



# Monitoring and Evaluation Toolkit for the Scale-Up of Emergency Obstetric and Newborn Care in Kenya

April 2017





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## ABBREVIATIONS

AMTSL	active management of third stage of labor
APHIA <i>plus</i>	AIDS, Population and Health Integrated Assistance
BEmONC	basic emergency obstetric and newborn care
CEmONC	comprehensive emergency obstetric and newborn care
EmONC	emergency obstetric and newborn care
GoK	Government of Kenya
M&E	monitoring and evaluation
MCSP	Maternal and Child Survival Program
MDGs	Millennium Development Goals
MNCH	maternal, newborn and child health
MoH	Ministry of Health
RMHSU	Reproductive and Maternal Health Services Unit, Ministry of Health
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
URC/ASSIST	University Research Co., LLC Applying Science to Strengthen and Improve Systems
USAID	United States Agency for International Development
WHO	World Health Organization





# 1.0. INTRODUCTION

The call to address the high rates of maternal and newborn mortality has received unprecedented support from governments and development partners over recent years. Increased investments in programs targeting maternal and newborn health have fueled demand for reliable and timely data to promote the rational allocation of resources where the burden of deaths is greatest. In Kenya, the Ministry of Health and county governments have committed to ensuring universal access to emergency obstetric and newborn care (EmONC).<sup>1</sup> The United States Agency for International Development (USAID) is a major partner of the Government of Kenya (GOK) in the effort to increase the national coverage of EmONC under its Ending Preventable Child and Maternal Deaths Strategy.

EmONC is an integrated strategy developed by the World Health Organization (WHO), the United Nations Population Fund (UNFPA) and the United Nations Children’s Fund (UNICEF) that aims to equip health facilities with the capacity to provide evidence-based, cost-effective interventions to attend to the leading causes of maternal and newborn mortality.<sup>2</sup> Two levels of care are recognized under this approach: basic (BEmONC) and comprehensive (CEmONC). BEmONC, provided at primary care facilities such as dispensaries and health centers, has seven essential medical interventions, known as signal functions. CEmONC, provided at hospitals, covers the seven BEmONC signal functions plus two more (Table 1).

**Table 1. BEmONC and CEmONC signal functions**

BEmONC Signal Functions
(1) Administer parenteral antibiotics
(2) Administer uterotonic drugs, such as parenteral oxytocin
(3) Administer parenteral anticonvulsants, such as magnesium sulfate, for preeclampsia and eclampsia
(4) Remove the placenta manually
(5) Remove retained products of conception using methods such as manual vacuum aspirations or misoprostol for medical evacuation
(6) Perform assisted vaginal delivery using methods such as vacuum extraction or forceps delivery
(7) Perform basic neonatal resuscitation, such as with bag and mask
CEmONC Signal Functions
Perform all seven components of BEmONC <i>plus</i>
(8) Perform Caesarean section
(9) Perform blood transfusion

This toolkit is the result of collaborative work by MEASURE Evaluation PIMA, USAID, the Maternal and Child Survival Program (MCSP), University Research Company/ASSIST, APHIA*plus*, AMPATH PLUS implementing partners, the Ministry of Health (MOH), and county health management teams

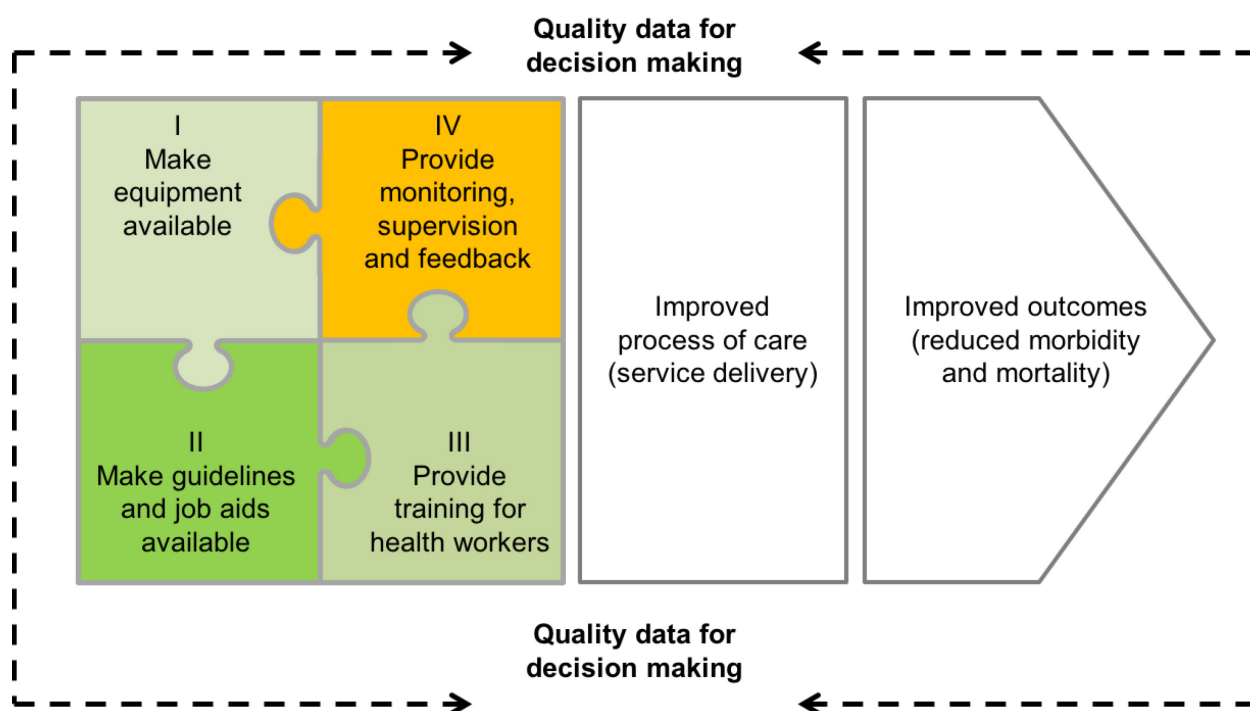
<sup>1</sup> Ministry of Health (MOH), Government of Kenya. (2009). National reproductive health strategy 2009–2015. Nairobi, Kenya: MOH.

<sup>2</sup> World Health Organization (WHO); United Nations Population Fund; United Nations Children's Fund; Averting Maternal Death and Disability, Columbia University Mailman School of Public Health. (2009). *Monitoring emergency obstetric care: A handbook*. Geneva, Switzerland: World Health Organization.

targeted in the initial phase of the national scale-up of BEmONC.<sup>3</sup> The toolkit incorporates experiences from the first two phases of the national EmONC scale-up exercise launched in July 2013.

The national scale-up of the monitoring and evaluation (M&E) of EmONC was based on the theoretical framework drawn from the Donabedian model, which categorizes quality of care in three interlinked unidirectional dimensions: (1) structure, (2) process, and (3) outcome.<sup>4</sup> An example of this interlinked framework is how changes in structure-related items, such as commodities, buildings, equipment, and guidelines, directly influence the process of care, such as patient diagnosis and treatment. In turn, patient diagnosis and treatment determine outcomes, such as morbidity and mortality. Through periodic assessments of health facility capacity to provide the EmONC signal functions, it is possible to infer the progressive capabilities to reduce maternal and newborn mortality. Figure 1 illustrates this framework.

**Figure 1. Theoretical framework for the evaluation of the scale-up of EmONC in Kenya**



### 1.1. Purpose of the Toolkit

The GOK and national and county implementing partners require timely quality data to develop appropriate targeted decisions based on needs. This toolkit was developed to produce data through coordinated periodic reporting of key interventions for maternal and newborn survival at the health facility, subcounty, county, and national levels. The materials in this package provide instruction in data collection on a set of harmonized indicators that are measurable at all health facilities and can be interpreted nationally and globally. The toolkit provides simple dashboards that can be used for data management, analysis, and reporting in counties, and subsequently for effective dissemination of M&E results that can be used to develop action plans.

<sup>3</sup> The participating counties are Baringo, Busia, Kitui, Machakos, Mandera, Meru, Murang'a, Narok, Nyamira, Samburu, Tharaka Nithi, Trans Nzoia, and Wajir.

<sup>4</sup> Donabedian, A. (1988). The quality of care. How can it be assessed? *Journal of the American Medical Association*, 260 (12):1743–1748.



## **1. 2. Toolkit Users**

This toolkit is intended primarily for county M&E officers, reproductive health coordinators, and other members of county health management teams and partners involved in implementing EmONC. It is also useful for national M&E officers and other professionals and donors who are involved in maternal and newborn health programs.

## **1.3. Toolkit Organization**

The toolkit is divided in two sections. Section I define the indicators used for monitoring and evaluating EmONC interventions and describes their relationship with the major causes of maternal and newborn deaths. . Two types of indicators are presented; (a) those used for assessing the structure, such as equipment, staffing, and consumables; and (b) indicators for assessing the process of care, such as documenting appropriate practices for providing EmONC. Section II lists resources for planning M&E, methods for conducting M&E, and outlets for disseminating the findings. This section includes training materials, data collection tools, analysis dashboard templates, and templates for health facility profiles.

## 2.0. SECTION I: EmONC M&E INDICATORS

The leading causes of maternal death are postpartum hemorrhage (PPH), hypertension, infections, obstructed labor, and complications arising from abortion. These causes account for over two-thirds of the estimated 289,000 annual global mortalities related to pregnancy and childbirth.<sup>5</sup> About three-quarters of neonatal deaths are attributable to infections, preterm birth, and intrapartum complications.<sup>6</sup> These top causes of maternal and newborn mortality are all largely preventable through the effective use of highly cost-effective interventions in EmONC.

### 2.1 Structure Indicators

Each signal function provides specific interventions to treat the life-threatening complication. Table 2 summarizes the nine CEmONC signal functions and the major causes of maternal and newborn mortality, the indicators, and the main conditions targeted.

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<sup>5</sup> Kassebaum, N. J., Bertozzi-Villa, A., Coggeshall, M. S., Shackelford, K. A., Steiner, C., Heuton, K. R., . . . Lozano, R. (2014). Global, regional, and national levels and causes of maternal mortality during 1990–2013: A systematic analysis for the Global Burden of Disease Study 2013. *The Lancet*, 384 (9947): 980–1004. Retrieved from [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(14\)60696-6/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)60696-6/abstract)

<sup>6</sup> Wang, H., Liddell, C. A., Coates, M. M., Mooney, M. D., Levitz, C. E., Schumacher, A. E., . . . Murray, C. J. L. (2014). Global, regional, and national levels of neonatal, infant, and under-5 mortality during 1990–2013: A systematic analysis for the Global Burden of Disease Study 2013. *The Lancet*, 384 (9947): 957–979. Retrieved from [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(14\)60497-9/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)60497-9/abstract)

**Table 2. EmONC M&E structure indicators**

<b>Basic Signal Functions</b>	<b>Indicators</b>	<b>Main Conditions Targeted</b>
(1) Administer parenteral antibiotics	Availability of: injectable penicillin <i>and</i> gentamicin <i>and</i> metronidazole OR ceftriaxone <i>and</i> metronidazole	Puerperal sepsis
(2) Administer uterotonic drugs	Availability of parenteral oxytocin	Postpartum hemorrhage
(3) Administer parenteral anticonvulsants for severe preeclampsia and eclampsia	Availability of magnesium sulfate	Preeclampsia/eclampsia
(4) Manually remove the placenta	Availability of sterile elbow-length gloves	Postpartum hemorrhage, puerperal sepsis
(5) Remove retained products of conception	Availability of manual vacuum aspiration (MVA) kit OR misoprostol for medical evacuation	Abortion
6) Perform assisted vaginal delivery	Availability of vacuum extractor	Obstructed labor
(7) Perform basic neonatal resuscitation	Availability of pediatric bag valve mask device	Perinatal asphyxia
<b>Comprehensive Signal Functions</b>		
(8) Perform surgery (e.g. Caesarean delivery)	Availability of Caesarean delivery set	Obstructed labor, preeclampsia/eclampsia, obstetric hemorrhage, perinatal asphyxia
(9) Perform blood transfusion	Availability of blood transfusion sets	Obstetric hemorrhage
<b>Additional indicators</b>		
Training of health workers on EmONC		All
Availability of EmONC clinical guidelines		All

The EmONC Health Facility Assessment Tool ([Appendix 6](#)) also collects information on the availability of equipment and consumables required for general maternal newborn and child health services, including equipment for provision of emergency care, basic surgical equipment, and equipment for routine clinical assessment.

## **2.2. Process Indicators**

While “structure-related” indicators represent the basic elements for the provision of quality care, their availability does not necessarily reflect appropriate use. Examination of this dimension of care requires the assessment of the “process of care.” Measures of process of care are, however, often difficult to define and, unless observed directly, are greatly affected by the quality of documentation—a major limitation in low- resource settings. Table 3 displays a set of indicators selected for the assessment of process of care of EmONC and the main causes of maternal and newborn mortality targeted.

**Table 3. EmONC M&E process indicators**

EmONC Process indicator		Indicator Assessed	Main Conditions Targeted
1	Administration of oxytocin within 1 minute of delivery	Proportion (%) of deliveries at the health facility for which oxytocin was delivered within 1 minute of delivery	Postpartum hemorrhage
2	Appropriate use of partograph	Proportion (%) of deliveries at the health facility for which partograph was filled in appropriately for monitoring of fetal heart rate and maternal condition and reporting the outcome of labor	Obstructed labor, preeclampsia/eclampsia perinatal asphyxia, postpartum hemorrhage
3	Appropriate monitoring of maternal blood pressure	Proportion (%) of deliveries at the health facility for which blood pressure was monitored <i>at least</i> every 4 hours during labor	Preeclampsia/eclampsia
4	Appropriate newborn resuscitation	Proportion (%) of newborns at risk of perinatal asphyxia documented to have received appropriate resuscitation <i>Risk of perinatal asphyxia defined by: 5 minute Apgar score &lt;7 or irregular shallow breathing or pulse rate &lt;60 beats/minute</i>	Perinatal asphyxia
5	Maternal death audits	Proportion (%) of sampled maternal deaths for which mortality audit was conducted	All
6	Perinatal death audits	Proportion (%) of total perinatal deaths reported and total number audited	All

## 3.0. SECTION II: RESOURCE MATERIALS

In this section, resources required for each phase of the M&E planning, implementation, and dissemination phases of the M&E cycle are provided.

### 3.1. Planning for M&E

The success of the M&E exercise is dependent on adequate preparation. Early identification of relevant stakeholders and their appropriate engagement allows for the incorporation of diverse views and preferences in the approach to conducting the exercise and timely modification where challenges are anticipated.

#### 3.1.1. Selection of Target Facilities

Health facilities are the primary units of the assessment. The approach to selection of target health facilities must therefore aim toward ensuring representativeness of the facilities in the region. Health facilities that attend to large volumes of clients and those with a high burden of maternal and newborn mortality should be prioritized during the selection process. However, both Tier 2 (health centers and dispensaries) and Tiers 3 and 4 (subcounty and county hospitals) should be included in the selection to provide data on the availability of BEmONC and CEmONC services, respectively. Attempt to ensure that the facilities selected are distributed across all regions of the county. Select health facilities that have been included in previous assessments before considering new facilities, to allow for the comparison of performance over time.

Upon identification of potential target health facilities, formal communication of the intended exercise needs to be delivered to the respective health facility administrators through the county health management teams. It is important to receive feedback from the health facilities confirming participation in the exercise and to take note of issues raised that may present challenges during the assessments.

#### 3.1.2. Participant Selection for Orientation Meetings

The orientation meeting is an opportunity to communicate the purpose, objectives, approach, and expected outputs of the EmONC assessments to a diverse audience of stakeholders at a single venue. Effective stakeholder engagement is critical for maximizing the impact of the data generated for decision making and resource allocation. The value of data is enhanced when stakeholders feel “included” during the design, implementation, and reporting of the M&E activity.

A significant part of the orientation meeting focuses on providing the participants with a detailed understanding of the M&E tools and their appropriate use. It is therefore important for the participants at the meeting to include people who will be responsible for the collection and reporting of data from the assessments at the health facilities. A target audience of 30 participants is appropriate. Invitations should be issued to members of the county and subcounty administration, including the county health executive and the county health director, health facility in-charges, maternity in-charges at the participating health facilities, health records information officers, and county M&E officers. Implementing partners conducting reproductive maternal and newborn health programs within the county are important stakeholders whose attendance is required to ensure coordination and harmony across ongoing and planned activities within the county. Timely delivery of invitations and follow-up communication to confirm attendance are essential to ensure participation by the target audience. Invited participants who are unable to attend the meeting should be requested to suggest appropriate alternative representatives.

#### 3.1.3 Organizing the Orientation Meeting

The orientation meeting should be scheduled to take place over one full day. Select a day that does not conflict with major activities that are likely to involve key participants. Planners need to account for the duration of travel to and from the destination of the meeting that can, in some regions, take up to one day.



The key objectives of the meeting are:

1. To describe the basis for and ensure uniform understanding of the EmONC scale-up exercise to all relevant stakeholders within the county, including county health officials, health facility administrators, health records information officers, implementation partners, and donors involved in maternal, newborn, and child health activities
2. To disseminate the findings of previous EmONC assessments at both national and county levels and to summarize progress toward achieving existing targets
3. To communicate the approach to conducting the health facility assessments, emphasizing the importance of data quality and timeliness of reporting
4. To orient the participants on the structure of the M&E tools and provide practical demonstrations of the appropriate approach to completion of the tools

### *Venue of the Meeting*

A suitable venue needs to be identified and reserved at least one month ahead of the meeting.

Characteristics of a suitable venue include central location, ample security, capacity to host all participants, and proximity to accommodation facilities for individuals traveling long distances.

Aspects of the environment where the meeting is conducted, such as lighting, acoustics, ventilation, arrangement of furniture, seating capacity, stationery, availability of restrooms, and access to electricity sources to power equipment, such as liquid crystal display projectors and laptops, are all essential considerations in the selection of a venue for the meeting. Catering services need to be negotiated in advance, either internally with the management of the host venue or externally, and should accommodate varying dietary preferences of the participants. These factors create an optimal setting for effective communication and can have a major effect on the interpretation of the meeting by the audience.

#### **Attributes of a suitable venue for the orientation meeting**

1. Central location
2. Ample security
3. Capacity to host all participants
4. Proximity to lodging

### *Facilitators*

A good facilitator will have a sound understanding of the material to be presented. The facilitator should affirm

her authority to be a mentor for the participants as early as possible during the presentation, by describing her qualifications and experience. The facilitator should make an effort to ensure that all presentations are relevant, meaningful, and engaging. Active participation should be encouraged, and presentations should be carefully moderated to ensure that the views aired are sensitive to and reflect the diversity of the audience. The facilitator must prepare adequately, to ensure that the content can be delivered clearly and within the allocated time.

### *Program for the Orientation Meeting*

The program should be prepared ahead of the meeting and distributed to the prospective participants along with the invitations to attend the meeting. This ensures that participants are aware of the start and finish times and specific sessions scheduled. Printed versions should be available for participants as they register at the beginning of the meeting. Each activity on the program should have a time assigned.

[Appendix 1](#) offers a sample program for the orientation meeting.

#### **(a) Registration**

All participants should be requested to register upon arrival at the meeting venue. The registration form should include details of the participants' names, designation, institutional affiliation, telephone, and email contacts. Each person should receive a nametag at the registration desk.

#### **(b) Introduction**

The main facilitator should welcome the participants to the meeting and introduce himself to the participants. Allow the participants to briefly introduce themselves if time permits. The chief guest (if

present) or a representative of the county administration should be invited to provide opening remarks. It is useful to spend a few minutes at the beginning of the meeting going over the agenda and expectations of the participants during each session. Assign a timekeeper to ensure that each speaker observes the allocated time.

### **(c) Overview of EmONC**

Introduce the session and state the objectives:

1. To review the burden of maternal and newborn morbidity and mortality
2. To describe the basis for EmONC and the signal functions

The presentation should begin with a summary of the trends and current burden of maternal and newborn mortality at the global, national, and (if possible) county levels. A definition of EmONC and the signal functions should then be provided. Each signal function should be explained with an emphasis on the respective cause of maternal mortality targeted. Questions from the audience should be invited and the presentation should end with a short summary. Presentation slides for this session are provided in [Appendix 2 \[External link\]](#).

### **(d) Data quality and data flow presentations**

Introduce the session and state the objectives:

1. To describe the importance of collecting quality data
2. To discuss measures for ensuring data quality during the assessments

Practical examples can be given to illustrate the principles described. A guided discussion on the importance of observing the principles presented in the lecture should be held at the end of the presentation if time permits. Invite questions before summarizing the learning objectives for the session. The PowerPoint slides for this session are provided in [Appendix 3 \[External link\]](#).

#### *Flow of EmONC M&E Data*

The flow of data from the assessments of the health facilities to the generation of reports for dissemination will be displayed. Each step should be described in detail and participants should be encouraged to seek clarification where necessary. The PowerPoint slide for this presentation is provided in [Appendix 4 \[External Link\]](#).

### **(e) Introduction to the M&E tools**

Introduce participants to the session and state the objectives:

1. To illustrate the organization of the M&E tools
2. To discuss the standard operating procedures for data collection using the M&E tools

Provide the participants with a general description of the tool, by stating that it consists of 15 sections that must be completed. Proceed to describe the M&E tools listed below in detail with the aid of the data collection user manual provided in [Appendix 5 \[External link\]](#).

- EmONC/Maternal, Newborn, and Child Health Facility Assessment Tool. [Appendix 6 \[External link\]](#)
- EmONC Health Facility Assessment Excel Dashboard. [Appendix 7 \[External link\]](#)
- EmONC Monthly Monitoring Tool. [Appendix 8 \[External link\]](#)

Invite questions from the participants and terminate the session after providing a summary of the session linked to the objectives stated above.

### **(f) Practical session using revised data collection tool**

Introduce participants to the session and state the objectives:

1. To demonstrate the use of the EmONC assessment tool
2. To identify potential errors during data collection

This session will require an adequate number of printed copies of the participants’ version of the Mock EmONC Health Facility Assessment Tool described in [Appendix 9 \[External link\]](#) and one copy of the facilitator’s version of the Mock EmONC Health Facility Assessment Tool described in [Appendix 10 \[External link\]](#).

After distributing copies of the participants’ version of the tool, instruct the participants to use training provided in the preceding session to identify errors in the mock tool. This exercise should take approximately 10 minutes.

Initiate a group discussion on the errors identified and their possible solutions. Encourage active participation by those who are likely to be involved in data collection.

Invite questions from the participants relating to the exercise. Summarize the learning objectives once again and terminate the session.

### 3.2 Dissemination of Results and Action Planning

Dissemination events bring stakeholders together to share the findings and experiences of the implementation exercise. Dissemination and action planning represent the final activities in the M&E cycle and can be powerful platforms for advocacy. When selecting participants for the dissemination event, ensure that all stakeholders are represented (see “Selecting Participants for Orientation Meetings” above). As described in the section on planning for the orientation meeting, timely distribution of invitations is crucial for the success of the event. A sample agenda of the orientation meeting is provided in [Appendix 11](#).

While planning the meeting, consider the following qualities of effective communication:

1. Understanding the needs of the target audience

The primary aim of a dissemination meeting is to communicate. While preparing the content for the meeting, bear in mind that different members of the audience have different expectations, expertise, and language preferences. Table 4 illustrates the varying expectations of a hypothetical panel of stakeholders attending a dissemination meeting.

**Table 4: Stakeholder expectations of dissemination events**

Stakeholder	Expected Information
Funding organization	Are the goals of the project being met?
Hospital staff	How did we perform? What changes in our day-to-day work environment do I expect?
Partners	Did we achieve our objectives? What new interventions can we launch in the next phase of implementation?
County government	How do the achievements of this intervention compare with the county targets?
National government	How do the achievements of this intervention compare with the national targets?

## 2. Focusing on goals

The dissemination meeting should focus on informing and motivating the audience rather than simply reporting the findings. The facilitator must aim to contextualize the information to help the audience understand the importance of the results, and begin to consider the potential actions that should be taken in light of the findings.

## 3. Encouraging dialogue

There is evidence to suggest that dissemination strategies that result in new ideas and actions tend to be based on relationships and dialogue, rather than unidirectional flow of information. To encourage the target audience to understand and use the findings of the evaluation, encourage controlled discussions while sharing the findings.

## 4. Preparing a clear and focused presentation

The presentation should be concise and to the point. Aim to limit the number of slides highlighting the main results to 15. While presenting, spend more time on highlighting the key findings and recommendations. Be sure to define any specialist terminology and adopt an attractive and readable format (use no more than five bullet points per slide with a minimum font size of 28 for text). Break the monotony of large blocks of text by incorporating relevant images and graphs. An example of a slide deck that could be presented at a dissemination meeting is in [Appendix 12 \[External link\]](#)

### *Action Planning*

The process of action planning should take place after the presentation of findings of the results of the evaluation. Printed copies of facility profiles (a sample of one appears in [Appendix 13](#)) should be distributed to the participants to provide additional details on the performance of individual health facilities included in the assessment. Depending on the organization of the venue, participants may be divided into heterogeneous groups of up to five people to deliberate on possible actions for the subsequent phase of implementation based on the results presented. A standard format should be adopted for documenting action plans. (A generic template is provided in [Appendix 14](#).) The small groups should then reconvene and share their discussions with the other participants. A rapporteur should be appointed from among the members of the audience to document the discussions and compile minutes of the meeting and a consolidated action plan for sharing with the stakeholders, including those who are not in attendance.

## APPENDIX 1. SAMPLE EMONC ORIENTATION MEETING PROGRAM

### EmONC Health Facility Assessment County Orientation Programme

Time	Activity	Facilitator
0800 - 0830	Registration	MOH
0830 - 0900	Introductions	MOH
0930- 1000	Overview of EmONC	MOH/RH Coordinator
0900 – 0930	County MNH indicators	MOH
1030 - 1100	<i>Tea</i>	
1100 - 11.30	Ensuring quality data for M&E	Partner/MOH M&E staff
1130 – 1145	Flow of assessment data	Partner/MOH M&E staff
1145 - 1245	Data collection tools - Description of sections and procedure for completion	Measure Evaluation PIMA/Lead partner
1245 - 1345	<i>Lunch</i>	
1345 - 1600	Practical session using revised data collection tools	Measure Evaluation PIM /Lead partner
1600-1615	<i>Break</i>	
1615-1700	Feedback, next steps	MOH/Lead partner

## APPENDIX 2. OVERVIEW OF EMONC SLIDE PRESENTATION

Maternal and newborn mortality are major public health challenges in many low-income countries. Emergency Obstetric and Newborn Care (EmONC) is an integrated package of care that aims to equip health facilities with the capacity to provide evidence-based, cost-effective interventions to attend to the leading causes of maternal and newborn mortality. Two levels of care are recognized under this approach: basic (BEmONC) and comprehensive (CEmONC). BEmONC, provided at primary care facilities such as dispensaries and health centers, has seven essential medical interventions, known as signal functions. CEmONC, provided at hospitals, covers the seven BEmONC signal functions plus two more. This appendix is linked to a [PowerPoint deck](#) that provides a summary of the current estimates of maternal and newborn mortality by cause and the relevance of the EmONC strategy in tackling these causes, focusing on the signal functions.

## APPENDIX 3. DATA QUALITY FOR MONITORING AND EVALUATION

The availability of high quality data underpins the theoretical framework of the EmONC Scale-up intervention for which this toolkit has been designed. By providing data on performance across successive assessments at national, county, subcounty and health facility levels, decision makers are able to benchmark their capacities and prioritize identified needs. Experience from initial phase of the scale-up indicated the need for focused communication on the importance of data quality during orientation and dissemination exercises. The [PowerPoint deck linked to this appendix](#) outlines the generic elements of quality data to provide a basis for a guided discussion of the relevance data quality in the monitoring and evaluation of the national EmONC scale-up.

## APPENDIX 4. FLOW OF EmONC MONITORING AND EVALUATION DATA

Data for M&E of the national EmONC scale-up that are shared during orientation and dissemination meetings and other forums undergo a series of checks from the point of collection at the health facilities through the generation and dissemination of reports. This process ensures that the findings presented are an accurate reflection of the situation at each of the health facilities assessed. The [PowerPoint slide linked to this appendix](#) illustrates the flow of data from the point of collection at the health facility to the development of a final report.

## APPENDIX 5. EmONC/MNCH M&E DATA COLLECTION USER MANUAL

High-quality data are an important resource for the health sector in planning, managing, delivering, and monitoring high-quality, safe, and reliable health care. The purpose of this manual is to aid the teams conducting M&E of the national EmONC scale-up exercise at health facilities through the process of data collection, to ensure uniform interpretation of data sources, indicators, and methods across locations and over time. The manual is also required during training exercises in preparation for M&E activities. It is divided into sections A, B, and C that provide directions for the use of the monthly assessment tool, Excel dashboards, and the monthly monitoring tool, respectively. The complete manual is linked [here](#).



## APPENDIX 6. EmONC Health Facility Assessment Tool

Data collection shall be undertaken by a designated enumerator for each facility using the EmONC Health Facility Assessment Tool. The methods are interviews, visual inspection, and data abstraction from facility records, as guided by instructions in the tool. The Health Facility Assessment Tool comprises 15 parts that should all be completed. The tool is linked here: [EmONC Health Facility Assessment Tool](#).

## APPENDIX 7. EmONC HEALTH FACILITY ASSESSMENT EXCEL DASHBOARD

The Excel dashboard is used to automatically generate basic graphs summarizing performance of the EmONC signal functions at the county and subcounty levels. Data from all health facilities in the county that are collected using the tool and that are included in the assessment will be entered by the respective implementing partner/county M&E teams in a standard Excel template specific for the region.

The document consists of two worksheets:

The first tab is titled BEmONC Data Collection. Use this worksheet to enter the data collected in the health facility assessment tools.

The second tab is the Data Summaries & Dashboards sheet, which generates dashboards automatically. It is not to be completed or changed. The dashboard results can be used by the partner/county teams to disseminate EmONC assessment results and conduct action planning. A sample dashboard is linked here: [EmONC Health Facility Assessment Excel Dashboard](#).

## APPENDIX 8. EmONC MONTHLY MONITORING TOOL

Completion of the monthly monitoring tool is recommended for each facility. Data for this exercise may be collected through scheduled physical visits to health facilities or through telephone interviews with the maternity in-charges or other senior staff stationed in the maternity and newborn departments of the participating health facilities. The structure of the monthly monitoring tool is similar to the health facility assessment tool. It comprises three sections in a single Excel document.

**1. Instructions:** This section is found on the first tab of the Excel document. It provides direction on the approach to completion of the structure-related signal function (shaded green) and process of care (shaded brown) sections of the monitoring tool. This section of the tool can be printed for convenience when data are being collected.

**2. Monthly monitoring tool:** A summary sheet with a row for each facility details performance across the nine EmONC signal functions and four process of care indicators. A sampling strategy similar to that used in the Health Facility Assessment Tool described above is used (refer to Section 14.0) that aims to select up to 35 records for deliveries conducted at each health facility. This section of the tool should be printed and copied to accommodate the total number of health facilities in the county.

**3. County summary:** The subsequent tabs labelled “County Summary” are completed using data collected in the printed and filled monthly monitoring tools located in the second tab of the Excel spreadsheet and described in the previous paragraph. This section provides monthly summaries of performance for a year across the EmONC signal functions and process of care indicators for the participating health facilities. Sections of this spreadsheet that display computed summaries of performance are locked for editing and cannot be modified directly. The tool is linked here: [EmONC Monthly Monitoring Tool](#).

## **APPENDIX 9. MOCK EmONC HEALTH FACILITY ASSESSMENT TOOL: PARTICIPANT**

Use the Mock EmONC Health Facility Assessment Tool to train participants on how to complete the facility assessment tool appropriately. Download and print an adequate number of copies of the participants' version of the document through [this link](#).

## **APPENDIX 10. MOCK EmONC HEALTH FACILITY ASSESSMENT TOOL: FACILITATOR**

Use the Mock EmONC Health Facility Assessment Tool for facilitators to train participants on how to complete the facility assessment tool appropriately. Download and print a copy for each facilitator through [this link](#).

## APPENDIX 11. SAMPLE PROGRAM FOR DISSEMINATION MEETING

### Program for EmONC Health Facility Assessment County Dissemination and Action Planning Meeting

Time	Activity	Facilitator
0800 - 0830	Registration	MOH
0830 - 0900	Introductions and outline of objectives	MOH
0930- 1015	Presentation of assessment results: county and facility profiles	MOH/RH coordinator/ M&E staff
1015 - 1100	Plenary discussions on assessment results	MOH/partner
1100 - 1130	<i>Tea</i>	
1130 - 13.30	Action planning	MOH/partner
1330 - 1430	<i>Lunch</i>	
1430 - 1530	Action planning	MOH/partner
1530 -1630	Plenary: Feedback on facility action plans	MOH/partner
1630 - 1700	Next steps and close	MOH/partner

## APPENDIX 12. SAMPLE PRESENTATION FOR DISSEMINATION MEETING

The dissemination meeting is a unique opportunity to communicate the findings and experiences of the implementation exercise to multiple stakeholders at a single event. It is the final activity in the M&E cycle. The main presentation summarizing the findings of the assessment should focus on informing and motivating the audience rather than simply reporting the findings. The facilitator must aim to contextualize the information to help the audience understand the importance of the results, and begin to consider the potential actions that should be taken in light of the findings. The [PowerPoint deck linked here](#) is an example of an EmONC assessment dissemination presentation. It should be modified to with relevant content.

## APPENDIX 13. SAMPLE HEALTH FACILITY PROFILE (FOR ILLUSTRATIVE PURPOSES ONLY)

### County EmONC Health Facility Profile Phase II

The facility profiles provide summaries of data collected on the availability of selected items required for the provision of the seven BEmONC signal functions from each facility surveyed in the county.

BEmONC Signal Function (SF)		Item Assessed
1	Administration of parenteral antibiotics	Availability of crystalline penicillin / ampicillin + gentamicin + metronidazole
2	Administration of uterotonic drugs	Availability of oxytocin
3	Administration of parenteral anticonvulsants	Availability of magnesium sulphate
4	Manual removal placenta	Availability of elbow-length gloves
5	Removal of retained products	Availability of manual vacuum aspiration kits
6	Performance of assisted vaginal delivery	Availability of vacuum extractor for assisted vaginal delivery
7	Performance of basic neonatal resuscitation	Availability of neonatal bag valve mask device
	Guidelines	National Guidelines for Quality Obstetrics and Perinatal Care
	Training	Proportion (%) of health workers working in maternity/newborn departments trained on the harmonized BEmONC training course in the preceding 12 months

## Sample Facility Profile Muranga County: EmONC Signal Functions

SF – Signal Function

1 - Able to Perform

0 – Unable to Perform

M – Missing data

! Error

Facility Name	Facility level	Injectable antibiotics	Oxytocin	Magnesium sulphate	Elbow-length gloves	MVA kit / misoprostol	Vacuum extractor	Pediatric Ambubag	C-section set	Blood transfusion set
Makuyu HC	HC/ Disp	0	1	1	0	1	1	1	0	0
Sabasaba HC	HC/ Disp	0	1	1	0	1	1	0	0	0
Maragua Ridge HC	HC/ Disp	1	1	1	1	1	1	1	0	0
Kandara SCH	Hospital	1	1	1	1	1	0	1	0	0
Muran'ga CRH	Hospital	1	1	1	1	1	1	1	1	1
Kangema SCH	Hospital	1	1	1	1	1	1	1	0	0
Kigumo SCH	Hospital	1	1	1	0	1	1	1	0	1
Muriranjias SCH	Hospital	1	1	1	1	1	1	1	0	1
Maragua DH	Hospital	1	1	1	1	1	1	1	1	1



Sample Facility Profiles: EmONC Process of Care

Facility Name	Level	HCW trained on BEmONC (%)	Oxytocin use for AMTSL (%)	Appropriate partograph use (%)	BP monitoring in labour (%)	Newborn resuscitation (%)	KMC for low birth weight neonates (%)	Audited maternal deaths (%)	Audited perinatal deaths (%)
Makuyu HC	HC/Disp	27	55	64	57	0	NA	NA	NA
Sabasaba HC	HC/Disp	0	16	39	16	NA	NA	NA	NA
Maragua Ridge HC	HC/Disp	57	71	90	90	0	NA	NA	NA
Kandara SCH	Hospital	0	45	54	30	100	NA	NA	NA
Muran'ga CRH	Hospital	0	100	77	77	67	NA	100	NA
Kangema SCH	Hospital	60	100	79	79	100	NA	NA	NA
Kigumo SCH	Hospital	0	52	33	2	NA	NA	NA	NA
Muriranjias SCH	Hospital	0	100	6	6	100	NA	100	NA
Maragua DH	Hospital	39	60	38	36	20	NA	100	NA

NA: No observations

## APPENDIX 14. TEMPLATE FOR DOCUMENTATION OF ACTION PLANS

EmONC Health Facility Assessment

Template for County Action Plan Development

Assessment Area	Gaps identified	Proposed Solutions	Progress	Target	Timeframe	Responsible Person	Resources
IV antibiotics (SF 1)							
Oxytocin (SF 2)							
Magnesium sulphate (SF 3)							
Elbow-length gloves (SF 4)							
MVA kits / misoprostol (SF 5)							
Vacuum extractors (SF 6)							
Neonatal ambu bags (SF 7)							
Caesarean section sets (SF 8)							
Blood transfusion sets (SF 9)							
EmONC training							
Guidelines							
Staffing							
Equipment							
Hygiene and sanitation							
Power supply							
Linking MPDSR to EmONC							
Process indicator 1							
Process indicator 2							
Process indicator 3							
Process indicator 4							
Quality improvement							

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