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Effects of Monitoring and Evaluation of Reports on Quality of Service Delivery within the Health Sector in Nyandarua County, Kenya

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Abstract: Reliable and accurate health information is important for monitoring health and for evaluating and improving the delivery of healthcare services and programmes. Studies on Health Information Systems in resource-poor countries often document problems with reporting such as incomplete records and untimely reporting. These systems are the source of data that can be used for continuous and routine monitoring of health programmes. The objective of the study is to determine the influence of monitoring and evaluation of writing of health reports on the quality of service delivery in health facilities in Nyandarua County, in Kenya. Descriptive design was used in order to determine the relationship between the completeness and accuracy of health reports and quality of healthcare. Under the design, in-depth information about how health workers practices, in relation to weekly and monthly health reports, affect the quality of healthcare provision will be understood. Majority of the health workers reported their ability to report using the tools comfortably. Some of the respondents revealed that they had challenges when writing reports as they did not understand the reporting tools adequately. Healthcare workers are seen to be conversant with the data collection and reporting tools. Findings therefore demonstrate that those who are not conversant with the reporting tools are likely to give inaccurate data. The study established that when monitoring and evaluation of health report-writing is not carried out, the quality of service is affected. For example, in relation to staff deployment, commodity procurement and disease management.

Keywords: *Health Reports, Quality of Service Delivery, Report Timeliness*

Introduction

Reliable and accurate health information is important for monitoring health and for evaluating and improving the delivery of healthcare services and programmes. The funding and support of health activities (for example immunization and outreach programmes) are dependent on routine statistics (Mphatswe *et al*., 2012). Studies on health information systems in resource-poor countries often document problems with data quality such as incomplete records and untimely reporting. These systems are the source of data that is utilized during the routine monitoring of health programmes. A study of this system however has reported that the quality of data is suboptimal and is hindering efforts to strengthen service delivery (Mphatswe *et al*., 2012).

A study by Nyamtema (2010) showed that some healthcare workers do not understand the purpose, use and the procedure for health data collection, leading to poor quality reports. Therefore, the decisions made by the healthcare managers are not appropriately informed. Some of the healthcare workers do not understand the data required by the health reporting tools and where to get such data from. According to the study, there is a challenge by the health workers in terms of understanding the reporting tools.

Most often, data set requirements are chosen without considering the technical skills of the healthcare workers who are going to utilize the reporting tools. In addition, lack of training on the health reporting tools in colleges and universities (pre-service training) has contributed to inadequate knowledge (Lippeveld, Sauerborn & Bodart, 2000). A study by Harikumar (2012) showed that most health facilities submit their weekly or monthly reports past the deadline. Although all healthcare workers are aware that reports are submitted every Monday (for weekly reports) and by 5th of every month (for monthly reports), most of them still are ignorant when it comes to submitting their reports on time.

Hakorimana (2016) shows the health facilities are supposed to submit reports at the end of every month, but few do submit their reports on time. A study by Simba and Mwangu (2005) showed the average data completion rate in health facilities within Kinondoni (Tanzania) to be slightly above average. The completion rate as per the study is higher in public health facilities as compared to the private health facilities. Moreover, lack of data or non-submission of reports is more pronounced among the private health facilities.

Data collected by health facilities in developing countries is often incomplete, inaccurate and is not submitted on time to the relevant offices or officers. This leads to poor quality and unreliable reports (Hera, 2000; Rajesh, 1993). The problem of lack of enough reporting tools for the various departments in the public health facilities has been a major challenge. Therefore, lack of the relevant health reporting tools forces health workers to improvise the reporting tools. This leads to errors of capturing less of the required or more of the unrequired variables. This is likely to affect the accuracy and completeness of the reports and data quality (Republic of Kenya, 2008). A study by Kiberu *et al.* (2014) shows that the roll-out of the District Health Information System 2 in Uganda and Kenya improved the completeness and timeliness of inpatient and outpatient reporting.

Research Methodology

This research was carried out within Ndaragwa Sub-County to determine the relationship between good reporting and quality healthcare service. Ndaragwa Sub-County is among the five sub-counties in Nyandarua County. Others include, Ol Joro Orok Sub-County, Kipipiri Sub-County, Ol Kalou Sub-County and Kinangop Sub-County. Ndaragwa Sub-County has a poor road network which makes accessibility to some of the health facilities not easy.

The sub-county was selected because of the researcher's conversance with all the health facilities in the area. This study had its main focus on healthcare workers of Ndaragwa Sub-County involved in the day-to-day provision of healthcare services. The sub county has 16 health facilities and a total of 106 health workers. 4 of the facilities are health centers and 12 are dispensaries (Department of Health Services Nyandarua, 2016).

The overall design of the research was descriptive. The study involved a large number of respondents with the results obtained being generalized to the target population. It also enabled objectivity and enhanced accuracy of results. Descriptive design was used in order to determine the relationship between completeness and accuracy of health reports and quality of healthcare. Under the design, in-depth information about how health worker practices, in relation to weekly and monthly health reports, affects the quality of healthcare provision was understood. This made the researcher gain more insight on the study. While employing descriptive design, questionnaires were utilized to collect data since they are more reliable and objective.

Systematic random sampling method was used to select the healthcare workers to be included in the study. All the healthcare workers had an equal chance of being included in the study, which was a precursor for reduction of bias. The number of healthcare workers in Ndaragwa Sub County (study population size) was 106. 83 was the desired sample size while 1.3 was the sampling interval. The research randomized the list of healthcare workers, whereby every Kth case (2^{nd} health worker) was picked for the study.

Secondary and primary data was used for the study. Data was collected using a structured questionnaire which was administered to the respondents selected from the study population. The advantage of the questionnaire was that the interviewer was able to get direct responses from respondents. Also, the ability to provide relevant

information on the variables in the study was high. Questions were developed to cover a wide range of topics. The questions were shorter to take less time, closed and open ended questions were used. Open ended questions assisted in gathering more views that were missed in the multiple choice questions.

Results

Respondents were asked questions to assess whether monitoring and evaluation is done by the sub county health management team and county health management team. This was to determine if healthcare workers submit the health reports on time. 73.5 % of the healthcare workers said that they do submit reports on time. 26.5 % of healthcare workers revealed that they did not submit their reports on time. Healthcare workers said that they submit their reports on time (mean of 2.53). However, findings reveal that reports which are not submitted on time will affect data analysis, consumption and utilization.

Respondents were asked if monitoring and evaluation is done on regular basis by the sub county health management team. This was to determine whether the required reporting tools are available. 80.7 % agreed that monitoring and evaluation of data collection and reporting tools availability is done in the facilities they work at. 19.3 % revealed that monitoring and evaluation is not done by the sub county health management team. Therefore, healthcare workers agreed that monitoring and evaluation of reporting tools availability is carried out (mean of 2.39). The findings mean that monitoring and evaluation is not done to some extent to assess the availability of data collection and reporting tools.

Health workers were asked if monitoring and evaluation is done to assess if they know how to use the data collection and reporting tools in their departments. 65.1 % of respondents agreed that monitoring and evaluation is done by the sub county health management team. 25.3 % of the respondents disagreed that monitoring and

evaluation is being done on regular basis. 9.6 % of health care workers strongly disagreed that monitoring and evaluation is carried out. Thus monitoring and evaluation to determine conversance with the reporting tools is carried out (mean of 2.8) according to the healthcare workers. Findings therefore mean that most health workers do not understand the reporting tools well and thus the likelihood of submitting inaccurate reports.

Healthcare workers were asked if monitoring and evaluation is done to ensure all the data elements in the data collection and reporting tools are filled during data collection and reporting. 41 % agreed that monitoring and evaluation is done by the sub county health management team. 15.7 % were not sure if monitoring and evaluation is being done and 43.4 % of the respondents disagreed that monitoring and evaluation on the same is carried out. Thus monitoring and evaluation is undertaken on average (mean of 3.02). The findings mean that lack of monitoring and evaluation to ensure that all data elements are filled may lead to gaps in the data collection tools and reports.

Respondents were asked how often monitoring and evaluation of report timeliness, completeness and submission is done. 26.5 % of HCW said it's done monthly. 14.5 %, 18.1 % and 6 % revealed that monitoring and evaluation is done quarterly, bi-annually and annually respectively. 34.9 % of the healthcare workers said that monitoring and evaluation is not being done. Thus according to health workers, monitoring and evaluation is undertaken biannually (mean of 3.08). This therefore means that monitoring and evaluation is not done often.

Health workers were asked how often monitoring and evaluation of the timeliness of report submission is done by the sub county health management team. 51.8 % of the respondents said that monitoring and evaluation is done on monthly basis. 21.7 % said that it's done quarterly. 26.5 % said that monitoring and evaluation is not being done. Therefore monitoring and evaluation is done on quarterly basis according to the healthcare work-

ers (mean of 2.28). The findings therefore mean that monitoring and evaluation is not undertaken as regularly as necessary.

The respondents were asked how often monitoring and evaluation is done to ensure that all data elements in the data collection and reporting tools are filled. 51.4 % revealed that monitoring and evaluation is not done. 30 % said that monitoring and evaluation is done on monthly basis. A few noted that monitoring and evaluation is carried out quarterly (11.4 %) and biannually (7.1 %). In summary, healthcare workers said that monitoring and evaluation is done bi-annually (mean of 3.21) and thus not are frequent as required. This means that the likelihood for data inaccuracy due to the incomplete data collection and reporting tools is high. This can be addressed through monitoring and evaluation.

Discussion, Conclusion and Recommendation

Findings revealed that the quality of service delivery depends on the quality of data produced by the different health facilities. Knowledge on the data collection tools will enable a healthcare worker to understand the data required and where to get the data from. The findings are in line with Nyatema (2010). He noted that some of the health workers do not understand the purpose, use and the procedure for health data collection thus leading poor quality data. Regular monitoring and evaluation to assess if health workers know how to use the data collection and reporting tools is very necessary. When the reports submitted to the sub county health management team and county health management team are faulty, the quality of service delivery is affected. This marries with the study by Mphatswe *et al.* (2012) which reported that the quality of data by some health workers is sub optimal. This therefore hinders efforts to strengthen service delivery. The study has revealed that some of the health facilities submit their weekly or monthly reports late.

This is in line with a study done by Harikumar (2012) which showed that most health facilities submit their weekly or monthly reports past the deadline. Monitoring and evaluation will also ensure that health workers take report submissions seriously. The findings are complimented by Hakorimana (2016) who also said that few facilities do submit their reports on time. Each data element in the data collection and reporting tool provides unique information. Thus, any missing data in the collection and reporting tools will render a submitted report not useful. This is consistent with the findings by Hera (2000) and Rajesh (1993). They argued that the data collected by health facilities in developing countries are often incomplete, inaccurate. The reports are thus not submitted on time thus leading to poor quality and unreliable reports.

The study has confirmed that when monitoring and evaluation of health reports writing is not carried out, there will be a negative impact in relation to the quality of service being offered. The quality of service will be affected in terms of staff deployment, commodity procurement and disease management. Monitoring and evaluation of reports writing should be undertaken as this will ensure that data collection and reporting tools are available and up to date. Reports will also be submitted on time. In addition, the daily activity registers in the health facilities and the reports submitted, will be completely filled.

Conflict of Interest

No potential confict of interest was reported by the authors

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