MONITORING PRACTICES AND HEALTHCARE SERVICES IN PUBLIC HOSPITALS IN UGANDA; A CASE OF ENTEBBE GRADE B HOSPITAL AND KITALA HEALTH CENTER III

BY

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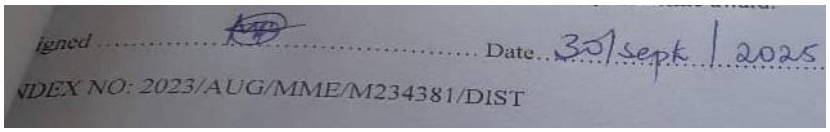
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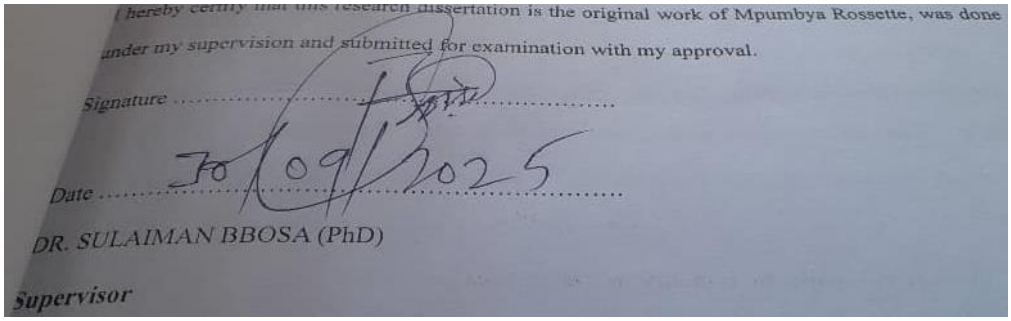
DECLARATION

I, Mpumbya Rossette, declare that this is my original work and that it has not been presented to any other university or institution of higher learning for any academic award.



APPROVAL

I hereby certify that this research dissertationis the original work of Mpumbya Rossette, was done under my supervision and submitted for examination with my approval.



DEDICATION

To God Almighty! All Glory and Honour to you for the gift of life, abundant provision, good health and the grace through this academic journey, eternally grateful for the far you have brought me!

I dedicate this work to my beloved husband Mr. Agaba Boaz, my children; Ankunda Favour, Ayebare Trevor& Shawn Ahimbisibwewho absolutely stood with me in all situations physically, emotionally, spiritually, economically and socially to see this academic project becomes a success. May God bless you abundantly.

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LIST OF ACRONYMS

M&E	:	Monitoring and evaluation
DV	:	Dependent variable
AFREA	:	African Evaluation Association
AC	:	The Audit Commission
AfrEA	:	The African Evaluation Association
NIMES	:	National Integrated Monitoring and Evaluation System
OPM	:	The Office of the Prime Minister
GoU	:	Government of Uganda
ISDM)	:	Integrated Service Delivery Model
DAC	:	Development Assistance Committee
SAME	:	Social accountability type of monitoring and evaluation
ICT	:	Information and Communication Technology
RPM	:	Remote Patient Monitoring
RHIS	:	Routine health information systems
WHO	:	World Health Organization

OPERATIONAL DEFINITION OF TERMS

Monitoring practices

This refers to the routine and systematic processes through which hospital management and relevant authorities assess, evaluate, and track the implementation of healthcare activities, quality of service delivery, and utilization of resources.

Healthcare services

These are the range of medical and public health interventions provided to patients at Entebbe Grade B Hospital and Kitala HCIII, including outpatient care, maternal health, immunizations, drug dispensation, laboratory services, and inpatient services.

Stakeholder feedback

This refers to the opinions, complaints, suggestions, and appraisals given by patients, caregivers, local leaders, and community members regarding the quality and effectiveness of healthcare services.

Public hospitals

These are Government-owned health facilities providing free or subsidized healthcare services to the public. For this study, the term specifically refers to Entebbe Grade B Hospital and Kitala Health Center III, which fall under Uganda's Ministry of Health service delivery system.

Feedback mechanisms

These are the formal and informal systems used within the healthcare facilities to collect, manage, and respond to input from patients and other stakeholders. Examples include feedback boxes, complaints registers, patient satisfaction surveys, and public forums.

Patient satisfaction

The degree to which patients feel their expectations regarding healthcare services have been met. This includes satisfaction with service quality, waiting time, staff behavior, drug availability, and the physical environment of the facility.

ABSTRUCT

The study examined monitoring practices and healthcare services in public hospitals in Uganda using a case of Grade B and Kitala HCIII. The study was guided by the following objectives: (i) To examine the effect of data collection frequency on the quality of healthcare services in Grade B and Kitala HCIII, (ii) To assess how reporting and documentation practices influence healthcare services in Grade B and Kitala HCIII, (iii) To investigate the effect of stakeholder feedback on healthcare services in Grade B and Kitala HCIII.The research design used was cross a case study research design. A sample of 114 respondents from Grade B and Kitala HCIII was used. The study employed both qualitative and quantitative approaches. The questionnaire and interview guide were the main instruments of data collection.

According to study findings, majority 55.4% agreed that data on patient care is collected regularly in this facility. This regular collection of patient data enhances service continuity, enables timely interventions, supports accurate health reporting and contributes to efficient patient follow-up in chronic care cases such as HIV/AIDS and tuberculosis where regular documentation is important for treatment adherence and outcome tracking. Results from the field on the second objective revealed that, majority 40.3% agreed that effective reporting and documentation practices facilitate communication and teamwork within these health facilities. According to the third objective, study findings, revealed that 56.5% agreed that Patients are encouraged to give feedback about the care they receive.

Based on the findings of the study on the effect of data collection frequency on the quality of healthcare services in Grade B and Kitala HCIII, it is concluded that regular and systematic data collection plays an important role in enhancing the quality of healthcare service delivery. Clear and timely documentation facilitates coordination, ensures continuity of care, and minimizes duplication of services. Majority of the respondents acknowledged that accurate documentation reduces medical errors and supports effective clinical decision-making.

The study recommends for regular capacity-building sessions to be implemented to equip healthcare workers with the necessary skills to collect, analyze and use health data effectively. Training modules should cover areas such as data accuracy, interpretation of quality indicators, and integration of data into clinical decision-making to improve service quality.

CHAPTER ONE

INTRODUCTION

1.1 Introduction

This chapter presents the background to the study, statement of the problem, General objective, specific objectives, Research questions, the significance of the study, justification of the study, scope of the study and the operational definitions.

1.2 Background to the Study

This study was built on the conceptual perspective, historical perspective, theoretical perspective and contextual perspective which shaded light on the situation in regard to the problem under study. This study examined monitoring practices and healthcare services in public hospitals in Uganda using a case of Grade B and Kitala HCIII. Monitoring practices is the independent Variable while healthcare services are the dependent variable.

Monitoring is a continuous management function that logically collects data on specific indicators of the project to offer management and stakeholders of an ongoing intervention (Arild, & Keith, 2018). Monitoring supports basic management and accountability and tracks actual performance against plans or expectations in the original design. The purpose of monitoring is to identify any corrective actions required for effective project implementation and to provide regular and timely updates on its progress (Francetic, Fink, &Tediosi, 2020)

The goal of universal health coverage is to provide everyone with health-care services of good quality that meet their needs without the risk of financial hardship linked to paying for them (Kimondo, &Ngugi, 2019). The regular monitoring of access to services and

service delivery is often a weak component of country and global monitoring of progress and performance.

Yet health policy-makers, planners and managers need sound evidence on which to base decisions about resource allocation and for programme monitoring and evaluation (Lankester, 2019). A fundamental component of the evidence base is the availability of health facilities and their readiness to deliver services. Some useful data, such as stock outs or the functionality of equipment, can be gathered through routine health facility reporting systems. However, information about the availability of health-care infrastructure, skilled health workers and resources for disease prevention, diagnosis and treatment is often incomplete or of poor quality, both in public and private facilities (Morris, &Lawrence, A. 2020).

1.2.1 Conceptual Perspective

Monitoring is an ongoing process of data collection and analysis for primarily project control with an internally driven emphasis on efficiency of project (Chaudhri, et al, 2017). Monitoring can be defined as a systematic and continuous process of collecting, analyzing, and using information for the purpose of the management and decision making (Mureithi, 2015). World Bank (2011) added that it is a continuing function that uses 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. Muzinda, (2017) stated that monitoring involves the collection of routine data that measures progress towards achieving projects objectives and helps to understand progress in the intervention performance over time.

Monitoring practice is relevant to the organization to ensure its independence and reliability and its potential aspects are the position of the structure, executing it and including all project contributors and informing the solutions of M&E procedure (Guarder, 2010). Productive M&E practice is very crucial in project management because it suited to provide incontrovertible data that is successful be used with regard to better program accomplishment. It helps the projects 'stakeholders to find out the fundamental merits of the projects, methods of promoting screening and tracking of the project, providing guideline of project successes, weaknesses and opportunities as well as strengths of the next projects undertakings (Guarder, 2010).

According to Kalali, Ali, & Davod, (2011) monitoring practices as part of design programmes as it ensures that there is logical reporting; the process that interconnects results and demonstration accountability, it quantifies efficiency and effectiveness, guarantees effective resource distribution, stimulates learning that is continuous along with enhancing better decision making.Though monitoring practices implementation have substantial cost, time as well as human resource implications, they are very vital for successful projects and should not be overlooked at the beginning of the process (Nabyonga-Orem, &Mijumbi, 2018).

It is then important to ensure that the management along with the donor agencies apprehend and are overly focused to these overheads and are committed to implement the recommendations arising from monitoring and evaluation. Those involved in the process understand the importance of evaluation. It is important that the project implementers recognize the methods and the thinking that is based on monitoring and evaluation techniques used (Okello, M. S. 2018).Thus, in this study, monitoring practices

wasconceptualized in terms of; data collection frequency, reporting and documentation and stakeholder feedback

The other variable of this study, Healthcare is a very important factor for the economic development of every country. Healthy populations live longer and thus are more productive. Higher productivity by the populace of a country produces economic progress and therefore every country strives to achieve it (World Health Organization. 2018). Healthcare service can be defined as the provision of health related goods and services to all persons especially those that cannot be provided by the private sector (Hubert, & Mulyungi, 2018). Healthcare is defined as the organized provision of medical care to individuals or a community. It involves a range of services provided by medical professionals to maintain or improve health through prevention, diagnosis, treatment, and recovery. Healthcare service delivery refers to the mechanism by which healthcare services are provided to patients (Nabukeera, 2016). It encompasses the entire spectrum of healthcare from preventive care to treatment and rehabilitation, ensuring that individuals receive timely, efficient, and effective health interventions.

Quality healthcare service is defined by the World Health Organization (WHO) (2018) as the degree to which health services for individuals and populations are consistent with current professional knowledge and increase the likelihood of desired health outcomes. Indicators of quality healthcare include safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. Healthcare service, the dependent variable, is operationalized by examining improvements in public healthcare services, such as reduced waiting times and adequate medical supplies, as defined by Karama, & Iravo, M. (2019). The SERVQUAL model is employed to measure various dimensions of

healthcare service, including timely service delivery, patient satisfaction, referral services, speed of delivery, responsiveness to patient needs, reliability, essential medical supplies and overall service quality rendered.

1.2.2 Historical Perspective

From a historical context, monitoring and evaluation is an old field that has been applied to various sectors and the health sector cannot claim monopoly. It has been suggested by Declich and Carter (1994) that the use of morbidity and mortality data in informing public health decisions dates about 600 years back in Europe following the emergence of scientific thoughts.

French revolution leaders, including Mirabeau, stressed that people's health was a state responsibility and recognized surveillance as part of a healthy population (Mutekhele, 2018).Health surveillance resulted in health policies in various countries like Germany where Johann Peter Frank introduced an approach to improve health and safety of the citizens through continued reporting (Onjole, 2021). The disease detection, management, and reporting in various countries under the surveillance system were the earliest examples of health monitoring and evaluation as they involved various data management processes that are integral parts of programme/project management. In the 1950s, Monitoring practice was dominated by a strong emphasis on prudent utilization of resources, reflecting the social scientific trend of the era (Hubert, N., & Mulyungi, P. (2018).

The focus of Monitoring then, sought to concentrate on lived experiences, and give voice to as many stakeholders in a consensus-shaping evaluation process.Since the early 1990s, monitoring and evaluation (M&E) has seen a steep climb within Africa in terms of

practice, profession and academic study (Hazir, 2018). As a field of practice, specialized departments housing the practitioners now exist and the demand for evaluation of policies, projects, programs and interventions remains on the increase. Legal and institutional frameworks for the practices of M&E are still weak. As a profession, over 30 national evaluation associations under the umbrella body-the African Evaluation Association (AFREA) are in existence.

As an academic field of study several universities now offer programs in M&E; notwithstanding the focus and locus dilemma regarding the discipline (Hazir, 2018).In Latin America at least 20 countries are currently working to strengthen their Monitoring and Evaluation frameworks, this was influenced by exemplary achievements of Chile, Colombia, Mexico, Brazil; the motivation has been boosted by the budget constraints (World Bank, 2011).

Most Governments such as Sri Lanka, Canada, USA among others have taken specific steps to strengthen Results-based M&E System at their national level (Amina, & Ngugi, L. 2022). M&E has served as an integral part of the development policy/programme cycle in improving performance accountability to provide effective feedback, which has improved planning, budgeting and policy making that has achieved development effectiveness Wambua, & James, (2018). Chile, meanwhile, has a long history of sound monitoring and evaluation of programs in their health sectors. Currently, Chile introduce ex-ante (before event) and ex-post (after event) evaluation methods and set up guidelines to carry out M&E in the ministry of Health throughout the country (Njeru, I. M. & Luketero, 2018). The Canadian M&E system has invested heavily in both evaluation and performance monitoring as key tools to support accountability and results-based

management in their health institutions. The current state of the M&E system has evolved over time, as the central designers have recognized that the development and implementation of monitoring and evaluation is long term and iterative therefore putting emphasis on the “process” of implementation as an important mechanism in itself in developing an “evaluation culture” or “results culture” in an organization and across the entire system (Wambua, & James, 2018).

In Africa, monitoring and evaluation has evolved over the years. Countries like South Africa adopted evaluative strategies in the 1980s, where it instituted the Audit Commission (AC) that oversees the adherence to national policies to ensure accountability, citizens' satisfaction, and value for money (Onjole, 2021). The Commission came into existence following the poor performance of local governments and sets frameworks against which local agencies can be held accountable. According to Kelly (2003), the Audit commission includes the National Health Services that conducts review with other inspectorates. Before, the commission came up to monitor and evaluate the actions of such lower government units to boost performance. M&E in Africa took the stage in the 1990s evidenced by the emergence of evaluation associations, with the oldest association being in Ghana as early as 1997 and the African Evaluation Association (AfrEA) in 1999 (Ochieng & Tubey, 2018). These associations indicate that monitoring and evaluation field has been in Africa for years.

In Ghana, after several years of implementing the national M&E system, significant progress has been made (Njeru, & Luketero, 2018). However, challenges include severe financial constraints; institutional, operational and technical capacity constraints; fragmented and uncoordinated information, particularly at the sector level (Muchelule, et

al, 2017). To address these challenges the Clear report argues that the current institutional arrangements will have to be reinforced with adequate capacity to support and sustain effective monitoring and evaluation, and existing M&E mechanisms must be strengthened, harmonized and effectively coordinated operational and technical capacity constraints; fragmented and uncoordinated information, particularly at the sector level.

In East Africa, M&E has been evolving just like in other regions. In Kenya, monitoring and evaluation became institutionalized around 2000 following the World Bank/International Monetary Fund requirement for government-wide evaluative arrangement for various interventions (Centrer for Learning on Evaluation and Results, 2019). Although Kenya had M&E practices before 2000, they were ad hoc project-based. As a result, Kenya has M&E instruments like draft M&E Policy, M&E department in National Treasury and Planning, National Integrated Monitoring and Evaluation System (NIMES), and a minimum of 1% of the development budget being allocated to evaluators (Centre for Learning on Evaluation and Results, 2019). In Tanzania, the demand for M&E of activities has been growing tremendously, leading to the evolution of M&E practices.

Monitoring and evaluation concept in Uganda has evolved continuously in various sectors, including the health sector. Various reforms in service delivery have been implemented to achieve result-based performance and to account for the monies spent. According to Ssentongo and Balasundaram (2018), Uganda focused on downsizing its civil service, gearing it towards Results Oriented Management to improve service delivery. The Office of the Prime Minister (OPM) (2013) highlighted a series of policies and reforms that have been an integral part of continuous and periodic assessments to

improve service delivery and account for the resources allocated. In 1999, Uganda is reported to have initiated the monitoring policy to monitor how government policies and interventions impacted poverty and citizens' well-being. For accountability reasons, the government introduced a budgeting and planning system where lower governments had to report quarterly. These added to the National Integrated Monitoring and Evaluation Strategy (NIMES) in 2006 to enhance execution management through streamlined information flow across sectors (OPM, 2013). As part of M&E, local governments are required to have budget framework papers and development plans annually to guide the central government's decision on resource appropriation and policy adoption.

Monitoring and Evaluation is a function of many agencies and institutions. At the apex of these agencies is the Office of the President. Specifically, in the health sector, Government of Uganda (GoU) introduced the State House Health Monitoring Unit in 2009 to support an effective and accessible health system that works for all Ugandans. The unit came into existence following the presidential directive that followed continued public outcry about inadequate drugs and impoverished health service delivery in the country (Health Monitoring Unit, 2012).

Furthermore, Uganda introduced the Integrated Community Case Management under the Local health systems to increase healthcare service accessibility in communities (Nanyonjo et al., 2020). The Office of the Prime Minister and the National Planning Authority are other key agencies of government involved in Monitoring and Evaluation. The next section examines the theoretical and conceptual framework adopted by the study.

1.2.3 Theoretical Perspective

This study wasunderpinned by the Systems Theory and Integrated Service Delivery Model (ISDM). The Integrated Service Delivery Model (ISDM) focuses on teamworkand clients while offering services. The model also encourages the provision of the right services, usingappropriate caregivers, the best setting (easy accessibility), provision of services when needed, efficiencyand economical, accountability, and gathering and sharing information (Reynolds & Sutherland, 2013).Evaluation continues to be an engine towards achieving set targets in all sectors, including healthcare service delivery. It is an ingredient that when applied appropriately yields quality service in healthcare. To that end, M&E and the healthcare service delivery standards are closely related. The relationship can further be explained by the Development Assistance Committee (DAC) criterion that looks at routine and periodic assessments through the lens of relevance, efficiency, effectiveness, impact, and sustainability which are integral parts of quality services (OECD/DAC, 2012). M&E practices will be conceptualized into three dimensions to bring out the relationships. The dimensions will be input indicators, output indicators and process indicators. On its part, Qualityof healthcare service delivery took on four dimensions as stressed by Pretorius (2018). These include accessibility, availability, effectiveness and efficiency, patient-centeredness and safety. Accessibility was considered asgeographical access, looking at how quickly and easily patients can reach healthcare services.

Availabilitywas considered to be how well the healthcare service providers (health centres) are equipped withnecessary materials like drugs, machines, and personnel to meet beneficiaries' needs. Patient-Centeredness (People-Centered Care) considered to be

providing care that respects and responds to individual patient preferences, needs and values.

Safety is considered to be minimizing risks and harm to patients during the provision of healthcare like preventing medical errors, ensuring hygiene, and proper medication management (Pretorius 2018).Systems Theory was proposed by Ludwig von Bertalanffy in the 1940s to explain how systems operate and evolve through interaction with their environments. Von Bertalanffy emphasized that systems are open structuresinteracting with external factors which results in continuous adaptation and transformation (Hammond, 2019). He argued that all components of a system are interrelated and must function cohesively to ensure the efficiency and stability of the entire system. An organization much like the human bodyis composed of interconnected elements working toward common goal.The relevance of Systems Theory in organizational management has evolved over time. According to Baecker (2019), employees, departments, workgroups, and units form the subcomponents of any organization. The theory posits that for an institution to function, managers must observe internal patterns and activities to determine the most suitable management strategies.

In relation to this study, Systems Theory aligns with the input, process and output indicators that underpin Monitoring and Evaluation (M&E) practices at Entebbe Grade B Hospital. The hospital can be viewed as a system composed of multiple interacting partsincluding human resources, financial inputs, medical supplies (inputs), service workflows and treatment protocols (processes), and patient outcomes or services rendered (outputs). For effective healthcare delivery, all these components must be well-coordinated and monitored.

Systems Theory also supports the idea that a well-structured and competent M&E unit is essential in identifying performance gaps, tracking progress and informing management decisions. Kithinji (2019) emphasized that the capacity and skills of the M&E team are central to the success of health interventions. Therefore, understanding the specific roles and responsibilities of the M&E team members within Entebbe Grade B Hospital is critical in ensuring that service delivery aligns with institutional goals and national healthcare standards.Furthermore, Folscher et al. (2019) advocated for the systematic development of M&E structures that consider both the human and technical capacities needed to manage data and performance information effectively.

1.2.4 Contextual Background

Health care in Uganda is delivered through a decentralized framework with the district responsible for all structures within the district except referral hospitals where they exist. Health care services are provided by both the public and private sectors, with each sector covering about 50% of the standard units of output (Republic of Uganda, 2010). Both sectors play an essential role in supporting communities to improve their health. The Uganda National Minimum Health Care Package was developed for all system levels for the public sector, and services are provided based on this package. The national health system consists of National Referral Hospitals, Regional Referral Hospitals, and the district health system (Republic of Uganda, 2010, 2018).

The district health system is further divided into health sub-districts and includes District General Hospitals, Village Health Teams, Health Centres II, III, and IV. The staffing level in public health facilities was 72% in 2016 (Republic of Uganda, 2018) and the

government health expenditure as a percentage of the total government expenditure was 7% in 2019/20 (Republic of Uganda, 2019).

The health centres throughout the country are graded as Health Centre (HC) II, Health Centre III, and Health Centre IV. The grading depends on the administrative zone served by the facility, with HCII serving a parish or ward, HC III serving a sub-county or division, and HC IV serving a county or municipality. Providers are expected to serve a certain number of people at each level and provide specific services. A Health Centre II serves a population of approximately 5,000 people. It offers outpatient care, antenatal care, immunization, and outreach. It is supposed to be staffed by one enrolled nurse, one enrolled midwife, and two nursing assistants. According to the HSSP, all HC IIs provide community-based preventive and promotive health services.

The government and the private sector undertake the financing and delivery of health care services in Uganda. In 2018, Uganda had a total of 6,937 health facilities, of which 3,134 (45%) were government-owned, 1,009 (15%) were private and not-for-profit, while 2,795 (40%) were private for profit (Republic of Uganda, 2018). The health worker population ratio was estimated at 1.87 per 1,000 population in 2019, which is still lower than the WHO ratio of 2.5 per 1,000 population (Republic of Uganda, 2019).The study will be conducted at Entebbe Regional Referral Hospital in Wakiso district in the Central region of Uganda. The hospital is a public facility which was constructed by the British in the 20th century as Entebbe grade B hospital. It is located in Entebbe town, approximately 37 Km by road southwest of Mulago National Referral Hospital. The district is bordered by Kampala, Kalangala, Mpigi, and Mukono districts. It has a bed capacity of about 200 beds.

Kitala Health Centre II (KHC II) is local community-owned facility located in Kitala Parish along Entebbe. It is the only free of charge clinical facility serving Katabi Sub-county with a total population of 104,335 (55,389 female). Each day, at least 20 expectant women visit the center for antenatal care.

Apart from these at least 34 community members visit the facility for treatment of other ailments. At the level of a Health Center II, the facility is only mandated to provide basic health care and antenatal services to women. However, when in labor, women stealthily approach the midwife at the center to help them deliver their babies.

Uganda's public healthcare system in rapidly urbanizing districts like Wakiso faces challenges in delivering quality healthcare services to the local people. Wakiso District with an estimated population of 3.3 million (UBOS, 2014) experienced a surge in healthcare demands, straining existing facilities such as Entebbe Grade B Hospital and Kitala Health Centre III (HCIII) (WHO Annual Report 2022). Monitoring practices are essential for ensuring effective healthcare delivery. However, Grade B Hospital and Kitala HCIII have faced issues that hinder effective monitoring. For example, Entebbe Grade B Hospital has been grappling with substantial utility debts, owing approximately UGX 189.6 million to the National Water and Sewerage Corporation and UGX 303.7 million to UMEME for electricity which has affected the hospital's operational capacity for over 2 years (Wakiso District Health Sector Report 2019).

Monitoring efforts at Entebbe Grade B Hospital and Kitala Health Centre III (HCIII) have been integrated into service delivery to enhance accountability and improve health outcomes (MoH, 2022). At Entebbe Grade B, several internal mechanisms (daily ward assessments, regular staff reporting systems, and scheduled internal reviews) have been

put in place to track service performance. The hospital also utilizes the District Health Information Software 2 (DHIS2) which enables real-time tracking of essential indicators (outpatient visits, drug stock levels and maternal care statistics (MoH, 2021). According to Wakiso District Health Department (2022), adoption of monitoring tools has contributed to improvement in patient satisfaction from 62% in 2019 to 79% by 2022.

Kitala HCIII, on the other hand, faces challenges related to staffing and infrastructure. Reports indicate that many health facilities in Wakiso District operate with staffing levels as low as 25% of the approved positions leading to overburdened staff and compromised patient care (Osundina, & Bola, 2021). Such understaffing affects service delivery and also impedes the implementation of effective monitoring systems because of insufficient personnel to collect, analyze and act upon health data (OPM 2018). Furthermore, audits have uncovered issues such as expired drugs in storage and inadequate record-keeping practices which highlights serious deficiencies in monitoring mechanisms and raising concerns about patient safety and the quality of healthcare services (OPM 2018)

1.2 Statement of the Problem

Monitoring is an essential part of monitoring and evaluation in the health sector. They are used to evaluate the quality of care provided in health institutions including infrastructure and resources available, and identify gaps for improvement. Health service delivery in Waksio District health centers hasseena high declining rate (Kimaro, & Nhampossa, 2019). Entebbe Grade B Hospital and Kitala Health Centre III have faced overwhelming demand from the public, yet these institutions are struggling with persistent system weaknesses that undermine the quality of healthcare. Entebbe Grade B Hospital which has a wide catchment area is severely understaffed, operating with 15–17% of the

recommended workforce (New Vision, 2023). Midwives report conducting deliveries with no proper delivery beds, resorting to using surgical beds meant for other procedures (Parliament Health Committee Report, 2023). The hospital also faces chronic utility bill arrears with over UGX 300 million in unpaid electricity bills alone; threatening continuity of healthcare services to the people (Uganda Radio Network, 2023).

At Kitala Health Centre III, although efforts have been made by the community to improve infrastructure like building a maternity ward in 2015 through local community fundraising, the health center still faces operational challenges. Staffing levels have remained low and many key services like adolescent reproductive health lack privacy and proper documentation (Nalwadda et al., 2018). Essential medicines at the health center are out of stock and data collection systems remain manual and fragmented with little follow-up on findings (Mugisha, et al. (2020). Despite government's efforts to develop and implement National Integrated Monitoring and Evaluation Strategy (NIMES) aimed at improving service delivery across all Ministries, Departments and Local Governments (OPM, 2013), there are still challenges related to monitoring data which is collected inconsistently. When reports are generated, they rarely inform budgeting or decision-making (Andersson, et al, 2024). Feedback from health workers and patients is never formally documented the attention required, coordination among district health offices, facility in-charges and ministry officials remains weak, budget allocations for monitoring activities are inadequate (Declich & Carter 2024), long queues of patients waiting for care, frustrated staff stretched beyond capacity, stock-outs of vital drugs and growing public dissatisfaction with government health services have all affected effective healthcare services in Entebbe Grade B Hospital and Kitala Health Center III. If these

monitoring issues are not addressed, public health facilities will continue to operate below their potential, putting lives at risk

1.3 Purpose of the Study

To examine the effect Monitoring Practices and Healthcare services in Public Hospitals in Uganda; a case of Entebbe Grade B Hospital and Kitala Health Center III

1.4 Specific Objectives

(i) To examine the effect of data collection frequency on the quality of healthcare services in Grade B and Kitala HCIII

(ii) To assess how reporting and documentation practices influence healthcare services in Grade B and Kitala HCIII

(iii) To investigate the effect of stakeholder feedback on healthcare services in Grade B and Kitala HCIII

1.5 Research Questions

(i) What is the effect of data collection frequency on the quality of healthcare services in Grade B and Kitala HCIII?

(ii) How does reporting and documentation practices influence healthcare services in Grade B and Kitala HCIII?

(iii) What is the effect of stakeholder feedback on healthcare services in Grade B and Kitala HCIII?

1.6 Scope of the study

The scope of the study is divided into the geographical scope, content scope, time scope and interviewee scope;

1.6.2 Content scope

The study focused on examining the effect of Monitoring Practices and Healthcare services in Public Hospitals in Uganda with Entebbe Grade B Hospital and Kitala Health Center III as the case study. The independent variable is Monitoring Practices whereas the dependent variable is Healthcare services. The study examined the effect of data collection frequency on the quality of healthcare services, assess how reporting and documentation practices influence healthcare services and investigate the effect of stakeholder feedback on healthcare services

1.6.3 Time scope

Reports of Entebbe Hospital (Grade B) and Kitala Health Center III ranging from 2019 to 2024 were used so as to acquire information on Monitoring Practices and Healthcare services. Hence the study considers a time period of (05) five years so as to get reliable information concerning Monitoring Practices and Healthcare services in Entebbe Grade B Hospital and Kitala Health Center III

1.6.1 Geographical Scope

The study will be conducted in Entebbe Grade B hospital and in Entebbe Municipality and Kitala Health Center III in Katabi, Busiro County, Central Uganda-Wakiso District. The hospital is located in the central business of the town of Entebbe, in Wakiso District, approximately 44 kilometres (27 mi), by road. The coordinates of the hospital are 0°03'50.0"N, 32°28'18.0"E (Latitude: 0.063874, Longitude: 32.471655). Kitala Health

Center III is a hospital in Katabi, Busiro County, Central Uganda situated nearby to Kitala Prison as well as near the community center Masjid Aisha.

1.7. Significance of the study

This section shows how the study results could be of importance to the various stakeholders especially hospital management, regulators at central government, and the academia. Hospitals in Uganda have faced challenges relating to health service delivery. Some of the findings, conclusions, and recommendations in this study can be of importance to some of the key stakeholder in the following ways:

Hospital leaders and administrators: Hospital managers and in-charges at Entebbe Grade B Hospital and Kitala HCIII are at the frontline of healthcare delivery. This study may provide evidence on how data collection, timely reporting and stakeholder feedback can be used to make informed decisions. The study results could be used to design better strategies on improving health services deliveries. These leaders can use the study results to learn lessons from past practices, which can be avoided while making future plans.

Health Centre staff and health workers: Finding from this may highlight the importance of Health Centre staff and health workers in data collection and feedback and offer recommendations on how to involve them in evaluating and improving service delivery. For example, regular monitoring meetings and feedback loops can help health centers better respond to local patient needs.

Regulators and Policymakers: The findings of the study may also assist in formulating public policies on health related subjects by the authorities to ensure health sustainability

Ministry of Health, Wakiso District Health Office: It is hoped that the findings of this study would be found useful by relevant government ministries among them include

Ministry of Health, Wakiso District Health Office and other health related organizations in providing information on Monitoring Practices and Healthcare services in Public Hospitals in Uganda.

Health related professions: The study is also significant to health related professions such as psychologists, sociologists on determining the health statistics through monitoring and evaluation in their respective health institutions

Researchers and Academicians

This study may contribute to the body of knowledge on how monitoring practices can drive or hinder healthcare performance. The findings shall be used as a foundation for further studies. In addition, to researchers and academic students, the results from the study may add to the pool of available literature for researchers to use while dealing with matters on the subject of Monitoring Practices and Healthcare services in Uganda.

1.8 Justification of the study

Monitoring practices are essential for improving healthcare service delivery in public hospitals, since they act as a basis for evaluating performance and identifying service gaps (Mackay, 2007). However, National monitoring and evaluation frameworks remain weak, fragmented and poorly coordinated at the Local Government Level (GoU, 2010). Reports from Wakiso District highlight challenges related to inadequate data use, irregular supervision and limited stakeholder feedback mechanisms (Wakiso DLG Health Performance Report, 2021). Despite national strategies (NIMES), there is limited evidence on how monitoring practices influence healthcare quality at Entebbe Grade B Hospital and Kitala HCIII which the current study seeks to address.

1.9 Organization of the Study

The study is organized into five chapters. The chapters include chapter one, two, three, four and five as stipulated by Nkumba University School of social sciences research guideline. The contents of each chapter are described in this section.

Chapter one covers the background of the study, the chapter describes the study's introduction and background, research problem statement, research objectives and research questions, significance, scope of the study, justification and organization of the study. The components of chapter one led to the review of literature in addressing those components.

Chapter two deals with the literature survey, Literature review, it describes how researcher reviewed and critiqued the theoretical and empirical works related to this study. The review of literature addressed the components drawn from chapter one especially objectives. The realistic nature of the relationships will be guided and achieved through certain methodologies addressed in chapter three of this study.

Chapter three concerned with the research methodology employed in the study. It specifically deals with the research design, population, sample size and sampling techniques, method of data collection, variables and their measurements, reliability and validity issues and data analysis methods. The methods guided and achieved the objectives of the study stipulated in chapter one. Furthermore, the method applied in this chapter resulted to the findings and their discussion presented in chapter four and five respectively.

Chapter four represent the study‘s findings based on the objectives of the study. The chapter shows how the findings of the analyzed quantitative and qualitative data will be presented in the study. The interpretation, meanings and details of the obtained findings are discussed in chapter five.

Chapter five deals with the summary, conclusion and recommendations of the study based on the objectives as stated in chapter one.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter reviews the previous studies on the related field, acknowledges the contribution made by the scholars’ publication seminar papers, conference proceedings, business journals text books and periodicals, identifies the gaps and provides the way forward. A critical review is done to identify gaps, thereafter a summary is made to show

how unique the study is. The literature review has been categorized under various sub headings based on objectives of the study.

2.1 Literature survey

Attempts have been made by scholars from different contexts to establish the relationship between monitoring practices and healthcare services in public hospitals in Uganda. In Uganda, Okello (2012) carried out research on Effects of Monitoring and Evaluation Frameworks on Service Delivery in the Health Sector in Uganda. There were four objectives that guided the study; to establish the relationship between Monitoring and Evaluation principles and service delivery; to examine the effect of resources on the service delivery; to investigate how the program outputs relate to the service delivery and explore how M&E plans are influencing service delivery of Marie Stopes Uganda.

Based on the literature and theories reviewed it was Hypothesized that; Principles of Monitoring and Evaluation frameworks affect service delivery; resources affect service delivery, Program outputs affect service delivery in Marie Stopes Uganda, Monitoring and Evaluation plans affect service delivery in Marie Stopes Uganda, but after the study three of the four variables studied had an effect on service delivery with the exception of program out puts.

The methodology employed was a case study design; data was collected at Marie Stopes centers in Northern Uganda using self-administered questionnaires and interviews. Qualitative data was analyzed using content analysis and quantitative data done using SPSS. The findings indicated a positive significant relationship between principles of monitoring and evaluation frameworks, resources, M&E plans and weak positive relationship with service delivery. The study concluded that M&E frameworks i.e.

principles, resources & M&E plans had an effect on service delivery; although program outputs didn't. The major limitation was the geographic focus; it was carried out in only northern Uganda and not a country wide study, secondly being a case study; generalization of the findings was limited.

The study recommended that Marie stopes Uganda needs to improve and strengthen M&E principles, resources; revisit the definitions of program outputs and strengthen the M&E plans in order to improve service delivery.

Nahabwe, Basheka & Mucunguzi, (2024) carried out research on Monitoring and evaluation of the quality of healthcare service delivery in Ntungamo district, Uganda. The research was based on the following specific objectives; to establish the relationship between implementation type of monitoring and evaluation (IME) and the quality of healthcare service delivery in Ntungamo District; to determine the effect of beneficiary type of monitoring and evaluation (BME) on the quality of healthcare service delivery in the Ntungamo District; to investigate the contribution of social accountability type of monitoring and evaluation (SAME) on the quality of healthcare service delivery in Ntungamo District. The study used a cross-sectional research design where data from 213 respondents was used to draw inferences. The quantitative findings were generated through a questionnaire method and findings were supplemented by qualitative data through interviews.

The study established that the implementation type of M&E has a statistically significant positive relationship with the quality of healthcare service delivery as depicted by a correlation coefficient of r=0.308**. Also, beneficiary type of M&E has a statistically significant positive relationship with the quality of healthcare service delivery as

indicated by correlation results r=0.378**. On its part, social accountability type of M&E had a positive correlation (r=0.345**). The study demonstrates that monitoring and evaluation has a medium impact on the quality of healthcare service delivery in Uganda. The implication of this finding is that there are other factors likely to influence the quality of health care delivery other than M & E. The findings appeal to contexts beyond a local government and convey that M and E is not the only factor likely to support the success of an intervention.

Despite previous studiesaddressing the relationship between monitoring and evaluation and healthcare service delivery in Uganda, Okello's research was limited to Marie Stopes Uganda and did not look at government hospitals or health centers. As a result, the findings cannot fully reflect the realities faced by public hospitals and health centers.

The study also left out important monitoring aspects of how data is collected, how reports are handled and whether patient or community feedback is used to improve services.On the other hand, the study by Nahabwe et al. (2024) looked at different types of monitoring and evaluation in Ntungamo District and confirmed a moderate link between M&E and quality healthcare. However, they did not focus on institutional-level monitoring practices in public hospitals.The current study seeks to close the contextual and knowledge gaps by examining the effect of data collection frequency on the quality of healthcare services, assessing how reporting and documentation practices influence healthcare services and investigating the effect of stakeholder feedback on healthcare services at Entebbe Grade B Hospital and Kitala Health Centre III

2.2 Theoretical Perspective

Kombo and Tromp (2009) looked at a theory as a seasoned statement that aids in providing a general explanation on an issue that requires evidence or support to provide insights to some occurrences. The theoretical framework binds the main variables being studied. Theories anchoring the current study are Systems Theory and Integrated Service Delivery Model (ISDM) discussed below.

2.2.1 Systems Theory

Systems Theory was proposed by Ludwig von Bertalanffy in the 1940s to explain how systems operate and evolve through interaction with their environments. Von Bertalanffy emphasized that systems are open structures interacting with external factors which results in continuous adaptation and transformation (Hammond, 2019). He argued that all components of a system are interrelated and must function cohesively to ensure the efficiency and stability of the entire system. An organization much like the human body is composed of interconnected elements working toward common goal. The relevance of Systems Theory in organizational management has evolved over time. According to Baecker (2019), employees, departments, workgroups, and units form the subcomponents of any organization. The theory posits that for an institution to function, managers must observe internal patterns and activities to determine the most suitable management strategies. In relation to this study, Systems Theory aligns with the input, process and output indicators that underpin Monitoring and Evaluation (M&E) practices at Entebbe Grade B Hospital. The hospital can be viewed as a system composed of multiple interacting parts including human resources, financial inputs, medical supplies (inputs), service workflows and treatment protocols (processes), and patient outcomes or services rendered (outputs). For effective healthcare delivery, all these components must be well-

coordinated and monitored. Systems Theory also supports the idea that a well-structured and competent M&E unit is essential in identifying performance gaps, tracking progress and informing management decisions. Kithinji (2019) emphasized that the capacity and skills of the M&E team are central to the success of health interventions. Therefore, understanding the specific roles and responsibilities of the M&E team members within Entebbe Grade B Hospital is critical in ensuring that service delivery aligns with institutional goals and national healthcare standards. Furthermore, Folscher et al. (2019) advocated for the systematic development of M&E structures that consider both the human and technical capacities needed to manage data and performance information effectively.

2.2.2 Integrated Service Delivery Model (ISDM)

The Integrated Service Delivery Model (ISDM) focuses on teamwork and clients while offering services. The model also encourages the provision of the right services, using appropriate caregivers, the best setting (easy accessibility), provision of services when needed, efficiency and economical, accountability, and gathering and sharing information (Reynolds & Sutherland, 2013). Evaluation continues to be an engine towards achieving set targets in all sectors, including healthcare service delivery. It is an ingredient that when applied appropriately yields quality service in healthcare. To that end, M&E and the healthcare service delivery standards are closely related. The relationship can further be explained by the Development Assistance Committee (DAC) criterion that looks at routine and periodic assessments through the lens of relevance, efficiency, effectiveness, impact, and sustainability which are integral parts of quality services (OECD/DAC, 2012). M&E practicewas conceptualized into three dimensions to bring out the

relationships. The dimensions wereinput indicators, output indicators and process indicators.

On its part, Quality of healthcare service delivery took on four dimensions as stressed by Pretorius (2018). These include accessibility, availability, effectiveness and efficiency, patient-centeredness and safety. Accessibility was considered as geographical access, looking at how quickly and easily patients can reach healthcare services. Availability was considered to be how well the healthcare service providers (health centres) are equipped with necessary materials like drugs, machines, and personnel to meet beneficiaries' needs. Patient-Centeredness (People-Centered Care) considered to be providing care that respects and responds to individual patient preferences, needs and values. Safety is considered to be minimizing risks and harm to patients during the provision of healthcare like preventing medical errors, ensuring hygiene, and proper medication management (Pretorius 2018).

2.3 Review of Literature

The literature was reviewed under the subtitles corresponding to the objectives of the study showing the relationships between the variables of the study depicted in the conceptual frame work.

2.3.1 Effect of data collection frequency on the quality of healthcare services

In recent years we have seen an increasing focus on health information systems globally, with significant human and financial resources being invested at various levels to improve them (Kihuba et al., 2018). Adoption of modern Information and Communication Technology (ICT) has greatly improved access to health information systems (Kimaro & Nhampossa, 2017). Access to timely and high quality data is very

important for strengthening health systems. Such data are vital for facilitating long term planning, policy formulation and day-to-day resource allocation within the health sector (AbouZahr & Boerma, 2015).

In order to run an efficient health information system, data are derived from several sources including census, surveys, service delivery reports, registration of births and deaths, (Ledikwe et al., 2018). Data from service delivery are gathered by health workers, particularly nurses, clinicians and laboratory staff, who document their service delivery work. Regularly, after the data are collected and entered in paper registers, the providers fill out summary forms and send them up to the next reporting level. Research has shown that data often get lost or become erroneous during these processes of data collection, collation and transfer; leading to mistrust in routine health information systems. It is argued that unless there are adequate mechanisms to provide high quality of data as well as for developing a culture for using data to inform decisions, health information systems have no value (Tara Nutley, 2016).

Despite the increased attention paid to health information systems in developing countries, some researchers argue that data from most of these systems contribute less to decision-making processes due to poor quality (Kihuba et al., 2018). When health managers are asked how many women delivered in health facilities or how many maternal deaths occurred at health facilities, they must answer them with facts, rather than beliefs and opinions. At the same time, data are too often used uncritically from health information systems without checking the data for any errors; often resulting in misleading interpretations, unwise decisions and increased costs (Chapman, 2015). Of the

three challenges identified above (poor data quality, non-use of data and non-critical use of data), this paper focuses mainly on data quality.

Determining the quality of data is complex. This is because data quality encompasses multiple dimensions. Juran and Godfrey (1999) posit that data quality is determined by how fit the data are for specific uses (Ledikwe et al., 2018).

Other researchers view data quality as "the measure of the agreement between the data views presented by an information system and that same data in the real-world" (Kihuba et al., 2018). Other data quality dimensions include accuracy, completeness (having all relevant information recorded), timely data, consistency and relevance.

Health data deal with a continuum that ranges from the clinical records of individual patients, detailing their interactions with health services, through aggregated data and data warehouses, knowledge-based data for planning and decision support, to comparative and community data that can be used at a policy development level (AbouZahr, & Boerma, 2015). Health care data include the administrative data required to manage the complex business of health care, but also data captured from the patient's medical record. Data are often collected at the individual patient level and referred to as 'unit level data'. Aggregated data are the sum of unit level data. Data are used to support the proper care of the patient from whom the data were obtained, and they may also contribute to the good of society through the aggregation and analysis of data concerning populations of individuals. In an aggregated form, health data within the health care organization provides information of the prevalence and distribution of disease in a population, and at the government level informs policy makers.

Diagnosis relies on data gathered through observations. Gathering data and interpreting their meaning is central to the health care process because these steps are central to the process of decision-making. Increasingly wide ranges of data are collected from the multidisciplinary team to eliminate or confirm the possibility of the presence of a specific disease. Data in health care are found in many different formats and are used in many different ways.

2.3.1.1 Real-time data utilization in healthcare

Real-time data collection and utilization have become key components in improving healthcare services, particularly in hospital settings where immediate access to information can influence critical decisions. The ability to access data in real time allows healthcare providers to quickly assess patient conditions and adapt care protocols (Ferranti et al, 2020). A key example is the Children's National Medical Center in Washington, D.C., where real-time monitoring and data collection led to substantial improvements in patient safety and reduction in hospital-acquired conditions. This was achieved through the integration of data from electronic health records (EHR) and other monitoring systems that provided clinicians with immediate insights into patient status (Goldstein et al. 2018). The use of real-time data is linked to the reduction of medical errors, as clinicians are able to intervene promptly in cases where patient conditions are deteriorating. In one study, real-time feedback systems for surgical teams improved both compliance with safety protocols and patient satisfaction. Real-time data has been beneficial in emergency departments where patients' conditions can change rapidly, requiring immediate clinical responses (PMC).

2.3.1.2 Remote patient monitoring (RPM) and data frequency

Remote Patient Monitoring (RPM) represents a growing area of healthcare where the frequency of data collection is critical to ensuring that patients with chronic conditions receive timely and effective interventions. RPM allows healthcare providers to monitor patients outside traditional clinical settings, reducing the need for in-person visits and enabling continuous care. Studies have shown that frequent data collection through RPM can improve outcomes for chronic conditions such as diabetes, hypertension, and cardiovascular diseases. For instance, one study on diabetes management found that patients who were monitored more frequently showed better glycemic control compared to those who had fewer touch points with healthcare professionals (Cruz et al, 2021). RPM technologies utilize wearable devices or smartphone apps to collect data continuously, such as heart rate, blood glucose levels, and sleep patterns. These frequent data points allow healthcare providers to detect early warning signs of health deterioration, reducing the risk of hospitalizations. This model also raises concerns about the potential for overwhelming patients with data or creating a false sense of security when interventions are not immediately actionable. Nonetheless, increasing the frequency of data collection through RPM systems reduces emergency room visits and hospital readmissions (NCBI).

2.3.1.3 Data quality and its impact on healthcare services

The quality of data collected plays a fundamental role in shaping the overall effectiveness of healthcare delivery. High-quality data is essential for making informed clinical decisions, assessing patient outcomes, and improving the quality of care provided. Despite the fact that routine health data is often inaccessible, under-utilized, incomplete,

and not used for institutional decision-making in sub-Saharan Africa, the quality of HMIS in low and middle-income countries is poor, with direct and indirect consequences (Chen et al, 2014). Poor quality routine data and data that are not sufficiently timely, credible, accurate, and complete will contribute to poor decision-making, negatively impact strategic planning, inefficient resource allocation, and loss of confidence in the health system, and may threaten the validity of impact evaluations. Access to complete and comprehensive data to guide resource allocation and program improvement efforts is increasingly important given the high burden of disease and limited resources in numerous low- and middle-income countries (Adedapo Adejumo, 2017).

A good-quality routine health information system is key to the success of the health information system and the entire health system. High quality data is required to enable safe and reliable health care delivery, and health facility data is a key input to monitoring performance (Kebede, Adeba, Chego 2020). Most of the studies were conducted about only determinants of data utilization in different places and times, but they did not conduct studies on data quality levels and associated factors. Also, the study was not conducted in Shashogo district concerning data quality and factors that affect the quality of data. Therefore, this study will help to fill this gap in the study areas and identify the factors that affect data quality in Shashogo district, as well as generate or form good quality data in routine health information systems for the use of information and decision-making and planning.

A concerted effort to improve data quality through targeted interventions such as training healthcare staff and conducting data quality audits helped increase data accuracy and completeness, thus enabling better management of healthcare services. The improvement

in data quality directly correlated with better decision-making and more efficient allocation of resources (PopHealthMetrics). In contrast, facilities that collect data less frequently may miss important trends or fail to act on emerging health threats, which can undermine healthcare quality.

Challenges in data collection frequency

There are many possible problems that undermine the quality of data in health information systems. Some of these problems relate to the set-up of the organization and the technical knowledge of those who work with the data. In a study conducted in Botswana, it was found that data quality was not only affected by the limited capacity to collect, analyze, and interpret but also by the lack of skills to ensure that data being collected are of good quality (Ledikwe et al., 2018). Data quality assessments conducted in Kenya in 2010 and 2014 consistently found many discrepancies between data in primary tools and those in the national system. The assessments outlined the following reasons for the discrepancies: failure to use registers as per instructions, failure for health workers to understand the indicators, the use of multiple tools to aggregate the data and lack of data collection tools (GOK, 2014). Researchers have also observed that there is a relationship between data quality and use (Braa & Sahay, 2022). Braa (2022) further hypothesized that, poor data quality will not be used, and because they are not used, the data will remain of poor quality (Braa et al., 2022). It has also been observed that when data remain in the system for too long without use, they lose their quality. The practice of collecting large amounts of data that are not of immediate use is therefore not recommended since it is clear that if an organization is not using data, then, over time, real -world changes will be ignored and the quality of the data in the system will decline.

Balancing data collection frequency and quality

Evidence on the detrimental effect of low quality health systems on preventable mortality worldwide has accelerated investments in large scale healthcare improvement (Kruk ET AL, 2018). Regular measurement of quality of care is a core principle of quality improvement programmes that has been promoted in some low resourced settings as the primary means to improve quality of healthcare that is, the degree to which health services for individuals and populations are effective, safe, and people centered (WHO, 2018).

Advances in information technology over the past decades, along with a growing demand for accountability and regular measurement of quality of care, have resulted in a proliferation of indicators, tools, and approaches to measuring the performance of health systems (Hysong et al. 2022). Routine health information systems (RHIS) that capture high quality data to facilitate regular use of data to monitor real-time trends in healthcare processes and outcomes are essential. Regular measurement, however, will not improve healthcare on its own.

Since health information systems in many settings with high mortality have been developed, to some extent, to facilitate the aggregation of information at sub national, national, and global levels to fulfill reporting requirements, they are often not fully used to improve health service management and quality at the local level (Hysong et al. 2022). Faced with the challenge of satisfying the diverse information needs of different consumers, health systems often struggle with data generation, collation, analysis, and reporting, let alone using these data to establish or monitor quality improvement efforts.

Health information systems in countries across all income levels fall short of their potential to contribute to improving health system performance because of three interrelated factors: technical limitations, including poorly structured data collection tools, limited interoperability, and inadequate investment in maintenance, support, and data privacy; behavioural factors, such as poor motivation to generate high quality data; and organizational determinants often arising from weak governance and resource constraints resulting in understaffing, commodity shortages, and limited workforce skills in data management and data use for quality improvement. Further, in many settings, health information technologies do not capture important measures of quality of care regularly (Lee et al.2021). Irrespective of country resources and how data are collected, measurement of quality of care indicators needs to be accompanied by strong leadership for change if it is to translate into improved patient outcomes.

Change management, as we are using it here, refers to leadership within an organization or health system for designing, testing, and implementing changes to close gaps in quality of care using real-time measurement. Changes are focused on the root causes of quality of care problems in a local setting, identified through systematic problem solving methods. Root causes of poor quality may span multiple health system areas such as health workforce (eg, weak leadership, skills, motivation); organization of care (eg, inefficient care flow in a clinic); governance and policies; and infrastructure and commodities among others (WHO.2021). Consider a local health team that wants to take action to improve early detection and management of high blood pressure in pregnant women in a setting with a high prevalence of hypertensive disorders in pregnancy. The team will need to identify, agree, and monitor a small number of process and outcome

measures to know whether the changes they introduce (such as assigning an auxiliary health worker to measure women's blood pressure before being seen by a midwife in a busy clinic) are improving care. These might include the percentage of women with a blood pressure check at every antenatal visit and the percentage of pregnant women being treated for hypertension who have a normal blood pressure value (WHO.2021).

Without regular measurement, managers and facility teams will not know whether the changes they are introducing are associated with improved care. Conversely, care will not improve unless specific actions are taken based on an understanding of the root causes of poor quality of care in a local setting (eg, a single midwife in a busy clinic does not have time to check the blood pressure of every pregnant woman). Both qualitative and quantitative data are important for evaluating and guiding improvement (Beane et al. 2020). Qualitative data from providers and health service users enable assessment of the feasibility, acceptability, and sustainability of changes being introduced to improve care in a local healthcare system. At the same time, care for pregnant women with hypertensive disorders of pregnancy is unlikely to improve or be sustained unless managers and their teams embrace the soft skills required to establish a culture that supports change management.

Improvements in care are more likely to be both sustained and widespread if all facilities in a given catchment area regularly monitor and share their results and the changes they are making as part of an intentional learning system (Shah 2019). Broader system improvement can occur if guided by strong leadership for change, if quality improvement efforts are embraced by managers, and if lower performing facilities can be identified and provided with additional support. In a systematic review of the effectiveness of strategies

to improve the performance of healthcare providers in low and middle income countries, group problem solving (often in the context of multisite improvement collaborative incorporating regular peer-to-peer learning) showed moderate to large improvements in provider practice outcomes (Shah 2019).

Improving data quality in the health care industry is linked to better overall management of health plans (Shah 2019). The practice of evidence-based medicine requires access to significant research data, collated and presented in a way that the clinician can use at the time of decision making. There are now overwhelming amounts of health research results available and continually being published, so much so that no clinician could ever remain completely up to date.

2.3.2 How reporting and documentation practices influence healthcare services

Medical documentation is any paper or electronically produced clinical or health-related facts about patients that clarifies the care or carrier supplied to that unique patient and consists of all types of documentation via a doctor, nurse or allied health professional (physiotherapist, occupational therapist, dietician etc.) recorded in a professional capability in relation to the provision of patient care (Akhu-Zaheya, et al, 2018). Documentation and file keeping is a crucial part of scientific practice and it demonstrates the clinician's accountability and records their professional practice and is a formal way of recording the account of what happened and when it came about and it often used to evaluate professional exercise as a section of first-rate assurance mechanisms such as overall performance reviews, audits and accreditation processes, legislated inspections and essential incident opinions (Alhawsawi, 2021).

It is a file of the care and the clinical assessment, professional judgment and critical thinking used by a health professional in the provision of that care, so documentation ought to be clear, concise, consecutive, correct, contemporaneous, complete, comprehensive, collaborative, patient-centered and confidential (Andualem, et al, 2019). It incorporates the information needed to plan, provide, and evaluate the care given to the individual, it serves as a tool for communicating information to all the health personnel who deal with the patient, and it contributes to the continuity of patient care. Health facts are a pillar of public health system and services and it is important for effective decision makings at different levels of the health system either in the clinical or managerial levels (Ayele, et al, 2021). A primary component of patient care is medical documentation which is defines as "a technique in which healthcare providers file the observations, impressions, plans and other activities arising from episodes of patient care" that "generally occurs with each interaction between patients and the healthcare system.

Healthcare organizations and employees are pillar to produce complete and accurate data for multiple data-intensive endeavors. So, to ensure safety, effectiveness, and quality, sustainability and positive experiences to users and professionals fundamentally depends on complete and accurate data and used health professionals (Beauty, 2020). High-quality documentation is necessary, and the practice of keeping good medical records assists health professionals to track, investigate and make informed decisions based on the medical profile of the patient easily and should be patient-focused, accurate, relevant, clear, permanent, confidential, and timely.

Documentation is a way of recording the account of what happened, when it happened and the act of authenticating with factual or substantial support of medical practices by

qualified workers (Belay, 2016). In addition, medical documentation is the process of recording the plan of care, patients' need, and interventions health providers need to implement and evaluation of the patient outcomes. Documentation includes a record of patient condition provided by health professionals; like clinical assessments, clinical evaluation, and professional judgment regarding the provision of patient care (Bøgeskov, 2018).

Specifically, it includes health documents, evaluation charts (a wall poster that help clinicians to track the progress of their patient), acts, tests (medical procedures involves testing sample of blood, urine and other substances from the human body), checklists (those for-mats used to collect data in an orderly and systematic manner), correspondence books, management reports, and clinical subjective notes or personal reflections; Physicians, nurses, midwives, laboratory technicians, Anesthesia and Pharmacy professionals can involve in medical documentation (Debora, et al, 2021). High-quality medical documentation is expected in every area of care and every setting. Documenting the medical record of a patient is essential for continuity of patient care, research, legal defense, reimbursement and it enhances communication among healthcare providers, and patients concerning diagnoses, laboratory results, treatments, and outcomes (Debora, et al, 2021).

To ensure the quality of medical services, good medical documentation is necessary, and the practice of keeping good medical records assists health workers to track, investigate and make informed decisions based on the medical profile of the patient easily. Medical records are believed to be the most vital resource that health workers use in their day-to-day practice in the health care arena. Health care facilities by-laws or policies should

require medical staff members to complete patient records within the allotted time (allocated or specified work time). Whether it is paper-based or electronic, medical documentation should be patient-focused, accurate, relevant, clear, permanent, confidential, and timely (Kasaye, et al, 2022). On the other hand, poor medical documentation practice affects both patient management and medico-legal issues, which arise from a breakdown in communication resulting from incomplete and inadequate documents.

Lack of Health literacy, computer skill, and related training among health workers has an influence and is indicated as a barrier and challenging issue to the documentation of health related information (Seidu, et al, 2021). Despite studies globally identified limitations in medical documentation practice, keeping the medical record of the patient is part of a professional obligation. Poor medical care documentation is linked with avoidable medical errors that can lead to adverse patient outcomes. A thumb rule of expression, “If it is not documented, it does not exist” holds true when we deal about documentation (Seidu, et al, 2021).

According to a survey by World Health Organization (WHO), poor communication between healthcare workers is one factor for medical errors. Evidence in USA showed that approximately 1.3 million people are annually injured and at least one person is killed due to medical documentation and medication errors (Sum, et al, 2013). In Africa, health workers working in health care institutions experienced medical documentation record keeping as a major challenging practice facing several challenges that include lack of time to complete the record, and shortage of recording materials (tools that the health care providers used to document the information about the patient). Studies also

identified that knowledge, attitude, in service trainings and practice shortages in medical documentation.

In Ethiopia, the act of medical documentation is poorly practiced and has reported left undone. The challenge for this could be due to lack of training, time, poor knowledge, and attitude of the health workers towards medical documentation (Kruk et al, 2018). In spite of the limited amount of studies done in Public Hospitals in Ethiopia, which is limited to nursing documentation practice among nurse workers, there is limited study has been indicated among Private hospitals that take the lion share of health care delivery to the population related to medical documentation practice and its associated factors. Private hospitals in Ethiopia has advantages for both the urban and rural communities by providing health care at any time when people are in need of particular services. Expanding private health sectors reduces the burden of the government as it increases consumer choice and competition (Kasaye, et al, 2022). Private hospitals are owned privately including for profits and non-profits. In reality, it is uncommon that good health service quality can be improved without recording the essential medical information about the patients. For good patient management and medical intervention, all the useful information of the patient should be well documented.

Shortages in recording the medical history of the patients may resulted in miscommunications of health workers like nurses, physicians and others and this leads to adverse patient outcomes. However, the information generated by the health workers in private hospitals seems left unsearched and not clearly indicated (Taiye, 2015). Hence, this study tried to revealing the magnitude of the problem and exploring the challenges for documenting the patient information by the health workers. The results of this study

can be used as a benchmark for designing future studies by the upcoming researchers. The objective of this study was therefore, to assess the medical documentation practice and identifying the factors among health workers at private hospitals (Taiye, 2015)

Advancements in technology have transformed nursing documentation processes, transitioning from traditional paper-based systems to electronic health record (EHR) platforms (Ngao, 2015). EHRs offer numerous benefits, including improved accessibility, legibility, data integration, and decision support tools (Alhawsawi, M.M. 2021).

However, challenges such as system usability, interoperability issues, data security concerns, and user proficiency impact the effective implementation and utilization of EHRs in nursing practice. Across different healthcare settings and regions, nursing care documentation practices vary in terms of documentation methods, standards, and challenges (Alhawsawi, M.M. 2021). While developed countries often leverage sophisticated EHR systems and standardized documentation frameworks, resource-constrained settings face challenges related to manual documentation, limited infrastructure, and workforce shortages (Gomes, et al, 2016). Despite efforts to enhance documentation practices, barriers such as limited training opportunities, insufficient supervision, and lack of standardized documentation guidelines persist (Ngao, 2015). Furthermore, the transition to electronic documentation systems is hindered by financial constraints, technological barriers, and infrastructural limitations (Alhawsawi, M.M. 2021).

2.3.3 The effect of stakeholder feedback on healthcare services

A stakeholder is defined as any group or individual who can affect or is affected by the achievement of the organization's objectives. Consistent with Freeman’s (1984)

definition, Conscannon et al. (2012) describe stakeholders in health as any individuals or groups accountable for or impacted by decisions related to health and healthcare based on research findings. Building on these definitions, stakeholders in this study are defined as people or organizations impacting or impacted by the provision of healthcare services. This includes the community, patients, healthcare professionals, local and federal governments, and statutory organizations like the Ministry of Health, Joint Medical Stores, and National Medical Stores.

Stakeholder engagement, according to Mitchell et al. (2022), is "the interaction among a firm and its stakeholders that addresses knowledge problems to improve correspondence in understanding between managers and stakeholders, thereby assisting in resolving ethical challenges faced by managers. Similarly, Leonidou et al. (2020) describe it as "procedures, solution development and/or usage, co-creation, interactions and/or relevant, marketing-based forms of service exchange, of all stakeholders within the micro- and macro-environment of an organization." Based on these definitions, this study defines stakeholder engagement as "a systematic process through which stakeholders and managers in a firm interact and relate to achieve the firm's or organization's goals and interests (Kujala et al., 2022).

Moodley (2002) asserts that adequate stakeholder participation is critical to the successful provision of healthcare services and has been recognized as a top priority by eminent medical professional’s worldwide. Stakeholder engagement improves accountability, fosters responsive, safe, and high-quality service care, and enhances collaboration, ownership, and empowerment of stakeholders in service delivery (WHO, 2020).

However, there is limited research specifically identifying the best practices, obstacles, and facilitators for stakeholder engagement in healthcare service delivery.

Stakeholder feedback is an essential part of any business, service or process. Feedback encompasses all aspects of communication about the delivery of the service be that comments, questions, complaints or concerns about the service. It is one of the key measures that delineates whether the service being delivered is right or wrong, whether it meets expectations or not, whether reputations are made or lost. Within the world of PSAPs, stakeholder feedback could be emotively described as a life or death process.

In common parlance the term feedback has come to serve as a euphemism for criticizing others, as in the boss gave me feedback on my presentation. This document does not intend for feedback to be used in the context of a criticism. Feedback within this document means information sought or supplied that is used in a positive manner for learning, improvement and development within a self-reinforcing or self-correcting process (King et al, 2020). In general, all stakeholders prefer feedback on professional practice and health care outcomes (Karama, & Iravo, 2019). The main reason mentioned was that feedback can improve health care, either at an individual level, hospital level or national level. Feedback can create awareness. It can also be a method for reflection on yourself and on peers or colleagues. Feedback can also be used to benchmark and improve health care with all health care providers together. Stakeholders agree that it is important to act upon feedback, either by developing improvement plans or by putting the feedback on the agenda as a start (Karama, & Iravo, 2019).

Both actions will result in more attention to the use of feedback in the hospital. Additionally, feedback can engage quality of care discussions among and with

professionals, patients and health insurers about the care delivered and the experiences of all parties involved. All four stakeholders agree that patients might not be interested in or might not understand the feedback on professional practice. In addition, health care professionals themselves mentioned that not all health care professionals would be able to understand the feedback properly (Mutekhele, 2018). Health insurers specifically stated that it is not their aim to judge hospitals for the good work they deliver, but to apply feedback as a discussion tool in their interactions with care providers. Health insurers consider feedback to be a necessary tool to improve care for the patient. In comparison, professionals consider feedback to be a method to improve care together with the patient (Natangelo 2017).

The main reason for patients to want to receive feedback on PROs and PREs is to be able to engage in the discussions with peers or professionals regarding their quality of life, experiences and received care. Medical specialists see the PROs and PREs as another way of benchmarking and improving health care.

Allied health professionals mention that feedback on PROs and PREs are of particular interest, because they are about “how” the patient lives instead of “whether” the patient lives for a longer period. For health insurers, PROs and PREs form a part of the outcome indicators and are necessary to measure quality; patient experiences are necessary to improve health care (Agyepong et al., 2015).

Patients would prefer to receive feedback on the professional practice that matches their health care pathway; for example, the patient does not want to receive feedback on the professional practice of the physiotherapist if the patient did not receive any physiotherapy at all (King et al, 2020). Medical specialists and health insurers alike

mention that health care outcomes are most relevant when they can be compared with the aspects of professional practice, because they deal with the effect of the treatment. In contrast with medical specialists, allied health professionals mention more frequently that they are more interested in feedback on the professional practice of their own discipline. However, both groups agree that feedback on all health outcomes and aspects of professional practice is needed, because they also form part of the health care pathway of the patient.

Patients' feedback based on their experiences of receiving health care is a vital tool for improving quality of health services (Debono D., Travaglia 2019). Patients can identify issues that management is not aware of and can offer health-care managers innovative ideas for improvement. The opportunity to respond to patients' feedback, in turn, leads to responsiveness which is a widely recognized objective of national health systems (Holmes-Bonney K. 2020). Feedback from patients can create an effective interaction between service users and service providers that is a key component of the responsive health system. Such interaction is significant in two ways.

First, it enables the service users to provide feedback on the service they receive as well as the skill and behavior of service providers. The term "feedback" from service users is used for both complaints (i.e., grievances) and praises. Second, the interaction allows improving the quality of health services and strengthening of the human resource management process through collection and utilization of the feedback (Debono Travaglia 2019).

Patients have the right to file complaints with organizations when they are unsatisfied with the treatment received, and health care organizations should have processes in place

for appropriately responding to these on time (Hsieh S. Y. 2020). Globally, the voice of health service users or patients is increasingly in demand in order to develop healthcare services. Complaints management systems are, therefore, an established feature of national health systems in high-income countries implemented to improve the patient experience (King et al, 2020). A well-functioning patient feedback system can provide opportunities for developing risk management or healthcare quality improvement programs in which preventive or proactive mechanisms can be set up. Such a system can also enable patients to contribute to the improvement of services and participate more actively in self-care. Tracking the trend of patient complaints may call attention to systems or individual performance problems and suggest areas for improvement (King et al, 2020). Conversely, positive feedback from patients can highlight well-functioning areas where patients are satisfied with their experiences of healthcare and therefore provide examples of best practice.

Patient feedback typically involves approaching local health facilities, and if needed, subsequently appealing to higher-level authorities such as courts or insurance companies (Mirzoev T., Kane S. 2018). Specific mechanisms for receipt of feedback include dedicated suggestion mailboxes, email addresses, text messaging systems, telephone hotlines, interactive websites, and office windows staffed with complaints handling officers. Issues raised by patients can vary in severity, from patients' concerns of not being listened to, through to death because of poor care. At the same time, specific causes typically relate to professional conduct, provider-patient communication, treatment and care of patients, medical errors, malpractice, lack of skills, waiting for care, and costs (Mirzoev T., Kane S. 2018).

A systematic review of the effects of involving users in health care through improving patient feedback found evidence of improved health services (Natangelo R. 2017). However, much of this evidence comes from high-income contexts, suggesting limited patient involvement in health care within low- and middle-income countries (LMICs), and consequently limited research in this area (Mirzoev & Kane, 2018). A review commissioned by the World Bank found only a few descriptions, reviews or evaluations, of feedback procedures in LMICs. Furthermore, there is a dearth of literature on patient feedback systems from primary health care facilities because most evidence comes from secondary and tertiary hospitals.

Studies have shown that involving stakeholders in planning can lead to improved health outcomes. For example, a study by Seth (2018) indicated that stakeholder involvement in planning led to better resource allocation and prioritization in health projects. However, research by Bukenya and Mutebi (2019) highlights that a lack of stakeholder engagement often results in misaligned priorities and resource wastage, limiting the effectiveness of health interventions.

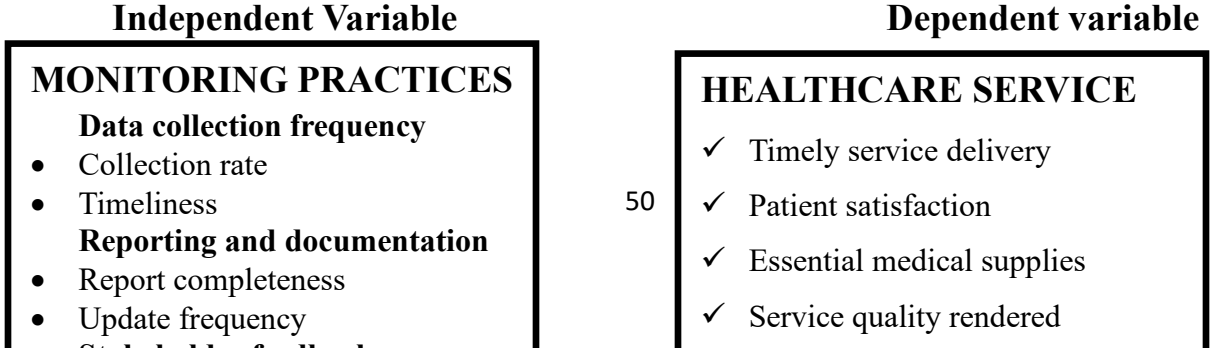
Stakeholder engagement in planning involves the participation of various stakeholders in setting priorities, developing work plans, and budgeting for healthcare services. Effective engagement ensures that the needs and preferences of the community are considered, leading to more relevant and sustainable healthcare interventions (Roberts, 2014).

Stakeholder feedback is increasingly recognized as a crucial component in the improvement of healthcare service delivery. Engaging key stakeholders, healthcare professionals, community representatives and policymakers healthcare systems are better positioned to align services with the actual needs and preferences of the population.

Evidence from Ghana indicates that involving stakeholders in the design and execution of community engagement interventions resulted in more sustainable and cost-effective healthcare improvements. This success was largely attributed to the utilization of existing local structures, which enhanced ownership and accountability (Agyepong et al., 2015). Similarly, a study conducted at Lyantonde Hospital in Uganda found that incorporating stakeholder input into planning processes, including priority setting and budgeting, led to healthcare interventions that were more relevant and sustainable (Tumwine, 2017). In Bangladesh, a study on patient feedback systems at primary healthcare centers revealed that while SMS-based feedback mechanisms were in place, their utilization was limited due to factors like low literacy levels and lack of awareness among patients. The study emphasized the need for combining verbal and written feedback channels to make the system more accessible.

2.4 Conceptual framework

The conceptual framework below illustrates the connectivity between the independent variable and the dependent variable. The framework also reflects the intervening variables that can influence both the dependent variable and the independent variable. The model shows how monitoring practices in terms of data collection frequency, reporting and documentation and stakeholder feedback influence healthcare service in terms of timely service delivery, patient satisfaction, essential medical supplies, service quality rendered and responsiveness to patient needs.



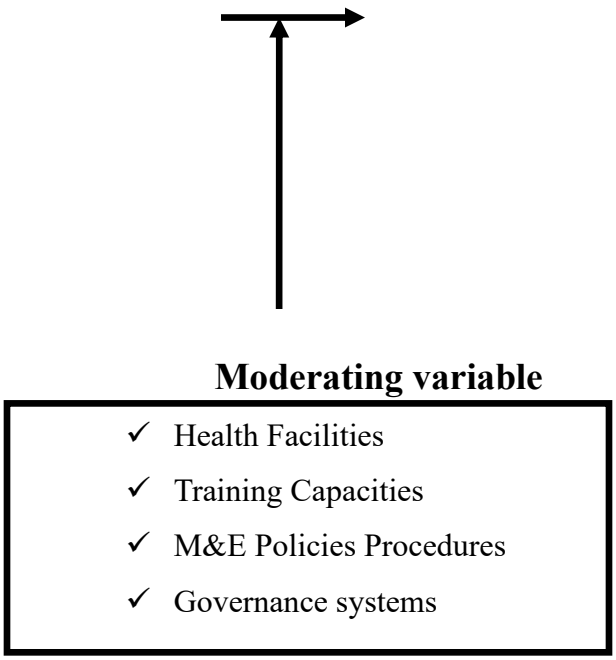


Figure 1: Conceptual framework.

Source: Adapted from literature review and modified by the researcher, 2025.

The conceptual framework is a research tool used to facilitate a clear understanding of the measurement of the key variables of interest and their interrelationship (Norton, 2006). In the above conceptual framework, the relationship between the Dependent variable and Independent Variable is explained. The independent variable is Monitoring Practices which will be measured in terms of in terms of data collection frequency, reporting and documentation and stakeholder feedback. The dependent variable is Healthcare service measured in terms of timely service delivery, patient satisfaction, essential medical supplies, service quality rendered and responsiveness to patient needs as its dimensions. The researcher identified some intervening variables, which could affect healthcare service provision. These included; Health Facilities, Training Capacities, M&E Policies Procedures and Governance systems.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0: Introduction

Katebire, (2007) defines methodology as the technical and scientific activities, tools, and procedures used to plan, gather and analyze data. This section presented the methods the researchers used in the study. This involves the research approach, Research Design, Study population, Sampling techniques, sample size, Data collection methods, Research Instruments, Data analysis, Data presentation, Data quality control, Data Validity, Data Reliability, Research procedure, Ethical considerations, limitations of the study and time frame and Conclusion.

3.1 Research approach

The researcher used both qualitative and quantitative approaches of data collection and analysis so as to capture the details and adequate information Kish (2005). The researcher used qualitative approach of data collection and analysis so as to capture the details and adequate information. This is due to the fact; qualitative research seeks to tell the story of a particular group's experiences in their own words, and is therefore focused on narrative. According to Kish (2005) quantitative research tends to be more exploratory in general. In addition, the quantitative approach is informed by inductive logic in which potential understandings of a phenomenon with statistical figures are collected and analyzed. The use of both methods ensures that the data is effectively interpreted using the numbers, figures as well as the narrative. According to Joshua (1998) both qualitative and quantitative tends to be exploratory in nature, seeking to provide insight into how individuals understand aspects of their worlds.

3.2. Research Design

A research design also called a research strategy is a plan to answer a set of questions (McCombes, 2020). It is a framework that includes the methods and procedures to collect, analyze, and interpret data. In other words, the research design presents how the researcher investigated the central problem of the research, and thus it is part of the research proposal. Research designs are plans and procedures for research that span the decisions from broad assumptions to detailed methods of data collection and analysis (Creswell, 2013). The research was based on a case study research design carried out at Entebbe Grade B Hospital and Kitala Health Center III. Creswell, (2013) defines a case study as a qualitative strategy in which the researcher explores in depth a program, event, activity, process, or one or more individuals. The researcher, therefore, used cases that are bounded by time and activity, and researcher collected detailed information using a variety of data collection procedures over a sustained period. The researcher used a mixed approach of qualitative and quantitative research. Thus, it is more than simply collecting and analyzing both kinds of data; it also involves the use of both approaches in tandem so that the overall strength of a study is greater than either qualitative or quantitative research (Creswell, 2007).

3.3: Study Population

Shukla (2020) defines population as the set or group of all the units on which the findings of the research are to be applied. The study mainly concentrated on the Medical Records staff of Entebbe Grade B Hospital and Kitala Health Center III. In this study, the target population comprises 160 participants and these include medical records officer, medical records assistants, data Entrants, and ward in-charges and M&E technical officers.

This is because they are the ones who are responsible for the management of the records from the time of creation to their ultimate disposal.

Table 3.1: Showing study population and sample size

Key respondents	Target population	Sample size	Sampling technique
Medical records officers	55	40	Stratified sampling
Ward in-charges	30	21	Stratified sampling
M&E technical officers	25	18	Purposive sampling
Medical records assistants	25	18	Purposive sampling
Data Entrants	25	17	Purposive sampling
Total	**160**	**114**	

Source; Primary Data, 2025

3.4: Sample size and sample selection

According to Institute for Work and Health, sample size refers to the number of participants or observations that a researcher includes in a study and tends to interact with participants when collecting data. This number is usually represented by the letter n. The sample size of the study was determined regarding the researcher's interest and it constitutes staff based on organization structure, especially the medical records department. The staffs who were involved in the study included medical records staff, Data entrants, and ward in-charges. To determine the appropriate sample size from a known study population, Yamane's (1967) formula is used. This formula is widely accepted for social science research where the confidence level is typically set at 95%, corresponding to a margin of error (e) of 0.05.

Yamane's Formula:

$$n = N / (1 + N(e)^2)$$

Where:

n = Sample size

N = Total population

e = Margin of error (typically 0.05 for 95% confidence level)

Substituting with Values:

Given:

N = 160

e = 0.05

n = 160 / (1 + 160(0.05)^2)

n = 160 / (1 + 160 * 0.0025)

n = 160 / (1 + 0.4)

n = 160 / 1.4

n ≈ 114.29

Therefore, the required sample size is approximately 114 respondents.

3.5 Sampling techniques and procedures

Colpo & Negreiros-Fransozo, (2016) defines a sampling technique as a plan of choosing the right elements of the sample to make a representative of the population under study. There are two types of sampling, probability sampling and non-probability sampling each having several sub-types but the researcher intends to use mixed method approach where probability and none-probability sampling techniques were used as explained below;

3.5.1 Purposive Sampling

Purposive sampling is sampling where the targets a category or individual respondents due to their expertise and resourcefulness on the matters under investigation (Neuman, 2006). Purposive sampling is when the researcher specifically targets certain people due to their knowledge about the research subject. Purposive sampling aims to ensure that the researcher finds and engages resourceful respondents to enrich the study (Berg, 2008). Purposive sampling was used to select the respondent category of M&E technical officers, Medical records assistants and Data Entrants

3.5.2 Stratified sampling

Stratified sampling is when the units of analysis are grouped into strata based on which samples are selected from each of the strata (in this case the Medical records officers and ward in-charges) to come up with a total study sample. The study used stratified sampling to target staff members. This method is selected because it gives an equal chance to each of the units in the sample population to be picked to take part in a study (Sarantakos, 2005). Stratified sampling is also preferred for data collection minimizes the bias on the side of the researcher while selecting respondents (Maxwell, 2005).

3.6: Sources of Data

According to Burns, (2000), Researchers need to consider the sources on which to base and confirm their research and findings. They have a choice between primary data and secondary sources and the use of both. This study used both Primary and Secondary data collection methods as explained below

3.6.1: Primary sources

According to Neuman, W (1994), Primary data is data collected by the researcher himself/herself. This is data that has never been gathered before, whether in a particular way, or at a certain period of time. Primary data consist of original research done to answer current questions regarding a specific operation. Primary data wasused as a source of data due to the fact that it can be directly applicable to the research problem at hand. The other merit is that data produced from primary data offers better control over data accuracy. However, primary data is time consuming because it requires time to conduct a detailed information-gathering study.

3.6.2: Secondary sources

According to Henwood, et, all, 1993), Secondary data is data collected and processed by others for the purpose other than the problem at hand, this is information that is already available and that can be used if the need arises. This was collected from already available data literature. Relevant documents and records wereused. Secondary data wasused to supplement the primary data in an attempt to answer the research questions raised. Secondary provides comparative data which makes it more illuminating interpretation of primary data and it is more accurate than primary data. However, secondary data does not apply on a specific problem being investigated, as it is collected for other purposes and also accuracy of secondary data is questionable, as research errors are possible in data collection and analysis.

3.7.: Data collection methods

Data collection is the process of gathering and measuring information on variables of interest, in an established systematic fashion that enables one to answer stated research questions, test hypotheses, and evaluate outcomes (Roux, 2022). Questionnaire method, Observation and interview were used in the study as elaborated in the context below

3.7.1. Questionnaire method

The researcher used questionnaire which wasadministered as data collection method. The questionnaire wasdesigned in a concise and precise language to avoid ambiguity, and also to arouse the respondent's interest. The questionnaire consisted of well structured (close ended) questions, which just require ticking the right answers by the respondent. The researcher decides to use questionnaire to allow responses to be gathered in a standard

way, bringing out objectivity, and reducing bias. Also, the use of questionnaire, allows information to be presented in numerical and graphical backgrounds. The use of questionnaire is not without its limitations. Since questionnaires are issued after the event being researched has taken place, there is the likelihood that many respondents would have forgotten major parts in the events being researched.

3.7.2: The interview method

Interview as a data collection method was used. An interview is a qualitative research method that relies on asking questions to collect data which is a face-to-face conversation between the researcher(s) and a respondent(s) conducted to obtain information. Interviews involve two or more people, one of whom is the interviewer asking questions to get answers from respondents involved in the study (George, 2022).As such, semi-structured individual interviews were conducted on M&E technical officers, Medical records assistants and Data Entrants to generate in-depth data in participants' own perspectives of monitoring practices and healthcare services. Before embarking on the actual interview, the pilot interview was conducted in order familiarize myself with the voice recorder and other necessary procedures of the interview. Each participant afforded three minutes of informal introductory conversation to ease possible tension prior to recording the actual interview. The duration of individual interviews ranged from 10 to 15 minutes depending on the inputs of the participant.

3.7.3Document review method

Documentary review analysis involves analysis of the relevant and topical literature that is related to the study. Documentary review analysis focuses on literature that is in line with the objectives of the study. The advantages of conducting documentary review

analysis are that it allows the researcher to learn more about the subject under investigation as presented by previous researchers. It enriches the research with various points of view. Documentary review analysis collected secondary data from text book, journals, etc., as well as reports from the organization under study, in this case Entebbe Grade B Hospital and Kitala Health Center III.

3.8: Data collection instruments

Research instrument refers to any tool that the researcher may use to collect or obtain data, measure data and analyze data from the respondents that is relevant to the subject of the study. In this study, several research instruments were used such as self administered questionnaire, interview guide and document review checklist as explained below (Discover PhDs, 2020).

3.8.1: Interview Guide

The interview guide is a logical sequence of topics and questions that help the researcher conduct an interview session. The guide was organized into sections according to the different areas that needed to be explored during the research; each section came with a detailed set of questions that helped the researcher(s) to cover the topic in the study. An interview guide was used which consisted of open-ended questions that solicit in-depth responses about the respondents‟ experiences, perceptions, opinions, and knowledge relevant to this study. The guide helps the researcher remember all the key aspects to explore. Burns, R (2000) prefers the interviews because of the lack of predetermined structure which allows free association with interviewees in order to yield a broader explanation of the issues in question

3.8.2: Self-Administered Questionnaire

A questionnaire was a tool that contained open-ended questions used to collected qualitative and quantitative data filled by respondents, with the help of a researcher. The questionnaire was generated by the researcher based on the three research objectives and the dimensions of the independent and dependent variables. A questionnaire was used because it was easy to administer and analyze. It was also economical in terms of time and money efficiency. Both closed and open ended questions were asked on the administered questionnaire (Mugenda&Mugenda, 2003). The questionnaire contained four sections; a section on the personal details about the respondent, the rest of the three sections, each, contained questions about each of the three research objectives

3.8.3 Document review checklist

Document review is a way of collecting data by reviewing existing documents. The documents may be internal to a program or organization (such as records of what components of an asthma management program were implemented in schools) or were external (such as records of emergency room visits by students served by an asthma management program). This document review checklist is designed to help specialists who have a duty to review and check documents to ensure their technical precision, correctness of content, readability etc. Documentary sources were also analyzed in order to find more about facts regarding monitoring practices and healthcare services.

3.9: Data Quality Control

This section explains how the study ensured research instruments are valid and both qualitative and quantitative data reliable. Validity of qualitative data was gauged by a pre-test of the interview guide.

3.9.1 Pre-testing

Pre-testing of the sample was done using 5 staff members to validate the questionnaire and interview guide for targeted respondents. The purpose of conducting a pre-test was to test the rigor of the appropriateness of the research questionnaire tool. The pre-testing ensured clarity and consistency throughout the study (Mugenda&Mugenda, 2003).

3.9.2 Validity

Validity refers to how accurately a method measures what it is intended to measure. If research has high validity, it produces results that correspond to real properties, characteristics, and variations in the physical or social world (Middleton, 2019). To ensure validity of the research tool, the researcher aligned questions in reference to each objective. The rating of using Likert scale; strongly disagree, disagree, neither agree nor disagree, agree, and strongly agree was used on top of each section of the questionnaire. The researcher needed assurance that the instrument being used translates into accurate results and conclusions. To ensure validity instruments were reviewed by the supervisors, as well as by computing the content validity index (CVI), as shown below.

$$CVI = \frac{\text{Number of items declared valid}}{\text{Total number of items}}$$

3.9.3 Reliability

Reliability refers to how consistently a method measures something. If the same result can be consistently achieved by using the same methods under the same circumstances, the measurement is considered reliable. The research questions for each measurable variable were pre-tested for reliability and to determine coefficient of alpha above 0.70 which is always considered reliable (Cronbach, 1951). The coefficient of alpha is useful

for estimating reliability in a particular and if a test has large alpha, then it can be concluded that a large portion of the variance in the test is attributable to the general and group factors. A large coefficient of alpha implies that there is very little item- specific variance. Reliability, according to Amin (2005) is the degree to which a measuring instrument is free from error or yields consistent results when used over different time periods. The Cronbach's Alpha approach was used to measure the consistency of the items corresponding to the selected variables in the questionnaire.

3.10 Data collection procedure

Successful defense of the proposal was followed by getting a letter of introduction to the field for data collection from the School of Social Sciences of Nkumba University. Data collection was done over a period of one month. A team of research assistants was led by the researcher in data collection. In the first week data collection instruments were developed and pre-tested for validity and reliability before full application. Still in the first week, contacting and making appointments with respondents was done. In the second week, questionnaires were administered to the selected respondents. This was done by two research assistants whose minimum qualification was a university degree. In the second week, interviews with key respondents were conducted. In the third week, all collected data was organized and sorted for correctness.

3.11 Data analysis and presentation

This section discussed the approaches that were followed when analyzing the documents and interview data. The purpose of data analysis was to reduce sets of data as a basis for data management. In this case, both non-qualifying and quantifying techniques of analysis were used to present the research findings.

3.11.1 Analysis of Quantitative Data

The quantitative data was analyzed using descriptive, correlation, and regression models under SPSS (statistical package for social sciences) model after cleaning, editing and coding of the data. This was because the study sought to establish the degree and direction of the effect the independent variable has on the dependent variable. The analyzed data is presented descriptively in the form of percentages, tabulations, and frequencies according to the objectives and finally the influence the independent has on the dependent variables was determined using the Pearson correlation matrix and regression analysis

3.11.2 Analysis of Qualitative Data

Qualitative data was analyzed through comparison of the narratives, opinions, the recurrent themes, benchmarking these narratives and opinions with industry standards and other researchers so that meaningful conclusions can be drawn.

3.12 Ethical considerations

According to Russell (2011), ethical issues in research concern the moral guidelines followed to ensure that research is conducted according to established and acceptable standards. Ethics are moral choices that affect decisions, standards and behavior hence the researcher ensured that the study is politically, religiously, socially and culturally acceptable. The ethical issues that the researcher dealt with concerned; confidentiality, informed consent, anonymity, plagiarism etc. **Informed Consent:** this is a voluntary agreement to participate in research. It is not merely a form that is signed but is a process, in which the subject has an understanding of the research and its risks. Informed consent is essential before enrolling a participant and ongoing once enrolled.

Informed: Obtaining consent involved informing respondents about their rights, the purpose of the study, the procedures to be undergone, and the potential risks and benefits of participation. The goal of the informed consent was to provide sufficient information so that a participant can make an informed decision about whether or not to enroll in a study or to continue participation.

Confidentiality: maintaining confidentiality of information collected from research participants means that only the investigator or individuals of the research team can identify the responses of individual subjects; however, the researchers must make every effort to prevent anyone outside of the project from connecting individual subjects with their responses (Dalar, 2017). Confidentiality of all information given by respondents was ensured. All data and information given by respondents was presented in its truest form free from any manipulation.

Anonymity: providing anonymity of information collected from research participants means that either the project does not collect identifying information of individual subjects (e.g., name, address, Email address, etc.), or the project cannot link individual responses with participants' identities. The study did not collect identifying information of research participants unless it is essential to the study (Virginia Tech Research, 2008).

Plagiarism: plagiarism is the unethical practice of using words or ideas; it can be planned or accidental use of another author/researcher or your own previous works without proper acknowledgment. It is considered as a serious academic and intellectual offense, plagiarism can result in highly negative consequences such as paper retractions and loss of author credibility and reputation (Enago Academy, 2018). Plagiarism was avoided by the researcher understanding the context, avoiding copying and pasting of the

text verbatim from the reference paper but restate the idea in your own words, paraphrase the ideas correctly, quoting exactly what is in the papers, citing any ideas that are not mine.

3.13 Limitations of the study

During the study a number of constraints were faced while conducting the study as follows;

Time scheduling; given that the collecting of data was done during working hours, a number of health workers at both hospitals were very busy treating patients, therefore it was not easy to fix appointments with them and a lot of time clashes especially with top managers. However, to remedy this, I exercised a lot of patience though time consuming hence coming up with quality results.

Failure to return and loss of questionnaires; some of the respondents failed to return the questionnaires while others misplaced them. To remedy this, I reprinted the questionnaires and waited for them to be filled once again by respondents.

Indispose of respondents; given that healthcare service delivery is a critical subject of discussion, some respondents were unwilling to share information with the researcher. Therefore, to mitigate this, I reassured the respondents of their confidentiality and anonymity of any information availed to the researcher.

Response bias: Individual characteristics of participants influenced their responses to questions; therefore, the research team anticipates biased responses, over-responsiveness, and acceptance.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND INTERPRETATION OF FINDINGS

4.0. Introduction

This chapter presents findings and analysis, interpretation as found and assessed from both primary and secondary sources of data. Tables with frequencies and percentages have been used to present and analyze the findings. Thedata collected from the field was processed and analyzed qualitatively and quantitatively. The qualitative approach used in analysis provided clarification and explanations on quantitative data. Quantitative information summarized by using tables and percentages to show the response of the respondents.

4.1 Analysis of response rate

The study targeted a sample of 114 respondents. A total of 114 questionnaires were printed and distributed to the respondents. The response rate was good; 92 questionnaires

were filled, 6 were not filled and 6 went missing. Presented in the table below is the response rate of the study

Table 4.1: Response rate

	Frequency	Percentage (%)
Total number of questionnaires distributed	114	100
Total number of questionnaires returned	92	90.7

Source; primary data, 2025

As seen in table above, out of the 114 questionnaires distributed, 92 were returned giving a response rate of 81.2%. As Amin (2005) asserts that a high response rate is indicative of a good representative position of the sample selected from the population. It also implied that the information gathered is useful to describe monitoring practices and healthcare services in public hospitals in Uganda; a case of Entebbe GRADE B Hospital and Kitala Health Center III

4.2. Demographic characteristics of respondents

The main purpose of this section was to analyze the background information of the respondents in relation to their age, gender, marital status, position held, duration in service and level of education. The information was presented by the use of tables.

4.2.1. Gender of respondents

The gender of the respondents was summarized in the table below.

Table 4.2: Sex

		Frequency	**Percent**
Valid	Female	28	30.4
	Male	64	70.2
	Total	**92**	**100.0**

Source: Primary Data (2025)

From table 4.1 above, the study revealed 64 (70 %) of the respondents were male and 28 (30.4%) were female. This shows that both male and female respondents were considered in this study. This means that the data collected is a representation of the equal views of both male andfemale. It implied that, the results from the study are free from error as a result of bias arising from gender

4.2.2. Age bracket of respondents

Respondents were asked to reflect their ages and the results are shown in table below.

Table 4.3: Age

		Frequency	Percent
Valid	20-29	7	7.6
	30-39	37	40.2
	40-49	40	43.5
	50-59	8	8.7
	Total	**92**	**100.0**

Source: Primary Data (2025)

According to the table 4.2 above, the data reveals that the majority of the respondents were aged 40 years to 49 years, who made the total of 40 (43.5%) of the total respondents. Other age group individuals comprised of 37 (40.2%) were between 30 – 39 years, 8 (8.7%) were between 50to 59 years, and 7 (7.6%) they were 20-29 years. This means that the respondents were mature enough to understand the essence of the study and provided adequate and reliable information. Implying that, the data generated were free from any error and provided a good basis for the analysis, interpretation and eventual recommendations.

4.2.3. Marital Status of respondents

Respondents were asked to distribute their marital statuses and results are shown in table below.

Table 4.4: Marital status of respondent

		Frequency	Percent
Valid	Single	9	9.6
	Married	46	48.9
	Cohabiting	29	30.9
	Separated	8	8.5
	Total	**92**	**100.0**

Source: Primary Data (2025)

According to the table 4.3 above, the respondents were asked about their marital status and 49% put it clear that they are married taking up the highest percentage, 31% are cohabiting while 8.5% separated and lastly 9.6% revealed that they are single. This is a clear indicator that most of the respondents had families and responsibility therefore, their results were genuine.

4.2.4. Academic qualification of respondents

The highest academic qualifications of the respondents were summarized in the table below.

Table 4.5: Highest level of education

		Frequency	**Percent**
Valid	Masters	20	21.7
	Bachelors	19	20.7
	Diploma	30	32.6
	Certificate	23	25.0
	Total	**92**	**100.0**

Source: Primary Data (2025)

Study findings in table 4.4 above indicates that 32% of the respondents had attained a diploma as their highest level of education, 25.0 % were certificate holders, 21.7% were masters holders and 20.7 % were bachelors holders.The finding revealed that majority

92(100%) had attained qualification ranging from certificate, diploma and bachelor degree levels. This means that the categories of respondents were competent and knowledgeable. The implication is that the information that the respondents gave was accurate, correct and valid to draw conclusion regarding the effects monitoring practices and healthcare services in public hospitals in Uganda

4.2.5 Department worked in

The study sought to establish the department under which the respondents worked in and their responses are presented below;

Table 4.6: Department of work

		Frequency	Percent
Valid	Medical records officers	6	6.5
	Ward in-charges	5	5.4
	M&E technical officers	14	15.2
	Medical records assistants	16	17.4
	Data Entrants	51	55.4
	Total	**92**	**100.0**

Source: Primary Data (2025)

According to table 4.5 above, the study found out that, 55.4% were data entrants, 17.4% worked under Medical records assistants, 15.2% worked under M&E technical officers, 6.5% worked under Medical records officers, and 5.4% worked under Ward in-charges. This implies that all the major departments were represented in this study, hence providing relevant information which is adequate for the success of this study.

4.2.6. For how long have you worked with this Public Hospital

Respondents were asked to avail information on their years they worked in Public Hospital and results are shown in table below

Table 4.7: Years worked in Public Hospital

		Frequency	Percent
Valid	Below 1 year	32	34.8
	2-3 years	20	21.7
	5-10 years	40	43.5
	Total	**92**	**100.0**

Source: Primary Data (2025)

Study findings from table 4.7 above revealed that 43.5% had spent 5-10 years working in Public Hospital, 34.8% had spent below 1 year and 21.7% had spent 2-3 years. The study revealed that the respondents had worked in Public Hospital for some good time, hence providing relevant information for this research.

4.3 SECTION B: TO EXAMINE THE EFFECT OF DATA COLLECTION FREQUENCY ON THE QUALITY OF HEALTHCARE SERVICES IN GRADE B AND KITALA HCIII

This section focuses on the first objective of the study which sought to examine the effect of data collection frequency on the quality of healthcare services in Grade B and Kitala HCIII. Tables with frequency and percentages were used to analyze data. The results obtained on each item are presented as follows;

4.3.1 Data on patient care is collected regularly in this facility

Respondents were asked whether data on patient care is collected regularly in this facilityand their responses are presented in table 4.8 below;

Table 4.8: Data on patient care is collected regularly in this facility

		Frequency	Percent
Valid	Strongly Disagree	20	21.7
	Disagree	9	9.8
	Not sure	12	13.0
	Agree	51	55.4
	Total	**92**	**100.0**

Source: primary data(2025)

According to table 4.8 above, majority 55.4% agreed that data on patient care is collected regularly in this facility. This implies that there is an operational data management system in place where patient information is captured, updated and used in real-time to support clinical workflows. This regular collection of patient data enhances service continuity, enables timely interventions, supports accurate health reporting and contributes to efficient patient follow-upin chronic care cases such as HIV/AIDS and tuberculosis where regular documentation is important for treatment adherence and outcome tracking. However, 32% of the total respondents disagreed with the statement that data on patient care is collected regularly in this facilityand 13.8% were not sure.

The findings are in line with Kihuba et al. (2018) emphasized that inconsistent data collection practices in healthcare facilities undermine the reliability of health information systems and hinder effective service delivery. When healthcare workers perceive data collection as poorly managed, it affects their ability to make timely and evidence-based decisions, thus compromising patient safety and organizational performance.(KI-1) asserted that*;* "In some departments, data collection is done routinely and documented properly, but in others, the process is either irregular or not taken seriously. This

inconsistency affects our ability to track patient trends, plan effectively and respond to issues in real time.

4.3.2 Effective budget monitoring ensures resources are used efficiently

The study set out to investigate whether effective budget monitoring ensures resources are used efficiently, and the results obtained are presented, analyzed and in interpreted in table 4.9;

Table 4.9: Effective budget monitoring ensures resources are used efficiently

		Frequency	Percent
Valid	Strongly Disagree	1	1.1
	Disagree	26	28.3
	Not sure	16	17.4
	Agree	42	45.7
	Strongly Agree	7	7.6
	Total	**92**	**100.0**

Source: primary data(2025)

According to table 4.9 above, majority 53.3% agreed effective budget monitoring ensures resources are used efficiently. This implies that most respondents recognize the importance of regular financial oversight in optimizing the use of available resources, minimizing waste and ensuring that funds are allocated appropriately to support healthcare service delivery.However, 29.4% of the total respondents disagreed and 17% were not sure. This indicates that there may be concerns among some staff regarding the effectiveness of budget monitoring which could reflect inconsistencies in oversight or limited involvement in financial management processes.

The findings are in conformity with Kimaro and Nhampossa (2017), who noted that while many healthcare facilities demonstrate strong budget monitoring practices that promote efficient resource utilization.Kimaro &Nhampossa emphasize that without continuous capacity building and transparent financial management, the full benefits of

budget monitoring may not be realized across all departments.These findings are in agreement with the assertion made by (KI-2)informant who stated that effective budget monitoring plays a fundamental role in ensuring that available resources are allocated and utilized appropriately, but emphasized that inconsistent follow-up and limited staff engagement sometimes hinder the full realization of these benefits across all units within the facility.

4.3.3 Frequent data collection improves decision-making in patient treatment.

The study set out to investigate whether frequent data collection improves decision-making in patient treatment, and the results obtained are presented, analyzed and in interpreted in 4.10;

Table 4.10: Frequent data collection improves decision-making in patient treatment

		Frequency	Percent
Valid	Strongly Disagree	2	2.2
	Disagree	22	23.9
	Not sure	26	28.3
	Agree	30	32.6
	Strongly Agree	12	13.0
	Total	**92**	**100.0**

Source: primary data(2025)

According to table 4.10 above, majority 45.6% agreed that frequent data collection improves decision-making in patient treatment. This implies that regular data collection is recognized by most healthcare workers as a valuable practice that enhances the accuracy and timeliness of clinical decisions enabling healthcare providers to identify patient needs promptly, monitor treatment outcomes effectively and adjusts care plans based on up-to-date informationleading to improved quality of patient care and service delivery within the facility.

However, 28.3% of the total respondents were not sure and 25.2% disagreed that with frequent data collection improves decision-making in patient treatment. This means that some healthcare workers either lack clarity on the direct impact of frequent data collection on clinical decision-making or have not observed tangible improvements linked to it in their work environment. The findings of the study are in line with AbouZahr and Boerma (2015) who emphasized that the regular collection and use of quality health data is central to improving patient outcomes and guiding effective clinical decisions. Health systems that institutionalize frequent data collection and ensure its integration into routine patient care are likely to experience improved service delivery, better monitoring of treatment effectiveness and enhanced accountability. (KI-3)asserted that regular data collection plays an important role in improving healthcare service delivery; it enables timely identification of patient needs, facilitates evidence-based decision-making and enhances accountability among healthcare providers. Key informants emphasized that consistent data gathering ensures that emerging trends in patient care are quickly identified and addressed leading to better planning, resource allocation and continuous improvement in treatment protocols.

4.3.4 Health workers use collected data to improve service delivery.

The study set out to investigate whether health workers use collected data to improve service delivery, and the results obtained are presented, analyzed and in interpreted in table 4.11;

Table 4.11: Health workers use collected data to improve service delivery.

		Frequency	Percent
Valid	Strongly Disagree	14	15.2
	Disagree	3	3.3
	Not sure	26	28.3
	Agree	40	43.5
	Strongly Agree	9	9.8

Total	**92**	**100.0**

Source: primary data(2025)

According to table 4.11 above, majority 53.3% agreed health workers use collected data to improve service delivery. This implies that healthcare personnel at Grade B and Kitala HCIII recognize the value of data-driven practices and are actively incorporating data insights into their routine operations. It reflects a culture of informed decision-making where data is not merely collected for reporting purposes but is analyzed and applied to enhance the quality, efficiency, and responsiveness of healthcare services offered to patients.However, 28.3% of the total respondents were not sure and 19% disagreed. This means that a number of health workers lack adequate training on how to interpret and apply collected data and others are not sufficiently involved in data utilization processes. The findings are in line with Ledikwe et al. (2018), who emphasized that effective utilization of health data by frontline health workers contributes to improved service delivery and patient outcomes. The study revealed that when health workers are equipped with the skills and tools to interpret and apply data in real-time, they are likely to make informed decisions that enhance the quality of care. (KI-43)asserted that collected health data plays a role in guiding clinical decisions, allocating resources effectively, and identifying service delivery gaps. Timely access to accurate data enables health workers to respond appropriately to patient needs and to implement corrective measures where service performance is lagging.

4.3.5 Delays in data collection affect service quality negatively.

The study set out to investigate whether Proper budget monitoring supports consistent availability of medicines and supplies, and the results obtained are presented, analyzed and in interpreted in table 4.12;

Table 4.12: Delays in data collection affect service quality negatively

		Frequency	Percent
Valid	Strongly Disagree	2	2.1
	Disagree	17	18.5
	Not sure	21	22.8
	Agree	8	8.7
	Strongly Agree	44	47.8
	Total	**92**	**100.0**

Source: primary data(2025)

According to table 4.12 above, majority 56.5% agreed that delays in data collection affect service quality negatively. This implies that timely data collection is considered essential for ensuring high-quality healthcare service delivery as delays may hinder effective planning, timely interventions and informed decision-making. Most healthcare workers recognize that outdated or late data compromises the ability to respond to patient needs efficiently leading to gaps in care, poor resource allocation and reduced overall performance within the facility. However, 22.8% of the total respondents were not sure, 21.1% disagreed. This indicates that some staff may not directly experience its consequences in their roles. It also reflects inconsistencies in training, communication, suggesting need for increased awareness and capacity building on how real-time data influences healthcare outcomes and service delivery efficiency.These findings are in line with Tara Nutley (2016) who emphasized that timely data collection is important for maintaining high-quality healthcare services. Delays in data gathering can disrupt the feedback loop necessary for continuous service improvement which affects patient outcomes and operational efficiency.

4.3.6 This facility has a schedule for routine data collection

The study set out to investigate whether this facility has a schedule for routine data collection, and the results obtained are presented, analyzed and in interpreted in table 4.13;

Table 4.13: This facility has a schedule for routine data collection

		Frequency	Percent
Valid	Strongly Disagree	14	15.2
	Disagree	33	35.9
	Not sure	20	21.7
	Agree	22	23.9
	Strongly Agree	3	3.3
	Total	**92**	**100.0**

Source: primary data(2025)

According to table 4.13 above, majority 51.1% disagreed that this facility has a schedule for routine data collection. This implies that there is a lack of formalized or consistent timing for data collection activities within the facility which may lead to irregular or incomplete data capture. Such inconsistency hinders effective monitoring and evaluation of healthcare services, making it difficult to identify trends, allocate resources appropriately and make informed decisions to improve patient care.However, 27.2% of the total respondents agreed that the facility has a schedule for routine data collection, indicating that some staff recognizes efforts or systems in place for regular data gathering. While scheduling may not be uniformly implemented or communicated across all departments, there are pockets within the facility where routine data collection practices are acknowledged and possibly followed.(KI-5)revealed that, despite the absence of a formalized and consistently applied schedule for routine data collection across the facility, some units have established regular data gathering practices. This

reflects differences in departmental management and highlights the need for standardized procedures to ensure consistent data collection throughout the entire facility.

4.3.7 Data collection helps track the availability of essential drugs

Respondents were asked whether data collection helps track the availability of essential drugsand their responses are presented in table 4.14 below;

Table 4.14: Data collection helps track the availability of essential drugs

		Frequency	Percent
Valid	Strongly Disagree	20	21.7
	Disagree	9	9.8
	Not sure	12	13.0
	Agree	51	55.4
	Total	**92**	**100.0**

Source: primary data(2025)

According to table 4.14 above, majority of the respondents 55.4% agreed that data collection helps track the availability of essential drugs. This implies that systematic data collection is integral to effective supply chain management within the facility ensuring timely identification of stock levels and potential shortages. Regularly monitoring drug availability helps the health facility to address existing gaps, avoids stockouts and improves patient care outcomes. Data-driven approaches support better planning and procurement processes, minimizing wastage and optimizing resource allocation. However, 32% of the total respondents disagreed with the statement that data collection helps track the availability of essential drugsand 13.8% were not sure. This indicates that some staffs have concerns about the effectiveness or consistency of data collection processes in managing drug supplies. Thereare possible gaps in how data is recorded, communicated, or utilized to inform inventory decisions. This reflects challenges in

delays in data entry, lack of training, or inadequate integration of data systems with procurement activities. The findings are consistent with Kihuba et al. (2018) who assert that ensuring medicines are available at health facilities is crucial towards the provision of quality medical treatment and care. Studies assessing patient satisfactionwith quality of service delivery have reported that availability of medicines among other factors was animportant factor for the patients to seek treatment at health facilities. Ensuring medicines are available to patients/clients at health facilities depends on four functions in the medicine management cycle: selection, procurement, distribution and use.

4.3.8Data frequency is adequate to monitor healthcare quality indicators

The study set out to investigate whether data frequency is adequate to monitor healthcare quality indicators, and the results obtained are presented, analyzed and in interpreted in table 4.15;

Table 4.15: Data frequency is adequate to monitor healthcare quality indicators

		Frequency	Percent
Valid	Strongly Disagree	1	1.1
	Disagree	26	28.3
	Not sure	16	17.4
	Agree	42	45.7
	Strongly Agree	7	7.6
	Total	**92**	**100.0**

Source: primary data(2025)

According to table 4.15 above, majority of the respondents 53.3% generally agreed that data frequency is adequate to monitor healthcare quality indicators.This implies that the current schedule for data collection is perceived as sufficient to provide timely and relevant information needed for evaluating key aspects of healthcare service delivery. Adequate data frequency ensures that any changes or trends in healthcare quality can be identified early, enabling prompt interventions to maintain or improve standards. This confidence among healthcare workers that the data collected regularly is useful for

tracking progress and addressing gaps in patient care. However, 29.4% of the total respondents disagreed and 17% were not sure. This suggests that a subset of staff perceived existing data collection schedules as insufficient to capture timely and comprehensive quality metrics. The disagreement of the respondents reveals potential gaps in communication or understanding regarding the role and effectiveness of current data monitoring practices. (KI-6) revealed that while data collection frequency is considered adequate, there are concerns about the consistency and timeliness of data reporting across departments. Some informants noted challenges related to limited staff capacity and resource constraints which delay data capture and entry. Others highlighted the need for enhanced training on data management to ensure all personnel understand the importance of regular and accurate data collection.

4.3.9 Staff are trained on how to collect and use health data effectively.

The study set out to investigate whether staff are trained on how to collect and use health data effectively, and the results obtained are presented, analyzed and in interpreted in table 4.16;

Table 4.16: Staff is trained on how to collect and use health data effectively

		Frequency	Percent
Valid	Strongly Disagree	2	2.2
	Disagree	22	23.9
	Not sure	26	28.3
	Agree	30	32.6
	Strongly Agree	12	13.0
	Total	**92**	**100.0**

Source: primary data(2025)

According to table 4.16 above, majority 45.6% agreed that staff are trained on how to collect and use health data effectively. This implies that nearly half of the workforce possesses the necessary skills and knowledge to handle health data accurately which is

critical for ensuring data quality and informed decision-making in healthcare service delivery. Proper training equips staff to collect relevant information systematically, minimizing errors and enhancing data reliability. This capacity building promotes a data-driven culture within the facility, enabling timely identification of health trends and resource needs. Such competence among staff can lead to improved patient outcomes and more efficient health system management. However, 28.3% of the total respondents were not sure and 25.2% disagreed. This indicates that the staff has not received adequate instruction on effective data collection and utilization. Such gaps lead to inconsistencies in data quality undermining reliability of health information used for decision-making. This highlights the need for a comprehensive and continuous training program to ensure all staff members are well-equipped to handle health data proficiently.The findings of the study align with Ferranti et al. (2020) which demonstrated that in-service training significantly improved the data management practices of primary healthcare workers. The intervention led to increases in the completeness, accuracy, and timeliness of health data reporting, as well as the utilization of feedback mechanisms. Staff training is acknowledged as an important activity when implementing health information systems (HISs)

4.4 SECTION: C:TO ASSESS HOW REPORTING AND DOCUMENTATION PRACTICES INFLUENCE HEALTHCARE SERVICES IN GRADE B AND KITALA HCIII

This section focuses on the second objective of the study which sought to assess how reporting and documentation practices influence healthcare services in Grade B and Kitala HCIII. Table with frequency and percentages were used to analyze data.

4.4.1 Clear and complete reporting improves coordination among healthcare staff

The study asked respondents whether clear and complete reporting improves coordination among healthcare staff. The results are indicated in table 4.17 below:

Table 4.17: Clear and complete reporting improves coordination among healthcare staff

		Frequency	Percent
Valid	Strongly Disagree	13	14.1

Disagree	20	21.7
Not sure	22	23.9
Agree	27	29.3
Strongly Agree	10	10.9
Total	**92**	**100.0**

Source: primary data(2025)

According to table 4.17 above, majority of the respondents 40.3% generally agreed that clear and complete reporting improves coordination among healthcare staff. This indicates that effective reporting and documentation practices facilitate communication and teamwork within these health facilities. Proper documentation ensures that patient information, treatment plans and follow-up actions are communicated across different healthcare providers, minimizing errors and improving patient care continuity. At Grade B and Kitala HCIII, clear reporting supports better task allocation and resource management which are essential for delivering timely and quality healthcare services. However, 36.1% of the total respondents disagreed and 23.9% were not sure. This indicates that some staff members at Grade B and Kitala HCIII have concerns about the clarity and completeness of reporting. This is because of inconsistent documentation practices or challenges in how reports are managed and shared. Not all staff fully understands or trusts the current reporting system. Improving training and establishing clearer reporting guidelines could help address these issues and strengthen teamwork and service delivery in the facilities.The findings are in line with Alhawsawi, (2021) who assert that documentation and file keeping is a crucial part of scientific practice and it demonstrates the clinician's accountability and records their professional practice and is a formal way of recording theaccountofwhat happened andwhenit cameabout andit often usedto evaluate professional exercise as a section of first-rate assurance mechanisms such

as overall performance reviews, audits and accreditation processes, legislated inspections and essential incident opinions.

4.4.2 Errors in documentation have previously led to poor health outcomes in this facility

The study asked respondents whether errors in documentation have previously led to poor health outcomes in this facility. The results are indicated in table 4.18 below:

Table 4.19: Errors in documentation have led to poor health outcomes in this facility

		Frequency	Percent
Valid	Strongly Disagree	2	2.2
	Disagree	23	25.0
	Not sure	9	9.8
	Agree	50	54.3
	Strongly Agree	8	8.7
	Total	**92**	**100.0**

Source: primary data(2025)

According to table 4.18 above, majority of the respondents 63.3% generally agreed that errors in documentation have previously led to poor health outcomes in this facility.This implies that inaccuracies in record-keeping and reporting are critical concern at Grade B and Kitala HCIII, potentially compromising patient safety and the quality of care. Such errors hinder effective clinical decision-making, disrupt continuity of care and increase risk of medical complications. This prevalence highlight need for improved documentation practices including comprehensive staff training, quality assurance measures and adoption of standardized reporting systems to mitigate errors and enhance healthcare outcomes.However, 27.2% of the respondents disagreed and 9.8% were uncertain about the impact of documentation errors on health outcomes. While majority recognized the negative consequences of poor documentation, some respondents noted to have encountered issues of lack of full awareness of their implications. This calls forthe

need for continuous training at Grade B and Kitala HCIII to ensure consistent and minimize errors that could compromise patient care quality.(KI-7)asserted that accurate and timely documentation plays an important role in improving service delivery, enhancing communication among health workers and supporting evidence-based decision-making within Grade B and Kitala HCIII. The key informants emphasized that consistent reporting practices reduce medical errors and also streamline patient care processes."

4.4.3 Timely documentation helps prevent duplication of healthcare services

The study asked respondents whether timely documentation helps prevent duplication of healthcare services. The results are indicated in table 4.19 below:

Table 4.19: Timely documentation helps prevent duplication of healthcare services

		Frequency	Percent
Valid	Strongly Disagree	16	17.4
	Disagree	15	16.3
	Not sure	13	14.1
	Agree	38	41.3
	Strongly Agree	10	10.9
	Total	**92**	**100.0**

Source: primary data (2025)

According to table 4.19 above, majority of the respondents 52.2% generally agreed that timely documentation helps prevent duplication of healthcare services at Grade B and Kitala HCIII. This implied that access to timely healthcare documentation promotes better communication and dissemination of information between members of the multi-professional team, access to timely healthcare documentation supports clinical teaching of medical and paramedical students. Timely documentation helps improve accountability in health care delivery, timely documentation promotes better communication and dissemination of information among members of the health team and timely

documentation supports effective clinical judgment.However, 33.7% of the total respondents disagreed that timely documentation helps prevent duplication of healthcare services. Complete healthcare documentation shows how decisions were made relating to thepatient's care, timely documentation ease access to healthcare documentation makes thecontinuity of care and timely documentation easy access to healthcare documentation supports clinical audit.The findings are in line with research carried out by Andualem, et al, (2019) who assert that Inadequacy or lack of timely updating and recording of health-related information in medical records do occur in various healthcare settings, which can lead to several issues, which can compromise the quality and continuity of care. Timely documentation among clinical staff, which facilitates diagnosis and treatment, communicates pertinent information to the other caregivers to ensure patient safety, reduce medical error and serves as an important medico-legal function in risk management.

4.4.4 Health workers consistently record patient information during every visit

The study asked respondents whether health workers consistently record patient information during every visit. The results are indicated in table 4.20 below:

Table 4.20: Health workers consistently record patient information during every visit

		Frequency	Percent
Valid	Strongly Disagree	12	13.0
	Disagree	30	32.6
	Not sure	29	31.5
	Agree	21	22.8
	Total	**92**	**100.0**

Source: primary data(2025)

According to table 4.20 above, majority of the respondents 54.3% generally agreed that health workers consistently record patient information during every visit at Grade B and Kitala HCIII.

This implies that Grade B and Kitala HCIII have established a relatively strong culture of clinical documentation where health workers recognize the importance of maintaining up-to-date and accurate patient records. Consistent recording of patient information during each visit supports continuity of care, facilitates follow-up treatment and minimizes the risk of errors in medication. It also enhances the ability of healthcare providers to track patient history, assess treatment effectiveness and make informed decisions. However, 30.9% of the total respondents were disagreement that health workers consistently record patient information during every visit and 31.5% were not sure.This means that there are inconsistencies in documentation practices at Grade B and Kitala HCIII due to factors such as inadequate supervision, high patient volumes, or limited training on proper record-keeping procedures.(KI-8) reported that documentation practices at both Grade B and Kitala HCIII are hindered by lack of standardized tools, limited staff training and high patient loads. They revealed that while some health workers are diligent in recording patient information, others either delay entries or omit crucial details due to time constraints or fatigue. One informant noted that inconsistencies in reporting stem from inadequate monitoring and supervision, which affects the accuracy and reliability of patient records. Another observed that the absence of regular refresher training has led to varying interpretations of reporting guidelines across departments.

4.4.5 Documentation practices are reviewed to ensure compliance with guidelines

The study asked respondents whether documentation practices are reviewed to ensure compliance with guidelines. The results are indicated in table 4.21 below:

Table 4.21:Documentation practices are reviewed to ensure compliance with guidelines

		Frequency	Percent
Valid	Strongly Disagree	4	4.3
	Disagree	5	5.4
	Not sure	24	26.1
	Agree	27	29.3
	Strongly Agree	32	34.8
	Total	**92**	**100.0**

Source: primary data(2025)

According to table 4.21 above, majority of the respondents 64.3% generally agreed that documentation practices are reviewed to ensure compliance with guidelines at Grade B and Kitala HCIII. This implies that the two health facilities have instituted mechanisms to periodically assess the accuracy and completeness of records which is a critical step in promoting accountability and maintaining quality standards. Regular review of documentation practices suggests that management is actively monitoring data integrity and ensuring that reporting aligns with institutional health guidelines. It reflects an organizational culture that values compliance, quality assurance, and the use of accurate information in decision-making processes. However, 9.7% of the total respondents disagreed and 26.1% were not sure. While there is a general perception of systematic documentation review, some staff members lack awareness of these processes in their implementation. If staffs are unconvinced about the review mechanisms, it undermines the effectiveness of quality assurance efforts and affects the reliability of health data used for planning and service delivery.(KI-9), argued that while documentation policies and procedures are in place, there is limited follow-up by supervisors to ensure adherence.

Some health workers expressed concern that reviews are reactive, only conducted after errors occur rather than being part of a routine quality assurance system. This, they noted, sometimes leads to inconsistencies in how patient records are maintained across departments, potentially affecting the continuity of care and decision-making based on incomplete or outdated information.

4.4.6 Reporting systems in this facility support fast and easy access to patient records

The study asked respondents whether reporting systems in this facility support fast and easy access to patient records. The results are indicated in table 4.22 below:

Table 4.22: Reporting systems in this facility support fast and easy access to patient records

		Frequency	Percent
Valid	Strongly Disagree	5	5.4
	Disagree	26	28.3
	Not sure	24	26.1
	Agree	23	25.0
	Strongly Agree	14	15.2
	Total	**92**	**100.0**

Source: primary data (2025)

According to table 4.22 above, majority of the respondents 40.2% generally agreed that reporting systems in this facility support fast and easy access to patient records at Grade B and Kitala HCIII. This implies that Grade B and Kitala HCIII have adopted relatively efficient reporting and documentation mechanisms that facilitate timely retrieval of patient information. Such systems improve clinical decision-making, enhance service coordination among departments and reduce delays in patient care delivery. Efficient access to records is important in managing chronic illnesses and emergency cases where accurate patient history is essential. Therefore, this means that the health centers are making commendable efforts toward digital or well-organized manual record systems

that positively impact the quality of healthcare services. However, 33.7% of the total respondents disagreed and 26.1% were not sure. This therefore, implies that healthcare workers at Grade B and Kitala HCIII perceive the reporting systems as being consistently effective or user-friendly. This also reflects inconsistencies in system use across departments, inadequate staff training, or delays in updating records which hinders prompt decision-making, reduce the efficiency of patient care and contribute to service delivery. The results are in line with (IFRC, 2011) argued that recognizing the value of patient record management is crucial before getting into the specifics of Patient Record Management Systems. Mishandled electronic health data may lead to medical blunders that can be fatal, affecting thousands of people each year. A World Health Organization research states that drug mistakes alone are a contributing factor. Not only a recording tool but also an efficient tracing system and the best consultation tool for patients.

4.4.7Quality of healthcare services has improved due to improved record-keeping

The study asked respondents whether the quality of healthcare services has improved due to improved record-keeping practices. The results are indicated in table 4.23 below:

Table 4.23: Quality of healthcare services has improved due to improved record-keeping

		Frequency	Percent
Valid	Strongly Disagree	13	14.1
	Disagree	20	21.7
	Not sure	22	23.9
	Agree	27	29.3
	Strongly Agree	10	10.9
	Total	**92**	**100.0**

Source: primary data(2025)

According to table 4.23 above, majority of the respondents 40.3% generally agreed that quality of healthcare services has improved due to improved record-keepingat Grade B

and Kitala HCIII. This implies that better documentation and systematic record maintenance contribute to accurate patient tracking, timely follow-up and informed clinical decisions. The availability of reliable data facilitates better coordination among healthcare providers, minimizes medical errors and strengthens accountability in service delivery. Improved record-keeping appears to play a significant role in enhancing the efficiency, responsiveness and quality of healthcare services within the two facilities. However, 36.1% of the total respondents disagreed and 23.9% were not sure. This indicates that a number of healthcare workers are unaware of tangible improvements resulting from record-keeping practices. (KI-10) stated that proper record-keeping has played a vital role in streamlining service delivery in managing patient histories and follow-up care. With organized and up-to-date records, health workers at both Grade B and Kitala HCIII are able to make informed decisions, avoid treatment errors and reduce service delays. The key informant further noted that when records are easily accessible and accurately maintained, it enhances coordination among departments, improves referrals, and contributes to more accountable and efficient healthcare provision.

4.4.8Reporting tools are user-friendly and promote efficiency in healthcare delivery

The study asked respondents whether reporting tools are user-friendly and promote efficiency in healthcare delivery. The results are indicated in table 4.24 below:

Table 4.24: Reporting tools are user-friendly and promote efficiency in healthcare delivery

		Frequency	Percent
Valid	Strongly Disagree	2	2.2
	Disagree	23	25.0
	Not sure	9	9.8
	Agree	50	54.3
	Strongly Agree	8	8.7

Total	**92**	**100.0**

Source: primary data(2025)

According to table 4.24 above, majority of the respondents 63.3% generally agreed that reporting tools are user-friendly and promote efficiency in healthcare delivery. Though, 27.2% of the total respondents disagreed and 9.8% were not sure. This implies that the majority of health workers at Grade B and Kitala HCIII find the reporting tools accessible and well-structured to support their day-to-day tasks, which in turn promotes efficiency in delivering healthcare services. The user-friendly nature of these tools likely facilitates timely data entry, minimizes reporting errors, and enhances decision-making processes. However, the fact that 27.2% disagreed and 9.8% were uncertain suggests that there may still be gaps in tool usability or training. Although majority of health workers at Grade B and Kitala HCIII acknowledged that the reporting tools are user-friendly and enhance efficiency in healthcare delivery, the existence of some respondents who either disagreed or were unsure reveals inconsistencies in the actual experience or utilization of these tools. This indicates that while the system has merits, there may be gaps in implementation, accessibility, or understanding. Therefore, there is the need for continued improvement in the reporting infrastructure, targeted capacity building and regular feedback mechanisms to ensure that all healthcare workers can equally benefit from and effectively use the available tools.

4.4.9Regular reporting helps in monitoring health trends and outbreaks

The study asked respondents whether effective planning allocates resources strategically to meet service demands. The results are indicated in table 4.25 below:

Table4.25: Regular reporting helps in monitoring health trends and outbreaks

	Frequency	**Percent**

Valid	Strongly Disagree	16	17.4
	Disagree	15	16.3
	Not sure	13	14.1
	Agree	38	41.3
	Strongly Agree	10	10.9
	Total	**92**	**100.0**

Source: primary data(2025)

According to table 4.25 above, majority of the respondents 52.2% generally agreed that regular reporting helps in monitoring health trends and outbreaks. This implied that regular and systematic documentation enables health workers at Grade B and Kitala HCIII to detect patterns in patient data, track disease progression and respond swiftly to emerging health threats. The ability to monitor health trends is important in improving preparedness and informing timely interventions, such as resource allocation and patient care strategies. Regular reporting not only strengthens routine surveillance mechanisms but also supports evidence-based decision-making, contributing to improved public health outcomes within the two facilities.However, 33.7% of the total respondents disagreed with the statement. This indicates that some healthcare staff at Grade B and Kitala HCIII do not observe the tangible benefits of reporting practices where such data is utilized. This reflects limited awareness of how routine reporting contributes to outbreak detection and health trend analysis.The findings are in line with research carried out by Kasaye et al. (2022) who established that consistent and accurate health reporting enhances the ability of health facilities to detect emerging disease patterns, allocate resources efficiently and implement timely interventions. Healthcare systems with healthy reporting frameworks are resilient to public health emergencies and better positioned to deliver quality care.(KI-11)asserted that regular and accurate reporting improves the responsiveness of healthcare interventions and promotes accountability

among health workers. When staffs are consistent in documenting patient data and submitting timely reports, it becomes easier for facility managers to identify service gaps, track disease patterns and make evidence-based decisions.

4.5 SECTION D:TO INVESTIGATE THE EFFECT OF STAKEHOLDER FEEDBACK ON HEALTHCARE SERVICES IN GRADE B AND KITALA HCIII

This section focuses on the third objective of the study which sought to investigate the effect of stakeholder feedback on healthcare services in Grade B and Kitala HCIII.Table with frequency and percentages were used to analyze data.

4.5.1 Patients are encouraged to give feedback about the care they receive

The study asked respondents whether Patients are encouraged to give feedback about the care they receive. The results are indicated in table 4.26 below:

Table 4.26: Patients are encouraged to give feedback about the care they receive

		Frequency	Percent
Valid	Disagree	33	35.9
	Not sure	7	7.6
	Agree	52	56.5
	Total	92	100.0

Source: primary data(2025)

According to table 4.26 above, majority of the respondents 56.5% generally agreed that Patients are encouraged to give feedback about the care they receive. However, 35.9% of the total respondents disagreed and 7.6% were not sure. This implies that encouraging patients to share their experiences allows healthcare providers to assess service delivery from the recipient's perspective, thereby identifying service gaps, inefficiencies, or areas of patient dissatisfaction. In both facilities, when patients are encouraged to give feedback about the care they receive, it promotes a culture of transparency and accountability and this leads to actionable insight that enhance clinical care,

communication, and responsiveness to patient needs. According to Leonidou et al. (2020), active stakeholder involvement through structured feedback systems like suggestion boxes, exit interviews or community health dialogues is associated with improved trust in health systems and increased patient satisfaction. (KI-12)asserted that many of the service improvements in Kitala HCIII such as better queue management and respectful communication from staff were a direct result of consistent patient feedback during community engagement forums. At Grade B facility, management has introduced quarterly service reviews with patient representatives, leading to more patient-centered service adjustments

4.5.2 Stakeholder feedback has led to changes in how services are delivered at this facility The study asked respondents whether stakeholder feedback has led to changes in how services are delivered at this facility.The results are indicated in table 4.27 below:

Table 4.27: Stakeholder feedback has led to changes in how services are delivered

		Frequency	Percent
Valid	Strongly Disagree	18	19.6
	Disagree	16	17.4
	Not sure	15	16.3
	Agree	43	46.7
	Total	**92**	**100.0**

Source: primary data(2025)

According to table 4.27 above, majority of the respondents 46.7% agree that stakeholder feedback has led to changes in how services are delivered at this facility. However, 16.3% of the total respondents were not sure and 37% disagreed. This implies that stakeholder feedback has influenced the way healthcare services are delivered in both Grade B and Kitala HCIII facilities. Engaging stakeholdersparticularly patients, caregivers, local leaders and community health workershas created a responsive mechanism through

which service delivery can be tailored to meet community needs effectively. At Kitala HCIII, for example, several operational adjustments were made following repeated complaints from patients about long waiting times and insufficient privacy during consultations. In response, the facility management reorganized patient flow systems and introduced partitions in examination rooms to enhance confidentiality.The findings are in line with research carried out by Kujala et al. (2022) who emphasized that systematic stakeholder feedback leads to measurable improvements in service delivery when healthcare institutions integrate such feedback into planning and operational decision-making. (KI-13)asserted that feedback collected during quarterly stakeholder meetings prompted the recruitment of additional nursing staff and the reallocation of duties to reduce service bottlenecks, especially during antenatal care days. Similarly, at Grade B health facility, feedback mechanisms such as suggestion boxes and health management committee dialogues have informed changes in drug dispensing protocols and the introduction of triage systems for emergency cases. These reforms have not only improved efficiency but also enhanced patient satisfaction and trust in the healthcare system.

4.5.3 Feedback from the community is considered when making decisions about healthcare

The study asked respondents whether compliance monitoring verifies adherence to standards, ensuring consistent service quality. The results are indicated in table 4.28 below:

Table 4.28: Feedback from the community is considered when making decisions about healthcare

		Frequency	Percent
Valid	Strongly Disagree	3	3.3
	Disagree	47	51.1
	Not sure	18	19.6
	Agree	15	16.3
	Strongly Agree	9	9.8
	Total	**92**	**100.0**

Source: primary data(2025)

According to table 4.28 above, majority of the respondents 54.4% disagreed that Feedback from the community is considered when making decisions about healthcare priorities. This reveals that despite existing feedback mechanisms in both Grade B and Kitala HCIII, there is a prevailing perception among community members that their voices are not meaningfully incorporated into the decision-making process. Feedback from the community is considered when making decisions about healthcare especially during planning and resource allocation exercises. For example, community complaints about the irregular availability of essential drugs led to the implementation of stock monitoring and procurement timelines. These approaches ensure that healthcare decisions are grounded in the lived realities and expressed priorities of the people being served. However, 26.1% of the total respondents agreed and 19.6% were not sure suggesting that a few stakeholders have observed instances where their feedback influenced decisions possibly in areas like drug availability or minor facility improvements. Community involvement in healthcare priority setting is increasingly recognized as essential for improving health outcomes and ensuring that services align with the needs and preferences of the population.According to Mitton et al. (2007), public engagement in health-system priority setting enhances legitimacy, transparency and accountability of decision-making processes.

4.5.4 Healthcare workers respond positively to constructive feedback from patients and the public The study asked respondents whether healthcare workers respond positively to constructive feedback from patients and the public.The results are indicated in table 4.29 below:

Table 4.29: Healthcare workers respond positively to constructive feedback from patients

		Frequency	Percent
Valid	Disagree	2	2.1
	Not sure	9	9.6
	Agree	23	24.5
	Strongly Agree	58	61.7
	Total	**92**	**100.0**

Source: primary data(2025)

According to table 4.29 above, majority of the respondents 86.2% generally agreed that healthcare workers respond positively to constructive feedback from patients and the public. However, 9.6% of the total respondents were not sure and 2.1% disagreed.An important aspect of effective healthcare service delivery is how healthcare workers respond to feedback from patients and the broader community. Healthcare workers in both Grade B and Kitala HCIII generally respond positively to constructive feedback from patients and the public. This promotes an environment conducive to continuous improvement where staffs are willing to adapt practices and address concerns raised by service users.Valuing patient input, healthcare workers contribute to enhanced trust, improved communication and better health outcomes. Nonetheless, sustained positive responses require supportive institutional policies that encourage openness, training in patient-centered care and mechanisms for monitoring feedback outcomes. In line with Greco et al. (2017) found that positive feedback can lead to short-term emotional changes such as increased motivation and improved psychological well-being among healthcare

workers. Feedback can result in work-related changes including enhanced performance and staff retention.

4.5.5 The facility has accessible channels for collecting feedback.

The study asked respondents whether the facility has accessible channels (e.g., suggestion boxes, surveys) for collecting feedback. The results are indicated in table 4.30 below:

Table 4.30: The facility has accessible channels for collecting feedback.

		Frequency	Percent
Valid	Disagree	16	17.4
	Not sure	27	29.3
	Agree	49	53.3
	Total	**92**	**100.0**

Source: primary data(2025)

According to table 4.30 above, majority of the respondents 53.3% generally agreed that the facility has accessible channels (e.g., suggestion boxes, surveys) for collecting feedback. However, 29.3% of the total respondents were not sure and 17.4% disagreed. The availability of accessible channels for collecting stakeholder feedback is a fundamental factor in strengthening participatory healthcare delivery. In both Grade B and Kitala HCIII, the facilities have put in place accessible mechanismssuch as suggestion boxes, patient satisfaction surveys, community dialogue meetings and health unit management committee engagementsto gather feedback from patients and the wider public. These channels are intended to create a two-way communication flow between service providers and beneficiaries allowing healthcare managers to identify issues, monitor service quality and tailor interventions based on actual community needs.However, while the presence of these channels is a positive step, the effectiveness

of these tools depends on how frequently they are used and whether the feedback received is acted upon. The findings above are in conformity with research carried out by Ochieng et al. (2023) asserting that while many healthcare providers in Tanzania reported the presence of suggestion boxes, a number of patients were unaware of their existence or perceived them as ineffective due to lack of response and fear of retaliation.(KI-16)revealed that although suggestion boxes are available and surveys are occasionally administered, there is limited follow-through in communicating outcomes back to the community. This gap leads to skepticism about whether the feedback provided has any real influence on service delivery.

4.5.6 Stakeholder feedback helps to identify service gaps and areas needing improvement The study asked respondents whether stakeholder feedback helps to identify service gaps and areas needing improvement. The results are indicated in table 4.31 below:

Table 4.31: Stakeholder feedback helps to identify service gaps needing improvement

		Frequency	Percent
Valid	Strongly Disagree	22	23.9
	Disagree	10	10.9
	Not sure	8	8.7
	Agree	23	25.0
	Strongly Agree	29	31.5
	Total	**92**	**100.0**

Source: primary data(2025)

According to table 4.31 above, majority of the respondents 56.3% generally agreed that stakeholder feedback helps to identify service gaps and areas needing improvement. Stakeholder feedback is instrumental in identifying service gaps and informing improvements in healthcare delivery. Through a structured process involving the

proposal, rating, and revision of potential knowledge-to-care gaps, the stakeholders identified nine key priorities for enhancing the quality and value of critical care services.In both Grade B and Kitala HCIII, stakeholder engagement through tools such as suggestion boxes, community forums and periodic surveys has proven instrumental in revealing deficiencies in service provision. Stakeholder feedback helps to identify service gaps needing improvement, such as delayed outpatient services, medicine stock-outs, staff shortages and lack of patient privacy. For example, feedback from patients at Kitala HCIII highlighted persistent challenges in maternal care which prompted the reallocation of midwifery personnel and the introduction of more structured antenatal schedules.These findings are in line with Natangelo (2017) which demonstrated that engaging diverse stakeholdersincluding frontline healthcare workers, managers and oversight committeesled to identification of nine priority areas requiring service improvements across intensive care units in Canada. (KI-17)*said that;*

> A key informant confirmed that repeated community complaints about inconsistent drug availability led to a facility-level audit of supply chain practices, resulting in more regular ordering and improved stock management. These adjustments emphasize how patient voices can directly influence operational improvements when feedback is systematically gathered and acted upon.

4.5.7 Feedback from stakeholders contributes to better relationships between staff

The study asked respondents whether feedback from stakeholders contributes to better relationships between staff and the community. The results are indicated in table4.32 below:

Table 4.32: Feedback from stakeholders contributes to better relationships between staff

	Frequency	Percent

Valid	Strongly Disagree	12	13.0
	Disagree	21	22.8
	Not sure	16	17.4
	Agree	43	46.7
	Total	**92**	**100.0**

Source: primary data(2025)

According to table 4.32 above, majority of the respondents 46.7% generally agreed that feedback from stakeholders contributes to better relationships between staff and the community. However, 17.4% of the total respondents were not sure and 36.0% disagreed. Stakeholder feedback serves not only as a mechanism for service improvement but also as a catalyst for strengthening relationships between healthcare providers and the communities they serve. Feedback from stakeholders contributes to better relationships between staff and the community by promoting dialogue, mutual understanding, and trust. In both Grade B and Kitala HCIII, the act of listening to community concerns and responding to them has helped to humanize healthcare interactions and reduce tensions often caused by miscommunication or unmet expectations. For example, after receiving community feedback about rude behavior from some staff, facility managers at Kitala HCIII organized refresher training sessions in customer care and patient-centered communication. A study by King et al, (2020) in Tanzania revealed that while many healthcare providers reported the presence of suggestion boxes, a significant number of patients were unaware of their existence or found them ineffective due to lack of response and fear of retaliation. When stakeholders feel heard and see tangible actions resulting from their input, it builds trust and collaboration, leading to improved healthcare outcomes and strengthened community relations.(KI-18)emphasized that when patients see their input valued and acted upon, they become more cooperative and appreciative,

which in turn enhances morale among health workers. This reciprocal dynamic creates a more supportive and empathetic healthcare environment.

4.5.8Healthcare services have improved due to stakeholder engagement and feedback

The study asked respondents whether healthcare services have improved due to stakeholder engagement and feedback;the results are indicated in table 4.33 below:

Table 4.33: Healthcare services have improved due to stakeholder engagement &feedback

		Frequency	Percent
Valid	Disagree	16	17.4
	Not sure	27	29.3
	Agree	49	53.3
	Total	**92**	**100.0**

Source: primary data(2025)

According to table 4.33 above, majority of the respondents 53.3% generally agreed that healthcare services have improved due to stakeholder engagement and feedback. However, 29.3% of the total respondents were not sure and 17.4% disagreed. There is growing evidence that healthcare services in Grade B and Kitala HCIII have improved as a result of stakeholder engagement and community feedback in areas such as patient waiting time, drug availability and staff responsiveness. Through community dialogues and feedback forums, stakeholders have expressed concerns that directly informed management decisions. For example at Grade B facility, regular feedback from patients regarding long queues and inefficient triage led to the introduction of a patient flow system that prioritizes the elderly and emergency cases. In Kitala HCIII, complaints about inadequate sanitation facilities prompted upgrades to the outpatient department and water access points.This is supported by findings from Stelfox et al. (2015), who

conducted a comprehensive stakeholder-driven study across 16 intensive care units. Through structured knowledge-to-care gap analysis, frontline staff, administrators and community stakeholders identified and prioritized key areas needing improvement. Field interview responses revealed that community members and key stakeholders perceive stakeholder feedback as a valuable tool for enhancing healthcare service delivery. Respondents noted that while some concerns take longer to address due to resource constraints, many issues raised such as staff attitudes, medicine stock-outs, and poor sanitation have been acknowledged and acted upon by facility leadership. For example, one community health worker stated that repeated complaints about unprofessional conduct by some nurses led to the organization of a customer care workshop at Kitala HCIII

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter contains a summary of the findings, conclusion and recommendations to the variables therein with the objective of remedying theeffect Monitoring Practices and Healthcare services in Public Hospitals in Uganda; a case of Entebbe Grade B Hospital and Kitala Health Center III. Using computer packages like statistical packages for social

scientist tables, the study has made important findings, which are the basis of the policy recommendations entailed in this chapter.

5.1 Summary of findings

The study was about effect Monitoring Practices and Healthcare services in Public Hospitals in Uganda; a case of Entebbe Grade B Hospital and Kitala Health Center III. The study obtained findings on the following key objectives; examine the effect of data collection frequency on the quality of healthcare services in Grade B and Kitala HCIII, assess how reporting and documentation practices influence healthcare services in Grade B and Kitala HCIII and investigate the effect of stakeholder feedback on healthcare services in Grade B and Kitala HCIII. The findings of this empirical study will, among other things, contribute to knowledge in this area under study.

5.1.1 Findings on the effect of data collection frequency on the quality of healthcare services in Grade B and Kitala HCIII.

According to study findings, majority 55.4% agreed that data on patient care is collected regularly in this facility. This regular collection of patient data enhances service continuity, enables timely interventions, supports accurate health reporting and contributes to efficient patient follow-upin chronic care cases such as HIV/AIDS and tuberculosis where regular documentation is important for treatment adherence and outcome tracking. However, 32% of the total respondents disagreed with the statement that data on patient care is collected regularly in this facilityand 13.8% were not sure. This means some staff may be experiencing irregularities in data collection practices due to gaps in staffing, inadequate training, lack of data collection tools, or weak supervision. The findings are in line with Kihuba et al. (2018) emphasized that inconsistent data

collection practices in healthcare facilities undermine the reliability of health information systems and hinder effective service delivery.

Field findings revealed that, majority 53.3% agreed effective budget monitoring ensures resources are used efficiently. However, 29.4% of the total respondents disagreed and 17% were not sure. This indicates that there may be concerns among some staff regarding the effectiveness of budget monitoring which could reflect inconsistencies in oversight or limited involvement in financial management processes.The findings are in conformity with Kimaro and Nhampossa (2017), who noted that while many healthcare facilities demonstrate strong budget monitoring practices that promote efficient resource utilization.Without continuous capacity building and transparent financial management, the full benefits of budget monitoring may not be realized across all departments.

Results of findings, majority 45.6% agreed that frequent data collection improves decision-making in patient treatment. However, 28.3% of the total respondents were not sure and 25.2% disagreed that with frequent data collection improves decision-making in patient treatment. This means that some healthcare workers either lack clarity on the direct impact of frequent data collection on clinical decision-making or have not observed tangible improvements linked to it in their work environment.

The findings of the study are in line with AbouZahr and Boerma (2015) who emphasized that the regular collection and use of quality health data is central to improving patient outcomes and guiding effective clinical decisions. Health systems that institutionalize frequent data collection and ensure its integration into routine patient care are likely to experience improved service delivery, better monitoring of treatment effectiveness and enhanced accountability.

Field results revealed that, majority 53.3% agreed health workers use collected data to improve service delivery. This reflects a culture of informed decision-making where data is not merely collected for reporting purposes but is analyzed and applied to enhance the quality, efficiency, and responsiveness of healthcare services offered to patients.However, 28.3% of the total respondents were not sure and 19% disagreed. This means that a number of health workers lack adequate training on how to interpret and apply collected data and others are not sufficiently involved in data utilization processes. The findings are in line with Ledikwe et al. (2018), who emphasized that effective utilization of health data by frontline health workers contributes to improved service delivery and patient outcomes. When health workers are equipped with the skills and tools to interpret and apply data in real-time, they will make informed decisions that enhance the quality of care.

5.1.2 Findings on how reporting and documentation practices influence healthcare services in Grade B and Kitala HCIII

Results from the field on the second objective revealed that, majority 40.3% agreed that effective reporting and documentation practices facilitate communication and teamwork within these health facilities. Proper documentation ensures that patient information, treatment plans and follow-up actions are communicated across different healthcare providers, minimizing errors and improving patient care continuity. At Grade B and Kitala HCIII, clear reporting supports better task allocation and resource management which are essential for delivering timely and quality healthcare services. However, 36.1% of the total respondents disagreed and 23.9% were not sure. This indicates that some staff members at Grade B and Kitala HCIII have concerns about the clarity and completeness

of reporting. This is because of inconsistent documentation practices or challenges in how reports are managed and shared. The findings are in line with Alhawsawi, (2021) who assert that documentation and file keeping is a crucial part of scientific practice and it demonstrates the clinician's accountability and records their professional practice and is a formal way of recording theaccountofwhat happened andwhenit cameabout andit usedto evaluate professional exercise as a section of first-rate assurance mechanisms.

According to findings from the field, majority of the respondents 63.3% agreed that errors in documentation have previously led to poor health outcomes in this facility.Inaccuracies in record-keeping and reporting are critical concern at Grade B and Kitala HCIII, potentially compromising patient safety and the quality of care. Such errors hinder effective clinical decision-making, disrupt continuity of care and increase risk of medical complications.However, 27.2% of the respondents disagreed and 9.8% were uncertain about the impact of documentation errors on health outcomes. While majority recognized the negative consequences of poor documentation, some respondents noted to have encountered issues of lack of full awareness of their implications. This calls forthe need for continuous training at Grade B and Kitala HCIII to ensure consistent and minimize errors that could compromise patient care quality.

According to study findings from the field, majority 52.2% agreed that timely documentation helps prevent duplication of healthcare services at Grade B and Kitala HCIII. Access to timely healthcare documentation promotes better communication and dissemination of information between members of the multi-professional team, access to timely healthcare documentation supports clinical teaching of medical and paramedical students. However, 33.7% of the total respondents disagreed that timely documentation

helps prevent duplication of healthcare services. The findings are in line with research carried out by Andualem, et al, (2019) who assert that Inadequacy or lack of timely updating and recording of health-related information in medical records do occur in various healthcare settings, which can lead to several issues, which can compromise the quality and continuity of care. Timely documentation among clinical staff, which facilitates diagnosis and treatment, communicates pertinent information to the other caregivers to ensure patient safety, reduce medical error and serves as an important medico-legal function in risk management.

According to results from the field, majority 40.2% agreed that reporting systems in this facility support fast and easy access to patient records at Grade B and Kitala HCIII. Grade B and Kitala HCIII have adopted relatively efficient reporting and documentation mechanisms that facilitate timely retrieval of patient information. Efficient access to records is important in managing chronic illnesses and emergency cases where accurate patient history is essential. However, 33.7% of the total respondents disagreed and 26.1% were not sure. This therefore, implies that healthcare workers at Grade B and Kitala HCIII perceive the reporting systems as being consistently effective or user-friendly. This also reflects inconsistencies in system use across departments, inadequate staff training, or delays in updating records which hinders prompt decision-making, reduce the efficiency of patient care and contribute to service delivery. The results are in line with (IFRC, 2011) argued that recognizing the value of patient record management is crucial before getting into the specifics of Patient Record Management Systems. Mishandled electronic health data may lead to medical blunders that can be fatal, affecting thousands of people each year. A World Health Organization research states that drug mistakes alone

are a contributing factor. Not only a recording tool but also an efficient tracing system and the best consultation tool for patients.

Accordingly, majority 40.3% agreed that quality of healthcare services has improved due to improved record-keepingat Grade B and Kitala HCIII. Better documentation and systematic record maintenance contribute to accurate patient tracking, timely follow-up and informed clinical decisions. Improved record-keeping appears to play a significant role in enhancing the efficiency, responsiveness and quality of healthcare services within the two facilities. However, 36.1% of the total respondents disagreed and 23.9% were not sure.

5.1.3 Findings on the effect of stakeholder feedback on healthcare services in Grade B and Kitala HCIII

According to study findings, majority of the respondents 56.5% agreed that Patients are encouraged to give feedback about the care they receive. However, 35.9% of the total respondents disagreed and 7.6% were not sure. Encouraging patients to share their experiences allows healthcare providers to assess service delivery from the recipient's perspective, thereby identifying service gaps, inefficiencies, or areas of patient dissatisfaction. In both facilities, when patients are encouraged to give feedback about the care they receive, it promotes a culture of transparency and accountability and this leads to actionable insight that enhance clinical care, communication, and responsiveness to patient needs. According to Leonidou et al. (2020), active stakeholder involvement through structured feedback systems like suggestion boxes, exit interviews or community health dialogues is associated with improved trust in health systems and increased patient satisfaction

According to results from the field, majority 46.7% agree that stakeholder feedback has led to changes in how services are delivered at this facility. However, 16.3% of the total respondents were not sure and 37% disagreed. This implies that stakeholder feedback has influenced the way healthcare services are delivered in both Grade B and Kitala HCIII facilities. Engaging stakeholdersparticularly patients, caregivers, local leaders and community health workershas created a responsive mechanism through which service delivery can be tailored to meet community needs effectively. At Kitala HCIII, for example, several operational adjustments were made following repeated complaints from patients about long waiting times and insufficient privacy during consultations.The findings are in line with research carried out by Kujala et al. (2022) who emphasized that systematic stakeholder feedback leads to measurable improvements in service delivery when healthcare institutions integrate such feedback into planning and operational decision-making.

Results of findings from the field, majority 54.4% disagreed that Feedback from the community is considered when making decisions about healthcare priorities. This reveals that despite existing feedback mechanisms in both Grade B and Kitala HCIII, there is a prevailing perception among community members that their voices are not meaningfully incorporated into the decision-making process. Feedback from the community is considered when making decisions about healthcare especially during planning and resource allocation exercises.

However, 26.1% of the total respondents agreed and 19.6% were not sure suggesting that a few stakeholders have observed instances where their feedback influenced decisions possibly in areas like drug availability or minor facility improvements. Community

involvement in healthcare priority setting is increasingly recognized as essential for improving health outcomes and ensuring that services align with the needs and preferences of the population.According to Mitton et al. (2007), public engagement in health-system priority setting enhances legitimacy, transparency and accountability of decision-making processes.

Results revealed that, 86.2% generally agreed that healthcare workers respond positively to constructive feedback from patients and the public. However, 9.6% of the total respondents were not sure and 2.1% disagreed.An important aspect of effective healthcare service delivery is how healthcare workers respond to feedback from patients and the broader community. Healthcare workers in both Grade B and Kitala HCIII generally respond positively to constructive feedback from patients and the public. Nonetheless, sustained positive responses require supportive institutional policies that encourage openness, training in patient-centered care and mechanisms for monitoring feedback outcomes. In line with Greco et al. (2017) found that positive feedback can lead to short-term emotional changes such as increased motivation and improved psychological well-being among healthcare workers.

Field results revealed that, majority 53.3% agreed that the facility has accessible channels (e.g., suggestion boxes, surveys) for collecting feedback. However, 29.3% of the total respondents were not sure and 17.4% disagreed. The availability of accessible channels for collecting stakeholder feedback is a fundamental factor in strengthening participatory healthcare delivery. In both Grade B and Kitala HCIII, the facilities have put in place accessible mechanismssuch as suggestion boxes, patient satisfaction surveys, community dialogue meetings and health unit management committee engagementsto gather

feedback from patients and the wider public. However, while the presence of these channels is a positive step, the effectiveness of these tools depends on how frequently they are used and whether the feedback received is acted upon. The findings above are in conformity with research carried out by Ochieng et al. (2023) asserting that while many healthcare providers in Tanzania reported the presence of suggestion boxes, a number of patients were unaware of their existence or perceived them as ineffective due to lack of response and fear of retaliation.

5.2 Conclusions of the study

The following concessions have been drawn from the relevant major findings of the study;

5.2.1 To examine the effect of data collection frequency on the quality of healthcare services in Grade B and Kitala HCIII.

Based on the findings of the study on the effect of data collection frequency on the quality of healthcare services in Grade B and Kitala HCIII, it is concluded that regular and systematic data collection plays an important role in enhancing the quality of healthcare service delivery. The study revealed that where data on patient care is collected consistently, it contributes to service continuity, informed decision-making and improved treatment outcomes in managing chronic conditions such as HIV/AIDS and tuberculosis. Frequent data collection enables real-time tracking of healthcare indicators, facilitates better monitoring of essential drug availability and supports more responsive and patient-centered services. However, inconsistencies in routine data collection practices were also noted, with some respondents highlighting the absence of formal

schedules and insufficient training in data management. This negatively affects the quality and timeliness of healthcare services.

5.2.2 To assess how reporting and documentation practices influence healthcare services in Grade B and Kitala HCIII

Based on the research findings regarding how reporting and documentation practices influence healthcare services in Grade B and Kitala HCIII, it is concluded that reporting and documentation practices positively influence the quality of healthcare services in Grade B and Kitala HCIII. Clear and timely documentation facilitates coordination, ensures continuity of care, and minimizes duplication of services. Majority of the respondents acknowledged that accurate documentation reduces medical errors and supports effective clinical decision-making. However, the presence of inconsistencies in staff perceptions and practicesdue to insufficient training, lack of awareness or limited access to user-friendly toolsindicates systemic gaps. While some mechanisms for compliance and review exist, not all healthcare workers are aware of or engaged in them. Strengthening documentation culture, system usability and data use feedback loops will be essential to improving service quality, accountability and health outcomes.

5.2.3 To investigate the effect of stakeholder feedback on healthcare services in Grade B and Kitala HCIII

Based on the research findings regarding the effect of stakeholder feedback on healthcare services in Grade B and Kitala HCIII, it is concluded thatstakeholder feedback has contributed to several improvements in service delivery. In both facilities, patients are generally encouraged to provide feedback and healthcare workers respond positively to constructive suggestions. This has helped identify service gaps such as long waiting

times, lack of privacy and stock-outs of essential medicines which in turn have led to changes like improved patient flow systems and better communication.However, the findings also show that in some cases, community feedback is not always considered when making decisions about healthcare priorities. While feedback channels exist, some community members feel that their input is ignored. The study concludes that stakeholder feedback plays a role in identifying problems, improving services and building better relationships between health workers and the community.

5.3 Recommendations for the study

After an extensive review of the researcher's findings, the following recommendations were made for consideration and possible implementation.

5.3.1 To examine the effect of data collection frequency on the quality of healthcare services in Grade B and Kitala HCIII.

The study recommends that the Ministry of Health in collaboration with Grade B and Kitala HCIII management should enforce a standardized schedule for routine data collection across all departments. This should be clearly communicated to staff and integrated into daily workflows.

The study recommends for regular capacity-building sessions should be implemented to equip healthcare workers with the necessary skills to collect, analyze and use health data

effectively. Training modules should cover areas such as data accuracy, interpretation of quality indicators, and integration of data into clinical decision-making to improve service quality.

5.3.2 To assess how reporting and documentation practices influence healthcare services in Grade B and Kitala HCIII

The study recommends that Grade B and Kitala HCIIIleadership should enforce routine audits of documentation and provide monthly feedback sessions to staff. These reviews should assess compliance with reporting standards and use data from reports to improve service planning. Engaging health workers in discussing audit findings can foster accountability and promote a culture of continuous improvement.

The Ministry of Health, in collaboration with Grade B and Kitala HCIII management should implement mandatory and periodic training for all health workers on proper documentation and reporting practices.

These sessions should focus on clarity, accuracy and completeness of records while also educating staff on the implications of poor documentation on patient outcomes and legal accountability.

5.3.3To investigate the effect of stakeholder feedback on healthcare services in Grade B and Kitala HCIII

The study recommends that the existing feedback tools such as suggestion boxes and surveys should be made more visible and user-friendly. This includes clearly labeling them, regularly reminding patients about their purpose, and ensuring that feedback is collected, reviewed, and responded to promptly. Feedback reports should be displayed on notice boards to demonstrate transparency and accountability.

Health facility management at Grade B and Kitala HCIII should establish regular community health forums and include community representatives in health planning meetings. This will ensure that stakeholder feedback is not only collected but also actively used in setting priorities and making decisions that affect service delivery.

5.4 Areas for Further Research

Due to time and research constraints, the research could not exhaust all areas of interest and the following areas should be further researched.

Further research is warranted to investigate the feasibility, adoption and impact of digital platforms on real-time monitoring of service quality and responsiveness in public health settings.

Further research should examine functionality, representativeness and authority of governance structures in driving change from community feedback.

References

Acevedo, G. L., Krause, P., & Mackay, K. (Eds.) (2022). Building better policies: the nuts and bolts of monitoring and evaluation systems. Washington DC, World Bank.

Acevedo, G. L., Rivera, K., Lima, L., & Hwang, H. (Eds.). (2020). Challenges in monitoring and evaluation: An opportunity to institutionalize M&E systems. Fifth Conference of the Latin America and the Caribbean Monitoring and Evaluation Network. Washington DC, World Bank.

Adan, J. (2016). The factors influencing the application of participatory monitoring and evaluation in community-based projects: A case of IDPs in Mogadishu, Somalia (MA Thesis, University of Nairobi).

Agutu, G. (2018). Performance-Based Monitoring and Evaluation for Development Outcomes: A Framework for Developing Countries.

Aiken. (2020). Strengthening Capacity for Monitoring and Evaluation in Uganda: A Results-Based Management Perspective.

Akhu-Zaheya, L., Al-Maaitah, R., & Bany Hani, S. (2018). Quality of nursing documentation: Paper-based health records versus electronic-based health records. J. Clin. Nurs., 27(3–4), e578–e589. https://doi.org/10.1111/jocn.14097

Alhawsawi, M.M. (2021). The accuracy of documented nursing care plan among registered nurses. Innovative Journal of Medical and Health Science.

Amina, M., & Ngugi, L. (2022). Effects of utilization of monitoring and evaluation results on project performance. European Journal of Social Sciences Studies, 7(5), 104–113.

Anderson, A. (2020). An Introduction to Theory of Change. The Evaluation Exchange, Volume XI Number 2, p.12

Andersson, B., Jensen, I. R., Naitore, H., & Christoplos, I. (2024). Final Evaluation of the National Integrated Monitoring and Evaluation System (NIMES) Capacity Development Project (CDP). Sida Decentralized Evaluation 47, Kampala-Uganda.

Andualem, A., Asmamaw, T., & Gedfew, M. (2019). Knowledge, attitude, practice and associated factors towards nursing care documentation among nurses in West Gojjam Zone public hospitals, Amhara Ethiopia. Clinical Journal of Nursing Care and Practice.

Appleton, S. (2018). Problems in measuring changes in poverty over time. IDS Bulletin, 27(1). Brighton, UK: Institute for Development Studies.

Arild, H. O., & Keith, M. (2018). Monitoring and Evaluation for Results: Lessons from Uganda. Capacity Enhancement Briefs; No. 3. World Bank, Washington, DC.

Ayele, S., Gobena, T., & Yadeta, T.A. (2021). Attitude towards documentation and its associated factors among nurses working in public hospitals of Hawassa City Administration, Southern Ethiopia.

Beane, A., Dondorp, A.M., Taqi, A., et al. (2020). CRIT CARE ASIA: Establishing a critical care network in Asia to improve care for critically ill patients in low- and middle-income countries.

Beauty, O. (2020). Knowledge, attitude and practice of health workers towards record keeping of patients' care. Afribary.

Belay, A.Y.N., & R. (2016). Medical documentation practice of health professionals and attitude towards it at University of Gondar Hospital, Gondar, North West Ethiopia. Int J Advanc Appl Sci (IJAAS), 5, 157–162.

Bøgeskov, B. O., & Grimshaw-Aagaard, S. L. S. (2018). Essential task or meaningless burden? Nurses' perceptions of the value of documentation. NJNR, 39, 9–19.

Braa, J., Heywood, A., & Sahay, S. (2022). Improving quality and use of data through data-use workshops: Zanzibar, United Republic of Tanzania. Bulletin of the World Health Organization, 90(5), 379–384.

Burgon. (2018). Monitoring and Evaluating Urban Development Programs – A Handbook for Program Managers and Researchers.

Chapman, A. D. (2015). Principles of data quality. GBIF.

Cruz, A.T., Perry, A.M., Williams, E.A., Graf, J.M., Wuestner, E.R., & Patel, B. (2021). Implementation of goal-directed therapy for children with suspected sepsis in the emergency department.

Debora, T., Adrian, Silaen, M., Nasution, S., & Suyono, T. (2021). Analysis of factors affecting the quality of inpatient medical records at Royal Prima Hospital Medan. International Journal of Health and Pharmaceutical

Declich, S., & Carter, A. (2024). Public health surveillance: Historical origins, methods and evaluation. Bulletin of the World Health Organization, 72(2), 285–304.

Francetic, I., Fink, G., & Tediosi, F. (2020). Impact of social accountability monitoring on health facility performance: Evidence from Tanzania. Health Economics, 30, 766–785.

Gomes, D.C., Cubasa, M.R., Pleisa, L/E., Shmeila, M.A.H., & Pelucia, A.PV.D. (2016). Terms used by nurses in the documentation of patient progress. Revista Gaúcha de Enfermagem, 37(1):e53927.

Hubert, N., & Mulyungi, P. (2018). Influence of monitoring and evaluation planning on

project performance in Rwanda: A case of selected non-governmental organizations in Gasabo District.

European Journal of Business.

Hysong, S.J., Arredondo, K., Hughes, A.M., et al. (2022). An evidence-based, structured, expert approach to selecting essential indicators of primary care quality.

Khan, M.A., Nilima, N., Prathibha, J., Tiwary, B., & Singh, M. (2020). Documentation compliance of in-patient files: A cross-sectional study from an East India state. Clin Epidemiol Glob Health, 8(4), 994–997.

Kihuba, E., Gathara, D., Mwinga, S., Mulaku, M., Kosgei, R., Mogoa, W., ... English, M. (2018). Assessing the ability of health information systems in hospitals to support evidence-informed decisions in Kenya. Global Health Action, 7.

Kimaro, H., & Nhampossa, J. (2017). The challenges of sustainability of health information systems in developing countries: Comparative case studies of Mozambique and Tanzania. Journal of Health Informatics in Developing Countries, 1(1).

Kimondo, B. N., & Ngugi, K. P. (2019). Determinants of effective implementation of monitoring and evaluation systems in county governments in Kenya. International Academic Journal of Information Sciences and Project Management, 3(5), 12–37.

Kruk, M.E., Gage, A.D., Joseph, N.T., Danaei, G., García-Saisó, S., & Salomon, J.A. (2018). Mortality due to low-quality health systems in the universal health coverage era: A systematic analysis of amenable deaths in 137 countries.

Kasaye, M.D., Beshir, M.A., Endehabtu, B.F., Tilahun, B., Guadie, H.A., Awol, S.M., Kalayou, M.H., & Yilma, T.M. (2022). Medical documentation practice and associated factors among health workers at private hospitals in the Amhara region, Ethiopia 2021.

Lankester, T. (2019). Monitoring and evaluating the health programme. https://doi.org/10.1093/med/9780198806653.003.0009

Lee, J., Lynch, C.A., Hashiguchi, L.O., et al. (2021). Interventions to improve district-level routine health data in low-income and middle-income countries: A systematic review. BMJ Glob Health.

Ledikwe, J. H., Grignon, J., Lebelonyane, R., Ludick, S., Matshediso, E., Sento, B. W., ... Semo, B.-w. (2018). Improving the quality of health information: A qualitative assessment of data management and reporting systems in Botswana.

Morris, J., & Lawrence, A. (2020). Learning from monitoring & evaluation – A blueprint for an adaptive organization. Social & Economic Research Group, Forest Research.

Nabyonga-Orem, J., & Mijumbi, R. (2018). Monitoring and evaluation of strategic change programme implementation Lessons from a case analysis. Evaluation and Program Planning, 66, 120–132.

Ngao, M.N. (2015). Assessing barriers to implementation of nursing process among nurses working at Machakos Level 5 Hospital (Unpublished Doctoral Dissertation, University of Nairobi).

Okello, M. S. (2018). Effects of monitoring and evaluation frameworks on service delivery in the health sector in Uganda. International Journal of Science and Research (IJSR).\

Ranon, P. N., & Phuenngam, W. (2019). Critical success factors for effective risk management procedures in financial industries: A study from the perspective of the financial institutions in Thailand (Master Thesis, Umea School of Business).

Seidu, A.A., Abdulai, A., & Aninanya, G.A. (2021). Factors influencing documentation in nursing care by nurses at the Tamale Teaching Hospital, Ghana. UDS International Journal of Development. https://doi.org/10.47740/567.udsijd6i

Shah, A. (2019). Using data for improvement. BMJ, 364:l189. https://doi.org/10.1136/bmj.l189

Sum, M.T., & Chebor, M.A. (2013). Documentation: Historical perspectives, purposes, benefits and challenges as faced by nurses. Int J Hum Soc Sci, 3(16), 236–240.

Taiye, B.H. (2015). Knowledge and practice of documentation among nurses in Ahmadu Bello University Teaching Hospital. IOSR J Nurs Health Sci, 4(6), 1–6.

Tara Nutley, E. S., & Nicole Judice. (2006). Data demand and use: An introduction to concepts and tools. http://www.cpc.unc.edu/measure/resources/publications/ms-12-54/at_download/document

World Health Organization. (2018). Handbook for national quality policy and strategy – A practical approach for developing policy and strategy to improve quality of care.

World Health Organization. (2021). The network for improving quality of care for maternal, newborn and child health: Evolution, implementation and progress. 2017–2020 report.

APPENDICES

NKUMBA UNIVERSITY

SCHOOL OF SOCIAL SCIENCES

Dear respondent,

Request to complete the questionnaire below

Dear Sir/Madam,

I am a student of Nkumba University pursuing of the degree of masters of Arts in Monitoring and Evaluation; I am carrying out a study on **"*MONITORING PRACTICES***

AND HEALTHCARE SERVICES IN PUBLIC HOSPITALS IN UGANDA; A CASE OF ENTEBBE GRADE B HOSPITA AND KITALA HEALTH CENTER III"This is to request you to kindly complete the attached questionnaire. There is no right or wrong answer. You just need to indicate how much you agree or disagree with each item by marking the answer that best represents your views on every statement. The information you provide will be used anonymously and for academic purposes only. Thank you very much for accepting to complete the attached questionnaire.

MPUMBYA ROSSETTE

(Researcher)

APPENDIX I: SELF ADMINISTERED QUESTIONNAIRE

SECTION A: Personal variables

Under this section, please provide the most appropriate answer by ticking against the alternative you most agree with

1	In which age bracket do you belong?	1. 20-29 2. 30-39 3. 40-49 4. 50-59 *5.* 50 years and above
2	What is your Gender?	1. Male…… 2. Female……
3	What is your current marital status?	1. Single 2. Married 3. Cohabiting 4. Separated
4	Your highest education level attained	1. Masters 2. Bachelors 3. Diploma 4. Certificate
5	What is your Designation	1. Medical records officers 2. Ward in-charges 3. M&E technical officers 4. Medical records assistants 5. Data Entrants
6	For how long have you worked with this Public Hospital	1. Below 1 year 2. 2-3 years 3. 5-10 years

SECTION B: TO EXAMINE THE EFFECT OF DATA COLLECTION FREQUENCY ON THE QUALITY OF HEALTHCARE SERVICES IN GRADE B AND KITALA HCIII

No.	Question	1	2	3	4	5
1.	Data on patient care is collected regularly in this facility					
2	Effective budget monitoring ensures resources are used efficiently					
3	Frequent data collection improves decision-making in patient treatment					
4	Health workers use collected data to improve service delivery					
5	Delays in data collection affect service quality negatively					
6	This facility has a schedule for routine data collection					
7	Data collection helps track the availability					

	of essential drugs					
8	Data frequency is adequate to monitor healthcare quality indicators					
9	Staff are trained on how to collect and use health data effectively					

SECTION: C: TO ASSESS HOW REPORTING AND DOCUMENTATION PRACTICES INFLUENCE HEALTHCARE SERVICES IN GRADE B AND KITALA HCIII

	Statement	1	2	3	4	5
1.	Clear and complete reporting improves					

	coordination among healthcare staff					
2.	Errors in documentation have previously led to poor health outcomes in this facility					
3.	Timely documentation helps prevent duplication of healthcare services					
4.	Health workers consistently record patient information during every visit					
5.	Documentation practices are reviewed to ensure compliance with guidelines					
6.	Reporting systems in this facility support fast and easy access to patient records					
7.	The quality of healthcare services has improved due to improved record-keeping practices					
8.	Reporting tools are					

	user-friendly and promote efficiency in healthcare delivery					
9	Regular reporting helps in monitoring health trends and outbreaks					

SECTION D: TO INVESTIGATE THE EFFECT OF STAKEHOLDER FEEDBACK ON HEALTHCARE SERVICES IN GRADE B AND KITALA HCIII

	Statement	1	2	3	4	5
1.	Patients are encouraged to give feedback about the care they receive					
2	Stakeholder feedback has led to changes in how services are delivered at this facility					
3	Feedback from the community is considered when making decisions					

	about healthcare priorities					
4	Healthcare workers respond positively to constructive feedback from patients and the public					
5	The facility has accessible channels (e.g., suggestion boxes, surveys) for collecting feedback					
6	Stakeholder feedback helps to identify service gaps and areas needing improvement					
7	Feedback from stakeholders contributes to better relationships between staff and the community					
8	Healthcare services have improved due to stakeholder engagement and feedback					

Appendix II: Interview Guide

NKUMBA UNIVERSITY

SCHOOL OF SOCIAL SCIENCES

Dear respondent,

Request to complete the questionnaire below

This is to request you to kindly complete the attached questionnaire. There is no right or wrong answer. You just need to indicate how much you agree or disagree with each item by marking the answer that best represents your views on every statement. The information you provide will be used anonymously and for academic purposes only. As part of my studies I am required to carry out field research and write a report on ***MONITORING PRACTICES AND HEALTHCARE SERVICES IN PUBLIC HOSPITALS IN UGANDA; A CASE OF ENTEBBE GRADE B HOSPITA AND KITALA HEALTH CENTER III.***

Thank you very much for accepting to complete the attached questionnaire.

MPUMBYA ROSSETTE

(Researcher)

1. What is your current role or position in the health facility?

   .....

   .....

2. How long have you worked in this facility?

   .....

   .....

3. What department or unit are you assigned to?

   .....

   .....

4. How frequently is patient data collected in your facility?

   .....

   .....

5. How is the collected data used to inform patient care or management decisions?

   .....

   .....

6. How would you describe the documentation practices in your facility?

   .....

   .....

7. Are there any systems or tools in place to support efficient documentation and reporting?

   .....

   .....

8. What gaps or challenges exist in your current reporting practices?

   .....

   .....

9. How is feedback from patients and the community collected in your facility?

   .....

   .....

10. Do you feel the management responds adequately to the feedback received from patients? Why or why not?

    .....

    .....

11. How can stakeholder feedback systems be improved to enhance service quality?

    .....

    .....

Thanks for your cooperation