

THE EFFECT OF DEVOLUTION ON MONITORING AND
EVALUATION OF HEALTH SERVICES IN KENYA: A CASE
STUDY OF THE COUNTY LEVEL OF GOVERNMENT IN
BUNGOMA AND BARINGO COUNTIES

by

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APPROVAL

THE EFFECT OF DEVOLUTION ON MONITORING AND
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In accordance with Daystar University policies, this thesis is accepted in partial fulfilment of the requirements for the Master of Arts degree.

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DECLARATION

THE EFFECT OF DEVOLUTION ON MONITORING AND
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THE COUNTY LEVEL OF GOVERNMENT IN BUNGOMA AND BARINGO
COUNTIES

I declare that this thesis is my original work and has not been submitted to any other college or university for academic credit.

Signed: _____

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Thank you to my colleagues for holding the fort when I was immersed in this study, and for encouraging me when I was about to give up.

Thank you to my colleagues for holding the fort when I was immersed in my paper, and for encouraging me when I was about to give up.

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LIST OF ABBREVIATIONS AND ACRONYMS

CEC	County Executive Committee Member
CHMT	County Health Management Team
CoH	Chief Officer, Health Services
CSO	Civil Society Organization
DHIS	District Health Information Software
HIS	Health Information System
LMIC	Low and Middle-Income Countries
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NGO	Non-Governmental Organization
SCHMT	Sub-County Health Management Team
SPSS	Statistical Package for the Social Sciences
WHO	World Health Organization

ABSTRACT

This study examined the impact of devolution on monitoring and evaluation (M&E) of health services Kenya, with a particular focus on Baringo and Bungoma counties. The study's objectives were to assess the type of M&E systems in place at the health departments of the two counties; determine the capacity of health services' M&E systems in the health departments of the two counties; assess the availability of data management systems that support M&E of health services in the two counties; establish the level of funding for health services' M&E systems in the two counties; and assess the effect of devolution on health services' M&E systems in the two counties. A cross-sectional research design was applied and quantitative and qualitative data were obtained. The study used stratified random sampling to identify the two counties (Baringo and Bungoma). The sample comprised 112 staff (47 from Baringo County and 65 from Bungoma County), and 28 senior managers (14 from each county) from the two counties' health departments. The 112 staff were identified through stratified random sampling, while the 28 senior managers were chosen through purposeful sampling. In collecting data, a questionnaire was used for the 112 staff, while focus group discussion (FGD) was used for the 28 senior managers. The response rate from the questionnaire was 72%, while that from the FGD was 100%. The study found out that devolution, through the allocation of resources, service management, and scheduling, has made the following possible: M&E staff to improve healthcare access, improvement of the capacity of M&E staff in the healthcare sector, and the enhancement of the quality of healthcare M&E systems. The study recommends, among other things, the establishment of M&E functions in the counties; and the filling of M&E positions in the counties with only persons with M&E qualifications.

DEDICATION

I dedicate this thesis to my dear parents and family members who encouraged and supported me while I was undertaking my studies at Daystar University.

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CHAPTER ONE

INTRODUCTION AND BACKGROUND TO THE STUDY

Introduction

Devolution has been described as a social-political mechanism that shifts the power and accountability of the central government (CG) to local councils for planning, administration, and decision-making (Conyers, 2007). This is partly due to the wish to make health programs more equal, inclusive, and egalitarian (Mills, Vaughan, Smith, & Tabibzadeh, 1990), as well as the creation of productive and effective services by politicians and policymakers (Litvack, Ahmad, & Bird, 1998). Decentralization initiatives in the health sector in the developing world have been applied on a wider scale in the last two decades, normally being a component in a larger reform process encompassing technological, economic, and political dimensions (Litvack et al., 1998; World Bank, 2007).

The Kenya Vision 2030 vision must be backed by sustainable, accessible, and reliable health and related services, whose aim should be to turn Kenya from a third world country to a developed, medium-income nation (Kibua & Mwabu, 2008). Health services at all levels must suit the middle-income economy, reach the highest possible health standards, respond to the public need, and achieve specific health impact goals. Such services need to meet people's needs (Peters, El-Saharty, Siadat, Janovsky & Vujcic, 2009). Kenya adopted a new constitution in August 2010 which established a modern governance structure for the central administration and 47 counties (Oyaya & Rifkin, 2003). Kenya has embraced devolved leadership and decentralized healthcare services towards the improvement of capital distribution and regional development (Peters et al., 2009).

Under the new framework, where the national government is responsible for policy, national reference hospitals, and capacity building, the counties are responsible for providing health services (Saltman, Bankauskaite, & Vrangbaek, 2006). Faced with shortcomings and weaknesses in the procurement and provision of public services, governments have put in place steps to adopt policies so as to enhance healthcare delivery quality (Ahmad, Devarajan, Khemani, & Shah, 2005).

An organization's main objective is to empower societies so that they can become owners of and monitor the wellbeing of their own (Mills et al., 1990). Health system delivery experiences are mixed. While some countries have been able to leverage devolution to improve healthcare; others have struggled (Saltman et al., 2006). Healthy communities anchor human development accomplishments on human resource. Human welfare and development promotes and protects good health and is therefore a fundamental human right (Mills et al., 1990).

Background to the Study

Global Perspective of Devolved of Health Projects

In 2005, Ahmad noted the following as the main features of rural healthcare in most states of India: the shortage of medication, low skills, lack of appropriate drugs, and insufficient control and surveillance. Service providers are not charged, neither are defaulters disciplined. Further, Singh in 2008 observed that research by the government of India showed a lack of decentralization of programs as the source of a lack of better healthcare. The privatization of health programs was one of the big consequences of Nepal's decentralized health sector. Conyers (2007) claimed that various countries in sub-Saharan Africa highly depend on donations and credits from

donor agencies to fund as well as expand healthcare services so as to speed up the implementation of the millennium development goals.

Of the overall spending on health in an approximate 48% out of 46 African countries, about 20% is funded by outside resources, which include UN organizations (World Bank, 2007). Furthermore, the World Bank (2007) reported that public health funding has over the past few decades greatly increased. In 1990, health funding aimed at growth was nearly US\$ 2.5 billion and in 2005 it had risen to nearly US\$ 14 billion globally (World Bank, 2007). The bank borrowed US\$ 15 billion, and, “assisted more than 100 countries with more than 500 projects and programs, with cumulative disbursements of US\$12 billion and cumulative new lending of US\$15 billion from 1997 through 2006” (World Bank, 2007, p. 13).

Local Perspective of Devolved Health Projects

In Kenya, on August 9, 2013, the task of health service provision was officially shifted to counties, and, following this change, one-third of a total \$210 billion of devolved spending was dedicated to health in the 2013/2014 budget (Kibui et al., 2015). The 2015 Kenya health bill introduced a consolidated health framework for regulating the health system of the counties and the central governance interrelationship; and, monitoring healthcare facilities suppliers, health goods, and health technology (Republic of Kenya, 2015). Developed governance mechanisms provide the leeway for county health authorities to engage and draw various development partners so as to promote and deliver health projects to people (Mwamuye & Nyamu, 2014).

Centralized health systems have been criticized for differences in healthcare delivery, resource allocation gaps, and failure to enable sufficient access to quality health services (Kimalu et al., 2004). Kenya has adopted changes over the past decade to 3

decentralize the country's health management system, improve district and facility resource distribution and service delivery decision-making capacity, and promote greater citizen engagement in health project management (Ndavi, Ogola, Kizito & Johnson, 2009). On August 4, 2010, a new Kenyan constitution was approved by 68% of Kenyan voters and it was signed into law on August 27, 2010. At the core of the new constitution was the idea of shifting political and economic power to 47 newly created counties (Wamuswa, 2015).

Monitoring and Evaluation (M&E)

Monitoring and evaluation (M&E) is a very vital tool for the preparation, decision-making, and management of economic policy efficiency. Mackay (2007) noted that most governments around the world are trying to integrate M&E into their systems of economic governance. Project success plays a key role in promoting growth and development in any enterprise. Many project managers appreciate the importance of M&E for the achievement of project goals and progress (Kahilu, 2010). The devolved governance system in Kenya resulted in significant growth, service delivery, and financial accountability obligations on the part of county governments (Mugo, 2014). As Shihemi (2016) observed, the legislative frameworks outlined in the 2010 Kenya constitution mandated county governments to create M&E structures.

The constitution requires adherence to principles of good governance and accountability in the management of public programs or projects (Wamuswa, 2015). To ensure the progress of devolution in Kenya, county and national governments are unified in understanding that M&E, as well as quality assessment and appraisal are key growth and service delivery mechanisms for leaders at all levels (Phiri, 2015). Therefore, county and national governments are increasingly focused on outcomes from growth and how best to calculate such outcomes (Kahilu, 2010), and as reported

by Shihemi (2016), county governments have developed M&E frameworks. These include organizational structures, management processes, policies, strategies, plans, benchmarks, information systems, reporting lines, and accountability relationships, and allow national and provincial agencies, municipalities, and other entities to effectively fulfil their M&E functions (Shihemi, 2016). In addition to these structured management elements, the organizational culture, ability, and other supporting factors decide whether the input from the role of M&E affects the decision-making, training, and service delivery of the organization (Mugo, 2014).

Data on the changes to the economic, legal, and structural context in which the mechanism is set is gathered as it is essential to the monitoring and assessment of devolution (United Nations Development Programme [UNDP], 2009). This includes collecting information on legislation and procedures that identify new structures, separate roles, and legally keep stakeholders accountable; and strategy, planning, and regulatory bodies and processes (World Bank, 2004). Only a few quantitative metrics are available for these political, organizational, and legal variables since much of the needed data focuses on non-quantifiable concerns (such as the level of government responsible for which role); or the availability of key inputs (such as the existence of government documents detailing the roles of the various levels of government) (John, 2007).

Most of the measures are dichotomous "yes/no" indicators. Consequently, systematic data collection, analysis, and documentation of results appear to be central to the devolution process (Estrella et al., 2000). Monitoring and evaluation is required at the local level in order to educate citizens and promote public engagement (Guijt & Gaventa, 1998). At the central level, M&E is expected to track and supervise local activities and provide feedback on policy development and other organizational

responses (Hatch, 2013). Improving local governance in terms of efficiency and transparency is increasingly recognized as a primary vehicle for shaping governance at the central, regional, and international levels (Rogito, 2010). This also refers to the corporate and civil society fields. Local democracy is claimed to provide citizens with a direct channel to engage in government, thus providing a framework that allows public interests to be expressed in decision-making systems (Guijt & Gaventa, 1998).

Statement of the Problem

When the Constitution of Kenya, 2010 was promulgated in August 2010, devolution was adopted as the newest and quickest decentralization process in the country (Kibui et al., 2015). The health sector was the first asset region to change in this new governance structure (Wamuswa, 2015). In the observation of Tsofa, Goodman, Gilson, and Molyneux (2017) and World Bank (2014), the rationale for the transition of the sector was to provide county governments with the possibility of coming up with creative models and approaches that deal with the health requirements particular to them. This was expected to promote active participation by people, hence enabling them to decide on future resource flexibility and management issues quickly and for themselves (Tsofa et al., 2017; World Bank, 2014).

Nonetheless, in almost all countries, the health sector faces serious challenges, including capacity gaps, human resource shortages, lack of proper legal and institutional facilities, broad corruption, and conflict among national governments (Mwangi, 2013; Standard Team, 2015). The net results of these issues are a decline in healthcare and reversal of some increase in health metrics (Kinuthia, 2016). There is no question that a sophisticated organizational strategy is needed to ensure good governance and active community engagement for this guarantees an efficient and reliable approach to health services (Patrick, 2013). This should, however, be

followed by changes to the government envisaged under the current constitution (Kariuki, 2014).

Several counties in Kenya have developed M&E systems that vary in relation to flexibility and openness in the health sector. In 2007, Mackay stated that there were substantial inequalities in the quality of the health sector in various county governments, leading to the development of monitoring systems. Kenya's 2015 annual health sector report mentioned various reporting rates for key indicators ranging from 55% in Mandera County to 96% in Nandi County (Republic of Kenya, Ministry of Health, 2015).

Although the exact reasons for these disparities were not understood, alleged causes included poor organizational structures, unavailability of registration and reporting sources, and the county health management teams' inability to effectively exercise county-level monitoring (Republic of Kenya, Ministry of Health, 2015). Focusing on physical infrastructure rather than on technological or theoretical learning, and providing more incentives to deliver service because of competitive goals, could contribute to a further increase in county governments' actual M&E program procurement rates (Wamuswa, 2015).

Regarding M&E of health in counties such as Baringo and Bungoma, much of the activities in the health facilities are controlled by the county governments of the respective counties. However, there is a gap in terms of policy-making and the implementation of M&E of health services due to the rampant challenges of resource structuring. There are further gaps regarding the allocation of resources for implementing M&E systems towards streamlining of health services. For this reason, this study aimed to find out the impact of devolution, that is, whether devolution has improved the situation or made it more challenging, specifically concerning

governance, assessment, and administration of health services in the counties of Bungoma and Baringo.

Purpose of the Study

This study sought to evaluate the effect of devolution on M&E of health services in Kenya, with a special focus on Bungoma and Baringo counties.

Objectives of the Study

The following specific objectives guided the study:

1. Assess the type of M&E systems in place at the health departments of Bungoma and Baringo counties.
2. Determine the capacity of health services' M&E systems in Bungoma and Baringo counties' health departments.
3. Assess the availability of data management systems that support M&E of health services in Bungoma and Baringo counties.
4. Establish the level of funding for health services' M&E systems in Bungoma and Baringo counties.
5. Assess the effect of devolution on health services' M&E systems in Bungoma and Baringo counties.

Research Questions

The study responded to the research questions outlined below:

1. What was the type of the M&E system in place at the health departments of Bungoma and Baringo counties?

2. What was the capacity of health services' M&E systems in Bungoma and Baringo counties' health departments?
3. Were there data management systems supporting M&E of health services in Bungoma and Baringo counties?
4. What was the level of funding for health services' M&E systems in Bungoma and Baringo counties?
5. What effect did devolution have on health services' M&E systems in Bungoma and Baringo Counties?

Justification for the Study

In a devolved system, local authorities exercise power and conduct public functions over specific geographical boundaries (Turin, 2010). In most nations, including the African countries, decisions concerning healthcare systems are made by central health ministry units, despite decades of strong support for decentralization (KPMG, 2015). Hence, these decisions are transmitted to the administrative services of districts, hospitals, health centres, and vertical network centres by the provincial (or regional) health management units (Blaise & Kegels, 2004). When governments are accountable for their position, decision-making, accounting, and management controls are turned over to essentially independent corporations with corporate status (World Health Organization, 2000)

Processes of decentralization could include one or more classes, depending on the roles and the transferred authorities (Okech & Lelegwe, 2016). The transfer of authority in healthcare has increased worldwide, with the idea of authority sitting with a central or health service shifting with time (Mwenda, 2010). After the promulgation of the Constitution of Kenya, 2010, a devolved governmental system with two levels of government: national and county, was formed in Kenya (Nyanjom, 2011; Okech &

Lelegwe, 2016). Health leadership on a national level is provided by the Kenya Ministry of Health (MOH), whose principal responsibilities include the development of national policy; technical assistance at all levels; quality monitoring, and health services standards (Local Development International, 2013). Specific areas include the development of medical tariff regulations, and the execution or management of organizational studies (Sousa, Scheffler, Nyoni, & Boerma, 2013).

The Constitution of Kenya, 2010 is clear that the Ministry of Health ought to develop national policies to guide all health workers in the country regarding hiring, deploying, training, and paying; control of the quality and standards in the provision of health services; and monitoring charges for various services to healthcare providers (Republic of Kenya, 2010). The same ministry also has the responsibility of providing the appropriate legal structures to ensure that healthcare is reliable and personally driven (Wamai, 2009).

This research was undertaken at a time of restructuring of the governance structures at the county levels in Kenya. Any business planning to supply goods must have a clear strategy and intend to track the execution of the strategy. Most of the counties in the country do not have sound M&E plans and this can affect the provision of health services. In this regard, this researcher found it essential to carry out a study to assess the use of M&E programs, the capacity for M&Es at the county level, and the need for and use of health departments in counties and sub-counties. The researcher had the hope that the findings of the study would form a basis for a discussion by the counties on the components of an M&E system towards addressing short-and long-term healthcare access needs.

Significance of the Study

This study's findings would provide important insights to the following key stakeholders:

1. Kenya's national government: The national government has stated healthcare progress intentions. The Kenya health policy 2014-2030 is aimed at enabling achievement of the highest level of health in a way that is responsive to the needs of the Kenyan people (Republic of Kenya, Ministry of health, 2014). This study would aid in determining the purpose and identifying areas of improvement.
2. The county governments: The researcher anticipated that this study would shed light on whether the county governments have achieved their primary goal; as well as identify areas that may need improvement in the counties' health facilities. Achievement of these expectations would imply the improvement of democracy and wellbeing, and minimization of tension.
3. Communities: It was also the researcher's expectation that the study findings would aid in the building of communities to keep leaders and those responsible for implementation accountable. This would result in enhanced public service delivery through effective allocation of resources, improving transparency, increasing patronage, and improving cost recovery.
4. Management and staff of health facilities: The study findings would additionally contribute towards better management of health facilities, as well as of staff - through raising awareness on the areas that need better delivery, and ensuring that primary healthcare is improved.

5. Academic research: The study would contribute significantly to the increasing research on M&E in relation to the effects of devolution in Kenya

Assumptions of the Study

In this study, the main assumptions comprised the following:

1. That there were some M&E systems in place at the counties' health departments.
2. That there was adequate capacity at the counties' health departments with regard to M&E systems,
3. The counties had data management systems supporting the M&E of their health services.
4. The counties had established levels of funding for M&E systems for their health services.
5. There were significant effects of devolution on M&E systems in the counties.
6. The management of the county health departments would permit the researcher to execute the study in their counties, and that the staff in the counties' health sectors would fully cooperate, as well as have the capacity to participate in the study.
7. That the respondents would be available at their workstations during the study period and would be willing to share the required information. To mitigate on the response rate, the questionnaire guide was mailed in advance to the respondents and appropriate meeting times were scheduled with them.

Scope of the Study

The study focused on two of the 47 counties in Kenya. The two counties, namely Bungoma and Baringo were randomly identified based on their performance on

immunization coverage, as the key indicator. Based on the DHIS-2 2015 data on the fully immunized children, the 47 counties were categorised into two, that is, those considered to be better performing in relation to the coverage of fully immunized children if they reported more than 70% in one category; and the other category being those who reported less than 70% in the same indicator (Republic of Kenya, Ministry of Health, 2015). This ranking was based on the information that fully immunized children coverage was one of the key service delivery indicators. It was therefore considered a fair representation of the performance in achieving health outcomes. Bungoma was randomly selected from the category considered as better performing. On the other hand, Baringo was randomly selected from the group considered to be poor performing.

The study focused on the county department management level staff at the county and sub-county levels. Specific focus was on employee skills regarding M&E, effects of data management systems on M&E, the effect of funding on M&E systems, effect of leadership on M&E, and effects of devolution on M&E systems.

Limitations and Delimitations

The main limitation of this study was that only two out of all (a total of 47) counties in the country participated in the study, hence the results may not be generalizable to the whole country. This limitation was mitigated by ensuring that the scope of the study was clearly indicated.

Another limitation was potential bias due to the self-administration of the questionnaire by the respondents. To mitigate on this, the respondents were assured that their responses would be treated confidentially and that no individual-level identifiers were to be included in the questionnaire feedback.

Other study limitations included the fact that some staff in the counties would probably be unwilling to participate since they were involved in health interventions' implementation. Based on this, they could have been unwilling to provide accurate information in cases where interventions could be perceived as weak or non-existent. Nevertheless, the researcher explained to the respondents that the results of the study would be confidential, would not be used in any manner to victimize the participants, and would hopefully eventually inform policymakers about issues that need to be discussed.

Definition of Terms

Decentralization: This involves assigning public functions to local governments, including a general mandate to promote local well-being, along with the structures and services needed to support specific objectives (Cheng, Daint, & Moore, 2007).

Devolution: The transfer by a statute of certain powers, duties, and services from the central government to popularly elected state or local governments (Kettl, 2000).

Evaluation: A comprehensive analysis of the task, plan, program, strategy, policy, trend, field, operating area, or quality of the organization. Evaluation focuses on anticipated and accomplished achievements, analysing the chain of results (inputs, actions, outputs, effects, and impacts), methods, situational variables, and causality to recognize achievements or lack of achievements (Boerma et al., 2009).

Leadership: The impact of leaders and followers on the achievement of organizational goals (Achua & Lussier, 2009).

Monitoring: A systematic method of gathering, evaluating, and using of information to track the progress of a program towards its goals and to direct decision-making in management (Mackay, 2007). Usually focuses on processes such as when and where

activities take place, who delivers them, and how many individuals or entities they reach (Mackay, 2007).

Organization: A collective group of people coordinated and productive enough to fulfil a need or accomplish common objectives. All organisations have a management structure that connects and separates; and assigns roles, responsibilities, and authority to carve out different tasks between different activities and the members (Armstrong, 2010).

Organizational performance: It involves evaluating an organization's success against its priorities and goals. In other words, organizational performance requires actual outcomes or outputs in comparison to anticipated ones (Kouzes & Posner, 2012). Three key findings were the focus of this study: first, the shareholder value qualities; secondly, financial performance; and thirdly, market performance (Kouzes & Posner, 2012).

Organizational structure: A structure that explains how activities in an organization are aimed at achieving the organization's objectives (Hatch, 2013). These may include laws, positions, and obligations. It also dictates how information flows across the company's operations (Hatch, 2013).

Strategic planning: Focuses on the combination of different business divisions in order to achieve organizational goals (accounting and funding, research and development, production, marketing, information systems, management) (Yukl, 2006). The norm is that corporate plans should be developed, implemented, and updated according to organizational objectives (Yukl, 2006).

Summary

This chapter has provided the context of this study, including a detailed articulation of the role played by M&E in executing strategic plans for the county health sector. The history of M&E, and the role of county health departments as outlined in Kenya's 2010 constitution have been provided. The problem statement has also been stated, together with the general and specific objectives of the study. The chapter has also covered the scope of the study, as well as its rationale and justification. Additionally, major terms used in the study have been delineated. The next chapter will provide a review of the literature in this area of study. The literature was reviewed based on the study's specific objectives as outlined in the current chapter.

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CHAPTER TWO

LITERATURE REVIEW

Introduction

The objective of the literature review in this study was to explore past studies relating to M&E emerging trends, as well as look at gaps in the said studies. In this chapter, the researcher discusses the theoretical framework that underpinned the study. The theoretical framework demonstrated how M&E provides a bridge to the attainment of health outcomes. The chapter also provides a review of the general literature on devolution, funding, and leadership employee skills concerning M&E evaluation system. In addition, the chapter presents an empirical literature review, highlighting various case studies from Hong Kong, Burkina Faso, and Kenya. Finally, the study's conceptual framework, in which linkages between the various independent, intervening, and dependent variables are discussed, is provided.

Theoretical Framework

Programme Theory of Evaluation

Program theory, developed by Bickman (1987), comprises “a set of statements that describe a particular program, explain why, how, and under what conditions the program effects occur, predict the outcomes of the program, and specify the requirements necessary to bring about the desired program effects” (Sidani & Sechrest as cited in Sharpe, 2011, p. 72). This theory has been applied in guiding programs' assessments for several years now. It reveals the program's ability in fixing a challenge by ensuring that needs are well captured at the stage on assessment of

need, and also provides tools for determining the impact aspects in an assessment (Seith & Philippines as cited in Wanjiru, 2013).

Program theory identifies major program components and articulates how the components should interact with each other (Donaldson & Lipsey, 2013), and provides a structure for evaluation of programs, within which plans for the collection of data are done. Through the plans, the nature and scope of each component's incidence are measured. The collected data is then analyzed as per the structure (Weiss, 1997). Data for each of the components of the program is obtained through various approaches or sourced diversely (Crawford & Bryce, 2003).

Yarbrough, Shulha, Caruthers, and Hopson (2010) put forth a model that requires a description of the proposed antecedents (whatever needs to be before a program is operational), operations (activities and outputs), and program results. A comparison is done between the statistics relating to the program in action, and what was expected (the program's benchmarks). Weiss (1997), also an early advocate of the theory, proposed the use of path diagrams to pattern the series of actions from programs' intervention to the preferred results. This sort of pattern aids the evaluator in identifying the elements to incorporate in the assessment; determine where, in the series of actions, the cycle stalls; and remain in tune with fluctuations in the execution of the program that could impact on the plan painted in the model.

Program theory has thus been defined in evaluation practice as the construction of a plausible and sensible model of how a program is supposed to work (Pilcher, 1992), or a set of propositions regarding what goes on in the black box during the transformation of input to output, that is, how a bad situation is transformed into a better one through treatment inputs. The theory has also been perceived as the process through which program components are presumed to affect outcomes (Olive, 2002).

Further, the theory is usually depicted as partly comprising “the organizational plan [on] how to garner, configure, and deploy resources, and how to organize program activities so that the intended service delivery system is developed and maintained” (Rosen et al., as cited in Shaw, Shaw, Greene, & Mark, 2006, p. 64).

Program theory also addresses the utilization plan, giving focus to “how the intended target population receives the intended amount of the intended intervention, through interaction with the programs service delivery system” (Rosen et al., as cited in Shaw et al., 2006, p. 64). Moreover, the theory focuses on how the planned mediation for a particular group produces the preferred social gains (impacts). Rodgers and Williams (2006) identified some of the advantages of the theory-based framework to M&E as being able to attribute projects’ outcomes to specific projects or activities and identifying unanticipated and undesired program or project consequences (Donaldson & Lipsey, 2013). Therefore, theory-based evaluations enable the evaluator to tell why and how the program is working (Olive, 2002).

Theory of Change

The theory of change was developed by Weiss (1997), who described it as a theory of how and why an initiative works. Weiss pointed out that it could be understood as a way to describe the set of assumptions that explain both the min-steps that lead to a long-term goal and the connections between these activities and the outcomes of an intervention or programme (Schwandt & Burgon, 2006). This theory explains how an intervention is expected to lead to intended or observed impacts (Briceno & Gaarder, 2009).

According to Ellis, Parkinson, and Wadia (2011), the theory of change is utilized in strategic planning by management in decision making as a project or programme

develops and progresses. It can also reveal what should be evaluated, and when and how, so that project and programme managers can use feedback to adjust what they do and how they do it so that they can achieve the best results (Armstrong & Baron, 2002).

The theory of change methodology also helps to identify the way people, organizations, and situations change as a result of an organization's activities or services, helping to develop models of good practice (Ellis et al., 2011). According to Chelimsky (2006), some projects may, based on their nature, yield high initial impacts while others may inherently take far longer, even decades, to show results; not because they do not work after three years, but because it is simply how long it takes. Furthermore, Briceno and Gaarder (2009) stated that the theory of change is useful during implementation as it can check on quality and thus help program teams distinguish between implementation failure and theory failure. Briceno and Gaarder further contended that it is essential to involve key stakeholders and staff in the development of the theory of social change as this will create a sense of ownership.

In terms of planning, Schwandt and Burgon (2006) maintained that the theory of change can help an organization to achieve a variety of results which are instrumental in its growth (Cheng et al., 2007). Such results include strengthened organizational capacity, through skills; staffing and leadership; strengthened alliances, through level of coordination; collaboration; mission alignment (Ellis et al., 2011); strengthened base of support through the grassroots, leadership and institutional relationships and alliances (Chelimsky, 2006); improved policy through stages of policy change in the public policy arena, including adoption, implementation, and funding (Bamberger, 2012); shift in social norms through the knowledge, attitude, values and behaviors; and changes in impact through the ultimate changes in social and physical lives and

conditions (Weiss, 1997). Impact is affected not just by policy change, but by other strategies such as community support and changes to behaviors (Bamberger, 2012). Thus, this theory was regarded as relevant to this study in relation to M&E planning and devolution.

In this study, program theory and theory of change were utilized to explain the various inputs of devolution such as change in governance systems, funding, leadership, data and management, as well as the effect of the inputs on the health services output.

General Literature Review

Devolution in Kenya

Decentralization has a long history in Kenya. In 1963, after independence, the British colonial government proposed to establish a system of regional governments based on ethnicity (Center for Health Solutions, 2014). The then newly independent country, which opted for a highly centralized state has never been able to achieve this structure. Nevertheless, the basis for further discussion on service decentralization has been laid down (KPMG, 2014). In the 1970s and 1990s, decentralization processes, including the World Bank and the International Monetary Fund (IMF), were developed and financed within the context of the structural adjustment programs (Esidene, 2011).

The new structures in Kenya have taken further responsibility for providing services but have not created new decision-making forces (Barasa, Manyara, Molyneux, & Tsofa, 2017). These changes were designed to promote decentralization. The poor constitutional framework for decentralization, restricted field for local government decision making, and low public participation (Kibui et al., 2015) are some of the

challenges associated with this process. Other challenges according to Kinuthia (2016) include local government disparities in capacity, continued dominance of the State, and reliance on system outcomes. Many have struggled in their efforts to decentralize Kenya (D'Arcy & Cornell, 2016).

After a long struggle for a new constitutional dispensation by the Kenyan people, a referendum was held in Kenya in 2010 as the final round of decentralization, and in the referendum, 67% of voters supported the then proposed constitution (Republic of Kenya, 2010). This was crucial to the challenge of the overly authoritarian presidencies. The new constitution established a new system of government, which delegated most national functions to 47 county governments. The new counties were based on the district system of Kenya (KPMG, 2014). The Constitution of Kenya, 2010 requires that both levels of government, that is, national and county be interdependent but also and consult and collaborate (Standard Team, 2015).

The Kenya constitution ensures effective involvement by the public in local decision-making processes (Republic of Kenya, 2010). It is applied through automation and networks. The main aim of decentralization is to foster democratic and responsive governance, foster domestic unity by appreciating diversity, and ensure self-government for people and their engagement in the exercise of state powers and in decision-making (Republic of Kenya, 2010).

Devolution of the Health Sector

The Constitution of Kenya, 2010 provides a legal framework to ensure that Kenya's health services are provided with a holistic approach (Republic of Kenya, 2010). This is meant to ensure that Kenyans have the highest possible level of health, including the right to providers of services such as reproductive health as per Article 43 of the

constitution. Article 53 stipulates that every child has the right to the fundamental needs, namely food, shelter, and healthcare (Republic of Kenya, 2010). Article 56 of the constitution stipulates measures for the State to ensure equal access to water, medical services, and infrastructure for minorities and marginalized groups (Jaszczolt, Potkanski, & Stanislaw, 2010). As per the constitution, the county and national governments have been split by healthcare obligations to improve these rights (Esidene, 2011). The fourth constitutional schedule lays down country guidelines or national policy to be followed by the national government (Acevedo, Rivera, Lima, & Hwang, 2010).

Healthcare providers are assigned critical services to provincial governments and national governments - maintain health policies, county technical assistance, and regional referral services (Kimalu et al., 2004). For health services to be all inclusive and equally based, the constitution requires four essential inputs, namely the provision of a health network, the distribution to facilities of trained and motivated workers, the provision of the needed medicine, and making funds available to those who operate and maintain these facilities in the medical services (Kenya Institute for Public Policy Research and Analysis [KIPPRA], 2003; Kibui et al., 2015; Kinuthia, 2016). These four factors are important as 62% of Kenyans rely on public health services (Mwangi, 2013).

Availability of health care facilities and personnel

Health facilities ought to be made physically accessible to both patients and workers. Only 63% of Kenyans have access to public health services within one hour (International Rescue Committee, 2015), and the decreased demand for medical care in Kenya is occasioned by wider distances from health facilities for Kenyans. Medical facilities in the 47 counties in Kenya are unequally distributed (Ministry of Health,

2013). For example, it takes two days for some residents of Turkana County to reach a health center in the county. As a result, health indicators in this county are much less than common in comparison to other counties (Ministry of Devolution and National Planning, 2015).

On average, 61.2% of births of children took place at health facilities at the national level, whereas an average national slow growth of 2.6% was estimated at 23.9% (Ministry of Devolution and National Planning, 2015). Half of the health centers in Kenya's most provinces have less than two health centers per 10,000 residents, and less than 4.2 facilities per 100 km². There is a dense population of 134 and 124,100 km² in Mombasa and Nairobi, but less than 10,000 residents respectively. Marsabit, Tana River, and Isiolo counties have the fewest medical facilities per 100 m² (Ministry of Health, 2013). While the local population has enough services, patients need to travel long distances to reach these services (Mwamuye & Nyamu, 2014). Regions such as Nairobi and Central Kenya have better resources compared to the distant and poor areas of Kenya (Center for Health Solutions, 2014).

The counties are responsible for recruiting personnel for the positions transferred under the constitution of Kenya. As indicated in article 235 of the constitution, every county is required to choose its officials in a uniform system of national standards under parliamentary rule (Republic of Kenya, 2010). Public service responsibilities include creating and removing public offices, administrative oversight, the dismissal of staff, and the recruitment of public servants (Kariuki, 2014).

The population density of doctors and nurses is a critical indicator of the county's ability to provide appropriate primary healthcare coverage. The number of doctors in the 47 districts ranges from zero (Mandera) per 10,000 people to two (Nairobi). Such

rates are below the national average of three health workers per 10,000 population (Ministry of Health, 2013). In Kenya, however, on the average, only four counties reach 8.7 nurses per 10,000 population (Republic of Kenya, Ministry of Health, 2014). It is worth noting that countries with a high population of physicians tend to have a high population (World Bank, 1997).

Wamuswa (2015) indicated that in most nations, the lack of adequate resources contributes significantly to health insecurity in a variety of jurisdictions. Between January and August 2015, over 22 countries reported health strikes, with understaffing as a major cause (Kariuki, 2014). A high level of patient desertion and lack of a proper process of assessing and responding to regional healthcare needs are major concerns (Cornell & D'Acry, 2014; Center for Health Solutions, 2014).

Healthcare financing

In 2001, Kenya was among the African countries that signed the "Abuja Declaration", agreeing to apportion 15% of their annual budgets towards the improvement of their health sectors (World Health organization, 2011). Paradoxically, over the past four years, the Kenya government has cut health funding drastically (Wamuswa, 2015). The country invested 7.20 shifts in healthcare out of each Sh100 in 2010. This fell to 6.10 in 2011, and 5.9 in 2013 (Kimalu et al., 2004). National and regional governments planned to invest 5.70% of shareholdings in the sector far below their 14% promise in 2014, corresponding to 5.7% of the 1.6 billion share budget (Center for Health Solutions, 2014). Such cuts resulted in poor service, drug shortages, regular accidents, and high rates of death and morbidity (Omar, 2002).

The national government to a large extent provides funding for county functions. The four sources of funding are property tax, revenue creation, business licenses, and

entertainment taxes by counties, (Esidene, 2011). The equalization fund is for marginalized communities with an extra 0.5% of the national income as well as contingent and unconditional State government subsidies (Kibui et al., 2015). The income distribution equation, as formulated by the commission on income allocation (CRA), contains the following parameters: the national population, the level of poverty, the area, the minimum fair share of income, and fiscal responsibility (Commission on Revenue Allocation, n.d.).

The county governments raise the most significant health funds as a redeployment product, and, on the other hand, customers are compensated by costs. The counties won about 25% of the total budget in 2014/15 (Wamuswa, 2015). Much of this money has been spent on personnel remuneration; and on the procurement, development, and maintenance of hospital facilities and services (Barasa et al., 2017). Yet, the limited payments, which have a direct effect on care performance (Kariuki, 2014), render insufficient money. The state has implemented a new health funding program to incorporate user fees and county contributions since the constitution was adopted in 2010. In the same year, the health sector service fund (HSSF) was launched to improve primary health care and resources (D'Arcy & Cornell, 2016).

The Kenya vision 2030 advocates for a fair and effective increase in the delivery of critical health services (Ministry of Devolution and National Planning, 2015). In order to facilitate the provision of services, the HSSF mobilizes external governmental and foreign partners (Ministry of Health, 2013). This guarantees fast and open cash flows for government and religious groups and a level playing field in healthcare centers (KPMG, 2014). Unfortunately, the allocation is small in comparison to the number of customers and the scale of the facility (Kinuthia, 2016), although the HSSF has been

significant, particularly in improving the health infrastructure in remote counties (World Bank, 2014).

Health governance

The 2012-2030 Kenya health policy offers an institutional framework detailing the organizational and management structures that this new model needs (Ministry of Medical Services & Ministry of Public Health and Sanitation, 2012). This includes providing safe, affordable, and inclusive health services; developing community-based clinical, administrative, and management services; engaging stakeholders; and maintaining transparency in health services and governance (Ministry of Medical Services & Ministry of Public Health and Sanitation, 2012).

Challenges Facing the Devolved Health Sector in Kenya

In the last 13 years, the health sector has encountered numerous national gaps including challenges over quality services. These are wide and far-reaching skills, in terms of human resources, infrastructure, legal framework, programs, and county-government relationships (Kibui et al., 2015; Ministry of Medical Services & Ministry of Public Health and Sanitation, 2012; Mwangi, 2013).

The transition from national to county governments has been plagued by instability, policy confusion, governance issues, and the lack of cooperation between the two levels of government (Center for Health Solutions, 2014). At the national level, wealth distribution, race issues, poor work conditions, and overtime pay have been difficult to manage, including lack of leadership and assets allotment (Cornell & D'Acry, 2014). Health workers usually worry about their safety at work (Mwamuye & Nyamu, 2014).

Some health workers argue that the work is overwhelming, and reports have indicated that many have withdrawn or found alternative employment (Center for Health Solutions, 2014). Many people have deferred payment since the transfer to county governments and feel that their safety at work has not been ensured (Hawkins, Srisasalux, & Osornprasop, 2009). Additionally, formal letters of appointment are yet to be issued for workers transferred to county governments (KPMG, 2014). Unfair redistribution of funds to counties leads to problems in asset management. This continues to disrupt county-level projects, generating more inefficiencies (Kibui et al., 2015).

There is also a lag regarding disbursement of funds at the county level, where delay in payments from the Minister of Finance frequently contributes to downstream time delays, resulting in regular strikes by health workers, a shortage of drugs, and lack of other basic healthcare requirements; and, eventually, desertion from the health sector by qualified staff (Center for Health Solutions, 2014). Moreover, most county governments do not have specific health procurement programs (Mutai, 2015). To increase economies while constantly monitoring the effectiveness of medicines, State governments are not required to buy medicinal products from the Kenya Medical Supplies Authority (KEMSA) (KPMG, 2014). This has also created an opportunity for corruption in drug procurement because suppliers cooperate with corrupt county officials to provide poor quality health supplies at high prices (Kinuthia, 2016). This not only leads to waste but also puts people's lives at risk (Standard Team, 2015).

Countries lose value from economies of scale by stressing the right of individual counties to conduct their own affairs (Barasa et al., 2017). Procurement diversity is likely to increase corruption costs and risks (Kibui et al., 2015). There are several support roles such as financial management and human resources control, which can

be performed more efficiently across districts to reduce costs and use limited skills (KPMG, 2014). Another key problem is the vertical structural programmes. Many vertically organized services, including HIV, Tuberculosis, and the promotion of wellbeing, are funded by external donors (Center for Health Solutions, 2014). In some cases, these donors are unaware of the mechanisms other county stakeholders use and have built their own vertical programmes, resulting in further complications in accrument of resources (Patton, 2008; World Bank, 2014). Full budget transfers also mean that large domestic services are hard to run, and fewer resources can be earmarked for them (Magokha, 2015).

Lessons from other Countries on Devolution

Ethiopia

Devolution principles were introduced in 1996 and were considered the main strategy for improving health services delivery in Ethiopia (Ben Shlomo, Brookes, & Hickman, 2013). It was part of a comprehensive transfer policy across various sectors, including healthcare (Barak, 2013). The first change took place at the regional level and was expanded in 2002 to the federal or Woreda levels (International Rescue Committee, 2015).

A four-tier treatment system has been established in national, state, and county hospitals; and in primary health facilities (Esidene, 2011). Some countries have developed the program. The federal block awarding districts are part of the transfer process (Tsofa et al., 2017). Besides, these districts have the right to organize themselves and to assess budget allocations based on local health demands (El-Saharty, Kebede, Olango Dubusho, & Siadat, 2009). As such, the districts oversee the human resources, services, and supply chains for medical facilities (KPMG, 2014).

Although the initial phases have been addressed, major improvements have been made in the quality of service (El-Saharty et al., 2009).

Ghana

Since Ghana became an independent country, decentralization became a key political component of the country's government (International Rescue Committee, 2015). The county assemblies in the country are restricted - under the 1993 local government act - to public health programs (for instance, health promotion and prevention and control of diseases) (Yukl, 2006). The Ghana ministry of health has named an independent entity, the GHS (Ghana Health Service), to operate its services (Center for Health Solutions, 2014). The GHS manages and maintains most of the facilities and offices of the country, and it evolved into a wider framework for national and regional health services (World Bank, 2014). Although the delegation and decentralization concepts are based on both systems, no single district health services management authority has been formed (Robinson, 2007).

Thailand

KPMG (2014) reported that in 1999, Thailand's local administrative organizations (LAOs) act, sought to shift a significant portion of the country's national budgets to the LAOs. The minimum budget share to be moved was 25% with a target of 35%. The act affects a variety of businesses, including healthcare (International Rescue Committee, 2015). The decentralization health services focused primarily on basic health centers and the transfer of ownership of the ministry of health's LAOs (Hawkins et al., 2009). The medical centers, with a lack of independence at the outset were able to provide services relating to the health ministry or transfer to LAO level

through the above-mentioned act and guidelines defined by the ministry of health (Chelimsky, 2006).

The relocation of health centers takes place only when there are two factors. First of all, the LAO has received a good governance award, which enables it to manage the health centers (Center for Health Solutions, 2014). The LAO also provides adequate support for health promotion services (Kensek & Noble, 2014). Next, at least half of the staff in health centers must be ready to go to work at the LAO (Jongudomsuk & Srisasalux, 2012).

The development of the primary healthcare system in Thailand also means that primary healthcare may be provided in healthcare centers by the LAOs (World Bank, 2014). Therefore, regular organizational responsibility has been provided to the LAO, including financial and human resources administration (Center for Health Solutions, 2014). The health ministry continues to be responsible for research, policy, regulatory aspect, training, and the discipline of health workers (Hawkins et al., 2009).

Uganda

Devolution was adopted under Uganda's local government act of 1997. Literacy, health, and agricultural advisory services were the subject of Uganda's research (Kyaddondo & Whyte, 2003). Studies have shown that most indices of health status are stagnating or declining in healthcare (Acevedo et al., 2010). In general, decentralized of education and healthcare has not led to greater participation by ordinary people or public supervision of service providers (Muoko & Baker 2014).

Lack of public participation, lack of financial and human resources, a small local tax foundation, and inadequate civil society have all demonstrated the need for reforms to achieve the desired results (Patrick, 2013). Uganda's case report warns against the

temptation to romanticize devolution as a new solution to historical and current social and economic inequalities (Omar, 2002). The transition of government institutions to the community would increase the community's resilience (World Bank, 2014), but only by encouraging the population to hold the public servants accountable and ensuring that the community members are active in the development process (Center for Health Solutions, 2014).

Key summary

The role of the devolved core offices is effectively transferred to the government, typically the health ministry - which authorizes not only the organizations, but also the regions to which tasks have been delegated (KPMG, 2014). Good governance will clearly demonstrate the (political) responsibility of the ministry of health for a committed medical system (Kariuki, 2014). Sources of this are the security policy, education, and training of physicians. As a result, the position of the ministry may not be "ownership and power" or "stewardship" in a departed process (Kyaddondo & Whyte, 2003).

Devolution is not an activity, but rather a mechanism directed, at a time when most Kenyans with more efficient access are aiming at improving their healthcare (Esidene, 2011). The situation is also apparent in the degree to which some lawmakers campaign for healthcare to return to the central government (Center for Health Solutions, 2014). Because a referendum that is both very costly and with unpredictable results is needed to make this possible, devolved medical services will never go back to the central government (Standard Team, 2015). Although it takes time to develop instruments to change devolved functions of government, it is important to ensure that such instruments are in place and that due legal process are followed (World Bank, 2014).

Monitoring and Evaluation Systems

The Organization for Economic Co-operation and Development (OECD) defined monitoring as:

a continuous function that uses the systematic collection of data on specified indicators to provide management and the main stakeholders of an ongoing development intervention with indications of the extent of progress and achievement of objectives and progress in the use of allocated funds. (as cited in Kusek & Rist, 2004, p. 12)

Mechanisms for M&E improve management processes and provide evidence of decision-making (Cheffins, 2011). A research by Kanyinga (2000) highlighted the appropriateness of the M&E information provided and how it fed into existing management processes. In Kanyinga's view, M&E may not replace good management practices but can improve management more comprehensively, and shed more light on new perspectives. Kusek and Rist (2004) viewed knowledge management as ... " capturing findings, institutionalizing learning, and organizing the wealth of information produced continually by the M&E system " (p. 143).

According to the South Africa Public Service Commission (2008), M&E provides the means to endorse or contradict claims, explain problems, foster understanding of goals and policy principles, record program implementation. This then creates institutional memory and includes additional people in program design and execution, thus enabling one to use M&E as a promotional tool (Jones, Jones, Steer, & Datta, 2009). As Wenceslau and Hobbs (2008) established, many companies have failed to set up effective M&E programs at various organizational levels. Therefore Wenceslau and Hobbs emphasised that the success of M&E systems is dependant on the existence of good governance systems.

Cheffins (2011) argued that beginning from the 1970s, the role of governance took an analytic and technical focus. This has been principally motivated by the need for privately-owned companies to have a better understanding of the relationship between company directors, investors, boards, customers - as a requirement for increasing their profits. Governance that is focused on partnerships' comprehension, goal-setting mechanisms, and incentive structures is needed (Cheffins, 2011).

The few studies conducted in this area have indicated a significant literature gap, especially concerning the impact of M&E in other counties in Kenya. Most of the counties lack sound M&E programs, a factor that could harm health services (Knack, 2000; Musomba, Kerongo, Mutua, & Kilika, 2013). No study has been done to analyze the effect of devolution on healthcare M&E in the country since the launch of the devolution. This is true despite the difficulties encountered (Koffi-Tessio, 2002).

Woodhill (2005) noted that a functioning M&E program will meet the following five objectives:

1. Responsibility: demonstrate to donors, beneficiaries and stakeholders that investments, activity, and results in a given situation are decided or reasonably expected.
2. Support for organizational management: providing critical management information needed to coordinate; maintain; and track the human, financial, and physical resources needed to achieve all goals.
3. Support for strategic management: provide information and promote the processes needed to establish and adjust goals, priorities, and strategies and improve quality and performance.
4. Creation of knowledge: to generate new ideas that add to the knowledge base in a certain area.

5. Capacity building: building the capacity, self-reliance, and confidence of recipients to incorporate personnel and stakeholders so as to effectively manage and enforce development initiatives.

Guijt (2004) concluded that M&E activities were mainly driven by stakeholders' growth and transparency, and the implementers thought that the reporting was repetitive and of little benefit to the performance. This can be attributed to reporting requirements that rely mostly on feedback and level of activity, resulting in more concise outcomes than evaluation of output (Ellis et al., 2011). Along with the importance of transparency, the way M&E was structured to serve certain functions was quite different from the four other functions listed above (Phiri, 2015). Nevertheless, there were improvements in the M&E structures, while extending the concept of transparency to include downward responsibility for beneficiaries (Guijt, 2004).

In the view of Cho (2007), the ability to perform enough tasks effectively, efficiently, and sustainably is the fundamental element of M&E process (Briceno & Gaarder, 2009). The M&E's capabilities are designed to help the program accomplish its goals and objectives and thus achieve the objectives of the company (Bamberger, 2012). According to Goergens and Kusek (2010), the following are the key components of an effective monitoring and assessment process: structure and organizational alignment; human capacity; human capacity; M&E partnerships; M&E plans; expenditure; advocates and communication; routine surveillance; regular data acquisition; data support management; performance preservation; analysis; and research.

Effect of employees skills on M&E systems

Rønde's view (2001) opined that the abilities of workers can be related to M&E in many respects. Skills in M&E improve employee productivity and thus the level of performance, providing a strong monitoring and appraisal process. Blaise and Kegels (2004) suggested that successful monitoring and appraisal programs rely heavily on employees' skills, abilities, and efforts to maintain their growth-oriented strategies. Fast-growth businesses have used monitoring and training programs, relative to their slow-growth rivals, to accomplish their goals and promote employee expertise far more effectively. Consequently, tracking and appraisal activities are more common in organizations with highly qualified workers.

Zhu (2004) observed that several companies and industries in Japan are taking a strategic-focused style that stresses the effect of expertise on long-term organizational M&E at the individual and organizational levels. Zhu established that employee training and development has a significant impact on both monitoring and assessment. Paul and Anantharaman (2003) stated that employee skills training programmes, which in effect promote commitment and dedication, improve staff efficiency, and ultimately economic output; thus, bearing witness to the organization's true interests in M&E.

De Cerio (2003) analysed Spain's manufacturing industry and found that product design and production quality management activities, together with skilled employees, were the most significant predictors of success in M&E. Jaszczolt et al. (2010) opined that NGOs need M&E training to improve performance; and also pointed out that NGOs need to be supported to help their M&E experts develop technical expertise and develop a wide-ranging depository of assessment documents

as a framework for enhancing institutional memory in regard to the lessons of previous initiatives (Jaszczolt et al., 2010).

Effect of data management systems on M&E systems

Management information systems (MIS) is an information-converting process transmitted by administrators at various levels of an enterprise. It can contribute to effective decision-making or planning (Patterson, 2005). Management information systems is essentially a collection, processing, storage, retrieval and communication process of relevant information to enable efficiency in the management of operations and planning of business in organizations (Bamberger, 2012). successful decision-making based on efficient monitoring and assessment is thus heavily dependent on available information, and, in part, on the functions that constitute the system (Nath & Badgujar, 2013). The information provided by MIS is in terms of documents and displays, pre-specified to support business decision-making, thereby helping to efficiently track and analyse processes (O'Brien & Marakas, 2006).

The suitable feature of MIS productivity is primarily the quality of data, that is - measures of the output of the information system instead of measuring the system functioning quality (Ragu-Nathan, Apigian, Ragu-Nathan, & Tu, 2004). Quality information allows for effective control and analysis and thus greatly contributes to management decision-making. According to Cho (2007), relevant and accurate information is needed to help decision-makers to develop effective M&E evaluation procedures. The information should contain all the necessary details and support the needs promptly. Also, the given data should be easy to understand.

Owing to MIS' contribution to improved M&E performance, managers have received help in decision making and are hence able to solve various problems occurring

during organizational management (Nath & Badgujar, 2013). Management information systems is known to have developed data services that serve most managers and business professionals' routine monitoring and assessment needs. Presentations and responses made possible by MIS provide evidence that decision-makers have confirmed sufficiently meets the needs they have (O'Brien & Marakas, 2006).

Good control and evaluation are achievable through high-quality MIS. Wu and Wang (2006) supported this argument, stating that system quality has a significant positive impact on effective M&E. Livari (2005) also argued that the quality of systems is a vital predictor of effective M&E. Moreover, Landrum, Prybutok, Strutton, and Zhang (2008) found a positive link between process reliability and successful M&E. Furthermore, Hussein, Karim, and Selamat (2007) were of the view that a higher level of IS capability results in an advanced level of M&E regarding the quality of the system, quality of the information, and overall user satisfaction.

Effect of funding on M&E systems

Having an M&E that is of the prerequisite value requires the allocation of sufficient resources. A 2009 UNDP manual on preparation, monitoring, and evaluation of development outcomes stated as follows:

Inadequate resources lead to poor quality monitoring and evaluation. To ensure effective and quality monitoring and evaluation, it is critical to set aside adequate financial and human resources at the planning stage. The required financial and human resources for monitoring and evaluation should be considered within the overall costs of delivering the agreed results and not as additional costs. (UNDP, 2009, p. 90)

Effect of county leadership on M&E systems

Dunham-Taylor (2000) explored the effect of corporate leadership, power relations, and organisations' environment on command and assessment processes. Dunham-Taylor's study revealed that managers often used corporate leadership and were extremely successful in encouraging effective monitoring and analysis. Similarly, Chen (2004) looked at the link between nursing facility management and the rate of M&E of health outcomes in Taiwan, and found that organizational leadership in Taiwan was more prevalent in nursing deans and managers and therefore promoted the M&E of results.

Vandenberghe, Nobre, and Price (2002) assessed the impact of organizational management on the control and assessment of the healthcare sector. Their study was done in Belgium with 1059 nurses as the sample. The study findings revealed that organizational leadership is closely linked to M&E and that perceived group efficiency is moderately linked to organizational leadership (Vandenberghe et al., 2002).

Effects of devolution on M&E Systems

Naidoo (2005) argued that improved performance, efficiency, and transparency are increasingly recognized as the primary vehicles for controlling local, global, and international governance through active M&E systems. This also related to civil society as well as the private sector (Mwangi, 2013). Devolution provides active M&E, thereby providing a clear channel for citizens to engage in government, thus establishing a framework that allows public interests to be reflected within policy structures (Naidoo, 2005).

In preparation for this transition, several governments and co-operation partners have committed resources to the delivery of services and community governance changes through ongoing monitoring and appraisal processes (Conyers, 2007). These improvements were made with the expectation of meeting community needs to ensure relevance and innovation (Goergens & Kusek, 2010). Such programs should leverage local knowledge and remain true and responsive to local priorities through regular elections and other avenues of participation (Hawkins et al., 2009).

According to Maina (2005), devolution in the African region has become very common. This is associated with the “democratization movement, a movement concerned with bringing decision-makers under the effective popular control of the people they govern as a way of influencing the manner in which the leaders make decisions affecting the people” (p. 3), through efficient M&E.

Empirical Literature Review

Most studies in Kenya, including Nyabuto (2010), Rogito (2010), and Mogaka (2010), have focused on specific projects or districts, making it difficult for the results to be generalized to the counties. Moreover, these studies did not look at a broader cross-section of projects funded by county governments. According to World Bank (1997), centralized healthcare systems result in denial of economic and political power for communities and inequitable resource allocation. Also, Ndavi et al. (2009) noted that when the system of government is greatly centralized, the result will be a system of health services’ delivery that is weak, irresponsive, ineffective, and unbalanced. Therefore, healthcare development poses prospects as well as impediments to the health sector. This plays a role in the efficiency of delivery of service along with the overall nature of the health system (Zhu, 2004).

According to Shaikh, Swaminathan, and Hooper (2012), in Pakistan, health has not been prioritized by district officials, and the result has been limited resource allotments. Thus the provision of healthcare deteriorated even with the implementation of devolution in the country. The World Bank (2004) warned that when devolution is poorly and hurriedly implemented, the provision of healthcare services may be adversely affected. To be successful, decentralization must get the right resources, policies, and institutional imperatives of delivering health services.

Wamai (2009) argued that health devolution can enhance impartiality and effectiveness, and offers reciprocal advantages to the beneficiary communities and the government who are the providers of the service. First, the devolution of the distribution system will foster dynamism, permitting the combination of private-public suppliers and facilities. Also, through permitting the input of the civil society input in the process of decision making, devolution fosters pluralism, thus improving administration and responsibility. Devolution can additionally boost contextualised inventions and modifications to the deployment of resources as well as cost-mindedness in addressing community health problems.

Decentralization is anchored on the supposition that units in the local governments will actively respond to the needs of the citizens and consider their likings while deciding on what services to provide, the level of resources needed, and the best way of guaranteeing meaningful delivery of service (Standard Team 2015). In Mwamuye and Nyamu's (2014) opinion, this requires units of local government with the political room plus ability for decision making. Thus, decentralization was preferred globally and encouraged. The World Bank (2004) warned that poorly and hurriedly applied devolution could adversely affect the delivery of health services. Further, WHO (2000) maintained that while devolution offers incentives for improving health

measures in Kenya, it also poses the danger of intensified inadequacies, worsening of current inequalities, and triggering of institutional and policy instability due to lack of proper M&E frameworks.

According to Musomba et al. (2013), factors affecting the effective M&E of Changamwe Constituency's constituency development fund (CDF) comprised absence of training for those engaged in M&E activities, indistinct institutional framework for doing the same, failure to incorporate M&E budgets in project' budgets, inadequate participation of principal stakeholders, and political intrusion. Barasa (2014) conducted a research on the influence of M&E tools on the completion of projects in Kenya, and the findings showed that M&E tools influence project completion. Eighty-eight-point-nine per cent of the respondents cited strategic plan, 80.7% mentioned logical framework, 80.8% indicated budget, and 90.4% cited analysis by stakeholders (Barasa, 2014). The findings showed an important association between the M&E software and the success of the project. The study concluded that the incorporation of these tools into project management is needed (Barasa, 2014).

Conceptual Framework

The conceptual framework is shown in Figure 2.1.

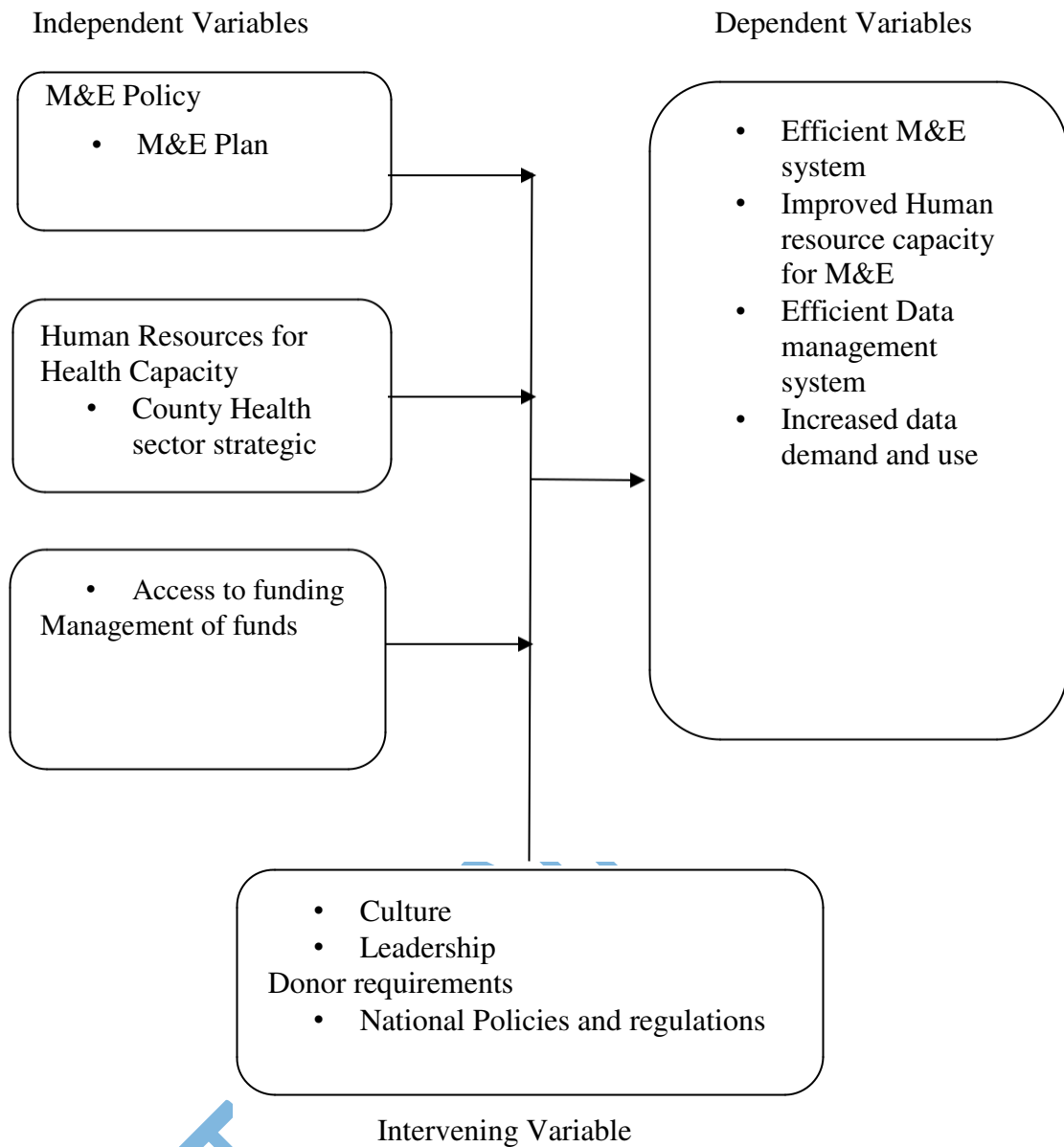


Figure 2.1: Conceptual Framework
Source: Author (2020)

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Discussion

The study was conducted with the thinking that health systems were devolved with the following: M&E policies and plans; human resource capacity required; funding for M&E processes; supporting national policies, regulations, and leadership - would determine the results to be achieved by county health departments. In this case, the optimal outcome would be an effective M&E system that can collect information real-time, assisted by an effective data processing system that can be used for decision-making at the different levels of the health system. The hope is county health departments would have strengthened human capital for health efficiency, and for M&E with a positive administration, and with a strong knowledge of M&E programs. With the county health departments' current design, there is the expectation that planning and monitoring processes will require increased use and demand for the data generated by the M&E system.

The literature review has shown how different scholars have defined and conceptualized M&E. An important definition of evaluation was the systematic and objective evaluation of the project, program, or policy that is ongoing or completed and the evaluation of the design, execution, and results of the project. Additionally, researchers have clearly shown the value of employee expertise and how that is linked to M&E. However, this researcher did not find any empirical studies focusing on the link between devolved employee functions, especially about M&E skills - particularly in the health sector.

Previous studies also discussed the role of M&E systems in improving data management systems. Some researchers have demonstrated how data management systems can be useful for effective M&E procedures in decision making.

Summary

In this chapter, a comprehensive review of literature pertinent to M&E implementation, M&E capacities, and data demand and use has been presented. Program theory and theory of change, two theories related to M&E, have also been discussed. In addition, the chapter has presented the study's conceptual framework. The next chapter delves into the research methodology used in the study.

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CHAPTER THREE

RESEARCH METHODOLOGY

Introduction

In this chapter, the following areas pertaining to the study are addressed: the research design, the study population and target population, sample size and how it was arrived at (sampling technique), the data collection instruments used and why they were the best fit, the procedure that was used in the collection of data, pretesting of the data collection instruments, how the data was analysed, and finally the steps taken to ensure that the study upheld ethical standards

Research Design

The research design has been described as the relationship and arrangements between data collection and analysis, to combine relevance with process economy for research purposes (Berg & Lune, 2012). A scientific model is a theoretical framework for science. The study design answers questions concerning the methods of data collection and the sampling system (Bryman, 2003). Survey layout is important because it encourages the accessibility of various research initiatives and ensures that the survey produces complete data as efficiently as possible and requires less time and money (Connaway & Powell, 2010). The purpose of a research design is to ensure that the evidence obtained helps one to solve the research question as clearly as possible (Cramer, 2003).

The study adopted a case study approach which is a descriptive research method (Kothari, 2004). A case study can be used to describe the characteristics of a specific subject (such as a person, group, event or organization) (Kumar, 2008). Instead of gathering a large volume of data to identify patterns across time or location, case 46

studies gather detailed data to identify the characteristics of a narrowly defined subject. Rather than aiming to describe generalizable facts, case studies often focus on unusual or interesting cases that challenge assumptions, add complexity, or reveal something new about a research problem.

Population

Loseke (2013) defined population as a whole group of people, events, or artifacts. The population to whom the results are generalized is first determined by a researcher (Neuman & Robson, 2004). For the absolute population known as the target universe population, researchers will probably want to generalize findings (Bryman, 2003).

In April 2013, Kenya fully devolved the country's health services to the 47 counties, in line with the Constitution of Kenya, 2010. This meant full decentralization of the country's health services (Republic of Kenya, 2010). The roles and responsibilities of county and domestic governments were well established (WHO, 2013).

Health stewardship in each county became the responsibility of a county health committee responsible for the overall legislative oversight of the health agenda (Republic of Kenya, Ministry of Health, 2015; World Bank, 2014); county executive committee (county cabinet) member responsible for health (CEC-health, health minister equivalent), providing overall policy; county head of health (CoH-equivalent secretary-general), providing overall administrative and executive oversight of the health agenda; (Republic of Kenya, Ministry of Health, 2015; WHO, 2013); county head of health (CDH-equivalent director general), providing overall professional oversight of the health agenda; and head of county health management (CHMT) (Republic of Kenya, Ministry of Health, 2015).

For this study, the total population was Kenya's 47 counties divided into two: those deemed to be better performing in relation to the coverage of completely immunized children if they reported more than 70% in one category; and those that reported less than 70% in the same measure (Republic of Kenya, Ministry of Health, 2015). A maximum of 27 counties were deemed to have performed better, while 20 were deemed not to have performed well. Data on fully immunized children coverage because is one of the key service delivery metrics and was thus considered a fair reflection of progress in achieving health outcomes (Republic of Kenya, Ministry of Health, 2015).

Target Population

Target population is a population subgroup composed of well-defined sets of persons, groups, objects, actions, or interesting households (Bryman, 2003). The two counties that were the subject of this analysis, that is, Bungoma and Baringo, were selected randomly based on based on the DHIS-2 2015 data on the fully immunized children for the year 2015 (Ministry of Devolution and National Planning, 2015). Bungoma was randomly selected from the best-performing band. In comparison, Baringo was randomly selected from the class considered poor performers.

This study focused on the county health departments in both counties (Ministry of Health, 2013). A county health department is comprised of county and sub-county health management teams (Ministry of Medical Services & Ministry of Public Health and Sanitation, 2012). These divisions are the health stewards responsible for driving the health agenda, the cornerstone of which is a highly functioning M&E system, and thus were the most appropriate level of research focus. The target population consisted of county and sub-county health management team members from the two selected counties.

Sample Size

The sample size is a deliberately selected small number from the entire population or cases (Connaway & Powell, 2010). Only when time and resources allow is a large sample recommended (Berg & Lune, 2012).

This research focused on Bungoma and Baringo counties, randomly chosen based on fully immunized children for the year 2015 as a critical indicator of quality service delivery. The focus was on the county health systems of the two counties. The county health department comprises county and sub-county health departments (Republic of Kenya, Ministry of Health, 2015). Some organizations handle the health agenda as program administrators (Ministry of Medical Services, Ministry of Public Health and Sanitation, 2012).

Tables 3.1 and 3.2 show the distribution of the sample sizes from the sampling frame of Baringo and Bungoma counties.

Table 3.1: Sample Size One (Baringo County)

Category	No of Staff	Sample Proportion (70%)	Sample Size
County Level	11	70%	8
Baringo Central	8	70%	6
Baringo North	9	70%	6
Baringo South	10	70%	7
East Pokot	9	10%	6
Koibatek	11	10%	8
Mogotio	9	10%	6
Total	67		47

Source: Republic of Kenya, Ministry of Health (2015)

Table 3.2: Sample Size Two (Bungoma County)

Category	No of Staff	Sample Proportion (70%)	Sample Size
County Level	10	70%	7
Bumula	9	70%	6
Bungoma Central	11	70%	8
Bungoma East	11	70%	8
Bungoma North	10	70%	7
Bungoma South	10	70%	7
Bungoma West	9	70%	6
Cheptais	8	70%	6
Kimilili	7	70%	5
Mt. Elgon	8	70%	6
Total	93		66

Source: Republic of Kenya, Ministry of Health (2015)

The sample size for this study was 70% of the population available. Kothari (2004) stated that a sample of 10-30% of the population is sufficient to generalize results for the entire population where the population is extremely uniform. A sample of 70% of the target population was chosen because it would make it possible for the respondents to view and generalize the survey results.

The sample comprised 70% of workers in the county and sub-county health departments of Bungoma and Baringo counties. At the county level, the targeted personnel were health services county manager, health care contracting and information officer, county health nurse, HIV district coordinator, malaria county coordinator, Integrated Disease Surveillance and Disease Response (IDRS) county coordinator, public health county officer, M&E country health department, and country head of health services. At the sub-county level, the officers targeted comprised medical sub-county staff, health and data officers, public health teachers, the TB sub-county coordinator, the HIV sub-county coordinator, the Malaria coordinators, the IDSR coordinator, and the public health officer.

Sampling Technique

For all studies, sampling techniques are needed because it is particularly impractical to evaluate a whole population using questionnaire surveys (Maxwell, 2012). Sampling processes can be described as research methods that allow researchers to infer population data from population data without having to study individuals (Neuman & Robson, 2004; Panneerselvam, 2004). This reduces costs and workload, enabling high-quality data collection.

This study used the stratified random method of sampling by dividing the population into subgroups with similar characteristics. This sampling technique was chosen because the researcher reasonably expected the measurement of interest to vary between the two main subgroups. There was representation from all the subgroups. The calculation 'total immunized childcare' used for this analysis to identify the two counties (Bungoma and Baringo) is a major indicator of the quality of medical services. A level of 70% and higher is often used as a cut-off to improve health sector quality (Republic of Kenya, Ministry of Health, 2015).

Following the completion of the categorization of counties based on the performance of the different counties, one county (Bungoma) was randomly selected from the category of the most successful counties and another county (Baringo) from the category of the least efficient counties (Ministry of Medical Services & Ministry of Public Health and Sanitation, 2012; Ministry of Health, 2006). From each of the two counties, the total number of management staff was established at both the county and sub-county levels, and 70% of the staff identified to form the sample. This type of sampling ensured that there was proportional allocation to each of the categories based on the number of management staff.

Additionally, for focused group discussions, the study adopted purposive sampling in selecting senior managers in the health departments of the two counties, who were critical in providing privileged information on the current state of devolution and its effect on the M&E of health services. The study purposefully selected 28 senior-level managers: 14 identified from Baringo County and 14 from Bungoma County as per guidance with the office of the governor and county health secretary of the various counties.

Data Collection Instruments

Good research needs valid findings, hence the need to determine methods for data collection (Creswell, 2013). The approach to data collection is the compilation and development of usable analytical data (Cramer, 2003). Methods for collecting data include focus groups, questionnaire, basic data surveys, interviews, and secondary data case studies (Sekaran, 2003). It has been further reported that questionnaires are one of the most powerful data collection instruments, which can be administered individually to respondents or even distributed electronically depending on the situation (Berg & Lune, 2012; Connaway & Powell, 2010; Singh, 2007; Suen & Ary, 2014).

This study used a formal questionnaire and FGD to collect data. The questionnaire had both qualitative and quantitative questions and was split into two parts. The focus of the first part was key data generation processes and quality aspects. This included the employee skills on M&E, effect of data management systems on M&E, effect of funding on M&E systems, and effects of devolution on M&E systems. This first part also included assessment of the systems that have been put in place at the county and sub-county levels. The second part of the questionnaire involved the abstraction of selected indicators that were representative of the different building blocks of the

health system. The questionnaire was structured to obtain the required information as per the proposed objectives, and it was administered to the management level staff at both the county and sub-county levels.

Focus group discussions were conducted with key informants in Baringo and Bungoma counties. This was done by the researcher at the respondents' respective offices upon acceptance of appointments.

Data Collection Procedures

There are several primary methods for collecting data, particularly in surveys and descriptive research (Sekaran, 2003), including assessment process, questionnaire interview program, schedules, and census among others (Kothari, 2004).

In this study, the researcher began by obtaining approvals to carry out the study first from the Department of Development Studies, Daystar University; and then from the National Commission for Science, Technology and Innovation (NACOSTI). He then introduced himself to the respondents, verbally explained the purpose of the study to them, and sought their informed consent regarding their participation in the study.

The researcher administered the questionnaire directly to the respondents and requested for follow-up sessions to ensure that complete answers were received from the respondents. The questionnaire was Likert scale based; hence the questions were easy to assess and answer.

Focus group discussions were conducted with key informants in Baringo and Bungoma counties, that is - senior managers in the health departments of the two counties. This was done by the researcher at the respondents' respective offices upon acceptance of appointments.

In the data collection process, the confidentiality of information obtained from the respondents was maintained by ensuring that no names were included in the data collection instrument.

The completed questionnaire copies were kept under a lock password-protected cabinet only accessible to the researcher, and the collected information was only used for the study.

Pretesting

Pretesting is the only way to assess whether respondents in a study are likely to experience challenges inherent in the instrument when responding to the questions (Presser et al., 2004). Therefore, the pretest checks for mistakes, ambiguity, vagueness, wordiness, redundancy, and other issues in the research instrument (Sekaran, 2003). To ensure that the questionnaire is not confrontational; accurate and reliable pretesting is important (Panneerselvam, 2004).

During this study, the self-administered questionnaire and the FGD were pretested in Nairobi County. The questionnaire was administered to seven respondents from the health sector, while the FGD was administered to one respondent. The purpose of the pretest was to check the questions' validity and reliability.

After the pretest, the instruments were redone to address the issues that were observed based on the pretest data. One of the areas modified in the questionnaire was the aspect of awareness of how much funding is allocated to M&E.

Reliability and Validity

The research reliability metric refers to the degree to which other researchers reproduce the case study with the same findings (Suen & Ary, 2014). All work must

pass quality checks in order to demonstrate its scientific value (Neuman & Robson, 2004). These four specific measures are required to test the research design standard: reputation generation, internal validity, external validity, and consistency (Panneerselvam, 2004). The validity of the structure is the judgment on the practical measures necessary for the concepts under consideration, and the validity of the structure applies to the concepts under consideration (Cramer, 2003).

Reliability

Each questionnaire used in the study was retained for future reference. All participants in the study submitted signatures on the instrument in combination with their details so that other researchers replicating the study can get roughly similar results. Also, the data gathered through the questionnaire were proof-checked by the office of the governor and the county health secretary as the information gathered would be used to assist the county of Baringo and Bungoma in policymaking and carrying out future research studies.

Validity

Data for this study were collected from a relatively small population. Questionnaires were distributed to the respondents and follow-ups were done until each respondent had completed filling their questionnaire. Each distributed questionnaire was recorded. Respondents were identified (sampling) based on their level of knowledge and experience on the subject being investigated to ensure objectivity.

Data Analysis Plan

Data analysis is the process by which the researcher draws conclusions and inferences from data obtained from the respondents (Kothari, 2004). Information gathered from

the field cannot be interpreted in a raw form, so it is important to wash, code, type into a computer and evaluate whether the research is meaningful (Mugenda & Mugenda, 2003).

The collected data were analysed using both quantitative and qualitative methods. This was done to enhance analytics' quality and reliability. Microsoft Excel and the Statistical Package for the Social Sciences (SPSS), version 24 were used to analyse the quantitative data and the results were presented in the form of tables, figures, frequency distribution, and percentages. The qualitative data were analyzed according to the objectives of the study and presented alongside the quantitative data in a narrative format. Initial conclusions were drawn and then and then verified using secondary data and discussions.

Ethical Considerations

Ethics is characterized by our behaviour as an examination of moral actions. Research ethics not only addresses general issues but also specific research problems (Berg & Lune, 2012; Bryman, 2003; Connaway & Powell, 2010). It also includes deciding if so-called research contradicts or undermines the developed community's fundamental moral values (Bless, Smith, & Sithole, 2013). All research must be transparent to ensure that the data transmitted are correct (Connaway & Powell, 2010; Mugenda & Mugenda, 2005).

This study put into consideration the following research ethics aspects:

Research approvals: Approvals to carry out the study were obtained from the Department of Development Studies, Daystar University; and from NACOSTI, before commencing the data collection process.

Informed consent: The researcher sought the consent of each of the respondents before administering the research instruments to them. This was done after having verbally explained the purpose of the study to them.

Confidentiality: To ensure confidentiality of the information obtained from the respondents, the researcher made sure to not include the names of the respondents on the questionnaire.

Safety of data: The completed questionnaire copies were kept under a lock password-protected cabinet only accessible to the researcher. The information collected was only used for the study.

Acknowledgement of sources: The researcher acknowledged all the sources that he referred to in the course of writing this document.

Summary

The methodology that was used to execute the study has been elaborated in this chapter. The presentation, analysis, and interpretation of the study data are addressed in the following chapter.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

Introduction

This chapter presents the study data, as well as its analysis and interpretation. The study endeavoured to ascertain the effect of devolution on M&E of healthcare services in Kenya, with a special focus on Bungoma and Baringo counties. Both qualitative and quantitative data were gathered. The quantitative data was analysed through Microsoft Excel and SPSS, version 24 and the results presented in form of tables, figures, frequency distribution, and percentages. The qualitative data was analysed as per the study objectives and presented in a narrative format alongside the quantitative data.

Analysis and Interpretation

Response Rate

The response rate is described as the percentage of individuals responding to a survey (Creswell, 2013). The study sample comprised 112 staff in the health departments of Baringo and Bungoma counties (both at the county and sub-county levels). Out of 112 questionnaire copies, 47 were administered to staff at Baringo County and 65 to staff at Bungoma County. The response rate was 34 from Baringo County and 47 from Bungoma County, hence an 81(72%) cumulative response rate. This was satisfactory as recommended by Mugenda and Mugenda (2003) who argued that a response rate of 50% is a reasonable response for a study.

Focus group discussions were also conducted in Baringo and Bungoma counties. Two interview sessions were held in each county. These focused on collecting data from

respondents in management positions. A total of 28 respondents participated in the FGDs, with each FGD having seven respondents (managers).

The response rate for the quantitative data (gathered through the questionnaire) is illustrated in Figure 4.1.

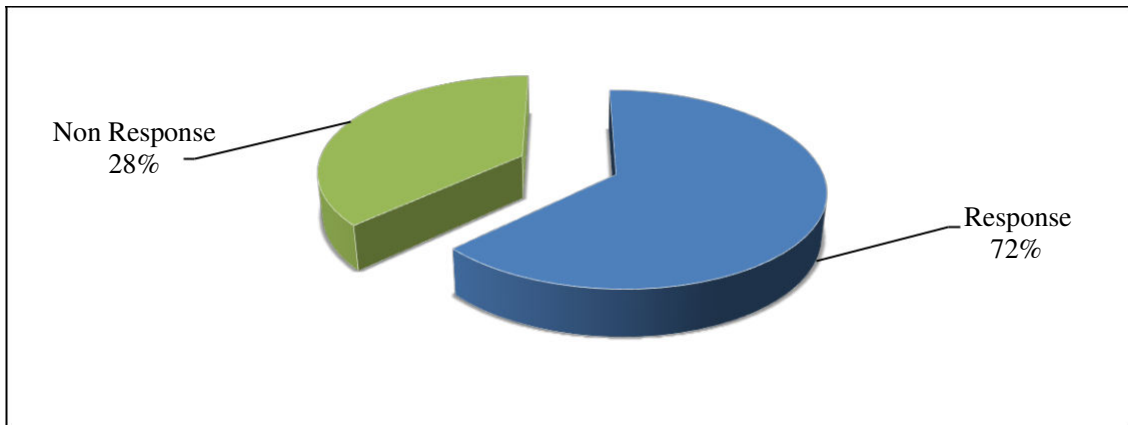


Figure 4.1: Response Rate (Quantitative Data)

Demographic Data

This section presents the general characteristics of the respondents. The personal data helped contextualize the findings and also in the formulation of appropriate recommendations based on the study findings. The demographic information related to age, gender, income, and place of residence.

Respondents' age

The respondents were asked to indicate their age group, and their responses are presented in Figure 4.2.

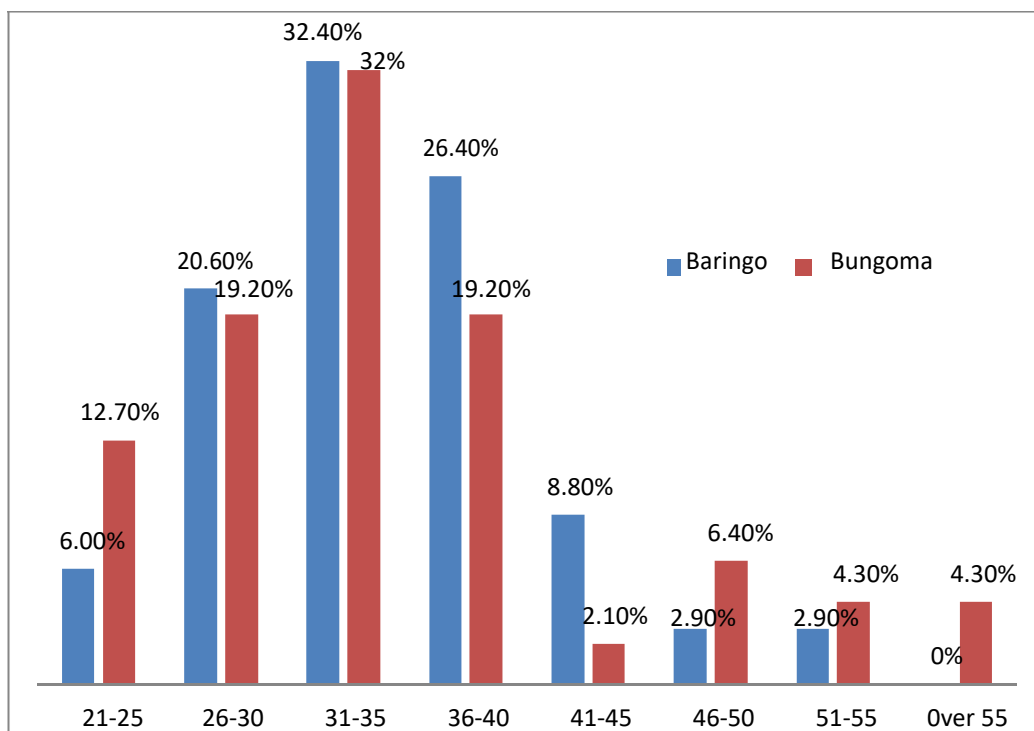


Figure 4.2: Respondents' Age

The age distribution of the respondents as depicted in Figure 4.2 shows that the highest number of respondents were in the age bracket of 31 to 35 years: 32% from Bungoma County and 32.4% from Baringo County. The second-ranking age bracket was between 36 to 40 years: 26.4% of the respondents from Baringo County and 19.2% from Bungoma County. The age bracket of 26 to 30 had 20.6% respondents from Baringo County and 19.2% from Bungoma County.

The age brackets of 51-55 and over 55 had the lowest number of respondents. Notably, Baringo County had no respondent in the over 55 years age category. These findings point out that most of the respondents employed in the health sector in the counties, and who took part in the study were between the ages of 31 to 35 years, an indication of a relatively younger age group. It also implied that the researcher was able to gather objective responses as the age group had adequate exposure regarding devolution initiatives in their respective counties.

Gender distribution

The research sought to find out the gender distribution of the respondents. The findings are shown in Figure 4.3.

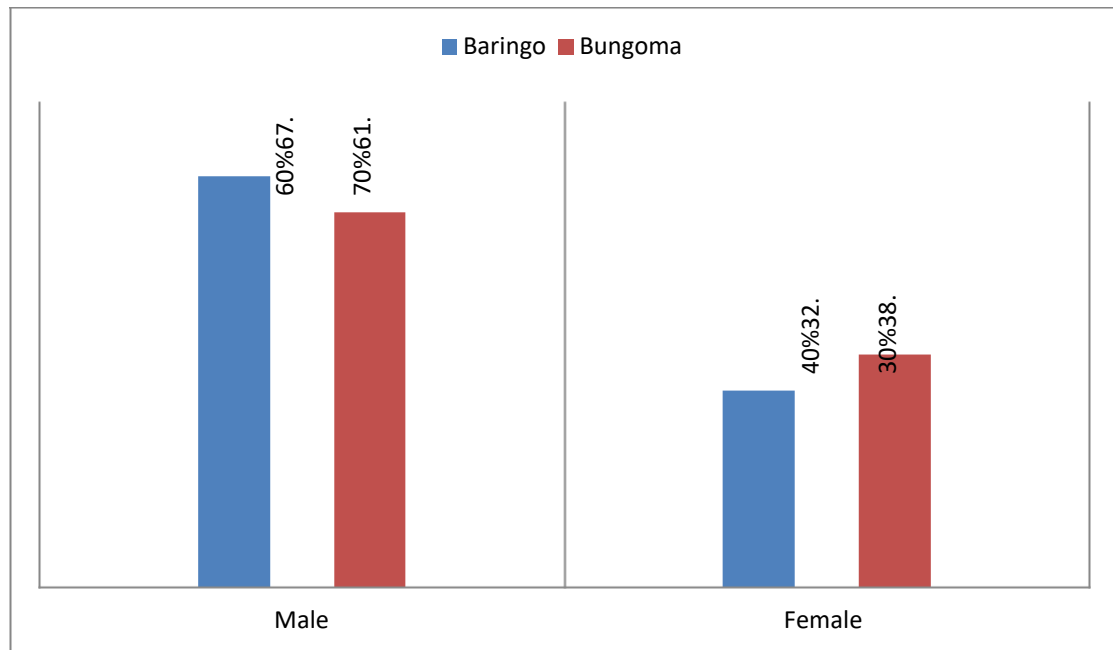


Figure 4.3: Respondents' Gender

As per the findings presented in Figure 4.3, 67.6% of the respondents from Baringo County were male, while 32.4% were female. From Bungoma County, 38.3% of the respondents were female, while 61.7% were male. The majority of the respondents were therefore male. The gender response rate met the gender parity as indicated in the Constitution of Kenya, 2010, which notes that either gender should not be more than two thirds. This denotes that there was an adequate representation of both genders, hence diverse views were obtained.

Academic qualification

The study sought to establish the highest level of education attained by the respondents. The feedback is displayed in Table 4.1.

Table 4.1: Respondents' Academic Qualification

Education Level	Frequency	%	Education Level	Frequency	%
Baringo			Bungoma		
Certificate	2	5.8	Certificate	0.0	0.0
Diploma	6	17.7	Diploma	8	17.0
Undergraduate	18	52.9	Undergraduate	24	51.1
Postgraduate	8	23.5	Postgraduate	15	31.9
Total	34	100.0		47	100.0

As the data in Table 4.1 reveals, 52.9% of the respondents from Baringo County had undergraduate level of education, 23.5% had postgraduate level, 17.7% had diploma, while only 5.8% had certificate level. From Bungoma County, 51.1% of the respondents had undergraduate level of education, 31.9% had postgraduate level, 17.0% had diploma, while none had certificate level

The results demonstrate that the respondents had a relatively high level of academic qualifications, since most of them had a minimum of a university first degree. Therefore, most of the respondents could give adequate and sufficient information regarding the study objectives.

Years in employment

The respondents were asked to indicate the number of years they worked for the county government and their responses are captured in Table 4.2.

Table 4.2: Respondents' Duration (in years) in Employment

Years in Employment	Frequency	%	Years in Employment	Frequency	%
Baringo			Bungoma		
Less than 1 year	2	5.8	Less than 1 year	4	8.5
1 year to 5 years	6	17.7	1 year to 5 years	11	23.4
5 years to 10 years	16	47.1	5 years to 10 years	18	38.3
Above 10 years	10	29.4	Above 10 years	14	29.8
Total	34	100.0		47	100.0

As captured in Table 4.2, the respondents who had worked for their respective counties for 5 to 10 years comprised 47.1% from Baringo County and 38.3% from

Bungoma County. Those whose work duration in their counties was more than 10 years included 29.4% from Baringo County and 29.8% from Bungoma County.

These results indicate that most of the respondents had above five years of experience working for the county government. Hence, most of the respondents could provide sufficient information regarding the effect of devolution on M&E in their respective counties

Monitoring and Evaluation Systems in Baringo and Bungoma Counties

County governments' strategic plan

The researcher required the respondents to indicate whether they had seen their respective county's health sector strategic plan. The responses were as pictured in Figure 4.4.

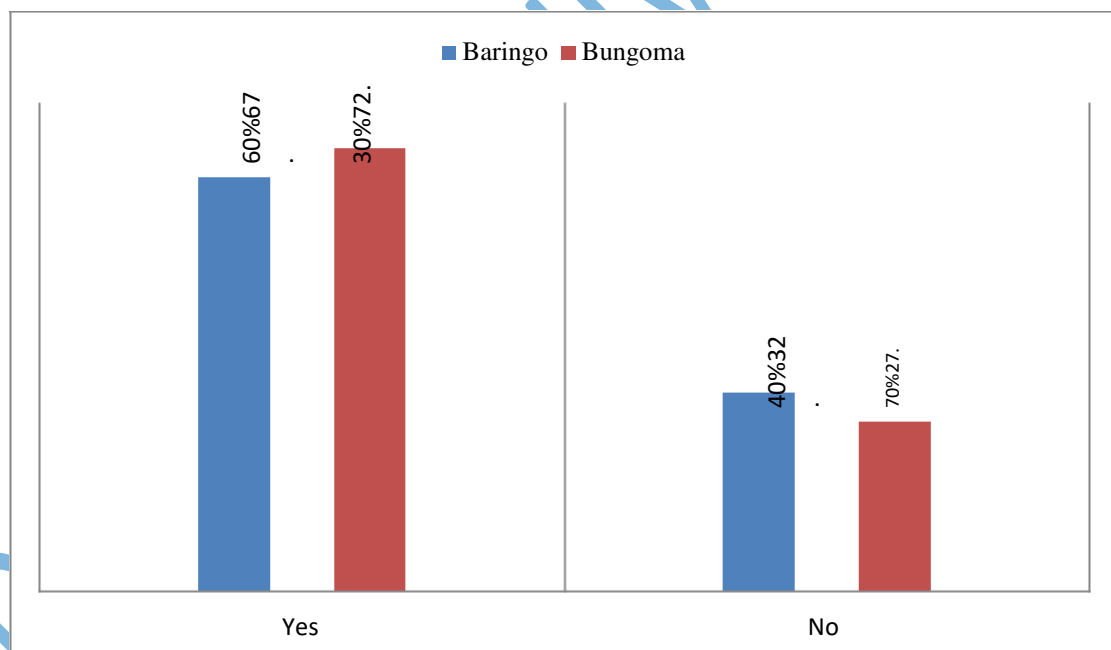


Figure 4.4: Whether Respondent Had Seen County Health Sector Strategic Plan

The findings (see Figure 4.4) demonstrate that while 67.6% of the respondents from Baringo County indicated that they had seen the strategic health plan for their county, 32.4% of the respondents from the same county pointed that they had seen the

strategic plan. Similarly, while 72.3% of the respondents from Bungoma County had seen their county's strategic plan, 27.7% had not.

From the findings it is noted that the majority of the respondents had already seen the strategic health plan for their respective counties hence they were in a better position in terms of addressing the research objectives.

The respondents were further asked if they had seen any other strategic plan for the Ministry of Health. Figure 4.5 gives the results.

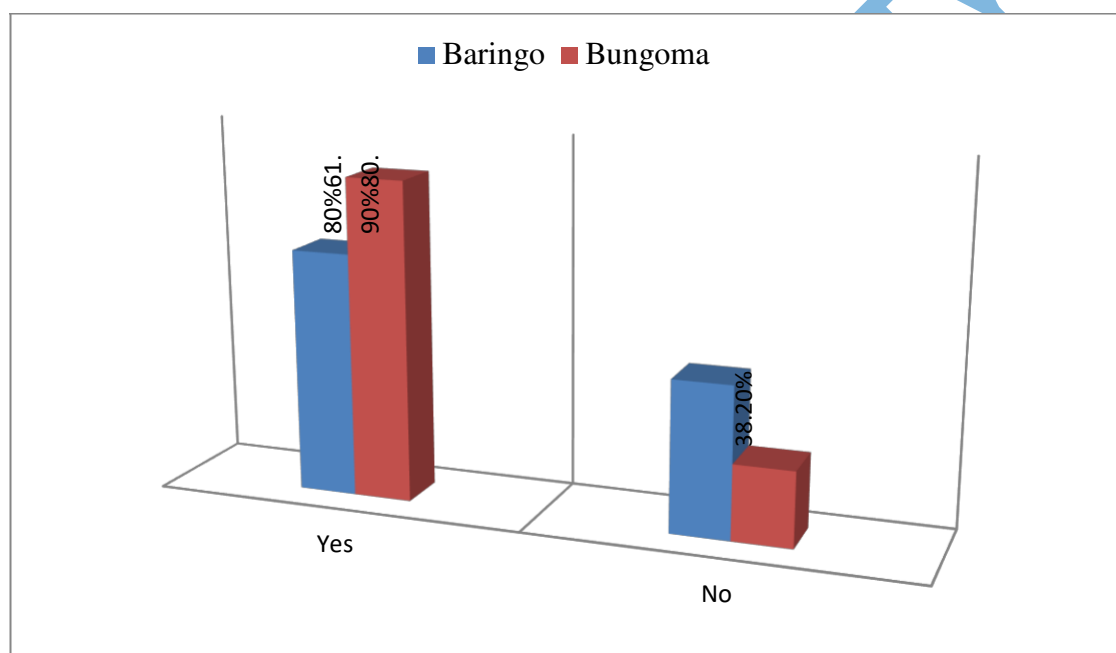


Figure 4.5: Whether Respondent Had Seen Ministry of Health Strategic Plan

As rendered in Figure 4.5, 61.8% of the respondents from Baringo County reported that they had seen another integrated strategic health plan for the ministry of health, while 38.2% reported that they had not. For Bungoma County, 80.9% of the respondents had seen another strategic plan for the ministry of health, while 19.1% had not.

The results therefore are clear that most of the respondents: 67.6% from Baringo County and 72.3 from Bungoma County have seen the strategic health plan for their respective counties (see Figure 4.4), denoting that the respondents were well informed

on the plans set in place by the devolved governments regarding healthcare and could therefore provide knowledgeable information on the subject of study.

The respondents were also asked to indicate if they possessed certain documents as listed in Table 4.3.

Table 4.3: County Governments' Documents

Baringo	F	%	Bungoma	F	%
County strategic plan	19	55.9	County strategic plan	21	44.7
County M&E Plan	0	0	County M&E Plan	11	23.4
MOH Strategic plan (KHSSP)	14	41.2	MOH Strategic plan (KHSSP)	14	29.8
MOH M&E framework for the health sector strategic plan	4	11.8	MOH M&E framework for the health sector strategic plan	12	25.5

As shown in Table 4.3, most of the respondents: 55.9% from Baringo County and 44.7% from Bungoma County revealed that they possessed their respective county's strategic plan. Ranking second were the respondents who reported that they possessed the ministry of health's strategic plan: 41.2% from Baringo County and 29.8% from Bungoma County. Additionally, 23.4% of the respondents from Bungoma County reported that they possessed the county's M&E plan, with none from Baringo County expressing that they possessed this plan. Regarding the MOH M&E framework for the health sector strategic plan, 25.5% of the respondents from Bungoma County indicated that they had it, compared to only 11.8% from Baringo County who also indicated they had it.

These findings were affirmed by a key informant, and manager in Bungoma County who stated as below:

Yes. We have a county health sector M&E plan. County Health Sector M&E framework is used mainly to monitor the CHSSP.

Regarding Baringo County, the findings differed as is shown by a key informant who is also a manager in the health department. The informant stated as follows:

There is an M&E plan available in the county, but the plan is still in draft stage. It has not been approved since the CHSSP was approved.

Thus, the findings suggest that respondents from Bungoma County have an M&E plan and also utilize the county M&E framework. Respondents from Baringo County also indicated that there were M&E plans available in their county but also pointed out that the plans were yet to be implemented.

Monitoring and Evaluation Unit Awareness in Baringo and Bungoma County

When asked whether they had an M&E unit in their counties, the respondents gave the feedback highlighted in Figure 4.6.

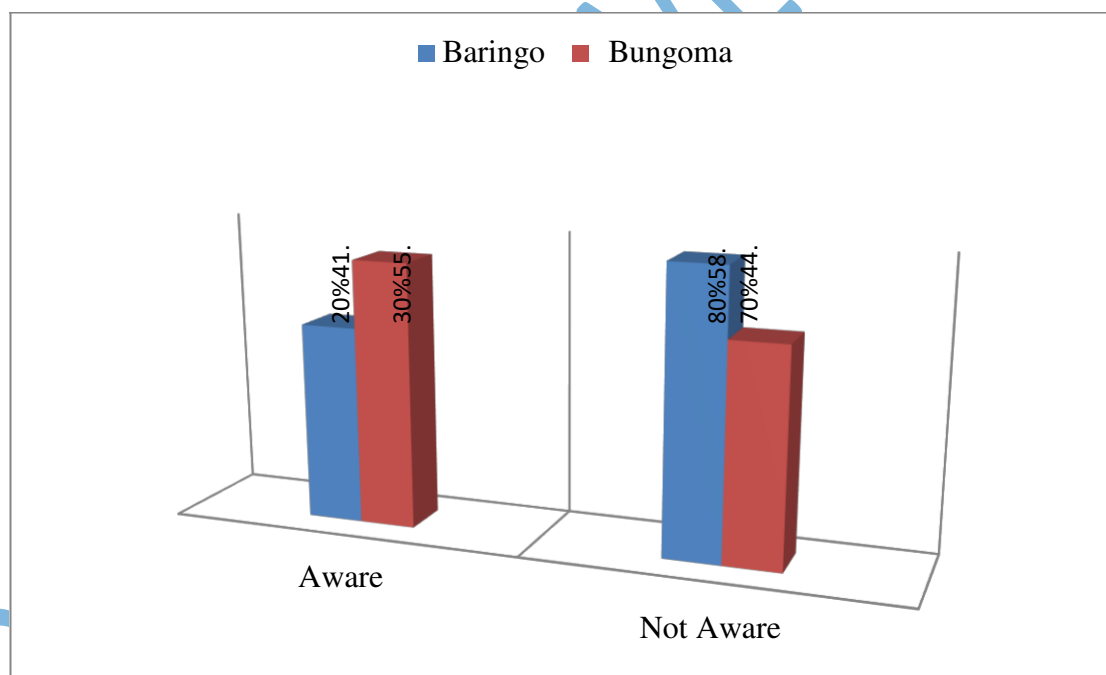


Figure 4.6: Whether Respondent Was Aware of M&E Unit in the County

The findings (shown in Figure 4.6) highlight that 41.2% of the respondents from Baringo County and 55.3% from Bungoma County were aware of an M&E unit within their respective counties. On the other hand, 58.8% of the respondents from

Baringo County and 44.7% from Bungoma County were not aware of an M&E unit within their respective counties

Capacity of M&E Personnel in Baringo and Bungoma Counties

The respondents were asked to indicate whether their county has qualified M&E employees; whether they train employees on M&E; and whether they hire qualified M&E employees. Tables 4.4 and 4.5 capture the results.

Table 4.4: Capacity of M&E Personnel in Baringo County

M&E Personnel Capacity in Baringo County	Yes		No	
	Frequency	%	Frequency	%
Believes county has qualified employees in M&E	20	58.8	14	41.2
County trains employees on M&E	8	23.5	26	76.5
County hires qualified employees on M&E	6	17.6	28	82.4

On whether Baringo County has employees qualified in M&E, 58.8% of the respondents answered in the affirmative, while 41.2% disagreed. On whether Baringo County trains its employees on M&E, 76.5% of the respondents disagreed while only 23.5% agreed (see Table 4.4). These sentiments were affirmed by a county health worker in a management position, who emphasized the following:

As far as I am concerned, no employee has been trained although according to the health records information it indicates that they have been trained.

In addition, 82.4% (28) of the respondents stated that Baringo County does not hire personnel qualified in M&E (see Table 4.4).

Table 4.5: Capacity of M&E Personnel in Bungoma County

M&E Personnel Capacity in Bungoma County	Yes		No	
	Frequency	%	Frequency	%
Believes county has qualified employees in M&E	33	70.2	14	29.8
County trains employees on M&E	19	40.4	28	59.6
County hires qualified employees on M&E	17	36.2	30	63.8

Concerning whether Bungoma County has employees qualified in M&E, 70.2% of the respondents were in agreement, while 29.8% did not believe so. Regarding whether Bungoma County trains its employees on M&E, 40.4% of the respondents concurred, while 59.6% disagreed (see Table 4.5).

These findings were confirmed by a key informant in Bungoma, who mentioned the following:

The staff here in Bungoma County health department are not adequately trained in M&E.

Further, 63.8% of the respondents did not believe that the Bungoma County government hires personnel who are qualified in M&E, while 36.2% believed the opposite (see Table 4.5).

A key informant confirmed this, stating as follows:

There is no formal M&E coordination system at Bungoma. There is no M&E at the level of the Sub-county. HRIO was assigned to perform the M&E functions by county level. Records officer usually performs M&E function.

The findings imply that personnel in Bungoma and Baringo counties are not adequately trained in M&E. Moreover, in Baringo County, respondents believed that some of their personnel were qualified in overseeing M&E functions, and gave an example of the records officer.

Number of M&E employees in Baringo and Bungoma counties

The researcher intended to ascertain the number of M&E employees in Baringo and Bungoma counties. The findings in relation to this are detailed in Table 4.6.

Table 4.6: Number of M&E Personnel

Baringo	Frequency	%	Bungoma	Frequency	%
Above 4 employees	0	0.0	Above 4 employees	0	0.0
4 employees	2	5.8	4 employees	11	23.4
3 employees	6	17.7	3 employees	18	38.3
2 employees	10	29.4	2 employees	14	29.8
1 employee	16	47.1	1 employee	4	8.5
Total	34	100.0		47	100.0

As the findings in Table 4.6 reveal, 47.1% of Baringo County respondents indicated that they had only one (1) personnel overseeing M&E in the county. An additional 29.45% from the same county indicated that the county had two M&E personnel.

A key informant from Baringo County explained the above findings as follows::

Baringo doesn't have dedicated M&E staff. However, it is the archives officer who supervises the M&E positions at present.

Most of the respondents from Bungoma County: 38.3% indicated that there were three M&E personnel in the county, 29.8% indicated that there the county had two M&E personnel. Further, according to 23.4% of the respondents, the county had four M&E personnel (see Table 4.6).

These findings were supported by a manager in the health department of Bungoma County who explained as follows:

There are no specific employees who only handle M&E activities. There are number of employees who do other things as well as M&E functions.

According to the findings, the number of personnel who oversee M&E functions in each of the two counties range between one and three.

Monitoring and Evaluation Capacity in Baringo and Bungoma Counties

The responses relating to the M&E capacity of Baringo County are displayed in Table

4.7. below:

Table 4.7: M&E Capacity in Baringo County

M&E Capacity in Baringo County	Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree	
	F	%	F	%	F	%	F	%	F	%
County has training plans for employees on M&E	7	32.3	19	37.1	2	19.4	2	3.2	4	8.1
County hires employees with adequate skills on M&E	3	8.8	7	20.6	3	8.8	4	11.8	17	50.0
Most M&E employees are well trained	8	23.5	6	17.7	1	2.9	10	21.3	9	26.5

According to the responses shown in Table 4.7, 69.4% of the respondents agreed that Baringo County has training plans on M&E for its employee. On whether Baringo County hires employees with adequate skills on M&E, 61.8% of the respondents disagreed, with only 29.4% agreeing. Asked whether most employees in the county are well trained on M&E, 41.2% of the respondents responded positively, while 47.8% disagreed.

These findings communicate that Baringo County has training plans for its M&E employees. The findings also point out that the county does not hire employees with adequate skills in M&E, and that more needs to be done with regard to investments in training of its M&E personnel.

Regarding the M&E capacity of Bungoma County, the findings were as outlined in Table 4.8.

Table 4.8: M&E Capacity in Bungoma County

M&E Capacity in Bungoma County	Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree	
	F	%	F	%	F	%	F	%	F	%
County has training plans for employees on M&E	7	14.9	22	46.8	1	2.1	6	3.2	11	23.4
County hires employees with adequate skills on M&E	11	23.4	18	38.3	4	8.5	9	19.1	5	10.6
Most M&E employees are well trained	8	17.0	20	42.6	1	2.1	9	19.1	9	19.1

With regard to whether Bungoma County has training plans on M&E for its employees, 61.7% of the respondents agreed. Another 61.7% agreed that the county hires employees with adequate skills on M&E, with 29% disagreeing. On whether most M&E employees in Bungoma are well trained, 59.6% of the respondents agreed. Based on these findings, it is clear that Bungoma County has put in place training plans for its M&E employees which have facilitated the hiring and training of M&E employees in the county.

Data Management Systems Supporting M&E in Baringo and Bungoma Counties

The researcher made various statements to the respondents about M&E data management systems and asked them to indicate the extent to which they agreed with each statement. The responses are presented in Table 4.9.

Table 4.9: Data Management Systems in Baringo and Bungoma Counties

Data Management Systems in Baringo	Strongly agree		Agree		Neutral		Disagree		Strongly disagree	
	F	%	F	%	F	%	F	%	F	%
County has data quality assurance plans	8	23.5	14	41.2	1	2.9	9	26.5	2	19.4
Computer software keeps track of work/doc progress	7	32.3	19	37.1	2	19.4	2	3.2	4	8.1
Data management software is available	3	8.8	7	20.6	3	8.8	4	11.8	17	50.0
Data management software is friendly	8	23.5	6	17.7	1	2.9	10	21.3	9	26.5
Computer software for data management is available	3	8.8	17	50.0	3	8.8	4	11.8	7	20.6
Data Management Systems in Bungoma	Strongly agree		Agree		Neutral		Disagree		Strongly disagree	
	F	%	F	%	F	%	F	%	F	%
County has data quality assurance plans	7	14.9	22	46.8	1	2.1	6	3.2	11	23.4
Computer software keeps track of work/doc progress	11	23.4	18	38.3	4	8.5	9	19.1	5	10.6
Data management software is available	7	14.9	15	31.9	5	10.6	11	23.4	9	19.1
Data management software is friendly	6	3.2	11	23.4	1	2.1	7	14.9	22	46.8
Computer software for data management is available	9	19.1	20	42.6	1	2.1	8	17.0	9	19.1

According to the findings displayed in Table 4.9, 64.7% of the respondents from Baringo County agreed that the county has quality assurance plans. In addition, 69.4% of the respondents from the same county agreed that computer software keeps track of work or documents' progress. On whether a data management software is available in Baringo County, 29.4% of the respondents agreed, while 61.8% disagreed.

A key informant in Baringo supported the findings, stating as follows:

No, we do not have a data management system in the county, but we use the District Health Information System (DHIS) which is a common reporting framework for the country.

A fair number of the respondents - at 41.2% indicated that data management software in Baringo is user friendly, while 47.8% were of the opinion that the software was not user friendly and therefore not easy to use. Notably, 68.8% agreed that a computer software for data management in Baringo County is available.

In relation to Bungoma County, 61.7% of the respondents in the county agreed that the county has quality assurance plans. In addition, 61.7% of the respondents agreed that computer software keeps track of work or documents' progress. On whether, a data management software is available in the county, 46.8% of the respondents agreed, while 42.1% disagreed.

A key informant in Bungoma County explained the above the findings, with the following statement:

I would not say it exists but there is a framework for reporting. In terms of existing data management system. We have District Health Information System.

On whether the data management software in Bungoma County was friendly, most of the respondents - 61.7% disagreed, while 26.6% agreed. Noteworthy, 69.4% of the

respondents in the county agreed that the computer software keeps track of work or documents' progress.

Effectiveness of the Healthcare Sectors of Bungoma and Baringo Counties

The respondents were asked to indicate whether their county's M&E system was effective, particularly in the healthcare sector. The responses are illustrated in Figure 4.7 below:

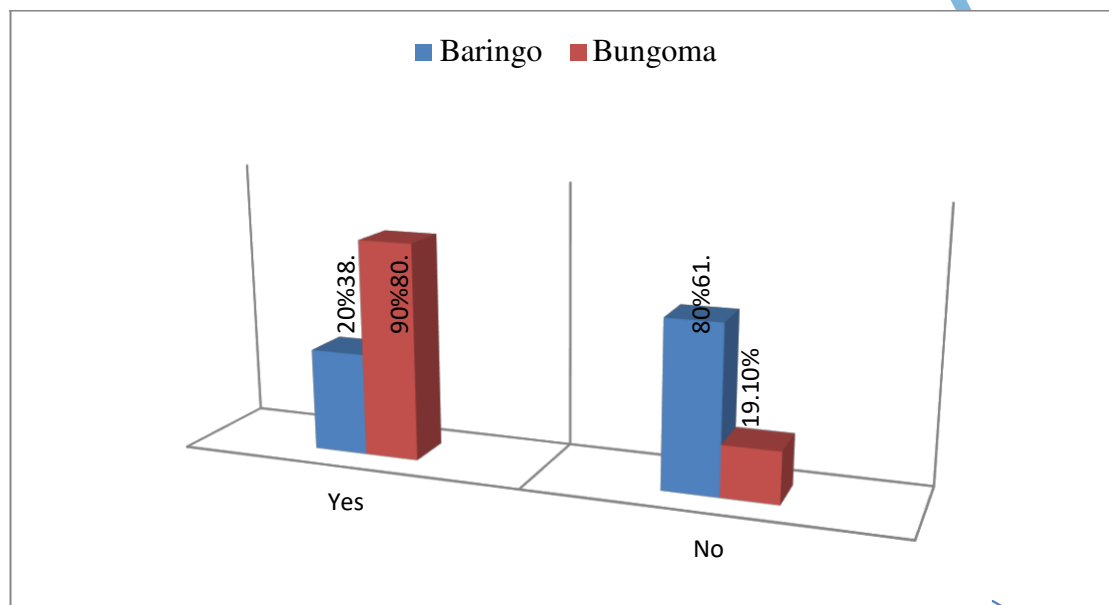


Figure 4.7: Effectiveness of Healthcare M&E System

The findings presented in Figure 4.7 demonstrate that 61.8% of the respondents from Baringo County stated that M&E system in the county was not effective in the healthcare sector, while 38.2% felt that the system was effective. A key informant who is also a manager in Baringo County's health department confirmed that support is partner-based which has created alignment challenges resulting in slower decision-making.

Regarding Bungoma County, 80.9% of the respondents felt that the M&E system for healthcare in the county was effective, while 19.1% of the respondents did not consider the system effective.

According to a key informant in Bungoma County, the effectiveness of M&E is dependent on the budget. The respondent stated as below:

M&E functions are not routine, we depend on national levels because we do not have dedicated budget lines. However, when done, it informs the programming of health service delivery. We use the findings to look at where services need improvement such as client satisfaction.

Level of Funding for M&E in Baringo and Bungoma Counties

The researcher sought to determine whether the counties have the ability to generate their own resources. The responses in this regard are depicted in Table 4.10.

Table 4.10: County's Ability to Generate Income

County's ability to generate income	Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree	
	F	%	F	%	F	%	F	%	F	%
Bungoma	17	36.2	20	42.5	7	14.9	2	4.3	1	2.1
Baringo	10	29.4	11	32.3	4	11.8	4	11.8	5	14.7

The results (in Table 4.10) reveal that 61.7% and 78.7% of the respondents from Baringo and Bungoma counties respectively agreed that their counties can generate their own resources, rather than relying on donors.

County allocates specific funding for M&E

The respondents were asked to indicate whether the county allocates specific funding to M&E, and their feedback is shown in Figure 4.8.

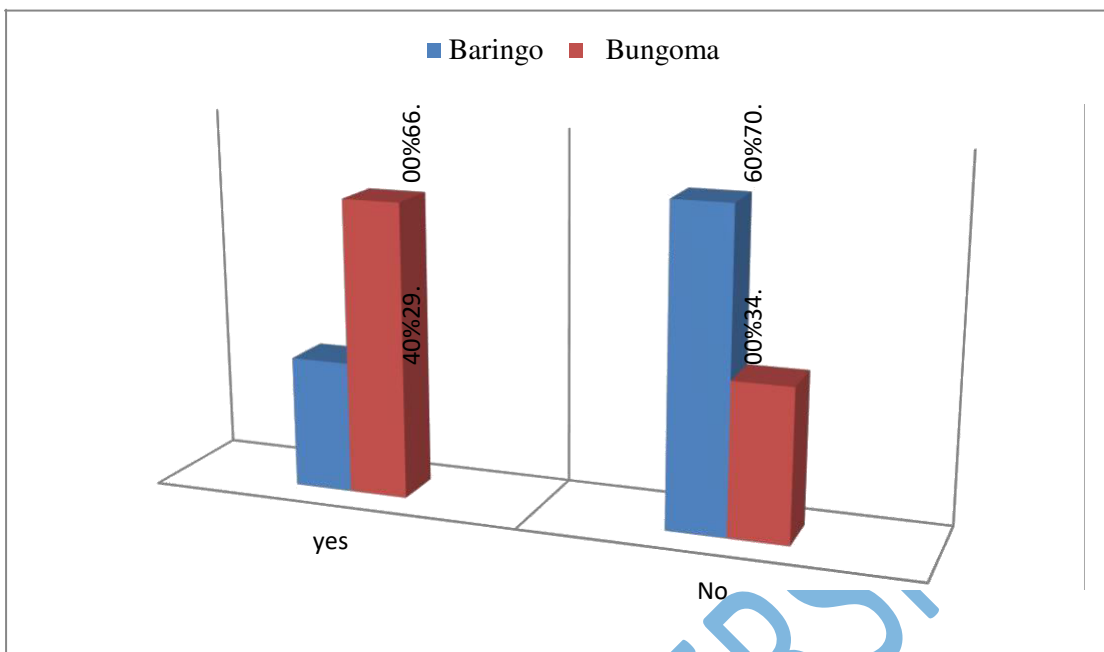


Figure 4.8: Specific Funding for M&E

The findings depicted in Figure 4.8 show that according to 70.6% of the Baringo County respondents, there is no specific funding allocated to M&E in the county. On the other hand, 29.4% of the respondents from the same county stated that there is a particular fund dedicated to M&E in the county. About Bungoma County, 66% of the respondents said that the county has specific funding allocated to M&E, while 34% responded to the contrary.

Amount allocated to M&E

The respondents were asked to indicate whether they were aware of the amount allocated to M&E by the county government. The responses are captured in Figure 4.9.

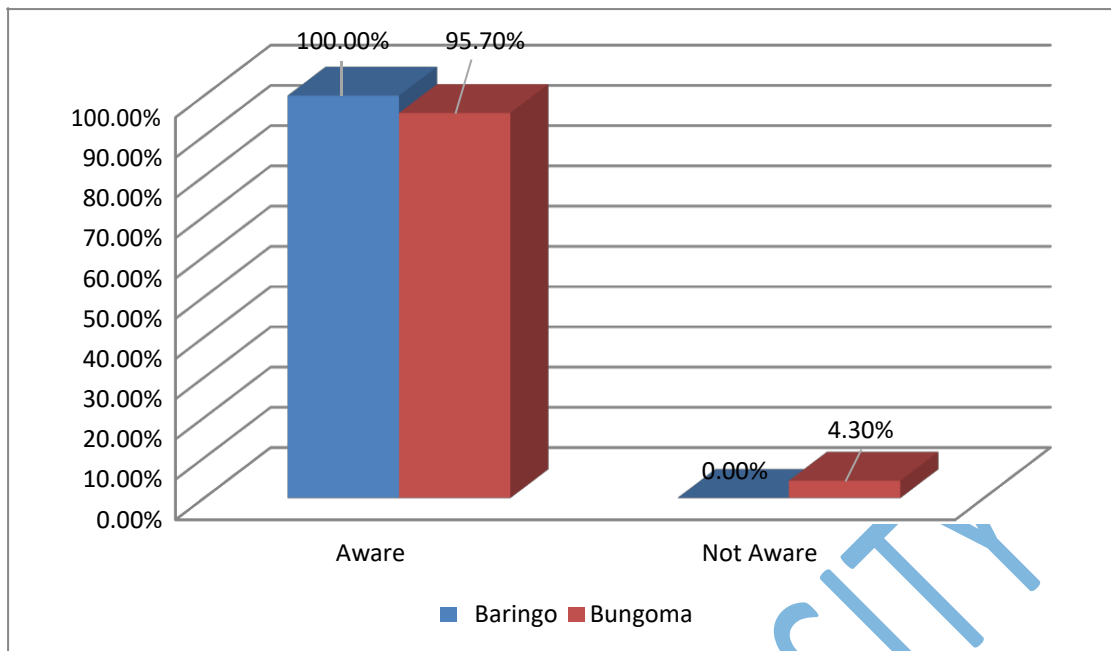


Figure 4.9: Amount Allocated to M&E

As per the findings captured in Figure 4.9, 100% of respondents from Baringo County and 95.70% of respondents from Bungoma County were aware of resources allocated for M&E. This means that in both counties the respondents understand the importance of M&E of projects and devolved functions hence they have to adhere to set standards of service delivery.

Effect of Devolution on M&E Healthcare Systems in Bungoma and Baringo Counties

The researcher set out to find out the extent to which the respondents agreed with various statements regarding the effect of devolution on M&E healthcare systems.

The responses are displayed in tables 4.11 and 4.12.

Table 4.11: Effect of Devolution in Baringo County

Effect of devolution in Baringo	Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree	
	F	%	F	%	F	%	F	%	F	%
Devolution has allowed M&E staff to improve healthcare access	8	23.5	17	50.0	1	2.9	6	17.7	2	5.9
Devolution has improved the capacity of M&E staff in the healthcare sector (training, service delivery, etc.,)	7	32.3	19	37.1	2	19.4	2	3.2	4	8.1
Devolution has improved the transparency of M&E systems in the healthcare sector	8	23.5	14	41.2	1	2.9	9	26.5	2	19.4
Devolution has improved the effectiveness of M&E systems in healthcare	3	8.8	17	50.0	3	8.8	4	11.8	7	20.6

Baringo County: 73.5% of the respondents in Baringo County agreed that devolution has allowed M&E staff to improve healthcare access; 69.4% agreed that devolution has improved the capacity of M&E staff in the healthcare sector (training, service delivery, among others); 64.7% agreed that devolution has improved the transparency of M&E systems in the healthcare sector; and 68.8% disagreed that devolution has improved the effectiveness of M&E systems in healthcare in the county.

A key informant who is a manager in Baringo health department mentioned the following:

Devolution has forced the county to think about use of data since they are the ones that have to procure commodities. Like malaria medicine, one has to know and keep track of cases for procurement purposes. Overall, it has raised the case of ME. Although there is still a lack of understanding of M&E. Most think ME is a data function.

Also Partner alignment. The support tends to skew the performance of the sector. Once money is gone, we are back to our old way of doing things.

Table 4.12: Effect of Devolution in Bungoma County

Effect of devolution in Bungoma	Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree	
	F	%	F	%	F	%	F	%	F	%
Devolution has allowed M&E staff to improve healthcare access	11	23.4	18	38.3	4	8.5	9	19.1	5	10.6
Devolution has improved the capacity of M&E staff in the healthcare sector (training, service delivery etc.)	7	14.9	22	46.8	1	2.1	6	13.2	11	23.4
Devolution has improved the transparency of M&E systems in the healthcare sector	9	19.1	20	42.6	1	2.1	8	17.0	9	19.1
Devolution has improved the effectiveness of M&E systems in healthcare	7	14.9	15	31.9	5	10.6	11	23.4	9	19.1

The findings (presented in Table 4.12) revealed that 61.7% of the respondents in Bungoma County agreed that devolution has allowed M&E staff to improve healthcare access in the county; 61.7% agreed that devolution has improved the capacity of M&E staff in the healthcare sector (training, service delivery, among others) in the county; 61.7% agreed that devolution has improved the transparency of

M&E systems in the healthcare sector in the county; and 46.8% agreed that devolution has improved the effectiveness of M&E systems in healthcare in the county.

A key informant in Bungoma County had the following sentiments:

Devolution has given some level of prominence. They engage us. It has raised the pedestal in terms of use of data for evidence.

Summary of Key Findings

1. Most of the respondents were Male: 67.6% and 61.7% male respondents from Baringo and Bungoma counties, respectively. Furthermore, most of the respondents had attained a minimum of undergraduate degree as indicated by 52.9% respondents from Baringo County and 51.1% from Bungoma County. Also, a majority of the respondents had above five years of experience working for their respective county government. Therefore, most of the respondents could provide sufficient information regarding the effect of devolution on M&E in their respective counties.
2. Most of the respondents have seen the strategic health plan of their county, as reported by 67.6% of the respondents from Baringo County, and 72.3% from Bungoma County. Notably, when asked which documents the respondents possessed, none of the respondents from Baringo County reported that they possessed the county's M&E plan, while only 23.4% from Bungoma County reported that they possessed the county's M&E plan.
3. With regard to the capacity of M&E personnel in the two counties, 58.8% of the respondents in Baringo believe that the county has qualified employees; 76.5% believe that the county does not train its employees on M&E; while

82.4% felt that the government does not hire qualified M&E employees. The results relating to Bungoma County showed that most of the respondents - 61.7% believe that Bungoma has qualified and trained employees.

4. On data management systems supporting M&E, a majority of the respondents - 64.7% in Baringo County agreed that the county has quality assurance plans; 69.4% agreed that computer software keeps track of work or documents' progress; while a small number of the respondents - 29.4% agreed that data management software is available in the county.

Bungoma County: 61.7% of the respondents agreed that the county has quality assurance plans; 61.7% agreed that computer software keeps track of work or documents' progress; and 46.8% agreed that data management software is available.

5. On the objective on level of funding for M&E of healthcare systems in Bungoma and Baringo counties, most of the respondents from the two counties: 61.7% from Baringo County and 78.7% from Bungoma County agreed that their counties can generate their own resources; 24.6% of the respondents from Baringo County indicated that there is no specific funding allocated to M&E in the county; and most (66%) of the respondents from Bungoma County said that there is a specific amount allocated to M&E in the county. Furthermore, all of the respondents from Baringo County reported that they were not aware of the amount allocated to M&E, whereas only two respondents (4.3%) from Bungoma County were aware of the amount allocated to M&E in their county. When the two respondents were further asked to indicate the percentage of the amount they mentioned, they indicated that the amount was less than 10% of the total county budget.

6. In relation to how devolution affects M&E healthcare systems in Bungoma and Baringo counties, A high number of the respondents from both Baringo and Bungoma counties: 73.5% and 61.7% respectively, agreed that devolution has allowed M&E staff to improve healthcare access. Another high number of the respondents: 69.4% and 61.7% from Baringo and Bungoma counties respectively agreed that devolution has improved the capacity of M&E staff in the healthcare sector. In addition, 64.7% of the respondents from Baringo County and 61.7% from Bungoma County agreed that devolution has improved the transparency of M&E systems in the healthcare sector.

Summary

In this chapter, the researcher has presented the analyzed data and also its interpretation. A summary of the key findings has also been provided. The study has gathered key information on the effect of devolution on M&E systems of health services in Kenya. In the next chapter, the findings are discussed in light of the study objectives. The study conclusions and recommendations are also provided.

CHAPTER FIVE

DISCUSSIONS, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

In this chapter, the researcher discusses the key findings of the study, draws conclusions based on the study findings, and gives the study recommendations. The study sought to assess the effect of devolution on the M&E of health services in Kenya, with a special focus on Bungoma and Baringo counties. The objectives guiding the study were to assess the type of M&E systems in place at the health departments of the two counties; determine the capacity of health services' M&E systems in the health departments of the two counties; assess the availability of data management systems that support M&E of health services in the two counties; establish the level of funding for health services' M&E systems in the two counties; and assess the effect of devolution on health services' M&E systems in the two counties. The chapter also covers the researcher's recommendations for further study.

Discussion of Key Findings

Monitoring & Evaluation Systems used in Baringo and Bungoma Counties

According to the study findings, most of the respondents have seen the integrated strategic health plan for their respective counties as indicated by 61.8% (21) of the respondents from Baringo County and 80.9% (38) from Bungoma County. Further, most of the respondents: 55.9% (19) and 44.7% (21) from Baringo and Bungoma counties respectively revealed that they possessed the county strategic plan. Also, 41.2% (14) and 29.8% (14) respondents from Baringo and Bungoma counties respectively indicated that they possessed the MOH strategic plan. This was affirmed by a key informant from Bungoma County. These findings agree with Goergens and

Kusek (2010) who described a possible correlation between M&E plans and healthcare efficiency. Goergens and Kusek (2010) stated that for an M&E system to be effective, there must be M&E plans in place, including the human capacity to execute said plans as well as advocacy and communication for M&E.

On the capacity of M&E personnel in the counties, 58.8% (20) and 70.2% (33) of the respondents from Baringo and Bungoma counties respectively believe that their respective counties have employees qualified in M&E. However, the respondents from both counties indicated that their employees did not receive adequate training in M&E.

Respondents from both counties also pointed out that the counties have data management software: An equal number - 69.4% (26) of respondents from each of the two counties reported that a computer software keeps track of work or documents' progress in the counties. Finally, when asked if M&E systems were effective, most of the respondents from Baringo County indicated that M&E systems in their counties were not effective in the healthcare sector, while 80.9%(38) respondents from Bungoma County felt that the M&E system for healthcare in the county was effective.

Capacity of County Health Department in M&E

The second objective of the study was to determine the capacity of county health departments' M&E of health services in Bungoma and Baringo counties. Most (69.4%) of the respondents from Baringo County indicated that the county has implemented training plans on M&E for its employees. However, most respondents from the same county - 61.8% felt that the county does not hire employees with adequate skills on M&E. Additionally, 47.8%(19) of the respondents from Baringo County indicated that most M&E employees in the county are not well trained.

Based on these findings, the study concluded that although there are training plans set in place for M&E employees in Baringo County, the county does not hire employees with adequate skills in M&E, nor do the M&E personnel have training on M&E. A key informant confirmed these findings and further revealed that no employee has been trained although the health records information indicated that they have been trained. Guijit (2004) maintained that one key element of an M&E system is the capacity element which relates to the ability to perform appropriate tasks effectively, efficiently, and sustainably on the following three levels: system capacity, organisational capacity, and individual capacity.

A high number of respondents - 61.7% (29) from Bungoma County agreed that the county has training plans for employees on M&E. Further 61.7% (29) of respondents from the same county reported that the county hires employees with adequate skills on M&E. Also, 59.6% (28) respondents from Bungoma county indicated that most M&E employees in the county are well trained. These findings imply that there are training plans set in place for M&E employees in Bungoma County, which have facilitated the hiring and training of M&E employees in the county. However, a key informant argued that although there are training plans for M&E, the staff dedicated to performing M&E functions were not properly trained, these findings agree with Bamberger's (2012) assertion that effective M&E systems highly depend on the skills, capabilities, and employees' endeavours to uphold strategies geared towards growth; a factor that has probably contributed to the slight improvement of healthcare services in Bungoma County.

Data management Systems that Support M&E of Health Services in Bungoma and Baringo Counties

As its third objective, this study assessed the availability of data management systems that support M&E of health services in Bungoma and Baringo counties. The findings in relation to Bungoma County revealed that most of the respondents - 64.7% (22) agreed that the county has quality assurance plans; and 69.4% (26) agreed that computer software keeps track of work or documents' progress. Nevertheless, the respondents felt that the data management softwares available were not friendly, a factor that may have contributed to the poor performance of M&E in in the county. These findings concur with Hussein et al.'s (2007) claim that higher levels of IT competency lead to higher degree of effective M&E in system quality, information quality, and overall user satisfaction.

With regard to Bungoma County, 61.7% (29) of the respondents agreed that computer software keeps track of work or documents' progress in the county; and 46.8% (23) agreed that the county has data management software. However, most of the respondents - 61.7% (29) were of the opinion that the data management software in the county is not friendly. These findings agree with Cho (2007) who found out that information was only effective if it was available quickly and timely, was in the appropriate amount, was easy to access, and was easy to understand.

Also, key informant interviews in both counties identified DHIS as a framework for reporting and managing data. This differs with Nath and Badgujar (2013) who recommended MIS as the recommended systems for day-to-day M&E needs of managers and business professionals.

Level of Funding for M&E Systems in Bungoma and Baringo Counties

In its fourth objective, the study set out to establish the level funding for M&E systems of health services in the Bungoma and Baringo counties. A high number of the respondents: 61.7% (21) and 78.7% (37) from Baringo and Bungoma counties respectively indicated that their counties are able to generate their own resources. Furthermore, most of the respondents from Baringo County stated that there is no specific funding allocated to M&E in the county. On the other hand, a high number of the respondents from Bungoma County said that there is a specific amount of funding allocated to M&E in the county.

All the respondents in Baringo County expressed that they were not aware of the amount allocated to M&E in the county, while only two respondents (4.3%) from Bungoma County expressed unawareness of the same. These two respondents were further asked to give the percentage of funds allocated to the county, to which they indicated the amount was less than 10% of the total county budget. These findings agree with Mwega (2009) who established that government and non-government funding of healthcare in Kenya is most often not directed towards M&E and in most cases is poorly planned and unpredictable. It is, therefore, challenging to exactly break down the direct amount allocated to various functions within the different sectors of the economy mainly due to misappropriation of funds (Kariuki, 2014).

It is critical to set aside adequate financial and human resources at the planning stage to ensure quality M&E (Cheffins, 2011). The financial and human resources required for M&E should be considered in the overall costs of delivering the agreed results, rather than as additional costs (Goergens & Kusek, 2010).

Effect of Devolution on M&E Healthcare Systems in Bungoma and Baringo Counties

The final objective of this study was to assess the effects of devolution on M&E systems of health services in Bungoma and Baringo counties. Onyango, Cheluget, Akello, and Keraro (2012) maintained that devolution makes democracy stronger by giving people more say in matters relating to their local areas, and it allows local authorities to exercise discretionary powers when making decisions on matters that affect local communities, thus leading to efficiency in service delivery. Additionally, Donaldson and Lipsey (2013) opined that devolution of formal political authority can enhance transparency, responsiveness, and accountability at the lower levels of government.

Most of the respondents: 73.5% (25) and 61.7% (29) from Baringo and Bungoma counties respectively agreed that devolution has allowed M&E staff to improve healthcare access; and 69.4% (26) and 61.7% (29) from Baringo and Bungoma respectively agreed that devolution has improved the capacity of M&E staff in the healthcare sector in their respective counties. These findings are in tandem with those of Donaldson and Lipsey (2013), that devolution is said to result in policies, programmes, and more importantly - public expenditure decisions that respond to the needs of the intended beneficiaries, increasing the supply of key government services such as healthcare and education.

Further, 64.7% (22) of the respondents from Baringo County and 61.7% (29) from Bungoma County agreed that devolution has improved the transparency of M&E systems in the healthcare sector in the respective counties. Also, 68.8% of the respondents from Baringo County and 46.8% from Bungoma County agreed that devolution has improved the effectiveness of M&E systems in healthcare in their respective counties.

Key informants from Bungoma County added that devolution has raised the pedestal in terms of use of data for evidence. In relation to Baringo County, key informants highlighted the effect of devolution on procurement efficiency, especially in sourcing needed medications.

Conclusion

The study determined that devolution provided an incentive for the county governments to increase the productivity of M&E employees by designing M&E training programs for them. However, some of the challenges faced when it comes to enabling M&E staff to perform effectively include poor training and failure to recruit M&E-skilled personnel. These challenges were identified in Baringo County; thus, the study can conclude that this has played a role in the county's poor performance in regard to health services. On the other hand, skilled M&E staff and access to M&E training were identified as factors that have contributed to improved health services in Bungoma County.

The findings showed that the county governments have made an effort to avail data management systems that support M&E staff. These management systems have improved M&E in Bungoma County by making it possible to keep track of work records and documents, as well as assess work progress. However, some counties have faced challenges when using such systems, and have identified issues such as poor software friendliness - which could be attributed to the lack of proper M&E training, resulting in poor performance in the aspect of health services.

The study findings also pointed out that devolution has provided access to financial resources for the county governments. Nevertheless, it is unclear how much is allocated to county governments, especially to M&E. Devolution - through resource

allocation, management, and scheduling has made the following possible: M&E staff to improve healthcare access, improvement of the capacity of M&E staff in the healthcare sector, and the enhancement of the quality of healthcare M&E systems.

Devolution is not an occurrence, but a mechanism whose ultimate goal is to improve healthcare for the majority of Kenyans, by ensuring more effective access to healthcare services. While the devolution technologies need to be given time for nurturing, it is important to ensure that adequate processes are in place to support monitoring and assessment programs and organizations. Failure to do this raises the risk of making the wrong investment in terms of time and cash.

The changes envisaged in devolution along with the implementation of monitoring and assessment mechanisms should provide both immediate and long-term gains. In the short term, they should promote trust in the devolution as a mechanism, and in the long-term lead to the systemic strengthening of health systems in various counties in Kenya.

Recommendations

The researcher made the following suggestions based on the findings of the study:

1. The national government needs to put in place mechanisms for enforcing laws, guidelines, and regulations - to ensure that national policies on devolution are translated into the county level.
2. There is a need for a mechanism of ensuring that functions or structures of M&E are established within the counties and that M&E positions are filled with staff who have M&E qualifications.

3. There is also the need to avail capacity building plans to county staff who hold M&E roles. Such plans should be funded, and staff appraised to ensure implementation of M&E requirements.
4. Dissemination of the counties' health sectors' strategic plans and their respective M&E frameworks should be carried out to reach each staff within the counties. This can be done through staff meetings within the counties.
5. Comprehensive data management systems need to be developed and enforced in the counties.

Recommendations for Further Research

1. This study was limited to Baringo and Bungoma counties hence its findings cannot be generalized to other counties in Kenya. The researcher, therefore, suggests that further research can be conducted on the effects of devolution on M&E of healthcare services in other counties in Kenya.
2. Further research can be done to examine patronage and bribery concerning local officials' actions. This would be aimed at making devolution more transparent by providing a check on corrupt practices, such as job appointments for family members.

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APPENDICES

Appendix A: Questionnaire

Introduction

Dear Sir/Madam, My Name is Hillary Kipruto, a student at Daystar University in Nairobi currently pursuing a Master of Arts Course in Monitoring and Evaluation. I would like to kindly request for your time in filling this Questionnaire. This questionnaire is in four parts. The interest of this study is to understand the effects devolution in the health sector has had on had on monitoring and evaluation of health services.

This study is voluntary and none of your identifiers will be listed in the questionnaire, feel free to ask any question or clarifications.

Sub-County offices visited	<hr/> <hr/> <hr/> <hr/>
Sub-County	<hr/>
County	<hr/>

SUB COUNTY LEVEL IDENTIFICATION		
<u>UNIT IDENTIFICATION</u>		
DVD_ DATE	Date	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> </div> <p style="margin-top: 10px;">DAY</p> <p>MONTH</p> <p>YEAR</p>
DVD_ INTERVIEWER	Interviewer number	<div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div>
DVD_0 01	County	<div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div>
DVD_0 02	Sub-County	<div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div>
DVD_0 04	Sub-county office(s) visited (NOTE: IT COULD BE ONE OR MORE OFFICES FROM WHICH INFORMATION IS COLLECTED. PLEASE LIST THEM HERE)	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
DVD_0 05	Location of Unit (Town/City/Village)	<hr/> <hr/>



SECTION A DEMOGRAPHICS

Section 1: Demographic Characteristics

Kindly respond to each of the questions below (put a tick (✓) where appropriate). Part A: Personal Data

1. County:Sub-County:
2. Please state your current position/title.....
3. What is your gender? Male () Female ()
4. What is your age bracket?
5. 21- 25 () 26-30 () 31-35 () 36-40 () 41-45 () 46-50 () 51-55 ()
Over 55 ()
6. What is your highest academic qualification?
 - Certificate ()
 - Diploma course ()
 - Bachelor's degree ()
 - Master's degree ()
 - Doctorate ()
7. For how long have you been in employment? _____ years
8. Length of service in current position.....
9. Have you seen the strategic plan that is being implemented by the County Health department?
 - a) Yes
 - b) No
10. Have you ever seen another strategic plan for the Ministry of Health?
 - a) Yes

b) No

11. Which of the following do you have a copy of?

a) County strategic plan

b) County M&E Plan

c) MoH strategic plan (KHSSP)

d) MoH Monitoring and Evaluation framework for the Health Sector

Strategic plan

12. Does the county/sub-County have an M&E unit? a) Yes b) No

SECTION B EMPLOYEES' SKILLS

No.	Question		Coding Category	Skip
Q006	Does your county have qualified employees on monitoring and evaluation?	1	Yes	
		2	No	
Q007	Does your county train employees on monitoring and evolution?	1	Yes	
		2	No	
Q008	Does your county hire qualified employees on monitoring and evaluations	1	Yes	
		2	No	
Q009	How many employees do you have on monitoring and evaluations	1	Above 4	
		2	4	
		3.	3	
		4.	2	
		5	1	
Q0010	The organization has well qualified employees on M&E	1	Strongly agree	
		2	Agree	

		3	Disagree	
		4	Strongly disagree	
Q0011	Most employees in the county are well trained on M&E	1	Strongly agree	
		2	Agree	
		3	Disagree	
		4	Strongly disagree	
Q0012	The county management make sure that they hire employees with adequate skills on M&E	1	Strongly agree	
		2	Agree	
		3	Disagree	
		4	Strongly disagree	
Q0013	The county has training plans for employees on M&E.	1	Strongly agree	
		2	Agree	
		3	Disagree	
		4	Strongly disagree	
Q0013	Does the County/sub-County have data quality assurance plans?	1	Strongly agree	
		2	Agree	
		3	Disagree	
		4	Strongly disagree	
B	DATA MANAGEMENT SYSTEM			

Q0016	We have computer software which we are keeping track of day to day progress of work, document and report to the Program level.	1	Strongly agree	
		2	Agree	
		3	Disagree	
		4	Strongly disagree	
Q0017	We have computer software which is used for data management	1	Strongly agree	
		2	Agree	
		3	Disagree	
		4	Strongly disagree	
Q0018	We have data management software which is available for use	1	Strongly agree	
		2	Agree	
		3	Disagree	
		4	Strongly disagree	
Q0019	The organization has a friendly data management system	1	Strongly agree	
		2	Agree	
		3	Disagree	
		4	Strongly disagree	
Q0020	The county has monitoring information system	1	Strongly agree	
		2	Agree	
		3	Disagree	
		4	Strongly disagree	

			disagree	
		2	Radio	
		3	CACC coordinator	
		4	County Health Office	
		5	County Development Office	
		6	Websites	
		7	Other organizations	
		8	Friends	
		9	Others (specify)	
C	FUNDING			
NO.	QUESTION		CODING CATEGORY	SKIP
Q0021	The county has means of generating its own resources other than donors.	1	Strongly Agree	
		2	Agree	
		3	Disagree	
		4	Strongly disagree	
Q0022	Does the county allocate specific funding for monitoring and	1	Strongly Agree	
		2	Agree	

	evaluation?	3	Disagree	
		4	Strongly disagree	
Q0023	Do you know how much money the county allocates to M&E?.	1	Yes	
Q0024	If yes to Q0023 above indicate the percentage (%)			

DAYSTAR UNIVERSITY

THE EFFECT DEVOLUTION HAS HAD ON MONITORING AND
EVALUATION OF HEALTH SYSTEMS AT THE COUNTY LEVEL

Q0025: Indicate the extent to which devolution has exhibited the following in your county (Kindly put a tick (√) in the appropriate space provided).

	Competence	To a very great extent (5)	To a great extent (4)	To moderate extent (3)	To a less extent (2)	Not at all (1)
i.	Devolution has allowed M&E staff to improve healthcare access					
ii.	Devolution has improved the capacity of M&E staff in the healthcare sector (Training etc.)					
iii.	Devolution has improved the effectiveness of M&E systems in healthcare					
iv.	Devolution has supported M&E in creating transparency of Healthcare services					

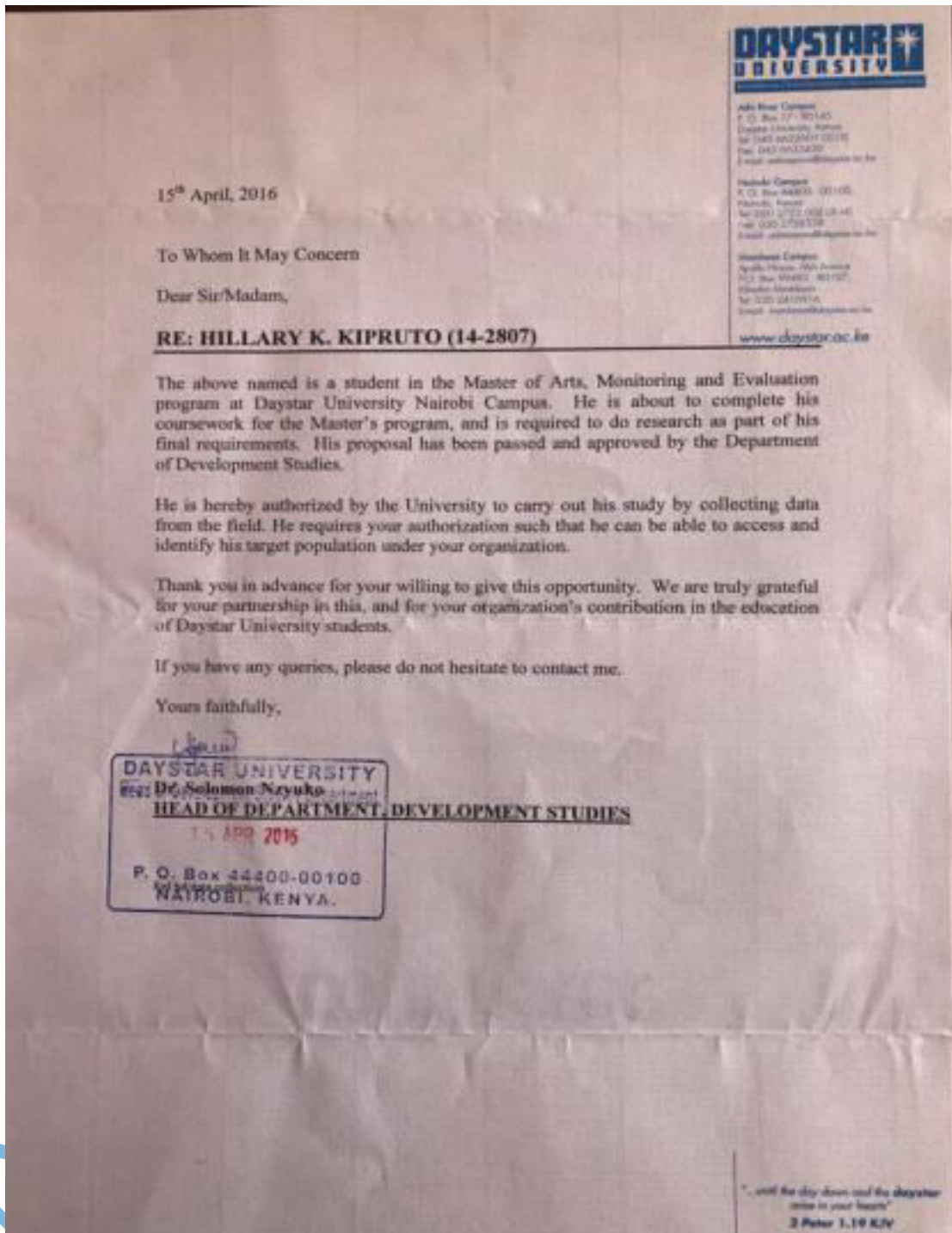
Appendix B: Focus Group Discussion Guide

Instructions:


Use the questions below to assess the different elements of the monitoring and evaluation system

- a) Does the county/Sub-County have a structure and organizational alignment for M&E systems?
- b) Are there dedicated staffs for Monitoring and evaluation at the county/sub-County?
- c) Are the staff dedicated for monitoring and evaluation adequately trained to carry out the M&E function?
- d) Do you have a data management system in the county/sub county?
- e) Do you have a county monitoring and evaluation plan?
- f) Is the M&E plan costed?
- g) Do you carry out routine monitoring of health services, if yes please explain how the process is accomplished?
- h) Do you carry out routine surveys to inform programming of health services delivery?
- i) Are there partners in the county/sub-County who support the M&E activities?
- j) What has been the effect of devolution on monitoring and evaluation of health services?

Appendix C: Letter of Approval from Daystar University



Appendix D: Research Permit



**NATIONAL COMMISSION FOR SCIENCE,
TECHNOLOGY AND INNOVATION**

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NAIROBI-KENYA

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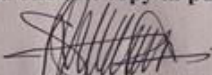
Dr. Hillary Kipchumba Kipruto
Daystar University
P.O Box 44400-00100
NAIROBI.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on *“Assessing the effect of devolution on monitoring and evaluation system of health services at the county level of government: A case study of Bungoma and Baringo counties,”* I am pleased to inform you that you have been authorized to undertake research in **Baringo and Bungoma Counties** for the period ending **7th June, 2017**.

You are advised to report to the **County Commissioners, the County Directors of Education and the County Coordinators of Health, Baringo and Bungoma Counties** before embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.



DR. STEPHEN K. KIBIRU, PhD.
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
Baringo County.

The County Director of Education
Baringo County.

The County Coordinator of Health
Baringo County.

National Commission for Science, Technology and Innovation is ISO 9001: 2008 Certified

Appendix E: Anti-Plagiarism Report

Hillary Kipruto thesis - 10th July 2020

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