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Strengthening Partnerships, Results, and Innovations in Nutrition Globally

Piloting and Implementing the District Assessment Tool for Anemia in Uganda:

Experiences and Lessons Learned

February 2018

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ABOUT SPRING

The Strengthening Partnerships, Results, and Innovations in Nutrition Globally (SPRING) project is a seven-year USAID-funded cooperative agreement to strengthen global and country efforts to scale up high-impact nutrition practices and policies and improve maternal and child nutrition outcomes. The project is managed by JSI Research & Training Institute, Inc., with partners Helen Keller International, The Manoff Group, Save the Children, and the International Food Policy Research Institute.

RECOMMENDED CITATION

SPRING. 2018. *Piloting and Implementing the District Assessment Tool for Anemia (DATA) in Uganda—Experiences and Lessons Learned.* Kampala: Strengthening Partnerships, Results, and Innovations in Nutrition Globally (SPRING) project.

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Cover photo: Joshua Yospyn

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Acknowledgments

The USAID SPRING/Uganda project, Dr. Robert Mwadime (Chief of Party) and Nancy Adero (Technical Advisor), would like to thank all the stakeholders who participated in the pilot and implementation of the District Assessment Tool for Anemia (DATA) in Uganda, especially the National Anemia Working Group (NAWG) taskforce members and facilitators, without whom implementation would not have been possible: Sarah Ngalombi (NAWG Secretariat Ministry of Health [MOH]); Tim Mateeba (Reproductive Health-MOH); Dr. Jane Nabakooza (Malaria Control Programme-MOH); Martin Bulamu (Resource Center-MOH); Doreen Abwola (National Medical Stores-MOH); Dr. Peter Rukundo (Kyambogo University); Susan Oketcho (Ministry of Education and Sports); Geoffrey Wakwabubi (Ministry of Water and Environment), Okweda Benedict (Ministry of Gender, Labour and Social Development), Ameny Basil (NMS), Christine Nsungwa (Ministry of Water and Environment), Cherirey Lawrence (National Medical Stores) and Thomas Abeja (Ministry of Water and Environment).

Our gratitude goes to the administrative management, political leaders, department and sector officials in Namutumba, Arua, Amuria, Sheema, Kanungu, Mbarara districts for implementation and ownership of the tool. Appreciation also goes to the USAID/Regional Health Integration to Enhance Services (RHITES) team: Dr. Edward Bitarakwate, Dr. Moses Walakira, Esther Naluguza, Dr. Mary Namubira and technical officers; as well as the South Western districts who made it possible to rollout and follow up DATA in the four Phase I districts and plan to roll out in 11 more districts during Phases II and III.

Special thanks also goes to the SPRING Washington and Uganda staff Danya Sarkar, Denish Moorthy, Sorrel Namaste, Irene Nasasiira, Jennifer Akello, Francis Ssebiryo, and Adera Asasiira for their support throughout the process.

It is our hope that the use of DATA will strengthen district anemia prevention and control initiatives and reduce anemia among children and women in Uganda.

Acronyms

CAO	Chief Administrative Officer
DATA	District Assessment Tool for Anemia
DHMT	District Health Management Team
DHO	District Health Office
DNCC	District Nutrition Coordination Committee
HMIS	health management information system
IFA	iron and folic acid
IPTp	intermittent preventive treatment in pregnancy
IYCF	infant and young child feeding
JSI	JSI Research & Training Institute, Inc.
MOES	Ministry of Education and Sports
MOH	Ministry of Health
MWE	Ministry of Water and Environment
NAWG	National Anemia Working Group
NMS	National Medical Stores
SPRING	Strengthening Partnerships, Results, and Innovations in Nutrition Globally
RHITES	Regional Health Integration to Enhance Services
USAID	U.S. Agency for International Development
WASH	water, sanitation, and hygiene
WRA	women of reproductive age

Executive Summary

Uganda has experienced slight increases in the rates of anemia in the past decade, from 49 to 53 percent in children under five and 23 to 32 percent in women of reproductive age (WRA).[1] The most notable causes of anemia at the public health level are iron and other nutrient deficiencies, inflammation and infections (malaria and helminthes), and genetic blood disorders. Preventing and controlling anemia requires understanding the leading causes of anemia in a particular setting and implementing programs across various sectors to address those causes. SPRING developed a District Assessment Tool for Anemia (DATA) to help countries strengthen district-level anemia programming. The DATA is presented as part of a facilitated workshop to increase awareness about the multi-factorial nature of anemia, understand its causes in a given context, and help districts plan and prioritize anemia actions using local data in a multi-sectoral framework. The target audience for DATA is district-level technical officers, planners, data officers, and administrative and political leadership.

In Uganda, the Ministry of Health (MOH) and the multi-sectoral National Anemia Working Group (NAWG), represented by government ministries, civil society organizations (CSOs), development partners, academia and research institutions, and the private sector, are instrumental in creating an enabling environment to strengthen anemia reduction efforts. In 2015 and 2016, SPRING oriented the MOH and NAWG members to the concept of DATA and how it works, and demonstrated its usefulness for anemia programming in three pilot districts of Namutumba, Arua, and Amuria. In February 2017, SPRING, MOH, and NAWG collaborated with USAID/Regional Health Integration to Enhance Services (RHITES) in the rollout of DATA in four districts (Phase I). Scale-up in an additional 11 districts (phase II and III) will be facilitated by USAID/RHITES and the NAWG in the South Western region from October to December 2017.

The DATA was presented to the NAWG prior to its pilot and implementation. The NAWG reviewed the tool and provided inputs ranging from its length, global anemia indicators, applicability in the country context, and pilot plan for the three districts.

Overall the national and district stakeholders showed great interest in using the tool and prioritizing key actions. The district workshop findings revealed the status of anemia prevalence among children and women and the performance coverage of anemia interventions across the different sectors. All districts registered implementation of the national programs related to nutrition, disease control, WASH, reproductive health, agriculture, and education. Barriers that led to poor performance of anemia-reduction programs were lack and or inadequate supplies, equipment, and funding; understaffing; limited skills/capacity; poor data management and use; lack of prioritization of activities, inadequate materials, and guidelines; and limited supervision. Prioritized actions included mobilizing funds to strengthen anemia-reduction programs; timely and proper quantification of supplies and equipment; mentorship and supervision of health workers in data management; and promoting use of data results in decision making and planning.

[1] Uganda Bureau of Statistics (UBOS) and ICF. 2017. Uganda Demographic and Health Survey 2016: Key Indicators Report. Kampala, Uganda: UBOS, and Rockville, Maryland, USA: UBOS and ICF.

Tracking progress was key to ensure successful implementation of the prioritized actions in the districts. In the pilot districts, department heads followed up priority activities by providing supportive supervision to the focal persons at the various levels. In the roll out districts, USAID/RHITES tracked progress of activities integrated within their routine services through supportive supervision. RHITES also committed to use the district nutrition coordination committees (DNCC) and the district health management teams (DHMT), which meet monthly, as a platform for monitoring progress.

In conclusion, DATA has been regarded as a good entry point to bridge NAWG and district anemia-reduction efforts. Districts understand anemia and know how to use the tool to measure performance and strengthen anemia-reduction programs using a multi-sectoral approach. However, funding for the provision of adequate anemia reduction services, including increased human resources, and improved management and use of data in prioritizing, planning, budgeting, and implementation is needed.

1.0 Background

Anemia is a critical public health problem in Uganda. Between 2011 and 2016, prevalence in children under five years increased from 49 to 53 percent and 23 to 32 percent among women of reproductive age (15–49 years) respectively.[2] These prevalence rates are considered to be of severe and moderate public health significance, respectively.[3] Causes of anemia include deficient nutrient intake leading to iron and other micronutrient deficiencies; inflammation caused by chronic infections; helminth infections leading to internal bleeding; and malaria and genetic diseases that increase destruction and reduce production of red blood cells. The various causes of anemia require a multi-sectoral and context-specific approach to prevention and control.

The Ministry of Health (MOH) with support from SPRING/Uganda coordinates the multi-sectoral National Anemia Working Group (NAWG) to strengthen the policy environment, planning, implementation, coordination, and monitoring of anemia prevention and control initiatives. The NAWG has accelerated the response to anemia in Uganda through a number of activities, one of which was the adoption of the global DATA.

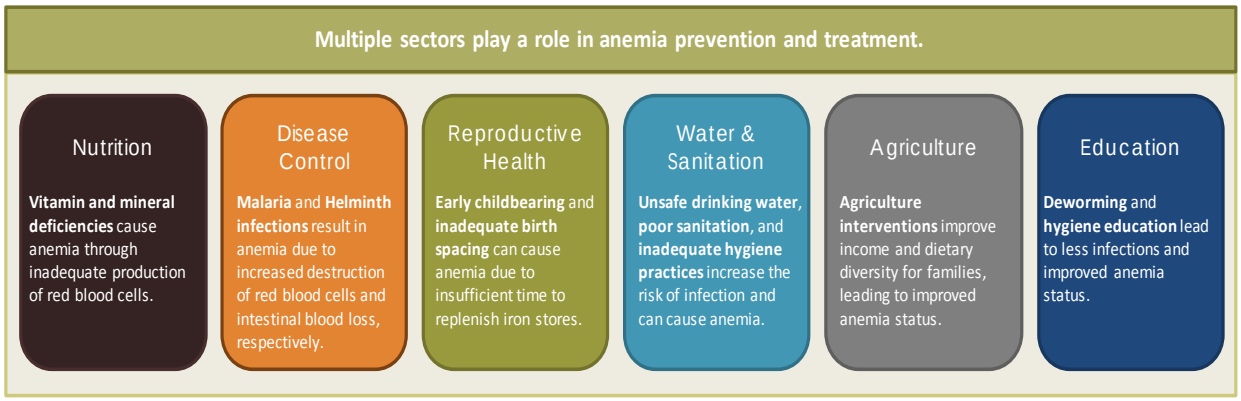
SPRING developed DATA to help countries strengthen district-level anemia programming. The objective of the tool is to increase awareness about the multi-factorial nature of anemia, understand of causes of anemia in a given context, and help districts plan and prioritize anemia interventions using local data. The target audience for DATA is district-level stakeholders in agriculture, water and sanitation, education, and health (which includes issues related to nutrition, reproductive health, malaria, and helminth infections), and cross-cutting areas like community development, statistics/health management information systems (HMIS), planning, and finance.

DATA's comprehensive nature allows users to discover facets of anemia prevention and control they might have not considered and recognize the importance of multi-sectoral efforts (as shown in Figure 1). The tool also leverages existing local data and knowledge to help inform stakeholders about programmatic entry points for addressing anemia.

[2] Uganda Bureau of Statistics (UBOS), and ICF International, Inc. 2012. Uganda Demographic and Health Survey 2011. Kampala, Uganda, and Calverton, Maryland: ICF International, Inc. and Uganda Bureau of Statistics (UBOS), and ICF International, Inc. 2017. Uganda Demographic and Health Survey 2016. Kampala, Uganda, and Calverton, Maryland: ICF International, Inc.

[3] World Health Organization (WHO). 2011c. Haemoglobin concentrations for the diagnosis of anaemia and assessment of severity. Vitamin and Mineral Nutrition Information System. Geneva: WHO. (WHO/NMH/NHD/MNM/11.1).

Figure 1. Programmatic Areas Showing the Multi-Disciplinary Nature of Anemia



DATA is implemented through a facilitated workshop to guide program managers and planners to improve anemia programs in their district. Users enter information into questionnaires in the tool's Microsoft Excel interface drawing on their local data and knowledge of factors that contribute to anemia. After the information is gathered using the DATA, outputs are presented in two dashboard tabs. The dashboards help district managers determine the local contextual factors that contribute to anemia; identify the gaps, enablers, and barriers to mitigating the risk factors that lead to anemia; and identify and prioritize actions to improve anemia-related programming. In advance of the workshop, the implementing team collects national-level data to inform district personnel about the broader anemia situation in-country and existing priorities and policies.

This report details SPRING/Uganda's experience, in partnership with the NAWG in piloting DATA in three districts and implementing DATA with USAID/RHITES project in four districts (Phase I).

2.0 Pilot and Implementation of DATA in Uganda

2.1 Orientation of the NAWG and Consultative Meetings to Review the Tool

With the assistance of SPRING/Uganda, the NAWG identified DATA as a means to increase awareness of anemia and strengthen anemia reduction efforts at the district level. Upon request from the NAWG, SPRING/Uganda conducted three orientation and consultative meetings between 2015 and 2016 to understand and review the draft global DATA for inputs. SPRING/Uganda demonstrated the use of the tool and facilitated discussions to review the tool, which contributed to the final global tool. The NAWG considered the tool timely and appropriate because it supports scaling down/decentralizing anemia reduction efforts to the district level. Discussions points included:

1. DATA is an entry point to raise awareness and a practical way to help districts prioritize and implement anemia reduction efforts.
2. Depending on need and availability of the data/information, the tool can be used quarterly, semi-annually, or annually.
3. DATA can be aligned with the district-level annual planning cycle, so that prioritized actions can be included in the plans and budgets.
4. DATA needs to be customized to each country.
5. DATA links national and district-level efforts in the reduction of anemia.

The discussions also recommended changes, which were included in the subsequent revision of the tool: removal of most of the biomarker indicators (with the exception of the iron deficiency and vitamin A deficiency) within the district tool, since most countries do not have micronutrient survey data; reduction in the number of indicators across the different sections of the tool to improve its usability; and alignment of definitions to WHO standard indicators and demographic health survey indicators. The NAWG then approved the pilot of the global tool at district level in Uganda.

2.2 Piloting DATA in Namutumba, Arua, and Amuria Districts

The NAWG selected Namutumba, Arua, and Amuria Districts for the piloting phase.

The selection criteria used by NAWG reflected the diversity of contextual factors related to anemia in the country:

- Namutumba in East Central Region has high levels of anemia and is a SPRING pilot district for micronutrient powders (MNP).
- Arua in West Nile Region has high levels of anemia and is a border district with refugee communities from Democratic Republic of Congo.
- Amuria district in Eastern Region has collected biomarker data on anemia and vitamin A deficiency, is a World Food Programme pilot district for MNP, and has moderate levels of anemia.

Pre-workshop visits to the districts on DATA

SPRING/Uganda and the NAWG secretariat visited the district offices in Namutumba, Arua, and Amuria in May, August, and November 2016, respectively, to explain the tool and gain approval for the pilot. They shared the DATA Overview and a one pager of Expectations of Participants for the DATA Workshop, two key pre-workshop materials. Discussions were held with the CAO, sector department heads, and biostatisticians and/or HMIS officer in the three districts on piloting the tool in their respective districts.

In the one-hour meetings, the DATA facilitators emphasized that each sector should come to the workshop with key data/information for indicators on production/agriculture, nutrition, health (disease control including malaria and helminth infections and reproductive health), education, and water, sanitation, and hygiene (WASH) (as highlighted in the Expectations of Participants one-pager). The biostatistician, HMIS officers, and data managers from key departments/sectors then met independently to discuss sources and availability of data and information that could be used to complete the tool during the pilot workshops.

Planning meetings by the NAWG and SPRING/Uganda facilitators

The NAWG, SPRING/Uganda and SPRING/Washington conducted additional national-level planning meetings in August and November 2016 to review the completed national questionnaire and agree on responses for prevalence rates and policy status, and review the facilitation process for the workshops. The NAWG as a multi-sectoral collaborative platform is familiar with each district in their respective regions, and could thus assess the usability and relevance across those districts/regions.

In addition, the planning meetings involved adapting the global presentations to suit the Ugandan context and a dry run of the presentations by the all the facilitator: Objectives and expected outputs of the workshop, which would be presented by a district official (coordinating office, usually DHO or district nutrition focal person); Overview of anemia and progress of anemia reduction efforts in Uganda; Overview of DATA; and Prioritization framework for anemia reduction actions to address barriers.

DATA pilot workshops

Following the national-level planning meetings, two-day district-level pilot workshops were conducted in Namutumba on August 17–18, 2016; Arua on August 22–23, 2016; and Amuria on November 31–December 1, 2016. The workshops were facilitated by SPRING/Washington and SPRING/Uganda, with the exception of Amuria where SPRING/Washington was not present, and all were co-facilitated by key members of NAWG.

Workshop participants included district administrative management, political leaders, department heads and technical officials from the different sectors: health (reproductive health, nutrition, and disease control), production (agriculture), education, WASH, community services, planning, and data managers (statisticians and HMIS focal persons). Since nutrition is a cross-cutting area, the nutritionist or appointed nutrition focal person was from the health department, although in other districts the nutrition focal person could come from any department. Participants also included staff from the district sub-county level, including health facility in-charges and antenatal care (ANC) focal persons/midwives, health assistants, head teachers, agriculture extension workers, and community development officers. In

Namutumba, there were 36 district-level participants, five NAWG members, and four SPRING staff, while in Arua there were 44 district-level participants, four NAWG members, and three SPRING staff. Amuria had 37 district-level participants, two district representatives from Namutumba and Arua, six NAWG members, and three SPRING staff (see list of participants in Annex 1).

The district workshops comprised a mix of didactic lectures, facilitated use of the tool by participants, group work, group presentations, and plenary group discussions. The lectures comprised: 1) an overview on anemia (causes, consequences, and evidence-based interventions to mitigate it); 2) and overview and global approach to DATA; and 3) a prioritization framework. See Annex 2 for the workshop agenda.

During the workshop, participants provided information to populate the district questionnaire tab of DATA then used the output from the tool (Dashboards, Annex 3) to identify a list of prioritized anemia interventions by sector. They completed this activity in sectoral groups, focusing on relevant interventions within the tool (nutrition, disease control, WASH, reproductive health, education, and agriculture).

Each group used a prioritization template during the prioritization process, for their respective anemia-related interventions. The prioritization template is a guided approach to assessing the anemia program situation according to given implementation categories, which include commodities, funding, provider training, client demand, and other factors. For each implementation category, spaces are provided to list enablers, barriers, degree of barriers, priority actions, lead and collaborating sectors, and timeline. Through group discussions and feedback, each sector group completed the prioritization template, identifying key activities under each intervention, according to where priorities were established. A representative of each sector group then presented the outputs of the prioritization template to the plenary. See Annex 5 for the prioritization template, with the prioritization lists from all the districts where DATA was piloted and implemented.

During the DATA pilot workshop in Amuria, SPRING conducted interviews with sector department heads and political and administrative management to ask about their experience with the workshop, how prioritized actions will be implemented, and how they intend to use DATA to improve anemia situation. The information was used to develop a video on DATA in Uganda.

2.3 After the Pilot: DATA Implementation in the South Western Districts

Piloting DATA in three districts was critical to evaluate the suitability of the tool to the local context and provide feedback on its usability and relevance in the reduction of anemia. Results from the pilot demonstrated that DATA increased awareness about the multi-factorial causes of anemia, assessed the anemia situation in the district, and prioritized actions for a multi-sectoral effort to reduce anemia.

The success from the pilot led to interest by the NAWG and partners to scale up DATA in additional districts. As a result, SPRING/Uganda, the USAID-funded Regional Health Integration to Enhance Services (RHITES) project and the NAWG collaborated to implement DATA in 15 districts in the South West region where RHITES operates. RHITES is a comprehensive integrated package in quality health, HIV/AIDS, VMMC, TB/HIV, nutrition, ECD, WASH, MNCH, and malaria. The partnership between SPRING and RHITES is well aligned with USAID/Uganda's 2017–2021 Country Development Cooperation Strategy (CDCS 2.0).

The approach that RHITES and SPRING/Uganda used in the scale-up districts was similar to that used in pilot districts, with exception of a few processes:

- SPRING/Uganda oriented and provided a training-of-trainers to more than 30 RHITES staff on DATA in Mbarara district. The two-day training helped the RHITES team support facilitation and implementation of DATA in 15 districts.
- Two existing entities, the district health management team (DHMT)[4] and the district nutrition coordination committee (DNCC),[5] helped coordinate the process, with facilitation by NAWG, RHITES, and SPRING. The aim was to ensure that existing systems and platforms are sustainable. The RHITES committed to facilitate the quarterly DNCCs meetings to track and discuss implementation of prioritized actions in the districts. RHITES committed to support health activities that were prioritized and are reflected in their work plan.
- The workshop included presentations from RHITES and the DNCCs on their responsibilities and key areas of focus. The presentations emphasized the need to use existing systems and resources to strengthen anemia reduction efforts.
- These Phase 1 workshops were funded by RHITES, which committed to fund the additional two phases of 11 districts, and to follow up with districts on progress of implementing prioritized actions.

[4]The DHMT meets monthly to coordinate health-related programs. Members include district health officer, assistant district health officer, district health inspector, district health educator, biostatistician, district cold chain technician, district medical management officer, CAO, secretary for health and education, in-charges of health sub-districts, district education officer, community development officer, HMIS focal person, reproductive health focal person, malaria focal person, Expanded Programme for Immunization and Child Health Days focal person, TB focal person, HIV focal person, laboratory focal person, district nutrition focal person, and district water officer.

[5] DNCCs ensure that nutrition activities take place within the districts. Members include representatives from health, planning, education, agriculture, gender, and social development; water and environment; and trade and industry. Administrative sectors/departments are responsible for planning, implementing, and monitoring district multi-sectoral nutrition activities.

3.0 Key Findings from Pilot and Implementation of DATA

The main findings from the DATA pilot in 3 districts and implementation in four districts in Uganda are detailed below.

3.1 Logistics and facilitation

- Overall, participants expressed satisfaction with the workshop format. There were positive reactions to the presentations and the group work session format, which promoted active participation. The educational and participatory nature of the workshop was also noted as positive.
- The two-day agenda was appropriate, but timetables need to be adhered to so that participants do not run out of time for group work and discussion.
- Joint facilitation between a national-level facilitator (e.g., SPRING/Uganda, NAWG) and a district-level facilitator led to strong collaboration on multi-sectoral issues.
- NAWG's contributions linked national anemia efforts to district efforts, and advanced support for the tool.
- In addition to the NAWG facilitators, buy-in from all members of the NAWG is essential prior to piloting to ensure uptake at the district level. A few NAWG participants had not attended the prior national meeting, and thus were not as familiar with the tool as the facilitators but their technical contributions were essential during the sector group discussions.
- Prioritized action plans should be integrated in the district annual work plans and budgets to allocate resources for implementation.

3.2 Content and usability

- DATA outputs, including the assessment of barriers, are essential to prioritize anemia actions; and the prioritization template utilized in Uganda aided in the process. The global tool relies on prioritized actions to be listed by a designated note-taker and shared with district participants, along with the completed tool. In Uganda, the NAWG wanted a more structured process for prioritization so developed a template to be completed during the group work sessions. The template guided and structured the discussions of the sectoral groups during prioritization.
- Overall, participants were satisfied with the tool's content, the sectors involved, and the indicators used for each sector.
- Inclusion of gender and community development sectors in the tool was mentioned. The Ministry of Gender, Labor, and Social Development, a key sector in the NAWG, was concerned that issues of gender and community development would not be addressed if not explicitly included in the tool. It was explained to participants that gender and community are cross-cutting and related issues would be brought up during the sector group discussions and prioritization process.

District-level community development officers in the workshop were able to participate across the different sectoral group work sessions, and bring in issues related to gender and community development.

- The national and district questions are broad and do not necessarily reflect each district's situation, but similar or proxy indicators can be used to answer these questions. There was a lot of discussion on which indicators could be used as a proxy for the global indicator. If there was confusion about which indicator to use or how to define the indictor (such as iron and folic acid [IFA] coverage definition, at first antennal care visit or fourth visit), then group consensus was sought. Participants used the indicators table, which noted the differences between the indicator questions asked in the tool and indicators collected at the local level.
- Along with customizing the indicators, there were questions about global definitions, for example: 1) The age range for adolescents, which the tool defined as 15–19 years. Uganda uses the WHO definition, which is 10–19 years), and; 2) exclusive breastfeeding was 0–5 months in the tool, but Uganda's is 0–6 months, per the country's infant and young child feeding (IYCF) guidelines.
- At first there was skepticism about the use of qualitative assessments for risk factor prevalence and program coverage. There was also a request for standard guidance for the assessments, particularly if the tool is to be used regularly (and potentially by different groups of people). It was noted that the qualitative assessments should be based on district staff's expertise and knowledge about programs, and that reason or justification for the qualitative assessments will be recorded. After these discussions, groups were able to discuss and reach consensus on qualitative assessments.
- In areas where data did not exist, or did exist but had not been analyzed, participants expressed that these issues were useful in showing gaps and would encourage advocacy for data collection and use at the district level.
- The prioritization template outlines all interventions and all associated categories. In Namutumba, participants were inclined to come up with priority activities under each implementation category. Prioritized activities must be feasible within the given timeframe.
- In a few instances, there seemed to be discrepancy between the qualitative assessments of program coverage versus degree of barriers. A few programs were rated qualitatively as "good" but then identified as having barriers in two or more implementation categories. These discrepancies should be discussed and resolved during the workshop.
- Funding, which controls the feasibility of implementation, was the main barrier. Participants said that part of prioritizing certain activities would involve advocating for more funding and possibly being more creative about funding sources.
- The majority of the district health service providers had outdated guidelines and strategies for anemia-related interventions. Districts were unaware of up-to-date guidelines.

3.3 Program findings

- The district workshop findings revealed the status of anemia prevalence among children and women and the performance coverage of anemia interventions across the different sectors.
- All districts registered implementation of all the national programs related to nutrition, disease control, WASH, reproductive health, agriculture, and education, as follows.

  Nutrition- IFA for pregnant women, vitamin A supplementation to children, exclusive and continued breast feeding [with the exception of IFA for women of reproductive age-non-pregnant and provision of micronutrient powders for most districts because it is a partner-driven intervention]

  Disease control- intermittent preventive treatment in pregnancy (IPTp) of malaria for pregnant women, distribution of insecticide-treated nets, active case management in all age groups, deworming in children and pregnant women.

  WASH- use of improved water source, household treatment of water for consumption, handwashing facility with soap and water, and access to improved sanitation.

  Reproductive health- use of modern family planning and delayed cord clamping.

  Agriculture-promotion of iron-rich beans and home food production.

  Education- deworm children and hygiene education in schools.
- The most notable barriers across all the programs were lack or inadequate supplies including IFA, IPTp, deworming drugs, vitamin A supplements, anti-malarials, water treatment supplies, blood for transfusion, agricultural seedlings, WASH equipment, agricultural technologies and inputs, malaria diagnostic and treatment testing kits, cord clamps, Hemocues, medical and diagnostic technologies for anemia-related issues like helminth infections, and tools for measuring biomarkers.
- Limited funding, under-staffing, limited skills/capacity, poor data management and use, low priority given to the programs, lack of materials and guidelines, and limited supervision were emphasized as the major contributing issues to poor performance of district anemia-reduction programs.
- Key actions included prioritizing and mobilizing funds to strengthen anemia-reduction programs; timely and proper quantification of supplies and equipment; mentorship and supervision of health workers in data management; and use of data results in decision making and planning.

3.4 Commitment from districts and NAWG

- The DATA workshops concluded by solidifying ownership to implement key prioritized actions across the different sector by sector department heads and technical officials, administrative management, and political leaders. The CAO, political leaders (e.g., local chairperson), and secretaries responsible for key sectors committed to follow up with each department to ensure implementation of prioritized actions.

- The NAWG facilitators from the ministries—education and sports; health (National Medical Stores [NMS], Malaria Control Programme, and reproductive health); agriculture; and WASH—pledged to provide continued technical assistance and supportive supervision to the respective sectors to improve the anemia situation in the districts.
- USAID/RHITES will facilitate the DNCC quarterly meetings to track progress on nutrition-related activities. RHITES also committed to harmonizing health prioritized actions with its work plan.
- Unlike the rollout districts that plan to track progress of the prioritized actions through the DNCC with overall leadership from the district nutrition focal person and USAID/RHITES, the pilot districts preferred to use existing platforms like DHMT and DNCCs to track progress across sectors.

4.0 After the Workshops: Follow-up with Pilot Districts on DATA Action Plans

Following the DATA pilots in Namutumba and Arua in August 2016 and in Amuria in December in 2016, SPRING/Uganda followed up on the progress in the implementation of the prioritized actions in April and May 2017. In the pilot districts, SPRING/Uganda worked with district heads of departments to follow progress with the multi-sectoral action plans to reduce anemia. The NAWG and SPRING/Uganda then facilitated a meeting and conducted interviews to provide further technical assistance to districts as they implement action plans. Interview questions focused on how the districts are operationalizing DATA; how the tool has been helpful in addressing anemia challenges; lessons; and use of DATA in the future.

Changes since the workshop

Agriculture

- Integration of key actions into existing projects.

Health

- Community sensitization by village health teams (VHTs) on the need for IFA supplementation and good IYCF practices
- Education on the need for IFA supplementation and good IYCF practices
- Quantification of adequate IFA, IPTp, and deworming drugs for pregnant women
- Deworming children during immunization

Water Department

- Community sensitization
- Construction of new bore holes
- Rehabilitation of non-functional boreholes
- Establishment of water user committees

Progress in the pilot districts

Namutumba

Operationalization of DATA

The district routinely conducts prioritization and implementation of activities. The tool enabled ownership and commitment by different departments to strengthen anemia-reduction efforts. It has also brought different departments and communities to work together. Current efforts include:

Agriculture: The multi-sectoral food security and nutrition project supported by the World Bank was used to integrate and emphasize increased food production and consumption of iron and other micronutrient-rich foods.

The **water department** held a follow-up meeting with department officials and community department and health assistants to plan implementation of prioritized actions. Community sensitization was conducted during football matches in the sub-counties of Kagalama, Ivukula, and Mazuba. Progress includes three new boreholes constructed by the Kibo Group; 20 new boreholes being constructed by Field of Life; Kibo and Busoga Trust has started the rehabilitation of non-functional boreholes in the district. The District Water Grant prioritized construction of 30 new boreholes, establishment of 30 water user committees, and community sensitization visits before rehabilitation of 60 non-functional boreholes.

The health department used the prioritized actions to quantify adequate IFA supplements during a standardization meeting. Mentorship of health workers was included in the quarterly plans, which has led

to improved health education for mothers on IYCF practices. Village health teams have been sensitizing communities on the need for IFA supplementation and IYCF practices. Though IFA supplementation for WRA (non-pregnant) was prioritized, due to limited resources the district has only been able to sensitize WRA on the importance of taking IFA supplementation.

Lessons

- DATA has raised awareness of the importance of multi-sectoral implementation in Namutumba. The district has moved to a holistic approach to anemia without duplication of efforts.
- The tool has enabled the district to focus on activities that contribute to the prevention of anemia.
- DATA was an opportunity for departments to appreciate their roles and how multi-sectoral engagement will be done through existing platforms like the DNCC.
- Strengthening coordination, ownership, and commitment among implementers is key to reducing anemia.
- DATA is a guiding tool and is being used to lobby for implementing partners to bridge the gap of funds for implementation.
- The tool is easy to use and has helped identify and track progress of appropriate interventions.

DATA use in the future

- Routine updates of the tool with new data/information on the performance of interventions.
- The district will conduct a comprehensive assessment to update DATA statistics.
- The tool has shown gaps that can only be filled if all stakeholders take action to realize the intended outputs.
- With supportive supervision from the national level (NAWG), the tool will be useful in providing technical assistance to strengthen key interventions.

Arua District

Operationalization of DATA

Prioritized actions listed during the DATA workshop were implemented to improve interventions in health, nutrition, education, and agriculture. The district integrated prioritized actions in the annual plans and budgets across the departments. In addition, the priority actions in nutrition have been used as a planning tool and integrated in the District Nutrition Action Plan (DNAP) to harness implementation of nutrition interventions.

Departments of health, education, and agriculture have mapped schools to ensure that adequate services are provided to prevent anemia.

Service delivery especially in maternity and outpatient departments, improved. The NMS delivered a supply of IFA for pregnant mothers and vitamin A supplements for children under five years as requested.

The district biostatistician has taken interest in monitoring anemia indicators, but frontline health workers need to be mentored to capture correct data.

Integration of the prioritized actions into ongoing projects like the multi-sectoral food and nutrition project by the World Bank synchronizes resources for implementation.

Changes since the workshop

- Integration of the prioritized actions into district annual plans and budgets.
- Integration of nutrition actions into the DNAP.

Health, education, & agriculture

- Mapped schools to reduce anemia.

Health

- Sufficient quantification and supply of IFA and vitamin A supplements.
- Increased the supply of IFA to pregnant women from 14 to 30 per month.
- Tracking of anemia indicators in the HMIS.
- Community sensitization of mothers to good IYCF practices and the need for IFA supplementation.
- Political leaders are aware of the multi-sectoral need in addressing anemia
- Collaboration by key departments has been registered.

Lessons

- DATA is simple to use and helps identify gaps in performance of key interventions and implementation. Acknowledging gaps in data management caused data managers to take interest in anemia-related indicators.
- The tool has led district officials from health, production, community services, and education to work collaboratively to achieve a common goal. Political leaders are aware of the multiple causes of anemia, which has influenced planning and budgeting.

DATA use in the future

- NAWG should provide technical support to districts especially for tasks that can only be handled at the national level.
- The district plans to update the tool and track progress in anemia prevalence quarterly. To aid this process, the district is engaging development partners to support a comprehensive assessment to document the prevalence of anemia in the district, because health facility data is not representative of the district situation.
- DATA indicators need to be incorporated in the District Health Information System 2 for comprehensive data collection and reporting at the district and national level.

Amuria District

Operationalization of DATA

The prioritized actions were incorporated into district annual plans and budgets for 2017/18.

Nutritionists are strengthening practices, especially targeting community-level feeding practices. Sub-counties such as Asamuk have been able to prevent emerging cases of severe acute malnutrition through improved sensitization and education.

The water department is in the process of constructing sanitation facilities in schools.

Changes since the DATA workshop

- Integration of prioritized actions in district plans and budgets.
- Construction of latrines in schools.

Lessons

- DATA is simple to use but requires collaborative efforts to achieve the intended goal.
- The tool was an opportunity for all departments to appreciate anemia, its multifaceted causes, gaps and role of each department in filling them.

DATA use in the future

- Responsible sectors must coordination to track implementation of actions that have been integrated into the annual district plans and budgets.

5.0. Lessons and Recommendations

5.1 Lessons

- DATA is a way to evaluate the performance of programs/interventions in the prevention and control of anemia. DATA helps districts understand the multi-disciplinary nature of anemia and each sector's role in the reduction of anemia.
- Commitment and ownership of the DATA process by administrative management, political leaders, district heads of key departments/sectors and technical officials, community and health service providers is key in moving the agenda forward.
- Since barriers to implementation stem from all levels, it is critical to have sector representation from NAWG to harmonize policy and programming for anemia reduction efforts. NAWG has a comprehensive understanding of DATA and the process of facilitation, which makes its participation essential, especially to link national level policy to district efforts.
- Partners are crucial to support gaps that districts cannot address because there is no funding. This must be in addition to district official's ownership and commitment to implement prioritized actions.
- In the absence of quantitative data/information, expert opinions based on factors and indicators are essential for a valid rationale and justification of qualitative consensus responses.
- Prioritized actions are not parallel or additional tasks for the district; they are embedded in the routine services provided across sectors. DATA enables the district to recognize the importance of prioritizing such activities, most of which require limited resources.
- The global tool uses standard indicators—mostly WHO's— that could be customized, and countries and districts are encouraged to change the indicators based on their context. Districts could also customize DATA facilitation to their own context, using the global tool and the global facilitation guide if resources permit. Due to absence of data/statistics for most of the standard indicators in the tool, districts could use proxy indicators as long as they are well-defined and justifiable.
- Pre-workshop visits are important to plan for the workshop and understand the information required for the workshops.
- Follow-up with the districts showed that DATA is a guiding tool and is being used to lobby implementing partners to bridge the gap of limited funds for implementation.

5.2. Recommendations for integration and scale up

If NAWG wants to integrate DATA into district level monitoring and planning cycles, the following critical issues must be considered.

- **Ownership of DATA by NAWG.** Develop a transition plan for regular use of the tool facilitated by NAWG and districts. SPRING/Uganda developed a training of trainer's manual that will be shared with the NAWG for scale up.
- **Scale up of DATA.** The NAWG should seek support from other implementing partners when SPRING/Uganda ends.
- **Implement prioritized actions.** Districts should review and integrate the prioritization actions during annual planning and budgeting to tap adequate resources for implementation.
- **Timelines for DATA workshops.** The DATA workshops are planned for two full days. Timetables must be strictly adhered to ensure sufficient time for group discussions and the prioritization session.
- **Routine use of DATA.** Districts should routinely update the tool (quarterly/semi-annually/annually) follow up meetings.
- The prioritization session is most critical and facilitator should use the performance coverage rates for the interventions and degree of barriers to guide prioritization by sectors.
- **Participant involvement.** Engagement of key stakeholders within the district, community, and health facility aids commitment and ownership. Key stakeholder groups include administrative management; political leaders; district heads of departments and technical officials, community members, and health facility workers.
- **Coordination.** The NAWG has representation from all stakeholder groups including sectors/ministries, academia and research institutions, civil society organizations, development partners, and the private sector. NAWG involvement will ensure accountability and effective tracking and reporting of prioritized actions at the district and community levels.
  - The NAWG will follow up with issues that need to be addressed at the national level, like supplies and equipment for anemia related interventions and funding.
  - Coordination between the NAWG, the district, and partners is critical to track progress in implementation of prioritized actions.
  - Commitment from the department responsible for coordination of sectors is critical to track progress in implementation of prioritized actions.
- **Use of existing platforms** to coordinate and track progress will support sustainable anemia reduction programs. Existing platforms like the DNCCs and DHMT or relevant platforms that foster multi-sectoral engagement.
- **Data or information is fundamental to guide the workshops.** To foster ownership, districts and partners should be supported to integrate anemia indicators in ongoing studies. The existing government data collection and analysis information systems should be strengthened to ensure reliable anemia data.
- **Disseminate updated guidelines, strategies, and policies** to service providers to improve efficiency and effectiveness of programs.
- Districts should identify and collaborate with partners supporting anemia reduction efforts to synchronize resources and improve anemia indicators.

6.0 Conclusion

The DATA pilot in three districts and implementation in the four districts increased understanding of anemia, its multiple causes, and the need for a multi-sectoral approach to reduce it. The tool was rated useful for linking national and district efforts. Data management was the main challenge to the use of DATA. The districts pledge to mobilize resources to strengthen data collection and use, and routinely update the tool to measure performance. The districts committed to implementing the prioritized actions in collaboration with key departments using existing platforms.

The follow-up activity by NAWG and SPRING showed that districts are committed to implementing the prioritized actions. It also indicated that challenges like stockouts and coordination during implementation had improved, though limited funding kept all the prioritized actions by the sectors from being implemented as planned. The districts also used the prioritized actions to solicit support from existing partners to bridge funding gaps in the future. If funding in annual plans and budget increases, existing district structures will be sustainable platforms for implementing anemia reduction efforts.

Annex 1: Lists of Participants for the Pilot and Rollout of DATA

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10.	Ainomugisha Primah	Secretary for education and social services	Isingiro District	785752722
11.	Ninsima Janepher	District vice chairperson	Isingiro District	777005545
12.	Nimusima Willis	ACAO	Isingiro District	782410316
13.	Tibahwa Bonny	Head teacher Kyabirukwa PS	Kyabirukwa	782292217
14.	Mukasa Siraji	Nutrition focal person	Rugaaga HCIV	778991299
15.	Niyibizi Deo	Health assistant	Nyakitunda HC III	704147384
16.	Kwesiga Sam	Logistics focal person	DHO	782898465
17.	Mugizi Godfrey	Community development officer	Kashumba Sub-county	702577048
18.	Rubaganzya Aron	DLFP	Mabona HCIII	787295718
19.	Twebaze Francis	Head teacher Kabuyanda Central	Kabuyanda	752690007
20.	Kajungu Clemmy	Nutrition focal person	DHO	757525992
21.	Kyarimpa Janet	EPI focal person	DHO	781638105
22.	Dr. Edson Tushemerure	DHO	Isingiro District	701391888
23.	Arinaitwe Emma Sam	Biostatician	Isingiro District	782521344
24.	Kiconco Judith	Registered midwife	Mabona HCIII	775662344
25.	Seth Ampurire	Clinical officer	Rushasha HCIII	782798813
26.	Namujulirwa Agnes	Secretary DHO/Rappoture	DHO	700237532
27.	Besigye Steven	District planner	Isingiro District	772652173
28.	Batyani James	DHE	DHO	701534365
29.	Muhwezi Stephen	Malaria focal person	Rugaaga HCIV	776198123
30.	Amanyire Deo	District inspector of schools	Isingiro District	772574941
31.	Namara Amos	HMIS FP	DHO	782052028
32.	Yahya Kiijana	HIV FP	DHO	782679978
33.	Muhimbura Nicholus	In charge	Kikagate HCIII	772849589
34.	Mulwani Francis	Clinical officer	Kabuyanda HCIV	752194204
35.	Tumwebaze Patrick	District agricultural officer	Isingiro District	776551008
36.	Kabirikye Nathan	District education officer	Isingiro District	772502059
37.	Komuhangi Sylivia	Enrolled midwife	Nyakitunda HCIII	702987486
38.	Kyohairwe Juliet	Registered midwife	Rwekubo HCIV	779546066

Mbarara

#	Name	Title	Organization	Contact
1	Dr. Owembabazi William	Ag. district production officer	MDLG	772493143
2	Dr. Ssebutinde Peter	Ag. DHO	DHO	782663159
3	Agaba Annet	Ag. district finance officer	MDLG	701020177
4	Ayebazibwe Kellen	DIS	MDLG	752622058
5	Musinguzi Jordan	Secretary for social services	MDLG	779419967
6	Atwebembeire Celestine	DLFP	Bwizibwera HC IV	772887770

#	Name	Title	Organization	Contact
7	Kansiime Jacinta	Head teacher	Rwampara	772396775
8	Masereka Umar	District health information/FP HIV and AIDS	MDLG	782326558
9	Connie Ainomugisha	District planner	MDLG	782512010
10	Ninsiima Collins	District supplies officer	MDLG	772488724
11	Kasande Peace	Data officer	DHO	703007256
12	Kyomugisha Justine	HMIS focal person	DHO	772685910
13	Musiime Remegio	Senior community development officer	DHO	782011844
14	Kiconco Hope	Community development officer	Bubare Sub-county	779798387
15	Tumushabe Evalist	Senior nursing officer	Bwizibwera HC IV	772890536
16	Kente Emmanueline	EPI focal person	DHO	772363545
17	Ahimbisibwe Gabriel	District education officer	MDLG	782560959
18	Cpt. Martha Asiimwe	Resident district commissioner	MDLG	772988888
19	Kansiime Annah	Secretary for community services	MDLG	779428887
20	Muganzi Prisca	Chair Social Services Committee	MDLG	774885085
21	Nshabohurira Agatha	Assistant DHO	DHO	782670101
22	Lubega .M. Kazooba	Malaria focal person	DHO	702305158
23	Mugabi Robinah	District nutrition focal person	DHO	772617187
24	Mbabazi Conny	Enrolled midwife	Mwizi HC III	783929319
25	Atukunda .R. Francis	District communications officer	MDLG	772558997
26	Basil .R. Bataringaya	Secretary finance (for LC V)	MDLG	772569324
27	Mugenyi Mudasiru	Driver for RDC	MDLG	702623556
28	Mwiine Aggrey	Driver for DHO	MDLG	783339884
29	Twinomujuni Deus	Escort for RDC	MDLG	773799159
30	Fred Mugarura	Driver for LC V	MDLG	772460112
31	Butungi Rodney Bruce	Driver for CAO	MDLG	759112892

Kanungu

#	Name	Title	Organization/ location	Contact
1	Atuhaire Innocent	D/planner	Kanungu	0772472568
2	Kansiime Benon	Ag. ADHO	DHO	0772550410
3	Nyirazirikana Charlotte	Education officer	Kanungu	0772878312
4	Shaban Adam	DIS	Kanungu	0774217535
5	Maari Karungi	DHE	Kanungu	0772670253
6	Katto M Besisira	HI	Kanungu	0777398922
7	Niwamanya Priscillah T	SNO for Ag.ADHO MNCH	DHO	0782304915
8	Mugyenda Ariyo	EPI F.P	DHO	0772577787
9	Byaruhanga Ambrose	DWO	Kanungu	0782292216
10	Mugarura Fred	SFO	Kanungu	0783913330
11	Kyokwijuka Desmond	DNCC media	Kanungu	0774613601
12	Turyahikayo Elias	H/A	Kambuga T/C	0783882823
13	Tibenda Ismail	Driver	DHO	0772335946

#	Name	Title	Organization/ location	Contact
14	Mubangizi Francis	Driver	District chairperson's office	0772451979
15	Bugumya Ntarwete Eliab	D/CAO	District HQ	0752308640
16	Dr. Sebudde Stephen	DHO	Kanungu	0772900138
17	Rwakoojo A Blair	DLFP	Kanungu	0774898086
18	Nzeirwenawe Emmanuel	HMIS focal person	Kanungu	0772892937
19	Komugisha Proscovia	CWO	Kanungu	0773084307
20	Asuman Kagwa	Imam	Kanungu	0782578472
21	Ahebwomugisha Michael	Nutritionist	Kanungu	0785472549
22	Orikushaba Alex	SVCO	Kanungu	0775044442
23	Musinguzi Philip	Asst. inventory officer	DHO	0779376492
24	Twinomuhangi Sylivia	E.M	Kambuga	0777880964
25	Twesigye Richard	DCO	Kanungu	0772557276
26	Namara Christopher	DCDO	Kanungu	0772514850
27	Kamara Christopher	District chair	Kanungu	0772658174
28	Nagaba Easton	Makiro Denary health coordinator	Makiro	0788563674
29	Ruhanga Hawkins	DISO	Kanungu	0774231705
30	Dr. Tumwesigye	DVO	Kanungu	0775550106
31	Habyarimaana Ezra	Head teacher	Kishenyi P/S	0774154689
32	Nduzeye Ezra	SPWO	Kanungu	0772856251
33	Mugisha Charles	Senior accountant	Kanungu	0772649751
34	Twebaze Kate	SCDO	Kanungu	0779220586
35	Rev. Caleb Bitindi	DOK	Kanungu	0782316222

Annex 2: Workshop Agendas

Pilot District Workshop

Day One		
Time	**Activity**	**Responsible person**
Moderators: DNFP & DHO		
8:30-9:00am	Arrival and registration	SPRING
9:00-9:05am	Prayer	
9:05-9:15am	Welcome remarks	CAO
9:15-9:30am	Self- introductions/icebreaker	Participants
9:30-9:35am	Presentation of workshop objectives	DHO
9:35-10:00am	Overview of anemia and progress of anemia reduction efforts in Uganda	Sarah Ngalombi/Tim Mateeba (NAWG secretariat)
10:00-10:15am	Discussions	Sarah Ngalombi/Tim Mateeba (NAWG secretariat)
10:15-10:30am	Tea break	Hotel
10:30-10:50am	Global approach to and general overview of DATA	Danya Sarkar (SPRING/DC)
10:50-11:10am	Discussions	All
11:10-11:30am	Presentation of the national questionnaire	Nancy Adero (SPRING/Uganda)
11:30-11:45pm	Discussions	All
11:45-12:30pm	Presentation of the district questionnaire and introduction to group work	Nancy Adero and Danya Sarkar (SPRING)
12:30-12:50pm	Discussions	
12:50-1:15pm	Remarks from national sector representatives	
1:15-2:00pm	Lunch	Hotel
2:00-3:30pm	Group work to fill out district questionnaire	All
3:30-5:00pm	Group work presentations and discussions	Group representative
5:00pm	Evening tea and departure	Hotel/all

Day Two		
Time	**Activity**	**Responsible person**
8:30- 9:00am	Arrival and registration	SPRING
9:00am-9:05am	Prayer	
9:05-9:10am	Recap of day one	Facilitator
9:10-10:00am	Presentation of findings/dashboards	Nancy Adero (SPRING/Uganda)
10:00-10:20am	Overview of the decision framework for prioritization of anemia activities-introduction to group work	Danya Sarkar and Nancy Adero (SPRING)
10:20- 10:35am	Tea break	Hotel
10:35-1:00pm	Group work-prioritization process	6 sector groups
1:00-2:00pm	Lunch break	Hotel
2:00-3:00pm	Continued group work-prioritization process	6 sector groups
3:00-4:30pm	Presentation of group work and discussions	6 sector groups
4:30-4:50pm	Workshop wrap up and evaluation	All
4:50-5:00pm	Closing remarks	CAO

Rollout District Workshop

Day One		
Time	**Activity**	**Responsible person**
Moderators: RHITES & district		
8:30-8:50am	Arrival and registration	NAWG
8:50-8:55am	Prayer	Volunteer
8:55-9:05am	Welcome remarks	CAO-Sheema District
9:05-9:30am	Self- introductions	Sheema district
9:30-9:35am	Presentation of agenda and workshop objectives	DHO Sheema District
9:35-10:00am	Overview of the DNCC	DNFP-Sheema District
10:00-10:30am	Overview of anemia-reduction efforts in Uganda	Sarah Ngalombi, MOH
10:30-10:45am:	Overview of the RHITES-SW nutrition program	RHITES-SW representative
10:45-11:00am	General overview of the DATA	Dr. Jane Nabakooza, MOH
11:00-11:10am	Reactions	Moderator (s)
11:10-11:20am	Remarks	NAWG members
11:20-11:30am	Official opening	RDC-Sheema District
11:30-11:45am	**Tea break**	**Hotel**
11:45-12:15pm	Presentation of the national questionnaire	Susan Oketcho, MOES
12:15-12:45pm	Presentation of the district questionnaire and introduction to group work	Tim Mateeba-MOH Nancy Adero-SPRING
12:45-1:00pm	Discussions	Moderator
1:00-2:00pm	**Lunch**	**Hotel**
2:00-4:00pm	Group work to fill out district questionnaire	Facilitators
4:00-5:00pm	Group work presentations discussions	Groups
5:00pm	Tea break and departure	All

Day Two		
Time	**Activity**	**Responsible person**
Moderators: Moderators: RHITES & Districts		
8:00-8:30am	Arrival and registration	NAWG
8:30-8:35am	Prayer	Volunteer
8:35-8:45am	Recap of day one	Esther Naluguza, RHITES
8:45-9:45am	Presentation of findings/dashboards	Irene Nasiisira-USAID/SPRING
9:45-10:15am	Overview of the prioritization framework & introduction to group work	Nancy Adero-USAID/SPRING
10:15-10:30am	**Tea break**	**Hotel**
10:30-1:00pm	Group work-prioritization	District Sector groups
1:00-2:00pm	Lunch break	Hotel
2:00-4:00pm	Presentation of group work and discussions	All sector groups
4:00-4:20pm	Adaptation of DATA into existing platforms and way forward	MOH, RHITES, SPRING & Sheema District
4:20-4:40pm	Remarks	Partners/CAO/sector secretaries, LCV
4:40-5:00pm	Closing remarks	RDC/LCV-Sheema District

Annex 3: Findings from the Pilot Districts (Dashboards)

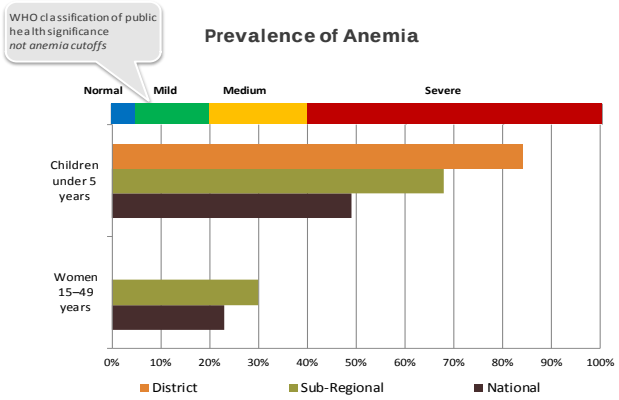
Namutumba

USAID FROM THE AMERICAN PEOPLE

District Assessment Tool for Anemia

SPRING Strengthening Partnerships, Results, and Innovations in Nutrition Globally

Prevalence of Anemia



Risk Factors for Anemia

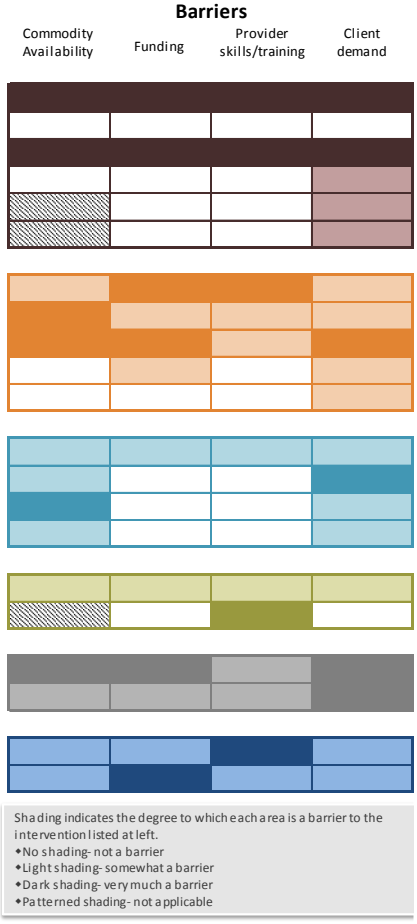
Risk Factor	Prevalence	Target Group
Malaria	47%	Children 6–59 months
	14%	Pregnant women
Helminth	Low	Children 6-59 months
	Medium	Pregnant women
Vitamin A deficiency	38%	Children 6–59 months
Iron deficiency	0%	Children 6–59 months
	0%	Women 15-49 years

Vitamin A and Iron represent national level indicators

Suggested Anemia Interventions

Strategy/ Policy	Program	Coverage
✓	IFA for pregnant women at ANC	Fair
✓	IFA for women of reproductive age	N/A
✗	Provision of micronutrient powders to children	55%
✓	Vitamin A supplementation to children	23%
✓	Exclusive breastfeeding in infants 0-5 months	56%
✓	Continued breastfeeding in children 6-23 months	45%
✓	IPTp of malaria for pregnant women	65%
✓	Distribution of insecticide treated nets	Fair
✓	Active case management in all age groups	Poor
✓	Deworming children	Fair
✓	Deworming pregnant women	Fair
✓	Usage of an improved water source	66%
✓	Household treatment of water used for consumption	Poor
✓	Handwashing facility with soap and water	42%
✓	Access to improved sanitation	Poor
✓	Usage of modern methods of family planning	63%
✓	Delayed cord clamping	N/A
✓	Promotion of iron-rich foods	Good
✓	Promotion of home food production	Good
✓	Deworming of children in schools	Good
✓	Hygiene education in schools	Good

Barriers



Shading indicates the degree to which each area is a barrier to the intervention listed at left.
- No shading- not a barrier
- Light shading- somewhat a barrier
- Dark shading- very much a barrier
- Patterned shading- not applicable

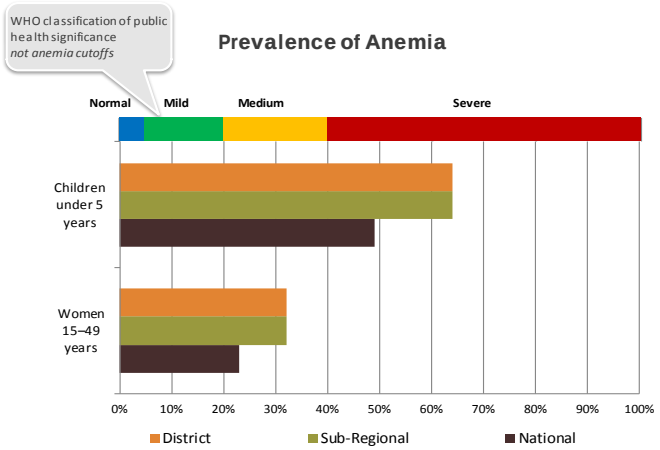
Arua

USAID FROM THE AMERICAN PEOPLE

District Assessment Tool for Anemia

SPRING Strengthening Partnerships, Results, and Innovations in Nutrition Globally

Prevalence of Anemia



Risk Factors for Anemia

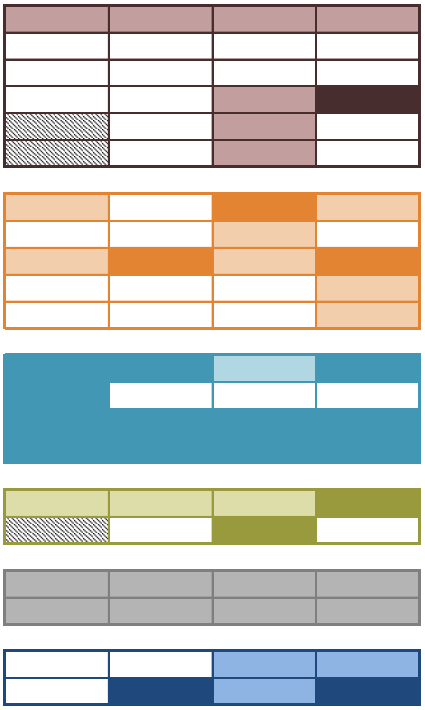
Risk Factor	Prevalence	Target Group
Malaria	High	Children 6–59 months
	26%	Pregnant women
Helminth	Medium	Children 6-59 months
	Medium	Pregnant women
Vitamin A deficiency	38%	Children 6–59 months
Iron deficiency	0%	Children 6–59 months
	0%	Women 15-49 years

Vitamin A and Iron represent national level indicators

Suggested Anemia Interventions

	Strategy/ Policy	Program	Coverage
Nutrition	✓	IFA for pregnant women at ANC	82%
	✓	IFA for women of reproductive age	N/A
	✗	Provision of micronutrient powders to children	N/A
	✓	Vitamin A supplementation to children	47%
	✓	Exclusive breastfeeding in infants 0-5 months	Fair
	✓	Continued breastfeeding in children 6-23 months	Good
Disease Control	✓	IPTp of malaria for pregnant women	52%
	✓	Distribution of insecticide treated nets	100%
	✓	Active case management in all age groups	Good
	✓	Deworming children	70%
	✓	Deworming pregnant women	Good
WASH	✓	Usage of an improved water source	76%
	✓	Household treatment of water used for consumption	Fair
	✓	Handwashing facility with soap and water	11%
	✓	Access to improved sanitation	73%
RH	✓	Usage of modern methods of family planning	32%
	✓	Delayed cord clamping	52%
Ag	✓	Promotion of iron-rich foods	Good
	✓	Promotion of home food production	Good
Ed	✓	Deworming of children in schools	Good
	✓	Hygiene education in schools	Fair

Barriers



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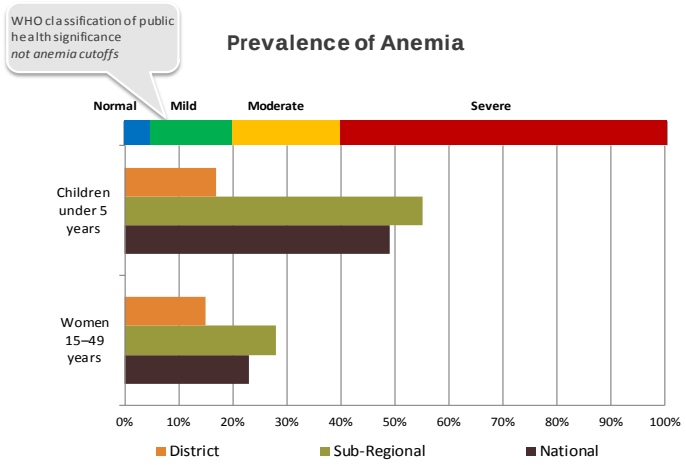
Amuria

District Assessment Tool for Anemia

Prevalence of Anemia



Risk Factors for Anemia

Risk Factor	Prevalence	Target Group
Malaria	64%	Children 6–59 months
	2%	Pregnant women
Helminth	5%	Children 6-59 months
	2%	Pregnant women
Vitamin A deficiency	38%	Children 6–59 months
Iron deficiency	0%	Children 6–59 months
	0%	Women 15-49 years

Vitamin A and Iron represent national level indicators

Suggested Anemia Interventions

Strategy/ Policy	Program	Coverage
✓	✓ IFA for pregnant women at ANC	90%
✓	✗ IFA for women of reproductive age	N/A
✗	✓ Provision of micronutrient powders to children	95%
✓	✓ Vitamin A supplementation to children	45%
✓	✓ Exclusive breastfeeding in infants 0-5 months	67%
	✓ Continued breastfeeding in children 6-23 months	55%
	✓ IPTp of malaria for pregnant women	75%
✓	✓ Distribution of insecticide treated nets	Good
	✓ Active case management in all age groups	Good
✓	✓ Deworming children	44%
✓	✓ Deworming pregnant women	100%
	✓ Usage of an improved water source	88%
	✓ Household treatment of water used for consumption	Fair
✓	✓ Handwashing facility with soap and water	47%
	✓ Access to improved sanitation	87%
✓	✓ Usage of modern methods of family planning	42%
✓	✓ Delayed cord clamping	100%
	✓ Promotion of iron-rich foods	20%
✓	✓ Promotion of home food production	60%
✓	✓ Deworming of children in schools	25%
✓	✓ Hygiene education in schools	14%

Barriers

Commodity Availability	Funding	Provider skills/training	Client demand

Shading indicates the degree to which each area is a barrier to the intervention listed at left.
- No shading- not a barrier
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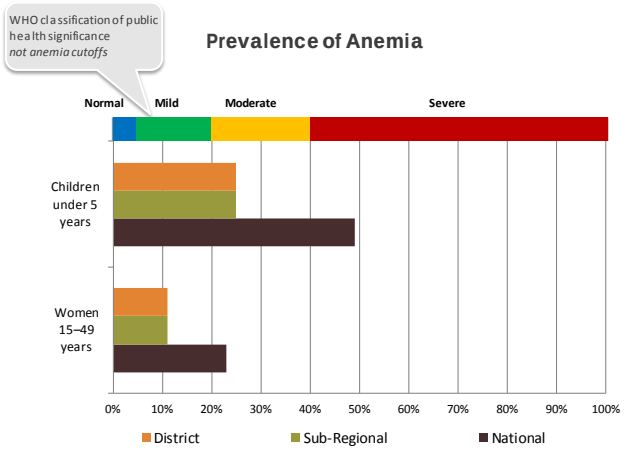
Sheema

USAID FROM THE AMERICAN PEOPLE

District Assessment Tool for Anemia

SPRING Strengthening Partnerships, Results, and Innovations in Nutrition Globally

Prevalence of Anemia



Risk Factors for Anemia

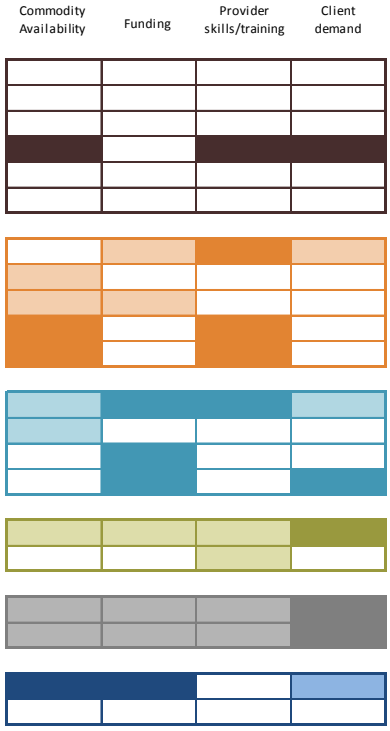
Risk Factor	Prevalence	Target Group
Malaria	20%	Children 6–59 months
	2%	Pregnant women
Helminth	Medium	Children 6-59 months
	Medium	Pregnant women
Vitamin A deficiency	38%	Children 6–59 months
Iron deficiency	0%	Children 6–59 months
	0%	Women 15-49 years

Vitamin A and Iron represent national level indicators

Suggested Anemia Interventions

	Strategy/ Policy	Program	Coverage
Nutrition	✓	IFA for pregnant women at ANC	95%
	✓	IFA for women of reproductive age	N/A
	✗	Provision of micronutrient powders to children	N/A
	✓	Vitamin A supplementation to children	20%
	✓	Exclusive breastfeeding in infants 0-5 months	67%
	✓	Continued breastfeeding in children 6-23 months	Good
Disease Control	✓	IPTp of malaria for pregnant women	46%
	✓	Distribution of insecticide treated nets	77%
	✓	Diagnosis and treatment of malaria in all age groups	100%
	✓	Deworming children	32%
	✓	Deworming pregnant women	Fair
WASH	✓	Usage of an improved water source	64%
	✓	Household treatment of water used for consumption	52%
	✓	Handwashing facility with soap and water	69%
	✓	Access to improved sanitation	89%
RH	✓	Usage of modern methods of family planning	41%
	✗	Delayed cord clamping	N/A
Ag	✓	Promotion of micronutrient-rich and biofortified foods	60%
	✓	Promotion of home food production	50%
Ed	✓	Deworming of children in schools	Poor
	✓	Hygiene education in schools	Good

Barriers



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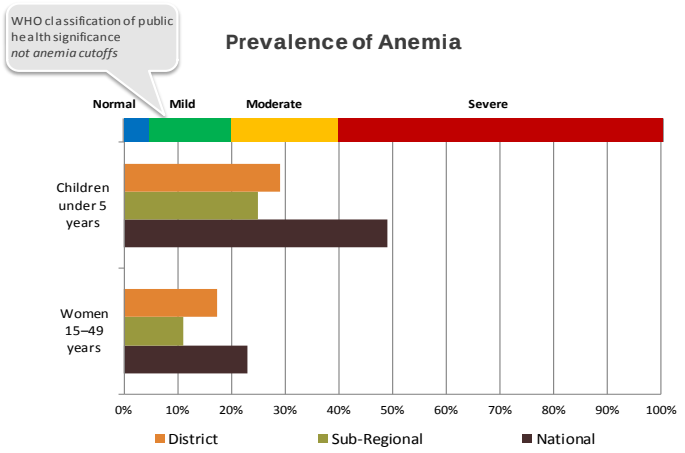
Kanungu

District Assessment Tool for Anemia

Prevalence of Anemia



Risk Factors for Anemia

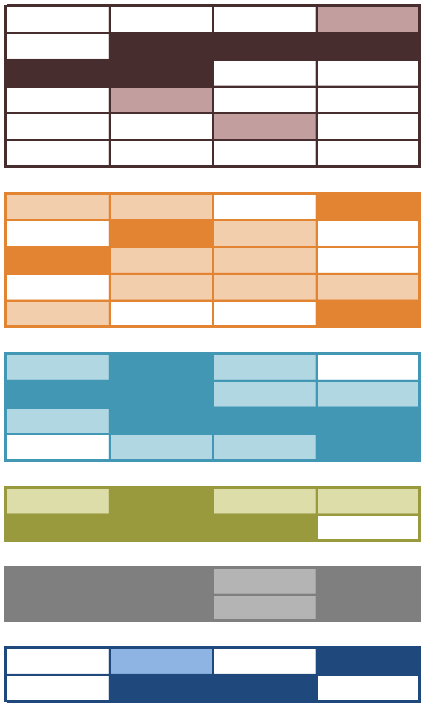
Risk Factor	Prevalence	Target Group
Malaria	32%	Children 6–59 months
	13%	Pregnant women
Helminth	35%	Children 6-59 months
	4%	Pregnant women
Vitamin A deficiency	38%	Children 6–59 months
Iron deficiency	0%	Children 6–59 months
	0%	Women 15-49 years

Vitamin A and Iron represent national level indicators

Suggested Anemia Interventions

	Strategy/ Policy	Program	Coverage
Nutrition	✓	IFA for pregnant women at ANC	Excellent
	✓	IFA for women of reproductive age	Poor
	✗	Provision of micronutrient powders to children	N/A
	✓	Vitamin A supplementation to children	Good
	✓	Exclusive breastfeeding in infants 0-5 months	76%
	✓	Continued breastfeeding in children 6-23 months	Poor
Disease Control	✓	IPTp of malaria for pregnant women	48%
	✓	Distribution of insecticide treated nets	0%
	✓	Diagnosis and treatment of malaria in all age groups	90%
	✓	Deworming children	88%
	✓	Deworming pregnant women	0%
WASH	✓	Usage of an improved water source	92%
	✓	Household treatment of water used for consumption	70%
	✓	Handwashing facility with soap and water	39%
	✓	Access to improved sanitation	93%
RH	✓	Usage of modern methods of family planning	39%
	✓	Delayed cord clamping	Poor
Ag	✓	Promotion of micronutrient-rich and biofortified foods	0%
	✓	Promotion of home food production	60%
Ed	✓	Deworming of children in schools	Good
	✓	Hygiene education in schools	30%

Barriers



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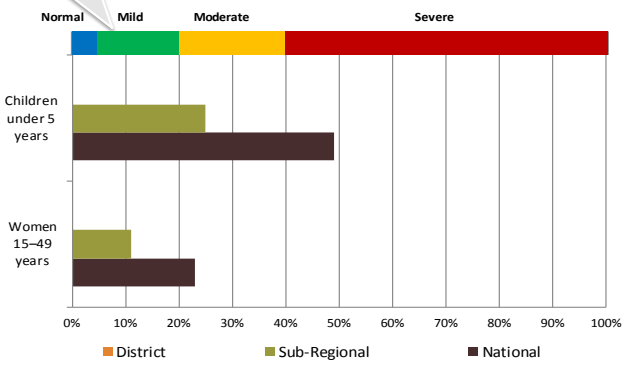
Isingiiro

District Assessment Tool for Anemia

WHO classification of public health significance
not anemia cutoffs

Prevalence of Anemia



Risk Factors for Anemia

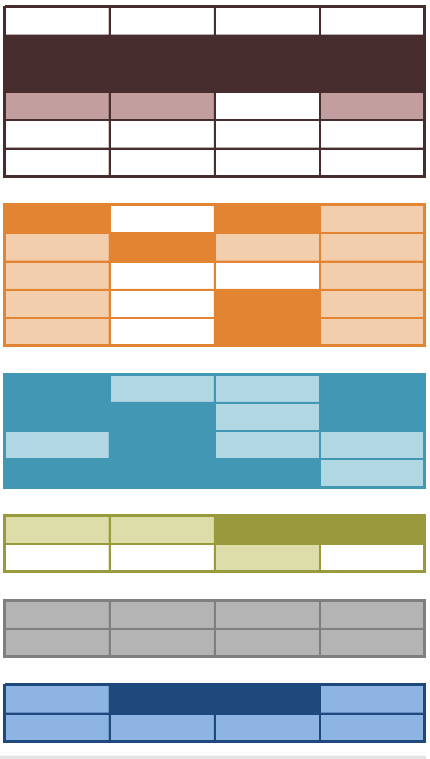
Risk Factor	Prevalence	Target Group
Malaria	38%	Children 6–59 months
	11%	Pregnant women
Helminth	8%	Children 6-59 months
	Medium	Pregnant women
Vitamin A deficiency	38%	Children 6–59 months
Iron deficiency	0%	Children 6–59 months
	0%	Women 15-49 years

Vitamin A and Iron represent national level indicators

Suggested Anemia Interventions

	Strategy/ Policy	Program	Coverage
Nutrition	✓	IFA for pregnant women at ANC	94%
	✓	IFA for women of reproductive age	N/A
	✗	Provision of micronutrient powders to children	N/A
	✓	Vitamin A supplementation to children	64%
	✓	Exclusive breastfeeding in infants 0-5 months	Good
	✓	Continued breastfeeding in children 6-23 months	Fair
Disease Control	✓	IPTp of malaria for pregnant women	65%
	✓	Distribution of insecticide treated nets	94%
	✓	Diagnosis and treatment of malaria in all age groups	Fair
	✓	Deworming children	Fair
	✓	Deworming pregnant women	Fair
WASH	✓	Usage of an improved water source	43%
	✓	Household treatment of water used for consumption	Fair
	✓	Handwashing facility with soap and water	58%
	✓	Access to improved sanitation	Fair
RH	✓	Usage of modern methods of family planning	25%
	✓	Delayed cord clamping	Fair
Ag	✓	Promotion of micronutrient-rich and biofortified foods	6%
	✓	Promotion of home food production	80%
Ed	✓	Deworming of children in schools	Good
	✓	Hygiene education in schools	55%

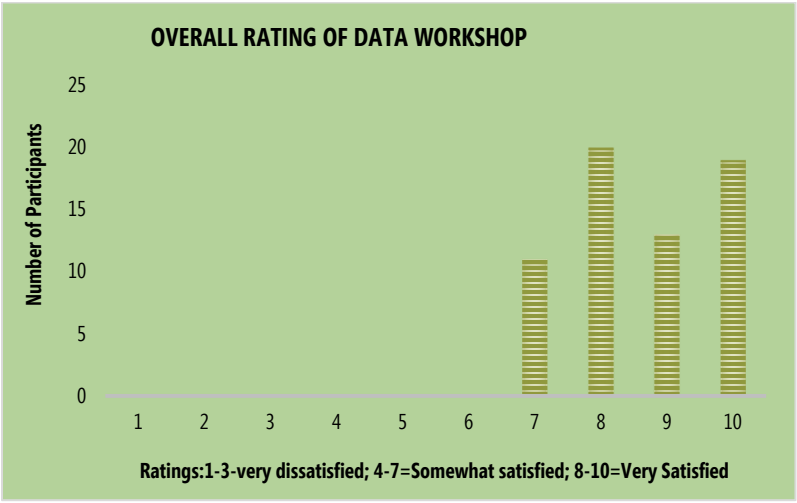
Barriers



Shading indicates the degree to which each area is a barrier to the intervention listed at left.
- No shading- not a barrier
- Light shading- somewhat a barrier
- Dark shading- very much a barrier
- Patterned shading- not applicable

Annex 4: Evaluation of DATA Workshops

Participants Ratings



Participants also provided qualitative feedback on the workshop and the tool

1. **Why participants anticipate using DATA district level prioritization of anemia programs in the future**

The majority of the participants appreciated the workshop and the importance of DATA in understanding of anemia, the need to use a multi-sectoral approach and aiding in prioritization of interventions to reduce anemia in the district.

Understanding of anemia as a problem

"Anemia is an issue in [the] population, however there is no proper baseline data in the district."

"Because it helps the stakeholders clearly understand the problem, the causes, interventions and current performance."

"I am now aware that anemia is such a public health concern in our district, yet can be [prevented]."

"…Gives the real picture on ground."

Anemia reduction requires multi-sectoral efforts

"….because multi-sectoral approach discussions have opened our minds"… [and] enabled comprehensive intervention."

"…department heads have been trained on how to reduce anemia in communities."

"….it's evidence-based and can be used in any programming by departments."

"It's a great tool and allows integration of many sectors and the objectives are achievable if supported."

DATA helps in prioritization

"It is key in establishing the progress or determining the scale of anemia therefore providing platform for an action plan."

"….the importance of data for district-level prioritization is understood and appreciated since a number of areas couldn't be quantified due to lack of appropriate data."

"The tool is useful because it addresses anemia in a multi-sectoral manner. It also identifies available programs and their level/coverage …and helps to prioritize actions to reduce anemia in the district per sector."

"Based on statistics …appropriate allocation of resources for effective and efficient results."

2. What was liked most and least about the workshop

Liked most	Like least
→ *The participatory and multi-sectoral approach* → *Workshop met all its objectives* → *Facilitators has knowledge and skills required* → *The prioritization template helps in identifying barriers and actions to address gaps* → *The level of organization* → *Full participation and involvement of resource persons* → *The concept on anemia* → *DATA* → *Group work and discussions* → *The workshop was a platform for awareness creation on anemia* → *Adequate information and level of analysis*	→ *Time was limited for the amount of work* → *Abbreviations* → *Poor time management by participants*

3. What would you improve about the content/format and suggestions for future workshops

Suggestion for improvement in content/format	Suggestions for future workshops
→ *Content and format were comprehensive and adequate.* → *Include overview of anemia situation in the host districts.* → *Not being too scientific especially when presenting health issues.* → *Other sectors to develop their indicators with the exception of health.* → *Include a training on data management* → *Add picture/photos of consequences of anemia, foods, interventions etc.* → *Simplify words like barriers and enablers.*	→ *Duration to 4-5 days* → *Continuous updates on new guidelines* → *Advocate to other districts to adopt DATA since it's a good tool* → *Continue with the multi-sectoral approach* → *Aligning DATA to existing district tools* → *Districts should ensure they have relevant data/information in place.*

District Workshop Evaluation Form (Sample)

District Assessment Tool for Anemia

District Workshop

August 16-17, 2016

Namutumba District, East Central Region

Workshop Evaluation

(This form has been formatted to fit the document; before printing it out for distribution, please allow more space for the answers to the open-ended questions.)

1. Indicate how well you think the workshop objectives were met by placing a check in the column that best describes your opinion.

	Workshop Objective	Objective Fully Achieved	Objective Adequately Achieved	Objective Partially Achieved	Objective Not Achieved
1	Understand the multi-factorial causes of anemia				
2	Understand the importance of context-specific, multi-sectoral approaches to address anemia				
3	Learn how to use DATA to prioritize district-level anemia prevention and control programs				

2. Do you anticipate the use of DATA for district-level prioritization of anemia programs in the future?

   □ Yes (Go to question 3)

   □ No (Skip to question 4)

3. If yes, why?

4. If no, why not?

ABOUT THE WORKSHOP

5. What did you like most about the workshop?

6. What did you like least about the workshop?

7. What would you improve about the content or format of the workshop?

8. What suggestions do you have for any future workshops?

9. Please rate the workshop trainers on a scale of 1–10 (with 1 being very dissatisfied and 10 being very satisfied). *(Circle one number.)*

Very dissatisfied Somewhat satisfied Very satisfied

1 2 3 4 5 6 7 8 9 10

Thank you for your feedback!

Annex 5: Prioritization Actions by Sector in the Three Pilot Districts

Sectors	Namutumba	Arua	Amuria
Nutrition	**Barriers**: IFA stockouts due to limited funds, limited knowledge on anemia; lack of policy documents; late and inconsistent ANC attendance by mothers; over-reliance on implementing partners to provide key interventions like micronutrient powders for 6–23 months. **Activities prioritized:** → Capacity building for health workers on anemia logistics and stock management. → Planning meetings at district and national level aiming at increasing the budget for IFA by MOH/NMS. → Community sensitization and use of VHTs to follow up and refer pregnant women to health facilities. → Advocate and lobby for sustained supply of MNPs. → Conduct community dialogue meetings and use of VHTs to distribute MNPs.	**Barriers**: IFA stockouts leading to inadequate supplies; untimely quantification; limited funds due to budget cuts and donor withdrawal; negative attitude toward IFA supplementation by pregnant women; knowledge gap and poor documentation on all anemia-related interventions (IFA and vitamin A supplementation and IYCF practices). **Activities prioritized:** → Increase budget funds for IFA drugs. → Provide refresher trainings for midwives/nurses on proper documentation and strengthening planning for all interventions (IFA for pregnant women, vitamin A supplementation among children) and promotion of proper IYCF practices. → Continued community sensitization to benefits of IFA. → Supportive supervision for all interventions. → Sensitize care givers and/or community volunteers to proper IYCF practices.	**Barriers:** IFA and vitamin A stockouts due to inadequate funding; knowledge gap among the communities and youth; understaffing and high attrition rates; anemia programs not integrated at all entry/contact points at health facilities. **Activities prioritized:** → Mentorship, refresher training, continued medical education for health workers. → Timely quantification and ordering of IFA drugs. → Prioritize supplies (IFA, vitamin A, deworming) and equipment during planning and budgeting. → Even without a national program on IFA for WRA (non-pregnant), the district prioritized this. → Sensitize caregivers and/or community volunteers to anemia interventions. → Radio talks, dissemination of IEC materials to provide information to the community. → Engage youth in the prevention and control of anemia through youth clubs. → Lobby for increased funding to fill gaps.

Sectors	Namutumba	Arua	Amuria
Disease Control	**Barriers:** Lack of supplies like directly-observed therapy (SP) for IPTp (3 or more doses), drugs for active case management of malaria, and inadequate coverage for mosquito nets for individual and households; limited funds allocated to implement anemia activities; poor health-seeking behaviors by the community. **Activities prioritized:** → Strengthen BCC messages to the communities. → Resource mobilization and advocating for more funds. → Orient health workers to new guidelines. → Encourage communities to purchase bed nets from the market. → Accurate forecasting and quantification of adequate anti-malarials.	**Barriers:** inadequate supplies SP for IPTp and anti-malarials for active treatment of malaria due to alien population from neighboring countries; lack of training for health workers on the new malaria in pregnancy guidelines; and self-medication for malaria by most of the population. **Activities prioritized:** → Orient midwives to the new malaria in pregnancy guidelines. → Advocate for more funding to cater for the alien population. → Sensitization/health education for community on need to seek medical advice at recognized health facilities for proper diagnosis and treatment for malaria.	**Barriers:** Stockouts (deworming drugs, SP for IPTp, ITNs, limited reagents for RDT and anti-malarial for active case management of malaria) due to limited funding; low demand by communities for deworming children 6–59 months; poor ANC attendance and health-seeking behaviors by pregnant women; poor staffing and health worker absenteeism; poor client care largely due to poor working conditions. **Activities prioritized:** → Sensitize communities to importance of deworming children, ANC visits, and seeking medical advice from a recognized health facility. → Engage and prioritize resources for supplies for anemia interventions. → Promote male involvement. → Advocate for recruitment according to the staffing norms. → Mentor and provide continued medical education to health workers on new policy documents and guidelines.

Sectors	Namutumba	Arua	Amuria
WASH	**Barriers:** knowledge gap on proper WASH practices; limited engagement of district officers in promotion of household treatment of water used for consumption. **Activities prioritized:** → District officer engagement in the promotion of treatment of household water for consumption. → Dialogue meetings with communities, school health talks and talk shows.	**Barriers**: poor maintenance of improved water sources (inaccessibility of hand pump parts and inadequate community contribution to maintenance); low coverage of household treatment of water, especially in rural communities due to the high cost and low coverage of improved water sources; minimal provider skills at district and community levels; poor cultural practices and perceptions on practices, especially use of sanitation services like latrine use; some communities prefer open defecation. **Activities prioritized:** → Advocate for establishment of hand pump parts shop by hand pump mechanics association. → Lobbying for funds from development partners for treatment of water sources and increased coverage of treated water sources in the rural setting; improved hand washing and hygiene facilities. → Sensitize community to contribute to payments of operations and maintenance funds; use and invest in other household treatment techniques like boiling water for consumption; improved hand washing and hygiene facilities. → Refresher trainings for district and community workers in proper management and use of maintenance technologies. → Improve monitoring of WASH practices.	**Barriers:** limited training among water user committees, especially on the use of high pump mechanic; limited funds for implementation of WASH activities; negative attitudes toward water treatment by the community; collapsing soil, and water logging affecting sanitation facilities. **Activities prioritized:** → Sensitize community to contribute to payments of operations and maintenance funds; use water treatment methods. → Campaigns to promote handwashing facilities (tippy taps demo sites) and promote use of hand washing with soap and consumption of safe treated water. → Training of water user committees and community workers on high pump mechanic and other technologies and manage barriers → Integration of WASH activities across sectors. → Lobby and advocate for funds for implementation of WASH activities, specifically water treatment in rural setting, commodities (treatment drugs and maintenance supplies and equipment).

Sectors	Namutumba	Arua	Amuria
Reproductive Health	The major barrier is knowledge gap and practice on delayed cord clamping in health facilities. Almost no midwives are aware of delayed cord clamping. **Activity prioritized:** → Orient/mentor midwives through supportive supervision on the WHO recommendations to practice delayed cord clamping.	**Barriers**: Lack of sustainability of FP projects by the district as most of the interventions are partner-supported; inadequate funds for refresher trainings especially on new methods for provision of quality family planning services; low male support and involvement; cultural and religious myths and misconceptions and side effects on family planning (e.g., Catholics do not support FP and some communities consider FP as a dubious action by government to limit births); lack of knowledge on revised tools for provision of quality family planning services; and delayed cord clamping is not practiced at health facilities because most midwives don't know about it. **Activities prioritized:** → Community sensitization on the importance of family planning methods. → Promote male, and cultural and religious leader involvement in FP. → Onsite mentorship and training on stock management/quantification of commodities for family planning and new tools and guidelines on FP and orienting midwives to practicing delayed cord clamping.	**Barriers:** Stockouts for FP commodities; limited knowledge by communities on the benefits of modern FP methods coupled with misconceptions, negative cultural and religious beliefs and myths about FP; limited access to FP services; low male support and involvement. **Activities prioritized:** → Advocate for buffer stocks of FP commodities by implementing partners. → Strengthen forecasting and ordering for modern FP methods from NMS. → Sensitize communities on the importance modern FP methods. → Promote male, cultural, religious leaders involvement in FP.

Sectors	Namutumba	Arua	Amuria
Agriculture	**Barriers:** high costs and poor quality of agricultural input; inadequate facilitation for extension workers; pests and diseases; commercialization of food crops; poor post-harvest handling techniques for agricultural produce. **Activities prioritized:** → Strengthen provision of agricultural inputs to farmers. → Increase the funds for extension workers → Sensitize farmers to improved post-handling harvest practices and technologies. → Promotion of intensive farming and improved farming techniques.	**Barriers:** Limited coverage of Iron rich foods and home food production; adulterated planting materials which lead to low yields; high prices of planting materials; inadequate funding for implementation of agricultural interventions; seasonal changes; limited extension workers to provide services to hard to reach areas; knowledge gap of district and extension workers on new technologies/tools to improve agricultural production. **Activities prioritized:** → Scale up production and supplies for planting materials. → Strengthen planning, budgeting for agricultural interventions. → Lobby for funds for purchasing supplies and modern technologies; recruitment of extension workers; refresher trainings. → Community sensitization on promotion of production and consumption of diversified foods and foods rich in Iron and associated micronutrients, e.g., promotion of home gardening and model homes exhibitions.	**Barriers**: Poor adoption of new technologies, low yields due to limited acreage and climate change; limited funding for implemented of interventions due to competing priorities; poor attitudes by communities towards modern technologies; low staffing at district and community levels, high population growth (children and pregnant mothers); and crop pests and diseases. **Activities prioritized**: → Promotion of block farming, model farming practices, intercropping; post-harvest handling and value addition. → Promotion of income-generating projects. → Continuous sensitization of the community on proper agricultural interventions. → Integrate agricultural activities and learning. → Enforce by-laws on improved farming practices. → Sensitization of the community on family planning awareness and adoption to limit the increasing population. → Control pests.

Sectors	Namutumba	Arua	Amuria
Education	**Barriers:** stockouts of deworming drugs for school children; funding gap for providing hygiene, sanitation and health education services in schools; limited health workers to support schools in administering dewormers. **Activity prioritized:** → Lobby and advocate for funding through writing project proposals to implementing partners. → Advocate for recruitment of resource persons to support the deworming programs in schools.	**Barriers:** pupil absenteeism; inadequate capacity of teachers to provide WASH services in schools; negative attitude of pupils and teachers on deworming drugs , limited funding for providing logistics for the programs; poor data management **Activity prioritized:** → Mentoring/training of teachers to administer deworming drugs and provide WASH services → Sensitization of schools and parents during school health days, school health competitions, health talks, and radio talk shows on importance of deworming school children and ensuring they attend school. → Encourage proper data management in schools for the services provided.	**Barriers:** stockouts of deworming drugs due to limited funds; poor collaboration among key sectors especially health and education; schools not engaged in direct planning for deworming/no integration into other existing school activities; limited human resources for providing hygiene education; lack of facilities and materials for hygiene education. **Activity prioritized:** → Mentorship and refresher training for teachers and pupils. → Strengthen the micro-planning between health and education department and schools. → Conduct a baseline assessment to document the number of schools and children in schools to ensure adequate deworming drugs are given. → Conduct needs assessment to optimize resources. → Provide refresher trainings on importance of hygiene education in schools. → Construct hygiene and sanitation facilities.

Prioritization Actions by Sector in Three Rollout Districts

**Note that prioritization actions were not completed in Mbarara District.*

Sectors	Sheema	Kanungu	Isingiiro
Nutrition	**Barriers:** Inadequate supplies of vitamin A, incomplete filling of child registers, limited knowledge by communities on the importance of exclusively breastfeeding. **Activities prioritized:** → DHT will engage with NMS to increase the supplies of vitamin A supplements. Consultation with neighboring districts to ascertain availability of excess vitamin A stock to ration to Sheema district. → Involvement of VHTs to provide documentation during outreach programs. → Sensitization of the mothers at community and at health facility levels on the benefits of exclusive breastfeeding.	**Barriers:** IFA and vitamin A stock outs; poor IFA adherence by pregnant mothers; lack of plans and funding for IFA supplementation to WRA (non-pregnant women); lack of MNPs policy guidelines and supplies in the district for effective implementation. **Activities prioritized:** → Community sensitization: for pregnant women through campaigns and during ANC sessions using relevant IEC materials; promote exclusive and continued breastfeeding for children <6months and 6–23months respectively; and encourage use of modern family planning methods. → Mobilization of funds to procure IFA and vitamin A for WRA and children respectively; train health and community workers and hold media campaigns	**Barriers:** inadequate IFA supplies; lack of MNPs policy guidelines and supplies in the district for effective implementation; limited knowledge on MNPs district staff and community; and inadequate funds for implementing child health programs **Activities prioritized:** → Timely planning, quantification and advocacy for procurement of adequate IFA → Advocate to partners to support the MNPs and child health days programs in the district. → o embrace MNPs program in the districts → Sensitize pregnant mothers to adhere to IFA supplementation. → Conduct a campaign in the communities on the importance of MNPs and child health days programs.

Sectors	Sheema	Kanungu	Isingiiro
		to promote the service. → Advocate (to partners) to procure and develop policy guidelines for MNPs implementation.	
Disease Control	**Barriers:** Limited training for health workers on the new malaria in pregnancy guidelines on IPTp due to poor selection of health workers for training; stock outs of IPTp and deworming drugs for pregnant women; limited community awareness (pregnant women) on the importance of deworming and IPTp; and limited funding to implement MIP activities. **Activities prioritized** → Identify and orient key district and health workers for Malaria In Pregnancy (MIP) trainings. → Timely quantification for all supplies. → Provide routine support supervision for all deworming and IPTp activities at community and health facility levels. → Community sensitization on the benefits of IPTp, deworming and malaria prevention and control program. → Advocate for more funding for anemia related activities.	**Barriers:** Stockouts of SP for IPTp and deworming tablets for pregnant women and child health days program; limited client demand for IPTp and deworming tablets; poor data management; inadequate funds for activities (sensitization, post distribution campaign of mosquito nets; support supervision); limited training of service providers. **Activities prioritized:** → Timely ordering of SP and deworming tablets laboratory supplies for proper diagnosis of malaria. Liaise with NMS for more support. → Updating of standard kits to include IPTp → Integrated support supervision. → Resource mobilization to adequately implement	**Barriers:** Non-operational IPTp program, lack of MIP reference guidelines, 24/32 health facilities on MIP; limited community awareness on the importance of IPTp; lack of supplies for SP, RDTs, ACTs, deworming drugs, poor data management and reporting for deworming for child health days and for pregnant women. **Activities prioritized:** Prioritize timely quantification and procurement of SP for IPTp, deworming drugs; ACTs, RDTs and engage MOH and NMS for support. → Community sensitization on the importance of IPTp, use of LLIN, proper diagnosis and treatment of malaria; deworming in children and pregnant women. → Advocate to MOH to disseminate MIP and

Sectors	Sheema	Kanungu	Isingiiro
		anemia related activities like (post- distribution campaign activities, involvement of VHT in post-distribution activities and effective training of service providers, support supervision, supplies and lab supplies) and recruitment of additional health workers → Community sensitization on the importance of IPTp and deworming programs → Provide mentoring, training and CMEs to health workers/service providers in data entry and management and implementation of anemia related activities like malaria.	malaria diagnosis and treatment guidelines; training and I.E.C materials. → Advocate for allocation of resources for support supervision; transportation of LLINs, procurements of anemia supplies. → Orient and provide support supervision and mentorship to health workers on updated anemia related guidelines; data management; and HMIS for effective implementation.

Sectors	Sheema	Kanungu	Isingiiro
WASH	**Barriers:** Lack of equipment and tools to construct safe and protected water sources; inadequate funding for rural water programs non-functional water user committees to follow up on WASH programs; inadequate water leading to high tariffs especially in the urban centers; national water and sewerage corporation is discouraging use of other water technologies; myths and misconceptions about treated water; delayed release of funds for construction and maintenance of handwashing facility with soap and water and for improved sanitation facilities; lack of cleaners/support staff to maintain health facility hand washing facilities; negligence of health workers towards hand washing with soap and water; pupil stance ratio (MOES=1:40) not prioritized during construction of latrines. **Activities prioritized:** → Lobby and budget to procure drilling equipment and spares for existing water sources and water projects. → Revitalize and train water user committees on their roles and responsibilities. → Advocate for national water to tap more water to boost their source and develop long term projects. → Engage and advocate to other sectors and other partners to fund activities that promote WASH activities. → Advocating for recruitment of cleaners (public Service to wave off the requirements from S4 level, since most of those willing to apply do not have S.4 qualification). → Building capacity of cleaners and health workers on the importance of WASH. → Community sensitization on appropriate technologies and WASH activities.	**Barriers:** Long distance to and poor maintenance of water sources; limited funding to implement WASH programs in sub-counties/communities and for adequate staff recruitment due to limited conditional grants and unreliable donor funds; limited capacity of staff/water user committees to train communities; negative attitudes towards of treated water by communities; low income for households to establish hygiene and sanitation facilities; limited prioritization sanitation facilities at the community and district offices. **Activities prioritized:** → Advocate for funding/develop proposals for additional funding for implementation of WASH programs like (protected water source, extending water to hilly areas and dry areas and recruitment of additional staff). → Conduct training-of-trainers in WASH for extension staff/water user	**Barriers**: Inaccessibility to the equipment's for maintenance and expansion of protected water, hygiene and sanitation facilities sources; inadequate funding for WASH programs, therefore slowing implementation of plans/policies; non-functional and unskilled water user committees; limited skills of district staff on pump mechanic and masons; inadequate supplies to enable household water treatment and limited coverage by NWSC; inadequate budget allocation for software activities, hygiene and sanitation activities, limited knowledge and negative community attitude on water treatment drugs. **Activities prioritized:** → Advocate and lobby service providers to establish nearby outlets for equipment's for WASH facilities: water sources (boreholes, iron removers, water harvesting fittings, water treatment drugs) and sanitation (treated poles,

Sectors	Sheema	Kanungu	Isingiiro
		committees. → Sensitize the community to maintenance of protected water sources, household procurement and use of water treatment drugs; village savings and credit association for household income to establish hand washing facility with soap and sanitation facilities (latrines). → Supportive supervision to communities to follow up on WASH practices. → Advocate for public hygiene and sanitation facilities at district offices and in schools.	san plats, slabs) → Lobby for MWE to increase funding for WASH program, software activities and implementing partners. → Guidelines on water grant should also cater for urban councils. → Train district staff and community extension workers on pump mechanic and masons, orient on water protection policy, household water treatment methods, construction of hand washing facilities (tippy taps) using local materials, and train water user committees on their roles and responsibilities. → Protection and rehabilitation of potential water sources. → Advocate for procurement of supplies (sand filters, chlorination reagents) and increase in coverage of treated water by NWSC. → Sensitize communities to the importance of water

Sectors	Sheema	Kanungu	Isingiiro
			treatment, hygiene, and sanitation facilities.
Reproductive Health	**Barriers:** Misconceptions, negative myths and peer pressure from communities on family planning; inadequate supplies of family planning methods e.g. HC-IIIs only get injection depo and HC-IVs get microgynon; limited funds for community outreaches and for VHTs; limited knowledge and skills of some midwives to administer and manage modern family planning and its side effects; limited knowledge on management of delayed cord clamping; DCC not integrated in current reproductive health policies and guidelines in the health facilities. **Activities prioritized:** → Sensitize communities on the importance of: family planning, side effects and management; and DCC. → Provide refresher training/CMEs/mentorship to health workers on administering and management of side effects for modern family planning; delayed cord clamping to address staff attrition. → Engage political and church leaders to advocate for use of family planning among community. → Prioritize primary health care (PHC) funds at facility and district level to support integrated outreaches (immunization, family planning and antenatal care). → MOH to integrate DCC in the HMIS and relevant policies and guidelines, maternity register and disseminate job aids to the health facilities.	**Barriers:** Inadequate supplies of family planning methods (implants, IUD and pills) and cord clamps by NMS; limited funding for family planning activities at the district; inadequate knowledge and skills for health workers in providing family planning and delayed cord clamping services. **Activities prioritized:** → Liaising with NMS regional office through the DHO to address issues on family planning supplies and cord clamps. → Mobilize funds for implementation of family planning programs from USAID/RHITES and UNFPA. → Provide mentorship/refresher trainings to health workers on provision of modern family planning methods and delayed cord clamping services.	**Barriers:** Inadequate supply of family planning methods, limited funds to procure supplies and provide services; limited knowledge and skills of health workers in provision of family planning services; negative beliefs by religious and cultural beliefs; misconceptions by community on family planning methods. **Activities prioritized:** → Adequate quantification and timely placement of orders for family planning methods. → Prioritize family planning programs during district planning and budgeting. → Sensitize community dialogues to address family concerns and the importance of family planning. → Provide mentorship/refresher training of health workers on provision of family planning and delayed cord clamping.

Sectors	Sheema	Kanungu	Isingiiro
Agriculture	**Barriers:** limited coverage and uncoordinated scale up of production and consumption of iron rich foods; poverty leading to sale of all the harvest; land shortage; slow adoption of improved technologies like iron rich beans; inadequate knowledge on the importance of iron rich foods by the communities; inadequate funding for scale up. **Activities prioritized:** → The priority activity is to intensify extension services. → Diversify enterprises and adopt modern methods of farming → engage communities in exchange visits and demonstration gardens to learn best practices and knowledge → Strengthen supply and scale up of the new technologies (iron planting materials/animal breeds) to reach a wide coverage of communities. → Provide refresher trainings to extension staff to provide adequate services to the communities.	**Barriers:** limited improved seeds (climbing beans); limited supplies of fertilizers and agricultural inputs in the local market, some of which are counterfeits; reliance on external support from partners; limited knowledge on the importance of iron-rich foods and good post-harvest handling practices by the community; limited participation of males in home food production; poor soil fertility and poor post-harvest handling. **Activities prioritized:**	**Barriers:** High costs, limited access, and counterfeits of Agro inputs; limited funding for scale up; conditional funds restricted to promote agricultural products other than iron rich-foods; prohibitive cultural beliefs on new technologies like iron-rich beans; expectation of free seeds from government; multi-sectoral project is partner-driven and implemented in only 100 schools; adverse weather conditions affecting yields; land shortage; declining soil fertility; inadequate community knowledge of proper food

Sectors	Sheema	Kanungu	Isingiiro
		→ Establish seed multiplication centers within the communities → Train farmers on how to make organic manure/fertilizers, post-harvest handling techniques, at community level. → Advocate for local fertilizer suppliers to be licensed and monitored to regulate counterfeits → Advocate for adequate funding from local revenues to scale up program. → Advocate for integration of agriculture-related interventions in other sectors. → Train community workers on importance of promoting iron-rich foods to households. → Sensitize communities to importance of consuming iron-rich foods and increase home food production. → Establish male action groups to aid promotion of	production and use; sale of harvest due to poor income status; limited skills and knowledge due to high staff turnover; inadequate facilitation for field kits and transport for supportive supervision. **Activities prioritized:** → Establish community-based seed and breed multiplication centers. → Provide certified inputs under Ministry of Agriculture and NARO. → Identify and lobby for alternative sources of funds for program scale up; to recruit additional staff and community-based facilitators, and for field kits and transport for supportive supervision. → Sensitize the community on proper crop production practices and the importance of production and consumption of iron rich foods → Provide refresher trainings for extension workers.

Sectors	Sheema			Kanungu	Isingiiro
				home food production.	→ Promote improved agronomic practices and climate-smart agriculture. → Encourage use of weather forecast information to plan production in the right season.
Education	**Barriers:** stock outs of deworming drugs; inadequate and delay of funds; inadequate trainers; lack of information for schools, pupils and parents on the benefits of deworming; negative attitude towards deworming drugs by the community. **Activities prioritized:** → Quantification of adequate deworming drugs for school-going children. → Lobby for adequate supply of deworming drugs from partners. → Mobilize funds to implement deworming activities.	**Barriers:** negative attitudes by communities towards intake of dewormers; pupil absenteeism; focus is mainly on primary schools leaving out secondary school students; limited funding for water, hygiene and facilitation facilities in schools; poor attitude of teachers in teaching hygiene and sanitation practices. **Activities prioritized:** → Sensitize communities through dialogues and radio talk shows, on the	**Barriers:** lack of safe drinking water, hygiene and sanitation facilities in schools, limited funds for implementation of deworming and WASH activities, lack of school health policy to guide implementation; misconception about the importance of de-worming; lack of dissemination of relevant guidelines to schools to ensure adequate resource allocation; pupils absenteeism; no practical sessions in hygiene education, lack of prioritization of hygiene and sanitation practices in schools; negligence of both teacher and children; poor perception of hand washing.		

Sectors	Sheema			Kanungu	Isingiiro
	→ Sensitize district staff, teachers, children, and parents and on the benefits of deworming using key messages and through radio talk shows to increase demand. → Hold quarterly coordination meetings with implementing partners to track progress in implementing health programs.	importance of deworming and WASH programs. → Advocate to national and district officials for a deworming program for secondary school children. → Prioritize funding for deworming and WASH activities. → Promote hygiene in schools during assembly, inter-class health competitions, health parades.	**Activities prioritized:** → Advocate for inclusion of funding for deworming in the budget framework. → Lobby through district area members of parliament for approval of school health policy. → Request for dissemination of the relevant to key stakeholders to guide implementation. → Sensitize schools to prioritize budgeting for hygiene and sanitation activities. → Sensitize communities to benefits of deworming and WASH services at schools and routinely sending children to school.		

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