Monitoring and Evaluation Practices and Performance of County Maternal Health Programmes

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Abstract

The study sought to establish the relationship between monitoring and evaluation practices and performance of County Maternal Health programmes in Kenya. The combined monitoring and evaluation practices included planning for M&E, stakeholder engagement, capacity building for M&E, and M&E data use. The study adopted a descriptive survey research design. To obtain 282 respondents, stratified random sampling was used. A self-administered structured questionnaire was the study's research instrument. Using descriptive narratives, qualitative data was analyzed within specific themes. Quantitative data was analyzed descriptively using measures of central tendencies and measures of dispersion. Regression was conducted for testing the study hypotheses. Data was presented using frequency tables. The study found that stakeholders' engagement in M&E and capacity building for M&E influenced the performance of County Maternal Health Programmes in Kenya. The study also found that the respondents agreed that planning for M&E and the data management for M&E. This implied that the combined monitoring and evaluation practices influence performance of County Maternal Health Programmes in Kenya.The study found a strong correlation between the performance of county maternal health programmes and

combined monitoring and evaluation practices. The study concluded that combined planning for M&E monitoring and evaluation practices influenced the performance of county maternal health programmes. The study suggests that management develop an effective methodology as well as raise awareness of M&E activities for the success of the project. The study also suggests that human resources issues such as workers charged with monitoring and evaluation ought to have technical capabilities, and roles and duties of monitoring and evaluation personnel should be outlined at the start of projects. To ensure M&E sustainability health sector reforms, investments in strong and vibrant technical harmonization platforms that can sustain the change agenda at all times and every required level.

Keywords: Monitoring And Evaluation, Performance, County Maternal Health Programmes, Stakeholders Engagement, Capacity Building, Planning For M&E, Data Management

Introduction

Performance is the sum of the outputs of an organization's work procedures and activities. An organization's performance includes its actual output or results as compared to its expected results (or goals and objectives). It is concerned with how successfully an organization converts inputs into outputs and includes the actual results as compared to the desired outputs. For decades, maternal and child health (MCH) has been a top public health concern. The implementation of these health-care programs continues to be a serious difficulty in low- and middle-income countries (LMICs). Between 1990 and 2015, one of the Millennium Development Goals (MDG5A) calls for a 75% reduction in worldwide maternal mortality ratio (MMR). MMR reduced by over 44 percent within 300 months of this aim, to an estimated 216, with an 80 percent uncertainty interval (UI) of 207 and 249 maternal deaths per 100 000 live births in 2015, compared to MMR of 385 per 100 000 live births in 1990, with a UI of 359–427 (Dieleman et al., 2015).

The rising globalization of the economy has increased demand for monitoring and evaluation solutions all over the world as a necessary component to improve the effectiveness of County Maternal Health programs. Monitoring and evaluation procedures guarantee that project results can be measured at the impact, outcome, output, process, and input levels, providing a framework for accountability and assisting in making informed decisions at the program and policy levels. According to International Fund for Agricultural Development- IFAD (2017), monitoring and evaluation practices are important components of design programs because they ensure logical reporting, the process that connects result and demonstration accountability, quantifies efficiency and effectiveness, ensures effective resource distribution,

stimulates continuous learning, and improves decision making. Monitoring and evaluation is a continual activity of management that assesses if there is an expected outcome achieving progress in order to identify challenges to execution as well as highlight any unforeseen repercussions from the investment, program, or project's plan and its activities. A monitoring and evaluation strategy incorporates a number of recognised best practices in the monitoring and evaluation system. Practices refer to a collection of activities such as planning and coordination, capacity building, surveillance, and data demand that can potentially contribute to project decision making and learning, which has an impact on project sustainability (Scheirer, 2017).

Monitoring and evaluation methods enable organizations to incorporate critical components of a project such as cost, time, and human resource consequences; they are critical for successful projects and should not be disregarded at the outset (Khan, 2016). As a result, it is critical to ensure that management, as well as donor agencies, understand and are committed to implementing the suggestions resulting from monitoring and evaluation (Dyason, 2019). It is critical that project implementers understand the methods and thinking that are based on monitoring and evaluation procedures (Kibukho, Kidombo & Gakuu, 2015). It is also critical that the project's implementers assume responsibility for the procedures used, are dedicated to them, and feel vested in convincing other stakeholders of their support as well as the long-term advantages..

Monitoring and evaluation methods ensure that project outcomes may be quantified at the impact, outcome, output, process, and input levels, establishing a framework for accountability and support in the formulation of informed program and policy decisions (Karanja & Yusuf, 2018). A monitoring and evaluation (M&E) strategy defines how the County maternal programs' entire M&E system works. This comprises the indicators, the people in charge of collecting them, the forms and tools that will be utilized, and how the data will be distributed within the organization. An M&E Plan is a table that expands on the log frame of a project/program to specify essential M&E requirements for each indicator and assumption. It enables program employees on the ground to track progress toward specific goals for more openness and accountability. This Monitoring and Evaluation Planning module is designed to provide brief direction for the establishment of a comprehensive monitoring and evaluation (M&E) system for international humanitarian relief and development operations. It addresses the major planning papers and processes required to establish and implement an M&E system for county maternity program planning, implementation, and evaluation. It is intended for use by M&E specialists, humanitarian and development program managers, and decision makers in charge of program oversight and funding (World Health Organization, 2016).

Stakeholder engagement is the process through which an organization involves people who may be affected by decisions it makes or who can influence how those decisions are implemented. Stakeholder participation in maternal health program planning, implementation, and quality improvement was recently recommended in guidelines to enhance the utilization of skilled care for women and newborns during pregnancy, labor, and the postnatal period. They may support or oppose the actions, have clout in the organization or the community in which it operates, have key official positions, or be long-term affected. Stakeholders have the opportunity to influence decision-making, which is a fundamental premise of stakeholder engagement. This distinguishes stakeholder involvement from communications methods that strive to issue a message or persuade parties to concur on an already determined choice (Burke, 2017).

M&E of performance can be a motivator for the creation of improved delivery capacities if accountability measures are available or given significant consideration. This has been attributed to the lack of glamour associated with assessing and comprehending the capacity enhancement process (compared to measurement of its apparent results, including improved performance). Another deterrent to giving the concept of 'capacity' careful thought is that it involves fundamentally subjective judgement based on partial or inadequate facts. Polidano (2020) investigated the viability of developing comparative indices of state and public sector capability in policy formulation, implementation, and operational efficiency. Organizational capacity development entails more than just training and can include a variety of planning and delivery techniques based on the organizational environment and need.

Statistics are an essential component of program and policy assessors' toolkits. If evaluators are to make good use of consultants' reports, communicate effectively with funders, and comprehend other people's assessment reports, they frequently need to have a conceptual knowledge of very complicated, newly developed statistical procedures (Mutekhele, Rambo & Ongati, 2018). The goals of this are to link common evaluation questions with appropriate statistical procedures, to provide a strong conceptual foundation in several important statistical procedures, and to describe how to interpret statistics results in principled and persuasive ways to intended audiences, as well as to equip those working in governments, funding agencies, and research (Issel & Wells, 2017).

Several scholars have examined the challenges affecting global efforts to improve the performance of county Maternal Health programs (Elmusharaf, Byrne, & O'Donovan, 2015; Banchani & Tenkorang, 2014; Wamalwa, 2015; Kasina, 2016), and they have been numerous and nearly uniform in middle developed economies like India, Malaysia, and LDCs (least developed

countries) like the Sub-Saharan Africa. According to UNICEF (2016), difficulties governing the health of mothers and their newborns are divided into two categories: environmental and economically structured challenges. Environmental issues like malnutrition among the under-fives have been cited as a global challenge in the 21st century on performance of the County Maternal Health programmes (Mitungu & Sakwa, 2020).

There has been some achievement in millennium development goals four and five over the last ten years. However, these achievements are uneven across various regions and countries. Both the under-five and maternal mortality are noted to have been increasing (UNICEF, 2016). In relation to the above realization, governments and various development agencies have increased their efforts to develop and implement various MCH programmes so as to curb the number of mothers dying, the pains of poor deliveries and the sorrow of losing their young ones. In response to the aforementioned reality, governments and various development agencies have strengthened their efforts to design and execute various MCH programs in order to reduce the number of mothers dying, the pains of poor births, and the anguish of losing their children (WHO, 2017). Globally, studies by experts such as Akhter (2015) and Chowdhury (2015) have focused on the implementation of MCH programs in African countries. According to Akhter, complications from pregnancy-related diseases and childbirth cause more fatalities and disabilities in Bangladesh than any other reproductive health problem.

This situation is worse as the Bangladesh population grows and County Maternal Health Care programs have been implemented in a haphazard and ineffective manner during the last two decades. According to UNFPA (2015), the country is losing its glory of attaining the SDGs due to insufficient access to contemporary health services or proper planning and implementation of MCH programs (Karani, Bichanga & Kamau, 2019).

According to a study conducted by Donaldson and Lipsey (2014), factors such as resource availability, management processes, politics, technology, and many others have a substantial impact on the implementation of MCH and other health programs. Across Africa, County Maternal Health programmes' success is still a complicated issue. Consider Angola, where inadequate implementation of County Maternal Health programs has been a persistent and systemic issue, resulting in a lower level of health in the early twenty-first century (WHO, 2017). Angola now has one of the highest maternal death rates in the world, according to UNICEF (2016). The MMR was estimated to be between 1,281 and 1,500 maternal deaths per 100,000 live births at the end of the Civil War. This estimate was made in the late 1990s, and it represented the country's MMR situation after the end of the conflict, according to UNICEF in 2002. Between 2008 and 2010, the expected number of deaths per 100,000 live births fell to 610. Even if this is an improvement, it

pales in comparison to Sweden, where the MMR is estimated to be 5 fatalities per 100,000 live births. The country's MMR has fallen after the end of the civil war in 2002, according to USAID (2011). This has been linked to the government's efforts in carrying out the various MCH programs. However, the MMR indicator remains one of the best in the world. It is believed that a woman gives birth 7.2 times on average.

The introduction of County Maternal Health programs compelled the Burundi government to borrow an additional $23.6 million from the World Bank in 2008/2009 to expand the MCH program, which began in 2006, train an additional 310 nurses and 34 doctors in Kenyan universities between 2005 and 2010, acquire cheap but highly suited technology from China and Japan, expand its road network, and install electric vehicles.

These were among the elements that had a 41 percent influence on the adoption of MCH programs from 2005 to 2013, and the country has experienced a 46.12 percent reduction in maternal fatalities and infant mortality rates between the stated years (UNICEF, 2016). These are the overall trends in East Africa. County governments were established in Kenya in March 2013, following the first general elections held under the new Kenyan Constitution (2015). County governments are required by the constitution to plan and budget for the supply of goods and services under their mandate. According to USAID (2018), MCH programs in Kenya have been prioritized since the NARC government took office in 2002. However, unlike the adoption of universal health programs, the implementation of MCH programs in the country has been fraught with difficulties, resulting in more deaths than survivors. This might be readily addressed by providing high-quality health-care delivery that ensures women deliver safely and avoids the majority of difficulties that occur during childbirth (UNFPA, 2015). All expecting mothers are at risk of experiencing unanticipated problems during childbirth, but almost all of these complications can be treated by competent birth attendants in well-equipped health facilities; nevertheless, in Kenya, only around (43%) of all deliveries take place in health facilities (KDHS, 2016). Investment in maternal-child health care programs is critical for generating economic growth and lowering poverty rates in the country (KNHCR, 2017). The County Maternal Health Program contributes to the creation of policies and standards that address the health barriers that the community has in order to keep them safe. Furthermore, the government has devised effective methods of assisting in the resolution of health issues, particularly given that the directorate has a significant monitoring and assessing role in the operation of the County Maternal Health Program (WHO, 2015). The M & E curriculum is also set to be implemented by a number of institutions of higher education, assisting in ensuring that employees and Kenyans receive proper M&E training. Kenya increased its facility-based delivery rate from 44 percent in

2008 to 61 percent in 2015 (Kenya National Bureau of Statistics (KNBS), 2015). This increase in skilled care deliveries can be attributed in part to Kenya's free maternity care policy, which was implemented in June 2013 (Kenya National Bureau of Statistics (KNBS), 2015). Despite the availability of free maternity treatments in all public health institutions, some Kenyan counties have reported significant maternal and perinatal morbidities and mortality as a result of laboring women being unable to receive emergency transportation to health facilities.

County Maternal Health Programmes in Kenya
Following the first general elections held under Kenya's new Constitution in March 2013, county administrations were constituted (2015). The constitution requires county governments to plan and budget for the supply of goods and services under their jurisdiction. According to USAID (2018), MCH programs in Kenya have been prioritized since the NARC government took office in 2002. However, unlike the adoption of universal health programs, the implementation of MCH programs in the country has been fraught with difficulties, resulting in more deaths than survivors. This is controlled by providing high-quality health-care delivery that assures safe women's delivery and prevents the majority of the difficulties connected with labor (UNFPA, 2015). Every expectant mother faces the danger of unexpected issues during childbirth, but practically every challenging situation can be addressed by competent birth attendants in well-equipped health institutions; nonetheless, in Kenya, about (43%) of all deliveries occur in health facilities (KDHS, 2016). Investment in maternal-child health-care programs is crucial for accelerating economic growth and eliminating poverty in the country (KNHCR, 2017).

This is easily handled by providing high-quality health-care delivery that ensures safe women's deliveries and prevents the bulk of labor complications (UNFPA, 2015). Every expectant mother faces the risk of unexpected complications during childbirth, but virtually every difficult situation can be addressed by competent birth attendants in well-equipped health institutions; despite this, approximately (43 percent) of all deliveries in Kenya take place in health facilities (KDHS, 2016). Investment in maternal-child health-care programs is critical for the country's economic growth and poverty-eradication efforts (Kenya National Bureau of Statistics (KNBS), 2015). This increase in skilled care deliveries can be attributed in part to the free maternity care policy that was implemented in June 2013. In Kenya, USAID has identified ten counties or regional units as priority locations for maternal health action: Baringo, Kakamega, Kilifi, Kisumu, Kitui, Migori, Nakuru, Samburu, Turkana, and Nairobi's informal settlements. These

counties are spread across Kenya and differ greatly in terms of cultural norms, access to health care, program coverage, poverty levels, and education.

The USAID program has established key national level targets for selected maternal and child health (MCH) indicators among partner countries, with the goal of increasing coverage by 2020, as follows: four or more antenatal care visits, 65 percent; use of skilled birth attendants, 60 percent; facility delivery, 60 percent; and postnatal care within two days of delivery, 55 percent (USAID, 2014). According to the most recent Demographic and Health Survey (DHS) in Kenya, these key maternal health indicators are near to these national goals (KNBS, 2015), while ongoing development in postnatal care, particularly prenatal care, is required. National indicators, on the other hand, have the potential to obscure regional differences and variance based on socioeconomic and demographic variables.

Kenya has several policies that support maternal health and provide strategic direction, including the Kenya Constitution, Vision 2030, the poverty reduction strategy, the Kenya health policy (2012-2030) (Ministry of Health 2012a), the National Health Sector Strategic Plan, the Kenya Health Sector Strategic and Investment Plan 2012-2018 (Ministry of Health 2012b), and the Kenya Reproductive Health Policy (Ministry of Health, 2016), among others. According to current data, qualified health personnel attend less than 61.8 percent of all deliveries in Kenya each year (Owuor & Amolo, 2019). Regular monitoring of policy success is required to respond to implementation challenges and to link the higher expense to the increased achievement. As a result, the need for this investigation was created.

Statement of the Problem

Maternal health is an essential and fundamental human right, as well as a significant predictor of long-term development. Maternal health program implementation has been hampered by poor infrastructure, insufficient financial resources from the central government and stakeholders, a lack of skilled personnel to handle expectant mothers' situations and their children, poorly informed clients, particularly those in rural areas, about the importance of MCH services, and a lack of technology. Inefficiency in M&E is one of the main management stages that has greatly contributed to the failure of operations in government organizations. This is due to the emphasis on monitoring the implementation process as well as progress toward project objectives achievement (Epstein, 2018).

Despite the Kenyan government's efforts to promote Maternal Health Programs, results remain unsatisfactory. Failure in M&E activities calls into question Kenya Vision 2030's plans for a healthy populace contributing to the country's development. Furthermore, Kenya's dismal performance comes as the country seeks to achieve global universal health coverage by 2030.The

country's Maternal Mortality Rate (MMR) is high, with 488 fatalities per 100,000 live births per year, owing mostly to women not giving birth under the care of trained health providers. These high rates of maternal mortality are due to well-known and avoidable factors. Obstructed labor, complications from unsafe abortion, infections, hemorrhage, and elevated blood pressure are among them. The majority of these deaths may be averted if the mother was cared for in a health facility by a skilled health practitioner. However, the majority of women (56 percent) give birth at home due to a shortage of transportation, concerns about negative attitudes of health-care professionals, lengthy distances to health-care facilities, cultural preferences, and service fees that are beyond the means of most women. With the new policies in place, County Maternal Health Programs in Kenya must implement monitoring and evaluation processes in order to minimize the Maternal Mortality Rate. As a result, the purpose of this study was to determine the combined effects of M&E on the performance of county maternal health programs in Kenya.

Likalama (2017) performed a survey of selected private schools in Kenya's Uasin Gishu County to examine the influence of monitoring and evaluation on financial performance. However, the study concentrated on private schools, as opposed to the current study, which concentrated on Maternal Health Programs. Using the example of Constituency Development Fund Projects in Kakamega County, Barasa (2014) evaluated the influence of M&E capacity building on project completion in Kenya. The study, however, did not employ a mixed method design, as the current study does. Therefore, this study aimed at contributing to the understanding of the relationship between monitoring and evaluation practices and performance of County Maternal Health programmes in Kenya.

Objectives of the Study
    i.   To examine the extent to which the combined monitoring and evaluation practices influence performance of County Maternal Health Programmes in Kenya.

Research Questions
    i.   To what extent does the combined monitoring and evaluation practices influence performance of County Maternal Health Programmes in Kenya?

Research Hypothesis
    H_0: There is no significant relationship between the combined monitoring and evaluation practices and performance of County Maternal Health Programmes in Kenya.

Monitoring and Evaluation Practices and Performance of Maternal Health Programmes

A monitoring and evaluation strategy incorporates a number of recognised best practices in the monitoring and evaluation system. Practices are a collection of actions such as planning and coordination, capacity building, surveillance, and data demand that can help to project decision making and learning. According to Scheirer (2017), this has an impact on project sustainability. M&E methods guarantee that project outcomes may be quantified at the impact, outcome, output, process, and input levels, providing a framework for accountability and assisting in making informed decisions at the program and policy levels. Ober (2017) considers monitoring and evaluation practices to be part of design programs because they ensure logical reporting; the process that connects result and demonstration accountability, it quantifies efficiency and effectiveness, ensures effective resource distribution, stimulates continuous learning, and improves decision making (Kinyanjui, Gakuu & Kidombo, 2015).

Monitoring and evaluation procedures enable project management to incorporate critical components of a project such as cost, time, and human resource consequences; they are critical for successful projects and should not be disregarded at the outset (Khan, 2016). As a result, it is critical to ensure that management, as well as donor agencies, understand and are committed to implementing the suggestions resulting from monitoring and evaluation (Ndungu, Gakuu & Kidombo, 2019). It is critical that project implementers understand the methods and thinking that are based on monitoring and evaluation procedures. It is also critical that the project's implementers assume responsibility for the procedures used, are dedicated to them, and feel vested in convincing other stakeholders of their support as well as the long-term advantages.

Building monitoring and evaluation techniques in Health Programs can guide on difficulties such as insufficient capacity-building programs and weak accountability systems. Donors in Sri Lanka employ their own systems rather than government systems to assure accountability by increasing local demand for assessment with an emphasis on utilization and addressing concerns related to skills, procedures, methodology, and data systems (Velayuthan, 2015).

It is best practice to plan ahead of time for an M&E system to be effective. This assumption is corroborated by Velayuthan (2015), who finds that an effectively written M&E plan motivates project stakeholders to perform M&E activities before project execution begins. As a result, specifics on how monitoring and evaluation would work inside a project should be written out as soon as possible. There is a need for further detail, which should be reflected in an M&E strategy. For M&E practice to improve tracking project accountability, project information must be fed into it to aid in tracking project

progress. This viewpoint supports that of Santosh (2017), who asserts that monitoring information should be fed into the project monitoring and evaluation process in order to create a data bank that can be used to improve the selection and design of future projects in addition to improving the project. In line with this observation, the study sought to investigate whether M&E information was fed into the M&E process in order to track project progress. M&E practice is critical during project execution, management, and as a tool for project sustainability. This is consistent with Khan (2016), who asserts that if project implementation is to improve performance, M&E practices must be at the center of project implementation. Evaluation in the light of M&E practices has shifted from the study of input and output, as well as their related causality processes, to the assessment of outcome, impact, and/or long-term results. As a result, it is critical that developmental practitioners include M&E methods into all phases of the project cycle in order to assure greater performance and sustainability (Ocharo, Rambo & Ojwang, 2020).

The fundamental challenge for Monitoring and Evaluation in Africa is that the promotion of transparency and, indeed, surveillance is immediately at the heart of opposing political hegemonies, which runs against the theory of social change's advocate of inclusivity. The freedom to present findings in the public realm may be curtailed or outright forbidden (Naidoo, 2018). This has the effect of weakening surveillance, which is a critical component of Monitoring and Evaluation. Such techniques undoubtedly have an impact on the relationship between Monitoring and Evaluation and project outcomes and sustainability. For measurement and data, Benin's Monitoring and Evaluation mechanism relies on the national statistics system. It faces limits such as a lack of data updating capacity, limited access to data to be collected and processed, and information gathering limitations.

Monitoring and evaluation in health programs may lack credibility if conducted by government agencies without prior verification and authentication, contrary to the theory of change that advocates for checking on implementation for quality to help distinguish between implementation failures and theory failures. Monitoring and evaluation are included in the Vision 2025 development framework in Burundi, with improved practices emerging in the terrain of localized monitoring and synergies being developed across different institutional structures in the Burundi government. Although project and program-based monitoring and evaluation have existed in Kenya since the 1980s, capacity and infrastructural constraints persist in the process of project implementation. Kenya's 2010 Constitution introduced Monitoring and Evaluation evolved governance structures, providing an opportunity to strengthen the country's Monitoring and evaluation practices while also posing a risk to its continued existence, particularly with regard to devolved units' flaccid' accountability mechanisms (John & Khilesh, 2018).

Monitoring and evaluation in Uganda is inextricably linked to the requirement to demonstrate government performance of Health Programs and receptivity to citizens' demands as an indicator of effective governance. In Uganda, monitoring and evaluation are carried out by a section within the Prime Minister's Office (OPM), with a small but expanding arm of evaluative practice by civil society, comprising national and international NGOs working alongside the government. A lack of demand for Monitoring and Evaluation products to aid decision-making is also a barrier, as is developing a culture of managers who use Monitoring and Evaluation data to improve performance (Sugut & Rambo, 2017). The incentive mechanism for driving Monitoring and Evaluation procedures in public-sector systems is likewise deficient. The limited use is ascribed to poor information distribution and the institution's inability to establish capability for timely information generation and dissemination (Crawford & Bryce, 2016).

Ensuring the efficient application of monitoring and evaluation procedures in health programs necessitates consideration of practical challenges from the outset. The government and donors should keep a tight eye on things through agreed-upon project planning and control processes. The Monitoring and Evaluation Programme Plan would need to be developed and incorporated into the Project Implementation Plan or Manual (PIP/PIM), with provisions for annual or more regular updates if necessary (Reuben & Arévalo, 2015). It is critical to highlight that project implementers focus their attention on projects during the implementation cycle rather than at the start of the project during the conceptualization stage.

Conceptual Framework

M&E Practices
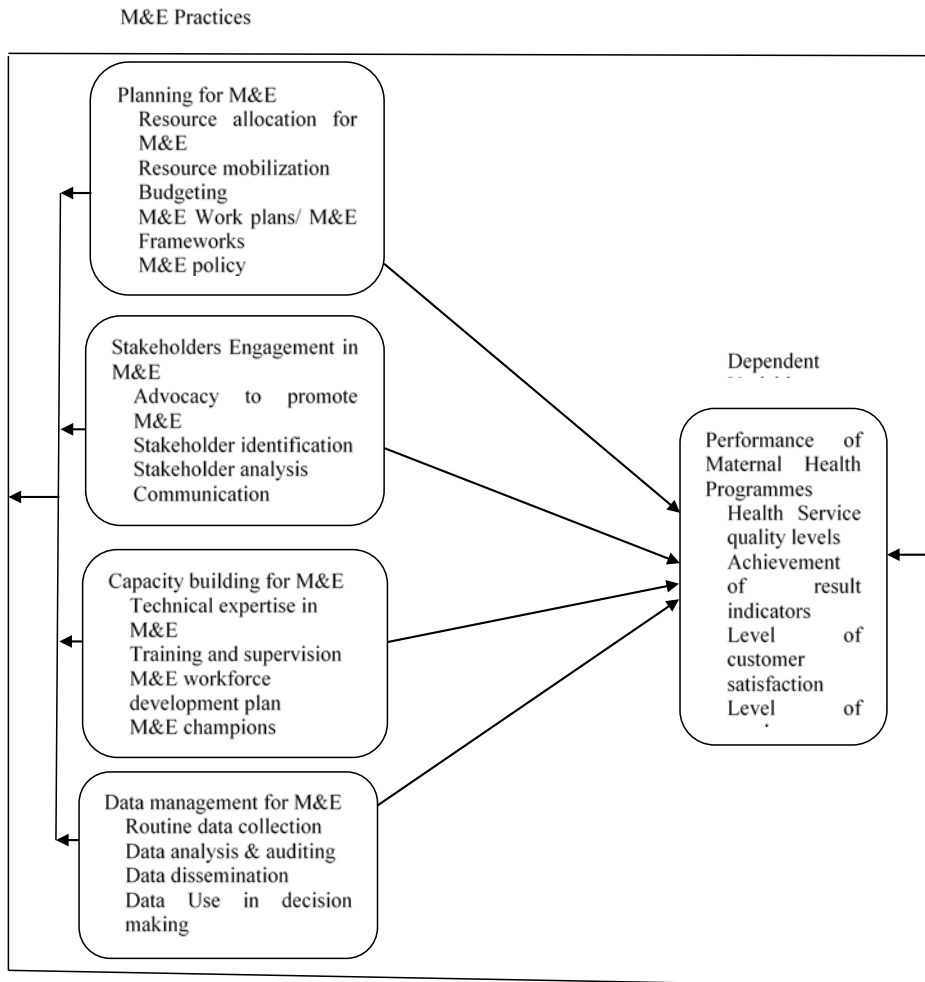
Research Methodology
Study Population

       The target population is the complete set of individuals or objects to which researchers want to generalize the research findings, whereas the accessible population is assessed based on the elements in the subject population within the scope of the study. The study's target population was County Maternal Health Programmes from Kenya's eight regional blocks (Central, Western, Coast, Rift Valley, Eastern, North Eastern, and Nairobi), with one county chosen from each block. However, two counties were picked from the Rift Valley block since it is large and has many counties to allow for equitable representation. The study targeted nine counties with 388 hospitals. From these counties the target population comprised of staff from level 4 and

5 hospitals (Nurses, Clinical officers, Medical officers, Nutritionists, Pharmacists, Health Records, Laboratory technologists, Counsellors, Medical superintendents, Hospital administrators, Nursing services managers and MCH in charge), County Health Management Team members, County governors/deputy governor, County Executive Members for Health, County Chief Officers for Health, County delivery unit members and Maternal health NGOs. The study considered medical staff from all the regional blocks in Kenya for representation and allow for generalization of data on maternal health programmes. The medical staff were also selected as they are familiar with maternal health programmes. This is as illustrated in Table 1.

Table 1. Target Population Distribution

Category	Population	Ratio
Nurses	198	17.0
Clinical officers	113	9.7
Medical officers	65	5.6
Nutritionists	102	8.8
Pharmacists	78	6.7
Health Records	61	5.2
Laboratory technologists	142	12.2
Counsellors	67	5.8
Medical superintendents	36	3.1
Hospital administrators	36	3.1
Nursing services managers	36	3.1
MCH in charge	36	3.1
County Health Management Team members	90	7.7
County governors/deputy governor	9	0.8
County Executive Members for Health	9	0.8
County Chief Officers for Health	9	0.8
County delivery unit members	27	2.3
Maternal health NGOs	35	3.0
National MoH officers	16	1.4
Total	1165	100

Sample size

A sample is a subset of a specific population chosen for the purpose of the study in order to draw conclusions about the population. The sample size of 282 was attained using (Yamane, 1967) simplified formula. This formula was used to compute the size of the sample as shown in the formula

$$n = \frac{N}{1+N(e)^2}$$

Where;   n is the sample size
N is the population size and
e is the margin of error.

$$N = 1165$$
$$e = 0.05$$
$$n = \frac{1165}{1 + 1165(0.05)^2}$$
$$= 282$$

Stratified random sampling was used to obtain a sample from each stratum. Stratified random sampling was chosen because it ensured small groups are represented in the sample. The categories formed strata from which the study sample was obtained. The formation of strata was based on the county officials linked to the health sector making each stratum a group of units with special characteristics. The sample was therefore 282 as shown in Table 2.

Table 2. Sampling Design

	Population	Ratio	Sample
1. Nurses	198	0.24	48
2. Clinical officers	113	0.24	27
3. Medical officers	65	0.24	16
4. Nutritionists	102	0.24	24
5. Pharmacists	78	0.24	19
6. Health Records	61	0.24	15
7. Laboratory technologists	142	0.24	34
8. Counsellors	67	0.24	16
9. Medical superintendents	36	0.24	9
10. Hospital administrators	36	0.24	9
11. Nursing services managers	36	0.24	9
12. MCH in charge	36	0.24	9
13. CHMT members	90	0.24	22
14. County governors	9	0.24	2
15. County Executive Members for Health	9	0.24	2
16. County Chief Officers for Health	9	0.24	2
17. County delivery unit members	27	0.24	7
18. Maternal health NGOs	35	0.24	9
19. National MoH officers	16	0.24	4
Total target population	1165		282

Data collection

The primary data was collected from the Medical officers, Clinical Officers, Nurses, Trained Community health workers, County Health Management Team (CHMT), County Delivery Unit officers in all counties by the research assistants. The research assistants used a drop and pick later method of questionnaire administration. Other questionnaires were filled in the presence of research assistants to avoid loss of questionnaires. The County Governors or their deputies, County executive committee members for health

(CEC health), County chief officers for health (CO health), County directors of health, the in charge of maternal health at the county level and Maternal health NGO officials working in the region were interviewed by the researcher assisted by well-trained research assistants.

Data collection instruments

A self-administered questionnaire was used to collect primary data. Medical officers, Clinical Officers, Nurses, Trained Community Health Workers, County Health Management Team (CHMT), and County Delivery Unit officers were chosen to fill in the questionnaire.

Pilot Testing of Instruments

Pilot testing was done to pretest the quality of research instruments in their ability to measure study concepts. During pilot testing, 32 questionnaires were administered to staff in the Ministry of Health headquarters in Kenya and selected counties at random representing 10% sample size. The results of the pilot test formed the basis for refining questionnaire items before administering the questionnaire on the study population. Burns et al (2015) suggest that the role of pretesting is to gain knowledge on how the questionnaire would be interpreted by the respondents. Pretesting was important for testing the appropriateness of measures, in order to gain insight as to whether the same questions were answered consistently in the same way. Validity can be classified into three types: construct validity, criterion validity, and content validity. A variety of measures were taken to achieve construct validity. One of the measures was to have my supervisors evaluate the questionnaire for appropriateness and meaning. Other measures included soliciting feedback from a panel of experts in the field of study to determine whether constructs were being measured correctly. To further enhance construct validity or suitability of indicators, factor analysis was done using principal component analysis (PCA) and those indicators found not to be suitable were left out in further statistical analysis. Factor loading for each item also gave an indication as to whether the constructs were distinct from each other (Thong & Olsen, 2017). Similarly, for content validity, a panel of experts reviewed the items in the instruments for appropriateness and clarity. The recommendations of experts including that of my supervisors and conclusions from pilot testing were used to review the research instrument items where necessary in as far as retaining meaning, change or elimination of questions (Bowden, Fox-Rushby & Nyandieka, 2017).

Reliability was enhanced by use of the split half method on the questionnaire. The reliability of the instrument was tested to determine the usefulness of the questionnaires to the current study. Burns et al. (2015) argue that reliability testing is important for new questionnaires because they have

not been used in previous studies and therefore their reliability is not known. To test reliability through the split half method, items of the same construct were split into two to obtain two sets from the same questionnaire. However, during piloting the entire instrument was administered to a population similar to that of the study area. The credibility of the qualitative instruments was ensured through consultations with research experts and the supervisors. Split half method for reliability requires only one administration of questionnaire to respondents. The administered questionnaire test results were split into two using an even and odd approach. Total scores for each half of scores were calculated for each respondent. Correlation between even and odd test results was computed to obtain a Cronbach's Alpha coefficient. A Cronbach Alpha reliability coefficient varies from 0 and 1. According to Creswell (2017) reliability of 0.7 and above is considered sufficient. The instrument was considered reliable if the Cronbach Alpha reliability coefficient is 0.7 and above. Cronbach's alpha (α) was used to calculate the reliability coefficient of the research instrument:

$$\alpha = k/k\text{-}1 \times [1\text{-}\sum (S^2)/\sum S^2 sum]$$

Where: α= Cronbach's alpha

k = Number of responses

$\sum (S^2)$ = Variance of individual items summed up

$\sum S^2 sum$ = Variance of summed up scores

The findings for the reliability were presented in Table 3.

Table 3. Reliability Analysis

Variable	Cronbach's Alpha	Number of items	Decision
Planning for M&E	0.915	25	Reliable
Stakeholders Engagement in M&E	0.831	25	Reliable
Capacity Building for M&E	0.773	25	Reliable
Data Management for M&E	0.819	25	Reliable
Performance of County Maternal Health programmes	0.909	25	Reliable
Composite Cronbach's Alpha	0.849		

From the results in Table 3, planning for M&E had an alpha value of 0.915, performance of County Maternal Health programmes had an alpha value of 0.909, stakeholders engagement in M&E had an alpha value of 0.831, data management for M&E had an alpha value of 0.819 while capacity building for M&E had an alpha value of 0.773. Cronbach's alpha was 0.869 as a whole. Because the Cronbach's alpha coefficient obtained was greater than 0.7, which is desirable, and less than 0.6, which is acceptable (Creswell, 2017), it was concluded that the internal consistency reliability measures used were

high and adequately measured the study's variables, and were thus considered for further analysis. The above reliabilities were calculated using data from a pilot study. The instrument was then tweaked to incorporate the findings of the pilot study. As a result, it aided in improving the instrument's validity and final reliability.

The primary data was collected from the Medical officers, Clinical Officers, Nurses, Trained Community health workers, County Health Management Team (CHMT), County Delivery Unit officers in all counties by the research assistants. The research assistants used drop and pick later method of questionnaire administration. Other questionnaires were filled in the presence of research assistants to avoid loss of questionnaires.

Data Analysis Techniques

This study utilized the descriptive and inferential statistics. Quantitative data was descriptively analyzed by use of measures of central tendencies and measures of dispersion. The measure of central tendency was the arithmetic mean while standard deviation was the measure of dispersion. The standard deviation determines how strong or weak data is from the measure of central tendency which is arithmetic mean.

The dependent variable which is the performance of the County Maternal Health Programme in Kenya is a single variable therefore univariate analysis was used to describe its properties. According to Bhattacherjee (2017), univariate analysis is a technique used to describe one variable. Consequently, this study used mean and standard deviation to describe performance of County Maternal Health programmes in Kenya.

According to Bonnett (2015), Pearson correlation is a way of knowing if two variables are related. Correlation between two variables is called bivariate correlation (Nachmias & Nachmias, 1996). Therefore, the study established if monitoring and evaluation practices separately are correlated to Performance of County Maternal Health programmes. Correlation coefficient (r) obtained in each case will indicate the existence of association and the extent two variables are associated. The correlation coefficient r ranges between -1 and +1 where -1 indicates that two variables are negatively perfectly correlated and +1 indicates the two variables are positively perfectly correlated. Therefore, a negative coefficient indicates a reverse relationship between the variables and a zero value of r means the variables are not correlated. The significance of correlation was established through a nondirectional null hypothesis: H: $r \neq 0$. Significance testing of correlation between two variables was done using a two tailed t-test. This is in agreement with Kothari (2017) and Bhattacherjee (2017) who indicate that correlation significance is tested with one tailed t –test or two tailed t-test. If p value is less than 0.05/2 then the null hypotheses regarding the non-significance of r

were rejected and the alternative hypothesis accepted at significance level alpha 0.05.

To test the hypotheses, the study used the regression and correlation models. The null hypotheses were rejected if their p-values were less than 0.05 and were accepted when their p-values were greater than 0.05.

Research Findings

The study objective of this study was to examine how monitoring and evaluation practices influence performance of County Maternal Health Programmes in Kenya. The combination of planning for M&E, stakeholder engagement, capacity building for M&E, M&E data use was referred to as combined monitoring and evaluation practices. The combined influence of these factors on performance of County Maternal Health Programmes was tested using inferential statistics.

Descriptive Analysis

The combined monitoring and evaluation practices were measured in terms of planning for M&E, stakeholder engagement, capacity building for M&E, and M&E data use. The composite mean and standard deviation of these factors are shown in Table 4.

Table 4. Descriptive Analysis

	Mean	Std. Dev.
Planning for M&E	3.893	0.529
Stakeholders Engagement in M&E	4.092	0.787
Capacity Building for M&E	4.001	0.800
Data Management for M&E	3.770	0.800

The study found the respondents agreed that stakeholders' engagement in M&E (mean score of 4.092 and a standard deviation of 0.787), and capacity building for M&E (mean score of 4.001 and a standard deviation of 0.800) influenced the performance of County Maternal Health Programmes in Kenya. The study also found that the respondents agreed that planning for M&E (mean of 3.893 and a standard deviation of 0.529) and the data management for M&E (mean score of 3.770 and a standard deviation of 0.800). This implied that the combined monitoring and evaluation practices influence performance of County Maternal Health Programmes in Kenya.

Inferential Statistics
Correlation Analysis

Correlation analysis of combined monitoring and evaluation practices as the independent variable and performance of county maternal health

programmes as the dependent variable was conducted to examine the strength and direction of the relationship. As shown in Table 5.

Table 5. Correlation between Monitoring and Evaluation Practices and Performance of County Maternal Health Programmes

		Planning for M&E	Stakeholder Engagement for M&E	Capacity building for M&E	Data Management for M&E
Performance of County Maternal Health Programmes	Pearson Correlation	0.859	0.838	0.796	0.855
	Sig. (2-tailed)	.023	.001	.028	.042

Outcomes in Table 5 indicate a positive and significant coefficient among the variables. Planning for M&E had a strong and positive correlation on performance of county maternal health programmes (r=0.859, p=0.023), stakeholder engagement for M&E and performance of county maternal health programmes were strongly and positively correlated (r=0.838, p=0.001), capacity building for M&E and performance of County Maternal Health Programmes were also strongly and positively correlated (r=0.796, p=0.028) while data management for M&E and performance of County Maternal Health Programmes were established to have a strong and positive correlation (r=0.855, p=0.042). This is an indication that combined monitoring and evaluation practices had a positive influence on performance of County Maternal Health Programmes in Kenya.

Hypothesis Testing

In addition, multiple regression analysis was carried out in accordance with the study's objective, which was to investigate how combined monitoring and evaluation practices influence the performance of county maternal health programs in Kenya. For each variable, a composite index was calculated and used in hypothesis testing. The linear regression was used to test the null hypothesis in accordance with the objective.

To meet the objective, the following hypothesis was tested using a simple regression model.

H_0: There is no significant relationship between the combined monitoring and evaluation and performance of County Maternal Health Programmes in Kenya

The following was the mathematical model used to test the null hypothesis:

Performance of County Maternal Health Programmes = f (planning for M&E, stakeholders engagement in M&E, capacity building for M&E and Data Management for M&E)

$$Y = f(X_1, X_2, X_3, X_4, \varepsilon)$$
$$Y = \beta 0 + \beta 1X1 + \beta 2X2 + \beta 3X3 + \beta 4X4 + \varepsilon$$

Where   Y = Performance of County Maternal Health Programmes
X_1 = Planning for M&E
X_2 = Stakeholders engagement in M&E
X_3 = Capacity building for M&E
X_4 = Data management for M&E
$\beta 0$ = Constant term
$\beta 1, \beta 2, \beta 3$ and $\beta 4$ = Beta coefficients
ε = Error term

Table 6 shows the regression results for the influence of combined monitoring and evaluation practices on the performance of county maternal health programs in Kenya.

Table 6. Regression Analysis Findings

Model Summary						
Model	R	R Square		Adjusted R Square		Std. Error of the Estimate
1	0.849	0.721		0.714		1.490

ANOVA						
Model		Sum of Squares	Df	Mean Square	F	Sig
1	Regression	921.983	4	230.496	101.895	1.02E-42
	Residual	357.41	158	2.262		
	Total	1279.393	162			

Regression Coefficients						
Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.267	0.182		6.962	.001
	Planning for M&E	0.889	0.143	0.859	6.217	.014
	Stakeholder engagement for M&E	0.895	0.245	0.838	3.653	.013
	Capacity building for M&E	0.802	0.212	0.796	3.783	.007
	Data Management for M&E	0.911	0.265	0.855	3.438	.016

Predictors: (constant), Planning for M&E, Stakeholder Engagement for M&E, Capacity Building for M&E, Data Management for M&E
Dependent Variable: Performance of County Maternal Health Programmes

Table 6 shows that r=0.849. This indicates that combined monitoring and evaluation practices have a strong relationship with performance of county maternal health programmes in Kenya. $R^2 = 0.721$ indicating that combined monitoring and evaluation practices explain 72.1% of the variations in the performance of county maternal health programmes in Kenya. The results on test of significance also indicate that; planning for M&E (β=0.859, p<0.014), stakeholders engagement in M&E (β=0.838, p<0.013), capacity building for M&E (β=0.796, p=0.007), data management for M&E (β=0.855, p=0.016) were all-significant at p<0.05 and 95% confidence level. This result implies that combined monitoring and evaluation practices explain 72.1% of the

variations in the performance of county maternal health programmes in Kenya.

The overall F statistics, (F =101.895, p<1.02E-42<0.05), indicated that there was a statistically significant link between combined monitoring and evaluation practices and performance of County Maternal Health Programmes in Kenya. As a result, the null hypothesis was rejected, and it was concluded that there is a significant relationship between the combined monitoring and evaluation practices and performance of County Maternal Health Programmes in Kenya.

The regression model can be substituted using the statistical findings in Table 5 as follows:

$$Y = 1.267 + 0.859X_1 + 0.838X_2 + 0.796X_3 + 0.855X_4$$

Where; X_1 = Planning for M&E

X_2 = Stakeholders engagement in M&E

X_3 = Capacity building for M&E

X_4 = Data Management for M&E

From the findings, combined monitoring and evaluation practices had a positive influence on performance of County Maternal Health Programmes in Kenya. This was in line with Scheirer (2017) that M&E practices ensure that project results at the levels of impact, outcome, output, process, and input can be quantified in order to provide a framework for accountability and to aid in making informed decisions at the program and policy levels. Ober (2017) supports the findings by stating that monitoring and evaluation practices as part of design programs ensure logical reporting; the process that connects result and demonstration accountability, it quantifies efficiency and effectiveness, ensures effective resource distribution, stimulates continuous learning, and improves decision-making.

The study found that combined monitoring and evaluation practices significantly influences performance of County Maternal Health Programmes in Kenya. This was supported by Velayuthan (2015) who observes that an M&E plan that is adequately documented encourages project stakeholders what to do in terms of M&E activities before implementation of a project begins. Therefore details of how monitoring and evaluation will work within a project should be written up at the earliest possible time. There is a need to provide greater detail which should be captured in an M&E plan. For M&E practice to enhance tracking project accountability there is a need to feed project information into it so as to help in tracking of project progress. This view supports that from Santosh (2017) that avers that Monitoring information should be fed into the project monitoring and evaluation process to build up data bank that can be used to improve the selection and design of future projects besides improving the project, in line with this observation the study

sought to investigate in M&E information was fed into the M&E process to track project transaction and enhancing improvements.

Conclusions

The study found that M&E planning (Mean=3.893) had a great influence on the performance of Kenya's County Maternal Health Programmes. It was also concluded that M&E planning has a statistically significant influence on the performance of Kenya's County Maternal Health Programmes. The research also found that stakeholder involvement in M&E (Mean=4.092) had a great influence on the performance of Kenya's County Maternal Health Programmes. The stakeholder involvement in M&E was also concluded to have a statistically significant impact on the performance of Kenya's County Maternal Health Programs. The study found that capacity building for M&E (Mean=4.001) had a great influence on the performance of Kenya's County Maternal Health Programmes. Capacity building for M&E was also concluded (β=0.796, p=0.007) to have a statistically significant impact on the performance of Kenya's County Maternal Health Programs. The study found that data management for M&E (Mean=3.770) had a great influence on the performance of Kenya's County Maternal Health Programmes. The researchers also concluded that data management for M&E has a statistically significant influence on performance of County Maternal Health Programmes in Kenya.

Since the overall F statistics, (F =101.895, p<1.02E-42<0.05), indicated that there was a statistically significant link between combined monitoring and evaluation practices and performance of County Maternal Health Programmes in Kenya. As a result, the null hypothesis was rejected, and it was therefore concluded that there is a significant relationship between the combined monitoring and evaluation practices and performance of County Maternal Health Programmes in Kenya.

Recommendations of the Study
Recommendations on Policy

From the findings that monitoring and evaluation practices have a significant influence on the performance of County Maternal Health Programmes in Kenya, the researchers suggest that policymakers should devise and implement a comprehensive monitoring and evaluation strategy that targets actors at all levels. After the intergovernmental forum and the respective leadership at the national and county levels have endorsed and adopted the guidelines, agreement on the monitoring and evaluation Improvement Plan will be required. This plan will serve as the foundation for advocacy and engagement with government at the national and county levels, with the goal of increasing allocations and direct investments in M&E capacity

strengthening. It will also serve as a foundation for convergence, reducing redundant investments in M&E.

Recommendations on Practice

i. The study reveals that effective stakeholder participation in M&E can improve transparency, accountability, project and program sustainability, and ensure positive community stakeholder attitudes toward projects. The researchers suggest that there is a need to increase stakeholder engagement in M&E training and awareness. Key stakeholders must also have the necessary qualifications and experience in developing a work breakdown structure for the project.

ii. The researchers also recommend that training be provided to develop M&E human capacity, allowing M&E systems to be managed effectively. As a result, more M&E formal and refresher training should be included in the programs to increase the capacity of M&E personnel.

iii. The study found that good data management entails developing effective processes for collecting and recording data on a consistent basis, storing data securely, backing up data, cleaning data, and modifying data so that it can be transferred between different types of software for analysis. The researchers recommend involving primary beneficiaries in key M&E areas such as data collection, M&E data dissemination, and decision making to improve the effectiveness of MHP activities using quality M&E data and information. This should be done carefully, at least once a year, so that their involvement does not cause project delays.

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