KCCA
KAMPALA CAPITAL CITY AUTHORITY
For a better City

Kampala Capital City-Nutrition Action Plan (KCC-NAP) 2023/2024-2029/2030

Nutrition and Sustainable Development Goals

Kampala Capital City-Nutrition Action Plan (KCC-NAP) 2023/2024-2029/2030

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Vision, Mission & Goal of The KCC-NAP

KCC - NAP Vision

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

KCC - NAP Theme

'Leaving no-one behind in scaling up nutrition actions in Kampala City.

KCC - Nutrition Action Plan' Goal

'Improve nutritional wellbeing for children under five years, adolescents (both in and out of school), pregnant and lactating women, people living in formal and informal settlements and other vulnerable populations by 2030 in Kampala City.'

Kampala Capital City Nutrition Action Plan' (KCC-NAP) programming is based in KCCA's Five Divisions and their respective parishes as per the map below.

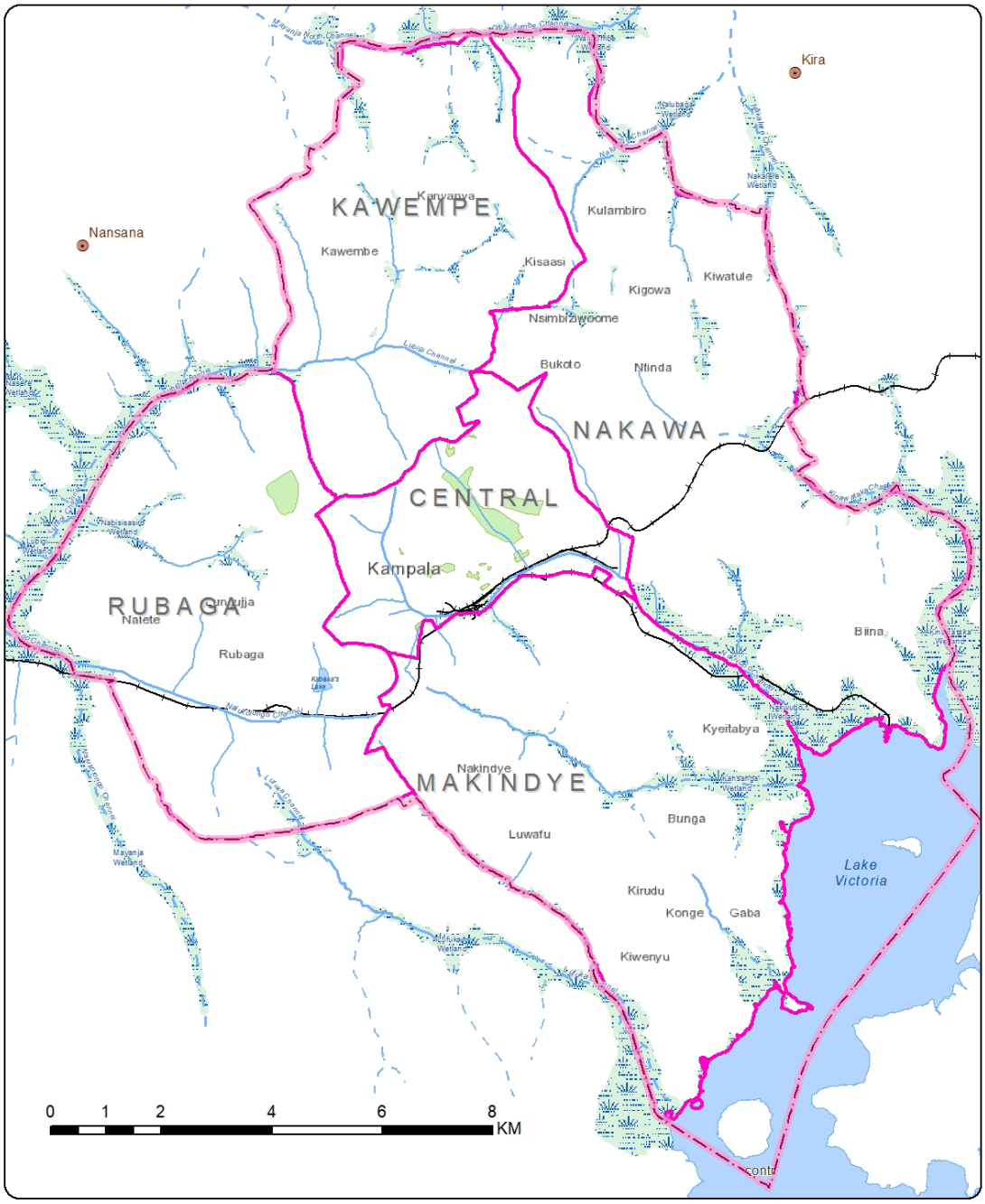

Figure i-1: Map of Kampala by Divisions

Acknowledgement

The Kampala Capital City-Nutrition Action Plan (KCC-NAP) has been collaboratively developed through an inclusive and participatory process. This process involved extensive stakeholder consultations, including KCCA leadership, staff, and key partners. The KCCA team expresses gratitude for the valuable contributions of both Government and Non-Government stakeholders in shaping this 7-year Nutrition Action Plan. This strategic initiative aims to lead the Capital City progressively and feasibly towards becoming free from malnutrition. KCCA extends appreciation to the following:

1. The Office of the Prime Minister team for their strategic guidance and oversight during the development of the Nutrition Action Plan.
2. The Senior Management Team, chaired by KCCA Executive Director, Mrs. Dorothy Kisaka, and heads of various directorates.
3. The KCCA Nutrition Coordination Committee, led by Director Public Health and Environment, Dr. Daniel Ayen Okello, along with Dr. Sarah Zalwango, Martha Nakyagaba Mutumba, Dr. Christopher Oundo, Jude Kirembwe Tadeo, Micheal Kirya, and Alice Busingye, for their dedicated efforts in formulating the plan.
4. The KCCA Strategy Management team, led by Deputy Director Strategy Management and Business Development, Mr. William Epiaka and Robert L. Kyukyu, with Alex Ssebagala and Marvin Mayanja.

KCCA extends special acknowledgment to USAID's Maternal Child Health and Nutrition activity (MCHN), implemented by Family Health International (FHI 360) for their technical and financial support. Technical support was provided by consultants; Mr. Asiimwe Charles, Mr. Andrew Musoke, and Mr. Joab Tusaasire, who played a crucial role in the development of this significant plan.

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OFFICE OF THE
PRIME MINISTER

fhi360

Minister's Foreword

Malnutrition is a significant City concern with far-reaching implications for health, economic development, and social well-being. It imposes a significant economic burden on individuals, families, communities, and societies. The costs associated with healthcare, lost productivity, and reduced economic growth due to malnutrition-related illnesses are substantial. Addressing malnutrition is crucial for promoting economic development and reducing poverty.

The Government of Uganda acknowledges the relevance of addressing malnutrition and this is evidenced in the country's laws, policies, and guidelines. These include the National Food and Nutrition Policy, Uganda Nutrition Action Plan, Food and Drug Act and others. Article 8 of the Constitution of Uganda recognizes the right of all Ugandans to the highest attainable standard of health. This includes access to health care services, facilities, and programs aimed at promoting health thus ensuring access to adequate nutrition is essential for realizing the right to health. The Constitution also recognizes various social and economic rights that are relevant to nutrition, including the right to food security, shelter, and social security. Article 20 of the Constitution of Uganda provides for the protection of these rights and obligates the state to take affirmative action to fulfill them, particularly for vulnerable groups such as children, women, and the elderly. Addressing the needs of these vulnerable groups is essential for achieving meaningful progress in tackling malnutrition in Kampala City.

It's crucial to acknowledge that the implementation and enforcement of these laws and policies may differ from one region to another. KCCA has chosen to be intentional in addressing the nutritional challenges in Kampala City. To this effect, the KCC Nutrition Action Plan has been developed. Through this action plan, nutritional challenges in Kampala will be addressed wholesomely.

It remains imperative that we maintain our collaborative efforts to ensure that all relevant stakeholders are fully engaged and aligned on this important initiative.

On behalf of Kampala Capital City Authority, I present to you the Kampala Capital City-Nutrition Action Plan (KCC-NAP) 2023/22024 – 2029/2030.

Minsa Kabanda

Hajjat Minsa Kabanda
Minister for Kampala Capital City &
Metropolitan Affairs

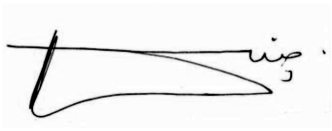
Message from His Worship the Lord Mayor

Numerous global commitments and initiatives exist to address malnutrition, including the Scaling Up Nutrition (SUN) Movement, the Global Nutrition Report, and various Regional and National nutrition plans and strategies. The International community has also set global targets to address malnutrition, including those outlined in the Sustainable Development Goals (SDGs), particularly SDG 2 (Zero Hunger) and SDG 3 (Good Health and Well-being). These targets aim to end hunger, achieve food security, improve nutrition, and promote sustainable agriculture by 2030. Kampala City now joins the fight against malnutrition through the Kampala Capital City-Nutrition Action Plan (KCC-NAP).

The population of Kampala is characterized by its diversity, dynamism, and resilience, with people from various backgrounds contributing to the city's social, cultural, and economic fabric. Understanding the different groups within Kampala is essential for addressing the city's unique challenges and promoting inclusive strategies. The Kampala Capital City-Nutrition Action Plan (KCC-NAP) has been developed with every Kampala dweller in mind because every life in Kampala matters. Together, we have the opportunity and responsibility to build a healthier, more prosperous future for Kampala. By prioritizing nutrition and investing in the well-being of our people, we can create a city where every resident can thrive and fulfill their potential.

We recognize that addressing malnutrition requires a multi-sectoral approach and collective effort, targeting both immediate and underlying determinants of malnutrition. The approaches in the KCC-NAP will focus on improving access to nutritious foods, promoting healthy eating behaviors, enhancing healthcare services, and addressing socioeconomic inequalities. We have prepared the Kampala Capital City-Nutrition Action Plan (KCC-NAP) as the footing for addressing the nutritional challenges in Kampala comprehensively.

As the Lord Mayor, I hereby affirm our unwavering dedication to addressing this critical issue through the Kampala Capital City-Nutrition Action Plan (KCC-NAP) 2023/2024 – 2029/2030. I pledge to fast track the implementation of this Action Plan that will have a transformative effect on the lives of the Kampala citizens.



Erias Lukwago
His Worship the Lord Mayor
Kampala Capital City

Message from the Executive Director

The pursuit of the Smart City vision is a transformative initiative aimed at making Kampala City more vibrant, inclusive, safe, sustainable, and resilient by leveraging on the three pillars of Technology for service delivery, Infrastructure improvement and People well-being (TIP). **The KCC Nutrition Action Plan** (KCC-NAP) seamlessly aligns with these key pillars of our smart city agenda.

At KCCA, we acknowledge the significant impact that proper nutrition can have on public health. Whether dealing with undernutrition or overnutrition, malnutrition can lead to various health issues. Our focus on nutrition is driven by the goal of cultivating a healthier and more resilient population. Urban living fundamentally changes how people eat, as they are more reliant on paid employment and are more limited in the ability to grow their own food. This shift towards more urban living is seeing big changes in food environments for most people, thus affecting food availability, affordability, and access. When considering maternal and child health, the importance of adequate nutrition during pregnancy and early childhood cannot be overstated. This emphasis on nutrition lays the groundwork for the healthy development of our children, breaking the cycle of intergenerational malnutrition and contributing to a healthier future for Kampala.

By investing in nutrition, we are, in essence, investing in the economic prosperity of Kampala. Our dedication to nutrition is not just a local initiative, it aligns with the priorities established by the government of Uganda.

In July 2019, the Government launched the "**Presidential Initiative on Healthy Eating and Lifestyle**" which calls for: (**i**) Promotion of healthy eating and lifestyle practices in households and communities (**ii**) Raising public awareness about malnutrition and its consequences and (**iii**) Advocating for engagement and involvement of public and private sectors, civil society, and other stakeholders in promoting healthy diets and lifestyles. As a city, it is imperative that we actively engage in national and international goals related to health and development, while prioritizing nutrition which serves as a critical step in this collective direction. This commitment is an integral part of our broader vision "**To be a vibrant, attractive and sustainable City**."

I therefore, call upon fellow leaders; The City Authority Executive, Senior Management, Technical Planning Committee, the Council, development partners, the business community, the media, cultural and religious leaders, plus the entire Kampala citizenry to embrace the KCC-NAP. Let us all mobilize resources and align our actions towards its effective implementation.

Together, we are building a Smart City.

Dorothy Kisaka
Executive Director
Kampala Capital City Authority

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Acronyms

ALN	African Leaders for Nutrition Initiative
AMIS	Agricultural Market Information System
ARIN	Academia and Research Institutions Network
ARNS	Africa Regional Nutrition Strategy
AU	African Union
BMI	Body mass index
CESCR	Committee on Economic, Social and Cultural Rights
CFS	Committee for World Food Security
COHA	Cost of hunger in Africa
COVID-19	Coronavirus disease
CBO	Community-based organization
CDO	Community development officer
CSOs	Civil society organizations
DD	Dietary diversity
DPs	Development partners
DRNCDs	Diet-related non-communicable diseases
EAC	East Africa Community
EAPA FSN	Eastern African Parliamentary Alliance for Food Security and Nutrition
ECD	Early childhood development
FAL	Functional adult literacy
FAO	Food and Agriculture Organization
FEWSNET	Famine Early Warning Systems Network
GBV	Gender-based violence
GHI	Global Hunger Index
GDP	Gross domestic product
GLOPAN	Global Panel on Agriculture and Food Systems for Nutrition
GNR	Global Nutrition Report
HCDP	Human Capital Development Program
HMIS	Health Management Information System
ICN	International Conference on Nutrition
ICSCN	Implementation Coordination Steering Committee on Nutrition
IECD	Integrated early childhood development
ITN	Insecticide-treated net
KCCA	Kampala Capital City Authority
KCC-NCC	Kampala Capital City Nutrition Coordination Committee
LBW	Low birth weight
LF	Lead farmer

LLG	Lower local government
LGs	Local governments
M&E	Monitoring and evaluation
MAAIF	Ministry of Agriculture, Animal Industry and Fisheries
MAD	Minimum acceptable diet
MDAs	Ministries, departments, and agencies
MDA NCC	Ministries, department, and agencies Nutrition Coordination Committee
MDD	Minimum diet diversity
MDNCC	Municipal Division Nutrition Coordination Committee
MEAL	Monitoring, evaluation, accountability, and learning
MIYCAN	Maternal, infant, young child, and adolescent nutrition
MNCC	Municipality Nutrition Coordination Committee
MoES	Ministry of Education and Sports
MoFPED	Ministry of Finance, Planning and Economic Development
MoGLSD	Ministry of Gender, Labor, and Social Development
MoH	Ministry of Health
MoLG	Ministry of Local Government
MoPS	Ministry of Public Service
MoSTI	Ministry of Science, Technology, and Innovation
MoTIC	Ministry of Trade Industry and Cooperatives
MoWE	Ministry of Water and Environment
MSMEs	Micro, small, and medium enterprises
MSNTCC	Multi-Sectoral Nutrition Technical Coordination Committee
MTEF	Mid-Term Expenditure Framework
N4G	Nutrition for growth
NCC	Nutrition Coordination Committee
NCD	Non-communicable diseases
NDP III	National Development Plan (Third)
NDPG	Nutrition Development Partner Group
NEPAD	New Partnership for Africa's Development
NGO	Non-governmental organization
NIPN	National Information Platform for Nutrition
NNF	National Nutrition Forum
NNP	National Nutrition Policy
NPA	National Planning Authority
NRM	National Resistance Movement
OPM	Office of the Prime Minister
ORS	Oral rehydration salts
ORT	Oral rehydration therapy
PCC	Policy Coordination Committee
PCCN	Policy Coordination Committee on Nutrition
PDC	Parish Development Committee

PG	Parental group
PIAP	Program implementation action plan
P/WNCC	Parish/Ward Nutrition Coordination Committee
RCNCC	Regional City Nutrition Coordination Committee
RCNFP	Regional City Nutrition Focal Person
RDI	Required dietary intake
RHF	Recommended homemade fluids
RI	Regional initiative
SBCC	Social behaviour change communication
SBN	SUN Business Network
SCI	Strategic coordination and implementation
SDG	Sustainable Development Goal
SDPs	Sector development plan
SNCC	Sub county Nutrition Coordination Committee
SOFA	State of food and agriculture
SUN	Scaling Up Nutrition
TBD	To Be Determined
TNCC	Town Council Nutrition Coordination Committee
TPC	Technical Planning Committees
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UGX	Uganda Shilling
UNAP I	Uganda Nutrition Action Plan (First)
UNAP II	Uganda Nutrition Action Plan (Second)
UNECA	United Nations Economic Commission for Africa
UNICEF	United Nations Children's Fund
UNPS	Uganda National Planning Survey
UNSCN	United Nations System Standing Committee on Nutrition
UNREACH	United Nations Renewed Efforts Against Child Hunger and under nutrition
UWEP	Uganda Women Entrepreneurship Program
USAID	United States Agency for International Development
VIP	Ventilated improved pit (latrines)
WASH	Water, sanitation, and hygiene
WFP	World Food Program
WHA	World Health Assembly
WHO	World Health Organization
WNCC	Ward Nutrition Coordination Committee

Executive Summary

This KCC Nutrition Action Plan (KCC-NAP) will guide Kampala Capital City Authority in delivering the nutrition related aspirations articulated in Uganda's Vision 2040, the third National Development Plan (2020/21-2024/25) and KCC–Strategic Plan 2020/21-2024/25. The 'KCC-NAP' presents an inroad into enhancing the nutritional wellbeing of Kampala people. The health, safety, and well-being of all the people of Kampala City remain a responsibility and top priority of the Kampala Capital City Authority. The KCC-NAP alongside other Authority projects and programs, will spur on the Authority`s commitment toward a city that is free of all forms of malnutrition. Considering this, the 'KCC-NAP' defines the strategic direction for the authority and sets strategic objectives, strategies, priority actions and targets to achieve optimum nutrition for all people in Kampala in a sustainable manner that is essential for a healthy and productive life.

Highlights of KCC-NAP vision, goal, and objectives

The vision of the KCC-NAP is: 'A well-nourished, healthy, and productive population effectively participating in the socio-economic transformation of Kampala City.' The goal is: 'Improved nutritional wellbeing for children under five years, adolescents (both in and out of school), pregnant and lactating women, people living in formal and informal settlements and other vulnerable populations and other vulnerable populations by 2030 in Kampala City.' The three strategic objectives are:

1. To increase access to and utilization of nutrition-specific services by children under five years, adolescents (both in and out of school), pregnant and lactating women, people living in formal and informal settlements and other vulnerable populations and other vulnerable populations.
2. To increase access to and utilization of nutrition-sensitive services by children under five years, adolescents (both in and out of school), pregnant and lactating women, people living in formal and informal settlements and other vulnerable populations and other vulnerable populations.
3. To strengthen the enabling environment for scaling up nutrition-specific and nutrition-sensitive services.

Several significant nutrition challenges within Kampala were highlighted in the Uganda Demographic and Health Survey (2022), including the following:

- Child stunting at 16.5 per cent.
- % of children aged 6-23 months fed on a Minimum Acceptable Diet reduced from 15.7 to 9.7. 32.2% of children receive a prelacteal feed.
- % of children aged 6-23 months fed on a Minimum Dietary Diversity decreased from 39.0 to 13.2
- The status of overweight in children under five years of age increased from 3.9 per cent to 6.3 per cent.
- The status of overweight among adult women increased from 26.5 per cent to 30.6 per cent, while adult obesity amongst women increased from 17.1 per cent to 19.2 per cent.
- Overweight among men increased from 16.3 per cent to 17.2 per cent, while adult obesity amongst men was registered at 3.27 per cent.

The Kampala comprehensive food security and vulnerability analysis (CFSVA) report, 2019 stated that Prevalence of acute malnutrition(wasting) in Kampala was at 2% while stunting was at 18%.

50% of all children aged 6-59 months in Kampala are anemic. (CFSVA), 2019).

The Kampala comprehensive food security and vulnerability analysis (CFSVA) report, 2019 also stated that the Kampala City population is unable to grow their own food. Only 11% of households engaged in urban farming. Urban households, therefore, rely heavily on markets as their primary source of food. This renders them vulnerable due to unstable incomes and fluctuating market prices.

There is also a high prevalence of overweight and obesity among non-pregnant women of reproductive age in Kampala (49%) mostly in formal settlements. (CFSVA), 2019). If not addressed, the increasing burden of overweight and obesity will contribute to elevated health risks and health care expenditures.

Inadequate integration of nutrition services in Social Protection, Gender-Based Violence programs; Early Childhood Development (IECD) services, and quality education and sports; Water Sanitation and Hygiene (WASH) services and Trade, Industry, and Investments

The following strategies in alignment with the Uganda Nutrition Action Plan will be employed to deliver the results.

The following five strategies will be implemented to realize **objective one**:

To increase access to and utilization of nutrition-specific services by children under five years, adolescents (both in and out of school), pregnant and lactating women, people living in formal and informal settlements and other vulnerable populations.

Strategy 1.1: Promote optimal maternal, infant, young child, and adolescent nutrition (MIYCAN) practices in formal and informal settlements within Kampala City.

- **Strategy 1.2:** Promote optimal micronutrient intake among children, adolescent girls, and women of reproductive age in formal and informal settlements within Kampala City.
- **Strategy 1.3:** Increase coverage of the management of acute malnutrition at health facility and community level within Kampala City.
- **Strategy 1.4:** Integrate nutrition services in the prevention, control and management of infectious diseases and epidemics.
- **Strategy 1.5:** Integrate nutrition services in the prevention, control, and management of diet-related non-communicable diseases.

The following seven strategies will be implemented to realize **objective two**:

To increase access to and utilization of nutrition-sensitive services by children under five years, adolescents (both in and out of school), pregnant and lactating women, people living in formal and informal settlements and other vulnerable populations

- **Strategy 2.1:** Increase the production of diverse, safe, and nutrient-dense food at the household level from plant, fisheries, and animal sources.
- **Strategy 2.2:** Increase access to diverse, safe, and nutrient-dense food from plant, fisheries, and animal sources.
- **Strategy 2.3:** Increase the utilization of diverse, safe, and nutrient-dense food from plant, fisheries, and animal sources.
- **Strategy 2.4:** Promote the integration of nutrition services in social protection programs.
- **Strategy 2.5:** Promote access to nutrition services through integrated early childhood development (ECD) services and quality education and sports.
- **Strategy 2.6:** Increase access to nutrition-sensitive water, sanitation, and hygiene (WASH) services.
- **Strategy 2.7:** Increase the participation of trade, industry, and investment actors in scaling up nutrition.

The following six strategies will be implemented to realize **objective three**:

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

- **Strategy 3.1:** Strengthen nutrition coordination and partnerships at all levels.
- **Strategy 3.2:** Improve the planning, resource mobilization, financing and tracking of nutrition investments.
- **Strategy 3.3:** Strengthen institutional and technical capacity for scaling up nutrition actions.
- **Strategy 3.4:** Strengthen nutrition advocacy, communication, and social mobilization for nutrition.
- **Strategy 3.5:** Strengthen coherent policy, legal and institutional frameworks for nutrition.
- **Strategy 3.6:** Strengthen and institutionalize nutrition evidence and knowledge management along with a multi-sectoral nutrition information system for effective decision making.

Implementation and coordination modalities

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

1. The KCCA Nutrition Forum (KCCA -NNF).
2. KCCA- Nutrition Coordination Committee
3. City division NCCs,
4. Ward NCCs

Total financing requirements

The seven-year 'KCC-NAP total cost is **131**bn **Uganda Shillings (UGX)**. Financing will be collaboration between the Government of Uganda, development partners, the private sector, communities, CSOs and households. Adequate financing is a crucial prerequisite for successfully implementing priority actions and achieving KCC-NAP' goals.

Key expected primary outcomes.

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

1. Reduced prevalence of under nutrition

The expected primary targets on under nutrition are:

1. Reduced prevalence of stunting in children aged 0-5 years from 18.1 per cent to 14.1 per cent.
2. Reduced prevalence of low birth weight (<2500 g) from 6.2 per cent to 4 per cent.
3. Reduced prevalence of wasting in children aged 0-5 years from 4.4 per cent to 3.9 per cent.
4. Reduced prevalence of anemia in children aged 0-5 years from 50.9 per cent to 39 per cent.
5. Reduced prevalence of anemia in women of reproductive age from 25per cent to 19.6 per cent.

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

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

- Reduced prevalence of overweight in children aged 0-5 years from 5 per cent to 4 per cent.
- Reduced proportion of overweight adult women aged 18+ years from 19 per cent to 11 per cent.
- Reduced proportion of overweight adult men aged 18+ years from 14 per cent to 9 per cent.
- Reduced proportion of obesity in adult women aged 18+ years from 27.4 per cent to 26.5 per cent.
- Reduced proportion of obesity in adult men aged 18+ years from 16.3per cent to 10.1 per cent.
- Reduced proportion of overweight in adolescents from 10 per cent to 6 per cent.
- Proportion of obesity in adolescent girls maintained at 1 per cent.
- Reduced age-standardized prevalence of raised blood glucose/diabetes among persons aged 18+ years from 3.3 per cent to 2.1 per cent.
- Reduced age-standardized prevalence of raised blood pressure among persons aged 18+ years from 24 per cent to 20 per cent.

Chapters

1 Introduction

1.1 Kampala Capital City Authority (KCCA)'s relevance to nutrition programming

KCCA is the governing body of the Capital City and was established to administer the Capital City on behalf of the central government. KCCA is the legal entity, established by an Act of Parliament as provided in the KCC Act 2010 Part III, Clause 5. It became operational in April 2011 replacing the Kampala City Council (KCC). In 2011, the affairs of Kampala were brought under the direct supervision of the central government through the Ministry for Kampala Capital City and Metropolitan Affairs. KCCA has the Political wing and the technical wing and in accordance with the KCC Act of 2010 as amended, the council is the governing body of the Authority.

Kampala was established as a municipality in 1947 and became Uganda's Capital City at independence in 1962. Kampala is said to have originally been built on seven hills: Kasubi, Mengo, Kibuli, Namirembe, Rubaga, Nakasero, Nsambya, and Kampala (also known as Old Kampala) Over the years, the city limits were substantially expanded to include Namirembe, Naakulabye, Bwaise, Kawempe, Kikaaya, Mpererwe, Kisaasi, Najjanankumbi, Nakawa, Kyambogo, Nagulu, Bugoloobi, Mbuya, Luzira, Port Bell and Butabika. Kampala has since grown to become the largest urban center and the capital City of Uganda. It is Uganda's political seat, the country's economic hub accounting for 80 percent of the country's industrial and commercial activities; and generates 65 percent of national GDP. The city is currently divided into five urban divisions namely: Central, Kawempe, Makindye, Rubaga and Nakawa, which cover a total of 189 square kms; with 169 square kms of land and 19 square kms of water. Uganda is one of the least urbanized countries in Africa but has one of the fastest urbanizing rates at 5.2%, and hence Kampala is the 13th fastest growing city in the world (2015, ranked the best city to live in East Africa (KCC Strategic Plan 2020/21 –2024/25).
The city is divided into five urban divisions namely, Kampala Central, Kawempe, Makindye, Nakawa, and Rubaga. Kampala has a total of 99 parishes and 857 villages.

Table 1-1: Administrative statistics of KCCA

	Central	Kawempe	Rubaga	Makindye	Nakawa	Total
Constituencies	1	2	2	2	2	9
Parishes/ Wards	20	22	13	21	23	99
Villages/zones	135	119	133	241	229	857

Source: (KCC Strategic Plan 2020/21 –2024/25).

1.2 Why Invest in Nutrition

Good nutrition is a catalyst for social and economic transformation; human development and wellbeing; buffer against infectious diseases and epidemics including COVID 19.

1. The total losses in productivity attributed to childhood malnutrition was estimated at approximately UGX 1.2 trillion which was equivalent to 3.91% of Uganda's GDP. COHA 2013.
2. Without improvement in nutrition, Uganda's Vision 2040 goal of a prosperous and modern Ugandan society cannot be achieved.
3. Nutrition is a catalyst towards Vision 2040, Agenda 2063, 2030 Agenda and SDGs.
4. Government loses revenue worth 1.8tn (equivalent to 5.6% of the GDP) COHA 2013 due to child malnutrition.
5. Nutrition is core to the achievement of the human capital development program of the NDPIII.

Evidence shows that investing in nutrition in young children can:

1. Boost gross national product by 11% in Africa and Asia.
2. Prevent child deaths by more than one third per year.
3. Improve school attainment by at least one year.
4. Increase wages by 5-50%.
5. Reduce poverty as well-nourished children are 33% more likely to escape poverty as adults.
6. Empower women to be 10% more likely to run their own business.
7. Break the inter-generational cycle of poverty.

Because when:

1. Girls & women are well-nourished and have healthy newborn babies,
2. Children receive proper nutrition and develop strong bodies & minds,
3. Adolescents learn better & achieve higher grades in school,
4. Young adults are better able to find work & earn more,
5. Families & communities emerge out of poverty,
6. Communities are productive & stable,
7. The world is a safe, more resilient & stronger place.

1.3 Global, continental, and national frameworks that guided the formulation of KCC-NAP

1.3.1 Global nutrition commitments and initiatives

The 'KCC-NAP' has been designed with a global outlook. The critical international nutrition declarations, commitments and initiatives informing it include: the Lancet Series on Maternal Child and Nutrition, 2013; Scaling up Nutrition (SUN) Movement, 2010; The 1,000 Days Initiative, 2010; The United Nations General Assembly on Non-Communicable Diseases, 2011; New Alliance for Food Security and Nutrition for sustained agriculture led growth in Africa and Asia launched in G8 Summit, 2012; The World Health Assembly Resolution, 2012; Nutrition for Growth Summit, 2013; Committee for World Food Security and Nutrition (CFS, 2013); The Global Panel on Agriculture and Food Systems for Nutrition (GLOPAN) (2013); Global Nutrition Reports; the 2nd International Conference on Nutrition (ICN2) (2015) Rome Declaration and Framework for Nutrition; Sustainable Development Goals (2015) and the UN Decade of Action on Nutrition (2016-2025).

1.3.2 Continental and regional frameworks context

The 'KCCA UNAP' has also been designed with a continental and regional outlook. The key regional and continental nutrition declarations, commitments and initiatives informing the plan include: African Union (AU) Agenda, 2063; Maputo Declaration, 2003; Grow Africa Initiative (AU & NEPAD) (2011); Malabo Declaration, 2014; Malabo Declaration on Nutrition, 2015; Africa Regional Nutrition Strategy (ARNS) (2015-2025); FAO Regional Initiative (RI) on Africa's Commitment to End Hunger by 2025; East and Southern Africa Regional Civil Society Nutrition Network, 2017; African Leaders for Nutrition Initiative (ALN), 2018; African Development Bank's Multi-sectoral Nutrition Action Plan (2018-2025); East Africa Community (EAC) Food and Nutrition Security Strategy (2018-2022); EAC Food and Nutrition Security Action Plan (2018-2023) and the Eastern African Parliamentary Alliance for Food Security and Nutrition (EAPA FSN), 2019.

1.3.3 National legal, policy and planning frameworks context

The 'KCCA UNAP' has been designed with a legal, policy and planning frameworks outlook. Nationally, the Constitution of the Republic of Uganda (1995) recognizes the right to food. Objective XXII of the Constitution requires the State to take appropriate steps to encourage people to grow and store adequate food. It also requires the State to establish national food reserves and to promote proper nutrition through mass education and other means to build a healthy state. In addition, the government has several sector policies and legal frameworks that guide the scaling up of nutrition. These include The Education Act (2008); **KCC Act 2010:** Supervising and monitoring delivery of services to the population within the city, including provision of public health services, environment protection and other services provided by law. National Trade Policy 2007: Second National Health Policy 2010: The National Community Development Policy for Uganda 2015; The National Extension Policy (2016); The National Integrated Early Childhood Development Policy (2016); The Social Protection Policy (2015); National Integrated Early Childhood Development Policy (2016): The Uganda Vision 2040 and Third National Development Plan (NDP III) and the Second Uganda Nutrition Action Plan 2020-2025.

1.3.4 The KCC Strategic Plan 2020/21-2024/25: The Strategic Plan provides four Themes and 33 key Sub Programs that indicate the strategic direction for the city. The Sub Programs are transformational, and their achievement will change the way in which the city functions to make Kampala more inclusive, safe, sustainable, efficient, and resilient – and ultimately, a better place to live, work and play. As such, the sub programs will drive the external and internal (organizational) structural and transformational changes required for the city to realise its vision. Considerable thought and care went into formulating, obtaining inputs for, and finally approving this Strategic Plan. Now, the focus shifts from conceptualization to implementation. This will require us to translate and apply the strategic intent of the Plan into everything that we do to achieve and secure the great possibilities that Kampala Capital City's future holds. Under the theme social Development and Protection/quality of life. It highlights that good Quality of life is dependent on several factors, including where people live, the quality of air they breathe, access to affordable and high-quality food, access to quality medical care and means to meet basic needs.

1.4 Contextual challenges

The number of people living in urban environments is growing at a rapid rate. For Kampala Capital City in particular, **it has a night population of 1,650,800 and a day population estimated at 4.0 million.** Urban living fundamentally changes how people eat, as they are more reliant on needing paid employment and are more limited with growing their own food. This shift towards more urban living also leads to big changes in food environments for most people, and what food is available, affordable, and accessible to them. This is contributing to fast shifting patterns of nutrition status among and between different income groups. Altogether, urban areas pose unique challenges and opportunities around diets and nutrition.

Due to urbanisation, the urban food environment has much to offer: Kampala city is a home to a large variety of formal and informal food outlets such as kiosks, retail stores, daily markets, supermarkets, informal food vendors, (fast food) restaurants, and street food vendors. There are fewer options to grow food in the city.

Therefore, city residents are more reliant on purchasing their food from different retail points and supermarkets. Compared to rural inhabitants, urban dwellers are more exposed to marketing and advertising, as well as to unhealthy foods. As they often have limited access to cooking facilities and little time to prepare meals, they consume more processed and convenience foods, street food and fast food. With urbanisation and rising incomes, diets are changing too. Traditional tend to be rich in unprocessed or minimally processed cereals (maize, rice, wheat), starchy staples (potato, cassava, plantain), and fibre. But changing dietary patterns include much higher shares of sugar, fats, and animal-source foods. These dietary changes are referred to as the nutrition transition. When combined with increasingly sedentary lifestyles (e.g. as technology displaces manual labour or physical play) as well as demographic and epidemiological changes, this contributes to nutritional impacts such as overweight, obesity and other non-communicable diseases.

Fresh vegetables, fruits and animal source foods tend to be more expensive than highly processed and convenience foods. Eating a healthy, nutritious, and safe diet can therefore be challenging, in the city. Household resources for food of low-income families are often small, making them more vulnerable to price fluctuations. Families cannot always afford fresh produce and micronutrient-dense food and instead purchase foods high in energy, fat, and sugar. The costs of the healthy and sustain-able diet most of the time exceeded the total income of the poorest in the city as own production is limited in urban areas, purchasing food is often the only option. Accompanied with a more sedentary lifestyle, these consumption patterns can increase the risk of overweight and obesity which are linked to non-communicable diseases such as cardiovascular diseases and diabetes.

When a healthy diet is not affordable, this may lead to malnutrition and related ill-health. Urban areas can result in higher income levels, but also higher levels of inequality. Slum dwellers are confronted with severe environmental and health issues including pollution, open sewage, and poor solid waste management. Use of dirty water and limited sanitation, cooking and (cold) storage facilities raise issues of food safety and hygiene concerns. This increases the risk for food-borne diseases, such as diarrhoea. Kampala Capital City Act (KCC Act) (2023/24-2029/30) outlines strategies to address nutrition needs of all population groups in Kampala City with a special focus on children under 5 years, school age children, adolescents, pregnant and lactating women, and other vulnerable groups by 2030.

There are also governance issues that affect the implementation of nutrition interventions in KCCA.

KCCA staff have not been oriented or sensitized on UNAP II strategies although multiple UNAP II strategies and priority actions are being implemented as part of the integrated actions under the KCC strategic plan. UNAP II strategies implemented in KCCA include those in the health sector, WASH, gender, and community service, and select actions in education. Private sector engagement is key, to removing economic barriers to affordable quality services, strengthening planning and coordination and increased access to services.

1.5 Opportunities to harness.

The KCCA is composed of 10 directorates plus the Office of the Executive Director. Directorates of Public Health and Environment, Education and Social Services, and **Gender Community services and Production** are already implementing nutrition actions as integrated actions under the KCC strategic plan. Already ongoing nutrition interventions are: Promote optimal Maternal, Infant, Young Child and Adolescent Nutrition (MIYCAN) practices in formal and informal settlements; Promote micronutrient intake among children, adolescent girls and women of reproductive age in formal and informal settlements, Increase coverage of integrated management of acute malnutrition at health facility and community level; Integrate nutrition services in prevention, control and management of infectious diseases; Promote access to nutrition sensitive WASH services; Promote integration of nutrition services in social protection and Sexual and Gender Based Violence (SGBV) programs

It should be noted; however, that the implementation is not systematic and not aligned to any set targets but to targets of the parent governing directorate. UNAP II strategies implemented heavily in KCCA are mostly those for health sector, WASH, gender, and community service, and select actions in education. The 'KCC-NAP' presents an opportunity to:

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

Food systems constitute the entire range of actors across the food chain from: production, aggregation, processing, distribution, and consumption of food originating from agriculture, forestry, livestock and fisheries activities and inputs. To build a sustainable food system there is need to 1) Ensure access to safe and nutritious food for all, 2) Shift to sustainable consumption patterns, 3) Boost nature-positive production, 4): Advance equitable livelihoods, 4) and (5) Build resilience to vulnerabilities, shocks, and stress. All these have been incorporated in the strategic direction of this action plan. 6) Access to safe water and sanitation is an absolute prerequisite for nutrition

1.6 Application of the KCC-NAP

The KCC Nutrition Action Plan was developed to guide Urban Nutrition programming in Kampala city and its divisions. It is worth noting that the number of people living in urban environments is growing at a rapid rate. Urban living fundamentally changes how people eat, as they are more reliant on needing paid employment and are more limited with growing their own food. This shift towards more urban living is seeing big changes in food environments for most people, and what food is available, affordable, and accessible to them. This is contributing to fast shifting patterns of malnutrition (over and under) among and between different income groups within the city. Altogether, urban areas pose unique challenges and opportunities around diets and nutrition and hence the need for deliberate nutrition programming for them within the context of the mainstream national nutrition programming (UNAPII).

The KCC Nutrition Action Plan provides a set of strategic objectives, strategies and actions aligned with the Uganda Nutrition Action Plan 2020/21-2024/25; the National Development Plan 2020/21-2024/25 and Kampala Capital City Strategic Plan 2020/21-2024/25 to guide various actors in the city in contributing to the achievement of better nutrition in a more coherent, concerted, and consistent manner. It is to be used

as a guide to the city in providing oversight on the implementation of multi-sectoral nutrition actions within the city. It will also be used by the City Authority to mobilize additional resources to fill the funding gaps for the plans priority actions that are not funded within the City's financing frameworks. This Nutrition Action Plan will therefore not be implemented as a standalone framework, but it has enabled the Capital City Authority to tease out priority actions from the four strategic themes and the 18 sub programs in the KCCA SP 2020/21-2024/25 that contribute to nutrition out comes at individual, household, and community levels. This plan will hence enable various departments at work planning and budgeting levels to identify which actual activities need to be implemented and reported on through the Program Based Budgeting System (PBS) as per established NDPIII reporting arrangements for MDAs.

The primary beneficiaries for the KCC-NAP are children under five years, adolescents (both in and out of school), pregnant and lactating women, people living in formal and informal settlements and other vulnerable populations. The **KCC-NAP** applies to all **Authority** Directorates, departments and units plus non-state actors involved in scaling up nutrition interventions within the **city**. Hence all these stakeholders MUST jointly plan, budget, implement, monitor, evaluate and report on the nutrition actions outlined in this KCC-NAP to ensure alignment and resource mobilization for increased coverage and effective delivery of the expected nutrition outcomes as one team.

2 Nutrition Situational Analysis

2.1 Nutrition Status Outcomes among NAP target groups

Nutritional status is the result of complex interactions between food consumption and the overall status of health and health care practices. Numerous socioeconomic and cultural factors influence patterns of feeding children and women and their nutritional status. From birth to age 2 is a period especially important for optimal growth, health, and development. Unfortunately, this period is often marked by **micronutrient deficiencies** that interfere with optimal growth. **In addition, childhood illnesses such as diarrhoea and acute respiratory infections (ARI) are common.** For women, improving overall nutritional status throughout the life cycle is crucial to maternal health. Women who become malnourished during pregnancy and children who fail to grow and develop normally due to malnutrition at any time during their life, including during foetal development, are at increased risk of perinatal problems, increased susceptibility to infections, slow recovery from illness, and possibly death. Improving maternal nutrition is crucial for improving children's health. Nutrition status analysis allows identification of subgroups of the child population that are at increased risk of faltered growth, disease, impaired mental development, and death.

2.1.1 The nutritional status of children under age 5

The nutritional status of children under age 5 is an important outcome measure of children's health. Prevalence of stunting, overweight and wasting among children under five years. Children whose height-for-age Z-score is below minus two standard deviations (−2 SD) from the median of the WHO reference population are considered short for their age (stunted), or chronically malnourished. The height-for-age index provides an indicator of linear growth retardation and cumulative growth deficits in children. Stunting reflects failure to receive adequate nutrition over a long period of time and is affected by recurrent and chronic illness. Height-for-age, therefore, represents the long-term effects of malnutrition in a population and is not sensitive to recent, short-term changes in dietary intake. Based on this index, sixteen-point five percent (16.5%) of the children aged 6-59 months in Kampala City are stunted.

Table 2-1: The nutritional status of children under age 5 between 2011-2022

Indicator	UDHS 2011	UDHS 2016	UDHS 2022	Comment on progress
Prevalence of stunting in children under five years of age	13.5	18.1	16.5	On course
Prevalence of overweight in children under five years of age	3.5	3.9	6.3	Off course
Prevalence of wasting in children under five years	4.4	3.9	2.9	On course

Source: UDHS reports

The weight-for-height index measures body mass in relation to body height or length; it describes current nutritional status. Children with Z-scores below minus two standard deviations (−2 SD) are considered thin (wasted) or acutely malnourished. Wasting represents the failure to receive adequate nutrition in the recent period and may be the result of inadequate food intake or a recent episode of illness causing loss of weight and the onset of malnutrition. Based on this index close to 3% of the children aged 0-5 years in Kampala were wasted with reference to the UDHS report of 2022.

The weight-for-height index also provides data on overweight and obesity. Children more than two standard deviations (+2 SD) above the median weight-for-height are considered overweight, or obese. Based on this index, close to 6.3% of the children under five years of age are overweight.

2.1.2 Anaemia in children 0-5 years and women of reproductive age

Anaemia is a condition characterised by a low level of haemoglobin in the blood. Haemoglobin is necessary for transporting oxygen to tissues and organs in the body. About half of the global burden of anaemia is due to iron deficiency. Iron deficiency, in turn, is largely due to an inadequate dietary intake of bio available iron, inadequate dietary iron during periods of increased iron requirements (such as pregnancy and infancy), and increased blood loss due to hookworm infestation and infections such as malaria. Nutritional anaemia includes anaemia due to deficiency in iron plus deficiencies in folate, vitamins B and B12, and certain trace elements involved with red blood cell production. Anaemia in children is associated with impaired mental and physical development and with increased morbidity and mortality. Anaemia can be a particularly serious problem for pregnant women, leading to premature delivery and low birth weight. WHO considers anaemia prevalence over 40 percent in a population to be a major public health problem, anaemia prevalence between 20 and 40 percent to be a medium-level public health problem, and between 5 and less than 20 percent to be a mild public health problem (WHO, 2001a). Anaemia in pregnant women results in an increased risk of premature delivery and low birth weight.

Table 2-2: Prevalence of anaemia among children 0-5 years, women of reproductive age

Indicator	UDHS 2011	UDHS 2016	Comment on progress
Prevalence of anaemia in children 0-5 years	39.8	50.9	Off course
Prevalence of anaemia in women of reproductive age	19.6	25.2	Off course –deteriorated

Source: UDHS reports

Comparing the data from the 2 sets of UDHS, the prevalence of anaemia among children 0-5 years, women of reproductive age has worsened over the period 2011 to 2016 as reflected in table above.

Table 2-3: Status Overweight and obesity among adults between 2011 and 2022

Indicator	UDHS 2011	UDHS 2016	UDHS 2022	Comment on progress
Proportion of overweight adult women aged 18+ years	27.4	26.5	30.6	Off course –deteriorated
Proportion of overweight adult men aged 18+ years	10.1	16.3	17.2	Off course –deteriorated
Proportion of obesity in adult women aged 18+ years	13.0	17.1	19.2	Off course –deteriorated
Proportion of obesity in adult men aged 18+ years	1.5	3.7	3.27	Slight improvement

Source: UDHS reports

2.2 Consequences of malnutrition

Malnutrition negatively affects human capital development and productivity. Impaired cognitive development due to malnutrition contributes to poor school performance and low educational attainment leading to losses in productivity later in life. Repeated and prolonged morbidity associated with malnutrition leads to lower wages for non-manual workers and increased health costs associated with treatment of malnutrition and related diseases. Furthermore, childhood under nutrition is associated with overweight, obesity, diabetes, hypertension, gout, some cancers, and heart diseases in adulthood (GNR, 2018). Effects of malnutrition can affect the entire generational cycle and be passed from one generation to the next

2.3 Nutrition Specific problems

The five key problems concerning access to, and utilization of nutrition specific services are: poor Maternal, Infant, Young Child, and Adolescent Nutrition (**MIYCAN) practices, sub optimal intake of key micronutrients of concern (Vitamin A, iron) intake**, low coverage of management of acute malnutrition, limited integration of nutrition actions in prevention, control and management of Infectious Diseases and Nutrition in Diet Related Non-Communicable Diseases. The paragraphs below describe the indicators of how each of the 5 problems manifests themselves and hence give an avenue for addressing them through the chapter of strategic direction.

2.3.1 Maternal, Infant, Young Child, and Adolescent Nutrition (MIYCAN) practices

Infant feeding affects both the mother and the child. Feeding practices affect the child's nutritional status, which in turn affects the risk of death. The duration and intensity of breastfeeding affect the mother's period of postpartum infertility, and hence the length of the birth interval and fertility levels.
Appropriate infant and young child feeding (IYCF) practices include exclusive breastfeeding in the first 6 months of life, 2-continued breastfeeding through age 2, introduction of solid and semi-solid foods at age 6 months, and gradual increases in the amount of food given and frequency of feeding as the child gets older. It is also important for young children to receive a diverse diet (i.e., foods from different food groups to address growing micronutrient needs) (WHO 2008).

a) Breastfeeding

Almost all children (95.8%) born two years before 2022 in Kampala were ever breastfed. However, only 81.7% started breastfeeding within 1 hour of birth while 32.2% received a prelacteal feed. Early initiation of breastfeeding is important for both the mother and the child. The first breast milk contains colostrum, which is highly nutritious and has antibodies that protect the new-born from diseases. Early initiation of breastfeeding also encourages bonding between the mother and her new-born, facilitating the production of regular breast milk. Thus, it is recommended that children be put to the breast immediately or within 1 hour after birth and that prelacteal feeding (i.e., feeding new-borns anything other than breast milk before breast milk is regularly given) be discouraged.
Unfortunately, the percentage of children who start breastfeeding within 1 hour of birth decreases as mother's education increases and the proportion of children who receive a prelacteal feed increases with increasing mother's education and household wealth.

Breast milk contains all the nutrients needed by children in the first 6 months of life and is an uncontaminated nutritional source. It is recommended that children be exclusively breastfed in the first 6 months of their life; that is, they should be given nothing but breast milk. Complementing breast milk before age 6 months is unnecessary and is discouraged because the likelihood of contamination and the resulting risk of diarrheal disease are high. Early initiation of complementary feeding also reduces breast milk output because the production and release of breast milk is modulated by the frequency and intensity of suckling.

Two thirds (66%) of children under age 6 months are exclusively breastfed. Exclusive breastfeeding declines with age, from 83% among children aged 0-1 months to 69% among those age 2-3 months and 43% among those age 4-5 months. The proportion of children who are breastfeeding and consuming complementary foods first increases with age (peaking at 87% among children aged 9-11 months) and then falls among children aged 12-23 months (as older children stop breastfeeding). The proportion of children who are not breastfeeding increases with age, from 2% among those aged 0-1 months to 50% among those age 18-23 months.

b) Complementary Feeding

After the first 6 months, breast milk is no longer sufficient to meet the nutritional needs of the infant; therefore, complementary foods should be added to the child's diet. The transition from exclusive breastfeeding to family foods is referred to as complementary feeding. This is the most critical period for children, as during this transition they are most vulnerable to becoming undernourished. Complementary feeding should be timely; that is, all infants should start receiving foods in addition to breast milk from 6 months onwards.

Types of Complementary Foods

UNICEF and WHO recommend the introduction of solid food to infants around age 6 months because by that age breast milk alone is no longer adequate to maintain a child's optimal growth. In the transition to the family diet, in addition to breastfeeding, children aged 6 months and older should be fed small quantities of solid and semi-solid foods frequently throughout the day. During this transition period (age 6-23 months), the prevalence of malnutrition increases substantially in many countries because of an increase in infections and poor feeding practices.

Appropriate complementary feeding should include feeding children a variety of foods to ensure that requirements for nutrients are met. Fruits and vegetables rich in vitamin A should be consumed daily. Eating a range of fruits and vegetables, in addition to those rich in vitamin A, is also important. Studies have shown that plant-based complementary foods by themselves, however, are insufficient to meet the needs for certain micronutrients. Therefore, it has been recommended that meat, poultry, fish, or eggs be part of the child's daily diet as well or eaten as often as possible (WHO 1998).

Infants and young children should be fed a minimum acceptable diet (MAD) to ensure appropriate growth and development. Without adequate diversity and meal frequency, infants and young children are vulnerable to under nutrition, especially stunting and micronutrient deficiencies, and to increased morbidity and mortality. The WHO minimum acceptable diet recommendation, which is a combination of minimum dietary diversity and minimum meal frequency, is different for breastfed and non-breastfed children.

Regardless of age or breastfeeding status, the food group most given to children was food made from grains: 52% among breastfeeding children and 82% among non-breastfeeding children. In general, the proportion of breastfed and non-breastfed children aged 6-23 months eating each type of food increases with child age. Non breastfed children aged 6-23 months are more likely than breastfed children to consume every type of food: fortified baby food (2% versus 0.2%); grains (84% versus 71%); vitamin A-rich fruits and vegetables (55% versus 50%); other fruits and vegetables (29% versus 19%); food from roots and tubers (63% versus 56%); food from legumes and nuts (58% versus 50%); meat, fish, and poultry (43% versus 33%); eggs (17% versus 13%); and milk products (7% versus 3%).

Minimum dietary diversity is a proxy for adequate micronutrient density of foods. Minimum dietary diversity means feeding the child food from at least four food groups. The cut-off of four food groups is associated with better-quality diets for both breastfed and non-breastfed children. Consumption of food from at least four groups means that the child has a high likelihood of consuming at least one animal source of food and at least one fruit or vegetable in addition to a staple food (grains, roots, or tubers) (WHO 2008).

The four groups should come from a list of seven food groups: grains, roots, and tubers; legumes and nuts; dairy products (milk, yogurt, and cheese); flesh foods (meat, fish, poultry, and liver/organ meat); eggs; vitamin A-rich fruits and vegetables; and other fruits and vegetables.

Minimum meal frequency is a proxy for a child's energy requirements. For infants and young children, the indicator is based on how much energy the child needs and, if the child is breastfed, the amount of energy needs not met by breast milk. Breastfed children are fed with a minimum meal frequency if they receive solid, semi-solid, or soft foods at least twice a day (for infants aged 6-8 months) or at least three times a day (for children aged 9-23 months).

In 2022, the UDHS report indicated that in total, 9.7 % of last-born children aged 6-23 months living with their mother were fed a minimum acceptable diet. Thirteen-point two percent (13.2%) were fed according to minimum dietary diversity (they were fed from at least four food groups), and 6 in 10 (62.4%) were fed according to minimum meal frequency (they were fed two to four times per day depending on age and breastfeeding status). Its key to note that, the proportion of children aged 6-23 months receiving the minimum acceptable diet rises with increasing mother's education, from 4.5% among children whose mothers have no education to 10.3% among children whose mothers have more than a secondary education. Hence promotion of education for a girl child is very critical for improving IYCF indicators on Minimum Acceptable Diet.

Table 2-4: Maternal Infant Young Child Adolescent and Nutrition (MIYCAN)

IYCF practices	UDHS 2011	UDHS 2016	UDHS 2022	Comment on progress
Proportion of infants initiated on breastfeeding within one hour of birth.	57.5	70.2	81.2	Progress registered
Proportion of babies exclusively breastfed for the first six months	63	66	-	-
Among all children aged 6-23 months, percentage fed on a Minimum Diet Diversity (MDD)	25.2	39.0	13.2	Decline
Among all children aged 6-23 months, percentage fed on a Minimum Meal Frequency Diversity (MMF)	56.6	43.0	62.4	Progress registered
Among all children aged 6-23 months, percentage fed on a Minimum Acceptable Diet	15.6	15.7	9.7	Decline

Source: UDHS reports

2.3.2 Micronutrient intake among children, adolescents, and women of reproductive age

Micronutrient deficiency is a major contributor to childhood morbidity and mortality. Children can receive micronutrients from foods, food fortification, and direct supplementation. Vitamin A is an essential micronutrient for the immune system that plays an important role in maintaining the epithelial tissue in the body. Severe vitamin A deficiency (VAD) can cause eye damage. VAD can also increase the severity of infections such as measles and diarrhoea diseases in children and slow recovery from illness. Vitamin A is found in breast milk, other milks, liver, eggs, fish, butter, red palm oil, mangoes, papayas, carrots, pumpkins, and dark green leafy vegetables. The liver can store an adequate amount of the vitamin for four to six months. Periodic dosing (usually every six months) with vitamin A supplements is one method of ensuring that children at risk do not develop VAD.

Low iron intake can also contribute to anaemia. Also, iron is essential for cognitive development. Iron requirements are greatest at age 6-11 months, when growth is extremely rapid.

Infection with helminths or intestinal worms has an adverse impact on the physical development of children

and is associated with high levels of iron deficiency anemia and other nutritional deficiencies. Regular treatment with deworming medication is a simple, cost-effective measure to address these infections.

Breastfeeding children benefit from supplements given to their mother. Iron deficiency is one of the primary causes of anaemia, which has serious health consequences for both women and children. Vitamin A is an essential micronutrient for the immune system and plays an important role in maintaining the epithelial tissue in the body. Severe vitamin A deficiency (VAD) can cause eye damage and is the leading cause of childhood blindness. VAD also increases the severity of infections such as measles and diarrheal disease in children and slows recovery from illness. VAD is common in dry environments where fresh fruits and vegetables are not readily available.

According to the UDHS, 2022, among last-born children aged 6-23 months only 24.2% ate foods rich in vitamin A and 45.1% ate foods rich in iron. Pregnant women should increase their intake of iron and prevent parasites to prevent anaemia. While 97.5% of women took iron supplements at least once during their most recent pregnancy, only 58.2% took them for 90 days or more. Seven in 10 (78.1%) women took deworming medication during their most recent pregnancy (UDHS, 2022).

Table 2-5: Coverage of micronutrient intake among children, adolescents, and women of reproductive age

Micronutrient intake among children, adolescents, and women of reproductive age	UDHS 2011	UDHS 2016	UDHS 2022	STATUS	Desired
Micronutrient intake among children					
Among youngest children aged 6-23 months percentage who consumed foods rich in vitamin A	60.5	63.6	24.2	Decline	80
Among youngest children aged 6-23 months percentage who consumed foods rich in iron	49	50.9	45.1	Decline	80
Proportion of children 6–59 months receiving Vitamin A supplementation	50.7	55.4	-	Improvement	80
Percentage of children 1-5 years given deworming medication	59.2	60.6	-	Slight improvement	80
Micronutrient intake among women					
Percentage of women who took deworming medication during pregnancy	51.5	63.2	78.1	Improvement	80
Percentage of women who took iron supplements at least once during their most recent pregnancy for 90 days or more.	10.1	35.7	58.2	Improvement	80

Source: UDHS reports

2.4 Access to management of acute malnutrition at health facility level and community level:

Low coverage of severe acute malnutrition treatment (Proportion of facilities providing IMAM services), low Proportion individuals (per age category) accessing nutrition assessment and screening services, low Percentage of individuals identified with malnutrition and referred for treatment, low Percentage of malnourished individuals receiving IMAM services and low Proportion of malnourished clients linked to support services at community level.

2.5 Nutrition services in prevention, control and management of infectious diseases and epidemics: Antenatal Care (ANC) is the care provided by skilled health-care professionals to pregnant women and adolescent girls to ensure the best health conditions for both mother and baby during pregnancy. The components of ANC include risk identification; prevention and management of pregnancy-related or concurrent diseases; and health education and health promotion. Presently, the trend for antenatal attendance is highest at first visit as compared to the fourth visit.

HIV is one of the key indicators measured in health and remains one of the main health challenges to the development of Kampala City. As the City population continues to grow, there are challenges in sustaining awareness campaigns especially among the least educated and poverty-stricken segment of the society.

Tuberculosis (TB) TB is a disease caused by bacteria (Mycobacterium tuberculosis) that most often affects the lungs. The most common symptoms include cough, fever, night sweats, and weight loss. Persons with compromised immune systems, such as people living with HIV, malnutrition or diabetes, or people who use tobacco, have a higher risk of contracting the disease. However, tuberculosis is curable and preventable. In Kampala, there are more men that fall sick of TB compared to women.

Family Planning (FP) FP is a measure that allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved using contraceptive methods and the treatment of involuntary infertility. There has been an upward trend in the use of both short- and long-term methods of FP in Kampala over the past years.

Table 2-6: Nutrition in Maternal and Child Health Care

Impact outcomes	UDHS 2011	UDHS 2016	Status
Percentage of children aged 12-23 months who received all basic vaccinations	51.1	63.4	Improvement
Percentage of children under age 5 with symptoms of Acute respiratory infection (ARI)	4.9	13.9	Decline
Percentage of children under age 5 with symptoms of fever	14	24	Decline
Percentage of children under age 5 who sleep under an ITN	62	52.1	Decline
Percentage of children under age 5 with symptoms of diarrhoea	15.5	24.1	Decline
Percentage of children with diarrhoea who were given ORS and zinc	23	-	
Number of births during a given reference period to women aged 15–19 years /1000 females (and aged 10–14)	132	134	Decline

Source: UDHS reports

2.5 Nutrition Sensitive problems

The seven key problems concerning access to, and utilization of nutrition sensitive services are: inadequate production, access and utilization of diverse, safe, and nutrient dense crop, fisheries and animal foods and inadequate integration of nutrition services in: Social Protection and SGBV programs; Early Childhood Development (IECD) services, and quality education and sports; Water Sanitation and Hygiene (WASH) services and Trade, Industry, and Investments.

2.5.1 Production of diverse, safe, and nutrient dense crop, fisheries, and animal foods

Low proportion of households adopting climate smart technologies aimed at increasing production of diverse, safe, nutrient dense food; low proportion of farmers provided with inputs and/or information for improved production of diverse, safe, nutrient dense food; low proportion of households supported to produce nutrient dense indigenous and underutilized plant fisheries and animal source food; low proportion of farmers adopting gender sensitive labor and energy saving technologies ; low proportion of farming households producing bio-fortified foods and low proportion of MSME actors involved in production and processing of industrial fortified foods-from production departmental reports

2.5.2 Access to diverse, safe, and nutrient dense crop, fisheries, and animal foods

Low proportion of actors involved in agro-processing and marketing of diverse, safe, nutrient dense plant and animal products; low percentage of farmers equipped with skills in postharvest handling technologies and value addition; low proportion of actors engaging in value addition and marketing of nutrition dense indigenous and underutilized plant, fisheries and animal source food; low proportion of farmer groups (especially women groups) marketing nutrient dense plant, fisheries and animal source food; low proportion of public private partnerships entities scaling up production, processing and marketing of nutrient dense plant, fisheries and animal source food and low proportion of farmers adopting agricultural enterprise mixes to ensure frequent (daily, weekly and monthly) flow of household's incomes and improved access to safe, diverse, nutrient dense foods

2.5.3 Utilization of diverse, safe, and nutrient dense crop, fisheries, and animal foods

Low proportion of agricultural extension workers passing nutrition and information services in their routine services to households; low proportion of people reached with awareness campaigns aimed at ensuring food safety along the value chain; low proportion of people who are aware on the benefits of consuming bio and industrial fortified foods and low proportion of people sensitized on the benefits of consuming nutrition dense indigenous and underutilized plant, fisheries and animal resources.

Table 2-7: Food availability, Access and Utilization

Impact outcomes	Baseline (%) 2011
Contribution of staples to daily caloric intake	60
Persistence of undernourishment (Proportion of households chronically undernourished)	16
Proportion of the national food secure population	69
Population experiencing acute food insecurity (Millions)	10.9
Proportion of HH suffering reduction in food production due to Weather shocks	90
Percentage increase in production volumes of priority food commodities	3.8% annual increment

2.5.4 Nutrition Services in Social Protection and SGBV programs

Reflected by low proportion of vulnerable populations covered by nutrition sensitive social protection programs and humanitarian assistance safety net programs; low proportion of vulnerable children protected from abuse, exploitation, violence and neglect in homes; low Proportion of vulnerable population covered by social protection programs; low proportion of poor and vulnerable households and engaging in income generating activities; low proportion of households living in Kampala and informal settlements who access adequate housing; low proportion of women empowered on rights, gender equality and their role in the development among other topics and low proportion of women participating in development initiatives such as the Uganda Women Entrepreneurship Program (UWEP) Fund.

2.5.5 Nutrition in Early Childhood Development (IECD) services, and quality education and sports

Reflected by Low proportion of children aged 36-59 months who are developmentally on track in at least three domains of ECD; low Proportion of public and private institutions promoting Maternity and paternity protection for improved nutrition; low proportion of learners completing the education cycle by gender; low proportion of schools implementing school feeding guidelines; low proportion of parent sensitized on the importance of good nutrition of their children and the need for school feeding and other nutrition programs.; low proportion of schools that have gardens and other school agricultural programs for education purposes and as source of nutrient dense diets in schools; low proportion of school children sensitized on food and nutrition security and low proportion of public and private actors implementing innovative models for improved nutrition in schools and other institutions.

Table 2-8: Early childhood development (ECD) related behavioural indicators

Impact outcomes	Baseline (%) 2016
Proportion of children aged 36-59 months who are developmentally on track in at least three domains of ECD	63.3
Children under age 5 left with inadequate care in a week	
Proportion of the population participating in sports and physical exercises	40.9
Proportion of school going children having meals at schools	54

2.5.6 Nutrition in Water Sanitation and Hygiene (WASH) services

This is reflected by; low proportion of households with access to safe water sources; low proportion of households with access to sanitation and hygiene services; low Proportion of Communities mobilized on sustainable use of WASH services; low Proportion of households sensitized on integrated hand washing, hygiene practices, safe food preparation and storage and MIYCAN and low proportion of households provided with water for production.

Table 2-9: Nutrition in Water Sanitation and Hygiene services

Impact outcomes	Baseline (%) 2011	2016 (%)	Data Source / Responsibility Center
Rural Safe Water Coverage	74	100	UDHS/MoWE
Urban Safe Water Coverage	68	81	UDHS/MoWE
Sanitation (Improved toilet) coverage	18	40	UDHS/MoWE
Coverage of Hand washing facilities	24	50	UDHS/MoWE

2.5.7 Nutrition in Trade, Industry, and InvestmentsReflected by; low proportion of industries supplying fortified foods on the market; low Proportion of value added Nutritious foods; low Proportion of industries complying to Fortification of wheat flour, maize flour, edible oil enforcement; low Proportion of SMEs in the food system availing fortified foods on the market; low Proportion of traders and processors of foods forming viable cooperatives for trade in quality nutritious foods and low proportion of non-tariff barriers that affect food and nutrition that have been mitigated.

2.6 Nutrition Enabling Environment problems.

The six key problems concerning inadequate enabling environment for Nutrition are as follows:

2.6.1 Policy and legal frameworks implementation:
Documentation of the provisions in Legal and Policy framework relevant to nutrition do not exist/ are not popularized/ are not implemented. Nutrition strategies/ interventions are not integrated in City Planning Frameworks.

2.6.2 Coordination and partnerships for nutrition:
NCC was formulated and trained on Nutrition governance. The stakeholder mapping for nutrition at City level is yet to be done.

2.6.3 Capacity development for MSN:
Nutrition capacity assessment is not conducted at City level. Nutrition capacity gaps within City departments are not known/not prioritized. There is no capacity development plan to guide actors on capacity building priorities for implementation of KCC-NAP. City level and partners do not integrate nutrition capacity Development activities in annual work plans and budgets.

2.6.4 Nutrition information and knowledge management:
Planning documents lack M & E framework for nutrition and tracking of NAP targets is not done: There is no institutionalization & coordination of data. City level assessment data from surveys, is not available or not used. Division level performance monitoring data from health facility-based nutrition services, nutrition programs and department information systems are not available/not used.

2.6.5 Nutrition Advocacy, SM and BCC.
There is no customization of Nutrition Advocacy Communications at City level. High-level nutrition advocates are not mobilized. There exists no nutrition commitment scorecard for SBCC at City level. SBCC Campaigns are ad hoc and not based on gaps at City level.

2.6.6 HRN and financing for nutrition:
There is no deliberate effort to plan for human resources for nutrition. There is no City level nutrition expenditure review conducted. The funding gap for nutrition is not known, and resource mobilization is ad hoc. No deliberate efforts are in place to undertake resource mobilization, financing and tracking of nutrition investments in the city.

2.7 Ongoing Nutrition sensitive programs

Economic Empowerment programs -under Kampala Capital City Authority
Kampala Capital City Authority through the Directorate of Gender, Community Services and Production, has several interventions aimed at promoting the Economic viability of the City residents. These interventions are targeting; men, women, youth and the PWDs and include among others the Market Development Program, Community Driven Development programs (CDD), NAADS and UWEP. These programs have registered a tremendous improvement in the wellbeing of the people in Kampala city over the years.

2.7.1 Markets
KCCA manages several markets and these deal in several products and produce.

2.7.2 Youth Livelihood Program (YLP)
The YLP is a Government Program being implemented under the Ministry of Gender, Labour, and Social Development since FY2013-2014. It was designed to respond to the existing challenge of unemployment among the Youths. This program is being implemented by the different divisions of Kampala.

2.7.3 Community Driven Development (CDD) in Kampala
The Community Driven Development program (CDD) program is the Government of Uganda Program in line with Uganda's development emphasis on demand-driven governance and prosperity for all. Under the program, community members are organised as CBOs, profile projects are prioritised by the members and indicate the financing requested from GOU. Each community project is entitled to a maximum allocation of US$ 2,500 for the duration of the project. The key outcomes of this program include Increased community participation in development programs and the organisation of communities through the CBO approach has seen an increase in community cohesion.

2.7.4 Uganda Women's Enterprise Program (UWEP)
This program started in FY 2015/2016 with a total budget of UGX 173,304, 418. The program is aimed at improving women access to financial service and equipping women with skills for enterprise growth, value addition and marketing of products and services.

2.7.5 Promoting Urban Agriculture in Kampala
A special form of food production system known as **Urban-agriculture** and referred to as **Intensive Metropolitan Agriculture**, is practiced in cities all over the world including Kampala and is on the increase. Urban agriculture is a chain of activities that involves growing of plants, raising of animals, processing, and marketing within and around cities, in a unique way that links the economic and ecological system of a city. KCCA is promoting urban agriculture with the aim of promoting food security, household income and employment. Urban agriculture has in the past, been a silent part of Kampala's economy and has not received much attention in national programs because it has been perceived as a nuisance, a risk to public health and its economic benefits were not appreciated. The negative views are slowly fading away, and the numbers of urban farmers is slowly rising. Interventions to promote urban agriculture include among others:

2.7.5.1 National Agricultural Advisory Services
NAADS is a Government of Uganda Program that aims to increase farmers' access to information, knowledge, and technology for profitable agricultural production. The NAADS program for Kampala started in FY 2011/2012. Given its urban setting the program has targeted market-oriented farmers with enterprises of high productivity per unit area as guided by the NAADS Secretariat. The following enterprises have been promoted over the years, Poultry, Piggery, Mushroom, backyard gardening with high value crops, fish farming and to a less extent dairy farming. Over the period, the program has benefited over 1,133 beneficiaries.

2.8 Opportunities for KCC-NAP implementation

The city will harness the following opportunities: Government commitment to nutrition as stipulated in the National Constitution of 1995, Vision 2040 and NDPIII. Sustained political will to prioritize and scale up nutrition H.E. the President initiative on healthy eating and lifestyles. Nutrition as a cross cutting issue in the NDP Planning Circular call and a development priority in the budget speech 19/20 and 20/21.-customise the opportunities. Global and Regional trends e.g. SDGs, 2063 Agenda, EAC, and Nutrition for Growth (N4G) and Synergies in the SUN movement and south to south cooperation. Coordination by an entity with convening power – (ED's office)

3 KCC-NAP' Strategic Direction

3.1 'KCC-NAP' theory of change

The KCC-NAP theory of change detailed in the Figure 3 is informed by the Theory of Change for the second UNAP. The KCC-NAP provides for nutrition specific, nutrition sensitive and enabling environment strategies to address the current situation. Assumptions that must hold true for the KCC-NAP goal to be achieved are also provided. The KCC-NAP scope includes diet related non communicable diseases (over-nutrition), undernutrition among women, children, and all vulnerable groups of the population. The current nutrition situation in the Capital City and Uganda in general, requires a mix of nutrition specific and nutrition sensitive strategies as well as strengthening the enabling environment for scaling up nutrition actions and promoting the wellbeing of Ugandans at large. It is important to note that enabling environment strategies such as strengthening nutrition governance, ensuring coherent policy, legal and institutional frameworks, and strengthening nutrition information, data, and evidence for effective decision making, play a catalytic role in promoting implementation of nutrition specific and nutrition sensitive actions within the City.

The KCC-NAP will ensure that viable linkages between nutrition specific and nutrition sensitive strategies are established, since nutrition sensitive approaches act as delivery platforms for increased coverage of nutrition specific interventions. Promotion of production, access, and utilisation of diverse, safe, nutrient dense food through agricultural and social protection strategies, coupled with promotion of MIYCAN practices will lead to improved dietary diversity and micronutrient intake. Integration of essential nutrition actions in prevention and management of infectious and non-communicable diseases together with increased access to WASH services will contribute to reduced disease burden. These strategies are all expected to be implemented through the Kampala Public Healthcare Strategic Plan, 2020/21- 2024/25 whose priority actions are: Strengthening safe food handling, Deepening the sustainability and quality of WASH; Ensuring provision of equitable and quality health care and Promotion of integrated public health surveillance and advocacy. This therefore requires the actors in the directorate to intentionally integrate the defined priority actions in this Nutrition Action Plan within their day-to-day activities.

The KCC-NAP outputs will be achieved with the assumption that quality nutrition information and sufficient financial and human resources (adequate number of skilled human resources) will be available leading to increased coverage of quality nutrition services. It is also assumed that adequate support to the target groups will lead to change in behaviours and practices and lead to continued utilisation of nutrition services. Sustained achievement of main NAP intermediate outcomes will lead to improved nutrition status among children under 5 years of age, school age children, adolescents, pregnant and lactating women, and other vulnerable groups by 2030. as shown in annex.

The 'KCC-NAP' Theory of Change (Adopted from UNAP 11)

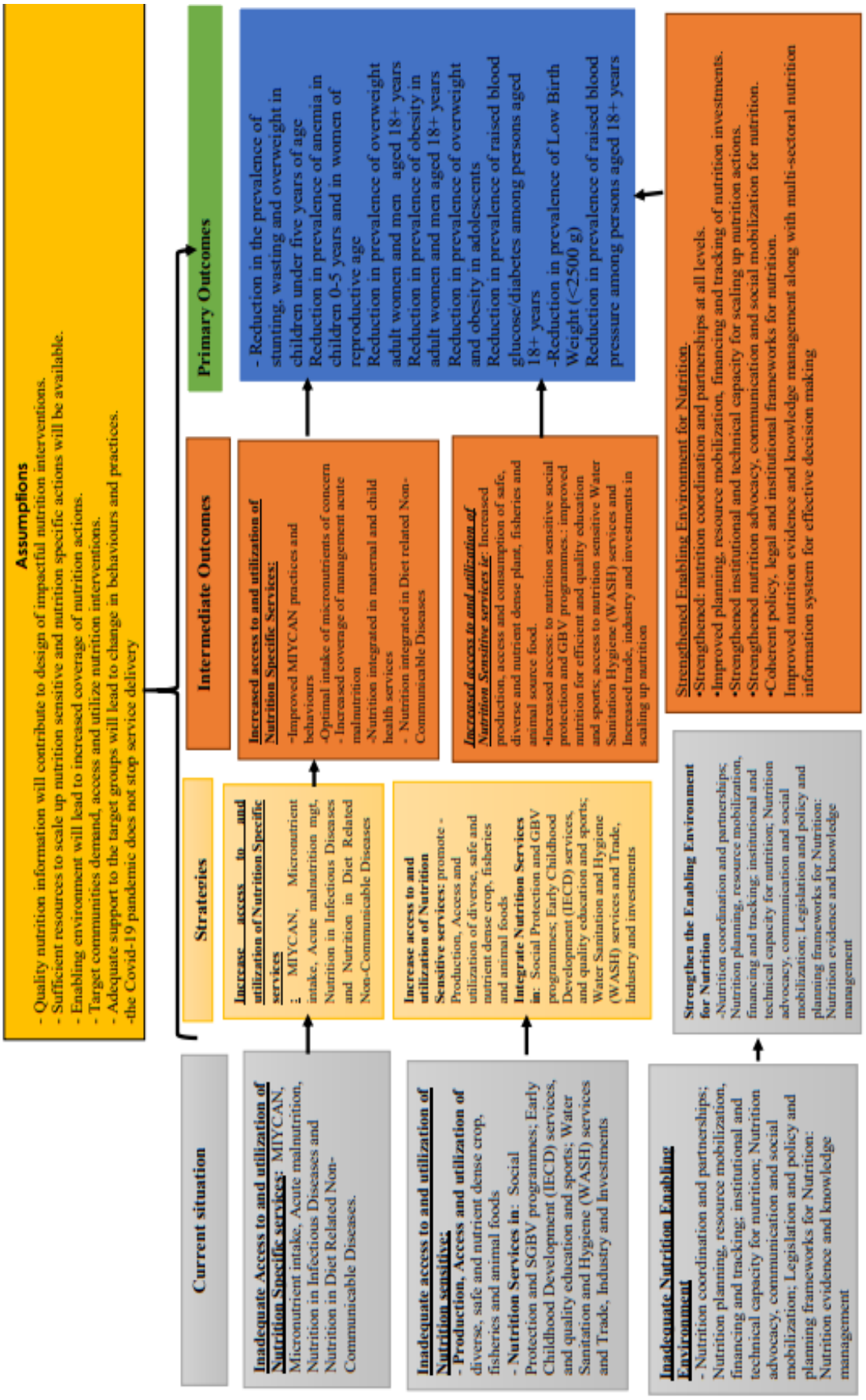

Figure 3-1

3.2 Vision

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

3.3 Goal

Improve nutritional wellbeing for children under five years, adolescents (both in and out of school), pregnant and lactating women, people living in formal and informal settlements and other vulnerable populations by 2030 in Kampala City.

3.4 Objectives

The 'KCC-NAP' objectives are based on a holistic approach to nutrition, considering all-encompassing global contemporary trends and demands. These include Scaling up Nutrition Movement, 2030 Agenda and SDGs, as well as the Vision 2040 aspirations operationalized in the 'NDPIII' and UNAPII. The focus areas are nutrition specific, nutrition sensitive and enabling environment. The spirit of the objectives is to uphold a multi-sectoral approach to nutrition. Over the period 2023/24-2029/30, 'KCC-NAP' seeks:

- **Objective 1**: To increase access to and utilization of nutrition-specific services by children under five years, adolescents (both in and out of school), pregnant and lactating women, people living in formal and informal settlements and other vulnerable populations.
- **Objective 2**: To increase access and utilization of nutrition-sensitive services by children under five years, adolescents (both in and out of school), pregnant and lactating women, people living in formal and informal settlements and other vulnerable populations.
- **Objective 3**: To strengthen the enabling environment for scaling up nutrition-specific and nutrition-sensitive services.

3.5 Strategies and priority actions

Objective 1

To increase access to and utilization of nutrition-specific services by children under five years, adolescents (both in and out of school), pregnant and lactating women, people living in formal and informal settlements and other vulnerable populations.

Strategy 1.1: Promote optimal maternal, infant, young child and adolescent nutrition practices in formal and informal settlements.

Priority actions

1. Promote exclusive breastfeeding for infants aged 0-5 months.
2. Promote complementary feeding for children aged 6-23 months.
3. Promote and support growth, promotion, and monitoring services at health facilities and in communities.

Strategy 1.2: Promote optimal micronutrient intake children under five years, adolescents (both in and out of school), pregnant and lactating women, people living in formal and informal settlements.

Priority actions

1. Provide routine vitamin A supplementation to all children aged 0-5 years during integrated child health days.
2. Educate and provide for all pregnant women attending antenatal care to uptake iron and folate supplementation.
3. Promote consumption of fortified foods especially in schools with focus on beans, rice, sweat potatoes, cooking oil, and maize.
4. Promote and enforce mandatory consumption of safe and fortified foods in schools.
5. Promote and support food fortification for specified foods.

Strategy 1.3: Increase coverage of the management of acute malnutrition at health facility level and community level.

Priority actions

1. Integrate routine screening and timely management of severe and moderate acute malnutrition into routine health and health services in public and private health facilities.

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

Priority actions

1. Increase access to immunization against childhood diseases.
2. Promote de-worming medications targeting children 1-14 years receiving at least two doses per year.
3. Reduce the burden of communicable diseases, focusing on high burden diseases (malaria and diarrhea) related to malnutrition through the primary health care approach.

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

Priority actions

1. Participate in the national physical exercise day.
2. Conduct sensitization of employers and workers on workplace physical activities for staff.
3. Assess workers and employees for body mass index.
4. Assess workers and employees for diabetes and hypertension.
5. Procure nutrition assessment and health fitness equipment.
6. Develop social behavior change communication on feeding habits and behaviors.
7. Sensitize households and communities on healthy eating and lifestyle.
8. Engage with public and private sectors, civil society, and other stakeholders to promote healthy diets and lifestyles.

Objective 2

To increase access to and utilization of nutrition-sensitive services children under five years, adolescents (both in and out of school), pregnant and lactating women, people living in formal and informal settlements and other vulnerable populations.

Strategy 2.1:3 Increase production, access and consumption of diverse, safe, and nutrient dense plant, fisheries, and animal source food at household level.

Priority actions

1. Promoting Agriculture as a business venture and divert labour from high intensity activities like trading and transport to production sectors.
2. Enhancing food security and household incomes
3. Promoting Urban Agriculture as part of the country's inclusive and green growth strategy
4. Support model production units that showcase best practices in production of nutrient dense food.
5. Provide technical support in addressing pest, diseases, and soil fertility for farmers especially women engaged in the production of nutrient dense food.
6. Support scale up of value addition, agro-processing and marketing of diverse, safe, nutrient dense foods including indigenous and underutilized food resources.
7. Build capacity of farmers on postharvest handling technologies and value addition
8. Support on farm agricultural enterprise mixes to ensure stable diversified food access.
9. Train mothers on how to prepare safe nutritious meals for children.
10. Conduct awareness campaigns aimed at ensuring food safety along the value chain.
11. Conduct household's awareness on the benefits of consuming bio and industrial fortified foods
12. Sensitize households on the benefits of consuming nutrient dense indigenous and underutilized plant, fisheries, and animal resources.

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

Priority actions

1. Identify, prioritize, and support programs and projects which can stimulate economic activity for the vulnerable poor and most affected cash for work programs to sustain livelihoods. These programs and projects include.
   - Youth Livelihood Project
   - Community Development Program
   - Youth Venture Fund
   - Uganda Women Entrepreneur Program
   - Provide Easy-to-Use Platform for Innovation and Engagement
2. Develop a Comprehensive Communications Strategy
3. Carry out annual citizen's satisfaction survey.
4. Provide Sufficient Staffing, Resources and Success Metrics
5. Supporting citizen groups that are most, socially, and economically vulnerable (such as children, women, unemployed young people, elderly persons and people living with disabilities)
6. Implement the Adolescent Girls Social Protection Project and the Social Assistance Grants for Empowerment (SAGE) program.

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

Priority actions

1. Register all ECD centers in accordance with the BRMS
2. Sensitize private players to spread ECD centres to the under-served areas
3. Develop Educational Quality Monitoring and Management Information Systems
4. Establishing systems to ensure that learners Enter, Stay and Complete their education cycles.
5. Increase access to ECD services for children 0-8 years.
6. Promote and enforce mandatory consumption of safe and fortified foods in schools.
7. Mobilize parents to provide meals to school going children in the city.

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

Priority actions

1. Increase access to inclusive safe water supply in KCCA.
2. Increase access to inclusive sanitation and hygiene services in rural areas.
3. Increase access to inclusive sanitation and hygiene services in urban areas.
4. Provide support to improved WASH services in institutions.
5. Improve nutrition and food safety with emphasis on children aged under 5, school children.
6. Strengthening safe food handling
7. Deepening the sustainability and quality of WASH

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

Priority actions

1. Conduct a mapping exercise on food business actors.
2. Hold meetings to create awareness on recommendations on donations, marketing, and promotion of food items.
3. Sensitize Business actors on food safety control recommendations among food producers/processors.
4. Hold meetings for food stuff sellers involved in the selling of fruits and vegetables and sensitize them on the hygiene sanitation, food safety and the nutritional value of different types of food.
5. Mobilize food vendors to support the sale of fortified foods on the market.
6. Mobilize food store operators to sell Fortified foods (wheat flour, maize flour, edible oil)
7. Form cooperatives for trade in quality nutritious foods.
8. Track success of intervention in addressing nutrition issues among children.
9. Undertaking business capacity building activities such as providing training in bookkeeping
10. Focusing on supporting new businesses registering to become formal.
11. Linking businesses to capital financing opportunities within and beyond KCCA ongoing programs
12. Reorganizing the retail trade (most in the urban markets)
13. Enhancing commercialization of agricultural produce.
14. Improving marketplace Infrastructure and creating more workspaces.
15. Enhancing the value of agricultural produce, while increasing localization of produce in selected markets.

Objective 3

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

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

Priority actions

1. Conduct annual nutrition stakeholder and action mapping for Kampala Capital City Authority
2. Establish and support functionality of Nutrition Coordination Committees at KCCA
3. Establish and support functionality of Nutrition Coordination Committees at the Division level.

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

Priority actions

1. Develop Nutrition Action Plans (KCCA and the 5 Divisions) aligned to UNAP II, NDPIII PIAPs and Kampala SP 2023/24-2029/30.
2. Develop Joint Annual Nutrition Work Plans Action Plans (KCCA and the 5 Divisions) aligned to Nutrition Action Plan Implementation Matrix
3. Undertake expenditure reviews for Nutrition.
4. Conduct detailed costing of the KCC-NAP
5. Develop and Implement resource mobilization and tracking plan for nutrition aligned to the KCC-NAP

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

Priority actions

1. Conduct annual Nutrition Capacity Assessments at KCCA.
2. Conduct annual Nutrition Capacity Assessments at Division levels.
3. Develop Nutrition Capacity Development Framework at KCCA.
4. Develop Nutrition Capacity Development Framework at Divisions levels.
5. Implement the Nutrition Capacity Development Framework for KCCA.
6. Implement the Nutrition Capacity Development Framework for Divisions.

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

Priority actions

1. Develop the Nutrition advocacy and communication strategy action matrix for KCCA fully aligned with the NACSII.
2. Implement KCCA specific Nutrition Advocacy and Communication Campaign.
3. Mobilize and institute High-level nutrition advocates to actively advance the nutrition agenda at KCCA and Division.
4. Develop Nutrition advocacy briefs and technical briefs for use at KCCA and Divisions
5. Develop nutrition commitments scorecards at KCCA and Division levels.
6. Build Capacity of Community Based structures to Trigger and deliver community-based advocacy, social mobilization, and behavioral change communication on nutrition interventions.
7. Undertake campaigns to reduce teenage pregnancy, GBV, & other harmful practices that result in malnutrition.

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

Priority actions

1. Implement the teacher's guide on nutrition and comic book in all schools.

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

Priority actions

1. Enhance use of evidence-based nutrition knowledge products at KCAA and Division levels

3.6 KCC-NAP alignment with 'NDP III'

Table 3-1: KCC-NAP alignment with UNAPII and NDPII

KCC-NAP	'NDP III' program	'UNAPII'
Strategy 2.1:3, 2.7	01. Agro-Industrialisation	Strategy 2.1
	05. Natural Resource, Environment, Climate Change, Land and Water Resources Management	Strategy 2.6
Strategy 1.1, 3.6	06. Private sector development	Strategy 1.1, 3.6
Strategy 1.1 -1.5	12. Human Capital Development	Strategy 1.1 – 1.5, 2.5
Strategy 3.4	14. Community Mobilization and Mindset Change	Strategy 3.4
Strategy 3.2	17. Regional Development	Strategy 3.1
Strategy 3.2	18. Development Plan Implementation	Strategy 3.2, 3.6

Table 3-2: Pillars of the Parish Development Model and KCC-NAP strategic direction

Sn	Pillars	KCC-NAP Strategies alignment	Directorate
1	Production, Storage, Processing and Marketing	Strategy 2.1,2.2, 2.3 and 2.7	Gender Community services and production
2	Infrastructure and Economic Services	Strategy 2.4	Gender Community services and production
3	Financial Inclusion	Strategy 2.4	Gender Community services and production
4	Social Services	Strategies 1.1 to1. 5	Gender Community services and production
5	Mind-set change and cross cutting issues (Gender, environment, Disability etc)	Strategy 2.4, 2.6	Gender Community services and production

6	Parish Based Management Information System	Strategy 3.6	Gender Community services and production, and Department of Strategy management and business development
7	Governance and Administration	Strategy 3.1-3.5	Administration and Human resource management, and Department of Strategy management and business development

3.7 Implementation principles

While adopting the implementation of KCC-NAP, the following principles will be applied by all actors.

- **Ensuring Community participation:** Community participation will be strengthened to address local nutrition challenges by including community members in assessing the extent of challenges, analysing causes, and taking actions in finding solutions.
- **Improve the Lives of Excluded Groups**; Kampala, as with all emerging cities, has significant numbers of residents who are socially and economically excluded such as women, children, young people (evidenced by the high unemployment rate and subsequent crime figures), people with disabilities and older people. Furthermore, the economic disruption created by the COVID-19 crisis will lead to a reconsideration of resource use and the fragility of supply lines. The strategy is an opportunity to strengthen approaches that address priority needs of the vulnerable poor in the city.
- **Strengthening community-based nutrition programming**: The KCC-NAP will put particular emphasis on mainstreaming and strengthening nutrition actions through community-based nutrition programs that contribute to the reduction of food insecurity and consumption of poorly diversified diets. The Parish Model approach will facilitate the implementation of the KCC-NAP strategic direction at community levels.
- **Deliberate targeting for vulnerable population groups:** Nutrition priority actions especially for sustain proper care for nutritionally vulnerable groups like Urban poor and street children shall be integrated with emergency response systems and shall be addressed in a coordinated manner.
- **Improving nutrition knowledge and skills:** Training in community nutrition is to be provided to both health, agriculture extension workers, community development workers.

3.8 Targeting

Although nutrition is important for all categories of the population, primary target groups must be focused on during the KCC-NAP implementation. Critical among the target groups are:

- **Pregnant and lactating Women:** Malnutrition during pregnancy poses a high risk for both the mother and the unborn child. Iodine deficiency in early pregnancy can cause still birth and other pregnancy related complications. When the fetus is born malnourished can cause irreversible defects. Similarly, iron deficiency anemia during pregnancy can increase the risk of maternal mortality and significantly contribute to low birth weight.
- **Infants and children under five years of age:** In most low-income countries including Uganda, growth faltering begins in the mother's womb. The damage caused by poor nutrition in the womb or in the first years of life will be a burden that an infant/child must bear for the rest of his/her life. Rarely does a child who is stunted at the age of two catch up with the mental and physical growth of his/her peers. Unless undernutrition is averted at this early age, the child becomes permanently stunted.
- **People living with HIV/AIDS:** People living with HIV/AIDS are particularly vulnerable to malnutrition because opportunistic infections reduce appetite, reducing food intake, further exacerbating the illnesses and the progression towards AIDS. Therefore, sensitizing and educating People living with HIV/AIDS on the importance of maintaining nutrition is vital.
- **Food Insecure Households:** Food insecure households are vulnerable to overt hidden malnutrition. In these conditions, children and mothers are the most vulnerable groups and should receive special attention.
- **Other Population groups:** The elderly, prisoners, students in boarding schools, children in orphanages and hospital in-patients as well as other population groups who are exposed to malnutrition must receive adequate attention during this action plan implementation.

4 KCC-NAP Implementation & Coordination Arrangements

The KCC-NAP coordination structure is derived from UNAPII framework

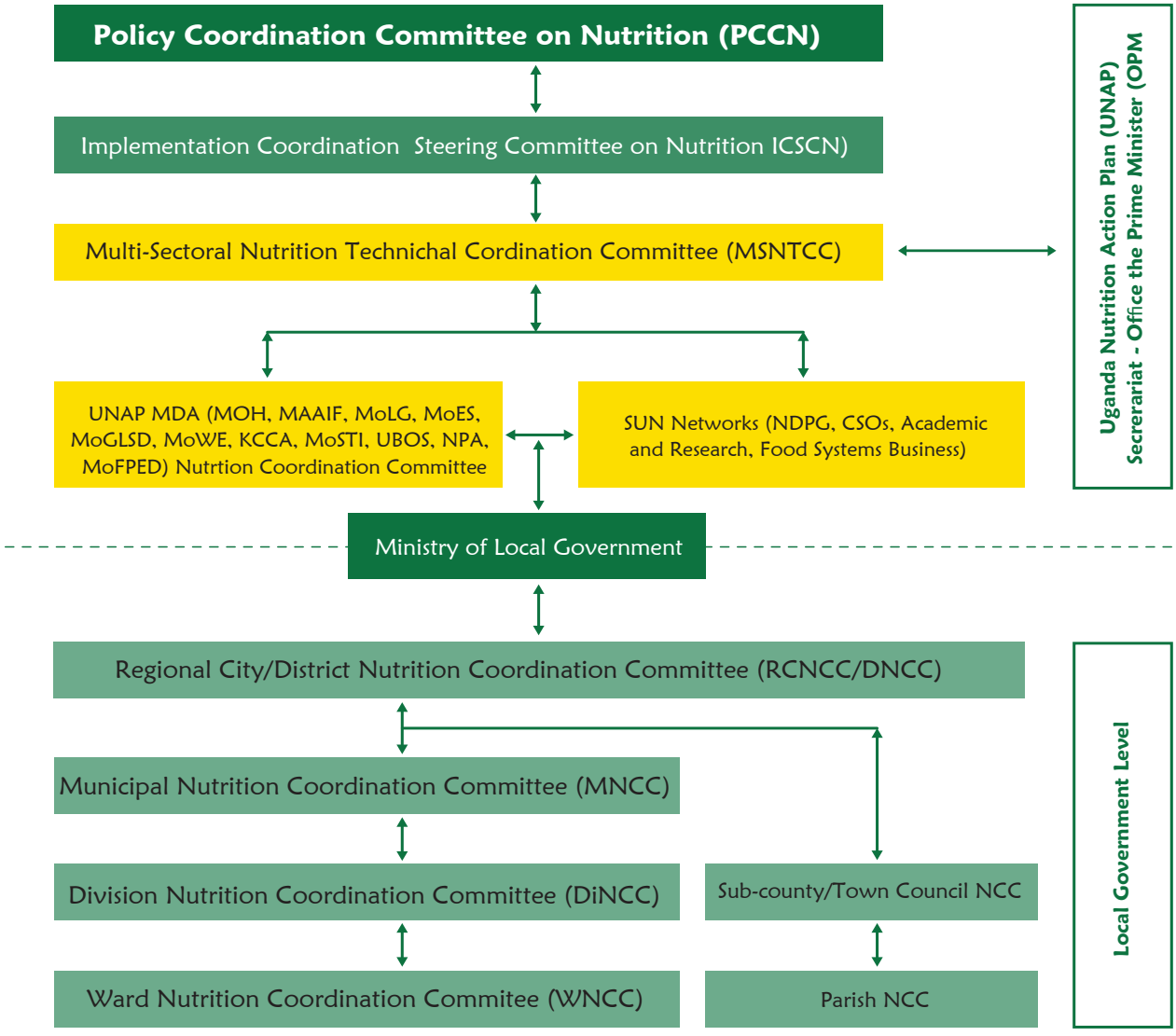

Figure 4-1: Schematic presentation of 'UNAP II' multi-sectoral coordination framework at the national and sub-national levels

4.1 The Kampala Capital City Nutrition (KCC-NCC) Nutrition Coordination Structures

Coordination of Nutrition in KCCA and the five Divisions is provided for under the second Uganda Nutrition Action Plan coordination framework. The three levels of coordination are: (i) Kampala City Authority (KCCA) Nutrition Coordination Committee (ii) Division Nutrition Coordination Committee (DiNCC) and (iii) Ward Nutrition Coordination Committee (WNCC). For each of these coordination structures Terms of Reference (TORs) which define the membership, roles and responsibilities, chair, secretariat, frequency of meetings and manner of call, as well as a functionality assessment tool, have been developed by Office of the Prime Minister for use in coordination of implementation of multi-sectoral nutrition programming. The roles and responsibilities of these NCCs are:

- Advocacy, planning, budgeting, and resource mobilisation.
- Coordination and partnerships.
- Nutrition behaviour change communication and social mobilisation.
- System capacity building and strengthening of nutrition interventions.
- Policy implementation and dissemination.
- Monitoring, evaluation, accountability and learning about the implementation of the 'UNAP II' in the respective entity levels.

4.1.2 Kampala Capital City Authority (KCCA) Nutrition Coordination Committee

The UNAPII coordination structure deliberately provide for KCCA and its five Divisions to facilitate and fast track coordination and implementation of nutrition programming in the KCCA as a matter of urgency. The Coordination of UNAP implementation in KCCA is cognisant of the KCC Act 2010 with its amendments (2019). The KCCA Nutrition Coordination Committee members are drawn from NCC members shall be drawn from the following Directorates of: Administration and Human Resources Management; Treasury Services; Engineering and Technical Services; Public Health and Environment; Education and Social Services; Legal Affairs; Revenue Collection; Gender, Community Services and Production and Internal Audit.

The KCCA Nutrition committee is chaired by Kampala City Authority Executive Director and reports to MSNTC through the UNAP Secretariat. KCCA NCC will particularly provide technical support in the coordination of City divisions actions while city divisions will particularly support strengthening of enabling environment implement at ward levels. The KCCA Nutrition Coordination Committees will regularly undertake support supervision to Divisions to strengthen nutrition governance and technical capacity for nutrition programming and subsequently provide updates to the MSNTC through established reporting arrangements.

4.1.3 KCCA Division Nutrition Coordination Committee (KCCA-DiNCC) and Ward Nutrition Coordination Committee (WNCC)

KCCA-DiNCC members shall be drawn from the following focus areas: Education services, medical operations; Veterinary services; Revenue collection; Gender, Production, and marketing; physical planning; law enforcement, Human Resource; Division clerk; Environmental and sanitation. The Town Clerk is the Chairperson of the KCCA- Division Nutrition Coordination Committee. The committee meetings are held on a quarterly basis and KCCA-DiNCC) reports to the TPC.

4.1.4 Ward Nutrition Coordination Committee WNCC)

Ward Nutrition Coordination Committee (WNCC): Members of the Ward Development Committee established as per the MoLG Parish Development Committee (PDC) Guidelines (2020) constitute the Ward Nutrition Coordination Committee. The WDC (which at the same time will work as the PNCC) is composed as follows: LCII Chairperson; Parish Chief; Members of the parish executives holding the following portfolios; Sec. Production, Sec. Information, Sec. Health, Representatives of the special interest group in the executive (Youth, PWD, Women); CSOs, NGOs, CBOs; Opinion Leaders (Male and Female) such as

retired civil servants; Business/Private Sector Representatives and Chairpersons LC1 Per village). The total number of WNCC will be the same number as the members of the Ward Development Committee. WDCs will be strengthened to effectively oversee planning, implementation, and monitoring of nutrition actions at the ward level as the center of convergence. Through the Parish model approach seven pillars to be implemented will be used as an entry point to KCCA—NAP implementation.

4.2 Roles and Responsibilities of the Stakeholders in the City

Various stakeholders from diverse sectors and organizations within Kampala City have crucial roles in implementing the Kampala Capital City Nutrition Action Plan, to address nutrition-related challenges effectively. Here's an overview of the responsibilities of different stakeholders involved:

4.2.1 Roles of Directorates in KCC-NAP implementation

The implementation matrix (**Annex 1**) provides for Directorates specific outputs and their respective indicators to facilitate monitoring and evaluation of progress of KCC-NAP implantation more regularly (quarterly, bi-annually and annually). It is expected that individual directorates will quality assure nutrition priority actions within their mandates as detailed in the implementation matrix. Implementation of enabling environment actions entirely takes place at Kampala City Authority Nutrition Coordination Committee (KCCANCC) and Division level while implementation of specific and sensitive nutrition actions take place at household, village, and ward levels.

The directorate of Public Health and Environment will provide quality assurance in the implementation of : Maternal, Infant, Young Child and Adolescent Nutrition (MIYCAN) practices in emergencies and stable situations; Promote micronutrient intake among children, adolescent girls and women of reproductive age in stable and emergency situations; integrated management of acute malnutrition in stable and emergency situations; Integrate nutrition services in prevention, control and management of infectious diseases and Integrate nutrition services in prevention, control and management of non-communicable disease.

The department of Production will provide quality assurance in production of diverse, safe, and nutrient dense plant, fisheries and animal source food at household level; access to diverse, safe and nutrient dense plant, fisheries and animal source food; utilization of diverse, safe and nutrient dense plant, fisheries and animal source food.

The department of Gender, Community Services will provide quality assurance in the integration of nutrition services in social protection programs. The directorate of Education and Social Services will provide quality assurance in the integration of nutrition services in access to Integrated Early Childhood Development (IECD) services, and quality education and sports through improved nutrition. The Public Health and Environment will provide quality assurance in the integration of nutrition services in access to nutrition sensitive WASH services. The Department of commercial services will provide quality assurance in Increasing trade, industry, and investments in scaling up nutrition.

4.2.2 Roles of Ministries Departments and Agencies (MDAs)

The KCC-NAP focuses on the implementation of Government nutrition strategies, policies and guidelines. The different MDAs will therefore provide technical guidance, set national nutrition policies and guidelines, and support capacity-building efforts in nutrition programming.

4.2.3 Development Partners, CSOs, NGOs, Private Sector and Non-State Actors

The Development Partners shall continue to play a critical role in the implementation of this policy since they provide the much-needed technical and financial support. The authority shall however gradually increase its role in financing the implementation of the KCC-NAP specifically alignment of resources within the Authority budget to intentionally focus on the target groups of this KCC-NAP at household level. The local government shall work with local and national CSOs, and NGOs engaged in nutrition at all levels. Lessons from experiences working with other non-state actors including religious leaders, academia, and political leaders shall be critical in informing public responses to malnutrition in general.

4.2.4 Community Structures and Households

This KCCA -NAP focuses broadly on reaching communities and households. This is where the impact needs to be felt – at the grassroots. Significant resources including time and technical effort will be devoted to working with community-based and faith-based organizations, including cultural leaders, to promote nutrition at household level. Awareness creation will be a key focus of this policy in order to reach the grassroots with messages on what nutrient mix is required for expectant mothers, infants below 1,000 days, children under-5, youth, women of reproductive age: male and female adults, patients from a host of diseases, PWDs as well as older persons. The KCC-NAP focus is on mind-set change at the household level on the type of foods that generate nutrients, which women can prepare for their households while involving men in the advocacy and behavior change campaigns.

4.2.5 Roles of Religious, Political, Traditional and Cultural Leaders

Political, traditional, and cultural leaders command considerable audience and influence over peoples' attitudes and practices. The Authority will work in close collaboration with traditional and cultural leaders, as well as politicians to advance and promote proper nutrition practices within various levels of governance. Key messages will be used to train and sensitize political and cultural leaders, so they effectively communicate the tenets of this policy while interacting with the public through the media and especially over local FM radios stations available within the region. The Authority will also work with religious organizations, churches, and mosques to ensure they are aware of this KCC-NAP and can communicate messages that support its implementation at the division, ward, village/cell and households.

4.2.6 Roles of Research and Academic Institutions:

To conduct research on nutrition-related topics, evaluate the effectiveness of nutrition interventions, and provide evidence-based recommendations for policy development and program improvement.

4.2.7 Roles of the Media

Broadcasters, Journalists, and Social Media Influencers: Raise awareness about nutrition issues, disseminate information about healthy eating practices, and promote behavior change through various media platforms.

5 Financing and Resource Mobilization

5.1 Estimated financial requirements for implementing KCC-NAP, 'UNAP II'.

The total indicative financial resource requirement is UGX **131.56 billion** for the entire period of seven years, distributed as follows.

131.56
UGX Billion

52.4%
Nutrition-specific interventions will cost
68.88 UGX Billion

32.6%
Nutrition-sensitive interventions will require
42.93 UGX Billion

15%
Enabling environment interventions will require
19.77 UGX Billion

Table 5-1 below summarises estimated cost of implementing the 18 KCC-NAP strategies and achieving results over the seven-year period.

Table 5-1: Summary KCC-NAP seven year Indicative Costs by Objective and Strategy

SN	Strategy	Indicative Cost (UGX Billions)	Lead Directorate
1	**Strategy 1.1:** Promote optimal maternal, infant, young child, and adolescent nutrition (MIYCAN) practices in stable and emergency situations.	63.50	Public Health and Environment
2	**Strategy 1.2:** Promote optimal micronutrient intake among children, adolescent girls, and women of reproductive age in stable and emergency situations.	0.86	Public Health and Environment
3	**Strategy 1.3:** Increase coverage of the management of acute malnutrition in stable and emergency situations.	4.26	Public Health and Environment
4	**Strategy 1.4:** Integrate nutrition services in the prevention, control and management of infectious diseases and epidemics.	-	Public Health and Environment
5	**Strategy 1.5:** Integrate nutrition services in the prevention, control, and management of diet-related non-communicable diseases.	0.26	Public Health and Environment
	Sub Total for Objective one	**68.88**	
6	**Strategy 2.1:** Increase the production of diverse, safe, and nutrient-dense food at the household level from plant, fisheries, and animal sources.	19.29	Gender, Community Services and Production

7	**Strategy 2.2:** Increase access to diverse, safe, and nutrient-dense food from plant, fisheries, and animal sources.	4.64	Gender, Community Services and Production
8	**Strategy 2.3:** Increase the utilization of diverse, safe, and nutrient-dense food from plant, fisheries, and animal sources.	4.48	Gender, Community Services and Production
9	**Strategy 2.4:** Promote the integration of nutrition services in social protection programs.	8.83	Gender, Community Services and Production
10	**Strategy 2.5:** Promote access to nutrition services through integrated early childhood development (ECD) services and quality education and sports.	1.90	Education and Social Services
11	**Strategy 2.6:** Increase access to nutrition-sensitive water, sanitation, and hygiene (WASH) services.	3.05	Public Health and Environment
12	**Strategy 2.7:** Increase the participation of trade, industry, and investment actors in scaling up nutrition.	0.74	Gender, Community Services and Production
	Sub Total for Objective two	**42.93**	
13	**Strategy 3.1:** Strengthen nutrition coordination and partnerships at all levels.	0.98	Administration and Human Resources Management
14	**Strategy 3.2:** Improve the planning, resource mobilization, financing and tracking of nutrition investments.	1.47	Administration and Human Resources Management
15	**Strategy 3.3:** Strengthen institutional and technical capacity for scaling up nutrition actions.	1.79	Administration and Human Resources Management
16	**Strategy 3.4:** Strengthen nutrition advocacy, communication, and social mobilization for nutrition.	7.35	Gender, Community Services and Production
17	**Strategy 3.5:** Strengthen coherent policy, legal and institutional frameworks for nutrition.	2.39	Administration and Human Resources Management
18	**Strategy 3.6:** Strengthen and institutionalize nutrition evidence and knowledge management along with a multi-sectoral nutrition information system for effective decision making.	5.79	Administration and Human Resources Management
	Sub Total for Objective Three	**19.77**	
	Grand Total	**131.56**	

The central government of Uganda together with KCCA, with support from Development Partners, CSOs, Private Sector, Academia and Research Institutions and other stakeholders supporting nutrition in Uganda, will finance the KCC-NAP. Effective coordination, clarity of accountabilities, capacity to complement and leverage resources is vital in ensuring that KCC-NAP is adequately financed. The KCC-NAP implementation matrix in Annex 1, defines directorate priority actions, outputs, and performance indicators. The matrix is

helpful in the process of estimating financial requirements to implement the KCC-NAP. It is important to note that the estimated figures summarised in Table 5.1 are only indicative of the resource requirements to implement KCC-NAP of costs already indicated in the various KCCA SP themes and subprograms and NDPIII PIAPs.

5.2 Generation of indicative costs for KCC-NAP

The indicative figures were arrived at based on existing UNAP II estimates. The Total amount for UNAPII was proportionately allocated to KCCA according to Population of the City. The projected resources for KCC-NAP include resources already available in the NDPIII PIAPs MTEF for line MDAs and ongoing projects and programs. Implementation will be mainstreamed in relevant directorate work plans and budgets generated from the NDPIII Program PIAPs for Agro-Industrialization, Human Capital Development, Community Mobilization and Mindset Change KCC-NAPs strategies and priority actions fall into three categories from cost estimations:

- Nutrition actions that already have an indicative figure provided under the NDPIII PIAPs or MDA work plans and KCCA SP sub programs.
- Existing nutrition actions of capital nature such as water and sanitation infrastructure costs under MoWE; infrastructure costs under MAAIF and MoTIC such as agro-processing industries construction; activities already at MDA level which are aggregated in nature such as disease prevention costs under MOH that contribute to nutrition outcomes without necessarily being included in the UNAPII cost estimate.
- New nutrition specific, nutrition sensitive and enabling environment actions that have not been costed given any cost in the existing government and non-Government plans and yet are a priority in realising of the desired KCC-NAP targets.

Categorisation of strategies and priority actions (as indicated above) helped in conducting targeted review of existing information sources and generating indicative costs. The following data sources were used to come up with KCC-NAP cost estimates: NDPIII Program Implementation Action Plans for (1) Agro-Industrialization (2) Human Capital Development and (3) Community Mobilization and Mindset Change MIYCAN Action Plan 2020-2025 by MOH guided the generation of indicative cost for strategy 1.1 and 1.2; Integrated management of acute malnutrition by MOH guided the indicative figure for strategy 1.3; activities under strategy 1.4 being the core function of MOH disease prevention and control cost were taken to be imbdeded in the mainstream MOH budgets. KCC Strategic Plan for 2020/21-2024/25 provided indicative costs for strategy 2.1 to 2.3. For Strategies 2.4 to 2.7 NDPIII Program Implementation Action Plans for (1) Agro-Industrialization (2) Human Capital Development and (3) Community Mobilization and Mindset Change were used to provide the indicative costs.

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

5.3 Resource mobilization

Development of resource mobilisation and tracking plan has been included as a key activity in the KCC-NAP. The estimated costs of implementing KCC-NAP actions will provide crucial information for development of the resource mobilization and tracking plan. The plan will ensure systematic and sustained financing of nutrition actions.

6 Monitoring, Evaluation, Accountability and Learning (MEAL)

6.1 Overview of the 'KCCA- NAP II' MEAL framework

KCC-NAP recognizes the importance of tracking and evaluating performance of various targets. In addition to tracking program implementation and performance, KCC-NAP will also track resources and build an evidence base for timely decision making, accountability and learning both at national and sub-national level. The MEAL framework is also helpful in aligning stakeholders' commitments, enhancing evidence-based policy dialogue and retaining institutional memory. The KCC-NAP MEAL framework is aligned with UNAPII Monitoring and Evaluation Framework, NDPIII Program Implementation Action Plans, SDGs, WHA targets and the SUN MEAL Framework. The KCC-NAP MEAL framework is detailed under annex 2. The MEAL framework has been developed with a focus on Primary outcomes and intermediate outcomes while the outputs and their indicators are entailed in the Implementation matrix. The outputs and their indicators will be majorly monitored at Division level.

6.2 Primary outcomes of the KCC-NAP

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

6.2.1 Reduced prevalence of under nutrition

- The expected primary targets on under nutrition are:
- Reduced prevalence of stunting in children aged 0-5 years from 16.5 per cent to 14.1 per cent.
- Reduced prevalence of low birth weight (<2500 g) to 4 per cent.
- Reduced prevalence of wasting in children aged 0-5 years from 2.9 per cent to 1.9 per cent.
- Reduced prevalence of anaemia in children aged 0-5 years from 50.9 per cent to 39 per cent.
- Reduced prevalence of anaemia in women of reproductive age from 25per cent to 19.6 per cent.

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

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

- Reduced prevalence of overweight in children aged 0-5 years from 6.3 per cent to 4 per cent.
- Reduced proportion of overweight adult women aged 18+ years from 30.6 per cent to 25 per cent.
- Reduced proportion of overweight adult men aged 18+ years from 17.2 per cent to 12 per cent.
- Reduced proportion of obesity in adult women aged 18+ years from 19.2 per cent to 26.5 per cent.
- Reduced proportion of obesity in adult men aged 18+ years from 3.27 per cent to 2 per cent.
- Reduced age-standardized prevalence of raised blood glucose/diabetes among persons aged 18+ years from 3.3 per cent to 2.1 per cent.
- Reduced age-standardized prevalence of raised blood pressure among persons aged 18+ years from 24 per cent to 20 per cent.

The nutrition-specific intermediate outcomes are:

- **Outcome 1.1:** Improved maternal, infant, young child, and adolescent nutrition (MIYCAN) practices in formal and informal settlements.
- **Outcome 1.2:** Optimal uptake of micronutrients of concern among children, adolescent girls, and women of reproductive age in formal and informal settlements.
- **Outcome 1.3:** Increased coverage of the management of acute malnutrition at health facility level and community level.
- **Outcome 1.4:** Nutrition services fully integrated in the prevention, control and management of infectious diseases and epidemics.
- **Outcome 1.5:** Nutrition services fully integrated in the prevention, control, and management of diet-related non-communicable diseases.

The nutrition-sensitive intermediate outcomes are:

- **Outcome 2.1:** Increased production of diverse, safe, and nutrient-dense food at the household level from plant, fisheries, and animal sources.
- **Outcome 2.2:** Increased access to diverse, safe, and nutrient-dense food from plant, fisheries, and animal sources.
- **Outcome 2.3:** Improved utilization of diverse, safe, and nutrient-dense food from plant, fisheries, and animal sources.
- **Outcome 2.4:** Increased access to nutrition-sensitive services in social protection programs.
- **Outcome 2.5:** Increased access to nutrition services through integrated early childhood development (IECD) services and quality education and sports.
- **Outcome 2.6:** Increased access to nutrition-sensitive water, sanitation, and hygiene (WASH) services.
- **Outcome 2.7:** Increased participation of trade, industry, and investment actors in scaling up nutrition.

The enabling environment intermediate outcomes are:

- **Outcome 3.1:** Strengthened nutrition coordination and partnerships at all levels.
- **Outcome 3.2:** Improved planning, resource mobilization, financing and tracking of nutrition investments.
- **Outcome 3.3:** Strengthened institutional and technical capacity for scaling up nutrition actions.
- **Outcome 3.4:** Strengthened nutrition advocacy, communication, and social mobilization for nutrition.
- **Outcome 3.5:** Coherent policy, legal and institutional frameworks for nutrition.
- **Outcome 3.6:** Improved nutrition evidence and knowledge management along with multi-sectoral nutrition information system for effective decision making.

6.3 'KCC-NAP II' MEAL arrangements

KCCA in collaboration with Divisions and relevant stakeholders will monitor and evaluate progress towards achievement of NAP results at output, intermediate ad primary outcome levels outcomes at output, objective, and goal levels using the set indicators as detailed in the implementation matrix and MEAL framework (Annex 1 and 2 respectively). In addition to routine monitoring, the results from UNPS and UDHS by UBOS will be used to assess the status of realization of KCCA desired results. The administrative data from directorates and divisions will be collated to facilitate KCC-NAP implementation monitoring on a regular basis.

Quarterly and annual monitoring, reporting and reviews.
The KCC-NAP implementation matrix in Annex 2 will guide quarterly work planning, budgeting, implementation and reporting in each Division through output indicators provided. The work plans will detail planned activities under each priority action, expected outputs, output indicator, annual target, timeframe, activity location and activity cost per strategy. It is important to note that the outputs provided in the implementation matrix are for priority actions at strategic level and hence lower-level outputs may be included in the annual work plans based on which activity is planned for implementation under the respective priority action.
From the annual work plan, Quarterly and annual reports will be generated track KCC-NAP implementation on a more regular basis. Quarterly reports will act as a key source of information for annual nutrition review in each Division. The annual reports will provide information on the following areas: achievement of relevant intermediate outcomes, achievement of commitments in line with nutrition scorecard, variance and remedial measures, lessons learned, risks analysis and mitigation measures among others**.**

Mid-term review and summative evaluation
The mid-term review will assess progress and changes in the nutrition context and recommend amenable revisions to strategic objectives and priority actions in response to the changing context. End-term evaluation criteria will highlight the impact, effectiveness, efficiency, sustainability and relevance of nutrition actions and cross cutting issues. DHS surveys, UNPS and Annual FSN Surveys will provide additional information.

Nutrition Data Collection Under the Parish Model
The Parish Based Management Information System (PBMIS) will be established under the custodianship of the Parish Chiefs and coordinated by the KCCA to among other things support community profiling, data collection, analysis, tabulation, storage, and dissemination at the Parish level. The KCCA/Division planning units will provide back-up technical support. Delivery of Nutrition services will be monitored at Parish Level and reports generated and consolidated at the Division Level fitting into the results framework for the PDM.

6.4 Learning

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

6.5 Risks and mitigation measures

The KCC-NAP will strive to identify and manage risks that may affect smooth implementation and achievement of results. The aim is to maximise on opportunities and reduce threats to the achievement of KCAA NAP objectives. This involves identifying and analysing risks through systematic use of available information with the aim of determining the likelihood of specified events occurring. It also involves determining the magnitude and consequences of risks and prioritising risks from the most critical to least critical. Risk mitigation involves the process of coming up with strategies to reduce the likelihood that a risk event will occur and/or reduce the effect of a risk event if it does occur. Various risks are anticipated during KCC-NAP implementation. It is therefore important to prioritise risks based on the likelihood of occurrence and impact using the risk prioritisation matrix in table 6-1 below:

Table 6-1 Risk prioritisation matrix

Likelihood of occurrence	Consequence/impact		
	High	Medium	Low
High	5	4	3
Medium	4	3	2
Low	3	2	1

Table 6-2: Risk prioritisation and mitigation Plan for KCCA- NAP

Identified risk event	Risk consequence	Likelihood of occurrence	Risk impact / consequence	Risk mitigation strategy	Responsibility
Limited integration and implementation of nutrition messages in the KCCA strategic programs and sub programs	Low coverage of nutrition programs leading to low performance	Medium	High	-Continuously monitor and report on integration and implementation convergence for nutrition actions -Ensure effective nutrition multi-sectoral nutrition coordination and linkage	KCCA-Nutrition Coordination Committee
Inadequate institutional and technical capacity to implement, monitor and evaluate KCC-NAP	Poor performance in meeting NAP objectives	Medium	High	-Conduct capacity assessment and use findings to develop and implement Capacity Development Framework for NAP	-KCCA directorates -Implementing partners
Lack of funding for the nutrition related activities which are not funded within the KCCA SP	Slow down or halt in plementation nutrition actions	High	High	-Develop and implement a robust resource mobilization and tracking plan for nutrition. -Champion integration of nutrition to relevant ongoing directorate programs	- KCCA -directorates -Implementing partners

Lack of compliance with requirements for promotion, support and protection of Breast feeding by both public and private actors	Limited compliance leading to missed opportunities in improving nutrition	High	High	-Include monitoring of enforcement and compliance as part of the M&E framework	- KCCA -directorates DP -Implementing partners
Access to Poverty Pockets within the city	Poor access and utilization of Nutritious food	High	High	Focused Community Mobilization to address poverty pockets in places like Namuwongo, Kivulu, and Kamwokya	KCCA -directorates DP -Implementing partners

The table 6-2 above, identifies specific risks, likelihood of occurrence, their consequences, and the risk priority. It proposes mitigation measures and stakeholders responsible for implementing and monitoring mitigation measures.

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- Cover Image by: www.freepik.com flat-lay-healthy-immunity-boosting-foods

Annexes

ANNEX 1: KCC-NAP IMPLEMENTATION MATRIX FY 2023/24-2029/2030

Details the priority actions, outputs, output indicators, estimated cost for the seven-year period, lead directorates and the relevant NDPIII (2020/21-2024/25) Program Implementation Plan (PIAP) alignment. From this matrix, annual work plans will be developed by KCCA and the Divisions to detail which activities will be implanted to deliver the expected outputs on an annual basis.

Objective	Priority Actions	Outputs	Output Indicators	Cost (UGX Bn)	Lead Directorate	NDPIII PIAP /KCCA SP sub program
Objective 1: To increase access to and utilization of nutrition specific services by children under 5 years, school age children, adolescent girls, pregnant and lactating women, and other	**Strategy1.1 : Promote Maternal, Infant, Young Child and Adolescent Nutrition (MIYCAN) practices in stable and emergency situations**			**63.50**	**Public Health and Environment**	**HCDP Objective 1 under intervention 1.2**
	Intermediate Outcome 1.1 improved Maternal, Infant, Young Child, and Adolescent Nutrition (MIYCAN) practices in stable and emergency situations					
	Promote Exclusive breastfeeding for the first six months	Baby Friendly Initiatives in health facilities and workplaces scaled up	Proportion of Health facilities certifies as Baby Friendly	3.17	Public Health and Environment	HCDP Objective 1 under intervention 1.2
			Number of Exclusive breastfeeding promotion activities	2.54	Public Health and Environment	HCDP Objective 1 under intervention 1.2
		Increased number of work places with breastfeeding corners in public & private institutions established	% of workplaces with breastfeeding corners	3.17	Public Health and Environment	HCDP Objective 1 under intervention 1.2
		Increased number of commercial outlets and health facilities monitored conforming to the code of marketing	% of commercial outlets and health facilities monitored conforming to the code of marketing	12.7	Public Health and Environment	HCDP Objective 1 under intervention 1.2

vulnerable groups		Increased number of breastfeeding mothers sensitized on optimal breastfeeding & complimentary feeding practices by peer mothers	Proportion of breastfeeding mothers sensitized on exclusive breastfeeding practices by peer mothers	19.05	Public Health and Environment	HCDP Objective 1 under intervention 1.2
	Promote Complementary feeding among Children 6-23 months of age	Peer mothers trained to mobilize & sensitize breastfeeding mothers to adopt optimal breastfeeding & complimentary feeding practices	Proportion of Peer mothers trained to mobilize & sensitize breastfeeding mothers on optimal breastfeeding & complimentary feeding practices	19.05	Public Health and Environment	HCDP Objective 1 under intervention 1.2
	Promote and support Growth promotion and monitoring services at health facilities and community	Increased number of children 0-5 years reached with Growth promotion and monitoring services at health facilities and community	Proportion of children 0-5 years reached with GMP services at Facility	1.27	Public Health and Environment	HCDP Objective 1 under intervention 1.2
			Proportion of children 0-5 years reached with GMP services at Community level	2.54	Public Health and Environment	HCDP Objective 1 under intervention 1.2
	Strategy 1.2: Promote Optimal intake of micronutrient intake among children, adolescent girls and women of reproductive age in stable and emergency situations			**0.86**	**Public Health and Environment**	**HCDP Objective 1 under intervention 1.2**
	Intermediate Outcome 1.2: Improved intake of micronutrient among children, adolescent girls and women of reproductive age in stable and emergency situations					
	Provide Routine Vitamin A supplementation to	Increased number of 6-59 months' children receiving	Vitamin A second dose coverage for children 6-59 months of age (%)	0.52	Public Health and Environment	HCDP Objective 1 under intervention 1.2

	all children U5 years during Integrated Child Health Days	Vitamin A second dose				
	Educate and provide all pregnant women attending ANC for uptake of iron and folate supplementation (women receiving iron/folate)	Increased number of pregnant women receiving iron/folate supplement	% of pregnant women receiving iron/folate supplement	0.34	Public Health and Environment	HCDP Objective 1 under intervention 1.2
	Strategy1.3: Increase coverage of management for acute malnutrition in stable and in emergency situations			**4.26**	**Public Health and Environment**	**HCDP Objective 4. Improve population health, safety, and management.**
	Intermediate Outcome 1.3: Increased coverage of management of acute malnutrition in stable and emergency situations					
	Integrate routine screening, and timely management of severe and moderate acute malnutrition into routine health services at health facility level and community level.	Availability and supply of essential nutrition commodities and logistics for management of acute malnutrition streamlined	Supply documents indicating Availability and supply of essential nutrition commodities and logistics for management of acute malnutrition	Imbedded in the MOH activities	Public Health and Environment	HCDP Objective 4. Intervention 4.1: Reduce the burden of malnutrition across all age groups emphasizing Primary Health Care Approach
		Nutrition assessment, counselling and support at health faculty and	Proportion individuals (per age category) accessing nutrition assessment and screening services		Public Health and Environment	HCDP Objective 4. Intervention 4.1:

		community levels scaled up				
		Referral systems for management of acute malnutrition strengthen	Percentage of individuals identified with malnutrition and referred for treatment		Public Health and Environment	HCDP Objective 4. Intervention 4.1:
		Increased number of health facilities providing IMAM services	Proportion of facilities providing IMAM services	1.92	Public Health and Environment	HCDP Objective 4. Intervention 4.1:
		Increased number of malnourished individuals receiving IMAM services	Percentage of malnourished individuals receiving IMAM services	1.28	Public Health and Environment	HCDP Objective 4. Intervention 4.1:
		Increased number of malnourished clients linked to support services at community level	Proportion of malnourished clients linked to support services at community level	1.06	Public Health and Environment	HCDP Objective 4. Intervention 4.1:
	Strategy 1.4: Nutrition services integrated in prevention, control, and management of infectious diseases					
	Strategy 1.4: Integrate Nutrition services in prevention, control, and management of infectious diseases					
	Increase access to immunization against childhood diseases	Communities mobilized to increase uptake for child immunization services	Proportion of villages mobilized to increase uptake for child immunization services	Imbedded in the MOH activities	Public Health and Environment	HCDP Objective 4 Intervention 4.1: Reduce the burden of communicable diseases with focus on high burden diseases, epidemic prone diseases across all age groups emphasizing Primary Health Care Approach
		Increased number of 1-year-old	Proportion of 1-year-old children who have	Imbedded in the	Public Health and Environment	HCDP Objective 4 under intervention 4.1

		children who have received the appropriate doses of the recommended vaccines	received the appropriate doses of the recommended vaccines in the national schedule	MOH activities		
	Promote de-worming medications targeting children above 1-14 years receiving at two doses per year	Increased number of children above 1-4 years receiving at two doses per year	Proportion of children 1-4 years receiving two doses of deworming medication per year	Imbedded in the MOH activities	Public Health and Environment	HCDP Objective 4 under intervention 4.1
		Increased number of children 5 to 14 receiving two doses of deworming medication per year	Proportion of children 5 to 14 years receiving two doses of deworming medication per year	Imbedded in the MOH activities	Public Health and Environment	HCDP Objective 4 under intervention 4.1
	Reduce the burden of communicable diseases with focus on high burden diseases (malaria and diarrhoea) related to malnutrition through the Primary Health Care Approach	Strengthened community-based behavioural change actions to harness and sustain positive malaria practices among children 0-5 years, pregnant and lactating women	% of the population with knowledge, utilize and practice correct malaria prevention, control, and management measures	Imbedded in the MOH activities	Public Health and Environment	HCDP Objective 4 under intervention 4.1
			% of Primary Health care programs integrating nutrition actions	Imbedded in the MOH activities	Public Health and Environment	HCDP Objective 4 under intervention 4.1
		Strengthened community-based behavioural change actions to harness and sustain positive	% of the population with knowledge, utilize and practice correct diarrhoea prevention, control, and	Imbedded in the MOH activities	Public Health and Environment	HCDP Objective 4 under intervention 4.1

		diarrhoea practices among children 0-5 years	management measures for 0-5 years children			
	Strengthening safe food handling	Safe food handling strengthened	Proportion of registered food handlers sensitised on food handling		Public Health and Environment	Kampala Public Health Care program
	Deepening the sustainability and quality of WASH;	Sustainability and quality of WASH deepened	Proportion of villages reached with Sustainability and quality of WASH messages		Public Health and Environment	Kampala Public Health Care program
	Ensuring provision of equitable and quality health care	Provision of equitable and quality health care ensured	Coverage of quality health		Public Health and Environment	Kampala Public Health Care program
	Promotion of integrated public health surveillance and advocacy.	Integrated public health surveillance and advocacy promoted	Proportion of wards promoting public health surveillance and advocacy		Public Health and Environment	Kampala Public Health Care program
	Strategy 1.5: Integrate nutrition services in prevention, control, and management of non-communicable diseases			**0.26**	**Public Health and Environment**	**HCDP Objective 4. Improve population health, safety, and management. Intervention 4.10 and 4.12**
	Intermediate Outcome 1.5: Nutrition integrated management of Diet Related Non-Communicable Diseases (DRNCDs)					
	Have a national physical exercise day	National physical exercise day held	National Physical exercise day organised	Imbedded in the MOH NCDs activities	Public Health and Environment	HCDP Objective 4 under intervention 4.12 Promote physical health activities and behavioral change across all categories of the population
	Conduct sensitization of employers and workers on	Employers and workers sensitized on workplace physical activities	No of workplaces with physical exercise initiatives	Imbedded in the MOH	Public Health and Environment	HCDP Objective 4 under intervention 4.12 Promote physical health activities and

	workplace physical activities for staff			NCDs activities		behavioural change across all categories of the population
			Physical fitness increased	Imbedded in the MOH NCDs activities	Public Health and Environment	HCDP Objective 4 under intervention 4.12 Promote physical health activities and behavioural change across all categories of the population
	Assess Workers and employees for Body Mass Index	Workers assessed for Body Mass Index	Proportion of workers and employees assessed for Body Mass Index	Imbedded in the MOH NCDs activities	Public Health and Environment	HCDP Objective 4 under intervention 4.12 Promote physical health activities and behavioural change across all categories of the population
	Assess Workers and employees for Diabetes and Hypertension	Assess Workers assessed for Diabetes and Hypertension	Proportion of workers and employees assessed for Diabetes and Hypertension	Imbedded in the MOH NCDs activities	Public Health and Environment	HCDP Objective 4 under intervention 4.12 Promote physical health activities and behavioural change across all categories of the population
			Proportion of workers and employees assessed for Hypertension	Imbedded in the MOH NCDs activities	Public Health and Environment	HCDP Objective 4 under intervention 4.12 Promote physical health activities and behavioural change across all categories of the population
	Procure Nutrition Assessment and Health fitness equipment	Nutrition Assessment and Health fitness equipment procured.	Proportion of households and communities sensitized on healthy eating and lifestyle	Imbedded in the MOH NCDs activities	Public Health and Environment	HCDP Objective 4 under intervention 4.12 Promote physical health activities and behavioural change across all categories of the population
	Social behaviour change communication on	Social behaviour change communication on	Proportion of healthcare providers trained on DRNCDs at all levels	Imbedded in the MOH	Public Health and Environment	HCDP Objective 4 under intervention 4.10 Improve nutrition and food safety with

	feeding habits and behaviours	feeding habits and behaviours		NCDs activities		emphasis on children aged under 5, school children, adolescents, pregnant and lactating women, and vulnerable groups
	Sensitize households and communities on healthy eating and lifestyle	Increased number of households and communities sensitized on healthy eating and lifestyle	Proportion of households and communities sensitized on healthy eating and lifestyle	0.16	Public Health and Environment	
	Engage in public and private sectors, civil society and other stakeholders in promotion of healthy diets and lifestyles	Increased number of healthcare providers trained on healthy diets and lifestyles	Proportion of public and private sectors, civil society and other stakeholders engaged in promoting healthy diets and lifestyles	0.10	Public Health and Environment	
Objective 2: To increase access to and utilization of nutrition sensitive services by	**Strategy 2.1: Increase production, access to and consumption of diverse, safe, and nutrient dense plant, fisheries, and animal source food at household level.**			**19.29**	**Gender, Community Services and Production**	**Kampala Urban Agriculture Program**
	Intermediate Outcome 2.1: Increased production, access and consumption of diverse, safe, and nutrient dense plant, fisheries and animal source food at household level.					
	Promoting Agriculture as a business venture and divert labour	Agriculture promoted as a business venture	Proportion of households practicing agriculture as a business venture	**3.86**	Gender, Community Services and Production	Kampala Urban Agriculture Program

children under 5 years, school age children, adolescent girls, pregnant and lactating women, and other vulnerable groups.	from high intensity activities like trading and transport to production sectors	Increased labour diversion from high intensity activities like trading and transport to production activities	Proportion households participating in labour diversion from high intensity activities like trading and transport to production activities	**5.79**	Gender, Community Services and Production	Kampala Urban Agriculture Program
	Enhancing food security and household incomes	Household food security enhanced	Proportion of food secure households	**2.89**	Gender, Community Services and Production	Kampala Urban Agriculture Program
		Household incomes enhanced	Proportion of households reporting urban agriculture as their key source of income	**2.89**	Gender, Community Services and Production	Kampala Urban Agriculture Program
	Promoting Urban Agriculture as part of the city's inclusive and green growth strategy	Urban Agriculture promoted as part of the city's inclusive and green growth strategy	Proportion of households promoting Urban Agriculture as part of the city's inclusive and green growth strategy	**3.86**	Gender, Community Services and Production	Kampala Urban Agriculture Program
	Strategy 2.4: Promote integration of nutrition services in social protection programs			**8.83**	**Gender, Community Services and Production**	**HCDP Objective 5: Reduce vulnerability and gender inequality along the lifecycle**
	Intermediate outcome 2.4: Increased access to nutrition sensitive social protection program					
	Identify, prioritize and support programs and	Households of the vulnerable poor and most affected	Proportion of vulnerable poor and most affected households identified to	**0.90**	Gender, Community Services and Production	Covid-19 Economic Support and Stimulus Program

	projects which can stimulate economic activity for the vulnerable poor and most affected cash for work programs to sustain livelihoods	identified to benefit from cash for work programs	benefit from cash for work programs			
		Increased number of Households of the vulnerable poor and most affected benefiting from cash for work programs	Proportion of Households of the vulnerable poor and most affected benefiting from cash for work programs	**1.77**	Gender, Community Services and Production	Covid-19 Economic Support and Stimulus Program
	Youth Livelihood Project	Increased number of Youth Livelihood beneficiaries engaged in nutrition sensitive interventions	Proportion of Youth Livelihood beneficiaries engaged in nutrition sensitive interventions	**3.48**	Gender, Community Services and Production	Citizen Support and mobilization program - Community
	Community Development Program	Increased number of women of reproductive age engaged in nutrition sensitive interventions with Uganda Women Entrepreneur Program Funds	Proportion of women of reproductive age engaged in nutrition sensitive interventions with Uganda Women Entrepreneur Program Funds			
	Uganda Women Entrepreneur Program	Increased number of women of reproductive age assessing Uganda Women Entrepreneur Program Funds	Proportion of women of reproductive age assessing Uganda Women Entrepreneur Program Funds			

	Provide Easy-to-Use Platform for Innovation and Engagement	Easy-to-Use Platform for Innovation and Engagement provided	Easy-to-Use Platform for Innovation and Engagement in place	**0.27**	Gender, Community Services and Production	Citizen Engagement Program
	Develop a Comprehensive Communications Strategy	A comprehensive Communications Strategy developed	A comprehensive Communications Strategy in place	0.27	Gender, Community Services and Production	Citizen Engagement Program
	Carry out annual citizen's satisfaction survey	An annual citizen's satisfaction survey conducted	An annual citizen's satisfaction survey report	0.80	Gender, Community Services and Production	Citizen Engagement Program
	Support citizen groups that are most, socially, and economically vulnerable	Citizen groups that are most, socially, and economically vulnerable supported	Proportion of Citizen groups that are most, socially, and economically vulnerable supported	**0.40**	Gender, Community Services and Production	Citizen Support Program
	Implement the Adolescent Girls Social Protection Project.	The Adolescent Girls Social Protection Project implemented	Proportion of Adolescent Girls benefiting from Adolescent Girls Social Protection Project	0.54	Gender, Community Services and Production	Citizen Support Program
	Implement the Social Assistance Grants for Empowerment (SAGE) program	The Social Assistance Grants for Empowerment (SAGE) program	Proportion of older persons benefiting from Social Assistance Grants for Empowerment (SAGE) program	0.40	Gender, Community Services and Production	Citizen Support Program
	Strategy 2.5: Promote access to Integrated Early Childhood Development (IECD) services, and quality education and sports through improved nutrition			1.90	**Education and Social Services**	**HCDP objective 1;**
	Intermediate Outcome 2.5: Increased access to efficient and quality Integrated Early Childhood Development (IECD) services, education, and sports through improved nutrition.					

	Register all ECD centres in accordance with the BRMS	ECD centres registered in accordance with the BRMS	% of ECD centres registered in accordance with the BRMS	0.10	Education and Social Services	HCDP objective 1; under output: ECD centres registered
	Sensitize private players to spread ECD centres to the under-served areas	Private players sensitised to spread ECD centres to the under-served areas	Proportion of private players who spread ECD centres to the under-served areas after being sensitised	0.57	Education and Social Services	HCDP objective 1under output: ECD centres registered
	Develop Educational Quality Monitoring and Management Information Systems	Educational Quality Monitoring and Management Information Systems developed	Educational Quality Monitoring and Management Information Systems in place	**0.48**	Education and Social Services	Education Quality Improvement program
	Establishing systems to ensure that learners Enter, Stay and Complete their education cycles	Systems to ensure that learners Enter, Stay and Complete their education cycles established	Systems to ensure that learners Enter, Stay and Complete their education cycles in place	0.47	Education and Social Services	Education Quality Improvement program
	Increase access to ECD services for children 0-8 years	Integrated Early Childhood Development Service Delivery Framework Rolled out	Proportion of children 0-8 years accessing ECD services	0.28	Education and Social Services	HCDP objective 1under output: Proportion of children 0-8 years accessing ECD services
	Promote and enforce mandatory consumption of safe and fortified foods in schools	Nutritious meals provided at schools	Number of schools (primary and secondary) providing safe and fortified foods to children		Education and Social Services	HCDP objective 4 Intervention 4.15 Establish and operationalize a multi-sectoral home-grown (context specific) school feeding initiative

	Mobilize parents to provide meals to school going children in the city	Parents mobilized to provide a hot healthy meal to their school going children during school days	% of Day-school going Children having at least a healthy hot meal a day.		Education and Social Services	HCDP objective 4 Intervention 4.15 Establish and operationalize a multi-sectoral home-grown (context specific) school feeding initiative
	Strategy 2.6: Increase access to nutrition sensitive Water Sanitation and Hygiene (WASH) services			**3.05**	**Public Health and Environment**	**Kampala Water and Sanitation Improvement Program**
	Intermediate Outcome 2.6: Increased access to nutrition sensitive Water Sanitation and Hygiene (WASH) services					
	Increase access to inclusive safe water supply in KCCA.	Lake Victoria Water and Sanitation for Millions implemented Project	Proportion of villages covered under the Lake Victoria Water and Sanitation Project Sanitation for Millions project	**3.05**	Public Health and Environment	Kampala Water and Sanitation Improvement Program
		Sustainable Water, Sanitation and Hygiene Services at Scale SWASH- City Wide Inclusive Sanitation (CWIS) Program implemented	Proportion of villages covered by the Sustainable Water, Sanitation and Hygiene Services at Scale up WASH- City Wide Inclusive Sanitation (CWIS) Program		Public Health and Environment	Kampala Water and Sanitation Improvement Program
	Increase access to inclusive sanitation and hygiene services in urban areas	Increased number of urban centres reached with social behaviour change communication for construction and use of improved sanitation facilities	% of population with access to basic sanitation in urban areas		Public Health and Environment	HCDP objective 4; Intervention 4.5

		Increased number of urban centres reached with social behaviour change communication for use of hand washing with water, investment in public hand washing facilities	% of population with hand washing facilities with soap and water at home in urban areas		Public Health and Environment	HCDP objective 4; Intervention 4.5
	Provide support to improved WASH services in institutions.	Increased number of schools reached with social behaviour change communication for use of sanitation facilities and hand washing with water	% of pupils enrolled in schools provided with basic sanitation and hand washing facilities		Public Health and Environment	HCDP objective 4; Intervention 4.5
	Improve nutrition and food safety with emphasis on children aged under 5, school children	Increased number of households sensitized on water usage and hand washing practices with particular focus on nutrition and food safety	Number of households sensitised on water usage and hand washing practices with particular focus on nutrition and food safety		Public Health and Environment	HCDP objective 4; Intervention 4.5
		Increased number of household monitor and evaluated on water usage and hand washing practices	Number of households monitor and evaluated for		Public Health and Environment	HCDP objective 4; Intervention 4.5

		with particular focus on nutrition and food safety				
	Strategy 2.7: Increase trade, industry, and investments in scaling up nutrition			**0.74**	**Small Medium Enterprise (SME) Development Project**	
	Intermediate Outcome 2.7: Increased trade, industry, and investments in scaling up nutrition					
	Undertaking business capacity building activities such as providing training in bookkeeping	Business capacity building activities such as providing training in bookkeeping undertaken		**0.37**	Gender, Community Services and Production	Small Medium Enterprise (SME) Development Project
	Support new businesses registering to become formal	Increased number of businesses registering to become formal			Gender, Community Services and Production	Small Medium Enterprise (SME) Development Project
	Link businesses to capital financing opportunities within and beyond KCCA ongoing programs	Improved linkage of businesses to capital financing opportunities within and beyond KCCA ongoing programs			Gender, Community Services and Production	Small Medium Enterprise (SME) Development Project
	Reorganizing the retail trade (most in the urban markets)	Retail trade (most in the urban markets) actors in food business reorganised to practice trade for improved nutrition			Gender, Community Services and Production	Market and Artisanal Park Infrastructure Development

	Enhancing commercialization of agricultural produce	Commercialization of agricultural produce enhanced			Gender, Community Services and Production	Market and Artisanal Park Infrastructure Development
	Improving marketplace Infrastructure and creating more workspaces	Improved Marketplace Infrastructure targeting more work spaces for food trade		**0.37**	Gender, Community Services and Production	Market and Artisanal Park Infrastructure Development
	Enhancing the value of agricultural produce, while increasing localization of produce in selected markets	Value of agricultural produce enhanced/increased for localization of produce in selected markets			Gender, Community Services and Production	Market and Artisanal Park Infrastructure Development
Objective 3: Strengthen the enabling environment for scaling up nutrition specific and nutrition sensitive services	**Strategy 3.1: Strengthen nutrition coordination and partnerships at all levels**			**0.98**	**HCDP Objective 1.**	
	Intermediate Outcome 3.1: Strengthened nutrition coordination and partnerships at all levels.					
	Conduct annual nutrition stakeholder and action mapping for Kampala City Authority	Nutrition stakeholder and action mapping for Kampala City conducted annually	Nutrition stakeholder and action mapping at MDA levels	0.29	Administration and Human Resources Management	Intervention 1.2 a. Strengthen the enabling environment for scaling up nutrition at all levels
	Conduct annual nutrition stakeholder and action mapping at the Division Level	Nutrition stakeholder and action mapping at City Division levels conducted annually	Nutrition stakeholder and action mapping at Local Government levels	0.29	Administration and Human Resources Management	Intervention 1.2 a. Strengthen the enabling environment for scaling up nutrition at all levels

	Establish and support functionality of Nutrition Coordination Committees at KCCA	KCCA NCC is fully established and fully functional	Overall Functionality score of the KCCA NCC	0.20	Administration and Human Resources Management	Intervention 1.2 a.Strengthen the enabling environment for scaling up nutrition at all levels
	Establish and support functionality of Nutrition Coordination Committees at the City Division level	Existence of nutrition coordination committees at all levels of Divisions	Functionality Index of Division Nutrition Coordination Committees	0.20	Administration and Human Resources Management	Intervention 1.2 a. Strengthen the enabling environment for scaling up nutrition at all levels
	Strategy 3.2: Improve planning, resource mobilization, financing and tracking of nutrition investments			**1.47**	**Intervention 1.2 a. Strengthen the enabling environment for scaling up nutrition at all levels**	
	Intermediate 3.2: Improve planning, resource mobilization, financing and tracking of nutrition investments					
	Develop Nutrition Action Plans (KCCA and the 5 Divisions) aligned to UNAP II and NDPIII PIAPs	Nutrition Action Plans (KCCA and the 5 Divisions) developed	Nutrition Action Plans (KCCA and the 5 Divisions) in place for implementation	0.44	Administration and Human Resources Management	Intervention 1.2 a. Strengthen the enabling environment for scaling up nutrition at all levels
	Develop Joint Annual Nutrition Work plans Action Plans (KCCA and the 5 Divisions) aligned to Nutrition Action Plan Implementation Matrix	Joint Annual Nutrition Work Plans (KCCA and the 5 Divisions) developed	Joint Annual Nutrition Work Plans (KCCA and the 5 Divisions) in place for implementation		Administration and Human Resources Management	Intervention 1.2 a. Strengthen the enabling environment for scaling up nutrition at all levels

	Undertake expenditure reviews for Nutrition	Nutrition expenditure review finalized, and report disseminated	Nutrition expenditure review report in place	0.29	Administration and Human Resources Management	Intervention 1.2 a. Strengthen the enabling environment for scaling up nutrition at all levels
	Conduct detailed costing of the KCCA-NAP	KCCA-NAP costed.	Report indicating costs per priority action in the KCCA-NAP	0.15	Administration and Human Resources Management	Intervention 1.2 a. Strengthen the enabling environment for scaling up nutrition at all levels
	Develop and Implement resource mobilization and tracking plan for nutrition aligned to the KCCA NAP	Resource mobilization and tracking plan for nutrition developed	Resource mobilization and tracking plan in place	0.59	Administration and Human Resources Management	Intervention 1.2 a. Strengthen the enabling environment for scaling up nutrition at all levels
	Strategy 3.3: Strengthen institutional and technical capacity for scaling up nutrition actions			**1.79**	**Intervention 1.2 a. Strengthen the enabling environment for scaling up nutrition at all levels**	
	Intermediate Outcome 3.3: Strengthened institutional and technical capacity for scaling up nutrition actions.					
	Conduct Nutrition Capacity Assessments at KCCA	Nutrition capacity gaps identified and prioritized for action by KCCA	KCCA Nutrition Capacity assessment report	0.17	Administration and Human Resources Management	Intervention 1.2 a. Strengthen the enabling environment for scaling up nutrition at all levels
	Conduct Nutrition Capacity Assessments among at Divisions	Nutrition capacity gaps identified and prioritized for action by Divisions	Division Nutrition Capacity assessment report	0.36	Administration and Human Resources Management	Intervention 1.2 a. Strengthen the enabling environment for scaling up nutrition at all levels
	Develop Nutrition Capacity Development Framework for KCCA	Nutrition Capacity Development Framework for KCCA developed.	Nutrition Capacity Development Framework in place	0.27	Administration and Human Resources Management	Intervention 1.2 a. Strengthen the enabling environment for scaling up nutrition at all levels

	Develop Nutrition Capacity Development Framework for Divisions	All Divisions integrate nutrition capacity Development activities in annual work plans and budgets.	Nutrition Capacity Development Framework for Divisions	0.36	Administration and Human Resources Management	Intervention 1.2 a. Strengthen the enabling environment for scaling up nutrition at all levels
	Implement the Nutrition Capacity Development Framework for KCCA	The Nutrition capacity development plan is fully implemented by KCCA and implementing partners.	Status of implementation of the Nutrition Capacity Development Framework for KCCA NAP	0.27	Administration and Human Resources Management	Intervention 1.2 a. Strengthen the enabling environment for scaling up nutrition at all levels
	Implement the Nutrition Capacity Development Framework for Divisions	The Nutrition capacity development plan is fully implemented by all Divisions	Status of implementation for the Nutrition Capacity Development Framework at Division level	0.36	Administration and Human Resources Management	Intervention 1.2 a. Strengthen the enabling environment for scaling up nutrition at all levels
	Strategy 3.4: Strengthen nutrition advocacy, communication, and social mobilization for nutrition			**7.35**	**Administration and Human Resources Management**	
	Intermediate Outcome: Strengthened nutrition advocacy, communication, and social mobilization for nutrition					
	Develop the Nutrition advocacy communication strategy for KCCA fully aligned with UNAPII strategic direction	Nutrition advocacy communication strategy fully aligned with UNAPII strategic direction developed	Nutrition advocacy communication strategy fully aligned with UNAPII strategic direction	1.10	Gender, Community Services and Production, Public Health and Environment, Education and Social Services	Intervention 1.2 a. Strengthen the enabling environment for scaling up nutrition at all levels

		Training packages for the NACSII developed	Training packages for the NACSII developed		Gender, Community Services and Production, Public Health and Environment, Education and Social Services	Intervention 1.2 a. Strengthen the enabling environment for scaling up nutrition at all levels
	Rollout Develop/Implement for KCCA specific Nutrition Advocacy and Communication Campaign	Sub regional context NACSII implementation framework developed and implemented	Number of Sub regional context NACSII implementation framework in place	0.37	Gender, Community Services and Production, Public Health and Environment, Education and Social Services	Intervention 1.2 a. Strengthen the enabling environment for scaling up nutrition at all levels
	Mobilize and institute High-level nutrition advocates to actively advance the nutrition agenda at KCCA and subdivision	High-level nutrition advocates instituted at national level and actively advance the nutrition agenda.	Number of High-level nutrition advocates instituted		Gender, Community Services and Production, Public Health and Environment, Education and Social Services	Intervention 1.2 a. Strengthen the enabling environment for scaling up nutrition at all levels
	Develop Nutrition advocacy briefs and technical briefs for use at KCCA and Division	Nutrition advocacy briefs and technical briefs are harmonized and used.	Number of Nutrition advocacy briefs/ technical briefs	0.37	Gender, Community Services and Production, Public Health and Environment, Education and Social Services	Intervention 1.2 a. Strengthen the enabling environment for scaling up nutrition at all levels
	Develop nutrition commitments scorecards at KCCA and Division levels	Advocacy and SBCC campaign systematically use scorecards at	Number MDAs with scorecards for Nutrition Advocacy and SBCC campaigns	1.84	Gender, Community Services and Production	Intervention 1.2 a. Strengthen the enabling environment for scaling up nutrition at all levels

		national and MDAs levels				
	Build Capacity of Community Based structures to Triger and deliver community-based advocacy, social mobilization, and behavioural change communication on nutrition interventions	Capacity of Community Based structures built to deliver advocacy, social mobilization, and behavioural change communication for nutrition	No. of Community engagement dialogues for advocacy, social mobilization, and behavioural change communication for nutrition	1.84	Gender, Community Services and Production	Intervention 1.2 a. Strengthen the enabling environment for scaling up nutrition at all levels
	Undertake campaigns to reduce teenage pregnancy, GBV, & other harmful practices that result into malnutrition	Campaign to reduce teenage pregnancy, GBV, & other harmful practices that result into malnutrition	Number of campaigns on teenage pregnancy, GBV, & other harmful practices that result into malnutrition conducted	1.84	Gender, Community Services and Production	
	Strategy 3.5: Strengthen coherent policy, legislation, and institutional frameworks for scaling up nutrition			**2.39**	Administration and Human Resources Management	Intervention 1.2 a. Strengthen the enabling environment for scaling up nutrition at all levels
	Intermediate Outcome 3.5: Coherent policy, legal and institutional frameworks for nutrition.					
	Implement the Teachers guide on nutrition and comic book implemented	Teachers guide on nutrition and comic book implemented	Status of implementation of the Teachers guide and comic book	2.39	Administration and Human Resources Management, Education and social services, public health, and environment	Intervention 1.2 a. Strengthen the enabling environment for scaling up nutrition at all levels

	Strategy 3.6: Strengthen and institutionalize nutrition evidence and knowledge management along with multi-sectoral nutrition information system for effective decision making.		**5.79**	Administration and Human Resources Management, Gender, Community Services and Production, Public Health and Environment, Education and Social Services	Intervention 1.2 a. Strengthen the enabling environment for scaling up nutrition at all levels
	Intermediate Outcome 3.6: Mechanism for nutrition evidence and knowledge management along with multi-sector nutrition information system institutionalized for effective decision making				
	Develop, disseminate, and enhance use of evidence-based nutrition knowledge products at all levels	Knowledge products for nutrition developed	Number of knowledge products for nutrition developed and disseminated	5.79	Administration and Human Resources Management, Gender, Community Services and Production, Public Health and Environment, Education and Social Services	Intervention 1.2 a. Strengthen the enabling environment for scaling up nutrition at all levels

ANNEX 2: KCC-NAP MEAL Framework 2023/24-2029/30 aligned with NDPIII, UNAPII and PDM Frameworks

Level of Results	Description of Results	Indicator	Base Year Value (Yr. -0) 2023	Year 7 Target 2030	National Framework aligned
Goal: Improve nutrition status among children under 5 years, adolescents (in and out of school), pregnant and lactating women and other vulnerable groups by 2030.	**Reduced prevalence of under nutrition**	Prevalence of stunting in children under five years of age	18.1	14	UNAP II MEAL
		Prevalence of Low Birth Weight (<2500 g)	8	7	UNAP II MEAL
		Prevalence of wasting in children under five years	4	2	UNAP II MEAL
		Prevalence of anemia in women of reproductive age	25.2	20	UNAP II MEAL
		Prevalence of anemia in children 0-5 years	51	35	UNAP II MEAL
	Reduced prevalence of overweight, obesity and diet-related non-communicable disease	Prevalence of overweight in children under five years of age	4	2	UNAP II MEAL
		Proportion of overweight adult women aged 18+ years	26.5	13	UNAP II MEAL
		Proportion of overweight adult men aged 18+ years	16.3	4	UNAP II MEAL
		Proportion of obesity in adult women aged 18+ years	17.1	5	UNAP II MEAL
		Proportion of obesity in adult men aged 18+ years	3.7	0.4	UNAP II MEAL
		Proportion of overweight in adolescents	10	6	UNAP II MEAL

		Proportion of obesity in adolescent girls	1	1	UNAP II MEAL
		Age-standardized prevalence of raised blood glucose/diabetes among persons aged 18+ years	3.3	2.1	UNAP II MEAL
		Age-standardized prevalence of raised blood pressure among persons aged 18+ years	24	20	UNAP II MEAL
Objective 1 Increase access to and utilization of nutrition specific services by children under 5 years, school age children, adolescent girls, pregnant and lactating women, and other vulnerable groups					
Strategy 1.1 Improve Maternal, Infant, Young Child, and Adolescent Nutrition (MIYCAN) practices	Intermediate Outcome 1.1: Improved Maternal, Infant, Young Child, and Adolescent Nutrition (MIYCAN) practices	Proportion of health facilities that are Baby Friendly Hospital Initiative (BFHI) certified	TBD	TBD	UNAP II MEAL
		Percentage of new-born who are put to the breast within one hour of birth.	TBD	TBD	UNAP II MEAL
		Percentage of infants 0–5 months old who were exclusively breastfed	TBD	TBD	UNAP II MEAL
		Proportion of mothers of children 0–23 months who have received counseling, support, or messages on optimal breastfeeding at least once in the last year	TBD	TBD	UNAP II MEAL
		Proportion of children aged 6 to 23 months who receive a Minimum Diet Diversity (MDD)	TBD	TBD	UNAP II MEAL
		Proportion of children aged 6 to 23 months who receive a Minimum Meal Frequency (MMF)	TBD	TBD	UNAP II MEAL
		Proportion of children 6 to 23 months who achieve Minimum Acceptable Diet (MAD)	TBD	TBD	UNAP II MEAL
		Prevalence of Women of Reproductive Age consuming a Minimum Diet Diversity	TBD	TBD	UNAP II MEAL
Strategy 1.2 Improve up-take	Improved up-take of micronutrients of	Proportion of children 6–59 months receiving Vitamin A supplementation	TBD	TBD	UNAP II MEAL

of micronutrients of concern among children, adolescent girls, and women of reproductive age	concern among children, adolescent girls, and women of reproductive age	Percentage of children aged 6-23 months who consume foods rich in vitamin A	TBD	TBD	UNAP II MEAL
		Percentage of children aged 6-23 months who consume foods rich in iron	TBD	TBD	UNAP II MEAL
		Proportion of children aged 12–59 months receiving at least one dose of deworming medication	TBD	TBD	UNAP II MEAL
		Proportion of pregnant women receiving Iron and Folic Acid supplementation	TBD	TBD	UNAP II MEAL
		Proportion of women of reproductive age who took iron tablets or syrup during pregnancy for 90 plus	TBD	TBD	UNAP II MEAL
		Percentage of women who took deworming medication during pregnancy	TBD	TBD	UNAP II MEAL
		Proportion of schools (primary and secondary) providing safe and fortified foods to children	TBD	TBD	UNAP II MEAL
Strategy 1.3; Increase coverage of integrated management of acute malnutrition	Increased coverage of integrated management of acute malnutrition	Proportion of children 6–59 months with severe acute malnutrition admitted for treatment	TBD	TBD	UNAP II MEAL
		% of HHs with children clinically diagnosed as malnourished over the past year	TBD	TBD	PDM
Strategy 1.4 Improved Integration of Nutrition services in prevention, control, and management of infectious diseases	Nutrition services fully integrated in prevention, control, and management of infectious diseases	Proportion of children under 5 years old with diarrhea receiving oral rehydration salts (ORS) and Zinc	TBD	TBD	UNAP II MEAL
		No. of HH members infected by Malaria over the last 30 days	TBD	TBD	PDM
		No. of HH members who returned an HIV positive test result (by gender and age) as recorded in the HMIS data per quarter	TBD	TBD	PDM
		Percentage children under age 5 in all households who slept under an ITN	TBD	TBD	UNAP II MEAL
		Percentage children under age 5 in households with at least one ITN who slept under an ITN	TBD	TBD	UNAP II MEAL

		Percentage who received three or more doses of SP/Fansidar	TBD	TBD	UNAP II MEAL
		Prevalence of malaria in children under 5 years of age	TBD	TBD	UNAP II MEAL
		Proportion of 1-year-old children who have received the appropriate doses of the recommended vaccines in the national schedule	TBD	TBD	UNAP II MEAL
		Prevalence of diarrhea in children under 5 years of age	TBD	TBD	UNAP II MEAL
Strategy 1.5. Improve Integration of Nutrition services in prevention, control, and management of Diet Related Non-Communicable Diseases (DRNCDs	Nutrition services fully integrated in prevention, control, and management of Diet Related Non-Communicable Diseases (DRNCDs	Proportion of adults considered physically inactive	TBD	TBD	UNAP II MEAL
		No of HH members who are hypertensive	TBD	TBD	PDM
		No. of HH members who are diabetic	TBD	TBD	PDM
		Proportion of workplaces with health wellness program, percent	TBD	TBD	UNAP II MEAL
		Age-standardized prevalence of persons (aged 18+ years) consuming less than five total servings (400 grams) of fruit and vegetables per day	TBD	TBD	UNAP II MEAL
		Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years.	TBD	TBD	UNAP II MEAL
		Proportion of the population participating in sports and physical exercises	40.9	60.9	PDM
Objective 2 Increase access to and utilization of nutrition sensitive services by children under 5 years, adolescent (in and out of school), pregnant and lactating women, in formal and informal settlements and other vulnerable groups.					
Strategies 2.1 to 2.3: **Increase production,**	**Increased production, access to and**	Volume of each of the priority agricultural food production lines (Kgs or Metric Tons/Liter) produced per household per annum as applicable to the locality	0	TBD	PDM

access to and consumption of safe, diverse, and nutrient dense crop, fisheries, and animal source food	**consumption of safe, diverse, and nutrient dense crop, fisheries, and animal source food**	No. of acres owned by the H/H that is at present under agricultural production	18.2	25	PDM
		Volume of each of the priority agricultural production lines (Kgs or Metric Tons/Liter) produced per acre per annum (reference the list above)	TBD	TBD	PDM
		% of HHs that faced food shortages and shocks for more than 8 of the last 12 months	69	89.4	PDM
		No. and % of HHs with improved food and cash crop storage facilities	37	15	PDM
		Volume of HHs produce deemed poor quality and not consumed nor sold per crop per annum	TBD	TBD	PDM
		Average price of commodities for the HH per season (referencing the list above)	TBD	TBD	PDM
		Value (Shillings) of HH agricultural production that is sold on the local market per location per annum	TBD	TBD	PDM
		Value (Shillings) of HH agricultural production that is sold on the local market per location per annum	TBD	TBD	PDM
		Percentage increase in production volumes of NDPIII priority food value chain commodities	TBD	TBD	UNAP II MEAL
		Percentage increase in production volumes of bio-fortified staple food commodities	TBD	TBD	UNAP II MEAL
		Proportion of households chronically undernourished	TBD	TBD	UNAP II MEAL
		Population experiencing acute food insecurity	TBD	TBD	UNAP II MEAL
		Proportion of households that are food secure	TBD	TBD	UNAP II MEAL

		Post-harvest losses for priority commodities percent)	TBD	TBD	UNAP II MEAL
		Total amount of fruit and vegetables and derived products (in grams) available for human consumption during the reference period (expressed in per capita terms)	TBD	TBD	UNAP II MEAL
		Share of total HH expenditure on food and non-alcoholic beverages	TBD	TBD	UNAP II MEAL
		Proportion of population able to meet the required daily dietary intake	TBD	TBD	UNAP II MEAL
		Percentage of calories from non-staples in food supply	TBD	TBD	UNAP II MEAL
		Prevalence of undernourishment (share of the population with insufficient caloric intake below 2,200 kcal)	TBD	TBD	UNAP II MEAL
		Proportion of HH suffering reduction in food production due to Weather shocks	TBD	TBD	UNAP II MEAL
		Prevalence of persons aged 18+ years consuming less than 400 grams of fruit and vegetables per day	TBD	TBD	UNAP II MEAL
		Dietary Diversity Score	TBD	TBD	UNAP II MEAL
		Household Food Security by CARI console	TBD	TBD	UNAP II MEAL
		Household Food Security by Food Consumption Score	TBD	TBD	UNAP II MEAL
		Household Food Security by food expenditure share	TBD	TBD	UNAP II MEAL
		Household Food security by livelihood coping strategies	TBD	TBD	UNAP II MEAL

		Situation of food stock at household level	TBD	TBD	UNAP II MEAL
		Livestock ownership	TBD	TBD	UNAP II MEAL
		Household kitchen garden	TBD	TBD	UNAP II MEAL
		Household crop production	TBD	TBD	UNAP II MEAL
		Extent of hunger in the population (%)	40	20	PDM
Strategy 2.4 Increase access to nutrition sensitive social protection programs	Increased access to nutrition sensitive social protection programs	Proportion of population accessing social insurance, %	5.0	20	PDM
		% population receiving direct income support	0.5	8.0	PDM
		Proportion of eligible population with access to social care services, %	N/A	15.0	PDM
		Proportion of population accessing social insurance, %	5.0	20	PDM
		No. of cases reported to local authority in a parish related to GBV per month	TBD	TBD	PDM
		Proportion of the HHs accessing Universal health care, (Universal Health Coverage Index), %	TBD	TBD	PDM
		% of HHs currently under any form of insurance arrangement	TBD	TBD	PDM
		% of HHs participating in public development initiatives	60	80	PDM
		% of HH population aware of the Parish Development Model objectives	30	90	PDM
		Percentage of Households participating in public development initiatives	TBD	TBD	UNAP II MEAL
		Percentage of vulnerable and marginalized persons empowered	TBD	TBD	UNAP II MEAL

		Proportion of Households' participating in saving schemes	TBD	TBD	UNAP II MEAL
		Proportion of small holder farmers covered by social assistance, social protection programs	TBD	TBD	UNAP II MEAL
Strategy 2.5 Increase access to access to integrated Early Childhood Development (IECD) services, and quality education and sports through improved nutrition	Increased access to access to integrated Early Childhood Development (IECD) services, and quality education and sports through improved nutrition	Percent of youngest children aged 36-59 months attending organized early childhood education programs	TBD	TBD	UNAP II MEAL
		Proportion of children aged 36–59 months who are developmentally on track in at least three of the following domains: literacy-numeracy, physical development, social-emotional development, and learning	TBD	TBD	UNAP II MEAL
		Proportion of school going children having meals at schools	TBD	TBD	UNAP II MEAL
Strategy 2.6 Increase access to nutrition sensitive Water Sanitation and Hygiene (WASH) services and Water for production	Increased access to nutrition sensitive Water Sanitation and Hygiene (WASH) services	Sanitation coverage (Improved toilet)	19	45	PDM
		Hygiene (Hand washing)	34	50	PDM
		Safe water coverage (%)	74	100	PDM
		Proportion of urban households with access to safe water supply	TBD	TBD	UNAP II MEAL
		Proportion of rural households with access to improved toilets	TBD	TBD	UNAP II MEAL
		Proportion of urban households with access to Improved hand washing facility	TBD	TBD	UNAP II MEAL
		Water usage (m^3 per capita)	30.27	59.1	PDM
		Cumulative Water for production Storage capacity (million m^3)	39.32	76.82	PDM
		% of HH with access to safe drinking water supply in urban areas	74	94.8	PDM

		% of HH with own toilet	19	37	PDM
		% of HH with own handwashing facility	34	46	PDM
		No. of HH who report that the health facility they went to provided services they expect (per gender of respondent her quarter-% readiness capacity of health facilities to provide general services	TBD	TBD	PDM
Strategy 2.7 Increase trade, industry, and investments in scaling up nutrition	Increased trade, industry, and investments in scaling up nutrition	Percentage increase in production volumes of bio-fortified staple food commodities	TBD	TBD	UNAP II MEAL
		Proportion of food losses across the food value chain	TBD	TBD	UNAP II MEAL
		Proportion of food based MSMEs in food processing and value addition	TBD	TBD	UNAP II MEAL
		Value (in Uganda shillings) loans to HHs under a revolving fund, parish based SACCOs, VSLAs or other saving scheme per annum	200Bn	1Trillion	PDM
		No. HHs who hold an agricultural insurance policy	174,000	1,000,000	PDM
		No. of HHs who report that they are part of a revolving fund, SACCO, VSLA or saving scheme and have received Business Development Services.	0	3million	PDM
		List of credit operatives (revolving fund, SACCO, VSLA or saving scheme) reporting non-performing loans (value of non-performing loans per annum)	0	20%	PDM
		No. of HHs accessing credit in the Parish Revolving Fund, Emyooga and other funds that reach the Parish (disaggregated-gender and age)	33	60	PDM
		% of women in HHs who accessed revolving fund, SACCO, VSLA or saving scheme loans (per age and location and value of loans)	0	40	PDM
		% of women in HHs who accessed revolving fund, SACCO, VSLA or saving scheme loans (per age and location and value of loans)	0	40	PDM

Objective 3 Strengthen the enabling environment for scaling up nutrition specific and nutrition sensitive services					
Strategy 3.1 Strengthen nutrition coordination and partnerships at all levels	Strengthened nutrition coordination and partnerships at all levels.	Percentage score on existence and functionality of KCCA based on the maturity model	NA	100	UNAP II MEAL
		Percentage score on Coordination for nutrition Actions based on the maturity model	NA	100	UNAP II MEAL
		Percentage score on Partnership and engagement for nutrition for KCCA based on the maturity model	NA	100	UNAP II MEAL
		Overall % Score on nutrition coordination and partnerships based on the maturity model	NA	100	UNAP II MEAL
Strategy 3.2: Improve planning, resource mobilization, financing and tracking of nutrition investments	Improved planning, resource mobilization, financing and tracking of nutrition investments	Percentage score on Integration of Nutrition into planning frameworks based on the maturity model	NA	100	UNAP II MEAL
		Percentage score on Financing for nutrition in the KCCA based on the maturity model	NA	100	UNAP II MEAL
		Average % score on Improved planning, resource mobilization, financing and tracking of nutrition investment based on the maturity model	NA	100	UNAP II MEAL
Strategy 3.3: Strengthen institutional and technical capacity for scaling up nutrition actions	Strengthened institutional and technical capacity for scaling up nutrition actions.	Percentage score on Nutrition Gaps Assessment for the KCCA based on the maturity model	NA	100	UNAP II MEAL
		Percentage score on Nutrition Capacity Development Plan for KCCA based on the maturity model	NA	100	UNAP II MEAL
		Percentage score on Competencies (number and skills) for nutrition for KCCA based on the maturity model	NA	100	UNAP II MEAL
		Percentage score on Human resources for nutrition in KCCA based on the maturity model	NA	100	UNAP II MEAL
		Overall % score on strengthened institutional and technical capacity for scaling up nutrition action based on the maturity model	NA	100	UNAP II MEAL

Strategy 3.4: Improve nutrition advocacy, communication, and social mobilization	Improved nutrition advocacy, communication, and social mobilization	Percentage score on Nutrition Advocacy and communication strategy for KCCA based on the maturity model	NA	100	UNAP II MEAL
		Percentage score on Behavior change communication for nutrition for KCCA based on the maturity model	NA	100	UNAP II MEAL
		Overall % score on Improved nutrition advocacy, communication and social mobilization based on the on the maturity model	NA	100	UNAP II MEAL
Strategy 3.5 Coherent policy, legal and institutional frameworks for nutrition	The Legal and Policy framework relevant to nutrition exist, fully popularized to increase awareness, fully implemented, and are regularly reviewed	Percentage score for Legal and policy frameworks implementation based on the maturity model	NA	100	UNAP II MEAL
Strategy 3.6: Strengthen and institutionalize nutrition evidence and knowledge management along with multi-sectoral nutrition information system for effective decision making.	Improved Nutrition evidence and knowledge management along with multi-sectoral nutrition information system for effective decision making.	Percentage score Commitment and Enabling Environment for Nutrition Data for KCCA based on the maturity model.	NA	100	UNAP II MEAL
		Percentage score on Assessment Data for KCCA based on the maturity model	NA	100	UNAP II MEAL
		Percentage score performance monitoring data for KCCA based on the maturity model.	NA	100	UNAP II MEAL
		Overall % score on Improved Nutrition evidence and knowledge management along with multi-sectoral nutrition information system for effective decision making based on the maturity model	NA	100	UNAP II MEAL

ANNEX 3: JOINT ANNUAL NUTRITION WORK PLAN (JANWP) TEMPLATE

UNAP Goal: Improve nutrition status among children under 5 years of age, adolescents, school age children, pregnant and lactating women including other vulnerable persons by 2030.

Priority Action	Output	Output Indicator	Activity	Targets and Costs per quarter										Activity Location	Lead Department	Partnerships
				Jul-Sep		Oct-Dec		Jan-Mar		April-Jun		Annual				
				Target	Cost	Target	Cost	Target	Cost	Target	Cost	Target	Cost			
Objective 1: Increase access to and utilization of nutrition specific services by children under 5 years, adolescents (in and out of school), pregnant and lactating women in formal and informal settlements and other vulnerable groups																
Outcome 1: Increased access to and utilization of nutrition specific services by children under 5 years, adolescents (in and out of school), pregnant and lactating women in formal and informal settlements and other vulnerable groups																
Strategy 1.1 Improve Maternal, Infant, Young Child, and Adolescent Nutrition (MIYCAN) practices																
Intermediate Outcome 1.1: Improved Maternal, Infant, Young Child, and Adolescent Nutrition (MIYCAN) practices																
Eg Promote Exclusive breastfeeding for the first six months	Increased number of work places with breastfeeding corners in public & private institutions established	% of workplaces with breastfeeding corners														
Objective 1: Increase access to and utilization of nutrition specific services by children under 5 years, school age children, adolescent girls, pregnant and lactating women and other vulnerable groups																
Outcome 1: Increased access to and utilization of nutrition specific services by children under 5 years, school age children, adolescent girls, pregnant and lactating women and other vulnerable groups																
Strategy 1.2 Improve up-take of micronutrients of concern among children, adolescent girls and women of reproductive age																
Intermediate outcome 1.2: Improved up-take of micronutrients of concern among children, adolescent girls and women of reproductive age																
E.g. Provide Routine Vitamin A supplementation to all children U5 years during Integrated Child Health Days	Increased number of 6-59 months' children receiving Vitamin A second dose	Vitamin A second dose coverage for children 6-59 months of age (%)														

Objective 1: Increase access to and utilization of nutrition specific services by children under 5 years, adolescents (in and out of school), pregnant and lactating women in formal and informal settlements and other vulnerable groups.																
Outcome 1: Increased access to and utilization of nutrition specific services by children under 5 years, adolescents (in and out of school), pregnant and lactating women in formal and informal settlements and other vulnerable groups.																
Strategy 1.3; Increase coverage of integrated management of acute malnutrition																
Intermediate Outcome 1.3: Increased coverage of integrated management of acute malnutrition																
Integrate routine screening, and timely management of severe and moderate acute malnutrition into routine health and health services in public and private health facilities.	Nutrition assessment, counselling and support at health faculty and community levels scaled up	Proportion individuals (per age category) accessing nutrition assessment and screening services														
Objective 1: Increase access to and utilization of nutrition specific services by children under 5 years, school age children, adolescent girls, pregnant and lactating women and other vulnerable groups																
Outcome 1: Increased access to and utilization of nutrition specific services by children under 5 years, school age children, adolescent girls, pregnant and lactating women and other vulnerable groups																
Strategy 1.4 Improved Integration of Nutrition services in prevention, control, and management of infectious diseases																
Intermediate Outcome 1.4: Nutrition services fully integrated in prevention, control, and management of infectious diseases																
Increase access to immunization against childhood diseases	Communities mobilized to increase uptake for child immunization services	Proportion of villages mobilized to increase uptake for child immunization services														
Objective 1: Increase access to and utilization of nutrition specific services by children under 5 years, adolescents (in and out of school), pregnant and lactating women in formal and informal settlements and other vulnerable groups.																
Outcome 1: Increased access to and utilization of nutrition specific services by children under 5 years, adolescents (in and out of school), pregnant and lactating women in formal and informal settlements and other vulnerable groups.																
Strategy 1.5. Improve Integration of Nutrition services in prevention, control, and management of Diet Related Non-Communicable Diseases (DRNCDs																

Intermediate Outcome 1.5: Nutrition services fully integrated in prevention, control, and management of Diet Related Non-Communicable Diseases (DRNCDs																
Commemorate the National physical exercise day	National physical exercise day commemorated in the district	National Physical exercise day in place														
Objective 2: To increase access to and utilization of nutrition sensitive services by children under 5 years, adolescents (in and out of school), pregnant and lactating women in formal and informal settlements and other vulnerable groups																
Outcome 2: Increased access to and utilization of nutrition sensitive services by children under 5 years, adolescents (in and out of school), pregnant and lactating women in formal and informal settlements and other vulnerable groups																
Strategy 2.1: Increase production of diverse, safe, and nutrient dense plant, fisheries, and animal source food at household level.																
Intermediate Outcome 2.1: Increased production of diverse, safe, and nutrient dense plant, fisheries and animal source food at household level																
Support access to improved technologies; including climate smart ones to increase production of diverse, safe, nutrition enhancing crop and animal products	Increased access to improved technologies	% of the districts including urban centers in Uganda having access to a package of nutrition sensitive technologies along the entire value chain														
Objective 2: To increase access to and utilization of nutrition sensitive services by children under 5 years, adolescents (in and out of school), pregnant and lactating women in formal and informal settlements and other vulnerable groups																
Intermediate outcome 2.2: Increased access to and utilization of nutrition sensitive services by children under 5 years, school age children, adolescent girls, pregnant and lactating women and other vulnerable groups.																
Strategy 2.2: Increase access to diverse, safe, and nutrient dense plant, fisheries, and animal source foods																
Intermediate Outcome 2.2: Increased access to diverse, safe, and nutrient dense plant, fisheries and animal source food.																
Support scale up of value addition, agro-processing and marketing of diverse, safe, nutrient dense foods including	Small scale cottage industries established	% of the districts with cottage industries following GMP														

indigenous and underutilized food resources																
Objective 2: To increase access to and utilization of nutrition sensitive services by children under 5 years, school age children, adolescent girls, pregnant and lactating women, and other vulnerable groups.																
Intermediate outcome 2.3: Increased access to and utilization of nutrition sensitive services by children under 5 years, school age children, adolescent girls, pregnant and lactating women, and other vulnerable groups.																
Strategy 2.3: Increase utilization of diverse, safe and nutrient dense plant, fisheries and animal source food																
Intermediate Outcome 2.3: Increased utilization of diverse, safe, and nutrient dense plant, fisheries and animal source food.																
Integrate nutrition and home economics in agricultural research and extension	Nutrition and home economics integrated in agriculture research and extension	Guidelines, Handbooks & I.E.C. materials on nutrition sensitive extension services in place														
Objective 2: To increase access to and utilization of nutrition sensitive services by children under 5 years, adolescents (in and out of school), pregnant and lactating women in formal and informal settlements and other vulnerable groups.																
Intermediate outcome 2.4: Increased access to and utilization of nutrition sensitive services by children under 5 years, adolescents (in and out of school), pregnant and lactating women in formal and informal settlements and other vulnerable groups.																
Strategy 2.4: Promote integration of nutrition services in social protection programs																
Intermediate outcome 2.4: Increased access to nutrition sensitive social protection program																
Implement the 15 Household model for social economic empowerment	A program aimed at promoting household engagement in improving H/H Income implemented	No. of Households benefiting from VSLA & investment clubs														
Objective 2: To increase access to and utilization of nutrition sensitive services by children under 5 years, adolescents (in and out of school), pregnant and lactating women in formal and informal settlements and other vulnerable groups.																
Intermediate Outcome 2.5: Increased access to and utilization of nutrition sensitive services by children under 5 years, adolescents (in and out of school), pregnant and lactating women in formal and informal settlements and other vulnerable groups.																
Strategy 2.5: Promote access to nutrition services through Integrated Early Childhood Development (IECD) services, and quality education and sports																
Intermediate Outcome 2.5: Increased access to nutrition services through efficient and quality Integrated Early Childhood Development (IECD) services, education and sports																

Promote establishment of Schools Gardens	Schools Gardens established	Proportion of schools with school gardens established															
Objective 2: To increase access to and utilization of nutrition sensitive services by children under 5 years, adolescents (in and out of school), pregnant and lactating women in formal and informal settlements and other vulnerable groups.																	
Intermediate Outcome 2.6: Increased access to and utilization of nutrition sensitive services by children under 5 years, adolescents (in and out of school), pregnant and lactating women in formal and informal settlements and other vulnerable groups.																	
Strategy 2.6: Increase access to nutrition sensitive Water Sanitation and Hygiene (WASH) services																	
Intermediate Outcome 2.6: Increased access to nutrition sensitive Water Sanitation and Hygiene (WASH) services																	
Increase access to inclusive sanitation and hygiene services in rural areas	Increased number of villages reached with social behavior change communication for construction and use of improved sanitation facilities	% of population with access to basic sanitation															
Objective 2: To increase access to and utilization of nutrition sensitive services by children under 5 years, school age children, adolescent girls, pregnant and lactating women, and other vulnerable groups.																	
Intermediate Outcome 2.7: Increased access to and utilization of nutrition sensitive services by children under 5 years, school age children, adolescent girls, pregnant and lactating women, and other vulnerable groups																	
Strategy 2.7: Increased participation of trade, industry, and investments actors in scaling up nutrition																	
Intermediate Outcome 2.7: Increased trade, industry, and investments in scaling up nutrition.																	
Support industrial uptake and value addition of bio-fortified plants	Increased value addition of Nutritious foods	Proportion of value-added Nutritious foods															
Objective 3: Strengthen the enabling environment for scaling up nutrition specific and nutrition sensitive services																	
Strengthened the enabling environment for scaling up nutrition specific and nutrition sensitive services																	
Intermediate Outcome 3.1: Strengthened nutrition coordination and partnerships at all levels.																	
Strategy 3.1: Strengthen nutrition coordination and partnerships at all levels																	

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