INFLUENCE OF MONITORING AND EVALUATION SYSTEMS ON PROVISION OF HEALTH CARE SERVICES IN PUBLIC HEALTH INSTITUTIONS IN MIGORI COUNTY, KENYA

BY

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DECLARATION

This research project is my original work and has not been presented for the award of a degree in any other university.

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DEDICATION

This project is dedicated to my family members; my wife Rose Ondigo and Children Joab Sammy Oduol and Bradley Elly Oduol for the moral support during the process of the research writing.

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ABBREVIATIONS AND ACRONYMS

AMREF:	African Medical and Research Foundation
CBO:	Community-Based Organization
CRIS:	Country Response Information System
DfID:	Department for International Development
CHMT:	County Health Management Team
CMOH:	County Medical Officer of Health
DSS:	Demographic Surveillance System
CTC:	County Technical Committee
GoK:	Government of Kenya
M&E:	Monitoring and Evaluation
MCG:	Monitoring and Coordination Group
MoH:	Ministry of Health
NIMES:	National Integrated Monitoring and Evaluation System
WHO:	World Health Organization
USAID	United States Aid for International Development

ABSTRACT

Provision of health services in hospitals lack priority that it should enjoy in terms of monitoring and evaluation. Developed countries have pursued results orientated development initiatives by adopting more effective monitoring and evaluation practices in health care services provision. Monitoring and Evaluation systems allow project activities to be measured and analyzed. The purpose of the study was to establish the influence of Monitoring & Evaluation systems on the provision of health care services in Public Health Institutions in Migori County, Kenya**.**This study was guided by the following research objectives; human capacity for Monitoring & Evaluation, partnership for managing Monitoring & Evaluation, Monitoring & Evaluation work plan and data auditing on Monitoring &Evaluation. The research design used was descriptive survey. The study targeted a sample of 60 doctors, 102 Nurses, 43 M&E officers, 9 social workers, 16 community health volunteers and 55 patients. The data collection instruments included a questionnaire and an interview guide. Data analysis was descriptive in the form of frequencies and percentage. Multiple regression was conducted .From the study findings, data collection was regular with data analysis carried mainly through SPSS21. The study found out that technical support increased the knowledge on monitoring and evaluation systems. Donor partnership was involved influenced provision of health services in public health institution to a moderate extent. The respondents agreed that data quality assurance in M&E influenced provision of health care services. The study concluded that technical support increased the knowledge on monitoring and evaluation systems to a moderate extent. Communication among organization involved influenced provision of health services in public health institution to a moderate extent. Inventory of organizations involved. Availability of skilled labour influenced provision of health services in public health institution to a great extent. Regular data assessment influenced provision of health services in public health institution to a great extent. The public health institution management should offer technical support to the personnel. The stakeholder support needs to be documented. The County government needs to encourage donor partnership so as to improve health services in public health institutions. The County government needs to employ qualified skilled labour. The management needs to conduct a regular data assessment.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Monitoring is an ongoing function that employs the systematic collection of data related to specified indicators in Public projects. Monitoring and evaluation is a tool in project management. Project management is possibly the second oldest profession (Ballard, 2013). Monitoring and evaluation (M&E) is described as a process that assists project managers in improving performance and achieving results (Agutu, 2014). The goal of M&E is to improve current and future management of outputs, outcomes and impact (United Nations Development Programme, 2015). Williams (2014) asserts that monitoring provides management and the main stakeholders of a development intervention with indications of the extent of progress and achievement of expected results and progress with respect to the use of allocated funds. Monitoring provides essential inputs for evaluation and therefore constitutes part of the overall evaluation procedure. Evaluation is an organised and objective assessment of an ongoing or concluded policy, program/project, its design, execution and results. The aim is to provide timely assessments of the relevance, efficiency, effectiveness, impact and sustainability of interventions and overall progress against original objectives. According to Ballard (2013), monitoring and evaluation is a process that helps program implementers make informed decisions regarding program operations, service delivery and program effectiveness, using objective evidence.

Since the early 1990s, monitoring and evaluation (M&E) has seen a steep climb within Africa–in terms of practice, profession and academic study (Hassan, 2013). As a field of practice, specialized departments housing the practitioners now exist and the demand for evaluation of policies, projects, programs and interventions remains on the increase (Shapiro, 2011). Legal and institutional frameworks for the practices of M&E are still weak. As a profession, over 30 national evaluation associations under the umbrella body – the African Evaluation Association (AFREA) are in existence. As an academic field of study several universities now offer programs in M&E; notwithstanding the focus and locus dilemma regarding the discipline (Agutu, 2014).

Many countries especially the developed ones have pursued results orientated development initiatives by adopting more effective monitoring and evaluation practices in health care services provision. As part of the broader efforts to institutionalize Managing for Development Results (MfDR), most Governments such as SriLanka, Canada, USA among others have taken specific steps to strengthen Results-based M&E System at their national level (United Nations Capital Development Fund, 2000). M&E has served as an integral part of the development policy/programme cycle in improving the performance accountability to provide effective feedback, which has improved planning, budgeting and policy making that has achieved development effectiveness Agutu (2014). Chile, meanwhile, has a long history of sound monitoring and evaluation of programs in their health sectors. Working with country teams, we are supporting the Ministry of Planning and of Health improve the M&E of their social programs. Currently, Chile introduce ex-ante (before event) and ex-post (after event) evaluation methods and

set up guidelines to carry out M&E in the ministry of Health throughout the country (Parks et al., 2012).

The Canadian M&E system has invested heavily in both evaluation and performance monitoring as key tools to support accountability and results-based management in their health institutions (Georgieva & Allan, 2013). Additionally, the current state of the M & E system has evolved over time, as the central designers have recognized that the development and implementation of monitoring and evaluation is long term and iterative therefore putting emphasis on the "process" of implementation as an important mechanism in itself in developing an "evaluation culture" or "results culture" in an organization and across the entire system (Agutu, 2014).

Scholarship regarding the state of the field is thus of utmost importance to coherently describe the 'ups and downs' of the new field which has become a 'grown up child' having jumped the infancy stage (Parks et al., 2013). For instance, The South African model has encountered many challenges because of a lack of direction in ministries to work together and achieve the stated outcome set by the Presidency Office (Lahey, 2010). Together with country teams, we are working with the Ministry of Rural Development and Land Affairs, a pioneer in carrying out rigorous evaluation, to help them develop and implement their M&E strategic plan and to sequence their actions to build the foundations of a sound M&E in the ministry (Ling et' al, 2010). Project M & E performance can be measured and evaluated using a large number of performance indicators that could be related to various dimensions (groups) such as time, cost, quality, client satisfaction, client changes, business performance, health and safety (Cheung et al., 2014). Time, cost and quality are, however, the predominant performance evaluation

dimensions. Another interesting way of evaluating project performance is through common sets of indicators (Pheng & Chuan, 2016).

In Ghana, after several years of implementing the national M&E system, significant progress has been made (Clear, 2012). However, challenges include severe financial constraints; institutional, operational and technical capacity constraints; fragmented and uncoordinated information, particularly at the sector level (DETR, 2010). To address these challenges the Clear report argues that the current institutional arrangements will have to be reinforced with adequate capacity to support and sustain effective monitoring and evaluation, and existing M&E mechanisms must be strengthened, harmonized and effectively coordinated operational and technical capacity constraints; fragmented and uncoordinated information, particularly at the sector level (Ling et' al, 2010).

In furtherance of the same objective, the National Integrated Monitoring and Evaluation System (NIMES) was established in 2004 by the Kenyan government (GOK, 2013). NIMEs was launched during the London investment summit 2012. The system is used to trace development at both National and County government level in the current devolved system of governance GOK, (2013).

1.1.1 Human Capacity for Monitoring and Evaluation

Understanding the skills needed and the capacity of people involved in the M&E system (undertaking human capacity assessments) and addressing capacity gaps (through structured capacity development programs) is at the heart of the M&E system (Gorgens & Kusek, 2013). The lack of capacity in low-income countries is one of the main constraints to achieving the Millennium Development Goals. Even practitioners

confess to having only a limited understanding of how capacity actually develop (Gorgens & Kusek, 2013). Building an adequate supply of human resource capacity is critical for the sustainability of the M&E system and generally is an ongoing issue. Furthermore, it needs to be recognized that "growing" evaluators requires far more technically oriented M&E training and development than can usually be obtained with one or two workshops. Both formal training and on-the-job experience are important in developing evaluators with various options for training and development opportunities which include: the public sector, the private sector, universities, professional associations, job assignment, and mentoring programs (Acevedo et al., 2010).

Regardless of how experienced individual members are, once a team to implement a project has been identified, training and capacity building for M&E reporting is important. This, it has been observed, enhances understanding of the project deliverables, reporting requirements and builds the team together (Wysocki & McGary, 2013). Generally, everybody involved in project implementation is also involved in the implementation of M&E, including partners, and should receive training (Acharya *et al,* 2016). Training of implementers in M&E is deliberately participatory to ensure that those responsible for implementing and using the system are familiar with its design, intent, focus, and how to use the M&E tools.

Health planners and managers are concerned with capacity because it enables performance. For example, a health facility that experiences regular stock-outs of pharmaceuticals might require additional capacity in financial planning or supplies management. It follows that a capacity development strategy for improving

pharmaceutical supply would call for a different approach than one aimed at strengthening community involvement in health. The link between capacity and performance, therefore, serves as the guide for both programming and evaluation of capacity-building interventions. Improved performance, in turn, is a good indicator of success in capacity development (Gorgens & Kusek, 2013).

In assessment of quality provision of Health care in the Nepal, UNDP (2015) discusses some of the challenges of organizational development as having inadequate monitoring and evaluation systems. Additionally, the lack of capabilities and opportunities to train staff in technical skills in this area is clearly a factor to be considered. During the consultation processes, there was consensus that their lack of monitoring and evaluation mechanisms and skills was a major systemic gap across the region (Adan, 2013). Furthermore, while there is no need for CSOs to possess extraordinarily complex monitoring and evaluation systems, there is certainly a need for them to possess a rudimentary knowledge of, and ability to utilize reporting, monitoring, and evaluating systems. There is a constant demand for training in planning, monitoring, review, evaluation and impact assessment for both program staff and partners in projects (Gosling & Edwards, 2013).

Skills for numeracy, literacy, interviewing and monitoring in qualitative and quantitative methods, for management information systems are necessary for participatory monitoring and evaluation (Adan, 2013). Staff need to be trained not only on collecting descriptive information about a health program, product, or any other entity but also on using something called “values” to determine what information and to draw explicitly evaluation inferences from the data, that is inferences that say something about the

quality, value or importance of something (Davidson, 2014). Players in the field of project management like project and programme managers, M and E officers, project staff and external evaluators will require specialized training not just in project management and M and E; but specifically in areas like Participatory monitoring and evaluation and results based monitoring and evaluation (Murunga, 2015).

1.1.2 Partnerships in Planning and Managing Monitoring and Evaluation

In order to ensure successful project implementation as per the set goals and objectives, governments and private businesses are continuously getting involved in the process of monitoring and evaluation. Monitoring and evaluation provides development partners with answers to questions like; what development interventions make a difference? Is the project having the intended results? What can be done differently to better meet goals and objectives? Monitoring and evaluation are therefore important management tools which are used to track project progress and facilitate decision making for better performance of the project. When planning for monitoring and evaluation, there are key steps that should be taken into account; firstly, identifying who will be involved in design, implementation and reporting which involves engaging stakeholders to ensure their perspectives are understood and feedback incorporated. Secondly, clarifying the scope, purpose, intended use, audience and budget for evaluation. Thirdly, developing the questions to answer what you want to learn as a result of the project. Fourthly, selecting measurable indicators and fifth, determining the data collection methods. Evaluation aims to analyze the past to understand the future of the project (Gaventa and Blauert, 2014). Providing support and strengthening of M & E team is a sign of good governance. Providing support and

strengthening of M&E team will also play a key role in ensuring that the M & E team adds value to the organizations operations (Naidoo, 2011). A motivated team usually achieves high performance.

Most scholars of project monitoring and evaluation argue that planning for M&E should be done just at the very point of project planning (Kohli & Chitkara, 2013) while a few contend that it should be created after the planning phase but before the design phase of a project or intervention (Nyonje *et al* 2015). Despite this difference in opinion however, almost all scholars agree that the plan should include information on how a project should be assessed (Cleland & Ireland, 2017).

From the studies reviewed, it has been noted that an M&E plan generally outlines the underlying assumptions on which the achievement of project goals depend, the anticipated relationships between activities, outputs, and outcomes- the logical framework. Other contents of an M&E plan are well-defined conceptual measures and definitions, along with baseline data needed; the monitoring schedule; a list of data sources to be used; and cost estimates for the monitoring and evaluation activities. Most plans also include a list of the partnerships and collaborations that will help achieve the desired results; and a plan for the dissemination and utilization of the information gained (Olive, 2014; Wysocki & McGary, 2015; Mackay, 2017; Alcock, 2013; Nuguti, 2015). This demonstrates that planning for monitoring and evaluation takes care of all aspects that need to be in place so that there is early detection of progress or lack thereof.

Literature also reveals that there are important considerations for an M&E plan: Brignall & Modell (2014) categorises these considerations into resources - how much money and

time will be needed to conduct the activities. Capacity - does the project have internal capacity to carry out the proposed monitoring and evaluation activities; including analysis of data collected? Other considerations made and also acknowledged by Armstrong & Baron (2015) are Feasibility- Are the proposed activities realistic? Can they be implemented? Timeline - Is the proposed timeline realistic for conducting the proposed activities? Ethics - What are the ethical considerations and challenges involved with implementing the proposed activities, and is there a plan in place for addressing those considerations? Has a protocol been submitted for review to a research ethics committee? With these considerations, it can be said that M&E planning is complete in terms of coverage for the purposes of giving an oversight on project direction during implementation (Mackay 2017).

1.1.3 Monitoring and Evaluation Work Plan

M&E plan is fundamental on any health care project. It provides the schedule to be followed on the project implementation to its sustainability. The Program Evaluation Standards, James (2013) indicates that, M&E plan involves evaluation of resources. The budget could certainly be more carefully estimated and actual expenditure on the evaluation more carefully monitored. The problem of cost overruns during evaluation has been raised up by several evaluators. Smith & Chircop (2013) say that financial resources are needed for the time people spend, for supporting information management system, training, transport and so forth. Key items to include in the budget are contracts for consultants/external expertise, physical non contractual investment costs, recurrent labour cost, focused labour input, training and study tours for M&E related capacity building,

and nonoperational costs like stationery, meetings, allowances for primary stakeholders and project implementers (John, 2017).

Among South African NGOs, there was widespread adherence to the logical framework as a foundation for evaluation and reporting with its‟ use as a planning tool locking organizations into established timeframes and specified outputs (Applebaum, 2017). These rigid timeframes of project funding and 14 LFAs do not accord well with the complex uneven nature of development work (Smith & Chircop, 2013). Furthermore, quantitative rather than qualitative indicators could be used to advantage as they were easily measured to demonstrate success while qualitative measures of how much was understood or subsequently used were largely avoided (Bornstein, 2016).

1.1.4 Monitoring and Evaluation on Data Auditing

The source of performance data is important to the credibility of reported results hence, it is important to incorporate data from a variety of sources to validate findings. Furthermore, while primary data are collected directly by the M&E system for M&E purpose, secondary data are those collected by other organizations for purposes different from M&E (Gebremedhin, Getachew & Amha, 2015). In the design of an M&E system, the objective is to collect indicator data from various sources, including the target population for monitoring project progress (Barton, 2013). The methods of data collection for M&E system include discussion/conversation with concerned individuals, community/group interviews, field visits, review of records, key informant interviews, participant observation, focus group interviews, direct observation, questionnaire, one-time surveys, panel surveys, census, and field

experiments. Moreover, developing key indicators to monitor outcomes enables managers to assess the degree to which intended or promised outcomes are being achieved (Kusek & Rist, 2004 The utilization of M&E information is central to the performance and sustainability of an M&E system and depends on the nature and strength of demand for M&E information (Mackay, 2017). Utility requires that commissioners and evaluators undertake the evaluation with the intention to use its results; that they undertake the evaluation at a time when the results can meaningfully inform decision making processes; and that evaluations be accessible. Otieno (2016) study indicates that the majority of the respondents were involved in 17 utilization of the monitoring and evaluation results in ways such as involvement in decision making of the project, redesigning of the project, strengthening/ improvement, advocacy for additional resources, program intervention of the project and project control. However, the low involvement of project members in project control after the offset of the implementing agency contributed to the immense negative impact of the current low degree of sustainability of the project performance. Incentives need to be introduced to encourage the use of performance information meaning that success needs to be acknowledged and rewarded, problems need to be addressed, messengers must not be punished, organizational learning is valued, and budget savings are shared (Kusek & Rist, 2014). The external demand for specific information on outcomes and impacts plays a key role in promoting measurement of those aspects of development work and in keeping the system honest overall. However, where external or internal demand is lacking, or where performance information is not linked to the reward system, the incentives for generating

and using performance information are deficient and, not surprisingly, M&E systems are weak (Thomas, 2014).

AusAID (2015) report, in Australia indicates that feedback during project implementation from local project staff and the opportunity for beneficiaries to influence appropriate revisions to project activities contributed to the quality of monitoring information in health care projects. Additionally, to improve performance information good baseline data combined with ongoing consultation with beneficiaries provides a firm basis upon which to make judgments about appropriate and timely interventions, and later about the achievement of major development objectives. Baseline data and needs assessments provide the information you need against which to assess improvements caused by project implementation over time thus in order to evaluate the impact your project has on the lives of beneficiaries, you have to be familiar with the situation of the beneficiaries before project implementation (Hunter, 2016). A baseline study will be necessary for most activities as it is important to find out what 18 information is already available. If baseline information will not be used (or subsequently replicated) to improve the quality of activity implementation or to measure development results, then the reason for collecting the data should be seriously questioned (USAID, 2015). Baseline data should provide only the minimum information required to assess the key aspects of quality of the activity delivery and measure the development results (including the eventual impacts). Anything more than this is likely to be a waste time, effort and resources and risks making the baseline study not replicable (UNDP, 2014).

1.2 Statement of the Problem

Quality monitoring and timely feedback help in controlling the workmanship thus enhancing the quality of a project. If each part of the activity of a project is monitored effectively and instances of poor workmanship and wastage of resources be it material, labor or plant and machinery are reported promptly, it aids in achieving the desired quality level, UNAIDS (2015).

Activities that define control are rescheduling activities, reallocating resources and altering project objectives. Kursave, (2013) reflects that monitoring and control ensure that all of the changes are incorporated into the original plan. Subramanian *et al,* (2010) focus on the aspects of learning, control, efficiency, and flexibility, identifying potential for improvement in those areas. As Faniran *et al,* (2014) stated, the purpose of carrying out these projects monitoring and control strategies is to complete a project within a scheduled time and cost and to specified quality standards. This understanding shows that monitoring and control cannot be separated from project performance. Ling & Chan (2012) and Thomas *et al, (*2013) use project performance as the basis for evaluating the effectiveness of project delivery processes. They describe project performance as the assessment of project success and use objective factors, including time, cost and quality objectives, and subjective factors, which are concerned with the assessment of stakeholders' satisfaction.

During the last 4 years of implementation county health sector, the coordinator of the project, learned several lessons including the accountability and effective monitoring of the community grants and government grants which were a major part of the

decentralization of health sector. Despite the existence of a Financial Management Agency (FMA), the lack of an effective M&E system negated the flow of information on how the community grants were used and the compliance to approved proposals and the contracts signed with the FMA. Furthermore, the lack of an effective M&E system meant that project outcomes could not be ascertained (USAID, 2017).

A study conducted by Lwala Community Alliance (LCA) a non-profit health and development agency working in Migori County in western Kenya indicated that through the Lwala Community Hospital, the organization provides 30,000 patient visits each year which has challenges such as the number of patient visits continues to increase which drives the need for more hospital space and more clinical staff (WHO, 2017). The mission of the organization is to meet the health needs of all people living in north Kamagambo, including its poorest part. The hospital is part of a larger effort to achieve holistic development in Lwala, including educational and economic development. Through this study there is need to determine the level of provision of health care services in the county through monitoring and evaluation.

In this study, we seek to establish whether the lessons learned during decentralization of the health sector are applied to improve the M&E, and ultimately, improving the county health care. Monitoring and Evaluation processes must be built in and tied to other project management practices to ensure that what is being implemented is per plan and delivers the intended results and outcomes. This study therefore sought to determine the influence of Monitoring and Evaluation practices on the provision of health care services in Migori, Kenya.

1.3 Purpose of the Study

This study sought to determine the influence of Monitoring and Evaluation systems on the provision of health care Services in public health institutions in Migori County, Kenya.

1.4 Objectives of the Study

This study was guided by the following objectives:

i. To determine the extent to which human capacity for Monitoring and Evaluation influence provision of health care services in public health institutions in Migori County, Kenya

ii. To assess how partnerships in planning and managing Monitoring and Evaluation Influence provision of health care services in public health institutions in Migori County, Kenya

iii. To establish the extent to which Monitoring and Evaluation work plan influence the provision of health care services in public health institutions in Migori County, Kenya

iv. To assess how Monitoring and Evaluation on data auditing influences provision of health care services in public health institutions in Migori County, Kenya**.**

1.5 Research Questions

This study answered the following research questions:

i. How does human capacity for Monitoring and Evaluation systems influence health care services in Migori County, Kenya?

ii. How does partnership for managing Monitoring and Evaluation systems influence health care services in Migori County, Kenya?

iii. To what extent does Monitoring and Evaluation work plan influence provision of health services in Migori County, Kenya?

iv. How does Monitoring and Evaluation data auditing on Monitoring and Evaluation influence health care services in Migori County, Kenya?

1.6 Significance of the Study

It is hoped that the findings of this study would be found useful by relevant government ministries among them include ministry of health, devolution and other health related organizations in providing information on factors influencing Monitoring & Evaluation systems on provision health services. It would also assist in formulating public policies on health related subjects by the authorities to ensure health sustainability. It is also significant to health related professions such as psychologists, sociologists on determining the health statistics through monitoring and evaluation. Moreover, it is also hoped that the findings of this study will add knowledge to the exiting literature on the subject. The study would provide drive upon which other related studies could be

anchored. Finally, it is hoped that this document would act as a source of reference to all scholars and interested researchers on the topic.

1.7 Basic Assumptions of the Study

The study was conducted under the assumption that the respondents are available and that they will give honest responses. This study assumes that provision of health care services is highly dependent on monitoring and evaluation systems in Migori County, Kenya. This study assumed that monitoring and evaluation in the health sector projects in the region need scrutiny for effective health care services.

1.8 Limitation of the Study

Migori County is expansive and has 223 health facilities scattered which means that high travelling costs was incurred, however the research used questionnaires to help gather information within the shortest time possible. Limited resources for doing the research were a barrier in this study; this is because the researcher needs to employ research assistants to help in the collection of data. This was handled by ensuring the researcher will work on the specified budget time and scope. The findings can only be relevant to Migori County because health statistics on monitoring and evaluation may differ from one county to another. Another limitation is that it was likely to be tiring and time consuming. The researcher did not get all the questions answered correctly by the sampled population and sometimes they may hide some useful information especially that is touching on data auditing for fear of the unknown or disclosure of the information to other parties. This was overcome by the researcher assuring the respondents that the

study was purely for academic purposes and all the information given here would not be divulged to any other third party and all the concern of ethical issues would observed.

Other limitation that the researcher may encounter is the distances to travel to reach the health facilities since the area is so large. This, the researcher overcame by engaging research assistant and also hire some cabs for transport to reach all the health facilities targeted.

1.9 Delimitations of the Study

The study only looked at health care services in the county mainly on the government sponsored facilities because they have a standardized way of management altogether. The study was only in process at the specified time, and scope and it was targeting the health care services. We only gave questionnaires and interview the respondents who were willing and comfortable for the exercise. This was geared towards retaining confidentiality.

This study was delimited to cover only the influence of Monitoring and Evaluation systems on the provision of health care Services in public health institutions in Migori County. This is because the researcher is a monitoring and evaluation officer in Migori County. Another delimitation is that, although monitoring and evaluation systems require 12 main components to function effectively and efficiently in order to achieve the desired results in health, the researcher was delimited to the aspects of human capacity, partnerships in planning and managing Monitoring and Evaluation systems, Monitoring and Evaluation work plan and Monitoring and Evaluation data auditing in relation to provision of health care services in public health institutions in Migori County because

these four components of monitoring and evaluation systems are the main hindrance to achieving desired results in provision of health care in Migori county **.**

1.10 Definition of Significant Terms used in the Study

Evaluation: The rigorous, science-based collection of information about health care services and activities, characteristics, outcomes and impact that determines the merit or worth of the measures put in place.

Monitoring: The routine tracking and reporting of priority information about health care services and its intended outputs and outcomes.

Monitoring and Evaluation Systems: All the indicators, tools and processes that you will use to measure if a program has been implemented according to the plan (monitoring) and is having the desired result (evaluation). An M&E system is often described in a document called an M&E plan.

Provision of health care services: This refers to the way inputs such as money, staff, equipment and drugs are combined to allow the delivery of a series of interventions or health actions. The goal of provision of health services is to protect and improve the health of individuals and defend populations from diseases.

Human capacity for Monitoring and Evaluation: This is defined as the capabilities of employees in a health institution to perform their monitoring and evaluation duties efficiently, effectively and sustainably to support the

M&E system. For the system to perform employees should have the skills and experience.

Partnership for managing Monitoring and Evaluation: This is an arrangement where the government, organizations and the health care centers known as partners, agree to cooperate to advance their mutual interest in provision of a quality monitoring and evaluation in provision of health care services.

Monitoring and Evaluation Plan: This is a work plan document/activities a health institution use to organize a health project in monitoring and evaluating its performance.

Data auditing on Monitoring and Evaluation: This is overseeing and profiling the data collected in monitoring and evaluation practices in health institutions and assessing the impact of poor quality data on the health institution performance.

1.11 Organization of the Study

Chapter one outlines various sections used in this research study which includes: introduction on monitoring and evaluation practices in provision of health care services; background on the study; objectives of the study; research questions; delimitation; limitation; assumption of the study and definition of significant terms.

Chapter two of the study will examine the literature review; theoretical background of the study and conceptual framework was illustrated diagrammatically to show the relationship between the independent variable and the dependent variables.

Chapter three will demonstrate the research design, research methodology. The validity and reliability of the research instruments and operationalization of the identified variable was discussed as well.

Chapter four will be on study findings and recommendations. The study findings will be presented in tables that show the varying trends of responses. Further the chapter will have interpretations of the findings in write up to explain the tables.

Chapter five being the final chapter for the study, will summarize of findings and again in tabular form with regard to the objectives of the study. Main findings will be discussed at length with linkages to existing knowledge. The chapter will end with a conclusion of the study and suggested possible recommendation of the study problem.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This section covers several topics which includes monitoring and evaluation systems, human capacity for M&E, Partnership for Managing M&E, M&E Plan and support supervision and data auditing. The chapter further outlines the theoretical, conceptual framework and summary of the literature.

2.2 The Concept of Monitoring and Evaluation Systems

Monitoring and evaluation (M&E) are tools employed to assess the relationships of intentions versus actions, actions versus outcomes, and outcomes versus impacts. However, the most important, yet quite often the most neglected aspect of monitoring and evaluation is feedback. It is the feedback of lessons learned through M&E that assists correction of current mistakes and improvement of future decisions (Khan, 2010). A results-based M&E system is essentially a feedback system; it is a management tool to measure and evaluate outcomes, providing information for governance and decision making (Gorgens & Kusek, 2010). A results-based system, whilst not neglecting the monitoring of inputs and outputs, attaches the highest importance to providing feedback on results at the level of outcomes and goals (Edmunds & Marchant, 2010).

Projects are aimed at solving social problems and the beneficiaries are key stakeholders. Monitoring and evaluation can help an organization to extract, from past and on-going activities, relevant information that can subsequently be used as the basis for

programmatic fine-tuning, reorientation and planning (Gyorkos, 2013). Without monitoring and evaluation, it would be impossible to judge if work was going in the right direction, whether progress and success could be claimed, and how future efforts might be improved (UNDP, 2012). Precisely, the overall purpose of monitoring and evaluation is the measurement and assessment of performance in order to more effectiveness manage the outcomes and outputs known as development results. Monitoring and evaluation are intimately linked project management functions and as a result, there is a lot of confusion in trying to make them work on projects (Crawford and Bryce, 2013).

Good M&E systems for civil society programs as ones which are: dynamic, participative, reflective and evolving. First, dynamic systems encourage `learning by doing‟ and are promoting regular ways of seeking dynamic feedback from multiple sources about the benefits, problems and impacts of the intervention (Kelly et al., 2010). Secondly, participative and gender sensitive systems actively seek to overcome barriers of gender, age, power, culture and other issues which limit the participation of all stakeholders in the monitoring and assessment process (Gyorkos, 2013). Thirdly, reflective systems encourage staff, partners and stakeholders to create regular space and time for analyzing information and reflecting back on the underlying assumptions or `theories of change‟ which underpin the interventions (Crawford and Bryce, 2013). Fourthly, evolving systems are adapting and changing in order to keep them as light and simple as possible while providing `real time‟ information which informs on-going improvement of the intervention (McCoy, 2015).

2.3 Concept of Provision of Healthcare Care Service

The objective of wellbeing administrations arrangement is to enhance wellbeing results in the populace and to react to individuals' desires while decreasing imbalances in both wellbeing and responsiveness (Houtzager, 2013). The social insurance needs of the populace ought to be met with the ideal amount and nature of administrations created at least expenses. Sorts of contributions to wellbeing administration arrangement largely decide conveyance of the administrations. The authoritative structure and procedures decide amount and nature of yields for a given amount of information sources. The amount and nature of administrations and their circulation, together with other wellbeing framework and non-wellbeing framework factors decide how much wellbeing increase can be accomplished in the general public (Aiken, 2015). The appraisal of supplier execution can illuminate approach choice with the proof on the normal or the genuine commitment of suppliers' expert activities into the accomplishment of the middle of the road and last objectives of wellbeing frameworks (WHO, 2015).

Health study in the US revealed that proper health system provision analysis should focus on three areas: health system inputs, organizational structure processes, and the quantity and quality of personal and non-personal health services in relation to health care needs of population. The outcomes of health service delivery process should be captured by the measurement of the overall level and the distribution of health (WHO, 2014). The outputs of the provision of health service process on the other hand can be monitored by the degree to which systems achieve effective coverage of the population with critical health interventions (WHO, 2015). Effective coverage of a health system can be characterized as the proportion of the acknowledged wellbeing pick up from an arrangement of

intercessions (weighed by the wellbeing hazard) over the aggregate potential wellbeing increase conceivable if suppliers performed at their ideal level for a given wellbeing framework. This applies to both individual and non-individual wellbeing mediations. The results of the administration arrangement work along these lines will be thought about the general level and dissemination of the soundness of populace (Aiken, 2015).

The WHO (2014) declares that a good health framework conveys quality services to all individuals, when and where they require them. The correct design of administrations differs from nation to nation, yet in all cases requires a strong financing system; an all-around prepared and satisfactorily paid workforce; dependable data on which to base choices and approaches; all around kept up offices and coordination's to convey quality drugs and advancements. From a framework viewpoint, quality is accomplished when medicinal services procedures and exercises are outlined and actualized keeping in mind the end goal to consistently live up to patients' needs and desires (Al-Assaf WHO, 2014). Along these lines understanding patient's desires is central to the arrangement of nature of administration, which eventually has affect on their fulfillment (Dyck, Clapper and De Jager, WHO, 2014).

2.4 Human Capacity for Monitoring and Evaluation Systems and Provision of Health Care Services

The M&E system function with skilled people who effectively execute the M&E tasks for which they are responsible. Therefore, understanding the skills needed and the capacity of people involved in the M&E system (undertaking human capacity assessments) and addressing capacity gaps (through structured capacity development

programs) is at the heart of the M&E system (Gorgens & Kusek, 2010). In its‟ framework for a functional M&E system, UNAIDS (2010) notes that, not only is it necessary to have dedicated and adequate numbers of M&E staff, it is essential for this staff to have the right skills for the work. Moreover, M&E human capacity building requires a wide range of activities, including formal training, in-service training, mentorship, coaching and internships. Lastly, M&E capacity building should focus not only on the technical aspects of M&E, but also address skills in leadership, financial management, facilitation, supervision, advocacy and communication. Building an adequate supply of human resource capacity is critical for the sustainability of the M&E system and generally is an ongoing issue. Furthermore, it needs to be recognized that "growing" evaluators requires far more technically oriented M&E training and development than can usually be obtained with one or two workshops. Both formal training and on-the-job experience are important in developing evaluators with various options for training and development opportunities which include: the public sector, the private sector, universities, professional associations, job assignment, and mentoring programs (Acevedo et al., 2010). Monitoring and evaluation carried out by untrained and inexperienced people is bound to be time consuming, costly and the results generated could be impractical and irrelevant. Therefore, this will definitely affect the success of projects (Nabris, 2012). In assessment of CSOs in the Pacific, UNDP (2011) discusses some of the challenges of organizational development as having inadequate monitoring and evaluation systems. Additionally, the lack of capabilities and opportunities to train staff in technical skills in this area is clearly a factor to be considered. During the consultation processes, there was consensus among CSOs that their lack of monitoring

and evaluation mechanisms and skills was a major systemic gap across the region. Furthermore, while there is no need for CSOs to possess extraordinarily complex monitoring and evaluation systems, there is certainly a need for them to possess a rudimentary knowledge of, and ability to utilize reporting, monitoring, and evaluating systems (Gala, 2011).

There is a constant demand for training in planning, monitoring, review, evaluation and impact assessment for both program staff and partners in projects (Gosling & Edwards, 2013). Skills for numeracy, literacy, interviewing and monitoring in qualitative and quantitative methods, for management information systems are necessary for participatory monitoring and evaluation (Adan, 2012). Staff need to be trained not only on collecting descriptive information about a program, product, or any other entity but also on using something called "values" to determine what information and to draw explicitly evaluation inferences from the data, that is inferences that say something about the quality, value or importance of something (Davidson, 2014). Players in the field of project management like project and programme managers, M and E officers, project staff and external evaluators will require specialized training not just in project management and M and E; but specifically in areas like Participatory monitoring and evaluation and results based monitoring and evaluation (Murunga, 2011). In a study by White (2013) on monitoring and evaluation best practices in development health facilities, indicate that health facilities encounter a number of challenges when implementing or managing M&E activities one being insufficient M&E capacity where M&E staff usually advises more than one project at a time, and have a regional or sectoral assignment with a vast portfolio. Furthermore, taking on the M&E work of too

many individual projects overextends limited M&E capacity and leads to rapid burnout of M&E staff whereby high burnout and turnover rates make recruitment of skilled M&E staff difficult, and limits the organizational expertise available to support M&E development. Mibey (2011) study on factors affecting implementation of monitoring and evaluation programs in kazi kwa kijana project, recommends that capacity building should be added as a major component of the project across the country (Kenya), and this calls for enhanced investment in training and human resource development in the crucial technical area of monitoring and evaluation.

In a study conducted in USA, Chicago health center, it indicated that the M&E system cannot function without skilled people who effectively execute the M&E tasks for which they are responsible. Therefore, understanding the skills needed and the capacity of people involved in the M&E system (undertaking human capacity assessments) and addressing 12 capacity gaps (through structured capacity development programs) is at the heart of the M&E system (Gorgens & Kusek, 2010). In its‟ framework for a functional M&E system, UNAIDS (2010) notes that, not only is it necessary to have dedicated and adequate numbers of M&E staff, it is essential for this staff to have the right skills for the work.

In US showed that a higher level of staffing with RNs per patient day was associated with decreased rates of unplanned extubation, hospital-acquired (Arcury, 2017). A prior cross-sectional investigation of information from 10,184 attendants, and 232,342 patients experiencing general, orthopedic and vascular surgery in 168 hospitals in the United States of America found that an extra patient for every medical caretaker was related with an expansion in both the hazard balanced 30-day mortality and the inability to-protect

rate of 7 %. Systematic review of 43 studies in the Western Europe found that richer nurse staffing was related to lower failure-to rescue rates among surgical patients and lower inpatient mortality rates and shorter hospital stays among medical patients (Vanessa, 2017). A systematic review and meta-analysis of 28 studies attempted to stratify the effect of nurse staffing by clinical setting and observation of incidences of pneumonia, respiratory failure, and cardiac arrest in intensive care units patients; lower failure-to-rescue rates in surgical patients; and a shorter duration of hospital stay in both intensive care and surgical patients were observed (Aiken, 2010).

In a study done in Mali, Guinea and Nigeria by WHO (2013) in public health centers, indicated that human Capacity can be perceived as a moving target. It often develops in stages that indicate improved readiness to influence performance (Goodman et al., 2013). Capacity building, therefore, is an ongoing process (the development of abilities), whose stages can be measured as "development outcomes". The study used a descriptive survey design on monitoring and evaluation. The dynamic nature of capacity is often a reflection of the many different forces that influence its development or decline (UNAIDS, 2010).

Another study done by, Sierra Leone's Ministry of Health (MOH) indicated that they might have the capacity to deliver childhood immunization services. However, frequent political instability in the country can challenge that capacity and reduce performance (e.g., immunization coverage) dramatically. Taking a more general example, the stagnation and decline of economic growth that occurred in Africa in the 1980s severely undermined public sector capacity to meet recurrent costs for salaries and supply of basic health commodities. Even well-established health systems, such as Ghana's, were unable to withstand the decline (Burgon, 2016).

In a study done in Kenya on human capacity by White (2013) on monitoring and evaluation best practices in development, indicate that health institutions encounter a number of challenges when implementing or managing M&E activities one being insufficient M&E capacity where M&E staff usually advises more than one project at a time, and have a regional or sectorial assignment with a vast portfolio. Furthermore, taking on the M&E work of too many individual projects overextends limited M&E capacity and leads to rapid burnout of M&E staff whereby high burnout and turnover rates make recruitment of skilled M&E staff difficult, and limits the organizational expertise available to support M&E development (Ramesh, 2002). Mibey (2011) study on factors affecting implementation of monitoring and evaluation programs in kazi kwa kijana project, recommends that capacity building should be added as a major component of the project across the country (Kenya), and this calls for enhanced investment in training and human resource development in the crucial technical area of monitoring and evaluation.

2.5 Partnerships in Planning and Managing Monitoring and Evaluation Systems and Provision of Health Care Services

Stakeholders and partners are groups of people, organization and institutions that will affect or maybe affected by the project. These stakeholders include the community-men, women and youth; project field staff, program managers, donors, government and other decision makers' supporters, critics, government and NGO'S (Davies, 2010). Growing emphasis on participatory approaches towards development, there has been recognition that monitoring and evaluation (M&E) should also be participatory (World Bank, 2016), for the purposes of enriching the quality of information. Garbutt (2013) argues that it is of

no use having a complex M&E system if your partners are unable to collect data that provides the information you need. Participation is a process through which partners at various levels engage in activities, such as monitoring or evaluation, of a particular project, program or policy, share control over the content, the process and the results of the (M&E) activity and engage in taking or identifying corrective actions.

Meaningful engagement of various stakeholders in M&E generates sufficient and relevant information that enhances project delivery. As UNFPA (2001) points out, involvement of various stakeholders such as programme stakeholders, central level decision makers, local level implementers, and communities, in programme design, implementation, monitoring and evaluation, improves programme quality and helps address local development needs. WHO (2006) also concurs with this view noting that in order to ensure effective M&E for Maternal and Newborn Health (MNH), partnerships should be established with different stakeholders, including the communities as well as other non-health sectors. Involvement of women and youth for instance has been argued to be beneficial by certain scholars. This view is confirmed by Agutu's (2014) findings on stakeholder involvement in School Feeding Programme by service providers in Kenya, which revealed substantive involvement of school administrators, students, parents and community in M&E. The resulting benefits were faster decision making, feedback, ownership, sustainability hence influence implementation of M&E (Agutu, 2014). Involvement of other marginalized groups such as women and youth has also been recognized as vital for the success of projects. Srinivas (2015) points out that participation of women in all decision making processes-whether micro or macro-will ensure that broader goals are achieved, and will benefit all sections of the society. DFID

(2010) also agrees that young people are the foundations for effective development, and if engaged they will improve many of the structural development challenges, including: enhancing the cohesion of families and communities, reducing health risks and advancing livelihood opportunities. However, studies still show that involvement of women in critical decision making positions is still limited in both government and NGOs. Were (2014) in her study of Lake Basin NGOs observed relative lower number of women in committee positions that managed NGO water projects in the region, further noting that the, involvement, did not necessarily translate into active participation in decision-making (Were, 2014).

In a study done in Germany on partnerships for managing M&E in 80 public health centers, implied that the more a team is strengthened, the better the performance and value addition to the organization (Müller and Turner, 2017). This also applies to the monitoring and evaluation teams in project management. There was no significant association between the maturity of quality management practices in project management organizations and the results of the projects that they produce (Pretorius et' al., 2012). Nevertheless, it is the view of the researcher that managers should indeed aspire to achieve quality in all the aspects and processes, including quality monitoring team, so as to achieve project success. The literature reviewed identifies the various aspects which are used in assessing the strength of monitoring team which is perceived to be one of the factors influencing project success. These aspects include: Financial availability, number of monitoring staff, monitoring staff skills, frequency of monitoring, stakeholders representation, Information systems (Use of technology), Power of M & E Team and teamwork among the members (Gwadoya, 2012) evaluation is at its maximum. The

execution stage is the most risky stage where the probability of not achieving project success is at its peak due to numerous project activities. It is during this stage that the project M&E team should be most active in monitoring and providing timely feedback. Finally, during closing down the monitoring and evaluation just like other management activities is less intensified as compared to the execution stage. Most of the monitoring activities during this stage involves reporting on the project outcome and preparing for future projects (Müller and Turner, 2017).

In a study done in South Africa, on partnership on M&E, in health sectors in Johannesburg depicted that public sector, business and civil society often come to the partnering table with very different views on the role and purposes of monitoring and evaluation in health sectors in the region (Kyriakopoulos, 2011). Depending on the resources they have available and other factors, such as the formality of the regulatory environments in which they operate, monitoring and evaluation can play more or less of a role in an organization's governance and management (Naidoo, 2011). For naïve, less experienced organizations, monitoring and evaluation can appear daunting from a technical point of view or may be perceived as an unwelcome distraction or an unnecessary drain on limited resources, which could otherwise be spent on educational improvements (Chin, 2012).

2.6 Monitoring and Evaluation Work Plan and Provision of Health Care Services

M&E plan is fundamental on any health care project. It provides the schedule to be followed on the project implementation to its sustainability. The Program Evaluation Standards, James (2013) indicates that, M&E plan involves evaluation of resources. The

budget could certainly be more carefully estimated and actual expenditure on the evaluation more carefully monitored. The problem of cost overruns during evaluation has been raised up by several evaluators. Smith & Chircop (2013) say that financial resources are needed for the time people spend, for supporting information management system, training, transport and so forth. Key items to include in the budget are contracts for consultants/external expertise, physical non contractual investment costs, recurrent labour cost, focused labour input, training and study tours for M&E related capacity building, and nonoperational costs like stationery, meetings, allowances for primary stakeholders and project implementers (John, 2017).

Among South African NGOs, there was widespread adherence to the logical framework as a foundation for evaluation and reporting with its‟ use as a planning tool locking organizations into established timeframes and specified outputs (Applebaum, 2017). These rigid timeframes of project funding and 14 LFAs do not accord well with the complex uneven nature of development work (Smith & Chircop, 2013). Furthermore, quantitative rather than qualitative indicators could be used to advantage as they were easily measured to demonstrate success while qualitative measures of how much was understood or subsequently used were largely avoided (Bornstein, 2016).

In a study conducted in USA on M&E plan and schedules followed in health care centers comprises of a field survey was conducted using a sample of 45 respondents who were selected by stratified random sampling (Anderson, 2010). The data were collected using structured questionnaires and analyzed using Statistical Package for Social Sciences (SPSS, Version 16.0). The results of the study reveal that project supervisors apply monitoring tools to a certain level in their project operations consequently producing

satisfactory levels of success. The findings further reveal that most health care development projects were completed within the stipulated time frame and budget and that majority of the respondents considered them a success (Fleming and Koppelman, 2010).

In an assessment done in Australia, on how M&E work plan practice influence health projects ,the White Paper on the Australian Government's Overseas Aid Program identified economic growth as being critical to poverty reduction and quality health care towards the Millennium Development Goals (MDGs) (Applebaum,2017). Infrastructure investment is one of the key drivers of economic growth in health care projects. In response, the Australian Government launched the Infrastructure for Growth Initiative (IFGI) in 2017 to help regional partners address their pressing infrastructure needs. IFGI is directed towards helping regional partner government improve their infrastructure policies and finance high-priority infrastructure in conjunction with other international donors. The Indonesia Infrastructure Initiative (IndII) has been developed within the IFGI framework and is supported by funding under IFGI. Accordingly, the development goal of IndII is to promote economic growth in Indonesia by enhancing the relevance, quality and quantity of infrastructure investment in Indonesia. To support the achievement of the development goal and other key objectives, IndII has developed a Monitoring and Evaluation Framework (MEF) to capture performance information and data at two levels – through individual activities and through defined program outcome areas. M&E for IndII is primarily about ensuring that the program delivers quality activities through appropriate selection of activities. It is imperative that the program supports improved

infrastructure priority setting and investment and to ensure resource allocation is appropriate between thematic and sectorial areas (Bennett, 2010).

In the Ugandan Rwenzori region a study by Busiinge (2010) found that donors rarely operate outside the log frame approach where they are boxed in results that are put in the project log frame, and yet sometimes the situation on the ground might affect the achievement of some of the results hence requiring some aspects of the project to be changed. Therefore, any suggested changes by the implementing organizations had to go through prolonged to and from communication over the changes. A critique to this argument however, is that the log frame brings significant benefits for a range of stakeholders while their longevity suggests that, to a great extent, they meet the needs of powerful decision-makers in development organizations (Jacobs, Barnett & Ponsford, 2010). Furthermore, they simplify complex social situations and make them relatively easy to understand, linking budgets to actions and expected results while also providing a tool for setting measurable goals, the basis for assessing performance towards them and for holding implementing organizations or staff to account. Bakewell and Garbutt (2015) in their study noted that, „where the Logical Framework Analysis (LFA) is used for monitoring and evaluation the focus is often the logical framework; to look at the expected achievements laid out in the matrix, rather than the work itself". In theory, Bakewell and Garbutt argue, that the logical framework can be revised through the programme cycle and changes made, at least to the output level; however, in practice this rarely happens. In the study, one donor representative claimed that they encourage NGO partners to review their logical frameworks, but the same person thought that a well-designed framework would not need changing.

A study done in Determining the effectiveness of M&E plan on health projects in Migori Kenya, This study sought to establish the determinants of effective monitoring and evaluation plans of County government funded health care projects. The term effective is used to mean whether the project monitoring and evaluation plan has or can achieve its objectives (Cohen, 2017). The study identified three independent variables which included staff technical skills, budgetary allocation and stakeholder participation (Mwende, 2014). Not only does best practice require that projects are monitored for control but also project stakeholders require transparency on following the time frame and schedule, accountability for resource use and impact, good project performance and to benefit future projects. Therefore, the study shed insight on the aforementioned benefits. The study was carried out using descriptive survey research design which entailed both qualitative and quantitative data collection procedures. The study was carried out within Rongo constituency which is located within Migori County and as such a beneficiary of county funds for health projects; the elected members of county assembly (MCA), and the residents of this formed the target population (Department of Health, 2010). A random sample of 387 residents was sought for the study out of which 341 respondents participated.

2.7 Monitoring and Evaluation on Data Auditing and Provision of Health Care Services

The source of performance data is important to the credibility of reported results hence, it is important to incorporate data from a variety of sources to validate findings. Furthermore, while primary data are collected directly by the M&E system for M&E purpose, secondary data are those collected by other organizations for purposes different

from M&E (Gebremedhin, Getachew & Amha, 2010). In the design of an M&E system, the objective is to collect indicator data from various sources, including the target population for monitoring project progress (Barton, 2017). The methods of data collection for M&E system include discussion/conversation with concerned individuals, community/group interviews, field visits, review of records, key informant interviews, participant observation, focus group interviews, direct observation, questionnaire, one-time surveys, panel surveys, census, and field experiments. Moreover, developing key indicators to monitor outcomes enables managers to assess the degree to which intended or promised outcomes are being achieved (Kusek & Rist, 2014).

In a project done on the use and utilization on M&E data from health institutions in China, throughout the process of developing the M&E plan, the end users' information needs must be addressed to ensure utilization of the findings from the research project (Mackay, 2017). In the M&E plan, your team should clearly articulate a plan for disseminating and utilizing M&E findings. Preliminary findings should be prepared and presented during strategically timed user meetings and/or workshops. The information should be tailored to the specific stakeholders' interests and needs (Booth, Ebrahim & Morin, 2012). Relevant information will solicit input and feedback that could affect decision-making and project improvement (Martin, 2011).

Monitoring and evaluation influence on project's performance found that a project implemented without the baseline study faced serious challenges on tracking its progress effectively on indicators (Thomas, 2010). According to Rogito (2010), a study done in Russia indicated that for best practice a baseline needs to be planned and done a year earlier to get full information on the project to undertake which was largely not done

from the study findings. He concludes that youth projects were poorly performing as baseline survey study was minimally done hence it was hard to achieve project goals. He recommends that baseline study need to be properly timed before project implementation and the findings kept properly and used to monitor progress of projects (Rogito, 2010).

In a study of RBM in Northern Ghana indicates a problem associated with post collection data management (Obure, 2010). As confessed by many field officers, the storage, processing and interpretation of data was ineffectively handled. Results from the study strongly point to a weakness in the system arising from the inability of stakeholders to handle and process data in a meaningful way. He concludes that this challenge could seriously lead to mere collection of large volumes of data which eventually might not be used in a helpful way. Data must be collected and analyzed regularly on the objectives and intermediate results (USAID, 2015). Furthermore, the PME&R system allows for three levels of information by project, activity and organization where the data for all organizations involved in a specific activity can be averaged up to the activity level, and the data for all activities can be averaged up to the project level (Booth, Ebrahim & Morin, 2012).

The numeric paper forms for NGOs, expressed concern regarding data collection namely: cost, time, training, data accuracy and consistency, storage, and means of data analysis (Singh et al., 2010). Additionally, those NGOs who had experimented with electronic systems highlighted difficulties with infrastructure and maintenance. Among the key findings of the study was that data collection and form-filling are important activities for many NGOs; cost and ease-of-use are major concerns, often preventing technology-heavy systems; and digitized data is desired, but digitizing data was the bottleneck for

data-collection efforts. A system of data collection should be self-organizing and evolving as it gathers information from the environment where the staff would then generate the information in the course of their daily activities (Innes & Booher, 2010). In a report of strengthening the M&E system of HIV and AIDS projects in Childfund Uganda, Ediau (2012) found that data was not routinely collected, compiled, stored, analyzed and shared by ChildFund Uganda and project stakeholders. As a result such data was not effectively utilized to track and measure performance as well as inform program improvement and learning.

The utilization of M&E information is central to the performance and sustainability of an M&E system and depends on the nature and strength of demand for M&E information (Mackay, 2017). Utility requires that commissioners and evaluators undertake the evaluation with the intention to use its results; that they undertake the evaluation at a time when the results can meaningfully inform decision making processes; and that evaluations be accessible. Otieno (2012) study indicates that the majority of the respondents were involved in 17 utilization of the monitoring and evaluation results in ways such as involvement in decision making of the project, redesigning of the project, strengthening/ improvement, advocacy for additional resources, program intervention of the project and project control. However, the low involvement of project members in project control after the offset of the implementing agency contributed to the immense negative impact of the current low degree of sustainability of the project performance. Incentives need to be introduced to encourage the use of performance information meaning that success needs to be acknowledged and rewarded, problems need to be

addressed, messengers must not be punished, organizational learning is valued, and budget savings are shared (Kusek & Rist, 2014).

Feedback during project implementation from local project staff and the opportunity for beneficiaries to influence appropriate revisions to project activities contributed to the quality of monitoring information in projects (AusAID, 2010). Additionally, to improve performance information good baseline data combined with ongoing consultation with beneficiaries provides a firm basis upon which to make judgements about appropriate and timely interventions, and later about the achievement of major development objectives. Baseline data and needs assessments provide the information you need against which to assess improvements caused by project implementation over time thus in order to evaluate the impact your project has on the lives of beneficiaries, you have to be familiar with the situation of the beneficiaries before project implementation (Hunter, 2010). A baseline study will be necessary for most activities as it is important to find out what information is already available (USAID, 2015). If baseline information will not be used (or subsequently replicated) to improve the quality of activity implementation or to measure development results, then the reason for collecting the data should be seriously questioned (USAID, 2012). Baseline data should provide only the minimum information required to assess the key aspects of quality of the activity delivery and measure the development results (including the eventual impacts). Anything more than this is likely to be a waste time, effort and resources and risks making the baseline study not replicable (UNDP, 2012).

The influence of monitoring and evaluation on project's performance found that a project implemented without the baseline study faced serious challenges on tracking its‟ progress

effectively on indicators (Rogito, 2010). For best practice, a baseline needs to be planned and done a year earlier to get full information on the project to undertake which was largely (Daykin, Petsoulas & Sayers, 2017). Youth projects were poorly performing as baseline survey study was minimally done hence it was hard to achieve project goals. He recommends that baseline study need to be properly timed before project implementation and the findings kept properly and used to monitor progress of projects (Rogito, 2010).

2.8 Theoretical Framework

The theoretical framework of this study is Theory of change and the Realistic evaluation theory.

2.8.1 Theory of Change

Theory of Change can be seen as an on-going process of discussion-based analysis and learning that produces powerful insights to support programme design, strategy, implementation, evaluation and impact assessment, communicated through diagrams and narratives which are updated at regular intervals (Vogel, 2012). Its purpose at the time it emerged was to address some of the problems evaluators faced when trying to assess the impact of complex social development programmes. These included poorly articulated assumptions, a lack of clarity about how change processes unfolded and insufficient attention being given to the sequence of changes necessary for long-term goals to be reached (O'Flynn, 2012). The theory of change provides a model of how a project is supposed to work. Further, the theory of change provides the basis for arguing that the intervention is making a difference (Msila & Setlhako, 2013).

However, this theory falls short since project success is much more complex (Babbie & Mouton, 2016). It is important to understand success beyond just knowing “what works”. Experience has revealed that blindly copying or scaling an intervention hardly ever works (Mackay, 2017). An important task for monitoring and evaluation is to gather enough knowledge and understanding in order to predict with some degree of confidence how a project and set of activities might work in a different situation, or how it needs to be adjusted to get similar or better results, hence influencing project performance (Jones, 2011).

2.8.2 Realistic Evaluation Theory

The realistic evaluation theory was first published by Pawson in 1997, provides a model centered on finding out what outcomes are produced from project interventions, how they are produced, and what is significant about the varying conditions in the which the interventions take place (Pawson & Tilley, 2014). This technique assumes that knowledge is a social and historical product, thus the social and political context as well as theoretical mechanisms, need consideration in analysis of programme or policy effectiveness. Realist evaluation techniques recognise that there are many interwoven variables operative at different levels in society, thus this evaluation method suits complex social interventions, rather than traditional cause-effect, non-contextual methods of analysis. This realist technique acknowledges that intervention programmes and policy changes do not necessarily work for everyone, since people are different and are embedded in different contexts (Fukuda-Parr, Lopes & Malik, 2016).

Realistic evaluation seeks to find the contextual conditions that make interventions effective therefore developing lessons about how they produce outcomes (Fukuda-Parr, Lopes & Malik, 2016). This theory can greatly aid in understanding how project deliverables are produced, however it falls short, as it is not explicitly about that influences project performance the concern of this study. Pawson & Tilley (2014) describe the procedure followed in the implementation of realist evaluation techniques in programme evaluation and emphasize that once hypotheses have been generated and data collected, the outcomes of the programme are explored, focusing on the groups that the programme benefitted and those who did not benefit. Effectiveness of a programme is thus not dependent on the outcomes alone (cause–effect), rather there is a consideration of the theoretical mechanisms that are applied, and the socio-historical context in which the programmes were implemented. Thus, the final explanation of a programme considers context-mechanism-outcome (Marchal, 2012).

2.9 Conceptual Framework

The independent variables in this study were the components of monitoring and evaluation practices and the dependent variable is the provision of health care services. The Moderating variables identified were Project management education, educational background, size of organization and location of the organization. These variables had a significant contributory or contingent effect on the relationship between the dependent and the independent variable.

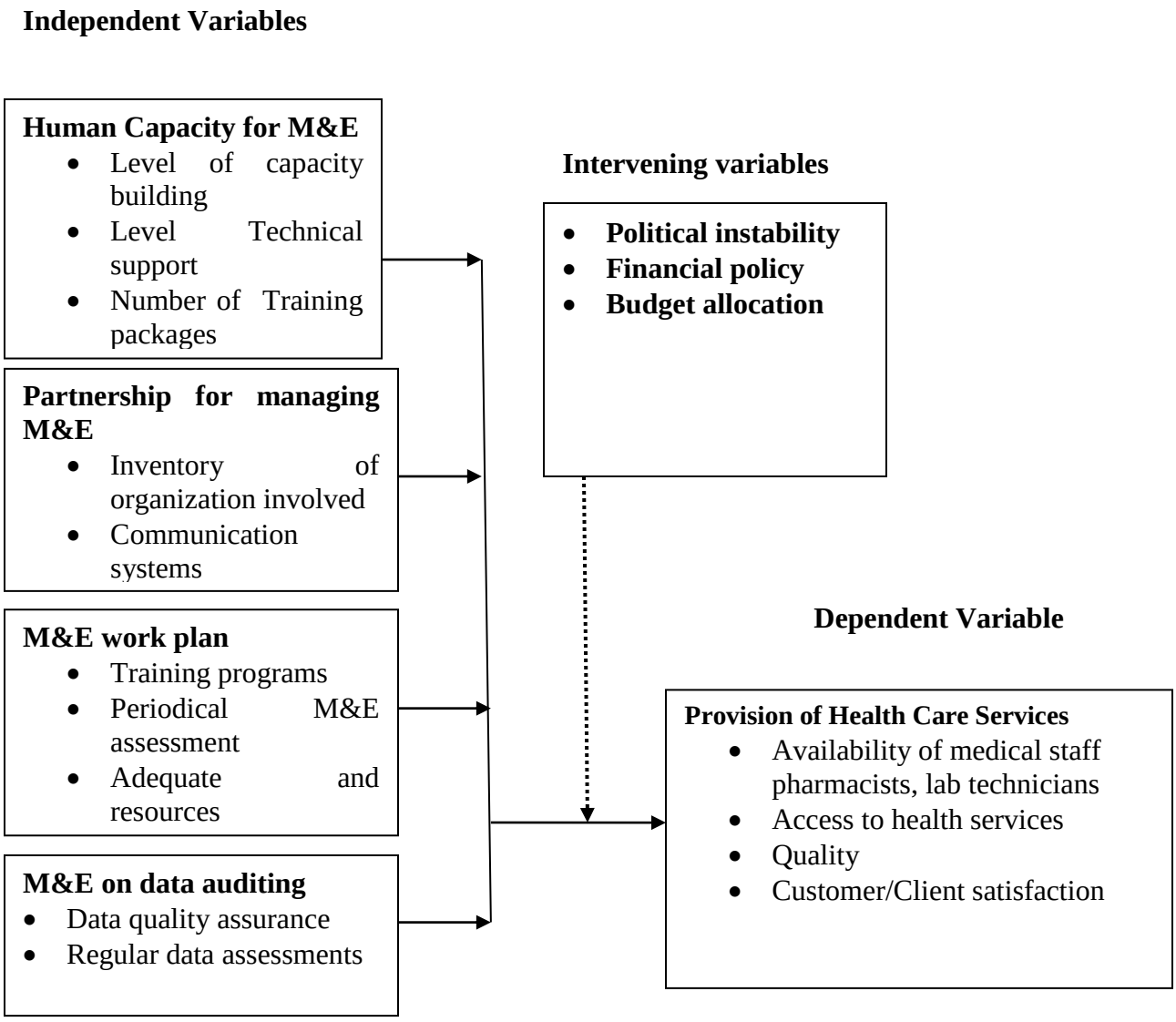

Figure 2.1: Conceptual Framework

Orodho (2002) argued that independent variable attempts to indicate the total influence in the study. It is hypothesized that the independent variable with its components human capacity, partnership for managing, M&E plan, supportive supervision and data auditing, directly influence the dependent variable which is provision of health care services; however moderating variables with its components political stability and financial support may accelerate or delay the provision of health care services.

2.10 Summary of Literature Review

Human capacity is another important factor in provision of health care services in Migori County (World Bank, 2014). M&E being a new professional field, it needs a human resource management in order to maintain a stable M&E staff (World Bank, 2014). In order to have an effective M&E the staff need to undergo training as well as possess skills in research and project management (Nabris, 2015). There is also a need to set up a national professional association of evaluators and a database for M&E evaluation reports, to aid in the development of the technical skills among the M&E specialist (Jaszcolt et al., 2010). Training and experience are fundamental factors in the provision of health care (World Bank, 2014). M&E being a new professional field, training is paramount in building an effective M&E human resource capacity both in quality and quantity (World Bank, 2014). Numerous training manuals, handbooks and toolkits have been developed for NGO staff in order to provide them with practical tools that will strengthen M&E awareness (Hunter, 2015). They also inform on innovations and methodologies (Handbook on M&E for results, 2012). Koffi-Tessio (2016), states that the poor acquisition of the appropriate M&E systems by health facilities could be attributed to their lack of emphasis on methodological and conceptual training. Jaszcolt et al (2010), therefore recommends that health facilities need to be educated on M&E in order to develop technical skills among the M&E specialists.

Stakeholders and partners play a major role in M & E. there has been recognition that monitoring and evaluation (M&E) should also be participatory (World Bank, 2016), for the purposes of enriching the quality of information. The more a team is strengthened, the better the performance and value addition to the organization (Müller and Turner, 2017).

Business and civil society often come to the partnering table with very different views on the role and purposes of monitoring and evaluation in health sectors in the region (Kyriakopoulos, 2015). The management is held responsible of the M&E system; hence the management support is vital for its success (World Bank, 2014). The management therefore ensures that the project staffs carry out the M&E job effectively (Guijt, 2012). The M&E process as well provides useful information for decision-making to all levels of the management (Gaitano, 2014). However, activities of the M&E systems are sometimes seen as a control by the bureaucratic management or a donor requirement (Shapiro, 2017).

M&E plan is fundamental on any health care project. It provides the schedule to be followed on the project implementation to its sustainability (James, 2015). There is widespread adherence to the logical framework as a foundation for evaluation and reporting with its‟ use as a planning tool locking organizations into established timeframes and specified outputs (Applebaum, 2017). Most health care development projects in USA were completed within the stipulated time frame and budget and that majority of the respondents considered them a success (Fleming and Koppelman, 2014). The logical framework can be revised through the programme cycle and changes made, at least to the output level (Bakewell and Garbutt, 2015). Stakeholders require transparency on following the time frame and schedule, accountability for resource use and impact, good project performance and to benefit future projects (Mwende, 2014). Jaszcolt et al (2013), states that health facilities mainly use two principal frameworks, which are the result framework and the logical framework. According to this survey (World Bank, 2013) the most commonly used tools and techniques by health facilities within Nairobi

County are: logical framework, participatory approaches, evaluation surveys, site visits and strategic planning frameworks.

It is important to incorporate data from a variety of sources to validate findings (Gebremedhin, Getachew & Amha, 2015). Throughout the process of developing the M&E plan, the end users' information needs must be addressed to ensure utilization of the findings from the research project (Mackay, 2017). Baseline study need to be properly timed before project implementation and the findings kept properly and used to monitor progress of projects (Rogito, 2014). Data must be collected and analyzed regularly on the objectives and intermediate results (USAID, 2015). A system of data collection should be self-organizing and evolving as it gathers information from the environment where the staff would then generate the information in the course of their daily activities (Innes & Booher, 2014). Utilization of M&E information is central to the performance and sustainability of an M&E system and depends on the nature and strength of demand for M&E information (Mackay, 2017). Feedback during project implementation from local project staff and the opportunity for beneficiaries to influence appropriate revisions to project activities contribute to the quality of monitoring information in projects (AusAID, 2015).

Table 2.1: Summary of the Literature Review

Variables	Indicators	Author and Year	Title of the study	Findings	Knowledge gap
Monitoring and evaluation systems	Regular assessment for the performance of provision of health care services per every 3 months	Marshall, 2007). Kerzner, 2006). (PMI, 2005).	Monitoring and evaluation practices influencing provision of health care services	The study indicated that quality monitoring and evaluation practices do assure credible performance of health care services.	The study did not indicate after how long is the standardized time to perform monitoring and evaluation
human capacity for M &E	Increased quality of working capacity in human resource, technical support and Core training packages	Mulandi (2013)	Human capacity for M&E in provision of health care services	Performance of monitoring and evaluation systems is satisfactory if information is accessible to organizational staff	Focuses more on M&E in Governance sector
Partnership for managing M&E	New partnerships locally, nationally & internationally in enhancing professional M&E practices and increased stakeholder support	(Butteriss, 2009). Gaebler (2011) (Mackay, 2017)	Partnership for managing M&E on provision of health care services.	The study findings indicated that when there is effective partnership, communication and stakeholder support there is remarkable M&E sytems which in turn brings positive outcome to provision of health care services.	The research gap in this study do not indicate on how to measure the stakeholder support

M&E plan	Schedules on Training programs, periodic schedules on M&E assessment and presence of adequate time and resources to conduct M&E practices.	(Rick, 2001). Taut (2007), Kusek & Rist, 2004). Kusek & Rist (2004),	M&E plan influencing provision of health care services	The study indicated that a well-planned monitoring and evaluation strategy involving adequate resources, periodic assessment reflects on a credible M&E practice and provision of health care services	The research assumed that after coming up with an effective work plan M&E will function successfully and automatically with other functions constant
Data auditing	Presence of advanced instruments on Data quality taking and assurance, regular internal and external auditors meetings and regular data assessment per every 3 months.	Rodgers & Williams, 2006). Cleland & Ireland, 2007). Mulandi (2013).	Data auditing influencing provision of health care services	The study indicated that proper recording and data supervision and auditing in M&E practices enhances effective service provision in the health industry Improve the accuracy, quality and access of information provided by the monitoring and evaluation system	The research gap In this concept is that the study did not provide information on how data quality is standardized and the test it has to pass.

Summary of Literature Review

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The chapter outlined the overall methodology that was used in the study. This includes the research design, population of the study, sample size, sample frame, data collection methods, research procedures and data analysis and presentation.

3.2 Research Design

This study employed a descriptive survey research design. Descriptive research design is used to describe an event or phenomena as it exists at present and is appropriate when the study is concerned in specific predictions, narrative of facts and characteristics concerning individuals or situations (Kothari, 2003). Enlightening review study plans are applied as part of preparatory and exploratory investigations to allow scientists to bring together facts, condense, show off and decipher with the stop aim of elucidation (Orodho, 2002). The purpose for engaging review inquire approximately outline is to look at, depict and record elements of a circumstance as it generally happens (Polit and Beck, 2008). Clear studies are fitting since it consists of watching and depicting the behavior of a subject without affecting it in any capability (Martyn, 2008). It is utilized to check demeanors and feelings approximately events, people or method.

3.3 Target Population

The study targeted all the 80 M&E officers, 159 doctors, 500 nurses, 37 Community health volunteers, 21 social workers and 200 patients who visits the hospital within an hour. This study focused on eight sub county hospitals and one referral hospital. Which includes; Migori county referral hospital. Awendo, Isibania, Karungu, Macalder, Ntimaru, Othoro, Rongo and Kuria sub county hospitals. Hair, (2003) defines population as an identifiable total group or aggregation of elements (people) that are of interest to a researcher and pertinent to the specified information problem. According to Salkind (2008), population is the entire of some groups. This is also supported by Sekaran and Bougie (2010). Population is defined as entire group of people the researchers want to investigate.

Table 3.1: Target Population

Health facilities	**M&E officers**	**Doctors**	**Nurses**	**Community health volunteers**	**Social workers**	**Patients**
Migori county referral hospital	20	54	201	7	4	65
Awendo	7	10	34	3	2	15
Isibania	7	10	34	3	2	15
Karungu	8	10	34	3	2	15
Macalder	7	10	34	3	2	15
Ntimaru	7	10	32	3	2	15
Othoro	7	10	36	3	2	15
Rongo	7	10	35	3	2	15
Kuria sub county hospital	10	35	60	6	3	30
Total	**80**	**159**	**500**	**37**	**21**	**200**

Target population= **159** doctors+ **80** M&E officers+**500** Nurses+**21** social workers+**37** community health workers +200 patients =**997**

3.4 Sample Size and Sampling Procedure

This section includes sample size and sampling procedure of the study. Sampling may be defined as the selection of some part of an aggregate or totality on the basis of which a judgment or inference about aggregate or totality is made (Fraenkel & Norman, 1990).

3.4.1 Sample Size

This sample size sought to introduce the simple random sampling which will be used in this study. This research used Yamane (1967) formula of sample selection to generate a sample size for the study as indicated:

$$n = \frac{N}{1 + Ne^2}$$

Where: n = Sample size

N = Target Population (997)

E = Error = 0.05

$$n = \frac{997}{1 + 997\ (0.05)^2}$$

n = 285

The study size therefore constituted 285 respondents (**60** doctors+ **43** M&E officers + **102** Nurses +**9** social workers +**16** community health workers + **55** patients) who were randomly picked.

3.4.2 Sample Procedure

The sampling technique used was simple random sampling. Every third item from the population was picked randomly. Yin (2013) argues that the sample size depends on what one wants to know, what is at stake and recommends 10-30% as an appropriate sample in a case study.

Table 3.2: Sample Size

Respondents	Target population	Sample size
Doctors	159	60
M&E officers	80	43
Nurses	500	102
Social workers	37	9
Community health workers	21	16
Patients	200	55
Total	997	285

3.5 Research Instruments

The research instrument that was used in the study were questionnaires and interviews. In developing the questionnaire items, the fixed choice of the item was used. A questionnaire was used to gather primary data. Patton (2014) argued that the advantages of using questionnaires are that information can be collected from a large sample. The

use of more than one method for gathering data was to ensure methodological triangulation as distinguished by Denzin (Alan, 2003). The questionnaire consists of items applying the likert scale with the responses ranging from strongly agree, agree, not sure, disagree and strongly disagree on a 1,2,3,4,5 rating scale. The questionnaire consisted of both open- ended and closed ended questions to offer opportunities for comments, suggestions and areas of improvement that would make a positive difference when using monitoring and evaluation systems.

However, in the fixed choice item, it involves "putting words" in the respondents' mouth, especially when providing acceptable answers, there is temptation to avoid serious thinking on the part of the respondent. To avoid such situations, the researcher provided respondent friendly questions to keep him/her comfortable. Interview schedules were for the patients and were used to solicit for more information that might not be captured by the questionnaire.

3.5.1 Pilot Testing of the Instruments

A 10% sample was piloted. Before the actual data collection, the data collection tools was piloted with a sample of 6-doctors, 10 Nurses, 4 M&E officers, 1 Social workers and 2-community health volunteers. Piloting was done in Homabay county referral hospital in Homabay County. Piloting was used to establish whether the questions are able to measure what they are intended to measure and whether the respondents are able to interpret all the questions in the same way, whether the wording of the questionnaire is clear and if there is any researcher bias. After the piloting exercise, errors detected was corrected thus enhancing the instrument's reliability and validity. Pilot testing refers to

pre-testing of the research instruments by administering it to a selected sample which is similar to the actual sample which is homogeneous and the researcher plans to use in the study (Mugenda and Mugenda, 2013).

3.5.2 Validity of Research Instruments

An attitude scale is considered valid, for example, to the degree to which its results conform to other measures of possession of the attitude. Validity therefore refers to the extent to which an instrument can measure what it ought to measure. It therefore refers to the extent to which an instrument asks the right questions in terms of accuracy. (Mugenda & Mugenda, 2013) validity is the accuracy and meaningfulness of inferences, which are based on research results. Validity is quality attributed to proposition or measures to the degree to which they conform to establish knowledge or truth and this is according to (Appa & Mathirajan, 2006).

Three elements of validity was determined for the gadgets. Face validity was mounted with the aid of assessing the gadgets at the tool and making sure that they appear relevant, meaningful and appropriate to the study participants. Content validity changed into decided by means of the supervisors who will check out the measuring approach and determine whether or not it measured what it is meant to measure. They were carefully tested the objects on the gadgets and ascertain that the gadgets contain good enough tendencies anticipated to measure the domain beneath look at. To ensure validity of the gadgets, the researcher thoroughly reviewed the relevant literature, to enable development of an initial list of items representing each of the examiner's constructs. Then, this list of items changed into modified based on hints from the respondents.

3.5.3 Reliability of Research Instruments

The reliability of the instrument looked at the extent to which the tool yields the same results on repeated trials hence consistence was realized. In the study reliability followed the following steps, developed questionnaire was given to a few identical respondents subjects not included in the main study, the answered questionnaires was answered manual. After two weeks, the same questionnaire was administered to the same group of subjects. The question responses were again scored manually. The two sets of score were then correlated to determine the degree of accuracy and reliability. A high correlation of positive 0.7 and above showed that the measuring tool measures the equal construct and is as a result dependable. The results obtained from the pilot study assisted the researcher in revising the questionnaire to make sure it covers the objectives of the study. Reliability of an instrument is the measure of the degree to which a research instrument yields consistent results or data after repeated trials (Mugenda and Mugenda, 2013).

3.6 Data Collection Procedures

The researcher administered questionnaires and wait for the respondents to fill. The researcher sought approval for this study from the University of Nairobi. As soon as permission is granted and the researcher obtains an introduction letter, the researcher will collect data. The study proceeded in the following chronology: recruitment of one research assistant; conducting briefing for the assistant on the study objectives, data collection process and study instrument administration; reproduction of required copies for data collection; assessment of filled questionnaires through serialization and coding

for analysis; data analysis and discussion; preparation of the conclusion and recommendations.

3.7 Data Analysis Technique

The questionnaires were checked for completeness and consistency of information at the end of every field data collection day and before storage. Data capturing was done using Excel software. The data from the completed questionnaires and interviews was cleaned, re-coded and entered into the computer for analysis to produce frequency tables, graphs, and the necessary measures of variances for interpretation. Descriptive statistics (that is frequency analysis) was computed for presenting and analyzing the data. Descriptive statistics enables the researcher to describe the aggregation of raw data in numerical term (Mugenda & Mugenda, 2013). Data was analyzed using correlation and regression analysis. The relationship between independent variables was measured through multiple correlation and multiple regression analysis, in order to find out the inter-relationship between the four independent variables and their influence on the dependent variable (Sharma, 2005). In addition, frequency distributions and percentage tables was used. Data will be presented in the form of frequency distribution tables that facilitated description and explanation of the study findings.

Multiple regressions will be guided by the model specification as follows

$\mathbf{Y=\alpha+\beta 1X1+\beta 2X2+\beta 3X3+\beta 4X4+\varepsilon}$. Where;

Y = Provision of Health Care Services β0 = Constant Term β1= Beta coefficients X1= Human Capacity for M&E X2= Partnership for managing M&E X3= M&E work plan X4= M&E data auditing

3.8 Ethical Issues

Permission to carry out the studies turned into sought from the Ministry of training, National Council for Science and Technology and the university administration who gave a letters authorizing the researcher to carry out the studies on that particular difficulty and in that precise location and to shield individuals who participated in the look at (Kombo and Tromp, 2009). The researcher also sought the consent of every participant and encouraged voluntary participation in the studies. Also because some of moral issues may want to get up during the academic research writing and publishing method of the study results, the researcher defined to the contributors the purpose and nature of the studies earlier than attractive them in the examine.

In this observe, the researcher assured all of the study participants that the facts given would only be used for educational purposes handiest and confidentiality became found. This changed into executed to make sure that honest statistics is acquired and additionally to beautify clean process of information series. Finally, the researcher assured the participants that nobody would be victimized about any information given, and no names or personal identification was reflected in the questionnaire, the numbering of the questionnaires was for ordering purpose only.

Question	Indicators	Scale: 1) nominal, 2) ordinal, 3) interval and 4) ratio	Instrument	Statistics text
Monitoring and evaluation practices	Regular assessment for the performance of provision of health care services	3	Interview and questionnaire	qualitative
Human capacity for M&E	capacity building, technical support Core training packages	3	Questionnaire and interview	Qualitative
Partnership for managing M&E	Inventory of organizations involved, communication Among organization involved, stakeholders support.	2	Interview and questionnaire	Qualitative & quantitative
M&E plan	Training programmes,periodic M&E assesments,adequate time and resources	3	Interview and questionnaire	Qualitative
Data auditing	Data quality assurance, regular meetings with internal and external auditors, regular data assessments	3	Interview and questionnaire	Qualitative

3.9 Operationalization of the Variables

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 Introduction

This chapter presents results based on the following thematic area: questionnaire return rate, demographic information of the respondents, human capacity for monitoring and evaluation and provision of health care services, partnerships in planning and managing monitoring and evaluation and provision of health care services, monitoring and evaluation work plan and provision of health care services, monitoring and evaluation on data auditing and provision **of health care services and regression analysis.**

4.1.1 Questionnaire Return Rate

The study issued 285 questionnaires to respondents and 220 were returned duly filled. Thus the return rate was 77.2 percent for the respondents studied. Cooper and Schindler (2005) recommends 75% response rate.

4.2 Demographic Information of the Respondents

The study sought to determine the demographic characteristics of the respondents as they are considered as categorical variables which give some basic insight about the respondents. The characteristics considered in the study were; range of ages of the respondents; gender and highest level of education attained by the respondents.

4.2:1 Distribution of Respondents by their Gender

The study was interested in knowing the gender of the respondents because it helped to understand the category of the people working in provision of health services by gender thus the respondents were asked to state their gender. Results are presented in table 4.1.

Table 4.1: Gender of the Respondents

Gender	**Frequency**	**Percent**
Female	136	61.8
Male	84	38.2
Total	**220**	**100**

The results in table 4.1 show that 136 (61.8%) respondents were females while 84 (38.2%) were male. This implies that the population of women working at the hospitals was higher than that for men. The findings indicate that the hospitals employed more female than male which means there is no discrimination on the side of female. This is in line with the constitution of Kenya (2010) which requires that in any employer situation there should be a third of either gender. This meets the threshold.

4.2:2 Distribution of Respondents by their Age Bracket

The study was interested in knowing the age bracket of the respondents because the age factor was important since the government is trying to encourage the youth to apply for jobs in the country. The respondents were asked to state their age bracket. The results are presented in table 4.2.

Table 4.2: Age Bracket of the Respondents

Age bracket	**Frequency**	**Percent**
18-35	26	11.8
36-45	137	62.3
46-59	57	25.9
Total	**220**	**100**

From the table 4.2, the findings shows that, 137 (62.3%) of the respondents were between 36 - 45 years of age, 46 - 59 years were 57 (25.9%), while 26 (11.8%) were 18 - 35 years. This implies that majority of the health workers providing health services were below 45 years of age 163 (74.1%) are younger falling within the age of 18-45 years who are energetic and expected to be innovative and may provide better health care services to the public institutions. This would enhance better health care in the facility and are for change of new technology.

4.2.3 Distribution of Respondents by their Level of Education

The study wanted to know the level of education of the respondents because it is believed that the higher the level of education the better the quality of health care provision. The respondents were asked to state their level of education. The results are presented in table 4.3.

Table 4.3: Highest Education Level of the Respondents

	Frequency	**Percent**
Certificate	15	6.8
Diploma	106	48.2
University degree	67	30.5
Master Degree	32	14.5
Total	**220**	**100**

From the Table 4.3 it shows that out of the 220 respondents who participated in the study, 106 (48.2%) of the respondents had attained Diploma education, 67 (30.5%) had a University degree, 32 (14.5%) had attained a Master degree, and 15(6.8%) had attained certificate. These findings show that the majority of health providers 205 (93.2%) have the required qualifications in health provision and it is therefore expected that provision of health care services in public health institutions in Migori county is expected to be better and if there is poor provision of health care services there is something else influencing other than education.

4.3 Human Capacity for Monitoring and Evaluation and Provision of Health Care Services

The first objective that the study wanted to achieve was to determine the extent to which human capacity for M&E influence provision of health care services in public health institutions in Migori County, Kenya.

To achieve this objective, the respondents were asked to give their opinions on the level of agreement or disagreement with the statements provided in a likert scale of 1-5 where 1=Not at all, 2= little extent, 3= moderate extent, 4= great extent, and 5= very great extent. The results are provided in table 4.4.

Table 4.4: Relationship Between Human Capacity and Provision of Health Care Services

Statements	NA	LE	ME	GE	VGE	Mean	Std dev
Capacity building on Monitoring & Evaluation increases access on provision of health services	27 (12.3%)	31 (14.1%)	48(21.8%)	87 (39.5%)	27(12.3%)	3.25	0.4
Technical support increases the knowledge on monitoring and evaluation	18 (8.2%)	34 (15.5%)	52(23.6%)	80(36.4%)	36(16.4%)	3.37	0.3
Core training packages increases the management capacity on provision of health care	20 (9.1%)	49(22.3%)	76(34.5%)	43(19.5%)	32(14.5%)	3.08	0.1
There are regular trainings on Monitoring &Evaluation	35 (15.9%)	62(28.2%)	33(15.0%)	52(23.6%)	38(17.3%)	2.98	0.1
The staff has a credible competency level on Monitoring &Evaluation	42 (19.1%)	45(20.5%)	68(30.9%)	47(21.4%)	18(8.2%)	2.79	0.2
Total						**15.48**	**1.3**
Composite mean and Std dev						**3.09**	**0.26**

On capacity building on Monitoring & Evaluation increases access on provision of health services, out of 220 respondents who participated in the study, 27 (12.3%) said not at all, 31 (14.1%) said to a little extent, 48 (21.8%) said to a moderate extent, 87 (39.5%) said to a great extent and 27 (12.3%) said to a very great extent. This was backed by a mean of 3.25 and standard deviation of 0.4. This is greater than the composite mean and standard deviation which implies that capacity building on Monitoring & Evaluation increases access on provision of health services.

On technical support increases the knowledge on monitoring and evaluation, out of 220 respondents who participated in the study, 18 (8.2%) said not at all, 34 (15.5%) said to a little extent, 52 (23.6%) said to a moderate extent, 80 (36.4%) said to a great extent and 36 (16.4%) said to a very great extent. This was backed by a mean of 3.37 and standard deviation of 0.3. This is greater than the composite mean and standard deviation which implies that technical support increases the knowledge on monitoring and evaluation.

On core training packages increases the management capacity on provision of health care, out of 220 respondents who participated in the study, 20 (9.1%) said not at all, 49 (22.3%) said to a little extent, 76 (34.5%) said to a moderate extent, 43 (19.5%) said to a great extent and 32 (14.5%) said to a very great extent. This was backed by a mean of 3.08 and standard deviation of 0.1. This is lower than the composite mean and standard deviation which implies that core training packages does not increase the management capacity on provision of health care.

On whether there are regular trainings on Monitoring &Evaluation, out of 220 respondents who participated in the study, 35 (15.9%) said not at all, 62 (28.2%) said to a little extent, 33 (15.0%) said to a moderate extent, 52 (23.6%) said to a great extent and 38 (17.3%) said to a very great extent. This was backed by a mean of 2.98 and standard deviation of 0.1. This is lower than the composite mean and standard deviation which implies that there were no regular trainings on Monitoring &Evaluation.

On the staff has a credible competency level on Monitoring &Evaluation, out of 220 respondents who participated in the study, 42 (19.1%) said not at all, 45 (20.5%) said to a little extent, 68 (30.9%) said to a moderate extent, 47 (21.4%) said to a great extent and

18 (8.2%) said to a very great extent. This was backed by a mean of 2.79 and standard deviation of 0.2. This is lower than the composite mean and standard deviation which implies that the staff did not have a credible competency level on Monitoring &Evaluation.

To achieve this objective, the respondents were asked to give their opinions on the level of agreement or disagreement with the statements provided in a likert scale of 1-5 where 1=strongly disagree, 2= disagree, 3= not sure, 4= agree, and 5= strongly agree. The results are provided in table 4.5.

Table 4.5: Agreement Level on Human Capacity and Provision of Health Care Services

Statements	SD	D	NS	A	SA	Mean	Std dev
Capacity building increases human capacity in provision of Health care services	15(6.8%)	45(20.5%)	45(20.5%)	92(41.8%)	23(10.5%)	3.29	0.6
Technical support increases knowledge in Monitoring &Evaluation	16 (7.3%)	43(19.5%)	47(21.4%)	85(38.6%)	29(13.2%)	3.31	0.5
Core training packages increases the quality of health care services	50 (22.7%)	33(15.0%)	65 (29.5%	40(18.2%)	32(14.5%)	2.87	0.2
Workshops on Monitoring &Evaluation trainings are regularly attended	28(12.7%)	65(29.5%)	42(19.1%)	60(27.3%)	25(11.4%)	2.95	0.1
The Monitoring &Evaluation officers has a high competent level in project management	12(5.5%)	72(32.7%)	65 (29.5%)	50(22.7%)	21(9.5%)	2.98	0.1
Total						**15.4**	**1.5**
Composite						**3.08**	**0.3**

On capacity building increases human capacity in provision of Health care services, out of 220 respondents who participated in the study, 15 (6.8%) strongly disagreed, 45 (20.5%) disagreed, 45 (20.5%) were not sure, 92 (41.8%) agreed and 23 (10.5%) strongly agreed. This was backed by a mean of 3.29 and standard deviation of 0.6. This is greater than the composite mean and standard deviation which implies that capacity building increases human capacity in provision of Health care services.

On technical support increases knowledge in Monitoring & Evaluation, out of 220 respondents who participated in the study, 16 (7.3%) strongly disagreed, 43 (19.5%) disagreed, 47 (21.4%) were not sure, 85 (38.6%) agreed and 29 (13.2%) strongly agreed. This was backed by a mean of 3.31 and standard deviation of 0.5. This is greater than the composite mean and standard deviation which implies that technical support increases knowledge in Monitoring & Evaluation.

On core training packages increases the quality of health care services, out of 220 respondents who participated in the study, 50 (22.7%) strongly disagreed, 33 (15.0%) disagreed, 65 (29.5%) were not sure, 40 (18.2%) agreed and 32 (14.5%) strongly agreed. This was backed by a mean of 2.87 and standard deviation of 0.2. This is lower than the composite mean and standard deviation which implies that core training packages does not increase the quality of health care services.

Whether workshops on Monitoring &Evaluation trainings are regularly attended, out of 220 respondents who participated in the study, 28 (12.7%) strongly disagreed, 65 (29.5%) disagreed, 42 (19.1%) were not sure, 60 (27.3%) agreed and 25 (11.4%) strongly agreed. This was backed by a mean of 2.95 and standard deviation of 0.1. This is lower than the

composite mean and standard deviation which implies that workshops on Monitoring & Evaluation trainings are not regularly attended.

On Monitoring & Evaluation officers has a high competent level in project management, out of 220 respondents who participated in the study, 12 (5.5%) strongly disagreed, 72 (32.7%) disagreed, 65 (29.5%) were not sure, 50 (22.7%) agreed and 21 (9.5%) strongly agreed. This was backed by a mean of 2.98 and standard deviation of 0.1. This is lower than the composite mean and standard deviation which implies that Monitoring & Evaluation officers did not have a high competent level in project management.

4.3.1 Regression analysis

In this study, a multiple regression analysis was conducted to test the influence among human capacity indicators. The research used statistical package for social sciences (SPSS Version 21) to code, enter and compute the measurements of the multiple regressions.

Table 4.6: Multiple Regression Between Human Capacity and Provision of Health Care Services (dependent variable) in Public Health Institutions

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.793	.629	.618	.1016

a. Predictors: (Constant), Level of capacity building, Level Technical support, Number of training packages.

The data in Table 4.6 indicated that R-Square (coefficient of determination) is a commonly used statistic to evaluate model fit. R-square is 1 minus the ratio of residual

variability. The adjusted $R^{2,}$ also called the coefficient of multiple determinations, is the percent of the variance in the dependent explained uniquely or jointly by the independent indicators of human capacity. 61.8% of the provision of health care services in public health institutions in Migori County. Variables could be attributed to the combined effect of the human capacity indicators.

Table 4.7: ANOVA Results of the Regression Analysis Between Provision of Health Care Services in Public Health Institutions and Human Capacity Indicators

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	12.672	3	2.176	3.184	.05
	Residual	94.682	213	.782		
	Total	107.354	216			

a. Predictors: Level of capacity building, Level Technical support, Number of Training packages.

b. Dependent Variable: provision of health care services in Public Health Institutions in Migori county.

The data in Table 4.7 indicated that the probability value of 0.05 indicates that the regression relationship was highly significant in predicting how level of capacity building, level technical support and number of training packages influenced provision of health care services in public health institutions in Migori County. The F critical at 5% level of significance was 3.184 since F calculated is greater than the F critical (value = 2.830), this shows that the overall model was significant.

Table 4.8: Regression Coefficients of the Relationship Between Provision of Health Care Services in Public Health Institutions and the Human Capacity Indicators

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	T	Sig.
1	(Constant)	1.403	0..356		3.674	0
	Level of capacity building	0.621	0.146	0.608	0.245	0.05
	Level Technical support	0.573	0.189	0.527	0.169	0.04
	Number of Training packages	0.482	0.254	0.461	0.382	0.001

a. Dependent Variable: provision of health care services in Public Health Institutions

As per the SPSS generated table above, the equation ($\mathbf{Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \varepsilon}$) becomes:

$Y = 1.403 + 0.621X_1 + 0.573 X_2 + 0.482 X_3$

The regression equation in Table 4.8 has established that taking all factors into account (level of capacity building, level technical support, and number of training packages) constant at zero provision of health care services in Public Health Institutions will be 1.403. The findings presented also show that taking all other independent variables at zero, a unit increase in level of capacity building would lead to a 0.621 increase in the provision of health care services in Public Health Institutions.

Further, the findings shows that a unit increases in level technical support would lead to a 0.573 increase in provision of health care services in Public Health Institutions. In addition, the findings show that a unit increase in number of training packages would lead to a 0.482 increase in provision of health care services in Public Health Institutions.

Overall, number of training packages had the least effect on provision of health care services in Public Health Institutions and level of capacity building had the highest effect.

Level of capacity building calculated p-value was found to be 0.05 which is statistically significant ($p<0.05$) which is level of confidence. The level of capacity building has a positive significant influence on provision of health care services in public health institutions. Level technical support calculated P-value was found to be 0.04 which is statistically significant since $P<0.05$. There is a positive correlation between level technical support and the provision of health care services in public health institutions. Number of training packages calculated P-value was found to be 0.001 which statistically $P<0.05$ hence significant. There is a positive correlation between number of training packages and the provision of health care services in public health institutions.

4.4 Partnerships in Planning and Managing Monitoring and Evaluation and Provision of Health Care Services

The second objective that the study wanted to achieve was to determine the extent to which partnerships in planning and managing for M&E influence provision of health care services in public health institutions in Migori County, Kenya.

To achieve this objective, the respondents were asked to give their opinions on the level of agreement or disagreement with the statements provided in a likert scale of 1-5 where 1=Not at all, 2= little extent, 3= moderate extent, 4= great extent, and 5= very great extent. The results are provided in table 4.9.

Table 4.9: Relationship Between Partnerships in Planning and Provision of Health Care Services

Statements	NA	LE	ME	GE	VGE	Mean	Std dev
Inventory of organizations involved are available	39 (17.7%)	48(21.8%)	37(16.8%)	50(22.7%)	46(20.9%)	3.07	0.1
Communication among organization is involved.	11(5.0%)	61(27.7%)	45(20.5%)	72(32.7%)	31(14.1%)	3.23	0.4
Stakeholder support is documented	2(0.9%)	54(24.5%)	56(25.5%)	68(30.9%)	40(18.2%)	3.41	0.3
Donor partnership is involved	5(2.3%)	69(31.4%)	39(17.7%)	65(29.5%)	42(19.1%)	3.32	0.3
Community participation is involved	14(6.4%)	70(31.8%)	58(26.4%)	43(19.5%)	35 (15.9%)	3.07	0.1
Total						**16.1**	**1**
Composite						**3.22**	**0.2**

On inventory of organizations involved are available, out of 220 respondents who participated in the study, 39 (17.7%) said not at all, 48 (21.8 said to a little extent, 37 (16.8%) said to a moderate extent, 50 (22.7%) said to a great extent and 46 (20.9%) said to a very great extent. This was backed by a mean of 3.07 and standard deviation of 0.1. This is lower than the composite mean and standard deviation which implies that inventory of organizations involved are not available.

On communication among organization is involved, out of 220 respondents who participated in the study, 11 (5.0%) said not at all, 61 (27.7 said to a little extent, 45 (20.5%) said to a moderate extent, 72 (32.7%) said to a great extent and 31 (14.1%) said to a very great extent. This was backed by a mean of 3.23 and standard deviation of 0.4.

This is greater than the composite mean and standard deviation which implies that communication among organization is involved.

On stakeholder support is documented, out of 220 respondents who participated in the study, 2 (0.9%) said not at all, 54 (24.5 said to a little extent, 56 (25.5%) said to a moderate extent, 68 (30.9%) said to a great extent and 40 (18.2%) said to a very great extent. This was backed by a mean of 3.41 and standard deviation of 0.3. This is greater than the composite mean and standard deviation which implies that stakeholder support is documented.

On donor partnership is involved, out of 220 respondents who participated in the study, 5 (2.3%) said not at all, 69 (31.4 said to a little extent, 39 (17.7%) said to a moderate extent, 65 (29.5%) said to a great extent and 42 (19.1%) said to a very great extent. This was backed by a mean of 3.32 and standard deviation of 0.3. This is greater than the composite mean and standard deviation which implies that donor partnership is involved.

On community participation is involved, out of 220 respondents who participated in the study, 14 (6.4%) said not at all, 70 (31.8 said to a little extent, 58 (26.4%) said to a moderate extent, 43 (19.5%) said to a great extent and 35 (15.9%) said to a very great extent. This was backed by a mean of 3.07 and standard deviation of 0.1. This is lower than the composite mean and standard deviation which implies that community participation is not involved.

To achieve this objective, the respondents were asked to give their opinions on the level of agreement or disagreement with the statements provided in a likert scale of 1-5 where

1=strongly disagree, 2= disagree, 3= not sure, 4= agree, and 5= strongly agree. The results are provided in table 4.10.

Table 4.10: Agreement Level on Partnership in Planning and provision of health care services

Statements	SD	D	NS	A	SA	Mean	Std dev
Organization inventories procedures influence the M&E in health service provision	18 (8.2%)	45(20.5%)	62(28.2%)	47(21.4%)	48(21.8%)	3.28	0.2
Communication management among organizations funding influence provision of health care services	26(11.8%)	39(17.7%)	47(21.4%)	58(26.4%)	50(22.7%)	3.3	0.5
Stakeholder support influence the level of provision of health services in public health institutions	25(11.4%)	54(24.5%)	55(25%)	39(17.7%)	47(21.4%)	3.13	0.2
Donor partnership assists in improving Monitoring & Evaluation	18 (8.2%)	37(16.8%)	58(26.4%)	57(25.9%)	50(22.7%)	3.38	0.1
The community is always available to provide relevant information on Monitoring &Evaluation in health related projects	19(8.6%)	55(25%)	60(27.3%)	49(22.3%)	37(16.8%)	3.14	0.1
Total						**16.24**	**1.1**
Composite Mean						**3.25**	**0.22**

On organization inventories procedures influence the M&E in health service provision, out of 220 respondents who participated in the study, 18 (8.2%) strongly disagreed, 45 (20.5%) disagreed, 62 (28.2%) were not sure, 47 (21.4%) agreed and 48 (21.8%) strongly agreed. This was backed by a mean of 3.28 and standard deviation of 0.2. This is greater than the composite mean and standard deviation which implies that organization inventories procedures influence the M&E in health service provision.

On communication management among organizations funding influence provision of health care services, out of 220 respondents who participated in the study, 26 (11.8%) strongly disagreed, 39 (17.7%) disagreed, 47 (21.4%) were not sure, 58 (26.4%) agreed and 50 (22.7%) strongly agreed. This was backed by a mean of 3.30 and standard deviation of 0.5. This is greater than the composite mean and standard deviation which implies that communication management among organizations funding influence provision of health care services.

On stakeholder support influence the level of provision of health services in public health institutions, out of 220 respondents who participated in the study, 25 (11.4%) strongly disagreed, 54 (24.5%) disagreed, 55 (25.0%) were not sure, 39 (17.7%) agreed and 47 (21.4%) strongly agreed. This was backed by a mean of 3.13 and standard deviation of 0.2. This is lower than the composite mean and standard deviation which implies that stakeholder support did not influence the level of provision of health services in public health institutions

On donor partnership assists in improving Monitoring & Evaluation, out of 220 respondents who participated in the study, 18 (8.2%) strongly disagreed, 37 (16.8%) disagreed, 58 (26.4%) were not sure, 57 (25.9%) agreed and 50 (22.7%) strongly agreed. This was backed by a mean of 3.38 and standard deviation of 0.1. This is greater than the composite mean and standard deviation which implies that donor partnership assists in improving Monitoring & Evaluation.

On the community is always available to provide relevant information on Monitoring &Evaluation in health related projects, out of 220 respondents who participated in the

study, 19 (8.6%) strongly disagreed, 55 (25.0%) disagreed, 60 (27.3%) were not sure, 49 (22.3%) agreed and 37 (16.8%) strongly agreed. This was backed by a mean of 3.14 and standard deviation of 0.1. This is lower than the composite mean and standard deviation which implies that the community is not always available to provide relevant information on Monitoring &Evaluation in health related projects.

4.4.1 Regression analysis

In this study, a multiple regression analysis was conducted to test the influence among partnership for managing M&E indicators. The research used statistical package for social sciences (SPSS Version 21) to code, enter and compute the measurements of the multiple regressions.

Table 4.11: Multiple Regression Between Partnership for managing M&E and Provision of Health Care Services (dependent variable) in Public Health Institutions

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.820	.672	.643	.1042

a. Predictors: (Constant), Inventory of organization involved, Communication systems, Stakeholder support.

The data in Table 4.11 indicated that R-Square (coefficient of determination) is a commonly used statistic to evaluate model fit. R-square is 1 minus the ratio of residual variability. The adjusted $R^{2,}$ also called the coefficient of multiple determinations, is the percent of the variance in the dependent explained uniquely or jointly by the independent indicators of partnership for managing M&E. 67.2% of the provision of health care

services in public health institutions in Migori County. Variables could be attributed to the combined effect of the partnership for managing M&E indicators.

Table 4.12: ANOVA Results of the Regression Analysis Between Provision of Health Care Services in Public Health Institutions and Partnership for Managing M&E Indicators

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	10.486	6	2.578	3.276	.03
	Residual	87.408	210	.436		
	Total	97.894	216			

a. Predictors: Inventory of organization involved, Communication systems, Stakeholder support.

b. Dependent Variable: provision of health care services in Public Health Institutions in Migori county.

The data in Table 4.12 indicated that the probability value of 0.03 indicates that the regression relationship was highly significant in predicting how inventory of organization involved, communication systems, stakeholder support influenced provision of health care services in public health institutions in Migori County. The F critical at 5% level of significance was 3.276 since F calculated is greater than the F critical (value = 2.830), this shows that the overall model was significant.

Table 4.13: Regression Coefficients of the Relationship Between Provision of Health Care Services in Public Health Institutions and the Partnership for Managing M&E Indicators

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	T	Sig.
1	(Constant)	1.608	0.281		3.275	0.0001
	Inventory of organization involved	0.432	0.275	0.426	0.165	0.04
	Communication systems	0.526	0.194	0.517	0.192	0.001
	Stakeholder support	0.502	0.256	0.489	0.207	0.02
a. Dependent Variable: provision of health care services in Public Health Institutions						

As per the SPSS generated table above, the equation ($\mathbf{Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \varepsilon}$) becomes:

$Y = 1.608 + 0.432X_1 + 0.526 X_2 + 0.502 X_3$

The regression equation in Table 4.13 has established that taking all factors into account (inventory of organization involved, communication systems, and stakeholder support) constant at zero provision of health care services in Public Health Institutions will be 1.608. The findings presented also show that taking all other independent variables at zero, a unit increase in communication systems would lead to a 0.526 increase in the provision of health care services in Public Health Institutions.

Further, the findings shows that a unit increases in stakeholder support would lead to a 0.502 increase in provision of health care services in Public Health Institutions. In addition, the findings show that a unit increase in inventory of organization involved

would lead to a 0.432 increase in provision of health care services in Public Health Institutions. Overall, number of training packages had the least effect on provision of health care services in Public Health Institutions and level of capacity building had the highest effect.

Communication systems calculated p-value was found to be 0.001 which is statistically significant ($p<0.05$) which is level of confidence. The communication systems have a positive significant influence on provision of health care services in public health institutions. Stakeholder support calculated P-value was found to be 0.02 which is statistically significant since $P<0.05$. There is a positive correlation between stakeholder support and the provision of health care services in public health institutions. Inventory of organization involved calculated P-value was found to be 0.04 which statistically $P<0.05$ hence significant. There is a positive correlation between inventory of organization involved and the provision of health care services in public health institutions.

4.5 Monitoring and Evaluation Work Plan and Provision of Health Care Services

The third objective that the study wanted to achieve was to determine the extent to which M&E work plan influence provision of health care services in public health institutions in Migori County, Kenya.

To achieve this objective, the respondents were asked to give their opinions on the level of agreement or disagreement with the statements provided in a likert scale of 1-5 where 1=Not at all, 2= little extent, 3= moderate extent, 4= great extent, and 5= very great extent. The results are provided in table 4.14.

Table 4.14: Relationship Between Monitoring and Evaluation Work Plan and Provision of Health Care Services

Statements	NA	LE	ME	GE	VGE	Mean	Std dev
Training programmes	23(10.5%)	43(19.5%)	47(21.4%)	75(34.1%)	32 (14.5%)	3.23	0.1
Periodic Monitoring & Evaluation assessment	12(5.5%)	18(8.2%)	58(26.4%)	87(39.5%)	45(20.5%)	3.61	0.3
Ability to work on time scope	24(10.9%)	28(12.7%)	56(25.5%)	72(32.7%)	40 (18.2%)	3.35	0.1
Availability of skilled labour	2(0.9%)	32 (14.5%)	48(21.8%)	89(40.5%)	49(22.3%)	3.69	0.6
Budget constraints	1(0.5%)	30(13.6%)	59(26.8%)	90(40.9%)	40 (18.2%)	3.63	0.4
Total						**17.5**	**1.4**
Composite						**3.5**	**0.28**

On training programmes, out of 220 respondents who participated in the study, 23 (10.5%) said not at all, 43 (19.5%) said to a little extent, 47 (21.4%) said to a moderate extent, 75 (34.1%) said to a great extent and 32 (14.5%) said to a very great extent. This was backed by a mean of 3.23 and standard deviation of 0.1. This is lower than the composite mean and standard deviation which implies that there training programmes did not influence provision of health care services.

On periodic Monitoring & Evaluation assessment, out of 220 respondents who participated in the study, 12 (5.5%) said not at all, 18 (8.2%) said to a little extent, 58 (26.4%) said to a moderate extent, 87 (39.5%) said to a great extent and 45 (20.5%) said to a very great extent. This was backed by a mean of 3.61 and standard deviation of 0.2. This is greater than the composite mean and standard deviation which implies that periodic Monitoring & Evaluation assessment influenced provision of health care services.

On ability to work on time scope, out of 220 respondents who participated in the study, 24 (10.9%) said not at all, 28 (12.7%) said to a little extent, 56 (25.5%) said to a moderate extent, 72 (32.7%) said to a great extent and 40 (18.2%) said to a very great extent. This was backed by a mean of 3.35 and standard deviation of 0.1. This is lower than the composite mean and standard deviation which implies that ability to work on time scope did not influence provision of health care services.

On availability of skilled labour, out of 220 respondents who participated in the study, 2 (0.9%) said not at all, 32 (14.5%) said to a little extent, 48 (21.8%) said to a moderate extent, 89 (40.5%) said to a great extent and 49 (22.3%) said to a very great extent. This was backed by a mean of 3.69 and standard deviation of 0.6. This is greater than the composite mean and standard deviation which implies that availability of skilled labour influenced provision of health care services.

On budget constraints, out of 220 respondents who participated in the study, 1 (0.5%) said not at all, 30 (13.6%) said to a little extent, 59 (26.8%) said to a moderate extent, 90 (40.9%) said to a great extent and 40 (18.2%) said to a very great extent. This was backed by a mean of 3.63 and standard deviation of 0.4. This is greater than the composite mean and standard deviation which implies that budget constraints influenced provision of health care services.

To achieve this objective, the respondents were asked to give their opinions on the level of agreement or disagreement with the statements provided in a likert scale of 1-5 where 1=strongly disagree, 2= disagree, 3= not sure, 4= agree, and 5= strongly agree. The results are provided in table 4.15.

Table 4.15: Agreement Level on Monitoring & Evaluation Work Plan and Provision of Health Services

Statements	SD	D	NS	A	SA	Mean	Std dev
Training programs do assist monitoring and evaluation officers to come up with a good and SMART plan in provision of health care services	18(8.2%)	35(15.9%)	46(20.9%)	65(29.5%)	56(25.5%)	3.48	0.1
Periodic M&E assessment do influence the level of accuracy in data analysis thus being reflected in provision of health services provision	7(3.2%)	15(6.8%)	40(18.2%)	90(40.9%)	68(30.9%)	3.9	0.5
The M&E work plan is always done on the specified time scope	11(5.0%)	18(8.2%)	42(19.1%)	76(34.5%)	73(33.2%)	3.83	0.4
There is the availability of skilled labour on M&E plan systems	11(5.0%)	20(9.1%)	50(22.7%)	69(31.4%)	70(31.8%)	3.76	0.7
Budget constraints do influence the delivery of M&E plan and provision of health care Services	7(3.2%)	19(8.6%)	51(23.2%)	78(35.5%)	65(29.5%)	3.8	0.4
Total						**18.76**	**1.7**
Composite						**3.75**	**0.34**

On training programs do assist monitoring and evaluation officers to come up with a good and SMART plan in provision of health care services, out of 220 respondents who participated in the study, 18 (8.2%) strongly disagreed, 35 (15.9%) disagreed, 46 (20.9%) were not sure, 65 (29.5%) agreed and 56 (25.5%) strongly agreed. This was backed by a mean of 3.48 and standard deviation of 0.1. This is lower than the composite mean and standard deviation which implies that training programs do not assist monitoring and evaluation officers to come up with a good and SMART plan in provision of health care services.

On periodic M&E assessment do influence the level of accuracy in data analysis thus being reflected in provision of health services provision, out of 220 respondents who participated in the study, 7 (3.2%) strongly disagreed, 15 (6.8%) disagreed, 40 (18.2%) were not sure, 90 (40.9%) agreed and 68 (30.9%) strongly agreed. This was backed by a mean of 3.90 and standard deviation of 0.5. This is greater than the composite mean and standard deviation which implies that periodic M&E assessment do influence the level of accuracy in data analysis thus being reflected in provision of health services provision.

On the M&E work plan is always done on the specified time scope, out of 220 respondents who participated in the study, 11 (5.0%) strongly disagreed, 18 (8.2%) disagreed, 42 (19.1%) were not sure, 76 (34.5%) agreed and 73 (33.2%) strongly agreed. This was backed by a mean of 3.83 and standard deviation of 0.4. This is greater than the composite mean and standard deviation which implies that the M&E work plan is always done on the specified time scope.

On there is the availability of skilled labour on M&E plan, out of 220 respondents who participated in the study, 11 (5.0%) strongly disagreed, 20 (9.1%) disagreed, 50 (22.7%) were not sure, 69 (31.4%) agreed and 70 (31.8%) strongly agreed. This was backed by a mean of 3.76 and standard deviation of 0.7. This is greater than the composite mean and standard deviation which implies that there is the availability of skilled labour on M&E plan.

On budget constraints do influence the delivery of M&E plan and provision of health care Services, out of 220 respondents who participated in the study, 7 (3.2%) strongly disagreed, 19 (8.6%) disagreed, 51 (23.2%) were not sure, 78 (35.5%) agreed and 65

(29.5%) strongly agreed. This was backed by a mean of 3.80 and standard deviation of 0.4. This is greater than the composite mean and standard deviation which implies that budget constraints do influence the delivery of M&E plan and provision of health care Services.

4.5.1 Regression analysis

In this study, a multiple regression analysis was conducted to test the influence among M & E work plan indicators. The research used statistical package for social sciences (SPSS Version 21) to code, enter and compute the measurements of the multiple regressions.

Table 4.16: Multiple Regression Between M & E work plan and Provision of Health Care Services (dependent variable) in Public Health Institutions

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.924	.854	.807	.1009

a. Predictors: (Constant), Training programs, Periodical M&E assessment, Adequate skilled labour and resources.

The data in Table 4.16 indicated that R-Square (coefficient of determination) is a commonly used statistic to evaluate model fit. R-square is 1 minus the ratio of residual variability. The adjusted $R^{2,}$ also called the coefficient of multiple determinations, is the percent of the variance in the dependent explained uniquely or jointly by the independent indicators of M & E work plan. 85.4% of the provision of health care services in public health institutions in Migori County. Variables could be attributed to the combined effect of the M & E work plan indicators.

Table 4.17: ANOVA Results of the Regression Analysis Between Provision of Health Care Services in Public Health Institutions and M & E work plan Indicators

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	13.654	5	2.279	3.176	.003
	Residual	82.673	211	.187		
	Total	96.327	216			

a. Predictors: Training programs, Periodical M&E assessment, Adequate skilled labour and resources.

b. Dependent Variable: provision of health care services in Public Health Institutions in Migori county.

The data in Table 4.17 indicated that the probability value of 0.003 indicates that the regression relationship was highly significant in predicting how training programs, periodical M&E assessment, adequate skilled labour and resources influenced provision of health care services in public health institutions in Migori County. The F critical at 5% level of significance was 3.176 since F calculated is greater than the F critical (value = 2.830), this shows that the overall model was significant.

Table 4.18: Regression Coefficients of the Relationship Between Provision of Health Care Services in Public Health Institutions and the M & E work plan Indicators

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	T	Sig.
1	(Constant)	1.503	0.346		3.186	0.01
	Training programs	0.769	0.283	0.738	0.186	0.002
	Periodical M&E assessment	0.526	0.209	0.496	0.256	0.001
	Adequate skilled labour and resources	0.502	0.197	0.473	0.248	0.07
a. Dependent Variable: provision of health care services in Public Health Institutions						

As per the SPSS generated table above, the equation ($\mathbf{Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \varepsilon}$) becomes:

$Y = 1.503 + 0.769X_1 + 0.526 X_2 + 0.502 X_3$

The regression equation in Table 4.18 has established that taking all factors into account (training programs, periodical M&E assessment, and adequate skilled labour and resources) constant at zero provision of health care services in Public Health Institutions will be 1.503. The findings presented also show that taking all other independent variables at zero, a unit increase in training programs would lead to a 0.769 increase in the provision of health care services in Public Health Institutions.

Further, the findings shows that a unit increases in periodical M&E assessment would lead to a 0.502 increase in provision of health care services in Public Health Institutions. In addition, the findings show that a unit increase in adequate skilled labour and resources would lead to a 0.432 increase in provision of health care services in Public

Health Institutions. Overall, adequate skilled labour and resources had the least effect on provision of health care services in Public Health Institutions and training programs had the highest effect.

Training programs calculated p-value was found to be 0.001 which is statistically significant ($p<0.05$) which is level of confidence. The training programs have a positive significant influence on provision of health care services in public health institutions. periodical M&E assessment calculated P-value was found to be 0.02 which is statistically significant since $P<0.05$. There is a positive correlation between periodical M&E assessment and the provision of health care services in public health institutions. Adequate skilled labour and resources calculated P-value was found to be 0.04 which statistically $P<0.05$ hence significant. There is a positive correlation between adequate skilled labour and resources and the provision of health care services in public health institutions.

4.6 Monitoring and Evaluation on Data Auditing and Provision of Health Care Services

The fourth objective that the study wanted to achieve was to determine the extent to which M&E on data auditing influence provision of health care services in public health institutions in Migori County, Kenya.

To achieve this objective, the respondents were asked to give their opinions on the level of agreement or disagreement with the statements provided in a likert scale of 1-5 where 1=Not at all, 2= little extent, 3= moderate extent, 4= great extent, and 5= very great extent. The results are provided in table 4.19.

Table 4.19: Relationship Between Data Auditing and Provision of Health Care Services

Statements	NA	LE	ME	GE	VGE	Mean	Std dev
Data quality assurance	37(16.8%)	32(14.5%)	49(22.3%)	56(25.5%)	46(20.9%)	3.19	0.2
Internal and external auditor meetings	24(10.9%)	29(13.2%)	59(26.8%)	50(22.7%)	58(26.4%)	3.4	0.9
Regular data assessment	11(5.0%)	43(19.5%)	52(23.6%)	51(23.2%)	63(28.6%)	3.51	0.7
Data is delivered on specified time scope	37(16.8%)	27(12.3%)	44(20.0%)	64(29.1%)	48(21.8%)	3.27	0.1
Donor partnership on data auditing	35(15.9%)	20(9.1%)	65(29.5%)	59(26.8%)	41(18.6%)	3.23	0.1
Technical knowhow on data assessment	40(18.2%)	25(11.4%)	50(22.7%)	65(29.5%)	40(18.2%)	3.18	0.2
Total						**19.79**	**2.2**
Composite						**3.3**	**0.37**

On data quality assurance, out of 220 respondents who participated in the study, 37 (16.8%) said not at all, 32 (14.5%) said to a little extent, 49 (22.3%) said to a moderate extent, 56 (25.5%) said to a great extent and 46 (20.9%) said to a very great extent. This was backed by a mean of 3.19 and standard deviation of 0.2. This is lower than the composite mean and standard deviation which implies that data quality assurance did not influence provision of health care.

On internal and external auditor meetings, out of 220 respondents who participated in the study, 24 (10.9%) said not at all, 29 (13.2%) said to a little extent, 59 (26.8%) said to a moderate extent, 50 (22.7%) said to a great extent and 58 (26.4%) said to a very great extent. This was backed by a mean of 3.40 and standard deviation of 0.9. This is greater than the composite mean and standard deviation which implies that internal and external auditor meetings influenced provision of health care.

On regular data assessment, out of 220 respondents who participated in the study, 11 (5.0%) said not at all, 43 (19.5%) said to a little extent, 52 (23.6%) said to a moderate extent, 51 (23.2%) said to a great extent and 63 (28.6%) said to a very great extent. This was backed by a mean of 3.51 and standard deviation of 0.7. This is greater than the composite mean and standard deviation which implies that regular data assessment influenced provision of health care.

On data is delivered on specified time scope, out of 220 respondents who participated in the study, 37 (16.8%) said not at all, 27 (12.3%) said to a little extent, 44 (20.0%) said to a moderate extent, 64 (29.1%) said to a great extent and 48 (21.8%) said to a very great extent. This was backed by a mean of 3.27 and standard deviation of 0.1. This is lower than the composite mean and standard deviation which implies that data is delivered on specified time scope did not influence provision of health care.

On donor partnership on data auditing, out of 220 respondents who participated in the study, 35 (15.9%) said not at all, 20 (9.1%) said to a little extent, 65 (29.5%) said to a moderate extent, 59 (26.8%) said to a great extent and 41 (18.6%) said to a very great extent. This was backed by a mean of 3.23 and standard deviation of 0.1. This is lower than the composite mean and standard deviation which implies that donor partnership on data auditing did not influence provision of health care.

On technical knowhow on data assessment, out of 220 respondents who participated in the study, 40 (18.2%) said not at all, 25 (11.4%) said to a little extent, 50 (22.7%) said to a moderate extent, 65 (29.5%) said to a great extent and 40 (18.2%) said to a very great extent. This was backed by a mean of 3.18 and standard deviation of 0.2. This is lower

than the composite mean and standard deviation which implies that technical knowhow on data assessment did not influence provision of health care.

To achieve this objective, the respondents were asked to give their opinions on the level of agreement or disagreement with the statements provided in a likert scale of 1-5 where 1=strongly disagree, 2= disagree, 3= not sure, 4= agree, and 5= strongly agree. The results are provided in table 4.20.

Table 4.20: Agreement Level on Data Auditing and Provision of Health Care Services

Statements	SD	D	NS	A	SA	Mean	Std dev
Data quality assurance in M&E influences provision of health care services	9(4.1%)	45 (20.5%)	45 (20.5%)	64(29.1%)	57(25.9%)	3.52	0.5
Regular meetings with internal and external auditors do influence the quality of data analyzed from M&E.	22(10.0%)	50(22.7%)	40(18.2%)	55(25.0%)	53(24.1%)	3.3	0.2
Regular data assements do ensure capturing of every single detail to enhance proper evaluation in giving the feedback on health care services provision.	20(9.1%)	37(16.8%)	56(25.5%)	59(26.8%)	48(21.8%)	3.35	0.2
Donor partnership assists in acquiring quality data	16(7.3%)	38(17.3%)	48(21.8%)	60(27.3%)	58(26.4%)	3.48	0.2
The advanced data assessment methods influence the supervision and auditing of quality information.	15(6.8%)	42(19.1%)	53(24.1%)	60(27.3%)	50(22.7%)	3.4	0.1
Total						**17.06**	**1.5**
Composite						**3.41**	**0.3**

On data quality assurance in M&E influences provision of health care services, out of 220 respondents who participated in the study, 9 (4.1%) strongly disagreed, 45 (20.5%) disagreed, 45 (20.5%) were not sure, 64 (29.1%) agreed and 57 (25.9%) strongly agreed.

This was backed by a mean of 3.52 and standard deviation of 0.5. This is greater than the composite mean and standard deviation which implies that data quality assurance in M&E influences provision of health care services.

On regular meetings with internal and external auditors do influence the quality of data analyzed from M&E, out of 220 respondents who participated in the study, 22 (10.0%) strongly disagreed, 50 (22.7%) disagreed, 40 (18.2%) were not sure, 55 (25.0%) agreed and 53 (24.1%) strongly agreed. This was backed by a mean of 3.30 and standard deviation of 0.2. This is lower than the composite mean and standard deviation which implies that regular meetings with internal and external auditors do not influence the quality of data analyzed from M&E.

On regular data assessments do ensure capturing of every single detail to enhance proper evaluation in giving the feedback on health care services provision, out of 220 respondents who participated in the study, 20 (9.1%) strongly disagreed, 37 (16.8%) disagreed, 56 (25.5%) were not sure, 59 (26.8%) agreed and 48 (21.8%) strongly agreed. This was backed by a mean of 3.35 and standard deviation of 0.2. This is lower than the composite mean and standard deviation which implies that regular data assessments do not ensure capturing of every single detail to enhance proper evaluation in giving the feedback on health care services provision.

On donor partnership assists in acquiring quality data, out of 220 respondents who participated in the study, 16 (7.3%) strongly disagreed, 38 (17.3%) disagreed, 48 (21.8%) were not sure, 60 (27.3%) agreed and 58 (26.4%) strongly agreed. This was backed by a

mean of 3.48 and standard deviation of 0.4. This is greater than the composite mean and standard deviation which implies that donor partnership assists in acquiring quality data.

On the advanced data assessment methods influence the supervision and auditing of quality information, out of 220 respondents who participated in the study, 15 (6.8%) strongly disagreed, 42 (19.1%) disagreed, 53 (24.1%) were not sure, 60 (27.3%) agreed and 50 (22.7%) strongly agreed. This was backed by a mean of 3.40 and standard deviation of 0.1. This is lower than the composite mean and standard deviation which implies that the advanced data assessment methods do not influence the supervision and auditing of quality information.

4.6.1 Regression analysis

In this study, a multiple regression analysis was conducted to test the influence among M&E data auditing indicators. The research used statistical package for social sciences (SPSS Version 21) to code, enter and compute the measurements of the multiple regressions.

Table 4.21: Multiple Regression Between M&E data auditing and Provision of Health Care Services (dependent variable) in Public Health Institutions

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.787	.619	.602	.1027

a. Predictors: (Constant), Data quality assurance, Regular data assessments, Adequate skilled labour and resources.

The data in Table 4.21 indicated that R-Square (coefficient of determination) is a commonly used statistic to evaluate model fit. R-square is 1 minus the ratio of residual variability. The adjusted $R^{2,}$ also called the coefficient of multiple determinations, is the percent of the variance in the dependent explained uniquely or jointly by the independent indicators of M&E data auditing. 61.9% of the provision of health care services in public health institutions in Migori County. Variables could be attributed to the combined effect of the M&E data auditing indicators.

Table 4.22: ANOVA Results of the Regression Analysis Between Provision of Health Care Services in Public Health Institutions and M&E data auditing Indicators

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	12.458	4	2.458	3.285	.001
	Residual	85.106	212	.239		
	Total	97.564	216			

a. Predictors: Data quality assurance, Regular data assessments.

b. Dependent Variable: provision of health care services in Public Health Institutions in Migori county.

The data in Table 4.22 indicated that the probability value of 0.001 indicates that the regression relationship was highly significant in predicting how data quality assurance and regular data assessments influenced provision of health care services in public health institutions in Migori County. The F critical at 5% level of significance was 3.285 since F calculated is greater than the F critical (value = 2.830), this shows that the overall model was significant.

Table 4.23: Regression Coefficients of the Relationship Between Provision of Health Care Services in Public Health Institutions and the M&E data auditing Indicators

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	T	Sig.
1	(Constant)	1.618	0.346		3.186	0.001
	Data quality assurance	0.684	0.283	0.738	0.186	0.0001
	Regular data assessments	0.594	0.209	0.496	0.256	0.02
a. Dependent Variable: provision of health care services in Public Health Institutions						

As per the SPSS generated table above, the equation ($\mathbf{Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \varepsilon}$) becomes:

$Y = 1.618 + 0.684X_1 + 0.594\ X_2$

The regression equation in Table 4.23 has established that taking all factors into account (data quality assurance and regular data assessments) constant at zero provision of health care services in Public Health Institutions will be 1.618. The findings presented also show that taking all other independent variables at zero, a unit increase in data quality assurance would lead to a 0.684 increase in the provision of health care services in Public Health Institutions.

Further, the findings shows that a unit increases in regular data assessments would lead to a 0.594 increase in provision of health care services in Public Health Institutions. Overall, regular data assessments had the least effect on provision of health care services in Public Health Institutions and data quality assurance had the highest effect.

Data quality assurance calculated p-value was found to be 0.0001 which is statistically significant ($p<0.05$) which is level of confidence. The data quality assurance has a positive significant influence on provision of health care services in public health institutions. Regular data assessments calculated P-value was found to be 0.02 which is statistically significant since $P<0.05$. There is a positive correlation between regular data assessments and the provision of health care services in public health institutions.

4.7 Inferential Analysis

4.7.1 Correlation Analysis

Table 4.24: Correlation Analysis of Provision of Health Care Services in Public Health Institutions and Independents Variables

		Provision of health care services	M&E human capacity	M&E partnerships in planning and managing	M&E work plan	M&E data auditing
Provision of health care services	Pearson Correlation	1	0.389	0.267	0.674	0.538
	Sig. (2-tailed)		0.0003	0.0001	0	0.0007
	N	220	220	220	220	220
M&E human capacity	Pearson Correlation	0.389	1	0.361	0.317	0.218
	Sig. (2-tailed)	0.0003		0.0003	0.0003	0.0003
	N	220	220	220	220	220
M&E partnerships in planning and managing	Pearson Correlation	0.267	0.245	1	0.208	0.197
	Sig. (2-tailed)	0.0001	0.0001		0.0001	0.0001
	N	220	220	220	220	220
M&E work plan	Pearson Correlation	0.674	0.586	0.549	1	0.519
	Sig. (2-tailed)	0	0	0		0
	N	220	220	220	220	220
M&E data auditing	Pearson Correlation	0.538	0.518	0.492	0.461	1
	Sig. (2-tailed)	0.0007	0.0007	0.0007	0.0007	
	N	220	220	220	220	220

Analysis in Table 4.24 above indicates strong correlations between independents variables and dependent variable: M&E human capacity, M&E partnerships in planning and managing, M&E work plan, M&E data auditing and provision of health care services in public health institutions (r=0.389 P<0.01. r=0.267 P<0.01. r=0.674 P<0.01. r=0.538 P<0.01 respectively). This shows that correlation is statistically significant.

4.7.2 Regression Analysis

In this study, a multiple regression analysis was conducted to test the influence among predictor variables. The research used statistical package for social sciences (SPSS Version 21) to code, enter and compute the measurements of the multiple regressions.

Table 4.25: Multiple Regression Between Monitoring & Evaluation and Provision of Health Care Services (dependent variable) in Public Health Institutions

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.821	.674	.672	.1037

a. Predictors: (Constant), human capacity, partnerships in planning and managing, work plan and data auditing.

The data in Table 4.24 indicated that R-Square (coefficient of determination) is a commonly used statistic to evaluate model fit. R-square is 1 minus the ratio of residual variability. The adjusted $R^{2,}$ also called the coefficient of multiple determinations, is the percent of the variance in the dependent explained uniquely or jointly by the independent variables. 67.2% of the provision of health care services in public health institutions in Migori County. Variables could be attributed to the combined effect of the predictor variables.

Table 4.26: ANOVA Results of the Regression Analysis Between Provision of Health Care Services in Public Health Institutions and Predictor Variables

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	12.223	4	3.112	3.264	.0001
	Residual	92.876	212	.641		
	Total	115.099	216			

a. Predictors: human capacity, partnerships in planning and managing, work plan and data auditing.

b. Dependent Variable: provision of health care services in Public Health Institutions in Migori county.

The data in Table 4.25 indicated that the probability value of 0.0001 indicates that the regression relationship was highly significant in predicting how human capacity, partnerships in planning and managing, work plan and data auditing influenced provision of health care services in public health institutions in Migori County. The F critical at 5% level of significance was 3.264 since F calculated is greater than the F critical (value = 2.830), this shows that the overall model was significant.

Table 4.27: Regression Coefficients of the Relationship Between Provision of Health Care Services in Public Health Institutions and the Predictive Variables

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	T	Sig.
1	(Constant)	1.607	0.422		3.472	0
	M&E human capacity	0.564	0.093	0.597	0.143	0.03
	M&E partnerships in planning and managing	0.437	0.085	0.472	0.135	0.02
	M&E work plan	0.862	0.087	0.902	0.349	0.003
	M&E data auditing	0.735	0.084	0.826	0.257	0.001

a. Dependent Variable: provision of health care services in Public Health Institutions

As per the SPSS generated table above, the equation ($\mathbf{Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \beta_4 X_4 + \varepsilon}$) becomes:

$$Y = 1.607 + 0.564X_1 + 0.437X_2 + 0.862X_3 + 0.735X_4$$

The regression equation in Table 4.26 has established that taking all factors into account (human capacity, partnerships in planning and managing, work plan and data auditing) constant at zero provision of health care services in Public Health Institutions will be 1.607. The findings presented also show that taking all other independent variables at zero, a unit increase in M&E work plan would lead to a 0.862 increase in the provision of health care services in Public Health Institutions.

Further, the findings shows that a unit increases in M&E data auditing would lead to a 0.735 increase in provision of health care services in Public Health Institutions. In addition, the findings show that a unit increase in M&E human capacity would lead to a 0.564 increase in provision of health care services in Public Health Institutions. Also, the findings show that a unit increase in M&E partnerships in planning and managing would lead to a 0.437 increase in provision of health care services in Public Health Institutions. Overall, M&E partnerships in planning and managing had the least effect on provision of health care services in Public Health Institutions and M&E work plan had the highest effect.

M&E work plan calculated p-value was found to be 0.003 which is statistically significant ($p<0.05$) which is level of confidence. The M&E work plan has a positive significant influence on provision of health care services in public health institutions. M&E data auditing calculated P-value was found to be 0.001 which is statistically

significant since P<0.05. There is a positive correlation between M&E data auditing and the provision of health care services in public health institutions. M&E human capacity calculated P-value was found to be 0.03 which statistically P<0.05 hence significant. There is a positive correlation between M&E human capacity and the provision of health care services in public health institutions. M&E partnerships in planning and managing calculated P-value was found to be 0.02 which statistically P<0.05 hence significant.

CHAPTER FIVE

SUMMARY OF FINDINGS, DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter comprises of and is organized into the following subheadings: summary of the findings, discussions, conclusions of the study, recommendations of the study and suggestions for further study.

5.2 Summary of Findings

The study assessed the influence of Monitoring and Evaluation systems on the provision of health care Services in public health institutions in Migori County, Kenya by: seeking to establish how human capacity for Monitoring and Evaluation systems influence provision of health care services in public health institutions in Migori County; assess how partnerships in planning and managing Monitoring and Evaluation systems Influence provision of health care services in public health institutions in Migori County; establish the extent to which Monitoring and Evaluation work plan influence the provision of health care services in public health institutions in Migori County; assess how Monitoring and Evaluation on data auditing influences provision of health care services in public health institutions in Migori County**.**

Research instruments used included one questionnaire for the doctors, M&E officers, Nurses, social workers, community health workers and interview guide for the patients. Data from the field was collected by the researcher and analyzed for basic descriptive statistics. The main findings of the study are:

5.2.1 Human Capacity for Monitoring and Evaluation Systems and Provision of Health Care Services

The study found out that technical support increased the knowledge on monitoring and evaluation systems to a moderate extent as indicated by a mean of 3.37 and standard deviation of 0.1. Capacity building on Monitoring & Evaluation increased access on provision of health services to a moderate extent. Core training packages increased the management capacity on provision of health care to a moderate extent. The respondents were not sure if technical support increased knowledge in Monitoring &Evaluation systems as indicated by a mean of 3.31 and standard deviation of 0.2. The respondents were not sure if the Monitoring &Evaluation officers had a high competent level in project management.

5.2.2 Partnerships in Planning and Managing Monitoring and Evaluation Systems and Provision of Health Care Services

The study found out that stakeholder support is documented and influenced provision of health services in public health institution to a moderate extent as indicated by a mean of 3.41 and standard deviation of 0.2. Donor partnership was involved influenced provision of health services in public health institution to a moderate extent. Communication among organization involved influenced provision of health services in public health institution to a moderate extent. The respondents were not sure if donor partnership assisted in improving Monitoring & Evaluation systems as indicated by a mean of 3.38 and standard deviation of 0.1. The respondents were not sure if communication management among organizations funding influenced provision of health care services.

5.2.3 Monitoring and Evaluation Work Plan and Provision of Health Care Services

The study found out that availability of skilled labour influenced provision of health services in public health institution to a great extent as indicated by a mean of 3.69 and standard deviation of 0.6. Budget constraints influenced provision of health services in public health institution to a great extent. Periodic Monitoring & Evaluation assessment influenced provision of health services in public health institution to a great extent. Ability to work on time scope influenced provision of health services in public health institution to a moderate extent. The respondents agreed that periodic M&E assessment influenced the level of accuracy in data analysis thus being reflected in provision of health services provision as indicated by a mean of 3.90 and standard deviation of 0.5. The respondents agreed that the M&E work plan was always done on the specified time scope. Budget constraints influenced the delivery of M&E plan and provision of health care Services.

5.2.4 Monitoring and Evaluation on Data Auditing and Provision of Health Care Services

The study found out that regular data assessment influenced provision of health services in public health institution to a great extent as indicated by a mean of 3.51 and standard deviation of 0.7. Internal and external auditor meetings influenced provision of health services in public health institution to a moderate extent. Data is delivered on specified time scope influenced provision of health services in public health institution to a moderate extent. The respondents agreed that data quality assurance in M&E influenced provision of health care services as indicated by a mean of 3.52 and standard deviation of

0.5. The respondents were not sure if donor partnership assists in acquiring quality data. The respondents were not sure if the advanced data assessment methods influence the supervision and auditing of quality information.

5.3 Discussion

5.3.1 Human Capacity for Monitoring and Evaluation Systems and Provision of Health Care Services

Capacity building on Monitoring & Evaluation increased access on provision of health services to a moderate extent as indicated by a mean of 3.25 and standard deviation of 0.4. White (2013) indicated that M&E staff usually advises more than one project at a time, and have a regional or sectorial assignment with a vast portfolio thus leads to rapid burnout of M&E staff whereby high burnout and turnover rates make recruitment of skilled M&E staff difficult, and limits the organizational expertise available to support M&E development. Core training packages increased the management capacity on provision of health care to a moderate extent as indicated by a mean of 3.08 and standard deviation of 0.4. Nabris (2012) found out that monitoring and evaluation carried out by untrained and inexperienced people is bound to be time consuming, costly and the results generated could be impractical and irrelevant.

5.3.2 Partnerships in Planning and Managing Monitoring and Evaluation Systems and Provision of Health Care Services

Community participation was involved influenced provision of health services in public health institution to a moderate extent as indicated by a mean of 3.07 and standard

deviation of 0.1. WHO (2006) notes that in order to ensure effective M&E for Maternal and Newborn Health (MNH), partnerships should be established with different stakeholders, including the communities as well as other non-health sectors. Stakeholder support is documented influenced provision of health services in public health institution to a moderate extent as indicated by a mean of 3.41 and standard deviation of 0.2. Garbutt (2013) argues that it is of no use having a complex M&E system if your partners are unable to collect data that provides the information you need.

5.3.3 Monitoring and Evaluation Work Plan and Provision of Health Care Services

Budget constraints influenced provision of health services in public health institution to a great extent as indicated by a mean of 3.63 and standard deviation of 0.1. Smith & Chircop (2013) say that financial resources are needed for the time people spend, for supporting information management system, training, transport and so forth. The respondents agreed that the M&E work plan was always done on the specified time scope as indicated by a mean of 3.83 and standard deviation of 0.3. Busiinge (2010) found that donors rarely operate outside the log frame approach where they are boxed in results that are put in the project log frame, and yet sometimes the situation on the ground might affect the achievement of some of the results hence requiring some aspects of the project to be changed.

5.3.4 Monitoring and Evaluation on Data Auditing and Provision of Health Care Services

Data is delivered on specified time scope influenced provision of health services in public health institution to a moderate extent as indicated by a mean of 3.27 and standard

deviation of 0.1. Ediau (2012) found that data was not routinely collected, compiled, stored, analyzed and shared by Child Fund Uganda and project stakeholders. As a result such data was not effectively utilized to track and measure performance as well as inform program improvement and learning. The respondents agreed that data quality assurance in M&E influenced provision of health care services as indicated by a mean of 3.52 and standard deviation of 0.5. Rogito (2010) found that a project implemented without the baseline study faced serious challenges on tracking its‟ progress effectively on indicators.

5.4 Conclusions

Human Capacity for Monitoring and Evaluation Systems and Provision of Health Care Services

The study concluded that capacity building on Monitoring & Evaluation increased access on provision of health services to a moderate extent. Technical support increased the knowledge on monitoring and evaluation systems to a moderate extent. Core training packages increased the management capacity on provision of health care to a moderate extent. There were regular trainings on Monitoring &Evaluation. Overall, number of training packages had the least effect on provision of health care services in Public Health Institutions and level of capacity building had the highest effect. Level of capacity building calculated p-value was found to be 0.05 which is statistically significant ($p<0.05$) which is level of confidence. The level of capacity building has a positive significant influence on provision of health care services in public health institutions.

Partnerships in Planning and Managing Monitoring and Evaluation Systems and Provision of Health Care Services

The study revealed that stakeholder support is documented influenced provision of health services in public health institution to a moderate extent. Donor partnership was involved influenced provision of health services in public health institution to a moderate extent. Communication among organization involved influenced provision of health services in public health institution to a moderate extent. Inventory of organizations involved were available influenced provision of health services in public health institution to a moderate extent. Community participation was involved influenced provision of health services in public health institution to a moderate extent. Overall, number of training packages had the least effect on provision of health care services in Public Health Institutions and level of capacity building had the highest effect. Communication systems calculated p-value was found to be 0.001 which is statistically significant ($p<0.05$) which is level of confidence. The communication systems have a positive significant influence on provision of health care services in public health institutions.

Monitoring and Evaluation Work Plan and Provision of Health Care Services

The study concluded that availability of skilled labour influenced provision of health services in public health institution to a great extent. Budget constraints influenced provision of health services in public health institution to a great extent. Periodic Monitoring & Evaluation assessment influenced provision of health services in public health institution to a great extent. Ability to work on time scope influenced provision of health services in public health institution to a moderate extent. Training programmes influenced provision of health services in public health institution to a moderate extent.

Overall, adequate skilled labour and resources had the least effect on provision of health care services in Public Health Institutions and training programs had the highest effect. Training programs calculated p-value was found to be 0.001 which is statistically significant ($p<0.05$) which is level of confidence. The training programs have a positive significant influence on provision of health care services in public health institutions.

Monitoring and Evaluation on Data Auditing and Provision of Health Care Services

The study revealed that regular data assessment influenced provision of health services in public health institution to a great extent. Internal and external auditor meetings influenced provision of health services in public health institution to a moderate extent. Data is delivered on specified time scope influenced provision of health services in public health institution to a moderate extent. Donor partnership on data auditing influenced provision of health services in public health institution to a moderate extent. Data quality assurance influenced provision of health services in public health institution to a moderate extent. Technical knowhow on data assessment influenced provision of health services in public health institution to a moderate extent. The findings presented also show that taking all other independent variables at zero, a unit increase in data quality assurance would lead to a 0.684 increase in the provision of health care services in Public Health Institutions. Data quality assurance calculated p-value was found to be 0.0001 which is statistically significant ($p<0.05$) which is level of confidence. The data quality assurance has a positive significant influence on provision of health care services in public health institutions.

5.5 Recommendations

Based on the study literature review and findings after the data analysis, the following recommendations were made:

1. The public health institution management should offer technical support to the personnel. This would help to increase the knowledge on monitoring and evaluation systems. Core training packages need to be emphasized. Regular trainings need to be put in place for all the personnel and especially the M & E department.

2. The stakeholder support needs to be documented. The County government needs to encourage donor partnership so as to improve health services in public health institutions. Communication among organization should be encouraged and facilitated by the management. The management needs to avail the inventory of the organizations involved. Community participation need to be sought.

3. The County government needs to employ qualified skilled labour. The finances offered to the health institutions need to be enough to cater for their annual budget. Periodic Monitoring & Evaluation assessment need to be put in place.

4. The management needs to conduct a regular data assessment. Internal and external auditor meetings need to be facilitated by the management. Data should be delivered on specified time scope. The donors need to be involved in data auditing. A policy on data quality assurance needs to be put in place.

5.6 Suggestions for further studies

The study also recommends that further research should be carried out on;

1. The influence of Monitoring and Evaluation systems on the provision of health care Services in public health institutions in other counties which would add to the findings of this study on the need for background knowledge on provision of health care Services in public health institutions.

2. To enhance effective provision of health care Services, on the challenges facing monitoring and evaluation of public health institutions.

3. Influence of information technology system on monitoring and evaluation of public health institutions.

4. Determining how to strengthen primary stakeholders' participation M & E Government Projects particularly how to ensure the beneficiaries can participate effectively in monitoring and evaluating projects.

5.7 Contribution to the body of Knowledge

Objectives	**Contribution to knowledge**
Human capacity for M&E	Core training packages increased the management capacity on provision of health care to a moderate extent. Thus the study adds to the knowledge, how empowering the personnel working at the public health institutions influence M&E in public health institutions.

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APPENDICES

APPENDIX I

LETTER OF INTRODUCTION

UNIVERSITY OF NAIROBI

P. O. BOX 30192-00100

NAIROBI.

13/04/2018

Dear sir/Madam,

RE: PERMISSION TO CARRY OUT ACADEMIC RESEARCH

I am a Master of Project Planning and Management student at University Of Nairobi conducting a research study entitled **"Influence Of Monitoring & Evaluation Systems On The Provision Of Health Care Services In Public Health Institutions In Migori County, Kenya".**

The purpose of this letter is to request you to kindly fill in the questionnaire with precision and accuracy. The questionnaire is supposed to assist in answering specific objectives of the research, which is being undertaken as part of the university requirement. Any information given herein was treated with utmost confidentiality and only be used for the purpose of research. So kindly feel free to fill the questionnaire.

Thank you.

Yours faithfully,

OCHIENG SYLVESTER OOKO

APPENDIX II

RESEARCH QUESTIONNAIRE

This questionnaire requires the respondents to provide information on the topic **Influence of Monitoring & Evaluation Systems on the Provision of Health Care Services in Public Health Institutions in Migori, Kenya.** The Information is purposely intended for academic use only and will not be divulged to any other person. Kindly complete all the sections hereunder. Note that all the Questions herein are interrelated and are equally important for the study.

PART A: DEMOGRAPHIC INFORMATION

1. Name of the respondent (Optional)……

2. What is your gender?

   Female( ) Male ( )

3. What is your age bracket

18-35 ( ) 35-45 ( )

46-59 ( )

4. State your level of education

Certificate ( ) Diploma ( ) University degree ( ) Master Degree ( )

PART B. HUMAN CAPACITY FOR MONITORING AND EVALUATION

5.This section captures Human Capacity for M&E. Based on this, you are asked to give your opinion on the extent in which you agree or disagree with the statement based on a Likert scale of 1-5 where **Not at all – 1, little extent – 2, Moderate extent – 3, Great extent – 4, Very great extent – 5.**

Statements	1	2	3	4	5
• Capacity building on Monitoring & Evaluation increases access on provision of health services					
• Technical support increases the knowledge on					

monitoring and evaluation systems					
• Core training packages increases the management capacity on provision of health care					
• There are regular trainings on Monitoring &Evaluation					
• The staff has a credible competency level on Monitoring &Evaluation					

6. Please tick appropriately your response regarding: how does human capacity for Monitoring &Evaluation systems influence provision of health care services in Migori County, Kenya? **Strongly Disagree – 1, Disagree – 2, Not Sure – 3, Agree – 4, Strongly Agree – 5.**

Statements	**1**	**2**	**3**	**4**	**5**
• Capacity building increases human capacity in provision of Health care services					
• Technical support increases knowledge in Monitoring &Evaluation systems					
• Core training packages increases the quality of health care services					
• Workshops on Monitoring &Evaluation trainings are regularly attended					
• The Monitoring &Evaluation officers has a high competent level in project management					

PART C: PARTNERSHIP IN PLANNING AND MANAGING MONITORING &EVALUATION SYSTEMS

This section captures Partnership for Managing M&E. Based on this, you are asked to give your opinion on the extent in which you agree or disagree with the statement based on a Likert scale of 1-5 where

7. How does partnership in planning and managing Monitoring &Evaluation Systems influence provision of health care services in Public Health Institutions Migori County, Kenya? **Not at all – 1, little extent – 2, Moderate extent – 3, Great extent – 4, Very great extent – 5.**

Statements	1	2	3	4	5
• Inventory of organizations involved are available					
• Communication among organization involved.					
• Stakeholder support is documented					
• Donor partnership is involved					
• Community participation is involved					

8. Please tick appropriately your response regarding; does partnership for planning, coordinating and managing Monitoring &Evaluation systems influence provision of health care services in Migori County, Kenya?

Strongly Disagree – 1, Disagree – 2, Not Sure – 3, Agree – 4, Strongly Agree – 5.

Statements	1	2	3	4	5
• Organization inventories procedures influence the M&E in health service provision					
• Communication management among organizations funding influence provision of health care services					
• Stakeholder support influence the level of provision of health services in public health institutions					
• Donor partnership assists in improving Monitoring & Evaluation systems					
• The community is always available to provide relevant information on Monitoring &Evaluation in health related projects					

PART D: MONITORING & EVALUATION WORK PLAN

This section captures M&E Plan. Based on this, you are asked to give your opinion on the extent to which you agree or disagree with the statement based on a Likert scale of 1-5 where

Not at all – 1, little extent – 2, Moderate extent – 3, Great extent – 4, Very great extent – 5. To what extent does Monitoring & Evaluation Work Plan influence provision of health services in public health Institutions in Migori County, Kenya?

Statements	1	2	3	4	5
• Training programmes					
• Periodic Monitoring & Evaluation assessment					
• Ability to work on time scope					
• Availability of skilled labour					

• Budget constraints					

10. Please tick appropriately your response regarding to what extent does Monitoring & Evaluation Work Plan influence provision of health services in Migori County, Kenya **Strongly Disagree – 1, Disagree – 2, Not Sure – 3, Agree – 4, Strongly Agree – 5.**

Statements	1	2	3	4	5
• Training programs do assist monitoring and evaluation officers to come up with a good and SMART plan in provision of health care services					
• Periodic M&E assessment do influence the level of accuracy in data analysis thus being reflected in provision of health services provision					
• The M&E work plan is always done on the specified time scope					
• There is the availability of skilled labour on M&E plan systems					
• Budget constraints do influence the delivery of M&E plan and provision of health care Services					

PART E: M&E DATA AUDITING

This section captures Support Supervision and Data Auditing. Based on this, you are asked to give your opinion on the extent in which you agree or disagree with the statement based on a Likert scale of 1-5 where **Not at all – 1, little extent – 2, Moderate extent – 3, Great extent – 4, Very great extent – 5.**

11. How does M&E data auditing influence provision of health care services in public health institutions in Migori County, Kenya? **Not at all – 1, little extent – 2, Moderate extent – 3, Great extent – 4, Very great extent – 5.**

Statements	1	2	3	4	5
• Data quality assurance					

• Internal and external auditor meetings					
• Regular data assessment					
• Data is delivered on specified time scope					
• Donor partnership on data auditing					
• Technical knowhow on data assessment					

12. Please tick appropriately your response regarding how Supportive Supervision and Data Auditing on M&E influence provision of health care services in public health institutions in Migori County, Kenya? **Strongly Disagree – 1, Disagree – 2, Not Sure – 3, Agree – 4, Strongly Agree – 5.**

Statements	**1**	**2**	**3**	**4**	**5**
• Data quality assurance in M&E influences provision of health care services					
• Regular meetings with internal and external auditors do influence the quality of data analyzed from M&E.					
• Regular data assements do ensure capturing of every single detail to enhance proper evaluation in giving the feedback on health care services provision.					
• Donor partnership assists in acquiring quality data					
• The advanced data assessment methods influence the supervision and auditing of quality information.					

Thank you for your participation

APPENDIX III

INTERVIEW (for the patients)

i. How does human capacity for Monitoring &Evaluation systems influence provision of health care services in public facilities in Migori County, Kenya?

……
……
……

ii. How does partnership for managing Monitoring &Evaluation systems influence provision of health care services in public facilities in Migori County, Kenya?

……
……
……..

iii. To what extent does Monitoring &Evaluation plan influences provision of health services in public facilities in Migori County, Kenya?

……
……
……

iv. How does data auditing on Monitoring &Evaluation systems influence provision of health care services in public facilities in Migori County, Kenya?

……
……
……..

APPENDIX IV

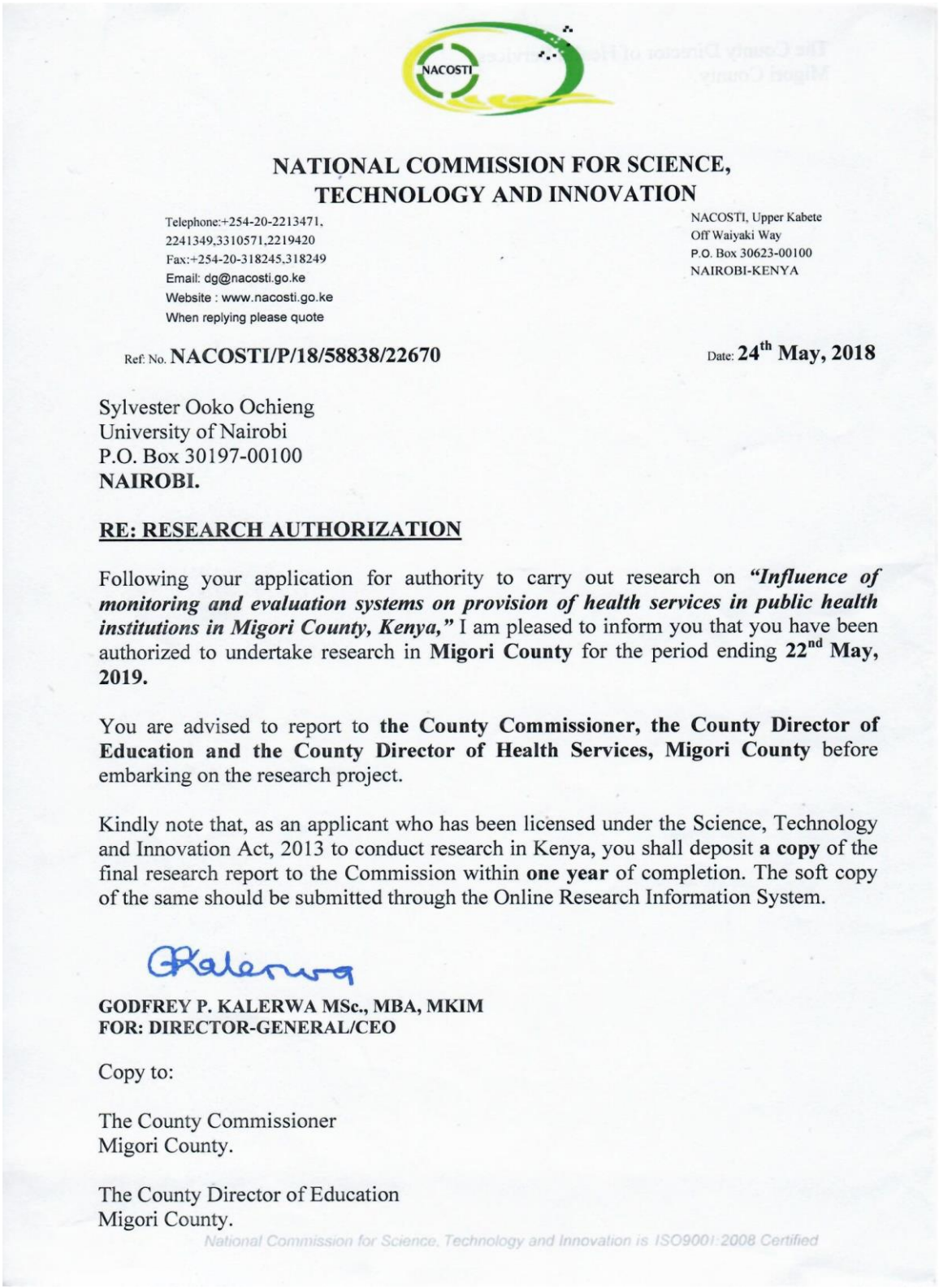
TARGET POPULATION

Table 3. 3: Target Population and Sample Population

Respondents	**Target population**	**Sample population**
Doctors	159	60
M&E officers	80	43
Nurses	500	102
Social workers	37	9
Community health volunteers	21	16
Patients	200	55
Total	**997**	**285**

APPENDIX V

RESEARCH PERMIT



NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

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Fax:+254-20-318245,318249
Email: dg@nacosti.go.ke
Website : www.nacosti.go.ke
When replying please quote

NACOSTI, Upper Kabete
Off Waiyaki Way
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No. **NACOSTI/P/18/58838/22670**

Date: **24th May, 2018**

Sylvester Ooko Ochieng
University of Nairobi
P.O. Box 30197-00100
NAIROBI.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Influence of monitoring and evaluation systems on provision of health services in public health institutions in Migori County, Kenya,"*** I am pleased to inform you that you have been authorized to undertake research in **Migori County** for the period ending **22nd May, 2019.**

You are advised to report to **the County Commissioner, the County Director of Education and the County Director of Health Services, Migori County** before embarking on the research project.

Kindly note that, as an applicant who has been licensed under the Science, Technology and Innovation Act, 2013 to conduct research in Kenya, you shall deposit **a copy** of the final research report to the Commission within **one year** of completion. The soft copy of the same should be submitted through the Online Research Information System.

GODFREY P. KALERWA MSc., MBA, MKIM
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
Migori County.

The County Director of Education
Migori County.

National Commission for Science, Technology and Innovation is ISO9001:2008 Certified

THIS IS TO CERTIFY THAT:
MR. SYLVESTER OOKO OCHIENG
of UNIVERSITY OF NAIROBI, 0-40600 Siaya,has been permitted to conduct research in *Migori County*

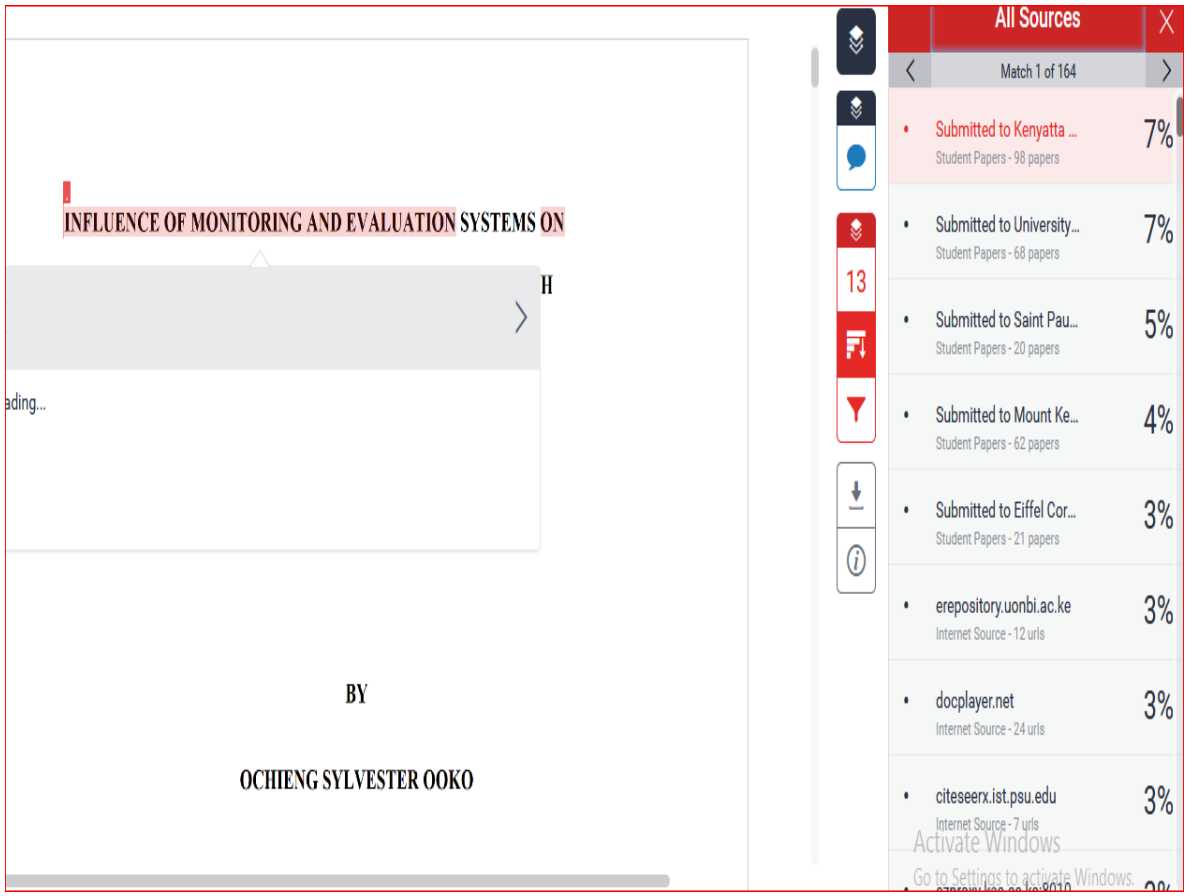
on the topic: *INFLUENCE OF MONITORING AND EVALUATION SYSTEMS ON PROVISION OF HEALTH SERVICES IN PUBLIC HEALTH INSTITUTIONS IN MIGORI COUNTY, KENYA*

for the period ending:
22nd May,2019

Permit No : NACOSTI/P/18/58838/22670
Date Of Issue : 24th May,2018
Fee Recieved :Ksh 1000

.....
Applicant's Signature

.....
Director General
National Commission for Science, Technology & Innovation


INFLUENCE OF MONITORING AND EVALUATION SYSTEMS ON
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BY
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Student Papers - 68 papers
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Submitted to Saint Pau...
Student Papers - 20 papers
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13
Activate Windows
Go to Settings to activate Windows.