OFFICE OF THE PRIME MINISTER

Multi-Sectoral Nutrition Coordination Committee Orientation

GUIDE FOR FACILITATORS

July 2017

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Foreword

The Government of Uganda has made significant progress in the fight against malnutrition and its resultant effects on productivity, early childhood education, child and maternal mortality. According to the UDHS 2016, the prevalence of stunting, a measure of chronic undernutrition, has reduced from 33% in 2011 to 29%. This is attributed to the collaborative implementation of the Uganda Nutrition Action Plan by Government, development partners, civil society organisations, and the private sector. However, the prevalence of anaemia in children and women of reproductive age increased from 49% to 53% and 26% to 32% respectively and more effort should be channelled towards this. Government will continue to support and implement multi-sectoral interventions to address the issue of malnutrition in all its forms to achieve the acceptable levels through the National Nutrition Policy and the Second National Nutrition Action Plan.

Improving the nutrition indicators at the local government level requires coordinated efforts by all stakeholders through the existing structures and frameworks to promote sustainable implementation of nutrition-sensitive and nutrition-specific interventions. To scale up nutrition interventions, the Uganda Nutrition Action Plan (UNAP) outlines a decentralised multi-sectoral coordination framework that supports the coordination, planning, monitoring, and evaluation of nutrition programmes to improve district nutrition outcomes.

All local governments should establish and operationalise the structures in the multi-sectoral nutrition coordination framework to ensure sustainability of planning and implementation of nutrition interventions at district level. The Office of the Prime Minister, with support from USAID, developed this Multi-Sectoral Nutrition Coordination Committee Orientation Guide to strengthen coordination structures at local government level on the composition, roles, and responsibilities of nutrition coordination committees in scaling up nutrition interventions at district level. This guide is intended for use by the nutrition stakeholders in various government, civil society, and private sectors to orient nutrition coordination committees in local governments.

I appeal to all stakeholders to support the orientation of all Local Government Nutrition Coordination Committees for smooth implementation of multi-sectoral nutrition interventions at decentralised levels.

Christine Guwatudde Kintu
PERMANENT SECRETARY
OFFICE OF THE PRIME MINISTER

Acronyms

BCC	behaviour change communication
BMI	body mass index
CAO	Chief Administrative Officer
CBO	community-based organisation
CSO	civil society organisation
DDP	District Development Plan
DiNCC	Division Nutrition Coordination Committee
DNCC	District Nutrition Coordination Committee
DPNCC	Development Partners Nutrition Coordination Committee
FANTA	Food and Nutrition Technical Assistance III Project
FBO	faith-based organisation
HMIS	Health Management Information System
IP	implementing partner
ISC	Implementation Steering Committee
IYCF	infant and young child feeding
IYCN	infant and young child nutrition
LLG	Lower Local Government
M&E	monitoring and evaluation
MAAIF	Ministry of Agriculture, Animal Industries, and Fisheries
MAM	moderate acute malnutrition
MDAs	ministries, departments, and agencies
MGLSD	Ministry of Gender, Labour, and Social Development
MNCC	Municipal Nutrition Coordination Committee
MOES	Ministry of Education and Sports
MOFPED	Ministry of Finance, Planning, and Economic Development
MOH	Ministry of Health
MOLG	Ministry of Local Government
MOPS	Ministry of Public Service
MSNAP	Multi-Sectoral Nutrition Action Plan
MSTNC	Multi-Sectoral Nutrition Technical Committee
MUAC	mid-upper arm circumference
MTIC	Ministry of Trade, Industry, and Cooperatives

MWE	Ministry of Water and Environment
NCC	nutrition coordination committee
NDP II	Second National Development Plan 2015/16–2019/20
NFPO	Nutrition Focal Point Officer
NPA	National Planning Authority
OBT	Output Budgeting Tool
OPM	Office of the Prime Minister
PCC	Policy Coordination Committee
PPT	PowerPoint presentation
PSCN	Parliamentary Sub-Committee on Nutrition
SAM	severe acute malnutrition
SDGs	Sustainable Development Goals
SFP	Supplementary Feeding Programme
SNCC	Sub-County Nutrition Coordination Committee
SUN	Scaling Up Nutrition
TNCC	Town Council Nutrition Coordination Committee
TPC	Technical Planning Committee
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic Health Survey
UNAP	Uganda Nutrition Action Plan (2011 – 2016)
UNICEF	United Nations International Children's Fund
USAID	U.S. Agency for International Development
VIPP	Visualisation In Participatory Programmes
WFP	World Food Programme
WHO	World Health Organisation

Purpose of the Orientation

This Multi-Sectoral Nutrition Coordination Committee Orientation Guide is intended for use in strengthening capacity of nutrition coordination structures at the local government level by providing information on the nutrition situation and the policy environment for addressing malnutrition in Uganda. It also covers the roles of and linkages between nutrition coordination committees (NCCs), technical planning committees (TPCs), and councils and provides guidance on the monitoring and reporting to be conducted by NCCs on multi-sectoral nutrition interventions.

Specifically, by the end of the orientation participants will:

- Have an enhanced understanding of the nutrition situation in Uganda
- Be able to explain the policy environment for nutrition and the Uganda multi-sectoral nutrition coordination framework
- Have improved understanding of the composition, roles, and responsibilities of NCCs at local government level
- Understand the roles of councils and TPCs in nutrition governance
- Understand the linkages between NCCs, TPCs, and councils
- Understand the criteria for measuring functionality of NCCs
- Understand NCC monitoring and reporting on coordination of multi-sectoral nutrition interventions
- Develop an action plan to operationalise NCCs at local government level together with partners

Process of Developing the Guide

The development of this guide started in 2012. This was followed by a series of review meetings organised by the Office of the Prime Minister (OPM) and the U.S. Agency for International Development (USAID)-funded Food and Nutrition Technical Assistance III Project (FANTA). The reviews focused on incorporating best practices and lessons learned from previous NCC orientations and incorporated the most recent global, regional, and national policy frameworks and nutrition information used to guide multi-sectoral nutrition programming.

Intended Facilitators and Target Audience

The primary users of this facilitator guide are nutrition stakeholders in government and civil society and their implementing partners who seek to orient local governments on nutrition as a part of the development agenda and the nutrition coordination mechanism at local government level. The orientation requires at least two facilitators who should be familiar with the nutrition situation in Uganda, the existing policies, legal frameworks, and programmes/strategies at national, district, and community levels to improve nutrition. When the orientation is targeting the district level (District Nutrition

Coordination Committee [DNCC] and its stakeholders), one of the facilitators should be a member of the national Multi-Sectoral Technical Nutrition Coordination Committee to ensure quality of the orientation process and for policy guidance. When the orientation is targeting NCCs at the LLG level (municipality nutrition coordination committees [MNCCs], division nutrition coordination committees [DiNCCs], town council nutrition coordination committees [TNCCs], and sub-county nutrition coordination committees [SNCCs]), DNCC members should take the lead in facilitation with support from national level facilitators as required.

Due to the multi-sectoral nature of nutrition programming, Ministries, Departments, and Agencies (MDAs)—including the following sectors: finance, planning, and economic development; health; agriculture; social development; education; trade and industry; and water—as well as implementing partners and development agencies, academia, and civil society organisations can also support the orientation of NCCs by using this guide.

The target audience for the orientation includes members of the local government NCCs, specifically DNCCs, MNCCs, DiNCCs, TNCCs, and SNCCs, and political and religious leadership within the districts/LLGs.

Orientation Process

A sample orientation agenda is provided in Annex 1. The content of this guide assumes a 2-day orientation for approximately 20 participants. Facilitators may choose to extend the orientation beyond 2 full days and spend extra time on certain sessions depending on the participants' knowledge and skills and the time available to spend on orientation. The orientation guide has an accompanying PowerPoint presentation to support the facilitators as well as a participant handbook to serve as a reference for participants throughout the orientation and upon return to their districts/LLGs.

Advance Preparation

At least 2 weeks prior to the orientation, facilitators should ask participants to collect district/LLG-specific nutrition statistics and information on food security and nutrition-related interventions and their impact, which will be used during the sessions. Example materials to gather in advance include District Development Plans (DDPs), district/LLG nutrition statistics from Health Management Information System (HMIS) reports, and any other nutrition situation analysis reports that have been conducted in the district/LLG. Districts/LLGs can also refer to the Uganda Demographic Health Survey (UDHS) to identify any data that is relevant to the district/LLG context.

The facilitators should arrive at the venue early to ensure it is correctly arranged to allow for small group work sessions and registration. Before the orientation, facilitators should ensure the following are available:

- **Equipment:** Computer, LCD projector
- **Stationery:** Visualisation in Participatory Programmes (VIPP) cards[1], flip charts, markers, masking tape, pens
- **Copies** of the orientation guide for each facilitator, copies of PowerPoint presentation (as required per facilitator preference), and a participant handbook for each participant.

[1] VIPP cards are cards of different colors, ideally with an adhesive backing, that can be used during interactive group work. If VIPP cards are not available, any smaller cards or papers of different colours can be substituted.

Structure of the Orientation

Table 1. Sections of the Guide

Unit/Sessions	Time
Introduction Unit	
Session 0.1: Opening and Introductions	30 minutes
Session 0.2: Introduction to the Orientation Objectives	30 minutes
Session 0.3: Participant Expectations	30 minutes
Unit 1: Nutrition Situation in Uganda and Policy Environment for Addressing Malnutrition	
Session 1.1: Nutrition Situation in Uganda	90 minutes
Session 1.2: Policy Environment for Nutrition	30 minutes
Session 1.3: Overview of the Uganda Nutrition Action Plan	15 minutes
Session 1.4: The Uganda Multi-Sectoral Nutrition Coordination Framework	30 minutes
Session 1.5: Roles and Responsibilities of Nutrition Coordination Committees	60 minutes
Unit 2: Roles of and Linkages between Nutrition Coordination Committees, Technical Planning Committees, and Councils	
Session 2.1: Roles of Councils and Technical Planning Committees in Nutrition Governance	30 minutes
Session 2.2: Linkages between LLG Nutrition Coordination Committees and the District	30 minutes
Unit 3: Nutrition Coordination Committee Monitoring and Reporting	
Session 3.1: Monitoring Nutrition Coordination Committees	30 minutes
Session 3.2 Nutrition Coordination Committee Reporting	60 minutes
Unit 4: Action Plan to Operationalise Nutrition Coordination Committees	
Session 4.1: Nutrition Coordination Committee Action Planning	60 minutes
Session 4.2: Closing	30 minutes

Location and Venue

If possible, conduct the orientation in the district/LLG where the participants work, at a location also accessible to participants from the departments. The venue should be comfortable and have enough space to display multiple flip charts on the walls and to project slides onto a white screen or wall.

The room should be set up with space for participants to easily work in district/LLG teams. There should also be access to multiple power sources so that participants can use laptops during the process. Additionally, a table for registration, a table/space for facilitator materials, and space for breaks should also be requested.

INTRODUCTION UNIT

Instructions for the facilitators: The purpose of this unit is to take participants through the orientation outline, introductions, objectives, and expectations.

This unit covers slides 2–6:

- Orientation Outline: slide 2
- Introductions: slides 3–4
- Objectives: slide 5
- Expectations: slide 6

UNIT 1

Nutrition Situation in Uganda and Policy Environment for Addressing Malnutrition

Purpose:

To enhance participant understanding and appreciation of the magnitude, causes, and consequences of malnutrition in Uganda and the overall policy environment for addressing malnutrition.

Objectives:

By the end of the Unit 1, participants should:

- Understand the nutrition situation in Uganda, including key statistics and the causes, and consequences of malnutrition
- Understand the policy environment at global, regional, and national level to address malnutrition
- Understand the national multi-sectoral nutrition coordination framework, including the composition, roles, and responsibilities of nutrition coordination committees

Session 1.1: Nutrition Situation in Uganda

Instructions for the facilitators: The purpose of this session is to enhance participant understanding and appreciation of the magnitude, causes, and consequences of malnutrition in Uganda.

This session covers slides 7–35:

- Nutrition Situation: slides 8–28
- Causes of Malnutrition: slides 29–31
- Consequences of Malnutrition: slides 32–35

Note that the slides include nutrition statistics for national and regional levels; however, if district/LLG statistics are also available, these slides can be updated to reflect the local context.

Presentation Notes

Slides 9–10

People are malnourished if their diet is not balanced with their nutritional needs. There are two main categories:

Undernutrition: acute malnutrition (thinness), chronic malnutrition (poor growth), micronutrient deficiency

Overnutrition: Overweight and obesity

Undernutrition: Undernutrition is a consequence of a deficiency in nutrient intake and/or absorption in the body. The different forms of undernutrition, which can appear alone or in combination, are acute malnutrition (bilateral pitting oedema and/or wasting), chronic malnutrition (stunting), underweight (combined form of wasting and stunting), and micronutrient deficiencies.

Overnutrition: Overnutrition happens when a person's daily energy intake consistently exceeds energy requirements. If this continues over time, a person may become overweight or obese.

Underweight: A composite form of undernutrition that includes elements of stunting and wasting and is defined by a weight-for-age of more than 2 standard deviations below the median WHO Growth Standard. This indicator is commonly used in growth monitoring and promotion (GMP) and child health and nutrition programmes aimed at prevention and treatment of undernutrition.

Slide 11

Here is an example of chronic undernutrition, or stunting. These girls are the same age, but the girl on the left is stunted due to poor nutrition.

Stunting: Stunting, or chronic malnutrition, occurs when a child fails to grow at a healthy pace and is shorter than expected for a healthy child of the same age. Stunting develops over a long period because of long-term inadequate nutrition (including poor maternal nutrition and poor infant and young child feeding practices) and/or repeated illness or infection. Stunted children have a higher risk of death from diarrhoea, pneumonia, and measles. Stunting is associated with poor cognitive and motor development and lower school achievement. It is defined by a height-for-age of more than 2 standard deviations below the median WHO Growth Standards.

Slide 12

Here we show images of some examples of undernutrition. You see an example of acute malnutrition in the form of wasting. Acute malnutrition has two categories: severe acute malnutrition (SAM), which can be treated either through inpatient care or outpatient care, depending on the severity and the presence of other medical complications, and moderate acute malnutrition (MAM), which can be treated through outpatient care and/or supplementary feeding programmes (SFPs).

Wasting: This occurs when an individual is very thin for his or her height. It happens when a person loses weight rapidly or a growing child does not gain adequate weight relative to their growth in height. Wasting may be caused by inadequate food intake, such as a drop in food consumption or sub-optimal infant and young child feeding practices; by disease or infection, including HIV or tuberculosis; or a combination. It is defined as weight-for-height of more than 2 standard deviations below the median WHO standards or mid-upper arm circumference (MUAC) under 125 mm. Wasting is one form of acute malnutrition.

Slide 13

Here we show another example of undernutrition. You see an example of acute malnutrition in the form of oedema.

Oedema (bilateral pitting oedema): An excess accumulation of fluid that starts in both feet and can progress to other parts of the body. Also known as nutritional oedema or oedematous malnutrition, bilateral pitting oedema is a sign of severe acute malnutrition. It is verified when thumb pressure applied on the tops of both feet for 3 seconds leaves an indentation after the thumb is lifted.

Slide 14

Between 1988 and 2016, stunting (low height-for-age, also known as chronic undernutrition) decreased from 48% to 29%, while wasting (a measure of acute undernutrition) decreased from 7% to 4% between 1995 and 2016. While progress has been made, these figures, particularly the 29% stunting level, are still unacceptable[2].

Slide 15

Vulnerability to malnutrition varies from one region to another. For example, the prevalence of stunting among children under 5 ranges from 14.3% in Teso sub-region to 40.61% in Toro sub-region. There has been a shift in regional variations from 2011–2016. In 2011, Karamoja and Southwestern regions registered the highest levels of stunting, 45% and 42%, respectively[3]. In 2016, Toro (40.6%), Bunyoro (34.5%), and Bugisu (35.9%) sub-regions were found to have the highest levels of stunting[4].

Slides 16–17

Regional differences can also be seen in prevalence of wasting and underweight.

Slide 18

Here you see examples of overnutrition.

Overweight: Overweight is a range of weight that exceeds what is generally considered healthy for a given height. For adults, overweight is having a body mass index (BMI) from 25 to 29.9.

Obesity: Obesity is a range of weight that is much greater than what is generally considered healthy for a given height. For adults, obesity is having a BMI of 30 or higher.

Overweight among children under 5 is 4%, an increase of 1% from 2011[5]. Overweight among women of reproductive age has remained high at 19%, while amongst men at 5%[6].

Slide 19

Micronutrient deficiency: Inadequate intake of micronutrients (vitamins or minerals) for the body's needs. The most common micronutrient deficiencies are: vitamin A deficiency, iron deficiency anaemia, iodine deficiency, and zinc deficiency. This is also known as 'hidden hunger'.

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[2] Uganda Bureau of Statistics (UBOS): Uganda Demographic and Health Survey Report, 2016
[3] Uganda Bureau of Statistics (UBOS): Uganda Demographic and Health Survey Report, 2011
[4] Uganda Bureau of Statistics (UBOS): Uganda Demographic and Health Survey Report, 2016
[5] Uganda Bureau of Statistics (UBOS): Uganda Demographic and Health Survey Report, 2016
[6] Uganda Bureau of Statistics (UBOS): Uganda Demographic and Health Survey Report, 2011

Slide 20

These graphs show trends in micronutrient deficiencies (anaemia, vitamin A, and iodine).

Slide 21

Like other forms of undernutrition, anaemia deficiencies vary in prevalence by region.

Anaemia in children (haemoglobin levels below 11.0g/dl) increased from 49% in 2011 to 53% in 2016. Children in rural areas are more likely to be anaemic than those in urban areas (54% and 48%, respectively). Vulnerability to anaemia in children varies from region to region. For example, prevalence of anaemia among children is lowest in Ankole sub-region, at 31%, and highest in Acholi sub-region, at 71%[7].

Slide 22

Anaemia in women of reproductive age (defined as having a haemoglobin level below 12.0g/dl) increased from 26% in 2011 to 32% in 2016. The proportion of women with anaemia is higher in rural areas than in urban areas (33% and 27%, respectively). Regional prevalence of anaemia among women ranges from 17% in Kigezi sub-region to 47% in Acholi sub-region[8]. In Uganda, anaemia is currently a moderate public health problem for women of reproductive age and a severe public health problem for children under 5 years.

Slide 23

However, malnutrition is not only a problem of low income households. The figure shows stunting and anaemia rates by wealth quintile. As you can see, rates even in the two highest wealth quintiles are still quite high. In the lowest wealth quintile, 32% of children were stunted, compared to 17% in the highest wealth quintile[9]. Similarly, anaemia prevalence generally decreases with increased levels of wealth, from 66% among children from lowest wealth quintile to 45% among children in the highest wealth quintile[10]. This suggests that more income at the household level does not always lead to better diet and health practices. Therefore, when planning nutrition interventions, these groups and interventions targeting them should also be considered. Similarly, the prevalence of stunting decreases as mothers' education levels increase. Four in every 10 children born to mothers with no education are stunted compared with 1 in every 10 children born to educated mothers.

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[7] Uganda Bureau of Statistics (UBOS): Uganda Demographic and Health Survey Report, 2016
[8] Uganda Bureau of Statistics (UBOS): Uganda Demographic and Health Survey Report, 2016
[9] Uganda Bureau of Statistics (UBOS): Uganda Demographic and Health Survey Report, 2016
[10] Uganda Bureau of Statistics (UBOS): Uganda Demographic and Health Survey Report, 2016

Slide 24

According to the UDHS 2016, 66% of infants under age 6 months are exclusively breastfed. Contrary to the recommendation that children under 6 months be exclusively breastfed, 7% of infants consume plain water, 6% consume non-milk liquids, 8% consume other milk, and 11% consume complementary foods in addition to breast milk before they reach 6 months of age. In addition, 2% of infants under 6 months are not breastfed at all. The percentage of children exclusively breastfed decreases sharply with age from 83% of infants age 0–1 month being exclusively breastfed to 69% of infants 2–3 months and, further, to 43% of infants 4–5 months. Eleven percent of infants under 6 months are fed using a bottle with a nipple, a practice that is discouraged because of the risk of illness to the child[11]. Breastfeeding a child until age 2, with proper complementary feeding practices beginning after the age of 6 months, is recommended.

Slide 25

Infant and young child feeding (IYCF) practices among children age 6–23 months are measured through the Minimum Acceptable Diet (MAD) indicator. The UDHS 2016 indicates that 14% of children age 6–23 months meet the criteria for MAD. The percentage of children meeting MAD requirements varies by age group: 6–8 months (15%), 9–11 months (13%), 12–17 months (15%), and 18–23 months (13%).

Slides 26–27

There is a period known as the '1,000 days' window of opportunity during which major gains in malnutrition prevention can be made. Here you see two of the previously mentioned target groups (pregnant women and children under 5, specifically those up to 2 years) are highlighted. This is because good nutrition in children under 5 begins with the nutritional status of the mother, as good growth and development begins during pregnancy. If a mother is malnourished, the baby growing inside will experience poor growth and development, leading to low birth weight and poor development. The period of growth up to 2 years has been identified as a key period for growth and development, particularly as it relates to stunting—as catch-up growth has been shown to be much more difficult to achieve after the age of 2.

However, achieving the benefits of the 1,000 days does not begin with pregnancy. Adolescent girls and women of reproductive age are also critical target groups as it is important for women to have a good nutritional status before becoming pregnant and to then maintain good nutrition throughout pregnancy.

[11] Uganda Bureau of Statistics (UBOS): Uganda Demographic and Health Survey Report, 2016

GROUP WORK SESSION

Slide 28

- Using nutrition data and information participants collected about their district/LLG, have participants discuss the following:
  - What LLGs and/or communities are most affected by malnutrition?
  - Which sub-counties/divisions/parishes/wards would you prioritise for support and why?
- Ask groups to write their responses on a flip chart or VIPP cards. Allow each group to make a short presentation.

Causes of Malnutrition in Uganda

GROUP WORK SESSION

Slide 29

- In groups, ask participants to discuss the possible causes of malnutrition in their district/LLGs. Make sure participants discuss the challenges in each department *(e.g., education, health, agriculture, planning, water, social development, trade and industry, and administration)* that could contribute to malnutrition.
- Have groups write identified causes on VIPP cards and paste at the front of the room.
- Have a brief group discussion about the findings and then begin the presentation on causes of malnutrition

Slide 30

To achieve improvement in nutrition outcomes, the various causes of malnutrition must be tackled. There are three levels of causes of malnutrition: basic causes at the societal level, underlying causes at the household and family level, and immediate causes at the individual level.

Immediate causes can lead directly to malnutrition. The most obvious immediate cause is poor dietary intake. A person may not be getting enough required daily calories or may be consuming food that does not have the necessary micronutrients, which can lead to chronic malnutrition (stunting)

and acute malnutrition (wasting) in children, or specific micronutrient deficiency such as iron deficiency, which contributes to anaemia in women and children. Extended and frequent illness/disease also can have an impact on the body's ability to absorb required nutrients. An example of this is a young child who has frequent diarrhoea, which can result in acute malnutrition due to poor nutrient absorption. In addition, consumption of unhealthy foods (e.g., fatty or high calorie and nutrient-poor food) and physical inactivity can lead to malnutrition in the form of overweight or obesity, which can lead to diet-related non-communicable diseases, such as diabetes and heart disease.

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

Finally, **basic causes** influence the underlying causes, and so can lead to malnutrition. At this level, all sectors are involved. Household food insecurity can be due to a lack of income, which can be the result of low levels of education, which restrict job opportunities and other income-generating opportunities. Educational disparity can lead to increases in gender-based violence, which can have an impact on a mother's ability to properly care for her children; this may result in inadequate feeding practices or the inability to take children for health services. Educational disparity and available household resources also contribute to individuals making poor dietary choices--consuming a diet that is low in diversity, high in fat and sugar, and low in micronutrient content (e.g., soda, chips, biscuits). Political will can have an impact on the availability of services, including health, education, community development, and agricultural extension, to name a few. It also has an impact on the enabling environment for pro-nutrition policies, which can help expand service coverage and provide funding for necessary services.

As you unpack this framework, it becomes apparent that every sector has a role to play in improving nutrition.

Slide 31

The causes of malnutrition within the household can be further explained using the factors identified as influencing infant and young child nutrition (IYCN) practices in Northern Uganda. These include women's workload and time, teenage pregnancies and frequent pregnancies, alcoholism and gender-based violence, traditions and polygamy, the lack of livelihoods, and food insecurity[12]. These require concerted efforts from various groups within the communities to improve nutrition outcomes.

Consequences of Malnutrition

GROUP WORK SESSION

Slide 32

- In groups, ask participants to discuss the possible consequences of malnutrition in their district/LLGs. Have groups write identified causes on VIPP cards and paste them at the front of the room.
- Have a brief group discussion about the findings and then begin the presentation on consequences of malnutrition.

Slide 33

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

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

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[12] K. Sethuraman, E. Okello, 2010.Opportunities for Addressing Malnutrition in Kitgum and Pader Districts in Northern Uganda. Washington, DC: AED, 2010

Children who suffer from underweight and/or wasting are at increased risk of mortality from illnesses such as diarrhoea and pneumonia[13,14]. The effects of undernutrition on the immune system are wide ranging and tend to be more frequent and severe in wasted children[15]. Stunting in childhood has short-term and long-term consequences that affect health and human capital development. In addition to poor physical growth, stunting increases childhood risk of infection and mortality, and affects development, learning capacity, and school performance. Later it affects productivity, wages, and reproductive health.

Slide 34

Stunting can also lead to excessive weight gain later in life, which contributes to higher levels of overweight and obesity. These conditions lead to increased risk of nutrition-related chronic diseases such as diabetes and heart disease[16]. Overweight and obese children are likely to stay obese into adulthood and are more likely to develop non-communicable diseases like diabetes and cardiovascular diseases at a younger age. Prevention of childhood obesity, therefore, needs to be a high priority to support improvement in adult nutrition outcomes as well.

Slide 35

At the conclusion of this session, allow time for participants to ask questions and discuss what changes are needed at the district/LLG level to improve the nutrition situation.

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[13] World Food Programme (WFP), U.N. Economic Commission for Africa, and African Union Commission. 2012. *The Cost of Hunger in Uganda.*
[14] World Health Organisation (WHO)/UNICEF/WFP. 2014. *Global Nutrition Targets 2025: Wasting Policy Brief* (WHO/NMH/NHD/14.8). Geneva: WHO.
[15] WHO/UNICEF/WFP. 2014. *Global Nutrition Targets 2025: Wasting Policy Brief* (WHO/NMH/NHD/14.8). Geneva: WHO.
[16] International Food Policy Research Institute. 2015. Global Nutrition Report: Actions and Accountability to Advance Nutrition and Sustainable Development. Washington, DC: IFPRI.

Session 1.2: Policy Environment for Nutrition

Instructions for the facilitators: The purpose of this session is to ensure enhanced understanding of the overall policy environment for addressing malnutrition.

This session covers slides 36–51.

Slides 37–40

While multi-sectoral nutrition planning and programming is informed by the national development agenda, efforts have been made to align strategies and interventions to the global and regional nutrition development agenda. Reference is made to the key global, regional, and national frameworks described below.

At the global level, the following frameworks were considered:

- 2030 Agenda for Sustainable Development and the Sustainable Development Goals
- Scaling Up Nutrition (SUN) Movement Strategy and Roadmap (2016–2020)
- United Nations Decade of Action on Nutrition 2016–2025
- Global Nutrition Targets 2025 (World Health Organisation)

Slide 41

The UN Decade of Action on Nutrition has six pillars for nutrition action. As shown in the image, if these pillars are not acted upon through policies and programmes, the result will be poor nutrition.

The six pillars are:

- Sustainable food systems for healthy diets
- Aligned health systems providing universal coverage of essential nutrition actions
- Social protection and nutrition education
- Trade and investment for improved nutrition
- Enabling food and breastfeeding environments
- Review, strengthen, and promote nutrition governance and accountability

Slide 42

At the regional level, reference was made to the following:

- African Union's Agenda 2063
- African Union 2003 Maputo Declaration on Agriculture and Food Security
- African Union 2014 Malabo Declaration on Accelerated Agricultural Growth and Transformation for Shared Prosperity and Improved Livelihoods
- East African Community Agriculture and Rural Development Strategy (EAC-ARDS) 2005–2030

Slide 43

Nutrition, especially that of young children and women of reproductive age, is a priority in the Uganda Vision 2040 and is identified as a key contributor to social transformation. The Government of Uganda recognizes malnutrition's complexity and the Second National Development Plan 2015/16–2019/20 (NDP II) and the Uganda Nutrition Action Plan 2011–2016 (UNAP) provide a multi-sectoral framework to improve the nutrition situation in Uganda. Nutrition must be included and planned for as a cross-cutting issue, as mandated in the NDP II, the Local Government Development Planning Guidelines 2014, and the Sector Development Planning Guidelines 2015. These policy documents also emphasize the need to plan and coordinate nutrition programming at national, district, and community levels.

Uganda has aligned its policy frameworks and strategies to the existing global strategies, such as the Millennium Development Goals, the Scaling Up Nutrition Movement, and the Sustainable Development Goals (SDGs). In this way, Uganda's national and local level objectives will make direct contributions to global nutrition goals.

Slides 44 - 49

At the national level, this guide is in line with the following:

- 1995 Constitution of the Republic of Uganda
- Uganda Vision 2040
- Second National Development Plan 2015/16–2019/20
- Uganda Nutrition Action Plan 2011–2016
- Local Government Development Planning Guidelines (2014), which highlight nutrition as a cross-cutting issue to be considered in planning
- National Nutrition Planning Guidelines (2015), which provide comprehensive guidance on multi-sectoral planning for nutrition at the national and local government level

The 1995 Constitution of the Republic of Uganda
Section XXII: Food security and nutrition

The State shall:

a) Take appropriate steps to encourage people to grow and store adequate food.

b) Establish national food reserves; and

c) Encourage and promote proper nutrition through mass education and other appropriate means in order to build a healthy state.

Slide 50

With this conducive policy environment for implementation of nutrition interventions, there is urgent need to invest in action at local government level and put in place sustainable systems for programming.

GROUP WORK SESSION

Slide 51

Ask participants to discuss the following, using district/LLG reference materials to guide them:

- What are the nutrition interventions included in the 5-year district/LLG development plan?
- What are the nutrition interventions included in the department annual work plans?
- What nutrition interventions are included in the Multi-Sectoral Nutrition Action Plan (MSNAP)?

Have a brief discussion during which participants share their findings.

Session 1.3: Overview of the Uganda Nutrition Action Plan

Instructions for the facilitators: The purpose of this session is to present the goal and objectives of the Uganda Nutrition Action Plan.

This session covers slides 52–58.

Slide 53

The Uganda Nutrition Action Plan 2011–2016 (UNAP) is the Government of Uganda's strategic multi-sectoral framework for scaling up nutrition under the coordination of the Office of the Prime Minister. The UNAP has been extended to 31 December 2017 to allow finalisation of the Multi-Sectoral Nutrition Policy and development of the Second Multi-Sectoral Nutrition Action Plan.

The goal of the UNAP is to reduce malnutrition levels among women of reproductive age, infants, and young children from 2011 to 2016 and beyond.

Slides 54–58

Table 2. UNAP Objectives and Strategies

Objectives	Strategies
Objective 1: Improve access to and utilisation of services related to maternal, infant, and young child nutrition	a) Promote access to and utilisation of nutrition and health services to all women of reproductive age, infants, and young children. b) Address gender and socio-cultural issues that affect maternal, infant, and young child nutrition.
Objective 2: Enhance consumption of diverse diets	a) Increase access and use of diverse nutritious foods at household level. b) Enhance post-harvest handling, storage, and utilisation of nutritious foods at the household and farm level. c) Promote the consumption of nutrient-enhanced foods.
Objective 3: Protect households from the impact of shocks and other vulnerabilities that affect their nutritional status	a) Develop preparedness plans for shocks. b) Promote social protection interventions for improved nutrition.
Objective 4: Strengthen the policy, legal, and institutional frameworks to effectively plan, implement, monitor, and evaluate nutrition programmes	a) Strengthen the policy and legal framework to coordinate, plan, and monitor nutrition activities. b) Strengthen and harmonise institutional framework for nutrition from local to central government levels. c) Strengthen human resource capacity to plan, implement, monitor, and evaluate food and nutrition programmes in the country. d) Enhance operational research for nutrition.
Objective 5: Create awareness of and maintain interest in and commitment to improve and support nutrition programmes in the country	a) Increase levels of awareness of and commitment to address nutrition issues in the country. b) Advocate for increased commitment to improve nutrition outcomes.

Session 1.4: The Uganda Multi-Sectoral Nutrition Coordination Framework

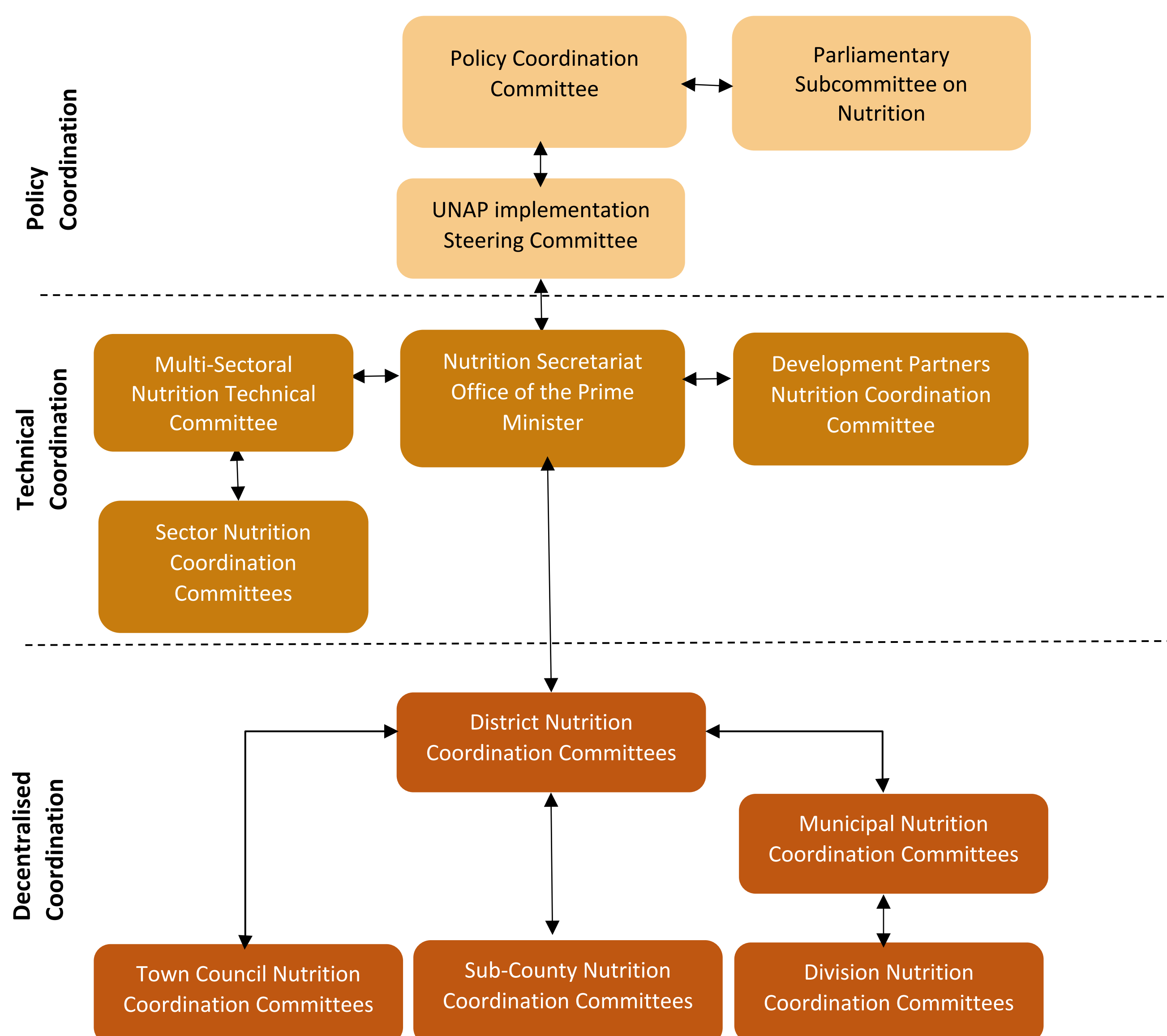
Instructions for the facilitators: The purpose of this session is to guide the participants through the nutrition coordination framework for Uganda from national to district to Lower Local Government level.

This session covers slides 59–61.

Slide 60

Multi-sectoral nutrition coordination in Uganda has three levels: policy, technical, and decentralised with defined linkages (Figure 1).

Figure 1. Uganda Multi-Sectoral Nutrition Coordination Framework



Policy Coordination

Policy coordination is done through three committees: the Policy Coordination Committee, the Implementation Steering Committee, and the Parliamentary Sub-Committee on Nutrition.

Policy Coordination Committee (PCC)

Policy Coordination Committee (PCC) is composed of cabinet ministers from the following line ministries: Ministry of Health (MOH); Ministry of Education and Sports (MOES); Ministry of Agriculture, Animal Industries, and Fisheries (MAAIF); Ministry of Gender, Labour, and Social Development (MGLSD); Ministry of Local Government (MOLG); Ministry of Water and Environment (MWE); Ministry of Trade, Industry, and Cooperatives (MTIC); Ministry of Finance, Planning, and Economic Development (MOFPED); Ministry of Public Service (MOPS); and the chairperson of the National Planning Authority (NPA). The PCC is chaired by the Right Honourable Prime Minister and meets annually to review progress on key nutrition indicators and to provide policy direction.

Parliamentary Sub-Committee on Nutrition (PSCN)

The Parliamentary Sub-Committee on Nutrition (PSCN) has not yet been formed. When formed, the PSCN will facilitate the generation of parliamentary debates and resolutions, advocate for increased resource appropriation and allocation, and support an enabling policy environment for the implementation of multi-sectoral nutrition interventions. The PSCN will review and approve recommendations from the PCC.

UNAP Implementation Steering Committee (ISC)

The UNAP Implementation Steering Committee (ISC) is composed of permanent secretaries of line ministries (MOH, MAAIF, MGLSD, MOES, MOLG, MWE, MTIC, MOFPED, MOPS, and the Executive Director of the National Planning Authority. The ISC is chaired by the Permanent Secretary of OPM and meets annually to review progress on performance of key nutrition indicators, analyse budget performance, identify constraints to multi-sectoral nutrition implementation, and provide strategic direction to the Nutrition Secretariat, OPM.

Technical Coordination

The Nutrition Secretariat, OPM is responsible for multi-sectoral nutrition technical coordination. Coordination is achieved through the following committees: the Multi-Sectoral Nutrition Technical Committee (MSTNC) and the Development Partners Nutrition Coordination Committee (DPNCC), and Sector Committees.

Nutrition Secretariat, OPM

The Nutrition Secretariat is housed within the Office of the Prime Minister in the Department of Policy Implementation Coordination, under the Directorate of

Monitoring and Evaluation. The secretariat is charged with the day-to-day functions of coordination, management, administration, and reporting on multi-sectoral nutrition programmes to ensure smooth implementation of the nutrition policy, strategies, and action plans. Tasks include:

- National-level coordination of multi-sectoral nutrition stakeholders
- Coordination of UNAP implementation at decentralised levels
- Multi-sectoral nutrition knowledge management and information sharing through experience sharing and learning events at global, regional, and national levels
- Coordination of the annual Scaling Up Nutrition (SUN) assessment
- Quarterly monitoring and support supervision to the DNCCs
- Implementation of the UNAP monitoring and evaluation framework

Development Partners Nutrition Coordination Committee (DPNCC)

The DPNCC is composed of representatives of nutrition development partners and feeds into the policy and technical coordination committees. The DPNCC members include USAID, U.N. agencies, Department for International Development (DFID), and civil society, private sector, and academia network representatives. The committee is responsible for promoting and identifying funding and resources to support the nutrition agenda in Uganda; promoting joint resource mobilisation, allocation, and support; responding to the proposed development partners' consolidated nutrition fund; and providing policy guidance on the alignment of nutrition programmes to the global and regional nutrition agenda.

Multi-Sectoral Nutrition Technical Committee (MSNTC)

The MSNTC is composed of nutrition focal point persons from MDAs and representatives from development partners, implementing partners, the private sector, academia, and civil society. The MSNTC fosters multi-stakeholder collaboration and partnership and joint planning and monitoring of the implementation of multi-sectoral nutrition programmes. The committee meets on a quarterly basis and is responsible for sharing, reviewing, and implementing decisions made by the committees at the policy coordination level (PCC, PSCN, ISC).

Sector Nutrition Coordination Committees

Each MDA has a committee that coordinates nutrition programmes. MDAs with sector committees include: MOH, MOES, MAAIF, MGLSD, MOLG, MWE, MTIC, MOFPED, NPA, and Uganda Bureau of Statistics (UBOS). At each MDA, the accounting officer selects committee members and designates a nutrition focal person to support nutrition coordination and to represent the sector at the MSNTC. These committees are responsible for policy development, coordination, capacity strengthening, planning, resource mobilisation, advocacy, and monitoring of nutrition interventions within their respective

MDAs. The sector nutrition coordination committees submit quarterly reports to OPM through the MSNTC.

Decentralised Coordination

Decentralised coordination is done at the district, municipality, town council, division, and sub-county levels through nutrition coordination committees at the district and LLG levels through district nutrition coordination committees (DNCCs), municipality nutrition coordination committees (MNCCs), town council nutrition coordination committees (TNCCs), division nutrition coordination committees (DiNCCs) and sub-county nutrition coordination committees (SNCCs). DNCCs should send nutrition coordination reports to the OPM on a quarterly basis. MNCCs, TNCCs, DiNCCs, and SNCCs should submit quarterly nutrition coordination reports to the district.

District Nutrition Coordination Committees (DNCC)

At the district level, the DNCC is constituted by the Chief Administrative Officer (CAO), who is the chairperson of the committee. The CAO designates a nutrition focal point person who should be a member of the District Technical Planning Committee. The DNCC is composed of 10–15 members from the following departments and groups: Planning, Health, Production, Works and Technical Services (Water); Education, Community Development, Trade and Industry, and Local Economic Development; civil society organisations (CSOs); the private sector; implementing partners, (IPs); and faith-based organisations (FBOs).

Municipal Nutrition Coordination Committees (MNCC)

At the municipality level, the MNCC is constituted by the Town Clerk (TC), who is the chairperson of the committee. The TC designates a nutrition focal point person who should be a member of the Municipal Technical Planning Committee. The MNCC should be composed of 8–10 members from the following departments and groups: Planning, Health, Production, Works and Technical Services (Water), Education, Community-Based Services, Trade and Industry, and Local Economic Development), CSOs, community-based organisations (CBOs), the private sector, implementing partners, and FBOs.

Division Nutrition Coordination Committees (DiNCC)

At the division level, the DiNCC is constituted by the Senior Assistant Town Clerk (SATC), who is the chairperson of the committee. The SATC designates a nutrition focal point person who should be a member of the Division Technical Planning Committee. The DiNCC should be composed of 5–10 members from the following departments and groups: Finance and Planning, Health, Works and Technical Services (Water), Education, Community-Based Services, CSOs, CBOs, the private sector, implementing partners, and FBOs.

Town Council Nutrition Coordination Committees (TNCC)

At the town council level, the TNCC is constituted by the Town Clerk (TC), who is the chairperson of the committee. The TC designates a nutrition focal point person who should be a member of the Town Council Technical Planning Committee. The TNCC should be composed of 5–10 members from the following departments and groups: Finance and Planning, Health, Production, Works and Technical Services (Water), Education, Trade and Industry, and Local Economic Development, Community-Based Services, CSOs, CBOs, the private sector, implementing partners, and FBOs.

Sub-County Nutrition Coordination Committees (SNCC)

At the sub-county level, the SNCC is constituted by the Sub-County Chief/Senior Assistant Secretary (SAS), who is the chairperson of the committee. The SAS designates a nutrition focal point person who should be a member of the Sub-County Technical Planning Committee. The SNCC should be composed of 5–10 members from the following departments and groups: Finance, Health, Production, Education, and Community-Based Services, CSOs, CBOs, the private sector, implementing partners, and FBOs.

Slide 61

Nutrition Coordination Committee (NCC) Composition and Influencing Actors

NCC core membership should include government representatives from the administration, health, planning, education, production, community development, trade and industry, and water departments.

Direct influencing actors include political leaders, civil society, and implementing partners. Because these actors have both financial and technical resources and political influence, they can be effective supporters of NCC operations even though they are not part of the core NCC membership. NCCs should engage with them to advance shared goals that are appropriate for the local context, as these actors are well placed to mobilise nutrition resources and can contribute technical assistance in areas such as data collection.

NCCs should also engage with indirect influencing actors such as academia, religious and cultural leaders, the media, and the private sector. Each of these actors has a sphere of influence in the community and access to platforms through which advocacy and behaviour change communication for nutrition can be done.

During planning and implementation, NCCs should also keep the national context in mind, including both development partners and government sectors. While many such actors do not directly engage with the NCCs on a regular basis, they can influence decisions that impact NCC operations through their work with influencing actors, such as implementing partners, at the district/LLG level.

Session 1.5 Roles and Responsibilities of Nutrition Coordination Committees

Instructions for the facilitators: The purpose of this session is to guide the participants through the roles and responsibilities of the NCCs.

This session covers slides 62–66.

Slide 63

NCCs at all levels have the following mandate:

NCCs provide technical advice to technical planning committees and subsequently to the Council. The committees will also monitor and evaluate nutrition activities, carrying out reviews and providing technical advice to districts and lower local government levels. Nutrition focal persons will coordinate nutrition activities within their area of responsibility.

Slide 64

NCC roles and responsibilities include the following:

i. **Technical guidance:** NCCs provide nutrition technical guidance at all local government levels, including to departments, partners, technical planning committees, and councils to ensure proper nutrition planning and quality of service delivery. This also includes identification of capacity strengthening needs.

ii. **Coordination and partnership with nutrition stakeholders:** The NCC provides a platform through which nutrition stakeholders from all departments can share information and build consensus on how best to address nutrition problems, use available resources, and harmonise the implementation of nutrition activities in the district/LLG. NCCs also have the responsibility to identify and build partnerships with nutrition stakeholders who can contribute to district/LLG nutrition goals and objectives.

iii. **Monitoring and reporting:** NCCs conduct joint monitoring and support supervision visits to their lower local government NCCs, departments, and partners to provide oversight to activity implementation. NCCs are also responsible for submitting quarterly reports. Reporting requirements capture progress on nutrition governance activities and on the implementation of activities in the multi-sectoral nutrition action plan.

iv. **Planning, budgeting, and resource mobilisation:** NCCs ensure integration and alignment of nutrition interventions in all local government development planning frameworks, including Development Plans, the MSNAP, annual work plans, and budgets. NCCs should also mobilise internal

and external resources to address resource gaps (e.g., local revenues, partners, and through proposal development).

v. **Advocacy:** NCCs should conduct advocacy to raise nutrition awareness among their district/LLG leaders. NCCs should also identify and work with nutrition champions to support advocacy efforts.

vi. **Nutrition behaviour change communication (BCC) and social mobilisation:** NCCs should utilise available platforms such as the media, community dialogue meetings (barazas), and community outreach to carry out behaviour change communication for nutrition. NCCs should also take the lead in ensuring that nutrition BCC messaging and social mobilisation efforts are harmonised across partners and lower local governments.

Slides 65–66

Roles of the Nutrition Focal Point Officer (NFPO)

The NFPO will provide the following services:

i. Act as Secretary to the nutrition coordination committee
ii. Ensure that the MSNAP is prepared and aligned to the development plan
iii. Compile and share district/LLG nutrition coordination reports on a quarterly basis
iv. Function as a link between nutrition stakeholders in the district/LLG

Key considerations

- The NFPO should have strong mobilisation skills
- The NFPO should be a member of the Technical Planning Committee (TPC)

UNIT 2

Roles of and Linkages between Nutrition Coordination Committees, Technical Planning Committees, and Councils

Purpose:

To explain the roles and responsibilities of the district/LLG level committees and explain their linkages.

Objectives:

By the end of the Unit 2, participants should:

- Understand the different committees, their roles and responsibilities
- Understand the linkages between the LLG NCCs and the district

Session 2.1: Roles of Councils and Technical Planning Committees in Nutrition Governance

Instructions for the facilitators: The purpose of this session is to guide the participants through the roles and responsibilities of various committees at the district/LLG level.

This session covers slides 67–72.

Slides 69–72

At district and LLG levels, TPCs, sectoral committees of council, executive committees, and councils play different roles in relation to nutrition governance as summarised in Table 3.

Table 3. Roles of TPCs, Sectoral Committees, Executive Committees, and Councils

Entity	Roles and Responsibilities
Council	• Approval of Multi-Sectoral Nutrition Action Plans (MSNAPs) and budgets • Monitor the implementation of nutrition interventions
Executive Committee	• Review district/LLG budgets and work plans and report on progress of implementation of multi-sectoral nutrition interventions • Provide policy direction for implementation of nutrition activities across departments • Monitor the implementation of nutrition interventions across departments
Sectoral Committees of Council	• Scrutinize departmental work plans and budgets to ensure nutrition interventions are planned and budgeted for • Receive reports from departments on nutrition-related issues and ensure alignment/integration with development plans, MSNAPs, annual work plans, and budgets • Monitor the implementation of nutrition interventions across departments
Technical Planning Committee	• Provide technical assistance to NCCs on nutrition interventions and relevant indicators within the development plans, MSNAPs, annual work plans, and budgets • Develop annual work plans, budgets, and actions plans that support alignment of nutrition interventions across departments • Receive reports from NCCs and departments that implement nutrition interventions • Provide supervisory oversight to all departments

Session 2.2: Linkages between LLG Nutrition Coordination Committees and the District

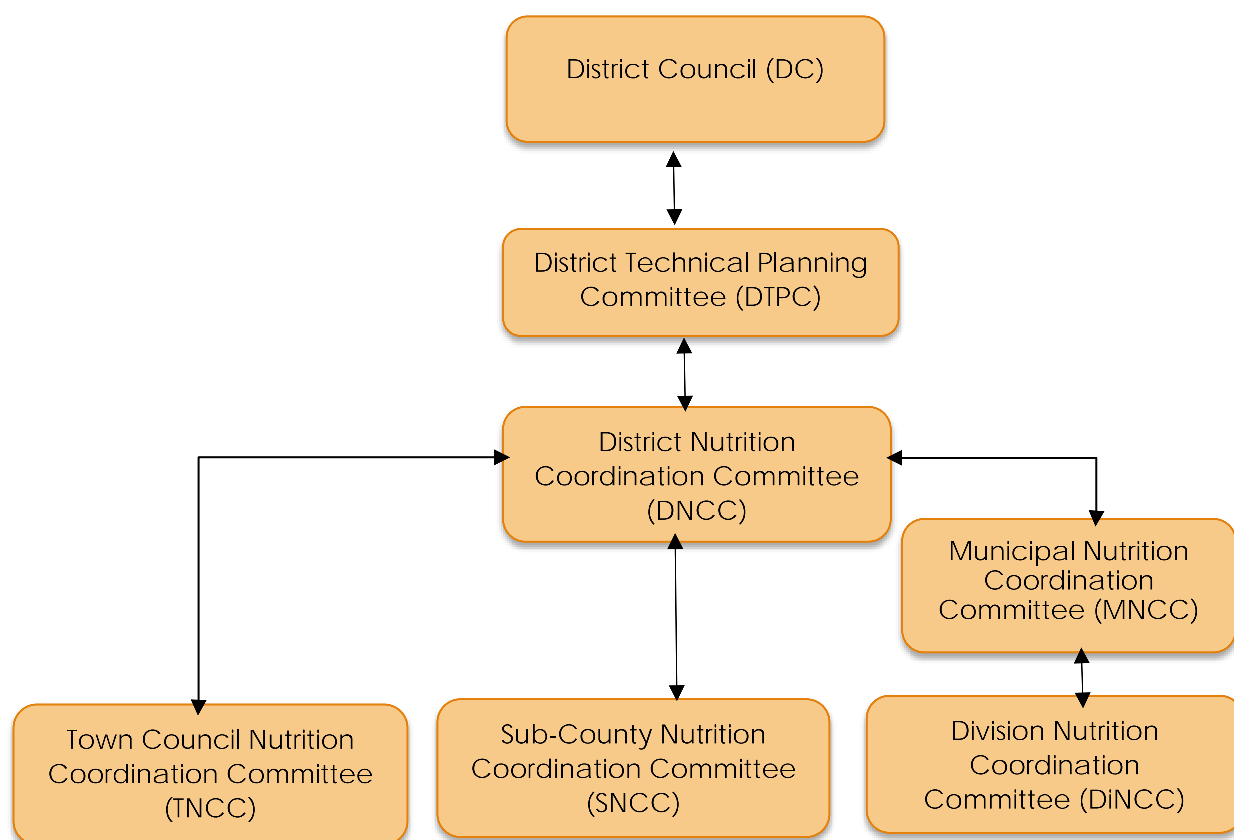
Instructions for the facilitators: The purpose of this session is to explain the linkages between LLG NCCs and the district level.

This session covers slides 73–74.

Slide 74

While each LLG NCC (MNCCs, TNCCs, DiNCCs, and SNCCs) has the responsibility of planning, implementing, monitoring, and reporting on nutrition activities within their respective LLGs, LLG NCCs all contribute to overall district nutrition plans, objectives, and goals. The DNCC oversees the work of all LLG NCCs within the district. The linkages between the LLG NCCs and the district level structures are illustrated in the graphic below.

Figure 2. Linkages between LLG NCCs and the District



UNIT 3

Nutrition Coordination Committee Monitoring and Reporting

Purpose:

To explain the discuss NCC monitoring and supervision criteria and explain NCC reporting requirements.

Objectives:

By the end of the Unit 3, participants should:

- Understand NCC monitoring and reporting requirements.

Session 3.1: Monitoring Nutrition Coordination Committees

Instructions for the facilitators: The purpose of this session is to discuss how NCCs are monitored to ensure they are undertaking their core roles and responsibilities to support nutrition governance.

This session covers slides 75–78.

Slides 77-78

NCCs are monitored based on the level to which their core roles and responsibilities are being carried out. Quarterly monitoring and support supervision visits are undertaken by the MSNTC, under the leadership of OPM, to assess DNCCs. MNCCs, TNCCs, and SNCCs, are monitored quarterly by the DNCCs. MNCCs are responsible for undertaking quarterly supervision visits to the DiNCCs. The checklist used by the MSNTC and OPM for DNCC monitoring and supervision is provided in Annex 2. The checklist used by DNCCs/MNCCs for monitoring and supervision visits to LLG NCCs is provided in Annex 3.

Session 3.2: Nutrition Coordination Committee Reporting

Instructions for the facilitators: The purpose of this session is to explain the nutrition coordination committee reporting mechanisms and discuss the NCC reporting template.

This session covers slides 79–82.

Slides 80-82

Reporting by NCCs should follow normal government reporting procedures. SNCCs and TNCCs should forward their reports to the DNCC on a quarterly basis. DNCCs consolidate these reports into a quarterly district nutrition coordination report. This report is submitted by the CAO to the Ministry of Finance, Planning and Economic Development (MoFPED), MoLG, and OPM. Similarly, DiNCCs submit reports quarterly to the MNCC for consolidation of the municipal quarterly nutrition coordination report. The Town Clerk submits the municipal quarterly report to MoFPED, MoLG, and OPM.

OPM will review DNCC and MNCC quarterly reports and provide feedback and action points to the districts and municipalities during quarterly monitoring and support supervision visits. The DNCCs and MNCCs provide feedback and action points to the LLG NCCs during support supervision visits and through the established structures. The NCC quarterly reporting template is provided in Annex 4.

Note that copies of the detailed reports for the NCCs should be retained by the DNCCs and MNCCs. Summaries of these reports should also be included in the narrative section of the Output Budgeting Tool (OBT).

UNIT 4

Action Plan to Operationalise Nutrition Coordination Committees

Purpose:

To develop an action plan to operationalize the NCCs.

Objectives:

By the end of the Unit 4, participants should:

- Have developed an action plan to operationalize their NCCs

Session 4.1: Nutrition Coordination Committee Action Planning

Instructions for the facilitators: The purpose of this session is to develop a short-term work plan for the NCCs to kick-start operations. Note: This action plan is for the NCCs to schedule activities and IS NOT the nutrition coordination committees' multi-sectoral nutrition action plan.

This session covers slides 83–86.

Note: The template for the NCC Action Plan is provided in Annex 4. Copies of this template should be provided to participants.

Slide 85

To kick-start NCC operations following this orientation, NCC members should develop short-term action plans guided by their roles and responsibilities as outlined in session 1.5. The action plan should indicate the planned next steps/activities, who is responsible, timelines for achievement, and methodology/approach (see Table 4). This short-term action plan will detail start-up activities in preparation for the development of the MSNAPs and the uptake of other NCC roles and responsibilities. A template for the Start-Up Action Plan is provided in Annex 5.

Slide 86

Table 4. Sample of a Start-Up Action Plan for Nutrition Coordination Committees

Next Steps/Activities	Responsible	Timeline	Approach/Methodology
1. Send circular to LLGs about formation of SNCCs	CAO	Within 1 week	Mail letters
2. Orient SNCCs	DNCC NFPO	Within 1 month	Use local government orientation materials
3.			
4.			

GROUP WORK SESSION

Ask groups to complete the NCC Action Plan template. To facilitate this process, participants should discuss the following questions:

- Who needs to know about the nutrition coordination mechanism? And how will we inform them? How will we engage them?
- Who are the stakeholders in nutrition and where do they operate? And how will we involve them?
- What is the plan of action for development of the MSNAP for the district/municipality/sub-county/division/town council?

Once completed, allow teams to share their action plans.

Session 4.2: Closing

Provide a brief recap of the orientation objectives, check to see if participant expectations were met, and have an appropriate official close the orientation.

ANNEXES

Annex 1. Sample Agenda for Nutrition Coordination Committee Orientation

Day 1		
Time	**Activities**	**Facilitator**
8:00–8:30	Registration	
8:30–9:00	Welcome, opening remarks, and introductions	
9:00–9:30	Introduction to the orientation objectives, time table, and materials	
9:30–10:00	Participant expectations	
10:00–10:30	Tea break	
10:30–11:00	Session 1.1: Nutrition Situation in Uganda	
11:00–11:45	Group exercise: Identifying LLGs most affected by malnutrition	
11:45–12:15	Session 1.1 continued	
12:15–1:15	Group exercise: Brainstorm causes of malnutrition	
1:15–2:15	Lunch break	
2:15–2:45	Group exercise: Brainstorm consequences of malnutrition	
2:45–3:15	Session 1.1 continued	
3:15–3:45	Session 1.2: Policy Environment for Nutrition	
3:45–4:00	Session 1.3: Overview of the Uganda Nutrition Action Plan	
4:00–4:45	Group exercise: Nutrition interventions included in development plans, MSNAPs, and annual work plans	
4:45–5:15	Session 1.4: The Uganda Multi-Sectoral Nutrition Coordination Framework	
5:15–5:30	Tea break and close of day	

Day 2		
Time	**Activities**	**Facilitator**
8:00–8:30	Registration	
8:30–9:00	Recap of Day 1	
9:00–10:00	Session 1.5: Roles and Responsibilities of Nutrition Coordination Committees	
10:00–10:30	Tea break	
10:30–11:00	Session 2.1: Roles of Councils and Technical Planning Committees in Nutrition Governance	
11:00–11:30	Session 2.2: Roles and Linkages of Nutrition Coordination Committees, Technical Planning Committees, and Councils	
11:30–12:00	Session 3.1: Monitoring Nutrition Coordination Committees	
12:00–1:00	Session 3.2: Nutrition Coordination Committee Reporting	
1:00–2:00	Lunch	
2:00–3:00	Session 4.1: Action Plan to Operationalise the Nutrition Coordination Committees	
3:00–3:30	Presentation of action plans	
3:30–4:00	Session 4.2: Closing	
4:00–5:00	Tea and departure	

Annex 2. District Nutrition Coordination Committee (DNCC) Monitoring and Support Supervision Checklist

Purpose of the tool

The Office of the Prime Minister (OPM) Nutrition Secretariat has the mandate to coordinate multi-sectoral nutrition efforts in Uganda, including monitoring and support supervision of District Nutrition Coordination Committees (DNCCs). The Monitoring and Support Supervision Checklist was developed to support this task. The tool can be used by national level stakeholders (OPM, sectors, and implementing partners) to monitor implementation of nutrition activities in the districts, check on the functionality of the DNCCs, identify gaps, and make recommendations to the district.

Using the tool

The questions in the tool seek to gather information about key aspects of nutrition governance. This includes DNCC composition and the thematic areas that make up DNCC core roles and responsibilities. Section 1 covers DNCC composition, sections 2–7 cover the six DNCC roles and responsibilities, as stated in OPM circular ADM/133/01 dated 17 June 2015.

Responses to the questions will be gathered during group discussions held with DNCC members. DNCC members should come from the following core departments: administration and planning, community development, education, health, production, and water. Participation of the Chief Administrative Officer (CAO) (or a representative) and the district nutrition focal person should be ensured as they are key DNCC informants. It typically takes the group two to three hours to complete the checklist. During the discussion, the group also agrees upon and completes the summary report.

Dissemination and feedback

OPM and the Multi-Sectoral Nutrition Technical Committee (MSNTC) are responsible for tracking progress and performance and providing feedback to DNCCs. DNCCs will be provided with a completed version of the checklist and the summary supervision report by OPM.

DISTRICT NUTRITION COORDINATION COMMITTEE (DNCC)

Monitoring and Support Supervision Checklist

District	
Core departments represented	
Date	
Administered by (Name/Position/Institution)	

SECTION 1: DNCC COMPOSITION		
No.	**Questions**	**Responses**
Q 1.1	Does the DNCC include all core departments? *Tick all that apply* ☐ Administration ☐ Community development ☐ Education ☐ Health ☐ Production ☐ Planning ☐ Trade and industry ☐ Water	☐ Yes **(If yes, skip to 1.2)** ☐ No If no, list core department missing and state why they are not included What is being done to engage missing sectors with the DNCC? Means of verification - Circular on formation of DNCC
Q 1.2	Have all members received letters of assignment from the CAO?	☐ Yes. *Probe if the letters include clear terms of reference/roles and responsibilities.* ☐ No. *Probe for who has not received, why, and what is being done.* Means of verification - Copies of assignment letters

SECTION 1: DNCC COMPOSITION		
No.	**Questions**	**Responses**
Q 1.3	Has the CAO formally designated a nutrition focal point officer (NFPO) for the DNCC?	☐ Yes. *Probe who is the appointed NFPO and list the position:* ☐ No. *Probe why the NFPO has not been appointed and what is being done to recruit one.* Means of verification - Copy of NFPO assignment letter
Additional comments on DNCC composition:		

SECTION 2: TECHNICAL GUIDANCE		
No.	**Questions**	**Responses**
Q 2.1	How many LLGs does the district have?	Number of LLGs: How many have established Nutrition Coordination Committees (NCCs)? What is being done to facilitate the establishment of the remaining NCCs? Means of verification - Circular on formation of NCCs
Q 2.2	Has the DNCC oriented the NCCs?	☐ Yes. *Probe how many have been oriented and the institution that supported the orientation.* ☐ No. *Probe what is being done to orient the NCCs.* Means of verification - Orientation report

SECTION 2: TECHNICAL GUIDANCE		
No.	**Questions**	**Responses**
Q 2.3	What nutrition issues were presented to District Technical Planning Committee (DTPC) in the last quarter?	List the nutrition issues presented: What actions have been taken as a result of presenting nutrition issues to the DTPC in the last quarter? *Probe for challenges if no nutrition issues were presented.* Means of verification - Action memo from the DTPC on nutrition issues
Q 2.4	What nutrition issues were presented to the District Council in the last quarter?	List the nutrition issues presented: What actions have been taken as a result of presenting nutrition issues to the District Council in the last quarter? *Probe for challenges if no nutrition issues were presented.* Means of verification - District Council minutes with nutrition issues
Q 2.5	What technical guidance was provided to departments and partners in the last quarter? List the activities:	

Activity	Platform Used	Target Audience	Results/Output

If no technical guidance was provided, explain why.

SECTION 2: TECHNICAL GUIDANCE		
No.	**Questions**	**Responses**
Additional comments on technical guidance:		

SECTION 3: COORDINATION AND PARTNERSHIPS WITH NUTRITION STAKEHOLDERS		
No.	**Questions**	**Responses**
Q 3.1	Does the DNCC have an approved annual coordination work plan for the district?	☐ Yes. ☐ No. *Probe what is being done to develop an annual coordination work plan.* Means of verification: - Copy of the approved annual coordination work plan
Q 3.2	Were any nutrition coordination meetings held in the last quarter?	☐ Yes. ☐ No. *Probe what is being done to overcome the challenge.* Means of verification - Minutes and action memos from coordination meetings
Q 3.3	Were any joint activities undertaken with stakeholders in the last quarter?	☐ Yes. *Provide details of activities.* ☐ No. *Explain.* Means of verification - Activity reports
Q 3.4	Is there an up-to-date nutrition partner database?	☐ Yes. ☐ No. *Probe what is being done to develop or update the database.* Means of verification - Database of nutrition partners

SECTION 3: COORDINATION AND PARTNERSHIPS WITH NUTRITION STAKEHOLDERS		
No.	**Questions**	**Responses**
Q 3.5	What platforms did the district use in the last quarter to share nutrition information (e.g., reports, presentations, results) with relevant stakeholders? *Tick all that apply* ☐ District Council meetings ☐ Sectoral committee meetings ☐ Senior management meetings ☐ District Technical Planning Committee meetings ☐ District Nutrition Coordination Committee meetings ☐ Extended District Technical Planning Committee meetings ☐ Departmental meetings ☐ School management meetings ☐ Budget conferences ☐ Barazas ☐ Experience sharing events ☐ Other (list) *Probe for examples of the types of information shared, the stakeholders involved, and for what is being done to continue or improve nutrition information sharing within the district.* Means of verification - Minutes, reports, action memos	
Additional comments on coordination and partnerships with nutrition stakeholders:		

SECTION 4: PLANNING, BUDGETING, AND RESOURCE MOBILISATION		
No.	**Questions**	**Responses**
Questions for new DNCCs and/or first monitoring and supervision visit:		
Q 4.1	Does the LLG have a 5-year District Development Plan?	☐ Yes. *If yes, list all cross-cutting issues (verify information provided from the District Development Plan)*: ☐ No. *Probe for the stage the district is at in the development of the development plan. What is being done to ensure its nutrition issues are included?* Means of verification: - Copy of the District Development Plan

SECTION 4: PLANNING, BUDGETING, AND RESOURCE MOBILISATION		
No.	**Questions**	**Responses**
Q 4.2	Does the district have an approved District Multi-Sectoral Nutrition Action Plan (DMSNAP)?	☐ Yes. ☐ No. *Probe for the stage the district is at in the development of the DMSNAP. What is being done to ensure its development/approval?* Means of verification: - Copy of the DMSNAP
Q 4.3	Does the district have an approved annual multi-sectoral nutrition implementation work plan and budget?	☐ Yes. ☐ No. *Probe for the stage the district is at in the development of the annual multi-sectoral nutrition implementation work plan and budget. What is being done to ensure its development/approval?* Means of verification: - Copy of the annual multi-sectoral nutrition implementation work plan and budget
Q 4.4	What resources are available for nutrition in the LLG?	*Tick all that apply* ☐ Local revenue ☐ Central government grants ☐ Implementing partners ☐ In-kind ☐ Direct support ☐ Private sector ☐ Other (list) Which of the above resources are currently being used for nutrition? Is there a resource gap (provide % if known)? What is being done to mobilize additional resource for nutrition?
Q 4.5	Were activities undertaken to mobilise additional resources in the last quarter?	Yes. *Provide details of activities.* ☐ No. *Probe what is being done to overcome the challenge.*
Additional comments on planning, budgeting, and resource mobilisation:		

SECTION 5: MONITORING AND REPORTING		
No.	**Questions**	**Responses**
Q 5.1	Did the DNCC conduct joint monitoring and support supervision visits for the NCCs in the last quarter?	☐ Yes. *Probe for the report and check for composition of the monitoring team.* Which platforms were used to share the reports? ☐ DNCC meetings ☐ NCC meetings ☐ Extended District Technical Planning committee meetings ☐ Others (list) What nutrition actions were taken as a result of the NCC monitoring? ☐ No. *Probe for the challenges and what is being done to facilitate this action.* Means of verification - Monitoring and support supervision reports
Q 5.2	Did the DNCC receive a joint monitoring and support supervision visit in the last quarter?	☐ Yes. *Probe for the report and check for composition of the monitoring team.* If yes, did you receive feedback on your DNCC monitoring and support supervision visit? What nutrition actions were taken as a result of the DNCC monitoring and support supervision visit? ☐ No. *Probe what is being done to overcome the challenge.* Means of verification - Monitoring and support supervision reports

SECTION 5: MONITORING AND REPORTING		
No.	**Questions**	**Responses**
Q 5.3	Did the DNCC prepare a consolidated quarterly coordination report last quarter?	☐ Yes ☐ No. *Probe for the challenges and what is being done.* If yes, which departments submitted written reports to the DNCC to be included in the consolidated report Tick all that apply: ☐ Administration ☐ Community development ☐ Education ☐ Health ☐ Production ☐ Planning ☐ Trade and industry ☐ Water **Others** ☐ Implementing partners (list) Did the DNCC share the consolidated quarterly report? *Probe who they shared the report with.* What actions were taken as a result of the DNCC quarterly report? Means of verification - Consolidated DNCC quarterly report
Additional comments on monitoring and reporting:		

SECTION 6: ADVOCACY		
No.	**Questions**	**Responses**
Q 6.1	Does the DNCC have an approved advocacy and communication plan?	☐ Yes. ☐ No. *Probe for the stage the district is at in the development of the advocacy and communication plan. What is being done to ensure its development/approval?* Means of verification: - Copy of the approved advocacy and communication plan
Q 6.2	Has the DNCC identified nutrition champions at district level?	☐ Yes. ☐ No. *Probe for the challenges and what is being done.* Means of verification: - Database of nutrition champions
Q 6.3	What nutrition advocacy activities were conducted in the last quarter? List the activities:	

Advocacy Activity	Platform Used	Target Audience	Results/Output

If advocacy activities were not conducted, probe for what is being done to strengthen nutrition advocacy.

Additional comments on advocacy:

SECTION 7: NUTRITION BEHAVIOUR CHANGE COMMUNICATION AND SOCIAL MOBILISATION		
No.	**Questions**	**Responses**
Q 7.1	What nutrition behaviour change communication and social mobilisation activities were conducted in the last quarter? List the activities:	

Activity	Platform Used	Target Audience	Results/Output

If activities were not conducted, probe for what is being done to strengthen nutrition behaviour change communication and social mobilisation.

Additional comments on nutrition behavior change communication and social mobilisation:

DNCC Monitoring and Support Supervision Summary Reporting Template

District	
Core departments represented	
Date	
Administered by (Name/Position/Institution)	

Focus Area	Strengths	Challenges	Proposed Actions/ Recommendation	Time Frame for Response/ Improvement	Person Responsible for Follow-up Action
DNCC Composition					
Technical Guidance					
Coordination and Partnerships with Nutrition Stakeholders					
Planning, Budgeting, and Resource Mobilisation					
Monitoring and Reporting					
Advocacy					
Nutrition Behaviour Change Communication and Social Mobilisation					

Annex 3. Nutrition Coordination Committee (NCC) Monitoring and Support Supervision Checklist for Lower Local Governments

Purpose of the tool

District Nutrition Coordination Committees (DNCCs) have the mandate to coordinate multi-sectoral nutrition efforts at district and lower local government (LLG) level in Uganda, including monitoring and support supervision of Nutrition Coordination Committees (NCCs). The Monitoring and Support Supervision Checklist was developed to support this task. The tool can be used by district/LLG level stakeholders (DNCC members and municipality coordination committee [MNCC] members, departments, and implementing partners) to monitor implementation of nutrition activities at the LLG level, check on the functionality of the NCCs, identify gaps, and make recommendations to the LLG.

Using the tool

The questions in the tool seek to gather information about key aspects of nutrition governance. This includes NCC composition and the thematic areas that make up NCC core roles and responsibilities. Section 1 covers NCC composition, sections 2–7 cover the six NCC roles and responsibilities, as stated in OPM circular ADM/133/01 dated 17 June 2015.

Responses to the questions will be gathered during group discussions held with NCC members. NCC members should come from the following core departments: administration and planning, community development, education, health, production, trade and industry, and water. Participation of the Accounting Officer (AO) (or a representative) and the nutrition focal point officer (NFPO) should be ensured as they are key NCC informants. It typically takes the group two to three hours to complete the checklist. During the discussion, the group also agrees upon and completes the summary report.

Dissemination and feedback

DNCC/MNCC members are responsible for tracking progress and performance and providing feedback to LLG NCCs. LLG NCCs will be provided with a completed version of the checklist and the summary supervision report by the DNCC/MNCC.

NUTRITION COORDINATION COMMITTEE (NCC)

Monitoring and Support Supervision Checklist for Lower Local Governments

LLG	
Core departments represented	
Date	
Administered by (Name/Position/Institution)	

SECTION 1: NCC COMPOSITION		
No.	**Questions**	**Responses**
Q 1.1	Does the NCC include all core departments? *Tick all that apply* ☐ Administration ☐ Community development ☐ Education ☐ Health ☐ Production ☐ Planning ☐ Trade and industry ☐ Water	☐ Yes **(If yes, skip to 1.2)** ☐ No If no, list core departments that are missing and state why they are not included What is being done to engage missing departments with the NCC? Means of verification - Circular on formation of NCC
Q 1.2	Have all members received letters of assignment from the Accounting Officer (AO)?	☐ Yes. *Probe if the letters include clear terms of reference/roles and responsibilities.* ☐ No. *Probe for who has not received, why, and what is being done.* Means of verification - Copies of assignment letters

SECTION 1: NCC COMPOSITION		
No.	**Questions**	**Responses**
Q 1.3	Has the AO formally designated a nutrition focal point officer (NFPO) for the NCC?	☐ Yes. *Probe who is the appointed NFPO and list the position:* ☐ No. *Probe why the NFPO has not been appointed and what is being done to recruit one.* Means of verification - Copy of NFPO assignment letter
Additional comments on NCC composition:		

SECTION 2: TECHNICAL GUIDANCE		
No.	**Questions**	**Responses**
Q 2.1	*For municipalities only:* How many divisions does the municipality have?	Number of divisions: How many have established Division Nutrition Coordination Committees (DiNCCs)? What is being done to facilitate the establishment of the remaining DiNCCs? Means of verification - Circular on formation of DiNCCs
Q 2.2	Has the DNCC oriented the NCC?	☐ Yes. *Probe to find out if any institution supported the orientation.* ☐ No. *Probe what is being done to orient the NCC.* Means of verification - Orientation report

<table>
<tr><th colspan="3">SECTION 2: TECHNICAL GUIDANCE</th></tr>
<tr><th>No.</th><th>Questions</th><th>Responses</th></tr>
<tr><td>Q 2.3</td><td>What nutrition issues were presented to the Technical Planning Committee (TPC) in the last quarter?</td><td>List the nutrition issues presented:

What actions have been taken as a result of presenting nutrition issues to the TPC in the last quarter?

Probe for challenges if no nutrition issues were presented.

<u>Means of verification</u>
- Action memo from the TPC on nutrition issues</td></tr>
<tr><td>Q 2.4</td><td>What nutrition issues were presented by the TPC to the Council in the last quarter?</td><td>List the nutrition issues presented:

What actions have been taken as a result of presenting nutrition issues to the Council in the last quarter?

Probe for challenges if no nutrition issues were presented.

<u>Means of verification</u>
- Council minutes with nutrition issues</td></tr>
<tr><td>Q 2.5</td><td colspan="2">What technical guidance was provided to departments and partners in the last quarter?
List the activities:
<table>
<tr><th>Activity</th><th>Platform Used</th><th>Target Audience</th><th>Results/Output</th></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
</table>
If no technical guidance was provided, explain why.</td></tr>
</table>

SECTION 2: TECHNICAL GUIDANCE		
No.	**Questions**	**Responses**
Additional comments on technical guidance:		

SECTION 3: COORDINATION AND PARTNERSHIPS WITH NUTRITION STAKEHOLDERS		
No.	**Questions**	**Responses**
Q 3.1	Does the NCC have an approved annual coordination work plan for the LLG?	☐ Yes. ☐ No. *Probe what is being done to develop an annual coordination work plan.* <u>Means of verification:</u> - Copy of the approved annual coordination work plan
Q 3.2	Were any nutrition coordination meetings held in the last quarter?	☐ Yes. ☐ No. *Probe what is being done to overcome the challenge.* <u>Means of verification</u> - Minutes and action memos from coordination meetings
Q 3.3	Were any joint activities undertaken with stakeholders in the last quarter?	☐ Yes. *Provide details of activities.* ☐ No. *Explain.* <u>Means of verification</u> - Activity reports
Q 3.4	Is there an up-to-date nutrition partner database?	☐ Yes. ☐ No. *Probe what is being done to develop or update the database.* <u>Means of verification</u> - Database of nutrition partners

SECTION 3: COORDINATION AND PARTNERSHIPS WITH NUTRITION STAKEHOLDERS		
No.	**Questions**	**Responses**
Q 3.5	What platforms did the LLG use in the last quarter to share nutrition information (e.g., reports, presentations, results) with relevant stakeholders? *Tick all that apply* ☐ Council meetings ☐ Sectoral committee meetings ☐ Senior management meetings ☐ Technical Planning Committee meetings ☐ Nutrition Coordination Committee meetings ☐ Extended Technical Planning Committee meetings ☐ Departmental meetings ☐ School management meetings ☐ Budget conferences ☐ Barazas ☐ Experience sharing events ☐ Other (list) *Probe for examples of the types of information shared, the stakeholders and NCC members involved, and for what is being done to continue or improve nutrition information sharing within the LLG.* Means of verification - Minutes, reports, action memos	
Additional comments on coordination and partnership with nutrition stakeholders:		

SECTION 4: PLANNING, BUDGETING, AND RESOURCE MOBILISATION		
No.	**Questions**	**Responses**
Questions for new DNCCs and/or first monitoring and supervision visit:		
Q 4.1	Does the LLG have a 5-year development plan?	☐ Yes. *If yes, list all cross-cutting issues (verify information provided from the development plan)*: ☐ No. *Probe for the stage the LLG is at in the development of the development plan. What is being done to ensure its nutrition issues are included?* Means of verification: - Copy of the development plan
Q 4.2	Does the LLG have an approved Multi-Sectoral Nutrition Action Plan (MSNAP)?	☐ Yes. ☐ No. *Probe for the stage the LLG is at in the development of the MSNAP. What is being done to ensure its development/approval?* Means of verification: - Copy of the MSNAP
Q 4.3	Does the LLG have an approved annual multi-sectoral nutrition implementation work plan and budget?	☐ Yes. ☐ No. *Probe for the stage the LLG is at in the development of the annual multi-sectoral nutrition implementation work plan and budget. What is being done to ensure its development/approval?* Means of verification: - Copy of the annual multi-sectoral nutrition implementation work plan and budget

SECTION 4: PLANNING, BUDGETING, AND RESOURCE MOBILISATION		
No.	**Questions**	**Responses**
Q 4.4	What resources are available for nutrition in the LLG?	*Tick all that apply* ☐ Local revenue ☐ Central government grants ☐ Implementing partners ☐ In-kind ☐ Direct support ☐ Private sector ☐ Other (list) Which of the above resources are currently being used for nutrition? Is there a resource gap (provide % if known)? What is being done to mobilize additional resource for nutrition?
Q 4.5	Were activities undertaken to mobilise additional resources in the last quarter?	Yes. *Provide details of activities.* ☐ No. *Probe what is being done to overcome the challenge.*
Additional comments on planning, budgeting, and resource mobilisation:		

SECTION 5: MONITORING AND REPORTING		
No.	**Questions**	**Responses**
Q 5.1	*For municipalities only:* Did the MNCC conduct joint monitoring and support supervision visits for the DiNCCs in the last quarter?	☐ Yes. *Probe for the report and check for composition of the monitoring team.* Which platforms were used to share the reports? ☐ DNCC meetings ☐ NCC meetings ☐ Extended Technical Planning Committee meetings ☐ Others (list) What nutrition actions were taken as a result of the DiNCC monitoring and support supervision visit? ☐ No. *Probe for the challenges and what is being done to facilitate this action.* <u>Means of verification</u> - Monitoring and support supervision reports
Q 5.2	Did the NCC receive a joint monitoring and support supervision visit in the last quarter?	☐ Yes. *Probe for the report and check for composition of the monitoring team.* If yes, did you receive feedback on your NCC monitoring and support supervision visit? What nutrition actions were taken as a result of the NCC monitoring and support supervision visit? ☐ No. *Probe what is being done to overcome the challenge.* <u>Means of verification</u> - Monitoring and support supervision reports

SECTION 5: MONITORING AND REPORTING		
No.	**Questions**	**Responses**
Q 5.3	Did the NCC prepare a consolidated quarterly coordination report last quarter?	☐ Yes ☐ No. *Probe for the challenges and what is being done.* If yes, which departments submitted written reports to the NCC to be included in the consolidated report Tick all that apply: ☐ Administration ☐ Community development ☐ Education ☐ Health ☐ Production ☐ Planning ☐ Trade and industry ☐ Water **Others** ☐ Implementing partners (list) Did the NCC share the consolidated quarterly report? *Probe who they shared the report with.* What actions were taken as a result of the NCC quarterly report? Means of verification - Consolidated NCC quarterly report
Additional comments on monitoring and reporting:		

SECTION 6: ADVOCACY		
No.	**Questions**	**Responses**
Q 6.1	Does the NCC have an approved advocacy implementation plan?	☐ Yes. ☐ No. *Probe for the stage the LLG is at in the development of the advocacy implementation plan. What is being done to ensure its development/approval?* Means of verification: - Copy of the approved advocacy implementation plan
Q 6.2	Has the NCC identified nutrition champions at LLG level?	☐ Yes. ☐ No. *Probe for the challenges and what is being done.* Means of verification: - Database of nutrition champions
Q 6.3	What nutrition advocacy activities were conducted in the last quarter? List the activities:	

Advocacy Activity	Platform Used	Target Audience	Results/Output

If advocacy activities were not conducted, probe for what is being done to strengthen nutrition advocacy.

Additional comments on advocacy:

SECTION 7: NUTRITION BEHAVIOUR CHANGE COMMUNICATION AND SOCIAL MOBILISATION		
No.	**Questions**	**Responses**
Q 7.1	What nutrition behaviour change communication and social mobilisation activities were conducted in the last quarter? List the activities:	

Activity	Platform Used	Target Audience	Results/Output

If activities were not conducted, probe for what is being done to strengthen nutrition behaviour change communication and social mobilisation.

Additional comments on nutrition behavior change communication and social mobilisation:

LLG Monitoring and Support Supervision Summary Reporting Template

LLG	
Core departments represented	
Date	
Administered by (Name/Position/Institution)	

Focus Area	Strengths	Challenges	Proposed Actions/ Recommendation	Time Frame for Response/ Improvement	Person Responsible for Follow-up Action
NCC Composition					
Technical Guidance					
Coordination and Partnership with Nutrition Stakeholders					
Planning, Budgeting, and Resource Mobilisation					
Monitoring and Reporting					
Advocacy					
Nutrition Behaviour Change Communication and Social Mobilisation					

Annex 4. Nutrition Coordination Committee Quarterly Reporting Template

General Reporting Guidance

Reporting by Nutrition Coordination Committees (NCCs) should follow normal government reporting procedures. Sub-county Nutrition Coordination Committees (SNCCs) and Town Council Nutrition Coordination Committees (TNCCs) should forward their reports to the District Nutrition Coordination Committee (DNCC) on a quarterly basis. DNCCs consolidate these reports into a quarterly district nutrition coordination report. This report is submitted by the Chief Administrative Officer (CAO) to the Ministry of Finance, Planning and Economic Development (MoFPED), Ministry of Local Government (MoLG), and Office of the Prime Minister (OPM). Similarly, Division Nutrition Coordination Committees (DiNCCs) submit reports quarterly to the Municipal Nutrition Coordination Committee (MNCC) for consolidation of the municipal quarterly nutrition coordination report. The Town Clerk submits the municipal quarterly report to MoFPED, MoLG, and OPM.

OPM will review DNCC and MNCC quarterly reports and provide feedback and action points to the districts and municipalities during quarterly monitoring and support supervision visits. The DNCCs and MNCCs provide feedback and action points to the LLG NCCs during support supervision visits and through the established structures.

Copies of the detailed reports for the NCCs should be retained by the DNCCs and MNCCs. Summaries of these reports should also be included in the narrative section of the Output Budget Tool (OBT).

The NCC reporting template has two parts. Part 1 is the quarterly update on the NCC annual coordination work plan. Part 2 details quarterly progress made towards achieving the objectives of the NCC's annual Multi-Sectoral Nutrition Implementation Work Plan.

Part 1: Quarterly Update on NCC Nutrition Coordination Work Plan

This section of the report is a narrative that describes activities undertaken as part of the nutrition coordination work plan. NCCs should provide updates on activities planned for and completed during the quarter and activities anticipated for the upcoming quarter. Examples of the types of activities to be reported on under each section of the report are detailed below. The reporting template is provided in Table 1.

Technical Guidance: Nutrition guidance provided by the NCC to departments and partners, including capacity strengthening activities; issues presented to the Technical Planning Committee (TPC) during the quarter and the resulting actions.

Coordination and Partnerships with Nutrition Stakeholders: Number of coordination meetings and joint activities conducted with stakeholders, detailing those involved and platforms used; results of stakeholder coordination efforts; and planned next steps.

Planning, Budgeting, and Resource Mobilisation: Efforts made to align department and partner plans with MSNAP activities; challenges implementing plans; budgetary challenges; and resource mobilisation activities.

Monitoring and Reporting: Frequency and types of data provided to the NCC by departments and partners; description of supervision activities undertaken; actions taken as a result of monitoring, supervision, and reporting.

Advocacy: Advocacy efforts undertaken by the NCC during the quarter and actions taken by stakeholders as a result of advocacy efforts. NCCs should also refer to their advocacy implementation plan when completing this section.

Nutrition Behaviour Change Communication (BCC) and Social Mobilisation: Messages shared and platforms used; efforts undertaken or needed to harmonize BCC messaging and social mobilisation activities within the district/LLG.

Additional comments: Describe general NCC achievements; nutrition innovations from community members, partners, or stakeholders; and any upcoming opportunities the NCC hopes to pursue. Detail any support required from the national level to achieve these efforts.

Table 1: Part 1—Coordination Work Plan Quarterly Report

District/LLG:

Reporting period (Quarter, Year):

Report compiled by:

Responsibility area	Planned activities for quarter	Activities conducted this quarter	Planned activities for the next quarter
Technical Guidance			
Coordination and Partnerships with Nutrition Stakeholder			
Planning, Budgeting, and Resource Mobilization			
Monitoring and Reporting			
Advocacy			
Nutrition Behaviour Change Communication and Social Mobilization			

Additional comments:

Part 2: Quarterly Progress on the Annual Multi-Sectoral Nutrition Implementation Work Plan and Budget

The NCC should refer to the annual Multi-Sectoral Nutrition Implementation Work Plan and Budget and the Multi-Sectoral Nutrition M&E Framework from the MSNAP to report on quarterly progress towards each activity's annual target. NCCs should call upon partners and sectors to provide updates and data to complete this section of the report. The reporting template is provided in Table 2.

Table 2: Part 2—Multi-Sectoral Nutrition Implementation Work Plan and Budget Template

	Activities	Indicator	Quarterly Targets				Annual Target	Department/ partner responsible for collection	Quarterly Budget				Cumulative budget
			Q1	Q2	Q3	Q4			Q1	Q2	Q3	Q4	
1.0	**Objective 1**												
1.2													
1.3													
2.0	**Objective 2**												
2.1													
2.2													
3.0	**Objective 3**												
2.3													
3.1													

Annex 5. Sample Start-Up Action Planning Template

Next Steps/ Activities	Responsible	Timeline	Approach/Methodology
1.			
2.			
3.			
4.			
5.			

Annex 6. Glossary of Terms

Acute malnutrition	This is a common term for identifying acute undernutrition, and it reflects a recent and severe process that has led to substantial weight loss and nutrient deficiency, usually associated with severe deprivation and/or disease. It includes wasting but also bilateral pitting oedema. Often used to assess the severity of emergencies because it is strongly related to mortality.
Anaemia	Low concentration of hemoglobin in the blood, as evidenced by a reduced quality or quantity of red blood cells. Anaemia could be caused by genetic traits, parasitism, infectious diseases, and/or nutritional deficiencies. For the latter, iron deficiency is the most important reason, especially in women of reproductive age, although other deficiencies of micronutrients such as vitamin A, vitamin B12, folate, and even vitamin B2 could also be important in developing countries.
Body mass index (BMI)	Body weight in kilograms divided by height in meters squared (kg/m2). For adults 20 and over, BMI is used as a screening tool to assess health risk. Individuals with both high BMI (overweight and obese, BMI between 25–29.9 and >30, respectively) and low BMI (underweight, BMI less than 18.5 in adults) face higher health risks.
Exclusive breastfeeding	When infants receive only breast milk, without any additional food or drink—not even water—for the first 6 months of life.
Indicator	A quantitative or qualitative variable that provides a valid and reliable basis for assessing or measuring achievement, performance, or change resulting from an intervention. Data or statistics that describe a person, place, or an event and/or the changes in it.
Infant and young child feeding (IYCF)	Term used to describe the feeding of infants (less than 12 months of age) and young children (12–23 months of age). IYCF programmes focus on the protection, promotion, and support of exclusive breastfeeding for the first 6 months; timely introduction of and appropriate complementary feeding, and continued breastfeeding for 2 years or beyond.
Low birth weight	Weight of less than 2.5 kg at birth.
Malnutrition	People are malnourished if their diet is not balanced with their nutritional needs. There are two main types: undernutrition and overnutrition.
Micronutrient deficiency	Inadequate intake of micronutrients (vitamins or minerals) for the body's needs. The most common micronutrient deficiencies are: vitamin A deficiency, iron deficiency anaemia, iodine deficiency, and zinc deficiency. This is also known as 'hidden hunger'.

Moderate acute malnutrition	Weight-for-height between -2 and -3 standard deviations below the median of WHO Child Growth Standards (moderate wasting) and/or mid-upper arm circumference (MUAC) of <125mm and ≥ 115mm.
Monitoring and evaluation	Monitoring is the routine tracking of a programme's activities by measuring on a regular, ongoing basis whether planned activities are being carried out. It is used to track changes in programme performance over time. Evaluation measures the extent to which change occurs consistent with programme objectives.
Multi-sectoral approach	An approach to nutrition planning and programming in which different sectors/departments coordinate and collaborate to address both direct and underlying causes of malnutrition.
Non-communicable diseases	Also known as chronic diseases, they are of long duration and generally slow progression. The four main types of non-communicable diseases are cardiovascular diseases (e.g., heart attacks and stroke), cancers, chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma), and metabolic disorders such as diabetes.
Nutrition governance	Nutrition governance represents actions taken to provide an institutional framework and systems to facilitate the institutionalization of nutrition in existing government structures, policies, and frameworks. Nutrition governance is strengthened through these six areas: technical guidance; coordination and partnership with nutrition stakeholders; monitoring and reporting; planning, budgeting, and resource mobilisation; advocacy; and nutrition behaviour change communication and social mobilization.
Nutrition-sensitive interventions	Nutrition-sensitive interventions address some of the underlying and basic causes of malnutrition—such as food insecurity; in adequate caregiving resources at the maternal, household, and community levels; and lack of access to health services and a safe and hygienic environment—and incorporate nutrition goals and actions from a wide range of sectors. They can also serve as delivery platforms for nutrition-specific interventions, potentially increasing their scale, coverage, and effectiveness.
Nutrition-specific interventions	Nutrition-specific interventions address the immediate causes of undernutrition (e.g., inadequate dietary intake) and some of the underlying causes (e.g., sub-optimum feeding practices and lack of access to food).
Obesity	Obesity is a range of weight that is much greater than what is generally considered healthy for a given height. For adults, obesity is having a body mass index (BMI) of 30 or higher.

Oedema (bilateral pitting)	An excess accumulation of fluid that starts in both feet and can progress to other parts of the body. Also known as nutritional oedema or oedematous malnutrition, bilateral pitting oedema is a sign of severe acute malnutrition. It is verified when thumb pressure applied on the tops of both feet for 3 seconds leaves an indentation after the thumb is lifted.
Overnutrition	Overnutrition happens when a person's daily energy intake consistently exceeds energy requirements. If this continues over time, a person may become overweight or obese.
Overweight	Overweight is a range of weight that exceeds what is generally considered healthy for a given height. For adults, overweight is having a BMI from 25 to 29.9.
Severe acute malnutrition	Weight-for-height below -3 standard deviations from the median of the WHO Child Growth Standards, or mid-upper-arm circumference (MUAC) of less than 115 mm, bilateral pitting oedema bipedal oedema, and/or oedematous wasting.
Stunting	Stunting, or chronic malnutrition, occurs when a child fails to grow at a healthy pace and is shorter than expected for a healthy child of the same age. Stunting develops over a long period because of long-term inadequate nutrition (including poor maternal nutrition and poor infant and young child feeding practices) and/or repeated illness or infection. Stunted children have a higher risk of death from diarrhoea, pneumonia, and measles. Stunting is associated with poor cognitive and motor development and lower school achievement. It is defined by a height-for-age of more than 2 standard deviations below the median WHO Growth Standards.
Target	Also called 'milestones', targets tell us what we plan to achieve at specific points during projects or programmes.
Undernutrition	Undernutrition is a consequence of a deficiency in nutrient intake and/or absorption in the body. The different forms of undernutrition, which can appear alone or in combination, are acute malnutrition (bilateral pitting oedema and/or wasting), chronic malnutrition (stunting), underweight (combined form of wasting and stunting), and micronutrient deficiencies.
Underweight	A composite form of undernutrition that includes elements of stunting and wasting and is defined by a weight-for-age of more than 2 standard deviations below the median WHO Growth Standards. This indicator is commonly used in growth monitoring and promotion (GMP) and child health and nutrition programmes aimed at prevention and treatment of undernutrition.

Vulnerable groups	Target resources and programmes to the most vulnerable populations including women of reproductive age, pregnant and lactating women and their children in the first 2 years of life (the 1,000-day window of opportunity), children under 5, children in adversity, adolescent girls, people with disabilities, people with infectious diseases, people with nutrition-related non-communicable diseases, people impacted by humanitarian crises, and people living in extreme poverty.
Wasting (or thinness)	This occurs when an individual is very thin for his or her height. It happens when a person loses weight rapidly or a growing child does not gain adequate weight relative to their growth in height. Wasting may be caused by inadequate food intake, such as a drop in food consumption or sub-optimal infant and young child feeding practices; by disease or infection, including HIV or tuberculosis; or a combination. It is defined as weight-for-height of more than 2 standard deviations below the median WHO Growth Standards or MUAC under 125 mm. Wasting is one form of acute malnutrition.

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