PERCEPTIONS AND PRACTICES OF HEALTH WORKERS ON MONITORING & EVALUATION OF HIV INTERVENTIONS AT MBAGATHI HOSPITAL, NAIROBI COUNTY

BY

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DECLARATION

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

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This project has been submitted for examination with our approval as the University Supervisors:

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DR. GEORGE ODIPO

DEDICATION

This project is dedicated to my parents.
This far I have come because of the love and sacrifices you made for me. Although you are not here to share with me in this milestone, your light still shines bright!

To the young children at the Comprehensive Care Clinic (CCC) at Mbagathi Hospital and the world over, living with HIV/AIDS may you all have a full life like all other children amidst the challenges you face.
Candle in the wind!

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ABSTRACT

The study on perceptions and practices of monitoring & evaluation of health workers on HIV/AIDs Interventions was conducted at Mbagathi Hospital, Nairobi County. The aim of the study was to establish how health workers at the Comprehensive Care Clinic at Mbagathi Hospital in Nairobi County perceive and practice monitoring and evaluation.

The study employed a cross sectional research design and purposive sampling technique. The target population was health workers working in the Comprehensive Care Clinic (CCC) at Mbagathi Hospital. A semi-structured questionnaire was administered to the health workers. Microsoft Office Excel 2007 was used in the quantitative data analysis.

The key results from the study indicate that the respondents agreed that it was important to keep proper HIV records. A majority of the respondents viewed M&E to be very useful. All the respondents stated that it was important to have an M&E Plan for it helps to monitor data activities and to improve efficiency. Most of the respondents were aware of written procedures/polices/guidelines that guide M&E processes within the CCC programme. On practices, all interviewed respondents indicated that they use M&E forms for record keeping; they summarize cases to get totals monthly. All respondents reported that at the end of the month they sent records to the HRIO. Most of the staff indicated that they take part in the development of data collection tools and data analysis. The respondents stated that there are feedback mechanisms in place and evaluation results are majorly used for decision making.

Key recommendations on policy included continuous sensitization and review of written M&E guidelines to the health workers to ensure clarity and deeper internalization. Enhance discussions on HIV/AIDs indicators to ensure broader understanding of the HIV/AIDs indicators. To increase ownership, the M&E agenda should be introduced at team/departmental level. Feedback mechanisms should be periodically reviewed and strengthened. To facilitate evidence based policy making there is need for the M&E information provided to also be linked to health advocacy.

CHAPTER ONE
INTRODUCTION

1.1 Background of the Study

Monitoring and Evaluation (M&E) provides crucial tactical information that policy makers, government bodies, development managers, programmers and donors employ in order to improve project design, planning, programme performance, the delivery of services, resource allocation and to enhance accountability. To constantly improve M&E systems performance, it is important to document M&E practices, recognize best practices and scale them up and ensure learning is promoted across diverse programmes and projects. In the Kenyan health sector relationships with the nationwide reporting structures has been reinforced through development and distribution of harmonized tools for use by health implementers. Reporting has been streamlined by using the District Health Information System (DHIS-2), IQ CARE, Open Medical Records System (MRS), Electronic Health Records (EHR) and COMPACT along other systems. These systems have been developed and introduced in an attempt to strengthen data management processes. M&E structures, capacities, roles and responsibilities have been reinforced through identification of appropriate staff, capacity development and supportive supervision.

KAIS (2012) indicates that Kenya is undergoing a mixed and regional varied HIV epidemic, this encompasses both an epidemic that is widespread in the typical populace and a saturated epidemic amid some key populations. HIV/AIDS prevalence amongst grownups aged between 15 to 64 years declined nationwide from 7.2 percent, as measured in Kenya AIDS Indicator Survey KAIS (2007), to 5.6 percent in KAIS (2012).The mandate to coordinate the management of HIV and AIDS operations in Kenya is designated to the National AIDS Control Council (NACC). This is directed by 5-year national approved strategic plans, currently operations are guided by the Kenya National AIDS Strategic Plan IV (KNASP IV) which covers the duration 2014/15-2018/19.

Challenges have overtime surrounded the achievement in HIV Programme Monitoring & Evaluation in Kenya. The M&E system experiences gaps in strategic approach on co-ordination, ownership and essential data utilization for decision-making and planning cutting across various stakeholders, levels and sectors. County level analytical capacities are weak and require to be supported to effectively address the strategic data needs at county and lower levels. County ownership and appreciation of the importance of effective and efficient M&E system has not yet been established (KNASP IV). The health workers are central in raising the appreciation and use on M&E and it is important to understand their participation in M&E and how they perceive it especially at the county level.

Monitoring and evaluation (M&E) while improving the performance of health personnel often assumes that programmes and implementers' goals are equally compatible. Perceptives on M&E are outlined by personalities and therefore often fail to mirror the actual M&E practice. To evaluate a program one should be conscious of the stakeholders' needs, problems and perceptions (Mbachu et al., 2013, p 2). This generally alludes that the stakeholders and in this case HIV health workers who practice M&E may not take wholly the M&E practices as introduced to them. How they will embrace M&E practices may to some extent be affected by their interests, socialization predispositions, etc. As key stewards in conducting monitoring and evaluation practices it is important to examine and understand perceptions that the HIV health workers prescribe to.

Perception could be described as a "complex process by which people select, organize, and interpret sensory stimulation into a meaningful and coherent picture of the world" (Berelson and Steiner, 1964 p 88). Consequently, this goes to show that perception is "about receiving, selecting, acquiring, transforming and organizing the information supplied by our senses" (Barber and Legge, 1976, p 7). According to Robbins, perception can be viewed as 'a process whereby people form and construe their sensual impersonations in order to provide significance to their surroundings' (Robbins, 2004, p 132). Perception is not essentially anchored on realism, but is simply a viewpoint from a specific individual's situation outlook. In examining the notion of organizational

behaviour, perception is vital since 'people's behaviour is founded on their reality of perception, not on the reality per se. (Robbins et al 2004, p.132).

"Factors influencing a person's perception can be broken down into three main categories. These include: the situation, the perceiver and the target. For example, the factors in the situation may include: time, work setting, or social setting. Whereas the factors in the perceiver may include: attitudes, motives, interests, experiences and expectations. Lastly, the factors in the target may include: novelty, motion, sounds, size background, proximity, and similarity" (Robbins et al 2004, p. 132).

Practice can be described as the actual appliance or utilization of ideas, principles or methodologies as opposed to theories about such application or use. Monitoring and Evaluation practices include monitoring and evaluation planning activities, actual selection of indicators, data collection and management processes, feedback mechanisms and utilisation of monitoring and evaluation information.

Mbagathi District Hospital in Nairobi County was established in the 1950s to provide health care services mostly for infectious diseases that needed seclusion such as Measles, Leprosy, Tuberculosis and Meningitis. It was then known as the Infectious Disease Hospital (IDH). In 1995, Infectious Disease Hospital (IDH) was curved out from Kenyatta National Hospital and converted to an independent District Hospital for Nairobi. The health facility had dilapidated and very poor amenities. The institution is government owned but sometimes receives support from various donors. It has received funding from the international donor community, like the Clinton Foundation, USAID and Concern. As a key player in the provision of comprehensive HIV/AIDS care and management, a beneficiary of public funding and a recipient of donor aid, Mbagathi District Hospital is crucial for pointing out HIV/AIDS patient's requirements in Kenya. The hospital is a vital health facility in Nairobi, and has been at the core of delivering comprehensive HIV/AIDS care in the heart of the telling epidemic in Kenya at the Comprehensive Care Clinic (CCC). Mbagathi Hospital offers VCT, PMTCT, DTC and PITC services, as well as TB care and counseling and other health services. The clinic is staffed by human resources from the Ministry of Health, Nairobi City County.

The Comprehensive Care Clinic (CCC) at Mbagathi Hospital is a partnership project between the government and the Afya Jijini project. Afya Jijini is a USAID funded project and it supports the programme through the deployment of staff, provision of equipments, drugs and infrastructure. It offers integrated health services for approximately 9800 HIV patients, giving support for the provision of critical life-saving HIV/AIDS treatment; nutrition sensitization and commodities; family planning; and direct administrative support, including staff training and salaries, laboratory reagents and community outreach. It is a vital health facility in delivery of HIV programmes.

1.2 Problem Statement

Mebrahtu (2002) study indicated that Monitoring and Evaluation is largely viewed as a highly complicated and technical apparatus introduced and implemented by superior staff for judgement, control and measurement of subordinate staff in organizations. It is not clear how these perceptions develop and if this is truly the view of health workers involved in M&E practices. The study aims to establish and understand how health workers perceive and practice monitoring and evaluation at Mbagathi Hospital. Perceptions and practice may affect the value placed on M&E by health practitioners thus it's also important to determine if health workers value monitoring and evaluation. Perceptions can have an effect on how M&E is implemented and ultimately the success of M&E thus it is critical to understand the views of those who actually practice and use M&E information.

"Two major difficulties have been identified as responsible for low perception of M&E in general and these are feelings of being controlled or measured and perceptions of M&E tasks as an additional burden. This is probably related to a poor understanding of the usefulness of M&E practice" (Mbachu et al., 2013, p 6). The situation is further complicated or heightened by the element that there are no set up or established and appropriate feedback mechanisms that routinely provide feedback to health practitioners when reports are advanced on the hierarchal ladder. Consequently, staff do not attribute any importance to the process basically because the information does not stream back

down. It is not clearly outlined how the health workers who are expected to be the Monitoring and evaluation fulcrum perceive and practice M&E at Mbagathi Hospital.

Oakley (1996) observed that a huge gap does exist among organizations declarations that M&E is an essential and valuable process and evidence of valuable quality practice of M&E, he proposes several explanations for this inconsistency. This study assesses the nature, make up, and interplay of such aspects by investigating perceptions and practice of monitoring and evaluation by health workers and their obligations and responsibilities within the facility. M&E with its varied purposes is perceived in very diverse ways, emphasizing facets of the process in accord with the practical surrounding interests and understandings of individuals engaged.

Oakley et al. (1998, p 65) 'the basis of evolving monitoring and evaluation seems to be 'perception, experience and proximity.' There is gradual realization by International Non-Governmental Organizations that M&E is more likely to be successful if sensitively created, and established within the immediate project environment. This has not been the case with monitoring and evaluation including in the HIV context and the study wants to fill in the gap by exploring a primary factor in the context which is perceptions of HIV/AIDS health workers and how they practice Monitoring and Evaluation. Monitoring and Evaluation and its diverse roles and purposes are perceived in divergent ways, creating emphasize on specific facets of the system in accord with the practical interests and previous experiences of the ones engaged. Therefore, there is clearly a worrying gap between how head offices and other staff perceive the key functions of M&E (Mebrahtu, 2002). This brings into question what are these diverse perceptions held by the different health workers and why the perceptions would differ.

1.3 Research Questions

What is the HIV Programme's health workers' perception and practice on Monitoring and Evaluation at Mbagathi County Hospital?

1.4 Study Objectives

The overall aim of the study was to establish how health workers in HIV programs perceive and practice monitoring and evaluation.

1.4.1 Specific Objectives

1. To evaluate how HIV programme health workers view Monitoring & Evaluation.
2. To assess how HIV programme staff are involved and practice the implementation of Monitoring and Evaluation.
3. To assess the views of HIV programme staff on the feedback mechanisms, learning and reflection in place at the facility.
4. To determine utilization of M&E information by the HIV programme health workers in service delivery and planning.

1.5 Justification

The study is expected to contribute to the understanding of quality of monitoring and evaluation of HIV/AIDS interventions within Kenya. This knowledge is beneficial for decision makers particularly programme management and people working in health management information systems in designing, developing and implementing monitoring and evaluation. It also important in identifying the possible effects of human aspects in establishing solid, quality and effective Monitoring and Evaluation. The health workers are viewed as the pivot on which M&E practices depend thus their perceptions or opinions towards M&E will greatly impact their drive and commitment to ensuring quality M&E practices are instituted.

1.6 Scope and limitations

The study primarily focused on the health workers based at the Mbagathi Hospital which is located in Golf Course Kenyatta environs, Dagoretti Sub County of Nairobi County. Originally identified as “Infectious Diseases Hospital” (IDH) under the then “King George VI Hospital,” presently Kenyatta National Hospital. The study mainly focused on health workers and monitoring and evaluation staff who interact with the routine data

collection specifically in the Comprehensive Care Clinic and did not spread out to all the cadres that are involved in Monitoring and Evaluation in the hospital.

This was a facility-based study and issues of selectivity bias may arise, however this was mitigated by the fact that the findings will not be generalized to other facilities. This being a case study it should be treated as institutional based and acknowledge that different institutions may have varying conclusions. Health facilities are sometimes very bureaucratic when it comes to giving of information and this paused a challenge to the study but to mitigate this, the right channels were used to ensure permission to proceed with the study. The researcher applied for research authorization (appendix I) from the National Commission of Science, Technology and Innovation (NACOSTI) and received a Research Authorization letter (appendix II) and a Research permit (appendix III). With this documentation, another application was made to the County Commissioner and the County Health Ministry for further approval. Once cleared the researcher submitted a final application (appendix IV) to the Mbagathi Hospital through the Medical Superintendent to be allowed to carry out the study at the hospital. This was approved and allowed the data collection process to kick off.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This section of the report presents reviews on the current applicable theoretical and experiential literature to the study. The objective is to identify existing knowledge gaps that the current study seeks to fill.

2.2 Monitoring and Evaluation Overview

Monitoring is essentially viewed as the routine or continuous tracking of significant elements of a project or programme and the intended results. It is a continuous activity employing systematic data collection on appropriate and identified indicators to provide project management and the key stakeholders of any development programme with signals of the degree of the project status and accomplishment of goals and advancement of fund utilization (Mbeche et al.,2009). Evaluation is rigorous, when contrasted with monitoring. It is a scientifically-anchored method of information collection on programme activities, features, and results that subsequently guide the determination of the meritocracy or value of a particular programme. Evaluations are majorly employed to improve, strengthen programmes and to a great extent inform decisions about future resource allocations. Evaluation can be defined as the methodical and unbiased examination of an ongoing or completed project, program, or policy that critically checks on design, implementation, and results. Essentially an evaluation is aimed at determining the relevance and achievement of objectives, development, effectiveness, efficiency, impact, and sustainability (Europe Aid, 2012).

Looking at the importance of monitoring and evaluation, Akroyd (1995) asserts that monitoring and evaluation are particularly important practices to any project since they allow an ongoing review of project effectiveness. A key ingredient is to monitor the various factors and to establish checkpoints at appropriate intervals during and after project implementation. The processes or activities of M&E require high levels of skills

and competencies from both the project staff and the implementers. The focus on capacity building of the project staff guarantees a labor force with appropriate technical skills to enhance participation and sustainability in implementation of the project. This indirectly empowers the community to be more analytical about their situations, resources and advance suitable interventions, in addressing their challenges (Eggers, 1998). Such a workforce may develop positive attitudes to M&E practices and may be more willing to participate in M&E practices and may also sell M&E to the community and eventually strengthen the process.

The Monitoring and evaluation of health programs that are essentially funded by international donors collaborating with the Kenya Ministry of Health particularly on HIV and AIDS, malaria, child survival, etc. have over the years been highly vertical. They have been employing donor programmatic data tools and processes and Ministry of Health tools in a parallel, overlapping and sometimes confusing manner. This created a load for health workers required to implement both sets of tools within these programmes. This may have affected health workers' perceptions on Monitoring & Evaluation.

In the Ministry of Health in Kenya the health records officers on a monthly basis gather data at the different primary health-care facilities. They consequently summarize this and send paper based monthly summaries to sub-county Health Records and Information Officer (HRIO). The once-a-month summaries are then fed by the HRIO into internet-based District Health Information Software (DHIS-2) who is strategically based within the sub-county health office. Bigger facilities which include the referral hospitals and sub-county hospitals have budgeted and dedicated facility recording officers who directly enter the facility data into the DHIS-2 system. Sub-county HRIOs oversee the input of all data into the DHIS-2.

The M&E Structure at the Mbagathi Hospital operates under four main objectives which include: to determine and understand end consumer information needs and requirements at the different stages of the health structure; to enable data collection, analysis,

information production, interpretation and storage. To institute information dissemination, feedback both horizontally and vertically and use of information for evidence- based decision making. Monitoring and Evaluation at Mbagathi Hospital is driven by the Medical Superindent and the Hospital Health Records and Information Manager. Each health programme has a lead HRIO deployed to it with assisting HRIO. Each department maintains and updates it's HIS which includes records, filing systems and registry for primary data collection tools. Primary data collection tools include registers, cards, file folders, etc. This are used to enter data on patients by the HRIO and other departments. Each patient should have a card and a number and a file. Summary forms that include CDs, reporting templates or forms, electronic backups are protected from identified risks e.g. floods, fires, theft, access by unauthorized person, etc. The hospital facility records and aggregates health data and health associated data from the primary community and health facility, this information is analyzed, disseminated and used for decision-making, there is provision of feedback on the data and then finally transmission of summaries to the county ministry of health.

2.3 Perceptions on Monitoring and Evaluation

Perceptions on monitoring and evaluation have been identified as critical in embedding the process. Mbachu et al. (2013) study on perceptions and practices monitoring and evaluation of malaria control interventions in South-East Nigeria by health workers observed that M&E was viewed as an extremely sophisticated or complicated and technical instrument employed by senior or middle level staff for, control, measurement and judgment of lower level staff in organizations. On monitoring and evaluation, a small percentage of respondents in the study said they kept records primarily because they were instructed or compelled to do so but seemingly a majority of the health workers felt it is imperative to ensure record keeping to ensure availability of information. The degree of perception of importance of keeping records and actual aim for doing so indicates that most health workers may not view M&E merely as a device or process for control and measurement but also a decision-making tool. Monitoring and Evaluation knowledge was observed to significantly increase as the age also increases. Positive effect that comes along with work could be a contributing factor to the increased knowledge and this keeps

with the study by Schmidt et al. (1986) which largely showed that work experience brought in a considerable direct influence on knowledge of the job and essentially a lesser impact on performance competences. There is indication that health workers may have understanding and appreciation of M&E but this need to be reinforced for them to fully embrace the practice and to implement and utilize M&E information. M&E is generally practiced in most institutions but there needs to be coordinated efforts, clarity on M&E work and reflection to fully make M&E functional and for staff to embrace it. The study was keen on finding out the views of health workers on monitoring and evaluation. If they appreciated monitoring and evaluation and looked at it as a positive and beneficial process or if the viewed it negatively either as a measurement or control measure as defined in Mbachu's study.

Individuals operate from a social structure that heavily influences their thinking and behaviours which has an impact on their roles and responsibilities in the work environment. Mebrahtu (2002) observed that how M&E is introduced to an individual and the M&E expectations or deliverables assigned to one may ardently affect how they eventually perceive or view M&E. Furthermore, prior experiences with Monitoring and evaluation activities had a significant influence on individual's perceptions or views concerning monitoring & evaluation processes. Mebrahtu (2002) also noted that these experiences were inevitably affected by the respondents hierarchical ranking in the given organizations, perceptions of M&E tended to contrast as a result. High ranking officials largely view M&E practices as strategic and key in decision making while junior staff may not be so positive about M&E and may see it as a tool to measure their performance or extra workload. It is also important to examine the standing of the HIV health workers in the organizational structure as this may contribute to shaping of their perceptions.

"Conflicting perceptions of M&E activities indicate that its practice is not simply the execution of an already specified plan of action but is rather 'an ongoing, socially constructed and negotiated process" (Long, 1990, p 6). Concentrating on the outlooks of various players within the M&E structure may successfully attract consideration so that whatever the original strategies and structures, when M&E structures are established into

a project, they are most likely to be outlined and altered by the strategies based on the interests and perceptions of the various players. One's feelings and understanding shapes their perspective and eventual interaction with M&E.

There are various organizational factors that fundamentally affect implementation of monitoring and evaluation. Rangsipaht S and Thaipakdee S (2005) found that implementors do practice the extension programme monitoring and evaluation moderately and so monitoring and evaluation was considerably valuable. The key clarification of these issues were depicted by their consensus and affirmations that shortage of staff in implementing the extension programme evaluation, the constraint of available resources, limited organizational care were aspects contributing to the execution of the extension program evaluation in a moderate level. It was recommended that there was need to stimulate and direct the organization consciousness and responsiveness on carrying out the extension program evaluation at both the institutional level and the staff level. The management within the organization also need to drive the M&E agenda for the staff to view it as important and religiously practice it.

In a study by King et al. (2011) he noted that evaluators employ two different sets of actions to engage project staff with the intention of raising commitment evaluations were (a) participation of the staff in the evaluation design and (b) assisting in the development of evaluation instruments. A recurrent concern has been how to identify the staff to aptly take part in these interactions. He observed that that irrespective of the tasks and responsibilities in which project staff participated in, the evaluators always found it vital to keep firm control over the ultimate design and instrumentation. King et al. (2011) observed that in an evaluation process an evaluator managing and overseeing an evaluation can involve the different actors in innovative methods to raise understanding and ownership but should by no means surrender the decision-making power aspect of the evaluation. This can have some effect on how health workers or implementers may view evaluations for they may see themselves as being in the periphery or being used in the process and never given full control of the process. Evaluations may appear threatening to programme staff as they may be under pressure to show case results more

so where external evaluators who may have had little or no contact with the programmes are involved. Subsequently how evaluations are presented and the involvement of staff in them is very vital for it may be imperative in the perceptions they will hold on evaluation as a practice.

Evaluation provides project implementers and managers and their stakeholders with critical information on achievements and learning points. Coyle (1989) states that project oversight and monitoring are very key in ensuring that projects are fully informed about evaluations relevant to them and to provide support when needed. Evaluation is often viewed as a sensitive aspect within any project and amongst the project staff making oversight and monitoring are also key and more acceptable. There is usually awareness that evaluations may seem threatening to professionals in this case HIV health workers because of the likelihood that evaluation research will show that their projects are not as effective as they believe them to be. These needs and susceptibilities should be considered as evaluation research management is developed. If not well managed it may have negative impact on health workers and they may view evaluations as judgmental practices and may form some resistance to M&E practices.

In a qualitative study conducted in Botswana by Mpofu et al. (2014) on monitoring and evaluation support provided to health workers observed that a noteworthy result of the capacity development actions was the enhanced appreciation and awareness of M&E, and the formation and nurturing of a way of life where its acknowledgement has brought its addition in regional forums specifically district meetings. In the same study when M&E district officers were posted to the regions, their duties were properly articulated and transferred to the officers, colleagues and even their supervisors. This resulted to them being tasked and coopted within other activities outside monitoring and evaluation. The regional M&E officers expressed that the missing clarity connected to responsibilities and roles was an inhibition to developing supportive work relationships with other workmates. In some occurrences, M&E officers were viewed with suspicion and viewed as a risk by implementing officers to their work security saw the officers had been posted to the regions to seize some of the work previously conducted by program and field

officers. The clarity of roles and responsibilities in M&E is very vital because if not clear the health workers or M&E personnel involved may run away of the activities, may perform them but ineffectively and some may see it as extra burden or a waste of time. It has strong implications on perceptions and eventual practice of M&E.

Wilson (1989:39) in his study noted that "a clearly outlined and broadly comprehended sense of intent consequently leads to improved internalization of an organization's objectives by employees. Subsequently scarcity of conceptual clarity and the widespread haziness of practical separations confirmed in a number of M&E guideline documents, compounded by the complex and hierarchical character of several M&E frameworks might deter internalization of M&E goals by institutions. The staff may be confused or may see M&E as very complex and form an attitude towards it. Mebrahatu (2002) in her study observed that whereas workers generally recognized the potential price of M&E, it was obvious that national and field staff particularly were incapable of defining their responsibilities and tasks in the M&E frameworks. This perplexity points out the need clarification for all the offices on the models if M&E policy is to be executed appropriately and successfully. There is need for every staff involved in M&E to clearly understand their role in order for them to cultivate positive views on M&E and actively and effectively take part in implementation.

Monitoring and evaluation is a relatively new phenomenon that needs to be internalized further as explored in Poland. Jaszczolt et al. (2008) argues that to large extent external donors' conditions to carry out evaluations contributed greatly in the introduction and popularization of the M&E model, approaches and tools in Poland. Despite this, a number of officers with an option of expenditures on tangible issues for example laying of sewerage pipelines, or something theoretical and intangible, like an evaluation report, would definitely strongly lean on selecting the former. The choice does not essentially imply they are poor administrators. Evaluation is at times perceived as somewhat outwardly forced and foreign. It may be acknowledged as an official and unavoidable obligation but may not be adopted as something required and beneficial. It is important to understand why implementers may hold such views on M&E since it can greatly enhance

programming but only if it is functional. Why do people view M&E as abstract? What can be done to make it more practical to staff and more so HIV programme staff.

Jaszczolt et al. (2008) indicates that similarly vital is the understanding and knowledge of M&E tools and concepts among evaluations prospective clients. Seemingly the fact that an outsider to an organization could offer new information worth investing in creates great reservation on contracting external evaluators for various institutions. Undoubtedly several instances of below average reports or big "user-hostile" embellishments that end up on the inferior bookshelves and drawers fuel further this labelling. Individual involvement in project management and exterior specialists is are central aspects that influence the implementers curiosity in evaluations. It is highly suggested that success stories of carrying out valuable evaluations should be continually documented and distributed. Capacity building for government and project representatives in designing, contracting and management of evaluation measures is also of equal importance. It cannot be underscored that evaluation quality hinges on the expertise of evaluator as well as the program manager's capability to frame a decent Terms of Reference for the study. Evaluations especially external evaluations have been disapproved for not speaking out to project needs and in most situations project staff do not refer to them. There is need to conduct more rigorous evaluations and clearly capture the key deliverables that staff can relate to.

Understanding of the monitoring and evaluation process and its intent varies in the different levels of an organization. Mebrahtu (2002:504) "while assessing perceptions of M&E at different organizational levels, noted that the most obvious point is that 'monitoring' and 'evaluation' were frequently employed by respondents in a way that reflected the discussion of such terms within the policy documents of their respective organizations. For instance, in INGOs whose documentation failed to make a conceptual distinction between the terms, respondents were far more likely to notice the ambiguity and to use the terms interchangeably. What is more, it became apparent that previous experiences with M&E activities significantly framed people's perceptions concerning these processes. The experiences were in turn determined by the hierarchical positioning

of respondents within their organization." This shows that it starts with organizational structures, how the structure depicts M&E is how staff within the organization will conceptualize it and implement it. There is need for deliberations and agreement of how M&E structures should be introduced and implemented in an organization to give staff a clear and precise way of involvement in M&E.

Mebrahtu (2002:504) "Generally, the staff at head office were greatly in favour of M&E goals and objectives. They perceived such activities to be one of the most important stages of the project cycle, if not the most important and generally associated it with the notion of strengthening and sustaining institutional development. To them M&E is an internal tool for improving standards and strengthening practices and as such, it is an increasingly essential component of the project cycle. Moreover, the study notes that these respondents generally favoured the increased prominence of M&E and acknowledged the enormous potential benefits for strengthening institutional learning. However, a significant number also voiced concerns regarding the validity or reliability of M&E findings at the project level. Higher ranking positions see M&E as key in defining an organization's strategic focus but it may also be the most reliable source of information about projects yet they are at times skeptical of information received from the field. There needs to be a unified thinking around M&E to enable the whole organization to actively participate in M&E."

The field-station project M&E could be an imperative avenue of enhancing knowledge if only there is assurance that data produced correctly echo the circumstances on the ground. The staff at field level agree that donors customarily have some influence on M&E activities and process and the possible restrictions on the movement of dependable information enforced or laid out by their financial components. Donors are in a robust place to inspire the movement of consistent information from organisations they sponsor, nevertheless 'undesirable information' generally does not appear in NGO reports until confidence is established that this will not compromise future funding. This clearly emphasizes that staff strongly relate M&E to measurement of their performance and this is very sensitive especially when setting up a quality and functional M&E system. It is

not clear from the studies if this fears of judgment stem from actions experienced earlier or from anecdotes within the organization. The donor needs to build confidence in the implementing partners that M&E results does not solely contribute to the cutting down of funds. Results also need to be contextualized and analyzed accordingly before drastic action is taken as the repercussions have undertones to people's livelihoods.

There are different understandings on monitoring and evaluation within projects. Mebrahtu (2002) demonstrates the influence of employee positioning within an institution on their M&E views and outlook remained predominantly manifest in deliberations with field staff who include both senior staff like the sector and project managers and junior staff like the village mobilizers, field development agents. Mebrahtu (2002:505) "the discourse of senior staff revealed a frequent association of 'monitoring' with 'financial assessment' and 'accountability', junior staff tended to associate such procedures with notions of 'external measurement' and 'judgment'. It was quite revealing that junior staff were responsible for undertaking daily reporting and monitoring activities (i.e. filling in 'daily report formats' and 'field diaries') yet not one respondent thought to include these activities in their descriptions of what the 'monitoring' process entails. Rather, such reporting systems were primarily viewed as instruments through which senior managers could assess the progress of junior staff." M&E practice is conducted by many junior staff but they may not be aware that what they are actually doing is part of monitoring and evaluation and so this may be treated casually and the staff may not really give quality information. At the same time if health workers see this as a judgment tool they may retreat or resist to take part in the process. When under duress staff may even conjure data that they think may win them favour from their superiors and this may compromise the M&E practice. The introduction and understanding of M&E is thus very important.

Mebrahtu (2002:506) "staff at lower levels perceived M&E procedures as a highly sophisticated and technical set of activities from which they were excluded by virtue of their inferior position. In the study a respondent effectively summarized this perspective by saying that they still tend to think of M&E as a set of complex and specialized

procedures that are beyond their understanding and beyond their duties within the organization. The idea that frontline staff could get involved in the design and planning of M&E systems was generally met with some degree of consternation. The study was not surprised to learn that such activities held little interest for junior field staff and so were undertaken without much enthusiasm. It later emerged that such widespread feelings of 'detachment' at the junior level had been further exacerbated by the staff not knowing the purpose of the information collated and its potential relevance for them as frontline actors. One of the respondents summarized this by stating that they collect most of the data necessary but they never see where or how it is used, they write reports, collect them, and pass them on to the sector manager who writes more reports and sends them off they don't learn anything from the process, then the whole thing starts again! Lack of feedback mechanisms to those central in M&E especially reporting may create disillusionment and detachment amongst the staff and may do it without the bigger picture of what the reporting is meant to contribute to which may affect perceptions and practice."

Failure or lack of giving feedback on pertinent information to staff in the implementation frontline seemingly may lead to an overall misunderstanding on the end usage of collated and analysed data. Detachment feelings from the M&E activities and processes are not exclusive to the lower or junior staff. High level field staff increasingly also perceive the M&E process as 'very formal' and 'very technical', additionally to largely being undertaken for need of other stakeholders especially the donors, as expressed below: For programmes that directly interact and work with beneficiaries, M&E information is useful in pointing out and rectify mistakes and omissions where and when necessary and to actively improve and strengthen practice. While this is the ideal, in reality the stakeholder factor takes precedence, not for the organization and the staff. There is confirmation from findings that trust and openness are fundamentals for the meaningful and engaging practice of monitoring and evaluation. Irrespective of their positioning in the organization structure, staff need a 'secure' environment for them to articulate or table their apprehensions and opinions. This subsequently advocates for much greater trust and objectivity between managers, operational staff and donors.

In spite of limited acquaintance of a number of players with M&E activities or processes, Mebrahtu (2002) observed that endorsement was profoundly prejudiced towards monitoring in opposition to evaluation by employees at all organizational tiers. Generally, the staff feeling was that evaluation results are produced to a large extent a little too late to be used by staff to create a change to the standards of programming. Evaluation is often regarded as complicated and labour and time intensive with little to show for the engagement. They do not offer tangible results that can be used in programming.

The project field staff generally see evaluations, be it external or internal, as performance measurements and evaluations by head offices. The staff at the field may thus be hesitant in allowing staff from headquarters to observe or check M&E systems at the project level. An obscure approach by head offices staff of perceiving that the field-level staff "needs something that they don't realize they need" create relationship complications between the two parties (White,2013). M&E should not appear imposed or authoritative it should be aligned and in harmony with implementation for the project cycle to be complete.

Recognizing and eventually negotiating various stakeholder needs and interests to detect what needs monitoring and evaluating and why, Participatory M&E employs a process which attempts to create opportunities that permit various stakeholders in articulation of their requirements and needs and make concerted decisions. PM&E enables peoples understanding of the values and principles they hold together, work on their various differences with others, advance long term plans and strategies, and consider cautiously examined and planned activities that fit their, urgencies, context and operating model' (Parachini and Mott, 1997). PM&E involves learning community issues and concerns, and how the diverse stakeholders view and measure project results and achievements. Stakeholders may have different opinions, goals and may even have competing claims with each other that need to be deliberated and determined, chiefly when specific entities are rendered incapable in contrast to the rest. This is still a vital enquiry in the establishment of a participatory monitoring and evaluation process.

There are two significant ways to illustrate monitoring and evaluation; by the initiator and the implementer of the process and by whose perspectives are mainly emphasized. The first differentiates between monitoring and evaluation which has an external lead, an internal lead and jointly led. The second one differentiates among which stakeholders are weighted and emphasized-these are the key stakeholders to the project, project beneficiaries or marginalized groups, (Estrella M and Gaventa J, 1998).

2.4 Monitoring and Evaluation Practices

Monitoring and evaluation practices generally constitute methods that are implemented at the ground level and who ultimately owns and uses the M&E end results. Practice related matters are separated into three classes that are quite distinct and address (a) different forms of methodologies used by NGOs, (b) indicator construction and indicator selection processes, and (c) info requirements and feedback instruments. Organizations lately use three various kinds of M&E approaches. The approaches broadly categorized as participatory M&E, predominantly executed by individuals directly concerned with implementation of the projects; non-participatory M&E, where evaluation is carried out by external experts; and joint evaluation whereby the evaluation is executed by a team that includes people from within and without the programme (Mebrahtu, 2002).

M&E Planning is considered by many as very vital to the success of establishing the M&E process. This is when the various stakeholders join to bring out their specific apprehensions and needs and deliberate opposing interests. Participants categorically work to determine their monitoring goals, and classify what information or project aspects need monitoring, involvement, responsibility and methods of data collection and information dissemination. Early design, development and authorization of a strategy and results framework in the planning stage contributes to robust M&E. Project staff frequently view M&E as cumbersome, donor fronted or imposed commitment unconnected to project interventions. Field partners and staff often fail to properly assess the time taken by M&E planning and usually do not have solid incentives to commit time for planning. This results to inadequate resource allocation for M&E in the project design and development, (White, 2013). This consequently affects how M&E is implemented

throughout the life of the project. It is given inadequate time and is sometimes implemented as an afterthought thus the M&E practice may be considered inconsequential.

M&E mechanisms should be built from a solid analysis at the onset of the planning process, and aligned to strategic objectives allowing the Theory of Change (ToC) to be tested to simplify and align expectations and assumptions during implementation. Common indicators, metrics, as well as agreed definitions of concepts are important to develop in the analysis and planning phases, so that stakeholders agree on what needs to be measured and how best to prove success or determine what needs to be adapted within the programme. Periodic reviews/evaluations should be undertaken to allow corrective action where necessary.

The process of appropriate indicator selection for use within M&E systems brings in more accurately, the value to recognize the presence of divergent participants data and information needs and numerous perspectives of how reality is conceptualized within programmes. Good M&E practice means collecting the right data and understanding how it is to be applied to ongoing processes. It means: regularly reviewing engagement; revising assumptions in the light of new data being collected; adapting approaches to an ever-changing context; ensuring broad participation and consultation within the implementation process as well as the monitoring of the activities; and revising activities based on whether or not they are having the intended impact. Ricafort (1996) points out that the procedure requires cautious investigation. Document review discovered that indicator selection is carried out diversely in different organizations. In the further decentralized organizations, for instance, suitable indicators were determined at sectorial or project level. Once data is collected, the next steps involve data processing and analysis.

In M&E focus usually heavily leans on data collection while overlooking data analysis, which in the long run leads to an overload of data collected, but less data utilization. Organisations characteristically have no required staff resourcing to transform

methodically originated data to beneficial and meaningful findings that inform decision making. Torres et al. (2001) Reporting on indicators significantly overshadow learning and subsequent programming adjustment to integrate lessons learned. Data collection repeatedly results in unnecessary information that cannot be equated to effort leveraged. Data management systems frequently do not enhance conceptualization and of how programs operate at the project implementation level. Agencies may accumulate ineffectual data for annual reporting that may not provide an effective program measure. Emphasis is put on data generation rather than analysis for reflection and learning.

Information needs and implementation of feedback mechanisms in M&E is also a vital M&E practice. The value of efficient feedback mechanisms cannot be underscored and this is a vital activity in monitoring and evaluation. Organizations need to put in place feedback mechanisms to share information with different stakeholders to build their knowledge base and for learning and reflection. There is widespread consensus on the insufficiency of current feedback platforms (Mebrahtu, 2002). Feedback mechanisms are usually considered as an afterthought and upward movement of information is more calculated or planned and there may even be repercussions to delays or non-transmission while little effort is placed on downward transmission. One key issue at this stage revolves around ownership and information use. Conventionally, information has often been detached from their original source and moved elsewhere, to meet information needs and requirements of funding bodies, government agencies and other outside institutions. This restricts indigenous stakeholders from holding information ownership and creating and building up their own knowledge base, (Estrella, 2000). Information needs to be shared with those who work tirelessly for it to be generated for them to appreciate it and utilize it. When efforts are greatly put forth and there is no feedback it can have negative effects on how the M&E practice is viewed by health workers more so HIV health workers.

Lack or little organisational mechanisms to apply M&E roles and tasks also diminishes the probability that staff carrying out M&E activities competently and thoroughly, (White, 2013). The health workers primary role may not be monitoring and evaluation

but over the years this has been crucial in establishing what has been done and the next cause of action. M&E has been embedded in the job description of health workers and in this case HIV programme health workers. The health workers have been capacity built on different aspects monitoring and evaluation. With the establishment of the Health Information System a specialized job group was instituted to take charge of information within the sector.

The review of past studies identified that employees in different fields develop perceptions on monitoring and evaluation overtime. How monitoring and evaluation is practised does not follow a linear structure it is shaped by interests and influences from those who actually conduct it. While an institution may develop its monitoring and evaluation system it may not be implemented as expected because the implementers also come in with their worldview and prejudices that eventually affect how they approach and practice monitoring and evaluation. The literature also identifies that sometimes those who actually carry out M&E may feel at the periphery especially if feedback is not given to them. The study seeks to understand the perceptions held by the health workers on monitoring and evaluation at Mbagathi CCC because this also helps to understand how they practice monitoring and evaluation.

2.5 Theoretical framework

Perceptions and practices can be examined from three different frameworks i) Social Exchange Theory ii) Psychological Contract iii) Perceived fairness. Social exchange theory is skewed towards costs and benefits of interactions while perceived fairness leans on employee perceptions of fairness of performance appraisal systems. The dominant framework in which this study will be anchored is the Psychological Contract which centers on obligations and responsibilities.

Rousseau (1989: 121) sees “psychological contract to include personal beliefs in a mutual obligation between the organization and the individual. Research has concentrated mainly on the outcome of contract development, breach of contract, and connected responses. Human Resource Management practices can be viewed as “indicators” of the

organization's intents towards its employees and are construed so by the individual employees" (e.g. Rousseau & Greller, 1994). Nevertheless, employees may not essentially perceive such "indicators" equally or react to them in the same manner. Guest (1999) noted that very little research concentrates on employees' responses to HRM. He proposes that the influence of Human Resource practices on employees' responsibility and performance largely hinges on how the employee perceives and evaluates these practices. Attitudes and perceptions may intercede and moderate the association between HRM practices and the employee performance-related behavior in our case M&E practices.

Principally, the Psychological Contract refers to the employer-employee connection and precisely concerns common prospects of results mainly inputs and outcomes. The Psychological Contract is frequently understood from the employee viewpoint or feelings, even though a total appreciation necessitates it to be understood from the employer side as well as the employee side. Basically, in an employment set up, the Psychological Contract is the equilibrium or equality as typically viewed by the employee, between: how the employee is handled by the employer, and what the employee brings to the occupation.

The study focuses on the health worker (employee) and how they perceive M&E which is part of the employer's (hospital's) structure. Mbagathi Hospital has employed the health workers under the CCC programme and part of their responsibilities is monitoring and evaluation activities which they are expected to take part in by their employer. There is a contract between the employer (hospital) and the employee (health worker) on implementation of M&E activities at the institution. The employees also develop views, attitudes and interests to the organizational M&E practices that eventually influence how they value and practice Monitoring & Evaluation within the hospital.

Three classes of workers applicable for health labour force analysis can be distinguished: A. health workers with specialized education and training employed in the health services sector; B. health workers with training in a non-health field working in the health services

sector; C. health workers with health training either working in a non-health-care–associated field, or are currently unemployed or not active in the labour market. Classes A and C compose the trained (skilled) health labour force weather active or inactive present in a given region or country, while A and B embody the workforce currently employed in the health industry. The sum total of the three components A, B and C offers the total potential health labor force present. A fourth class, D, includes all non-health workers who include workers without health occupation training and not working in the health sector, (Dal poz et al., 2009). Thus the study will look at A and B as the health workers in the CCC.

2.6 Operational Framework

The study will assess perceptions held by the CCC program health workers on monitoring and evaluation by operationalizing the psychological contract theory. This will be determined by how the health workers value M&E and its importance in CCC programming. It will also establish how they practice monitoring and evaluation by asking specific questions on data collection, reporting, feedback mechanisms, and utilization. The M&E structure is seen to operate under the larger organizational structure that the employer expects the employee to conform to in the institution. There is a salient contract between the organization and employees. How do the employees view the contract and how are they willing to work with it. What is the understanding of employees on the M&E process and do they consider M&E as useful? This is depicted in Figure 2.1 below.

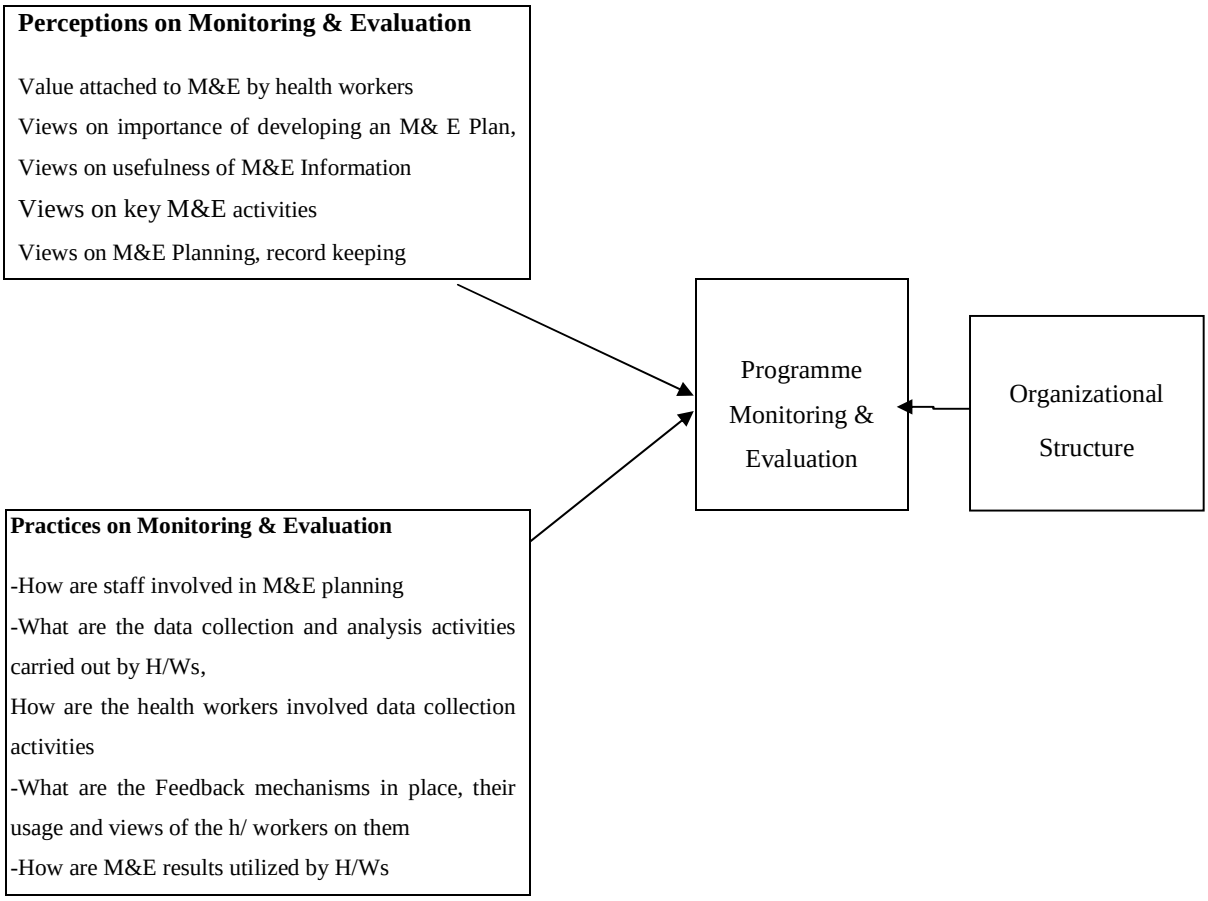

Figure 2.1: Operational Framework

Source: Author

2.7 Roles and Responsibilities of M&E under HMIS

In the Ministry of health under the Health Management Information System(HMIS) M&E roles for the different health institutions and units are clearly outlined as shown on table 2.1 below to ensure that each entity understands what they are expected to deliver in terms of M&E. This is the bigger M&E contract between the government and the institutions. Consequently, institutions roll this down to the contract that they have with their employees i.e. the health workers. Perceptions and practices of the employees thus shape how they relate to this contract with the institution.

Table 2.1 Roles and Responsibilities of M&E under HMIS

Institution	Role	Frequency	Reporting Tool
Service delivery points (Health facilities)	Report health sector data	Monthly	MOH 711 & 713
County health records and information officer	Collate health sector HIV response data	Monthly	MOH 713- To DHIS
County HIV coordination unit and county AIDS and STI coordinating officer (CASCO)	Provide the health sector HIV response data for use at the county level	Quarterly	DHIS
MoH (NASCOP)	Review DHIS data and liaise with NACC to improve data quality	Quarterly	KASF data collation tool

Source: Kenya Aids Strategic Framework –M&E Framework 2014/15-2018/19

CHAPTER THREE
METHODOLOGY

3.1 Introduction

This chapter presents the methodologies that were employed in the study. This includes research design, target population, sampling strategy, instrumentation, data collection techniques, and data analysis.

3.2 Research Design

The study adopted a cross sectional design. Cross sectional studies are usually a relevant way to determine frequency and are suitable at identifying relations that could be more rigorously investigated using a randomized controlled study or cohort study (Mann, 2003). The research design allowed a number of diverse variables to be tested at the same time. The study examined perceptions and practices of health workers and drew conclusions. It examined the feedback mechanisms, learning and reflection in place at Mbagathi health facility and the utilization of M&E information within the facility.

3.3 Target Population

The target population consisted of the health workers working at the Comprehensive Care Centre at Mbagathi Hospital. The health workers targeted are engaged mainly in Monitoring and Evaluation especially routine data collection processes. The senior management team was also a key target group since they are central in ensuring that monitoring and evaluation structures are in place and operational within the hospital. The study sought to interview health workers at the Comprehensive Centre who are directly involved in data collection, analysis, reporting and transmission to various levels, the hospital management and the staff involved in Health Information System at the hospital and the county level.

3.4 Sampling Method

Purposive sampling technique was used because of the non-homogeneity in terms of management sizes, number of staff in each area and nature of products offered by the hospital. Purposive sampling is a non-probability sampling method mainly dependent on the researcher's judgement. Purposive sampling enabled the researcher to focus on key personnel of the HIV programmes who have the technical know-how of the projects and are involved in monitoring and evaluation. The health workers at the CCC are 30 in number. The CCC has various departments including pharmacy, laboratory, medical social work, counseling, clinical unit, mobilization, peer support, health records and information. The study identified at least two respondents from each department. Based on this criterion, 25 key health workers were identified and interviewed in the study.

3.5 Data Collection Instruments

Primary data was collected using a semi-structured questionnaire which was designed to capture the different variables of the study. The questionnaire had both open-ended and closed questions for data collection. The closed questions which had five choices on a likert scale were used for the quantitative data collection process. The likert scale was employed in rating the respondents' answers on statements on a scale of 1-5 expressed either positively and negatively and presumed to have the same value.

The semi-structured questionnaire that was developed is attached as appendix V. It enabled the respondents to select answers from the stated alternatives. The alternatives were developed in a simplified manner to allow easy understanding among the respondents. Face to face interviews were employed whereby the respondents were interviewed as the researcher filled in the questionnaire. The research ensured good communication skills and established relationships of trust with the respondents encouraging the respondents to talk freely and openly on the research questions. The filled questionnaires were reviewed carefully to check on completion and accuracy.

Some of the questionnaire items were adopted from a study on “How Do Health Workers Perceive and Practice Monitoring & Evaluation of Malaria Control Interventions in South-East Nigeria” (Mbachu et al., (2013). Extensive review of secondary data was carried out to inform and furnish primary data collection.

3.6 Data Analysis

Data analysis was carried out by use of quantitative techniques. Microsoft Office Excel 2007 was used in the quantitative data analysis where by descriptive statistics like percentages were generated. The research findings were presented using, percentages, pie charts and bar graphs.

The questionnaires and the different variables were coded and entered manually into the excel sheets. The variables or questions were entered in the columns while the cases or respondents were entered on the rows. An individual cell, therefore, contained a respondent’s answer to a specific question. Each case or respondent in the dataset was given a unique numerical identifier (ID), this was simply done by numbering them consecutively from 1 through to n (where n is the number of cases). This enabled east sorting and tracking of responses in the data cleaning process.

CHAPTER FOUR
HEALTH WORKERS MONITORING AND EVALUATION PERCEPTIONS AND PRACTICES

4.1 Introduction

This chapter presents results on the perceptions, practices, and feedback mechanisms of M&E processes at the Mbagathi Comprehensive Care Clinic (CCC). The chapter discusses the M&E aspects of the HIV/AIDs programme, bringing out the study on the staffs' perception and utilization of M&E.

4.2 Respondents Profile

The CCC programme has a total of 30 health workers of whom 25 of them were respondents in the study. Disaggregation was such that 48 percent were female and 52 percent male. Purposive sampling was carried out and respondents from the various departments in the programme were interviewed. The departments in the programme include pharmacy, social work, counselling, mobilization, research, medical unit, nursing, peer education, laboratory and health records and information department. Mean working years among the health personnel was 3.5 years. The scale up of the Comprehensive Care programme in Mbagathi hospital has enabled the unit to cater for the programme recurrent expenditures and this has enabled the programme to maintain the health personnel.

Table 4.1 Respondents Profile

Age	Male	Female	Total	Percentage
20-29	7	5	12	48%
30-39	4	6	10	40%
40-49	2	1	3	12%
50-59			0	0%
60+			0	0%
Total	**13**	**12**	**25**	**100%**

Majority of the health workers had achieved some form of tertiary education, 4 percent had a college certificate, 60 percent had a college diploma and 36 percent had a university degree. The education levels are depicted in Figure 4.1 below.

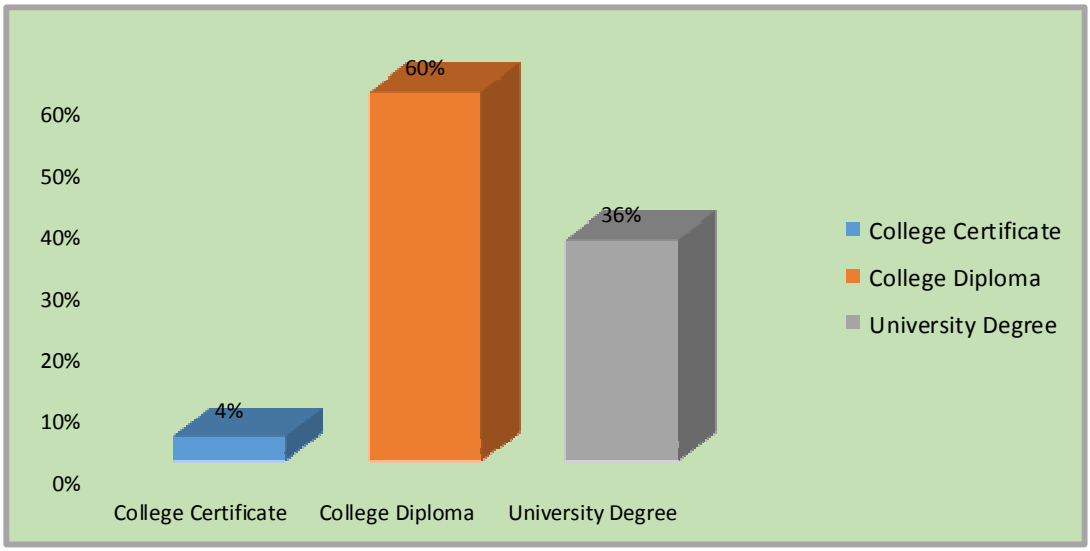

Figure 4.1: Respondents Percentage Education Levels

Source:Computed by Author using survey dataset

There are different cadres of health workers work within the programme and this include Health Records and Information Officers, nurses, pharmacists, laboratory officers, clinical officers, counsellors, medical social workers, nutritionists and research officers. The specialization would indicate that the health workers have knowledge and experience to carry out their responsibilities within the Hospital given their different specialization. The team is led by a Medical Officer.

4.3 Respondents Perceptions on Monitoring & Evaluation

All respondents (100 percent) stated that it was important to keep proper records of HIV/AIDs cases in order to have information on the number of HIV/AIDs clients attended to at the Comprehensive Care Clinic. The respondents also provided other reasons which include proper patient management, follow up and monitoring of patients, for trend analysis, commodity management, planning and decision making. The

responses given are a clear indicator that health workers perceive proper record management to be important and useful in their work. This is consistent with (Mbachu et al 2013) findings which state that the degree of perception of the value of record keeping indicates that a majority of health workers may not perceive monitoring and evaluation as merely a measurement tool or for control purposes but also as a decision-making instrument. Record keeping is a key M&E function to the institution and this has been internalized by the health workers who view it as important and therefore implement it. This is also in line with a study on government bureaucratic systems whereby, Wilson (1989:39) noted that a well-articulated and extensively comprehended sense of purpose can subsequently lead to improved internalization of an organization's goals by its employees.

There are different aspects of information that need to be collected, 80 percent of the respondents agreed that important information to be documented include date of consultation, name of patient, occupation and treatment offered. Other information that they felt was important include residence, sex, age, next of kin, contacts, tests done and the results, reason for visiting the clinic, anthropometric measures, side effects, partner details, treatment given return date, progress, nutritional status. This shows that the health workers have a good understanding of what is valuable information in the programme and can identify key information needs.

The M&E plan is a blueprint to M&E implementation within the hospital as an organization and it is expected that each department or programme develops one and rolls it out. The heads of programmes and the HRIOs are in charge of the M&E Plan and are expected to guide their implementation. The CCC programme at Mbagathi Hospital has an M&E plan, which is used as a roadmap to the implementation of M&E activities. The CCC uses the M&E Plan as a guide to what they should evaluate, what information is needed, methods and tools needed to collect the data and audiences for the M&E information. On M&E Planning all or 100 percent of the health workers agreed that it is important to have an M&E Plan. A respondent stated that the M&E Plan makes it easy to keep track of any information if needed anytime. Another respondent viewed the plan as

contributing to effectiveness in data collection, linking project objectives to data collection especially identification of variables and tools. The health workers viewed the M&E Plan as an important factor to enable M&E activities to be conducted effectively within the programme this is seen from the health workers responses. The M&E Plan is a blue print to how M&E activities will be carried and the health workers viewing this as important depicts that they see M&E as a key and strategic aspect that needs a plan for it to be effectively implemented.

M&E information is usually collected to be utilized, on usefulness 80 percent of the respondents view information collected from M&E practices as very useful while 20 percent consider information derived from M&E practices as useful. This is summarized in figure 4.2 below. This is a clear indication that M&E is perceived to produce imperative information on programme performance, achievements and improvements. Consequently, this implies that it is viewed highly within the programme. M&E information was also viewed as a prerequisite to be able to receive supplies from their various departments. A respondent indicated that they are not supplied with more drugs or commodities unless reports submitted. Mebrahtu (2002) study indicated that Monitoring and Evaluation has been regarded as an extremely complicated and technical tool used high level staff for control, measurement and judgment of lower staff in organizations. When M&E is seen as a prerequisite to other operations it may be equated to a control or measurement tool and may eventually result to low perceptions by health workers and equated to a control measure so it very sensitive to be applied as a control measure.

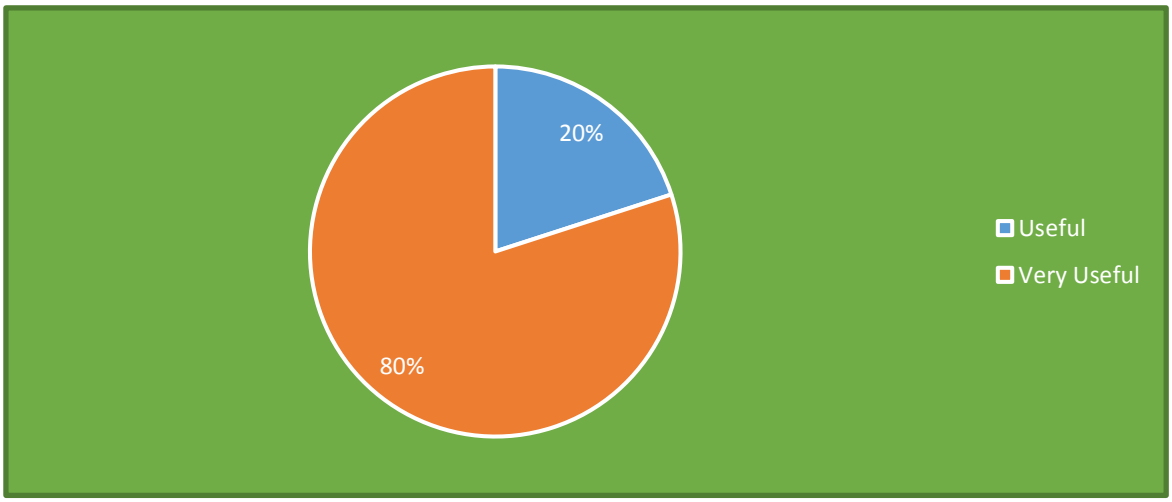

Figure 4.2: Usefulness of information derived from M&E practices

Source:Computed by Author using survey dataset

The HIV/AIDs indicators are determined at national level and the health institutions are mandated to collect data on the indicators. Mbagathi Hospital as an institution operates within the set national guidelines and each programme is expected to collect data on these national indicators. Data collection tools which facility stated were developed in a participatory manner are in place to facilitate data collection. The health workers had mixed feelings on the current HIV indicators. Some of the health workers perceived them positively with different responses. Some saw the indicators as helpful in knowing those on ART and those ones who are not while others saw them as very useful for they help give information on the gains and lows.

Some felt that the trends are still very worrying with HIV transmission rates still high in Kenya and the Mother to Child Transmission reduction is still at a low rate. Some health workers indicated that the indicators captured the required information, were accurate and measurable. On the other hand some of the health workers felt there were still some gaps on the indicators. There were views that there was need to review the current HIV indicators and even add some other indicators in line with the new HIV/AIDs guidelines. One respondent observed that if properly followed and put in practice then we would be

experiencing a big change in terms of HIV prevalence & stigmatization". Human Resource Manager, Mbagathi Hospital.

This shows that the health workers see the indicators as key to their work and even proceed to draw inferences from them. Good M&E practice means collecting the right data and understanding how it is to be applied to ongoing processes. It means: regularly reviewing engagement; revising assumptions in the light of new data being collected; adapting approaches to an ever-changing context; ensuring broad participation and consultation within the implementation process as well as the monitoring of the activities; and revising activities based on whether or not they are having the intended impact, this process direly needs cautious investigation (Ricafort, 1996). Indicators are core to M&E and are usually viewed to be technical thus if the health workers are able to relate and deliberate on the sectors indicators it shows that they have adequate knowledge and appreciation of M&E.

The health facility in partnership with the Afya Jijini project developed written guidelines to structure M&E implementation within the CCC programme. In the appraisal of written procedures 71 percent of the respondents were aware of written procedures /polices /guidelines that guide M&E processes within the HIV programme while 29 percent were not aware as summarized in figure 4.3 below. This could be attributed to the fact that there is strong emphasis on data within the programme especially coming from the donor partner. The guidelines have been placed in strategic areas within the facility and this may serve as a reminder to the health workers on their requirements on data management and M&E.

There were divergent perceptions on the guidelines with some quarters seeing them as useful, helpful or key in the management of HIV/AIDs data within the facility. Some felt that as much as the guidelines were useful they cannot be properly implemented because of a human resource gap. One respondent acknowledged that the guideline was somehow good but there was need for it to be formatted to accommodate the generational challenges and bring more players on board for holistic approach.

While some felt that as much as they were good they were sometimes subject to misunderstandings. Others felt that the guidelines needed to be reviewed regularly to accommodate the data challenges within the programme. One respondent stated that the guidelines are too ambitious and there was still more to be done since health care providers to implement the guidelines were few. Some felt that there are capacity issues that need to be addressed for the guidelines to be properly implemented. A new staff was not sure of guidelines of M&E. This also shows that new staff should be sensitized on the guidelines. The guidelines are the contractual basis of engagement on M&E and so they need to be clear and structured to allow the employee (health worker) and the employer (the hospital) to optimally gain from them.

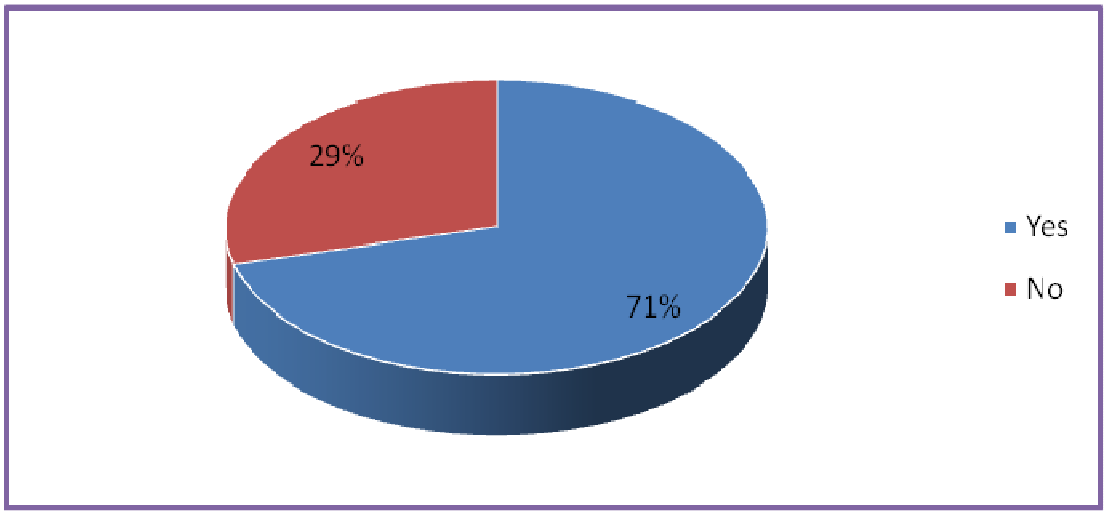

Figure 4.3: Awareness of written procedures/policies/guidelines on M&E

Source: Computed by Author using survey data set

The respondents had been with the institution for an average of 3.5 years. Their education levels were also high which could have contributed to the high perception they had for monitoring and evaluation.

4.4 Involvement & practices on Monitoring and Evaluation

All respondents, 100 percent indicated that they use M&E forms to keep records. This could be attributed to the fact that they have designate forms for data collection. All

respondents, 100 percent indicated that they get total summaries monthly. All respondents, 100 percent agreed that at the end of the month they sent records to the HRIO. All respondents, 100 percent agree that at the end of the month when they accumulate all the HIV cases then send them to the HRIO. The M&E practices are clear amongst the health workers and they are seemingly committed to the practices. Long (1990) concentrating on the outlooks of various players within the Monitoring and Evaluation system effectually attracts consideration to the point that whatsoever the original plans, when M&E systems are established within a project, they will most likely be outlined and changed by the strategies based on the players perceptives and interests of these different actors. Thus, it is crucial to ensure that perceptions can actually yield effective practices. We can infer that the health workers perceptions and interest has catalyzed the implementation of M&E activities.

On the departmental reports 65 percent of the respondents indicated that reports are submitted on time always while 22 percent indicated that they are often submitted on time and only 13 percent reported that the reports were sometimes submitted on time as depicted Figure 4.4 below. The staff provided various reasons for timely submission which included reports are submitted on time so that planning & implementation of shortages can be acted upon. One of the respondents stated that they have a deadline of 5th of every month that every facility must have submitted reports in order to get commodities and it always came with penalties if you fail thus it was a tradition to always submit reports on time always. The institution ensures there is submission of reports to the management and subsequently to the county government and there are set timelines for report submissions. This corroborates the study by Mebrahtu (2002) who observed that how M&E is introduced to an individual and the M&E expectations or deliverables assigned to one may ardently affect how they eventually perceive or view M&E. It is clear that there is a an established system for reporting within the CCC that the staff work

Some respondents observed that occasionally there may be delays but it's in accordance with national guidelines that MoH reports have to be reported. The fact that the system is electronic and enables the various departments to generate daily reports which are

compiled weekly and shared with the HRIO facilitates faster compilation of the reports. This was noted by a respondent who stated that reports are computerized and by the end of the day they are compiled and sent to the HRIO focal person. The respondents felt that reports are submitted on time since everyday a report is done then compiled weekly. Some of the health workers said that the fact that the reports are needed at the national level for administrative purposes propelled them to submit the reports on time. Those who mentioned that the reports are sometimes not submitted on time gave various reasons including errors that occur that may need rectification hence taking time. The other reasons include heavy workloads, data errors which that may need verification with some form of back and forth which may take time. Systems failure or network errors were also seen as affecting reporting timelines from time to time. The reasons for not meeting the deadlines seem reasonable and the institution can address this to ensure both parties meet their obligations. The reporting aspect in monitoring and evaluation is very vital and key in any M&E contract. The fact that it is seemingly well executed shows that the staff know what is expected of them and deliver but this should not be an end in itself the health workers should continually discuss the reporting to understand implementation and results.

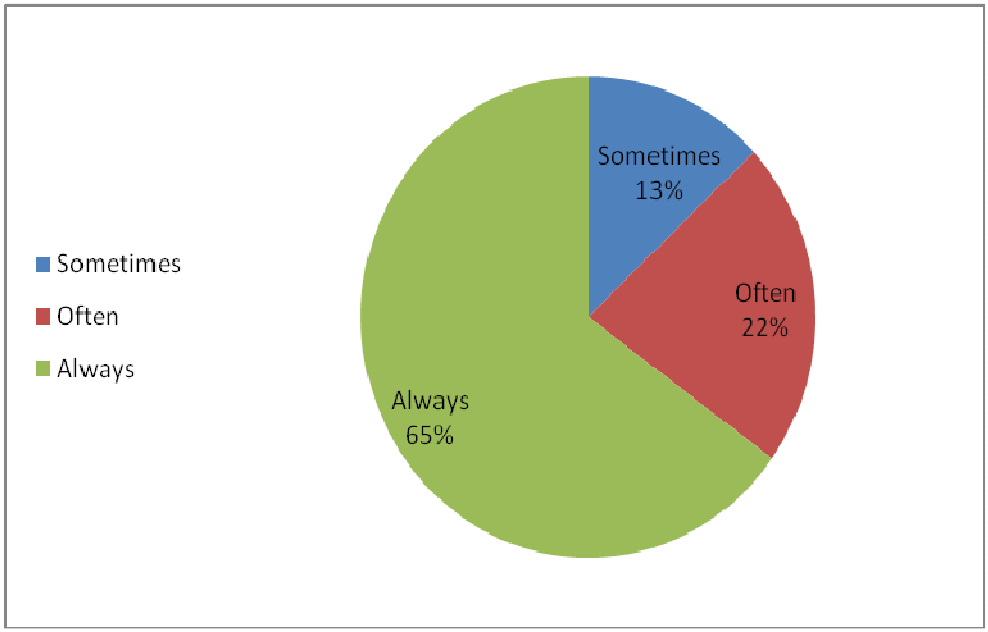

Figure 4.4: Timely submission of reports

Source:Computed by Author using survey dataset

Participatory approaches to data collection tools is important and 48 percent felt that they always take part in development of data collection tools, 21 percent felt that they often take part, 13 percent felt they sometimes do while 9 percent felt they rarely do and another 9 percent felt they never take part in the development of data collection tools. This is summarized in figure 4.5 below. Those who felt they are involved saw the process as participatory and felt like they were part of the process and owned the process.

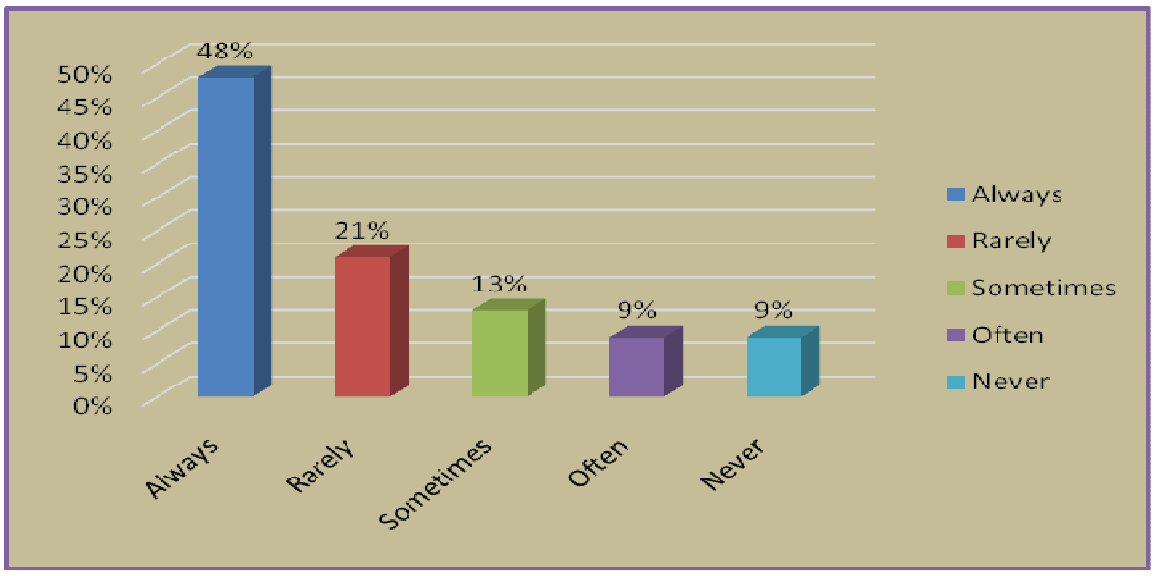

Figure 4.5: Participation in development of data collection tools

Source:Computed by Author using survey dataset

The respondents reported that they are involved in the development of the data collection tools. “We aid in the designing of the data tools by providing relevant ideas” HRIO Mbagathi CCC Programme. The health workers felt they were involved when they provide relevant ideas, views, opinions and designing of the tools. Some of the staff felt that by virtue of each department being involved in the generation of reports they were also co-opted in development of data collection tools and perceived data collection as a responsibility across the departments. A responded stated that through Continued Medical Education (CMEs) they are able to voice their concerns pertaining the current tools in use and sometimes such changes can be effected if deemed viable and cost effective.

Some of the respondents viewed themselves as very instrumental in the development of the data collection tools given that they are the ones who handle clients and thus are very much resourceful in data collections. One respondent indicated that they are invited to give opinions of tools especially concerning our departments. They mentioned that meetings are held to discuss data collection tools and to ensure simplicity and suitability in data collection.

There are some respondents who felt that they are never involved in the development of data collection tools. One stated that they have never been involved in development of data collection and are only trained after the tool is developed. Some mentioned they work with the IQ CARE system where they enter patient information, drug dispensed and duration and amount dispensed thus to them the data collection tools are already developed. In a case study by King et al. (2011) he noted that evaluators use two classes of actions to include project staff with the anticipation of elevating commitment to the evaluation (a) staff participation evaluation design and (b) staff assistance in development of instruments. A frequent question was how to point out the people to take part in these interactions. The programme seemed to have put different avenues in place to involve staff in development of data collection tools though not all staff are on board.

In relation to data analysis 76 percent of the respondents indicated that they take part in data analysis while 24 percent felt that they do not take part in data analysis as shown in figure 4.6 below. Some respondents alluded that this was part of their responsibilities they stated that everyone's responsibility in our department while some mentioned that they do take part to ensure that every information fed in the DHIS is accurate since it is always difficult to change an error on DHIS thus it calls for consultations and analysis to ensure that the data is accurate. This depicts commitment and value placed in this key M&E process. They see the data analysis as key in assisting them their various duties as mentioned. A respondent stated that data analysis is key for future reference in case of any defaulter client so as to be followed up also for the budget of the department. The HRIOs take lead in the data analysis as mentioned by some of the health workers and affirmed by the HRIOs. Others felt that only the HRIO was given the mandate to analyze

the data. Data analysis brings with it deeper understanding and involving staff to draw analysis makes them relate and understand more.

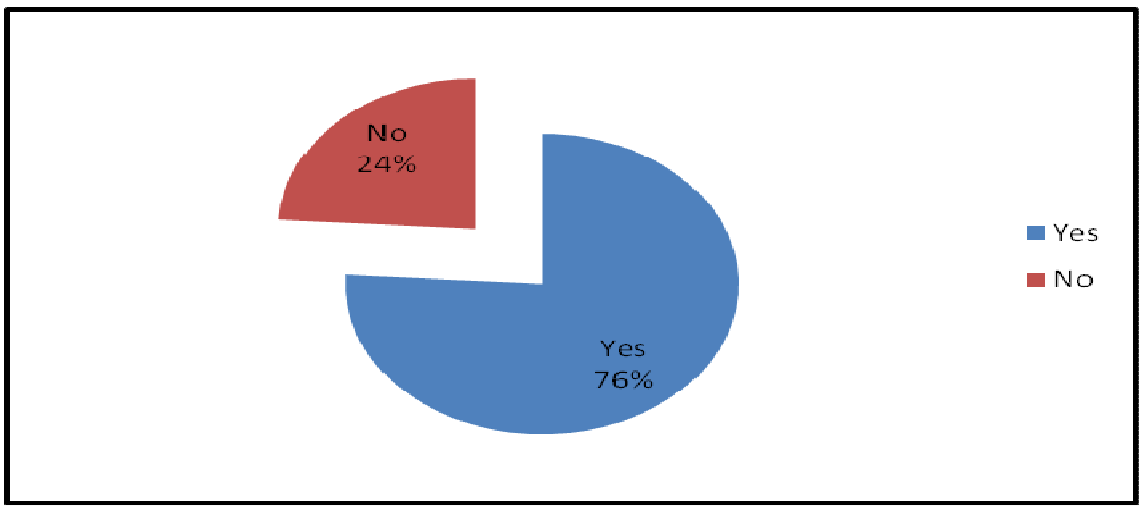

Figure 4.6: Staff participation in data analysis

Source:Computed by Author using survey dataset

A majority of the respondents i.e. 83 percent agreed that they send data on HIV cases monthly to the health county office, 12.5 percent indicated daily while 4.5 percent indicated. The varied responses may be because of different positions, reporting lines or we could also assume that some of the respondents are far removed from the reporting process and so are not aware of the reporting timelines.

The staff felt that health workers involved in M&E activities should be involved in the planning of M&E activities and 83 percent felt they should often be included while 17 percent felt that they should always be involved in the M&E planning. This could be an indication that they perceive for ownership they should be involved in the planning process.

4.5 Feedback mechanisms, learning and reflection in place at the facility

The identification of changing information requirements without adequate feedback into development interventions basically warrants that the M&E process eventually becomes

an end in itself, rather than a means through which improvements can be made (Abbot and Guijt 1997).Feedback is therefore a key component in monitoring and evaluation and 36 percent of the staff indicated that they always received feedback once M&E reports are submitted upwards,24 percent said they often received feedback,36 percent said that they sometimes received feedback while 4 percent indicated that they rarely received feedback. At least no respondent said they never receive feedback. This is depicted in Figure 4.7 below.

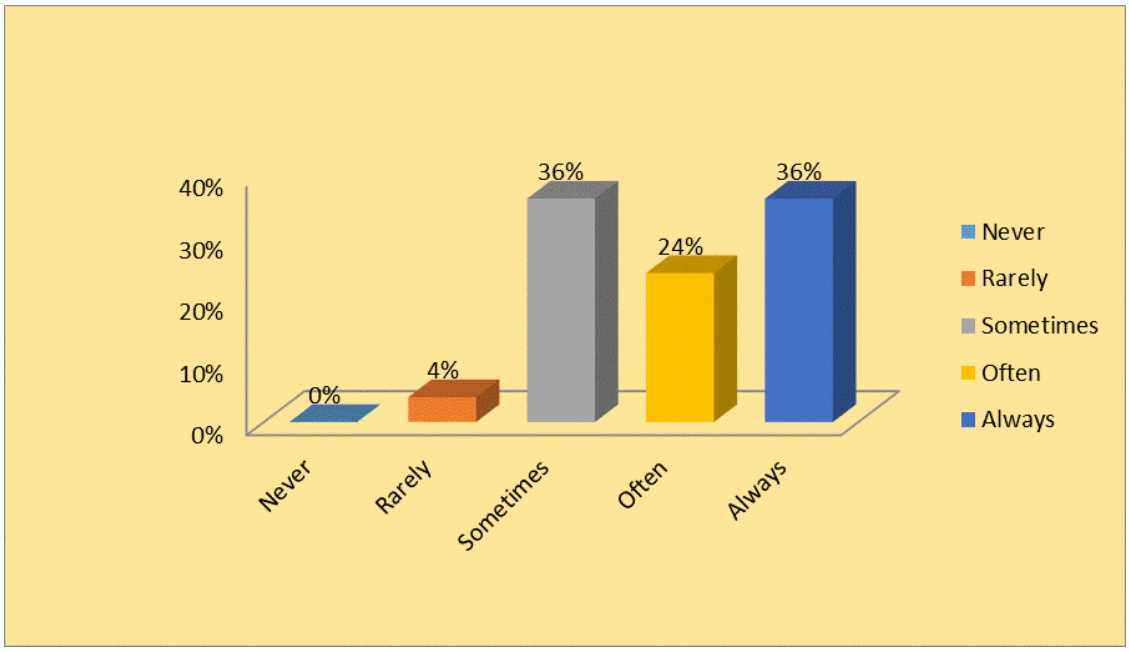

Figure 4.7: Feedback on M&E especially reports once submitted upwards
Source: Computed by Author using survey dataset

The organization has established a number of feedback mechanism platforms that include monthly work improvement meetings and operational meetings. The HRIO also provides feedback on reporting to the departments on individual basis.

The respondents noted that the M&E focal person was very helpful and there was a lot of cooperation and support. The health workers mentioned that they normally had various meetings including operations meeting where feedback on reports is shared. Some felt the

Work Improvement Meetings where feedback was discussed more exhaustively were monthly. The health workers noted that feedback was displayed on PowerPoint and they were satisfied with the feedback process. They stated that feedback is given through meetings, displayed on PowerPoint. Key to note is that they indicated that they were satisfied with the feedback process since grievances & issues raised were addressed. The health workers felt that feedback should be shared more often while some mentioned that the feedback process should be consistent or regular. This is in line with Mebrahtu's study which noted that the value of efficient feedback mechanisms cannot be underscored and this is a vital activity in monitoring and evaluation. Organizations need to put in place feedback mechanisms to share information with different stakeholders to build their knowledge base and for learning and reflection. There is widespread consensus on the insufficiency of current feedback platforms (Mebrahtu, 2002).

The health workers saw the feedback given as crucial as it shows appreciation and boosts morale of the health workers. One respondent stated that feedback improves morale of workers as feedback is appreciation of work well done adjustments and improvements are made to give finer details on programmes in place. They also indicated in the feedback sessions there is improvement on data resulting to more quality information. The feedback sessions were also seen to help identify strengths and weaknesses of the health workers in regards to monitoring and evaluation.

When asked whether they think feedback from M&E activities were used to improve the project 80 percent of the respondents strongly agreed while 20 percent agreed. This alludes that the health workers recognize a strong relationship between M&E activities and project improvement. This is noted by a response give that the health workers that they should get feedback often because they would like to know what is happening in HIV field within Mbagathi and ways in which we can improve.

Some of the respondents felt that feedback was not properly addressed. They stated that feedback takes sometime before it is given and that sometimes the views of the health

workers are not taken into account. One respondent felt that feedback should be provided consistently.

4.6 Utilization of Monitoring and Evaluation Information

When asked the types of evaluations that are carried out within the programme 68 percent identified baselines, 60 percent identified needs assessments,40 percent outcome evaluations,32 percent impact evaluations,32 percent process evaluation and 28 percent summative evaluations. The least conducted evaluations at the programme were mid-term evaluations at 24 percent post ex-ante and ex-ante evaluations at 4 percent respectively. This is depicted in Figure 4.8 below. Baselines are important to understanding the emerging change. Outcome, summative and impact evaluations validate the change. The health workers are conversant with the types of evaluations and could differentiate them.

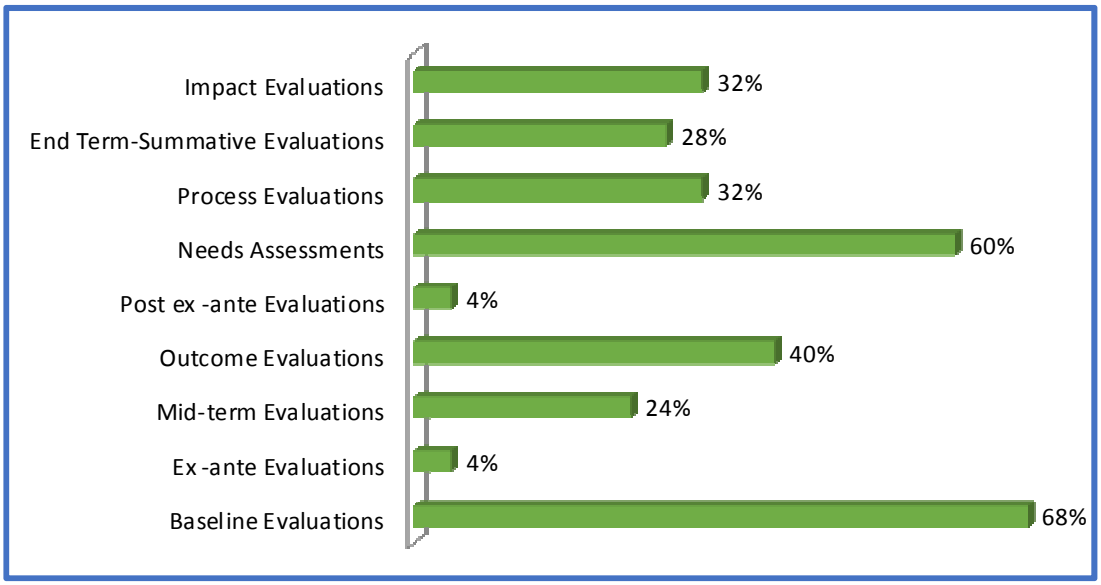

Figure 4.8:Types of evaluations conducted in the programme

Source:Computed by Author using survey dataset

In the programme from the responses given evaluation reports are shared in a number of ways which include through Continued Medical Education (CMEs), through meetings and discussions especially through the work improvement meetings, digitally, etc. Evaluations done through the county are also shared and different representatives sit in meetings and forums where the results are shared and cascade them back to the CCC.

One of respondents mentioned. In a study by King et al. (2011) he noted that evaluators employ two different sets of actions to engage project staff with the intention of raising commitment to evaluations (a) participation of the staff in the evaluation design and (b) assisting in the development of evaluation instruments. A recurrent concern has been how to identify the staff to aptly take part in these interactions. The Mbagathi CCC has worked towards gaining staff commitment in the evaluation process by disseminating evaluation results and ensuring discussions and consultations on the evaluation results.

When asked how often they used evaluation results 43 percent of the respondents said always, 39 percent said often, 5 percent said sometimes while 13 percent said seldomly as shown in the figure below. It is quite encouraging to note that at least there is no respondent who said they do not use evaluation results. This augments the value placed on M&E and the information it generates within the CCC programme. There is still a percentage that is not using the evaluation results optimally and there should be concerted efforts to ensure that they maximize utilization of results.

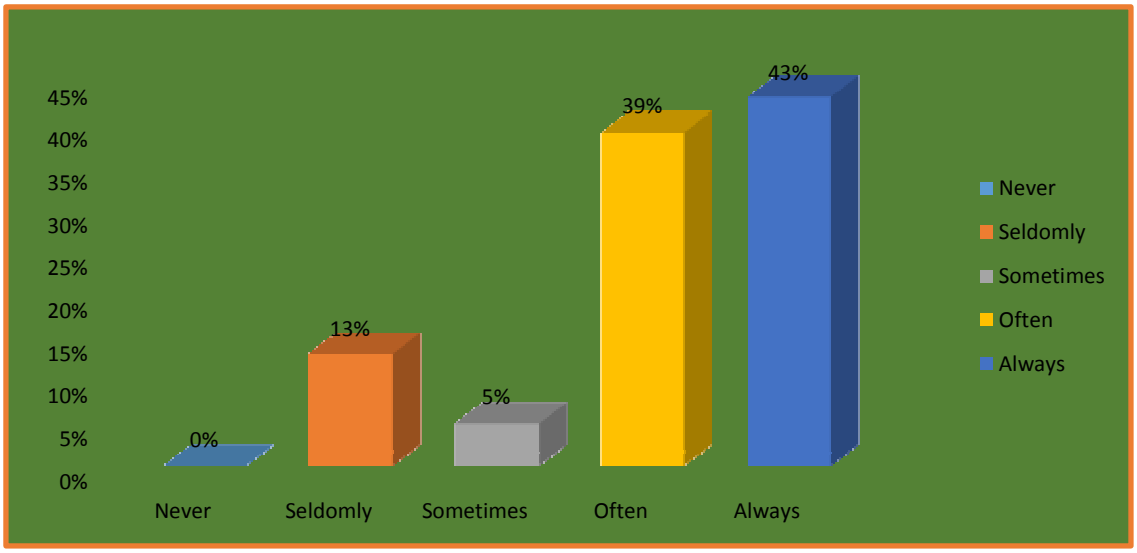

Figure 4.9: Utilization of evaluation results

Source: Computed by Author using survey dataset

The respondents agreed that evaluation results were significantly used in decision making (68 percent) and to improve implementation (62 percent). This shows the significance placed on evaluations. The health workers also indicated that they used the results for accountability and transparency (52 percent), to show achievements and results (52 percent), to identify gaps (52 percent).Only (24 percent) used evaluation results to understand the implementation process. The respondents did not identify the evaluation results with advocacy which they rated at (12 percent) this could be attributed to the fact that the hospital is more of an implementing or service delivery point. The results of this are summarized in figure 4.10 below. The respondents seemingly understand the importance of M&E and use results in key areas needed.

Coyle (1989) states that there is awareness that evaluations may appear threatening to practitioners in this case HIV health workers because of the possibility that evaluation research will show that their projects are not as effective as they believe them to be. These needs and vulnerabilities should be taken into account as evaluation research management is developed. If not well managed it may have negative impact on health workers and they may view evaluations as judgmental practices and may form some resistance to M&E practices. From the positive attitude depicted by the health workers on evaluations we can conclude that evaluations and their objectives are properly understood thus the health workers are more inclined to implement them and use their results. The programme seems to have considered and addressed the vulnerabilities associated with evaluations to enable more enthusiasm in implementing them.

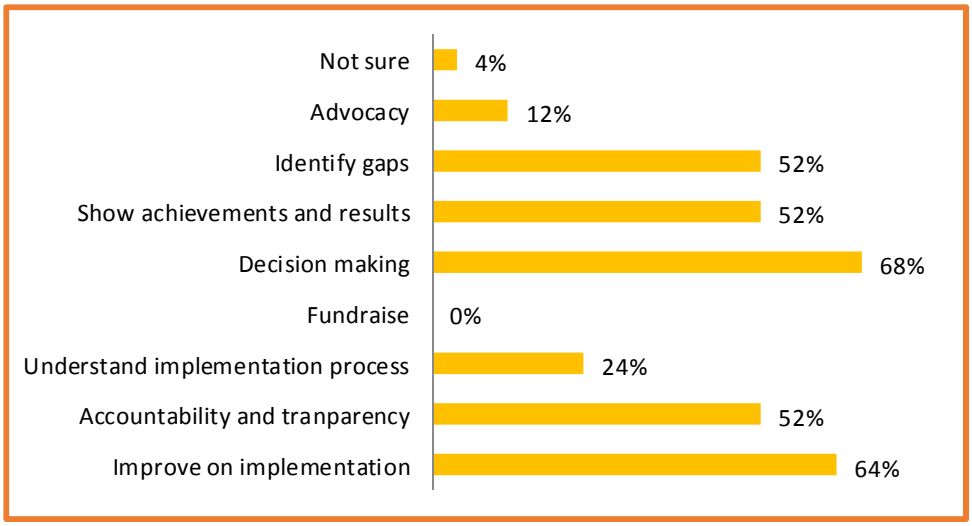

Figure 4.10: Utilization of evaluation results
Source:Computed by Author using survey dataset

Some of the M&E weaknesses cited by respondents included they felt that the health workers are involved in many different activities and sometimes they lack support or motivation. Some felt they lacked an accurate interconnected system within the facility and at times they experienced interconnectivity challenges. Some of the health workers mentioned that some of the clients at the clinic were not straight forward and lied so much when giving information and this had an effect on the kind of information that was collected. Another weakness identified was poor documentation of SGBV cases. The programme was very strong on documentation and some of the health workers saw this positively as providing adequate information, at the same time they felt that the information was captured properly.

CHAPTER FIVE
SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary of the study findings, the conclusions derived from the findings and the recommendations to the programme and the wider sector.

5.2 Summary

The study on perceptions and practices of monitoring & evaluation of health workers on HIV/AIDs Interventions was conducted at Mbagathi Hospital, Nairobi County. The aim of the study was to establish how health workers at the Comprehensive Care Clinic at Mbagathi Hospital in Nairobi County perceive and practice monitoring and evaluation.

The study employed a cross sectional research design and purposive sampling technique. The target population was health workers working in the Comprehensive Care Clinic (CCC) at Mbagathi Hospital. A semi-structured questionnaire was administered to the health workers. Microsoft Office Excel 2007 was used in the quantitative data analysis where by descriptive statistics like percentages were generated.

Key results indicated that the health workers had a good understanding of the HIV/AIDs information that is required by the programme. They all agreed it was important to keep proper records and they had a good perspective of the important information needed. They regard monitoring and evaluation as very useful or useful. Most of the health workers were aware of written M&E guidelines within the programme. The health workers had mixed views on the current HIV/AIDS indicators some had positive views while some were skeptic, they were especially concerned with their being effective in light of the new HIV/AIDS strategy, the 90-90-90 Strategy. This is an ambitious strategy to ensure treatment of HIV/AIDS. It aims that by 2020, 90 percent of all people living with HIV will know their HIV status. By 2020, 90 percent of all individuals diagnosed HIV infection will obtain continuous antiretroviral therapy. By 2020, 90 percent of all

individuals getting antiretroviral therapy will have viral suppression. These are the key indicators that HIV/AIDS programming should now focus on.

The health workers agreed that they use M&E forms for keeping records. They summarize results on a monthly basis and submit to the HRIO. It appears the M&E system is clearly laid out and the staff know and actively play their roles to ensure that the system is functional. Most of the staff agreed that they take part in the development of data collection tools and data analysis. This has ingrained appreciation and value for M&E within the programme. There are a few who felt differently. The respondents affirmed that they submitted reports in good time but a small percentage felt this was not always the case as some back and forth sometimes took place on the data. The feedback mechanisms are in place within the programme.

5.3 Conclusion

The study indicates that perceptions and practices of monitoring & evaluation at the Mbagathi hospital CCC are very strong. M&E is perceived to be important and M&E practices are continuously carried out. The programme has actively involved health workers in M&E practice bringing in a silent but binding contract between employer and employee. The main challenge on this is that it is driven from the HRIO department. M&E is viewed as useful but it is strongly tied to conditions or made a prerequisite for other operational activities. This may be intended to enhance performance but it may breed negative attitudes or feelings of control. There are mixed feelings on HIV/Indicators that may distort the accurate narrative on the indicators, clarity on the indicators is very crucial. M&E policies/guidelines are the basis of contract of the employee (health worker) engagement and the institution (Mbagathi) on M&E issues. A good percentage of the health workers are aware of the guidelines but their level of internalization is not very high.

In terms of practice, a lot is taking place as far as M&E is concerned notably data collection, analysis and management and feedback mechanisms. The data collection process is optimally functional and electronic database system i.e. the IQ within the

programme has enhanced the data collection and analysis process. Reporting is structured and there are set time lines as to when reports should be submitted. Feedback mechanisms are largely in form of meetings especially monthly progress meetings. Feedback is associated with motivation, appreciation and work improvement by the health workers consequently how it is communicated and how often should be well addressed. In development of an M&E system stakeholder empowerment is very important.

Evaluation results are shared to the staff mainly through meetings and Continued Medical Education (CME) sessions that are not formalized as lesson learning sessions. Utilization of M&E information within the programme is viewed highly and M&E is closely tied to decision making, results demonstration, transparency and accountability it is not strongly linked with advocacy. As much as the institution is a service delivery point they should analyse the information that they generate and use it to advise policy makers in order to contribute to evidence-based policy making. The programme seems to have addressed the needs and vulnerabilities that usually make evaluations to appear threatening subsequently the health workers value and identify with the evaluation process.

M&E and its various functions are perceived in very different ways, emphasizing particular aspects of the process in accordance with the interests and past experiences of those involved some departments see it as core while others see it on the periphery. Continuous management support, resource allocation and assessment for improvement, will ensure positive M&E perceptions and practices at Mbagathi Hospital, which can be an exemplary system for adoption by other institutions.

5.4 Recommendations

On the basis of the conclusions above, the following recommendations were made for key components of the programme:

5.4.1 Recommendations on Policy and Programmes

Written M&E guidelines/policies: Periodically the health workers should be sensitized on the written guidelines/policies to ensure clarity and deeper internalization. The guidelines should also be reviewed periodically to accommodate new issues/situations and challenges. The written guidelines are displayed in Health Records Information offices but there is need to continually discuss them so that the health workers are constantly reminded of their commitment and role to the M&E and information agenda within the programme. The hospital and the programme also have an obligation to conduct participatory reviews of the guidelines.

M&E Ownership: M&E implementation should not have conditions attached to it or be viewed as a prerequisite to other activities. It is important to sensitize staff on the importance of M&E and its use so that they are willing in the process and not viewing it as a condition. The programme needs to adopt innovative ways of making staff embrace M&E more.

Sensitization on the HI/AIDS Indicators: Ensure broader understanding and implications of the HIV/AIDS indicators within the programme and the institution. The Continued Medical Education (CME) could be a good starting point. There is also need to review the HIV/AIDs indicators in light of the new HIV/AIDs guidelines this can be pushed from all quarters starting at programme level moving up to the national level.

Inculcating the M&E culture: M&E agenda should be continuous. The weekly departmental meetings should bring in the M&E agenda before the wider monthly meetings. The M&E agenda or discussions should also be encouraged at departmental level to ensure a stronger establishment of M&E so that it's not just driven by the HRIO department. Each department should identify an M&E champion to drive M&E within the department.

Review and strengthening of Feedback Mechanisms: The feedback mechanisms within the programme should be periodically reviewed and enhanced to ensure that all health workers in the different programme levels receive timely and appropriate feedback. Feedback should be positively delivered as this can be a very sensitive issue. The CCC should explore simpler, fast and innovative ways of sharing feedback within the programme including exploring electronic avenues.

Enhanced utilization of evaluation results: Evaluation results should be shared in formalized learning sessions so that staff can view results more seriously and draw action plans to implement the lessons learnt. Usage of evaluation results should also be enhanced within the programme. Peer support should further facilitate utilization of evaluation results. The results should be simplified and more tailor made to routine programming to allow the health workers to easily relate to them. It is important to underscore that the end result of M&E information is utilization. Evaluation results should also be linked to advocacy to enhance evidence based policy making from the grass root level.

5.4.2 Recommendations on Further Research

The study looked at perceptions and practices of health workers in monitoring and evaluation but there is need for further research on internalization of monitoring and evaluation policies and guidelines.

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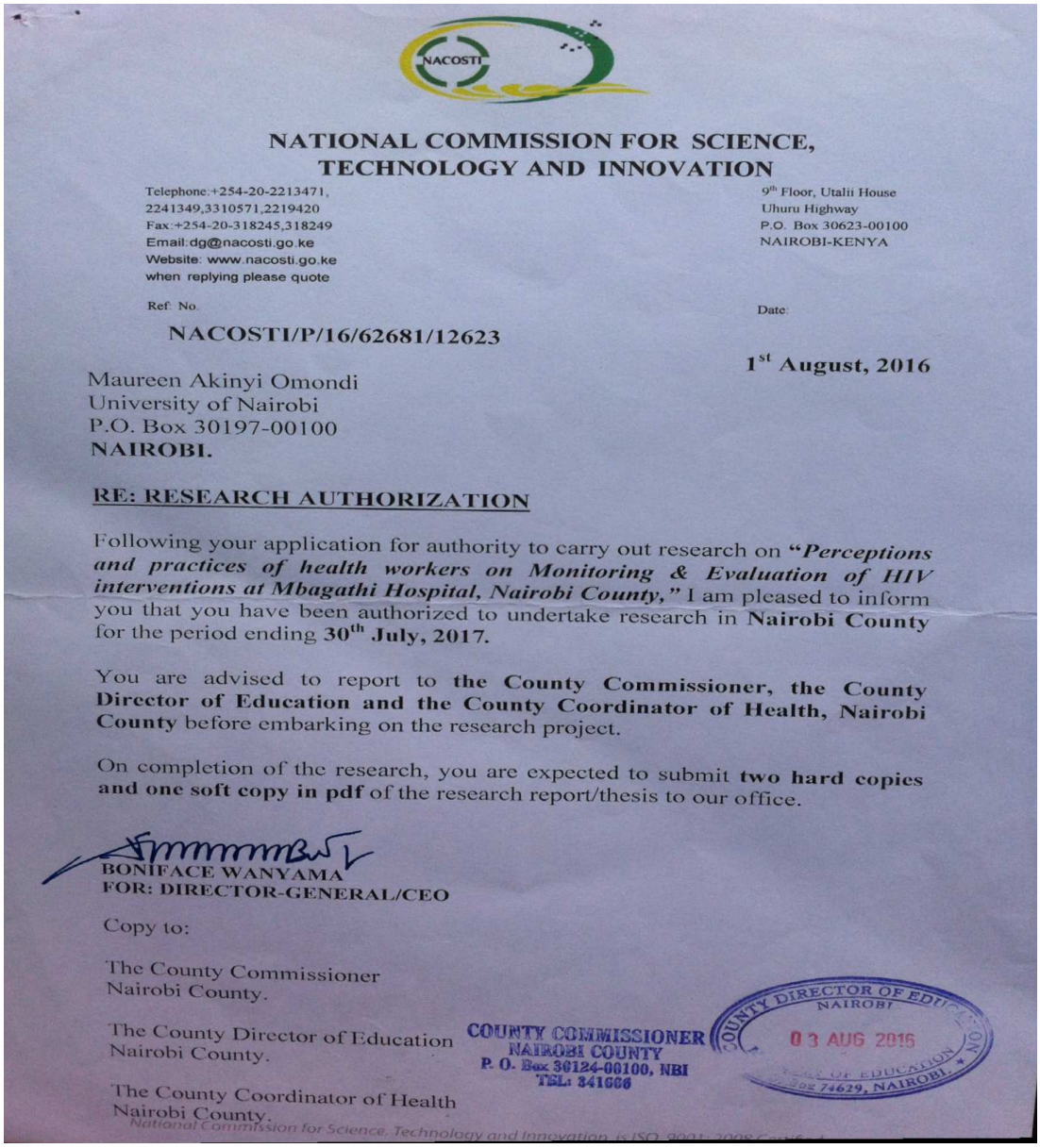
APPENDICES

APPENDIX I: RESEARCH AUTHORIZATION FROM NACOSTI



NACOSTI

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

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9th Floor, Utalii House
Uhuru Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No.

NACOSTI/P/16/62681/12623

Date:

1st August, 2016

Maureen Akinyi Omondi
University of Nairobi
P.O. Box 30197-00100
NAIROBI.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Perceptions and practices of health workers on Monitoring & Evaluation of HIV interventions at Mbagathi Hospital, Nairobi County,"*** I am pleased to inform you that you have been authorized to undertake research in **Nairobi County** for the period ending **30th July, 2017.**

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

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

BONIFACE WANYAMA
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
Nairobi County.

The County Director of Education
Nairobi County.

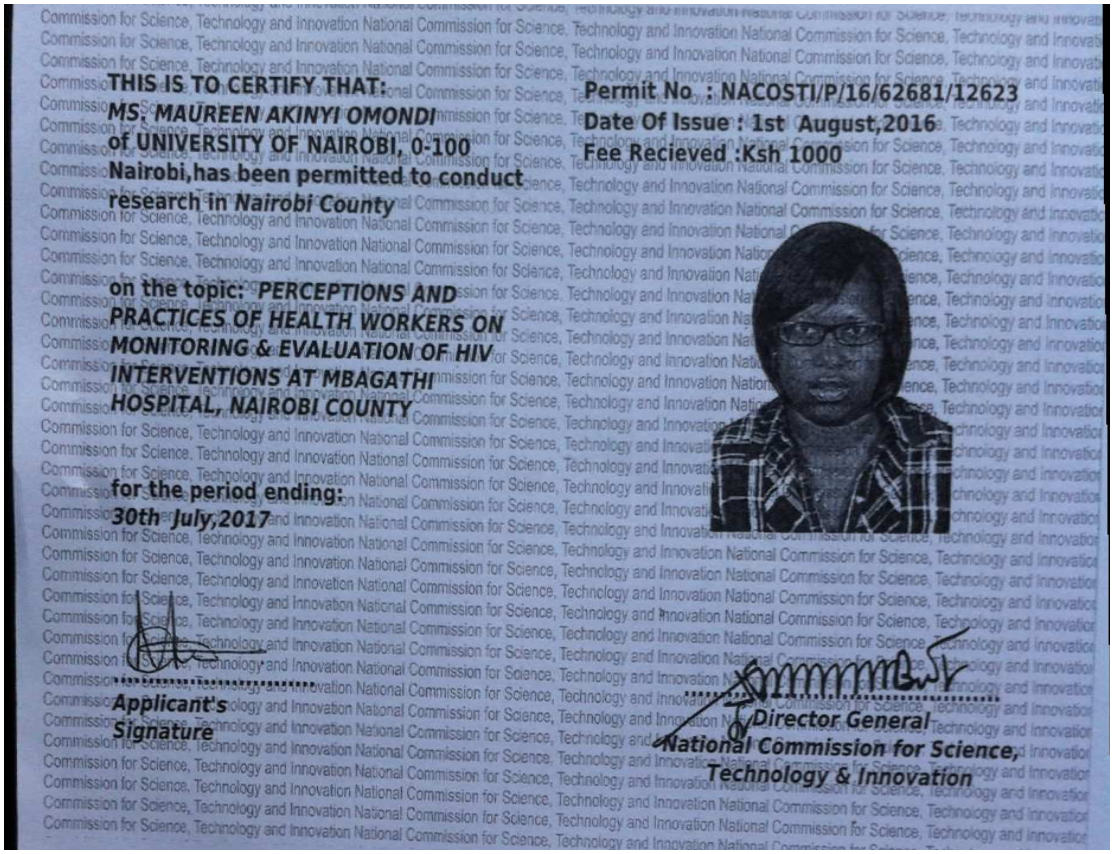
The County Coordinator of Health
Nairobi County.

COUNTY COMMISSIONER
NAIROBI COUNTY
P. O. Box 30124-00100, NBI
TEL: 341666

COUNTY DIRECTOR OF EDUCATION
NAIROBI
03 AUG 2016

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

APPENDIX II: RESEARCH PERMIT BY NACOSTI



THIS IS TO CERTIFY THAT:

MS. MAUREEN AKINYI OMONDI

of UNIVERSITY OF NAIROBI, 0-100

Nairobi, has been permitted to conduct

research in *Nairobi County*

on the topic: *PERCEPTIONS AND PRACTICES OF HEALTH WORKERS ON MONITORING & EVALUATION OF HIV INTERVENTIONS AT MBAGATHI HOSPITAL, NAIROBI COUNTY*

for the period ending:

30th July,2017

Permit No. : NACOSTI/P/16/62681/12623

Date Of Issue : 1st August,2016

Fee Recieved :Ksh 1000

.....

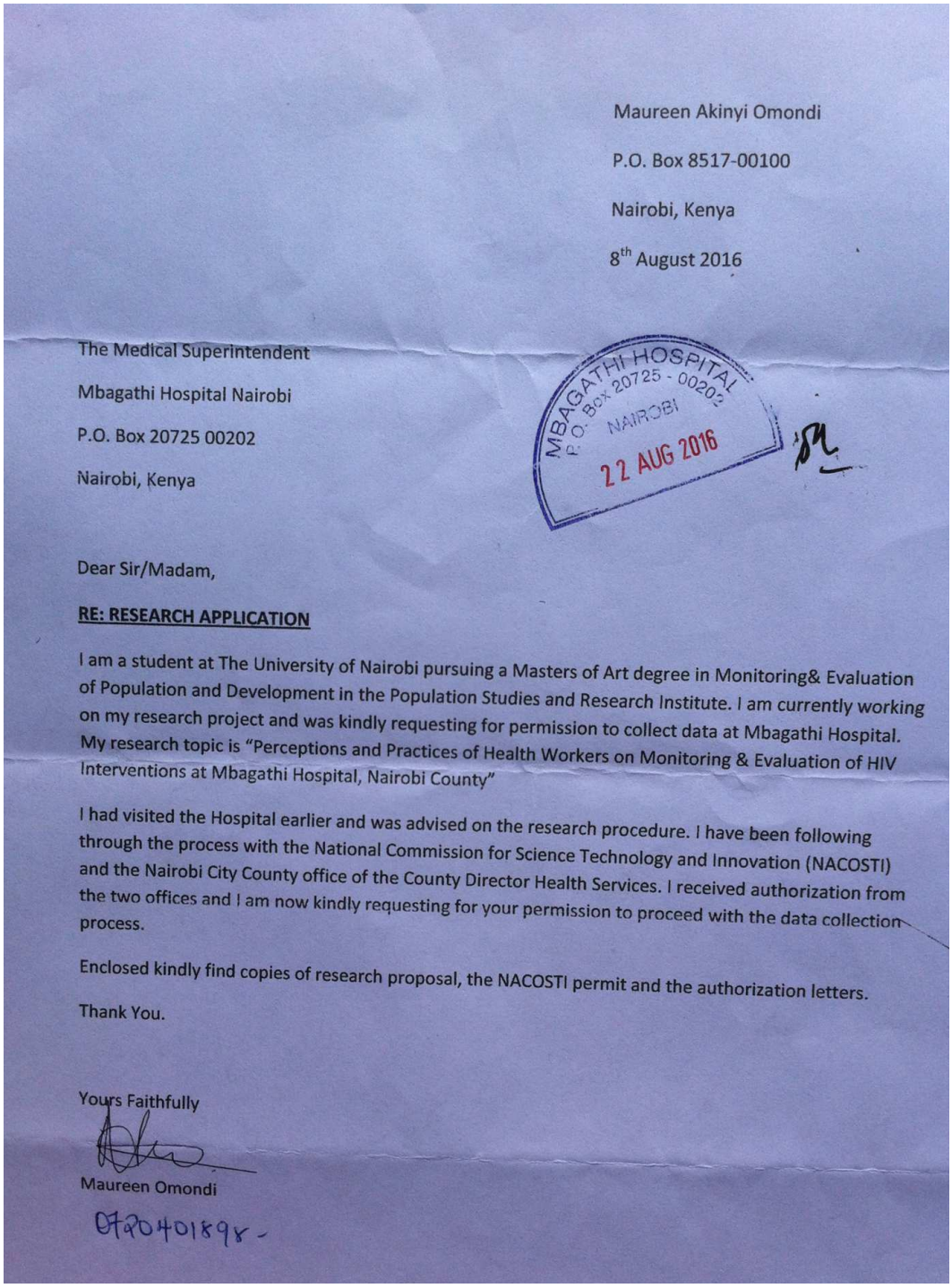
Applicant's Signature

.....

Director General

National Commission for Science, Technology & Innovation

APPENDIX III: APPLICATION TO MBAGATHI HOSPITAL



Maureen Akinyi Omondi

P.O. Box 8517-00100

Nairobi, Kenya

8th August 2016

The Medical Superintendent

Mbagathi Hospital Nairobi

P.O. Box 20725 00202

Nairobi, Kenya

MBAGATHI HOSPITAL
P.O. Box 20725 - 00202
NAIROBI
22 AUG 2016

Dear Sir/Madam,

RE: RESEARCH APPLICATION

I am a student at The University of Nairobi pursuing a Masters of Art degree in Monitoring& Evaluation of Population and Development in the Population Studies and Research Institute. I am currently working on my research project and was kindly requesting for permission to collect data at Mbagathi Hospital. My research topic is "Perceptions and Practices of Health Workers on Monitoring & Evaluation of HIV Interventions at Mbagathi Hospital, Nairobi County"

I had visited the Hospital earlier and was advised on the research procedure. I have been following through the process with the National Commission for Science Technology and Innovation (NACOSTI) and the Nairobi City County office of the County Director Health Services. I received authorization from the two offices and I am now kindly requesting for your permission to proceed with the data collection process.

Enclosed kindly find copies of research proposal, the NACOSTI permit and the authorization letters.

Thank You.

Yours Faithfully

Maureen Omondi

0720401898

APPENDIX IV: INTRODUCTION LETTER

UNIVERSITY OF NAIROBI

HEALTH WORKERS QUESTIONNAIRE

INTRODUCTION

I am a student in the Population Studies Research Institute in the College of Humanities and Social Sciences at the University of Nairobi undertaking a Master of Arts Degree in Monitoring & Evaluation. As part of the course I am carrying out a study on how HIV health workers perceive and practice monitoring and evaluation at Mbagathi health facilities within the university.

The study will generally look at perceptions and practice within the health facility. Your participation in the study is voluntary. The data collected will be handled with utmost confidentiality and anonymity. The interview will take at least 1 hour.

We thank you for agreeing to be part of this study.

APPENDIX V: SEMI STRUCTURED QUESTIONNAIRE

Demographic Data

1) Sex of the respondent □ Male □ Female

2) Age of the respondent

□20-29 □30-39 □40-49 □50-59 □60+

3) Cadre of the health worker _____

4) Highest level of education

□O-Level □College Certificate □College Diploma □University Degree

5) Number of years at the health facility_____

Perceptions on Monitoring & Evaluation

6) Why do you think it's important to keep proper records of all HIV cases seen at the health facility?

□ Because we are asked to do so

□ To keep busy

□ To have information on the number of HIV cases seen at the facility

□ Don't know

7) Important information that should be documented on a patient who visits the health facility include: Tick all the appropriate

□ Date of consultation

□ Name of patient

□ Occupation of the patient

□ Treatment offered

8) For data to be useful and effective it should

□Should meet the set timelines

□Should be complete data/information

□Should be accurate

□Should take into account the previous updates from the field

9) Do you think it is important to develop an M&E Plan for programmes or projects?

□Yes □No

10) Give reasons for the answer above

_____
_____
_____
_____

11) How do you regard information derived from M&E practices?

□Useless □somewhat useful □useful □very useful

12) What do you think of the HIV indicators currently in place?

_____
_____
_____
_____

13) Are you aware of any written procedures/policies/guidelines that guide M&E processes within the HIV programme?

What are your views on the guidelines?

_____
_____
_____
_____

Practice of Monitoring & Evaluation

14) What do you use to keep records?

□Exercise book

□Smart phone

□Any available paper

□Health facility M&E forms

□Any available form

15) What do you do with all the records you collect in a month?

□Put the records in my drawer

□Summarize the cases to get totals

□Discard them since the month has ended

□Take to my house for safe keeping

16) At the end of the month when you have put together all the HIV cases what do you do with the forms

□Wait for the HRIO focal person to come for them

□Keep them with me until they are requested

□Send them to the HRIO focal person

□Don't know

17) Are reports submitted on time?

□Never □Rarely □Sometimes □Often □Always

Reasons for the answer above

_____

_____

_____

18) Do the staff take part in the development of data collection tools?

□Never □Rarely □Sometimes □Often □Always

19)How are staff involved in the development of data collection tools?

_____

_____

_____

_____

20) Do you take part in the analysis of the data collated? Give reasons for the answer.

_____

_____

_____

21) How often do you send data on HIV cases to the health county office?

□Daily □Weekly □Monthly □Quarterly □Semi-annually □Annually □Never

22)How often do you think that health workers who carry out M&E activities should involved in planning for the M&E activities?

□Never □Rarely □Sometimes □Often
□Always

23) How would you describe the planning of M&E activities?

_____

_____

_____

24)Do you get feedback on M&E activities especially on reports and data collected once they are transmitted upwards?

□ Never □ Rarely □ Sometimes □Often
□Always

25) What are your views given the answer above?

26) Do you think M&E feedback can be used to improve implementation?

□Not sure □Strongly Disagree □ Disagree □Agree
□Strongly Agree

27) What kind of evaluations does your organization conduct internally and externally?

□Baseline evaluations □Needs Assessments

□Ex ante Evaluations □Process Evaluations

□Mid Term Evaluations □End Term/Summative Evaluations

□Outcome Evaluations □Impact Evaluations

□Post Ex ante Evaluations

28) How are evaluation results shared with health workers at the Comprehensive Care Centre?

_____

_____

29) How often do you use evaluation results?

□ Never □Seldomly □Sometimes □Often □Always

30) How do you use evaluation results?

□ To improve on implementation

□ For decision making

□ For accountability and transparency

□ To show achievements and results

□ To understand the implementation process

□ To identify gaps

□ To fund raise

Any other reason

_____

_____

_____

31) In your view what are the strengths and weaknesses within HIV programmes

_____

_____

_____

_____

32)What recommendations can you give to strengthen M&E practices within the programme

_____

_____

_____

_____

This is the end of the interview

Thank you very much for your participation and cooperation.