmes whose funding source is already known have been included in the costing plan.

The following programmes whose funding sourceare already available have been included to form part of the financing plan for the UNAP II.

- The Uganda Multi-Sectoral Food Security and Nutrition (2015-2019) Project funded by Global Agriculture and Food Security Program (GAFSP) at a cost of grant of US$27.64 million and implemented in 15 Districts. This project will come to an end in 2019, two years from the start of UNAP 2 implementaion.
- The Uganda Nutrition Information Platform for Nutrition (2018-2021) project to be implememted during the first four years of the UNAP 2018-2025. The NIPN an EU/DFID funded project will enhance evidence-based programming that will contribute to improve nutrition outcomes.

- The Development initiative for Northern Uganda (DINU) 2018-2023 to be implemnted Karamoja, Lango, West Nile, Acholi, Teso sub-regions: during the first five years of the UNAP 2018-2025.

5.2 Financial resources available and the funding gap

The UNAP II estimated resources will be available from Government, Development Partners, Civil Society Organizations and the private sector. This will be guided by sharing of the Key priorities and stakeholders availing their estimated financial commitments for UNAP II (2018-2025). The various intermediate results and priority actions together with the potential responsible stakeholders are presented in the implementation matrix shown in the Annexure.

5.3 Resources Mobilization for UNAP II

The resources mobilization plan shows that a larger share of the resources is planned to be mobilized from the Government of Uganda and the remaining from Development Partners and the Private Sector (Table 4). A key strategy for resource mobilization for the funding gap is ensuring that the Multi-Sectoral Nutrition Technical Committee develops a resource mobilisation strategy for the UNAP II.

Table 4: Finance and Investment Plan for UNAP II

Priority Action Area for investment in the decade of action	UNAP II Objectives	UNAP-II Strategies	Lead sector	Indicative financial resource investment	
				GOU	DP
Aligned health systems providing universal coverage of essential nutrition actions	Obj 1	• Promote Optimal maternal, infant, young child and adolescent nutrition practices • Promote micronutrient intake in children and women of reproductive age • Increase coverage of management for acute malnutrition in stable and in emergency situations	MoH	[10]Direct Nutrition investment - $184m [11]Indirect investments in nutrition - $5755.33m	

[10] Extracted from the Ministry of Health SDP (MoH SDP, 2016-2020 page 81)
[11] Extracted from the Ministry of Health SDP – it is an amalgamation of program areas costs of RMA Health, Child Health, Immunization, Malaria, TB and Non-communicable diseases (MoH SDP, 2016-2020 page 81)

Priority Action Area for investment in the decade of action	UNAP II Objectives	UNAP-II Strategies	Lead sector	Indicative financial resource investment	
				GOU	DP
		• Integrate Nutrition services in prevention, control and management of infectious diseases. • Integrate Nutrition services in prevention, control and management of non-communicable diseases.			
Sustainable, resilient food systems for healthy diets	Obj 2	• Promote production and consumption of bio-fortified and industrial fortified foods • Promote and increase production, access and consumption of diverse high nutrient value and safe foods	MAAIF	[12]6500.8 Billion	
Social protection and nutrition education, behavior change communication;		• Promote access to integrated early childhood development and child protection services for improved nutrition	MGLSD	[13]1,25Tn	
Trade and investment for improved nutrition;		• Promote trade and investment for improved nutrition through involving the business community in scaling up nutrition actions	MoTIC	[14]Indirect nutrition investment UGX 830,000 Bln	
Safe and supportive environments for nutrition at all ages		• Promote access to classroom education through school food and nutrition programmes as guided by the 2013 school feeding and nutrition guidelines.	MoES	[15]12,470.21 Bln	
		• Promote integration of food and nutrition programming into water, sanitation and hygiene (WASH) services	MoWE	[16]8698.6 Billion	
Strengthened governance and accountability for nutrition	Obj 3	• Strengthen nutrition governance at central and local government levels	OPM		DINO – Euro 6m
		• Institutionalize nutrition research and knowledge management for decision making	OPM		NIPN – Euro 2.4m

[12]Investment costs that will contribute to attainment of Nutrition outcomes extracted from MAAIF SDP, 2015/16-2019/20 (Page 75-76)
[13] Extracted from the National Integrated Early Childhood Development Policy Action Plan (2016-2021) Uganda (Page 23)
[14] Investment costs that will contribute to attainment of Nutrition outcomes extracted from MoTIC SDP, 2015-2020 (Page 109)
[15] Extracted from the MOES ESSP (2017/18-2019/20) Uganda (Page29) – Costs for SO1 and SO3
[7]Extracted from the MOWE Project Sector Investment (2015/16-2019/20) Uganda (Page 56) – Sub sectors: Water and Sanitation Devt. Infrastructure and Water for Production Infrastructure

5.4 Strategic prioritization of proposed Priority interventions for the UNAP II

There will be need to prioritize interventions and activities in case of funding constraints. This is due to the high prevalence of child stunting and anaemia in the country. A large proportion of children 6-23 months are having low minimum acceptable diet, while a large number of school children are going hungry at school. There is a high refugee influx, a large number of children with severe acute malnutrition in West Nile and Karamoja. These nutrition indicators will be prioritized for scale up during UNAP II.

Activities to be prioritized are those that contributes to: (1) increased coverage of maternal infant, young child and adolescent nutrition activities; (2) scale-up of integrated management of acute malnutrition among children under five; and (3) those that prevent anaemia among women of reproductive age (15-49 years).

If scaled up to 90% coverage, nutrition-specific interventions have potential to reduce the prevalence of stunting by estimated 20% (The Lancet Maternal and Child Nutrition Series June 2013). When accompanied with nutrition-sensitive interventions that address the underlying and basic causes of under nutrition and implemented by multiple sectors, the impact of nutrition specific interventions will be significantly great and considerably more sustainable. The Nutrition sensitive interventions to be scaled up will be those already in existence and have an entry point for embedding in nutrition message/objective.

The nutrition sensitive interventions if implemented to scale in a consistent and concerted manner with the right targeting of households with children under the age of 5 years, adolescents, women of reproductive age and other vulnerable groups will solve 70% of the nutrition problems. In order to implement the nutrition specific and nutrition sensitive interventions for better nutrition outcomes, the

enabling environment will be strengthened at all levels of implementation. These interventions will be predominantly delivered at household level. Prioritized nutrition sensitive interventions will be those that are most cost-effective with proven evidence on reducing stunting and are easy to implement at large scale through the existing delivery platforms in the sectors of Agriculture, social development, education, trade, industry and cooperatives, water and environment. Other activities to prioritize will be those focusing at the removal of bottlenecks and providing enabling environment.

Chapter Six

6 Monitoring, Evaluation, Reporting and Learning (MEAL)

6.1 Monitoring and Evaluation Framework

The M&E framework for UNAP is aligned with the National standards indicator framework (NSI) or the second national development plan (NDP II), and the government annual performance review systems.

For effective and coherent coordination of implementation of the second UNAP a comprehensive Monitoring and Evaluation (M&E) Plan will be developed. The M&E plan will describe the M&E framework, indicators, processes, sources of data, methods and tools that the ministries, Departments and Agencies will use to collect, compile report and use data to provide feed-back as part of the national M&E machinery. Office of the Prime Minister will take lead in the monitoring and evaluation of the progress and results of implementing the UNAP.

The M&E framework has been developed to capture the progress at four levels; the primary outcome indicators will measure the progress towards the global nutrition targets**.** The Intermediate outcome indictors will monitor how specific diseases and conditions on the causal pathways affect national trends relating to the global nutrition targets; process indicators will monitor programme and situation-specific progress; policy environment and capacity indicators will measure the political economy and capability within the country. The intermediate, process and policy environment indicators will facilitate regular monitoring of the progress towards the achievement of primary target outcomes at national level.

Annual reports on the UNAP implementation will be generated through holding joint annual review meetings. The reports will describe the overall progress on the implementation of intermediate, process and policy outcomes related to the realization of the primary nutrition outcomes. In addition, the reports will generate

a mapping of the commitments made by Ministries, Departments and Agencies, Development Partners, Civil Society Organizations, business community, academia and research actors to assess progress and achievements. The reports will contribute to the UNAP MEAL Plan reporting needs.

Tracking implementation of policy and UNAP progress and country-specific commitments will be based on the Scaling up Nutrition Movement Joint Assessments, panel surveys, administrative assessments in the sectors and ad hoc validation studies performed by the multi-sectoral nutrition platforms. The annual reports will provide opportunities for discussion among multi-sectoral stakeholders of the progress under the UNAP 2018-2025.

An open and inclusive dialogue among all stakeholders to evaluate the progress of the UNAP (2018-2025) will be convened at mid-term (2021) after the UDHS 2021 and at the end of the UNAP (2025). Progress in achieving the global nutrition and diet-related NCD targets is to be measured throughout the UNAP period at decentralized and national levels. Targeted programme and policy evaluations will be carried out, with support by the multi-sectoral nutrition stakeholders to identify good practices. Details of the Monitoring and Evaluation framework are in Table 5.

Table 5: Monitoring and Evaluation Framework

#	Indicator	Baseline	Target		Data Source(s)	Frequency of reporting
		2016	2020	2025		
World Health Assembly and NCD Target Indicators						
1	Proportion of stunted children under five years of age	29	24.4	19.8	UDHS	5 years
2	Prevalence of infants born below 2500 g (low birth weight)	10	8.5	7	UDHS	5 years
3	Prevalence of overweight children under five years of age	3.7	2.7	2	UDHS	5 years
4	Prevalence of wasting in children under five years of age	2	1	0	UDHS	5 years
5	Proportion of overweight women of reproductive age	17	17	17	UDHS	5 years
6	Proportion of obese women of reproductive age	7	7	7	UDHS	5 years
7	Prevalence of raised blood glucose/diabetes among persons aged 18+ years	3.4	3.4	3.4	UDHS	5 years
8	Prevalence of raised blood pressure among persons aged 18+ years.	24	21	18	UDHS	5 years
9	Prevalence of anaemia in pregnant women	32	22	11.5	UDHS	5 years
10	Prevalence of anaemia in children under five years	53	39	24.5	UDHS	5 years
11	Mean population intake of salt per day in grams in persons aged 18+ years.	-	-	-	UDHS	5 years
12	Exclusive breastfeeding for the first six months	66	68	70	UDHS	5 years
13	Prevalence of persons aged 18+ years consuming less than 400 grams of fruit and vegetables per day	14	17	20	UDHS	5 years
Intermediate Outcome Indicators						
1	Proportion of underweight women of reproductive age	9	4.5	0	UDHS	5 years
2	Prevalence of overweight in adolescents	19	11.5	4	UDHS	5 years
3	Prevalence of obesity in adolescents	17	10	3	UDHS	5 years
4	Prevalence of diarrhea in children under 5 years of age	20	10	0	UDHS	5 years

5	Prevalence of malaria in children under 5 years of age	30	15	0	UDHS	5 years
6	Prevalence of ARI in children 0-5years	9	4.5	0	HMIS	1 year
7	Percentage of children 0-5years with fever	33	15.2	0	HMIS	1 year
8	prevalence of HIV infection	6.2	4	0	UDHS	5 years
9	Percent of women 15-49years of age taking 3+ doses of Fansider	17	33.5	50	HMIS	
10	Tuberculosis incidence per 1,000 populations	-	-	-	HMIS	5 years
11	Gross enrollment ratio of in secondary school	24.5	35.5	45.5	EMIS	5 years
12	Gender parity index for secondary school level	0.9	1	1	EMIS	1 year
Process Indicators						
1	Initiation of breastfeeding within one hour of birth	66	83	100	UDHS	5 years
2	Proportion of children aged 6 to 23 months who consume minimum Acceptable Diet (MAD)	14	17	20	UDHS	5 years
3	Proportion of children aged 6 to 23 months who receive a Minimum Diet Diversity (MDD)	40	62.5	85	UDHS	5 years
4	Proportion of women of reproductive age consuming a Minimum Diet Diversity (MDD)	40	62.5	85	UDHS	5 years
5	Percentage of the population consuming food that is fortified according to standards	-	-	-	UDHS	5 years
6	Proportion of health facilities that are Baby Friendly Hospital Initiative (BFHI) certified	-	-	-	UDHS	5 years
7	Percentage of births in baby friendly facilities	-	-	-	UDHS	5 years
8	Proportion of mothers of children 0–23 months who have received counseling, support or messages on optimal breastfeeding at least once in a year	-	-	-	UDHS	5 years
9	Proportion of children 6–59 months with severe acute malnutrition admitted for treatment	-	-	-	UDHS	5 years
10	Proportion of children 6–59 months receiving Vitamin A supplementation	55	72.5	90	UDHS	5 years

11	Proportion of pregnant women receiving Iron and Folic Acid supplementation	88	94	100	UDHS	5 years
12	Number of trained nutrition professionals /100,000 population				UDHS	5 years
13	Percentage of households that have iodized salt (>0 ppm)	99	100	100	UDHS	5 years
14	Proportion of children under 5 years old with diarrhea receiving oral rehydration salts (ORS) and Zinc	47	73.5	100	UDHS	5 years
15	Proportion of children aged 12–59 months receiving at least one dose of de-worming medication	60	75	90	UDHS	5 years
16	Use of insecticide treated nets in children aged 0–5 years	62	81	100	UDHS	5 years
17	Use of insecticide treated nets in women of reproductive age	-	-	-	HMIS	1 year
18	Percentage of children age 12-23 months who have received all basic vaccines	55	60	70	UDHS	5 years
19	Contribution of staple foods to caloric intake	50	72.5	95	UDHS	5 years
20	Proportion of children 6-23months of age who consume iron rich foods of iron fortified foods	40	55	70	UDHS	5 years
21	Proportion of children 6-23months of age who consume vitamin A rich foods of Vitamin A fortified foods	67	73.5	80	UDHS	5 years
22	Proportion of the population covered by social protection services	-	-	-	SP[17] reports	1 year
23	Percentage of safe rural water supply coverage	66	79	81	SP reports	1 year
24	Percentage of safe urban water supply coverage	80	100	100	SP reports	1 year
25	Percentage of safe rural sanitation coverage	82	95	100	SP reports	1 year
26	Percentage of safe urban sanitation coverage	95	100	100	SP reports	1 year
27	Proportion of women aged 20–24 in early motherhood	24.8	17.4	10	UDHS	5 years
28	Persistence of undernourishment	16	10	0	UDHS	5 years

[17] SP- Sector Performance Reports

Policy and Capacity Indicators						
1	Existence of Multi-Stakeholder Platforms (MSP)	3	4	5	SUN MEAL reports	1 year
2	Existence of functional information systems for nutrition	-	-	-	SUN MEAL reports	1 year
3	Annual National budget spendinganalysis completeness	-	-	-	SUN MEAL reports	1 year
4	Annual Development Partner budget spendinganalysis completeness	-	-	-	SUN MEAL reports	1 year
5	Resource mobilization gap analysis completeness	-	-	-	SUN MEAL reports	1 year
6	Coherent implementation of the International Code of Marketing of Breast-milk Substitutes	-	-	-	SUN MEAL reports	1 year
7	Coherent implementation of the maternity act	-	-	-	SUN MEAL reports	1 year
8	Coherent implementation of the nutrition policy	-	-		SUN MEAL reports	1 year

6.2 Risks and Mitigation Measures

It is important that this UNAP is able to identify and manage risks that may affect its smooth implementation. The Risk and mitigation for the UNAP II has been summarized as shown in the table below, looking at the risk level and proposed mitigation measures.

Table 6: Risk Mitigation Plan for the UNAP II

Risk	Risk level	Risk Mitigation
Emphasis on delivering general sector mandates may compromise programming for delivery of nutrition sensitive outcomes	High	Align and use nutrition-sensitive indicators at all levels to ensure that programme activity implementation is nutrition-sensitive
Low institutional capacity to lead and manage the UNAP	High	Enhance the capacities of sectors to effectively lead, coordinate and manage implementation of the UNAP
Inadequate and low skilled human capacity especially at community level to deliver multi-sectoral nutrition services	High	Human resource development in multi-sectoral nutrition services delivery and allocate adequate number of skilled staff to implement the UNAP at all levels especially at sub county

Risk	Risk level	Risk Mitigation
		and parish level through the existing structures under the Local Governments
Inadequate funding of UNAP	Medium	Prioritize interventions and activities and develop a funding mobilization strategy.
Low commitment and collaboration by some key stakeholders	Medium	Provide and strengthen Multi-Sectoral Nutrition Platforms to ensure sector and development partner policy, strategies and plans on nutrition are in alignmentwith the UNAP
Political Will and Government Commitment fades	Low	Continue keeping nutrition high on the country's development agenda through holding regular Nutrition Forum at National, Regional and district level. Monitor and track inclusion of nutrition objectives in the political agenda (manifesto) of the Government
Occurrence of natural and man-made Disasters (e.g. Floods, drought, deforestation	Medium	Need to monitor all possible disasters closely and respond appropriately. Prioritize areas historically known to suffer from emergencies prepare emergency/disaster response plans
Climate change and environment deteriorates	Medium	Foster the adoption of sustainable farming practices (climate smart agriculture, water-scarce, etc.) that also contribute to the resilience of agro-ecosystems, and efficient water and energy management techniques.
Continued Influx of refugees	High	Monitor closely and adjust plan as appropriate. Embed the nutrition governance objective in refugee and disaster response plans

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Annex

Implementation Matrix

Intermediate Result	Priority Action	Lead sector	Other stakeholders
Strategic Objective 1. To increase access to and utilization of nutrition specific services among households of children under 5 years of age, Adolescents, women of reproductive age and other vulnerable groups[18]			
1.1 Improved maternal, infant, young child and adolescent nutrition practices	Promote infant and young child nutrition practices	MoH	DPs
	Promote community and health facility- based growth promotion and monitoring	MoH	MoLG, MGLSD, DPs
	Promote and support health and nutrition education to increase the level of awareness of good nutrition.	MoH	MoLG, MGLSD, DPs
	Promote integration of nutrition services in all routine and outreach health services and programmes targeting children and mothers.	MoH	DPs
	Manage nutrition for sick children, pregnant and lactating mothers, and other women of reproductive age.	MoH	DPs, MGLSD
	Integrate the management of severe and moderate acute malnutrition into routine health services.	MoH	DPs
	Promote utilization of antenatal and postnatal care services among all pregnant and lactating mothers to monitor child growth, the health and nutrition status of both the mother and the child.	MoH	DPs, MGLSD
	Promote and support breastfeeding policies, programmes and initiatives.	MoH	Parliament, DPs

[18] Priority actions drawn from, 2nd National Development plan (2015-2020); Sector Development plans (2015-2020); The Rome Declaration Framework of Actions (2014); Consultations with district and national stakeholders, The Ruling Government Manifesto 2016-2021 and Nutrition Development Partners Projects and Programmes

Intermediate Result	Priority Action	Lead sector	Other stakeholders
	Promote and support appropriate complementary feeding practices.	MoH	MGLSD, DPs
	Promote proper food handling, hygiene and sanitation through increased knowledge, use of safe water and hand washing practices at household level.	MoH	MoWE, MoES, MGLSD, DPs
1.2 Increased micronutrient intake in children and women	Vitamin A supplementation for children	MoH	MoES, DPs
	Promote deworming in Children	MoH	MoES, DPs
	Promote Iron folic acid supplementation for pregnant women	MoH	MGLSD, DPs
	Promote consumption of iodized salt	MoH	MoTIC, DPs
	Promote therapeutic zinc supplementation with ORS	MoH	DPs
	Promote consumption of iron fortified staple foods	MAAIF	MoH, MGLSD, DPs
	Promote consumption of home-based fortified foods	MAAIF	MoH, MGLSD, DPs
***1.3 Increased coverage* of management for acute malnutrition in stable and inemergence situations.**	Implement Integrated management of acute malnutrition targeting refugee children and women.	MoH	OPM, MoLG, DPs
	Implement Integrated management of acute malnutrition targeting children and women from refugee host communities and other areas in the country.	MoH	OPM, DPs
	Implement Integrated management of acute malnutrition targeting food insecure communities such as Karamoja	MAAIF	OPM, MoLG, DPs
1.4 Improved coverage ofnutrition services in disease	Integrate diet therapy into routine disease management	MoH	DPs

Intermediate Result	Priority Action	Lead sector	Other stakeholders
prevention, control and management of infectious	Promote actions that prevent and improve management of childhood diarrhea and gastro intestinal infestations for improved nutrition.	MoH	DPs
	Ensure universal access to and use of insecticide-treated mosquito nets	MoH	MGLSD, DPs
	Prevent and treat malaria for pregnant women and children and other age groups	MoH	DPs
	Promote and sustain universal coverage of available routine immunization services	MoH	MoLG, DPs
	Prevent and treat acute respiratory infections (ARIs) for children	MoH	DPs
	Prevent and treat childhood fevers	MoH	DPs
1.5 improved coverage of*Nutrition services in disease prevention, control and management of diet related non-communicable disease and communicable diseases*	Promote actions that prevent and improve management of nutrition-related non-communicable diseases	MoH	DPs
	Train Healthcare providers on diet and nutrition related Non-communicable diseases at all levels	MoH	DPs
	Sensitize communities on The Tips for a Healthy Life Style; Eating Healthy and exercising regularly	MoH	MGLSD, DPs
Strategic Objective 2: Increase availability and utilization of nutrition sensitive service by children under 5 years of age, adolescent girls, pregnant and lactating women, older persons and other vulnerable groups			
2.1 *Increased production, Increased access and*	Promote food safety interventions at different levels	MAAIF	MoTIC, MoH, DP's

Intermediate Result	Priority Action	Lead sector	Other stakeholders
consumption of diverse high nutrient value and safe foods	Scale up nutrition sensitive and climate smart agriculture projects that build resilience to climate change and other shocks to the food supply system.	MAAIF	DPs
	Strengthen local food production and processing, especially by smallholder	MAAIF	DP
	Promote indigenous food production and processing of diversified nutritious foods at household and community levels.	MAAIF	MoTIC, DP
	Promote the uptake and use of the adapted small-scale irrigation technologies/options	MAAIF	MoWE, DP
	Promote the diversification of crops including underutilized traditional crops, appropriate production of animal-source products as needed.	MAAIF	MoWE, DPs
	Promote production, accessibility and consumption of a variety of cereals, legumes, fruits, animal –source foods, including fish, meat eggs and dairy products	MAAIF	DPs
	Promote post-harvest handling and value addition technologies along the food value chain.	MAAIF	MoTIC, DPs
	Strengthen monitoring and surveillance for compliance to food control systems.	MAAIF	DPs
	Development of processing/packaging tools and equipment	MoTIC	MAAIF, DPs
	Improve storage, preservation, transport and distribution technologies and infrastructure to reduce seasonal food insecurity, food and nutrient loss and waste	MAAIF	MoW, DPs

Intermediate Result	Priority Action	Lead sector	Other stakeholders
2.2 Increased production and consumption of fortified foods	Promote production of bio-fortified foods.	MAAIF	DPs
	Generate foundation seed for bio-fortified crops.	MAAIF	DPs
	Increase awareness on the consumption of fortified foods.	MoH	MGLSD, DP's
	Promote micronutrient enhancement through industrial and bio-fortification	MoH	MoTIC, DP's
2.3 Improved coverage of nutrition Security services in Social protection programmes	Mainstream nutrition interventions into social protection programmes and into humanitarian assistance safety net programmes	MGLSD	OPM, DPs
	Develop and implement programmes for special social assistance and for livelihood promotion and protection in areas with high levels of malnutrition.	MGLSD	OPM, DPs
	Implement the school feeding and nutrition programme in humanitarian situations and refugee	MoES	OPM, DPs
	Promote social transfers to support livelihoods for the most vulnerable households and communities.	MGLSD	OPM, MoLG, DPs
	Promote energy saving technologies targeting women	MGLSD	MoTIC, DPs
	Mainstream nutrition in the youth livelihood programme implementation	MGLSD	MoLG, DPs
	Strengthen and scale up early warning systems on food and nutrition information from community to national levels.	MAAIF	OPM, DPs

Intermediate Result	Priority Action	Lead sector	Other stakeholders
2.4 Increased access to classroom education	Mobilize school going children to access nutrition education during Integrated Child Health Days.	MoES	DPs
	Mainstream nutrition education in key development programmes.	MoES	OPM, MGLSD, DPs
	Strengthen nutrition education in pre-primary, primary school, health and agriculture training institutions.	MoES	MoH, DPs
	Implement the parent led School feeding and Nutrition using sustainable school feeding models	MoES	OPM, DPs
	Link OWC to school garden projects	MoES	MAAIF, DPs
	Expand and improve provision of safe water supply and sanitation infrastructure to Schools within the mandate of the education sector	MoWE	MoES, DPs
2.5 improved coverage water, sanitation and hygiene (WASH) in Food and nutrition programmes	Promote access and utilization of safe water at household level.	MOWE	MoLG, DPs
	Scale up Community Led Total Sanitation (CLTS) practices	MoH	MoWE, DPs
	Increase access to improved Water and sanitation, food safety and hygiene	MoH	MoWE, DPs
	Increase access to safe water supply in rural and urban areas	MoWE,	DPs
2.6 Increased coverage of Integrated early childhood development and child protection	Promote early childhood care education	MGLSD	MoES, DPs
	Promote food security and nutrition for ECD	MGLSD	MoES, DPs
	Promote child protection services	MGLSD	OPM, DPs
	promote Primary Health care, WASH and environment hygiene for ECD	MoH	MoES, DPs
2.7 Increased participation of the business sector Trade and	Conduct a mapping exercise for the business community actors in food and nutrition	MoTIC	MAAIF, DP's

Intermediate Result	Priority Action	Lead sector	Other stakeholders
investment for improved nutrition	Develop and implement strategy for business community actor's participation in scaling up nutrition as per the SUN guidelines	MGLSD	OPM, DPs
	Strengthen the capacity of the business in agricultural inputs production, processing and marketing	MAAIF	MoTIC, DPs
	Support and facilitate VSLAs and SACCOs for improved access to incomes, food and nutrition	MAAIF	MoTIC, DPs
Objective 3: Strengthen the enabling environment for scaling up nutrition specific and nutrition sensitive interventions			
3.1 Functional nutrition governance at central and local government levels	Enhance capacities of nutrition coordination structures at local government to coordinate, plan, implement and monitor the implementation of UNAP-II	OPM	DPs
	Enhance capacities of nutrition coordination structures MDAs to coordinate, plan, implement and monitor the implementation of the nutrition Policy and UNAP-II	OPM	DPs
	Support the implementation of the nutrition advocacy and communication strategy for UNAP II at national and local government level	OPM	MoLG, DPs
	Implement the National Family Policy to promote the rights of the family members and foster nutrition and wealth creation	OPM	DPs

Intermediate Result	Priority Action	Lead sector	Other stakeholders
	Mainstream nutrition in the Uganda women empowerment programme implementation	MGLSD	OPM, DPs
	Implement the 2015 nutrition behavioral change communication and advocacy (BCCA) strategy	OPM	MoLG, DPs
3.2 Improved Decision-making based on evidence generated from Nutrition research	Create capacity within national institutions to operate and maintain a National Information Platform for Food and Nutrition;	OPM	DPs
	Strengthen capacity to track progress in meeting UNAP-II objectives to prevent malnutrition and monitor nutrition investments;	OPM	DPs
	Build the capacity of national policy makers, nutrition programme planners and implementers to make better use of evidence in designing and implementing nutrition-related policies, programmes and projects	OPM	DPs
	Establish the academic and research institutions network for scaling nutrition research in the country	OPM	MoES, DPs
	Establish and implement systems for mobilizing and tracking finances for nutrition in the public, private and civil society sectors	OPM	DPs
	Design and implement a monitoring, evaluation, reporting and learning plan for UNAP-II	OPM	DPs