



INFLUENCE OF MONITORING AND EVALUATION OF HIV/AIDS INTERVENTIONS ON PERFORMANCE OF HIV/AIDS CARE AND TREATMENT PROGRAM IN NAKURU COUNTY, KENYA

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Abstract

The purpose of this study was to evaluate the influence of monitoring and evaluation of HIV/AIDS interventions on performance of HIV/AIDS care and treatment program in Nakuru County, Kenya. This was guided by the following objectives: to establish the influence of monitoring and evaluation of decentralization process and to establish the influence of monitoring and evaluation of access to HIV care and treatment services on performance of HIV/AIDS care and treatment program, in facilities in Nakuru County, Kenya. This study may be of significance to scholars in the health sector, and may also help decision makers and clients. This study was carried out in Nakuru West Sub County, Nakuru County, Kenya, targeting 11,630 active people living with HIV/AIDS and 50 health care providers in 14 health facilities in the Sub County offering HIV/AIDS care and treatment services. The study used descriptive cross-sectional survey. Data was subject to descriptive inferential statistics using Statistical package for social science (SPSS). From the findings, the researcher concluded that there is increased number of facilities offering HIV/AIDS care and treatment and a significant number of the population is reached with HIV/AIDS care and treatment services, majority of the clinicians and patients agreed that some patients bypass other ART sites when coming for HIV /AIDS

care and treatment services. The researcher recommends that all lower level facilities should offer HIV/AIDS care and treatment and put in place mechanisms to Monitor and Evaluate decentralization and integration of HIV/AIDS care and treatment services. The researcher also recommends that health facilities should increase health staff to help them meet PLHIV needs and increase inter-professional and inter-departmental collaboration to improve access to their services. More studies should be done on; Influence of monitoring and evaluation of HIV care and treatment interventions and performance of HIV/AIDS care and treatment program in other parts of the country since this study focused only Nakuru county and on other interventions.

Keywords: Health management, monitoring and evaluation, HIV/AIDS interventions, decentralization process, integration of services, capacity building, access to HIV/AIDS care

INTRODUCTION

HIV/AIDS is a global phenomenon, it affects all people around the world and it is killing more people than any war or famine in history (United Nations Committee on social and behavioral science base for HIV/AIDS prevention and intervention workshop of 1995). HIV/AIDS is a major public health concern and fifth cause of morbidities and mortality in many parts of the world and ranks second in Sub Sahara Africa (Murray et al. 2012). According to World Health Organization (WHO) and United Nations Development Program (UNDP) on HIV, 35million people were living with HIV globally at the end of 2013 with sub Sahara Africa accounting for 71 percent of the people living with HIV worldwide. According to United Nations Program on HIV/AIDS (UNAIDS) data of 2017, Western and Central Europe and North America had 2.1 million people living with HIV by 2016 with an HIV adult prevalence of 0.3 percent, 18,000 AIDS related deaths had been reported and there were 73,000 new infections. UNAIDS data of 2017 reveal that East and South Africa is the region most hit by HIV/AIDS in the world and it is home to 6.2 percent (19.4 million) of the world's population, the largest number of people living with HIV. In 2016, there were 790,000 new infections, 43 percent of the Global total, the HIV prevalence is 7 percent for adults. South Africa has 7.1 million people living with HIV (18.9 percent prevalence rate) and accounted for one third (270,000) of the region's new infections in 2016. Just under half a million people (420,000) people died of AIDS related illnesses in the region in 2016. Nigeria bears the second largest burden of HIV infection in Africa, second to South Africa, with estimated 3.1 million people living with HIV (2.9 percent adult prevalence) by 2016 and 1.4 million HIV infected persons needing antiretroviral therapy (ART), only a third of them were accessing treatment by the end of 2012.

In 2003, governments, international and funding bodies began to implement plans to increase antiretroviral therapy (ART) coverage in resource limited countries. Unfortunately, people living with HIV in resource limited countries who receive ART still do not have a normal life expectancy. Time and expenses of travelling long distances to keep clinic appointments are widely recognized as a major barrier to accessing HIV care and treatment in Sub Sahara Africa (Sydney Rosen and Mathew P. Fox, 2011). Despite the scale up of HIV care and treatment services, treatment programs have been concentrated in the national, county and Sub County hospitals. In 2007, the WHO director-General called for an integrated approach to the delivery of health care services, citing a rise in single disease funding and low income country health services resource constraints. Integration was piloted in rural Kenya between 2008 and 2010. Despite the evidence suggesting benefits to integration, the patient and service level is unclear.

Capacity is the ability to carry out stated objectives (Goodman et al, 1998). It is important to monitor and evaluate capacity building so as to assess the current level of capacity and identify existing needs and gaps for support; determine which interventions will address the gaps in capacity and performance; define performance objectives and determine the outcome measures to evaluate progress; plan for long term support for capacity building and develop a time frame for periodic evaluation of outcome and determine the level of stakeholders commitment and ownership. Monitoring and Evaluation of Capacity building strategies is done in order to demonstrate how program investments are resulting in improved capacity and performance.

Access is clearly critical factor in HIV/AIDS care and treatment program, and other characteristics of health services such as price and quality and of individuals such as education, views towards modern medical care, income, and wealth may exert greater influence than physical proximity to care. Studies have shown that people will bypass facilities that are close by in order to access higher quality care (Akin and Hutchinson, 1999). Achievement of universal access to HIV care and treatment services require more effective use of data to identify service gaps in the cascade of HIV/AIDS care and treatment performance and improve programs and services to meet targets. A culture of data use for program improvement at all levels, from facility level to national program management, is needed to improve uptake and retention of people living with HIV and maximize the benefits of HIV/AIDS care and treatment services for improved survival for people living with HIV and reduced transmission of HIV (UNAIDS, 2013).

Statement of the Problem

Significant success has been made on scaling up ART programs worldwide, yet many people living with HIV do not have a normal life expectancy; do not enroll in care, while others enroll

and drop out, while others start ART late in the progression of HIV infection, resulting to high mortality on ART. The role of decentralization, integration, capacity building and improved access to HIV care and treatment services is to widen utilization of care and improve survival rate among PLHIV. Decentralization is geared towards decongesting the current systems of the current ART sites, located in most district and provincial hospitals to lower level health centers and dispensaries. This expectation is in variance with current situation because PLHIV are still travelling far to access HIV care and treatment services, others bypass health facilities near their homes and there is still congestion in higher level facilities. This is reflected by reports in Kenya District Health Information System (DHIS) whereby out of 11,630 active patients on HIV/AIDS care and treatment in Nakuru west sub county, 8,850 are at Nakuru level 5 hospital while the remaining 2680 is shared among the other 13 health facilities offering HIV/AIDS care and treatment services. This puts a lot of strain on Nakuru level 5 hospitals whereby resources and staff are overwhelmed by the large numbers who visit the facility.

Most Countries report high proportions of people living with HIV on HIV care and treatment as a result, HIV prevalence is generally low, but still far too many people are still being diagnosed late, gaps in provision of HIV services remain with key affected population facing a number of barriers. In Brazil, HIV/AIDS care and treatment services have been concentrated in urban areas where the prevalence is high but the population is low leaving the other areas like the North, North east and Midwest with inadequate available HIV services. In South Africa, delivery of HIV care and treatment to rural communities presents unique challenges. In Nigeria, despite many PLHIV reporting many advantages of decentralization of HIV /AIDS care and treatment services, there are both geographical and socio-economic inequities to access.

According to Uganda based impact assessment report of 2017, integration of HIV/AIDS care and treatment with other services predominated the HIV response in 2014, and despite improvements in geographical coverage for ART, persistent disparities in sex, age and districts' ART coverage continue and there is insufficient tracking of National HIV Monitoring and Evaluation plan and limited popularization of the plan. Studies done in Kenya have shown that during the first few years of decentralization, access to crucial HIV care and treatment services and quality of services increased and the researcher proposed further studies to confirm his findings and assess the long term effects of decentralization on provision of care and quality of services. Monitoring and Evaluation of decentralization include collecting information on decentralization program for verifying compliance with policy goals, analyzing alternative outcomes and guiding decision making. Despite the evidence suggesting system and national-level benefits to integration, the patient and service level is unclear. Capacity is rarely a one off

investment and calls for continuous monitoring of capacity demands and ability of organizations to meet them. According to Okwonko et al., (2014), characteristics of individuals accessing treatment may change over time, and this may affect overall outcomes, therefore monitoring treatment outcomes is essential to identify constraints or deficiencies in program performance. Hence, this study intended to evaluate the extent monitoring and evaluation of decentralization process, and access to HIV care and treatment services influence performance of HIV/AIDS care and treatment programs in Nakuru County, Kenya.

Objectives of the Study

General Objective

The purpose of this study was to evaluate the influence of monitoring and evaluation of HIV/AIDS interventions (Decentralization process, Integration of HIV care and treatment services, Capacity Building and access to HIV/AIDS care and treatment services) on performance of HIV/AIDS care and treatment program in Nakuru County, Kenya

Specific Objectives

1. To establish the influence of monitoring and evaluating decentralization process on performance of HIV care and treatment program in Nakuru County, Kenya.
2. To establish the influence of monitoring and evaluating access to HIV/AIDS care and treatment services on performance of HIV/AIDS care and treatment program.

Research Questions

1. Does monitoring and evaluation of decentralization process influence performance of HIV/AIDS care and treatment programs in Nakuru County, Kenya?
2. What are the effects of monitoring and evaluation of access to HIV care and treatment services on performance of HIV/AIDS care and treatment program?

LITERATURE REVIEW

Theoretical Review

The study adopted Evaluation theory and Andersen's model

Evaluation theory

The evaluation theory consists of the social, science theory as well as the program theory. The social theory plays a major part and role in evaluation practice. Such a theory and prior research are instrumental for providing information on the initial needs assessment and program design.

Evaluation can provide lessons about what is not effective hence save program designs and other resources (Donaldson, 2001). Lipsey (1990) argued that program theory on the other hand contributes to evaluation practice through the identification of key program elements as well as providing information on how these elements relate to each other. Rossi (2004) argued that a program theory consist of an organization plan on how to deploy resources and organize the activities of the program activities to ensure that the intended service systems is developed and maintained. The theory also deals with the service utilization plan which analyses how the intended target population receives the intended amount of intervention through interaction of the service delivery systems.

Evaluation theory looks at how the intended intervention for the specified target population represents the desired social benefits. When patients access HIV care and treatment services, they will be retained in care hence be followed up and offered essential services that will lead to improved health and survival. The aim of decentralization is to achieve universal HIV care and treatment by providing services close to those in need, in a sustainable fashion. It was also expected that decentralization would foster integration of HIV programs with other services provided at the health facilities and result in improved quality of services and patient care. Evaluation theory will assist in evaluating whether decentralization and integration is meeting the above goals

Andersen's model

Andersen's model of health service utilization states that how an organization distribute its resources (decentralization) and whether or not the organization has adequate labor volumes (capacity) will determine if an individual uses health services. Resources comprise the volume and distribution of both labor and capital, including education of health care personnel and available equipment. Organization refers to how a health care system manages its resources, which ultimately influences access to and structure of health services. Decentralization within a geographical region results in shared responsibility (task sharing and integration) for the comprehensive care of HIV positive patients among all available levels of health care facilities and community.

In Kenya resources such as financial for upfront costs like strengthening and provision of appropriate laboratory infrastructure and equipment; capital equipments like refrigeration equipments, shelving; training of personnel; refitting and remodeling of existing structures to ensure adequate space and privacy to clients is scarce and therefore clients are not able to get all that is required. This makes patients travel far for the service if referred and sometimes some prefer to go to a far facility where they can get all the services at the same time, the same day.

When patients go to one facility that has the services, it causes congestion and a patient will take a long time to be served which can cause him/her not to come for the service again leading to poor retention in HIV/AIDS care and treatment.

Empirical Review

Monitoring and evaluation are an essential part of any health care program for informed decision making and in order to assess the effectiveness, cost-efficiency and acceptability of interventions. It enhances the project management decision making during implementation phase thus securing the success of the project (Gyorkkos, 2003; Crawford and Bryce, 2003). Monitoring and Evaluation has become an increasingly important tool within the global efforts in achieving environmental, economic and social sustainability. Monitoring tracks and documents resources use throughout the implementation of the project (Uitto, 2004), helps those involved with projects to assess if progress is being achieved in line with expectations. It is aimed at improving efficiency and effectiveness of the project by providing regular oversight of implementation (Nuguti, 2010).

Monitoring and Evaluation is a process of continual gathering of information and assessment of it in order to determine whether progress is being made towards pre-specified goals and objectives, and to highlight whether there are any unintended (positive or negative) effects from a project and its activities. This enables managers to keep track of progress, identify problems, and alter operations to take account of experience (Center for Global Development, 2011). The information required to measure progress can be drawn from such sources as national surveys of HIV/AIDS care and support, program reports or other documents.

AIDS Indicator Surveys are standardized surveillance tools used by countries with generalized epidemics to provide in a timely fashion and indicators for effective monitoring of HIV. European countries report to European Centre for epidemiological Monitoring of AIDS. In Denmark, Germany, Switzerland and the United Kingdom, strong first and second generation surveillance systems have been put in place but systems for monitoring and evaluation of HIV epidemic in certain risk groups, such as migrants and ethnic minorities, remain unsatisfactory (Atun et al 2005). South Africa has a monitoring and Evaluation framework which is designed to measure progress towards the achievement of two interrelated goals of the comprehensive HIV/AIDS plan. Uganda has a national HIV/AIDS monitoring and evaluation plan for 2015/2016-2019/2020 to track and manage Uganda's national HIV/AIDS response for five years.

Kenya AIDS Indicator Survey is done every 5 years to assess Kenya's national HIV response. Results from KAIS 2007 and 2012 have helped to redesign elements in the national

strategy for HIV prevention, treatment, and care to address deficiencies and seize opportunities as new interventions have been introduced (Maina W.K. et al, 2014). Kenya has a monitoring and evaluation framework of 2014/2015-2018/2019 whose purpose is to facilitate the tracking of progress towards KASF results and generation of strategic information to inform decision making by stakeholders at national and county levels. Information generated at the facility level flows to the sub county level for compilation and analysis for further uploading to District Health information system (DHIS).

Global evidence points a direct correlation between the size of a country's health workforce and its health outcomes (Health sector human resource strategy, 2014-2018). In 2006, WHO alerted the world of a shortfall of 4.3 million trained health workers, with the worst shortages being experienced in the poorest countries in Africa. WHO report of 2006 say Kenya is one of the 57 countries in the world that face severe health workforce crisis and is one amongst 36 within Sub Sahara Africa. The HIV epidemic has increased pressure on the Kenyan health care system as a whole by increasing the workload for health personnel whose numbers have not increased proportionally to the demand and straining infrastructure capacity and public expenditure.

Globally, regional and locally, the goal of HIV care and treatment is to improve the wellness and health outcomes for people living with HIV/AIDS, a common barrier being access to the HIV/AIDS prevention, care and treatment services (WHO, 2004). According to Young, access may be the most important influence on health care utilization (Wolinsky, 1988). Access describes the ability to utilize services and incorporates economic, geographic location, abundance of health services and physical and social resources. If health services are not accessible, it is likely that there will be unmet need for health care.

Monitoring and Evaluation of Decentralization process

It is also important at the outset to make a clear distinction between evaluating decentralization as a process with defined objectives and goals and evaluating decentralized health system. In decentralized/centralized health systems, planners will want to answer basic questions about how and where money is spent, whether resources meet the population's health needs, and other aspects of health system functioning. In contrast, evaluation of decentralization as a process involves determining the success of the collecting of interventions that might constitute a decentralization program in attaining definable goals such as more efficiently delivered health services, more responsive governments, greater accessibility to health services for the poor and vulnerable groups, or improved quality of care and stages of change that take place along the way.

In Brazil, in 2001, leaders decided to embrace more deeply the principle of decentralization. All levels adopted the decentralization policy by 2003 and it was implemented in 2004 (Arnquist et al. 2011). In Western Europe, there is full-scale, multisectoral, client-sensitive interventions that are integrated into mainstream health systems. They offer broad coverage, albeit with some fault of low coverage for the marginalized groups. In most central and Eastern Europe countries, health systems are administratively centralized and vertically organized, with subsystems for HIV, TB, STIs and substance abuse services delivered by specialists; and continuity of care fragmented. These features combined with systems rigidities, meant that rapid, integrated responses to the HIV epidemic could not be mounted (WHO, 2006).

In Sub Sahara Africa, decentralized health systems have frequently been two-tiered corresponding to the central and district levels. In South Africa, limited human resources are a major constraint to achieving ART coverage. Studies done on treatment outcomes in a decentralized ART program in Northern Nigeria by Okwonko et al in 2014 showed that rapid scale up of ART delivery through decentralized secondary level care program is feasible in resource limited settings and produces outcomes comparable to those reported in other settings.

In Uganda, decentralization was supported by the local government. The goal of decentralization included bringing political power closer to the local communities, responding to local needs, and building local capacity (Jeppson and Okuonzo, 2000). The Country's Structural and resource barriers to HIV/AIDS care and treatment services include frequent stock outs of HIV test kit and inadequate human resource to offer comprehensive testing and treatment services. This is despite the presence of implementing partners that provide buffer stocks. Services are further constrained by lack of tools and health workers trained to meet specific needs of key population groups, weak data management and limited coordination of efforts by the numerous implementing partners involved in Uganda's HIV response.

In Kenya, the management of HIV/AIDS services initially assumed a parallel dimension. However it is now clear that it is only through decentralization and integration with other services, that the great impact can be realized towards combating this epidemic (NAS COP, 2009). With more service provision points offering services, the program has seen the number of ART sites increase from 15 in 2003 to 700 in 2007 and the number of those accessing antiretroviral therapy increased in Kenya from 10 000 in 2003 to 689,156 in 2014 (NAS COP, 2014). In Nakuru County HIV care and treatment sites have increased to 110 by 2017. In Nakuru wet Sub County, the HIV care and treatment sites have increased from 4 in 2007 to 14 by 2017.

A study done on impact of decentralization in central Kenya between 2006 and 2010 by Kimanga revealed that enrolment increased in primary health facilities substantially during the period of decentralization; death rates were comparable between primary health facilities and secondary health facilities, where lost to follow up among Pre- ART patients was lower at primary lower facilities (Reidy WJ, et al. 2014). This study also showed that the first few years of decentralization of HIV care in Central Province increased access to crucial HIV care and treatment services. In addition, the data presented suggested that the quality of services at primary health care (lower level facilities) is in very least comparable to the quality of services provided at secondary health facilities (higher level facilities).

Capacity constraints have limited the effectiveness of many decentralization efforts. These deficiencies have included limitations both in the absolute numbers of human resources and in their level of training and preparedness for their new functions. A survey in Uganda of district directors of health services in Uganda, for example, indicated that one of the impediments experienced by them was the shortage of trained staff to undertake the expanded service delivery and supervisory roles (Hutchinson, 1999). As key result therefore of many decentralization processes is the need for capacity building both before and during the process. Because of the widespread nature of decentralization as a health reform strategy, decentralization has further exacerbated problems of public sector efficiency, and the need for regular health system monitoring and understanding the performance of decentralized health systems is an important activity for developing countries.

While decentralization has been extensively studied, there has been shortage of studies that have attributed in a rigorous and scientific manner positive outcome uniquely to the influence of decentralization process (Hutchison L. & LaFond K., 2004). Research institutions should be involved to monitor and analyze practical aspects of the decentralization process (Pokharel, 2001). That is why this study tried to evaluate the influence of monitoring and evaluation of decentralization processes on performance of HIV care and treatment program.

Monitoring and Evaluation of Access to HIV/AIDS Care and Treatment

Access means having a timely use of personal health services to achieve the best health outcomes (IOM, 1993). Attaining access to health care requires three discrete steps: gaining entry into the health care system; getting access to sites of care where patients can receive needed services and finding providers who meet the needs of individuals and with whom patients can develop a relationship based on mutual communication and trust. Access describes the ability to utilize services and incorporates economic, geographic location, abundance of health services and physical and social resources. If health services are not

accessible, it is likely that there will be unmet need for health care. Distance and transport are major barriers to retention in care in a wide variety of settings in Africa and Asia. Measures of physical accessibility focus on the time and distance that individuals must travel to use health services.

Decentralization can improve physical accessibility if local planners use their informational advantage on the spatial distributions to better target health services. A recent study using geographical information system (GIS) in Bangladesh, found that rural households in the poorest socioeconomic quintile were nearly six kilometers farther, on average from the closest hospital than rural households in the wealthiest socioeconomic quintile (Measure Evaluation, 2003).

The presumption that all populations should have equal access to health care services ignores, however, the importance of weighing costs relative to benefits and the importance of considering issues of equity. The optimal distribution of clinics will depend upon time elasticities, that is, the responsiveness of individual's changes in distance or time in increased use of funds. Care should be taken not to overemphasize the importance of access. A study done by Muchedzi et al in 2008 in Zimbabwe on factors associated with access to HIV care and treatment in prevention of mother to child transmission program revealed that challenges faced by HIV positive women from the program who accessed HIV care and treatment services include long queues at ART clinics, constant breakdown of laboratory equipment, ART clinic too congested with very sick people, transport for repeat visits too high, service too slow, may be due to staff shortages among others. Several barriers were reported by participants who did not access HIV care and treatment services. The factors that were associated with access to HIV care services include; age group, sex, residence and having a family support.

A variety of further policy options exist to address barriers and improve access to ART (WHO/UNAIDS/UNICEF, 2007). One example is the delivery of ART within the primary health system (integration) as Medecins Sans Frontieres did in Khayelitsha, South Africa, where educating and empowering patients as well as involving the community in decisions on patients ensured local ownership over the process (Kasper et al, 2003). These community and patient centered approaches increase the demand of HIV services and reduced social barriers to entry into care (Schneider et al, 2006). Decentralization may improve the quality and availability of public sector health services, but that is not an assurance that the services will be used. The existence of alternatives in the private sector may limit the impact of improved public sector service availability. Further, individuals must value the services sufficiently to be willing to pay in time or money to use the services. Only a handful of studies have examined the effects of decentralization on other aspects of equity, such as equity of access, utilization of health

services, or health outcomes. In Zambia, access to health care and consumer satisfaction actually worsened during decentralization and health sector reform (Blas and Libamba 2001). In Uganda, while decentralization was initially associated with declining expenditures on primary healthcare, the greater fiscal autonomy provided by decentralization increased utilization of all health services, both public and private (Hutchinson, Akin, and Ssengooba, 2003).

A review by Mariana Posse analyzed barriers to access ART in developing countries demonstrated that despite the availability of treatment and free drug provision, there are still barriers to accessing HIV/AIDS care and treatment. Countries face different circumstances, especially with regard to the availability of human resources in the health sector, and context specific strategies need to be considered (Van Damme & Kegels, 2006). That is why this study aimed at evaluating the influence of monitoring and evaluation of access to HIV care and treatment services on performance of HIV/AIDS care and treatment program.

Conceptual Framework

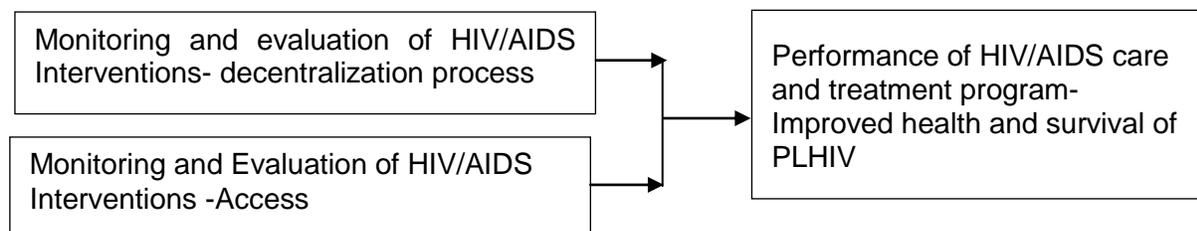


Figure 1: Conceptual Framework

Knowledge Gap

To assess the relative importance of decentralized service delivery and to identify what type of decentralization works and what does not in particular institutional settings, empirical work has to be carried out and data need to be collected. Only a handful of studies have examined the effects of decentralization on other aspects of equity, such as equity of access, utilization of health services, or health outcomes. According to WHO, information on effective strategies for integrated treatment is lacking globally and WHO is encouraging research to identify the best delivery models for collaborative interventions. It is important to monitor and evaluate capacity building so as to assess the current level of capacity and identify existing needs and gaps for support. A review by Mariana Posse on barriers to accessing ART in developing countries demonstrated that despite the availability of treatment and free drug provision, there are still barriers to accessing HIV/AIDS care and treatment. Countries face different circumstances, especially with regard to the availability of human resources in the health sector, and context

specific strategies need to be considered (Van Damme & Kegels, 2006). That is why this study tried to evaluate the influence of monitoring and evaluation of decentralization process, integration, capacity building and access to HIV/AIDS care and treatment services on performance of HIV/AIDS care and treatment in Nakuru County, Kenya.

Summary of Literature Reviewed

The literature review was done by reading guidelines on monitoring and evaluation, decentralization, integration, capacity building, access to HIV/AIDS care and treatment and performance of HIV/AIDS care and treatment program. The review was biased to WHO guidelines as it is the main source of international guidelines. The review also focused on studies published which have been done on the variables globally, regionally and locally. The source of the literature was guidelines, books published on the different variables, internet and journals. The review was done with the aim of trying to find answers to the study objectives and questions. Theoretical framework and conceptual framework was also discussed.

RESEARCH METHODOLOGY

The study adopted a descriptive research design using a cross-sectional survey. Data was collected from patients on HIV/AIDS care and treatment program and health care providers in hospitals offering HIV/AIDS care and treatment services in Nakuru West sub County at a specific point and time. The researcher preferred cross-sectional survey as it gives quantitative data and data is collected at the same time and point and in the natural setting and in a short time, using questionnaires (Brink and Wood 1998).

Target Population

The study was conducted in Nakuru West Sub County, Nakuru County, Kenya in October 2018 after obtaining research permit and letter of authority from the National Commission for science, technology and Innovation (NACOSTI), and the director county government of Nakuru, department of health after being cleared by the University of Nairobi. The researcher administered the questionnaires to PLHIV in the 14 health facilities and Health care providers at comprehensive care centers in Nakuru West Sub County. Nakuru west Sub County has a population estimate of 206,695 most of them live in informal settlements. The target population of the study was 11, 630 active clients on HIV/AIDS care and treatment program and 50 health care providers who are involved in the HIV/AIDS care and treatment in the 14 health facilities in Nakuru west Sub County. The study adopted census technique to include all the 50 health care providers who are involved in the HIV/AIDS care and treatment in 14 health facilities in Nakuru

west Sub County and Convenience sampling design was utilized for the selection of the active patients. The researcher preferred the method because the sampling frame was readily available from the facilities.

Data Collection Instruments and Procedure

Questionnaires were used to collect data. Likert scale by Rensis Likert was used to conduct the research. The researcher chose Likert scale as it is quicker and cheaper to administer, and the attractive layout of the questionnaire is likely to enhance rates of response (Dill Man, 1983). The researcher preferred Questionnaires because they are easy to understand, can be completed by respondents in a short time and it enables the investigator to be consistent in asking questions and data is easy to analyze (Hungler and Polit, 1995). The questionnaire was self designed, had closed questions and had several sections. Section 1. was introduction; section 2. comprised of biographical information, which seeks to obtain respondents' details such as age, sex, marital status, educational status and employment status and the sub sequent sections was on the statements and the response columns for the respondents. The format for indicating level of agreement is 5 point scales going from strongly agree to strongly disagree. Each respondent's reply on each item was scored and the scores for each item were aggregated to form an overall score.

The researcher visited the chosen health facilities and administered the questionnaires to gather the data after obtaining clearance from University of Nairobi, research permit and letter of authority from National Commission for Science and Technology and Innovation (NACOSTI) and getting permission letter from County government of Nakuru department of health to conduct the research in the County. The prospective respondents attending HIV/AIDS care clinics were requested to participate in the study.

Data Analysis and Presentation

Data was subject to descriptive statistics with the aid of Statistical Package for social Science (SPSS). Descriptive statistics was ideal because it helped describe the phenomenon under study. The data has been presented in tables to make it easy for users to understand. Hardy and Bryman (2004) have pointed out that the large amounts of data represent a problem, and then they have to be distilled and by reducing the amount of data, the data can then make sense. Descriptive statistics involves the use of percentages, frequencies, measures of central tendencies (mean) and measures of dispersion (standard deviation). Inferential statistics was used to determine the relationship between the variables.

FINDINGS AND DISCUSSIONS

Response Rate

Response rate is defined as the number of questionnaires that are filled completely and returned or collected against the questionnaires that are issued to the respondents. To this effect of the 50 questionnaires issued to clinician 43 were fully completed representing 86 per cent response rate while out of 109 issued to active client 95 were fully completed representing 87 per cent response rate which was way above the accepted questionnaire return rate of 70 per cent (Nulty, 2008).

Background Information

Age of Respondents

Table 1: Age of Respondents

| Age | Clinician | Percentage | Active clients | Percentage |
|----------------|-----------|------------|----------------|------------|
| 24 years below | 3 | 7% | 25 | 26% |
| 30 -40 years | 19 | 44% | 27 | 28% |
| 41-40 years | 10 | 23% | 17 | 18% |
| 51 -60 years | 11 | 26% | 15 | 16% |
| Above 60 years | 0 | 0% | 11 | 12% |
| Total | 43 | 100 | 95 | 100 |

From the findings majority of the clinicians were in the age of 30-40 years (44%). Out of the 95 active clients majority (28%) were in the age of 30-40 years.

Gender

Table 2: Gender of Respondents

| Gender | Clinician | Percentage(%) | Active clients | Percentage |
|---------------|-----------|---------------|----------------|------------|
| Male | 23 | 53% | 45 | 47% |
| Female | 20 | 47% | 50 | 53% |
| Total | 43 | 100 | 95 | 100 |

It was established that 53% of the clinicians and 47% of the active clients were male while 47% of the clinicians and 53% of active clients were female. This implies that most active HIV/AIDS clients were female while majority of the clinicians were male.

Descriptive Findings & Discussion

The findings are presented in measures of central tendencies (means) and measures of variation or dispersion (standard deviations). The analysis of the collected data was in line with the following five-point Likert scale.

Influence of monitoring and evaluation of decentralization process on performance of HIV care and treatment program in Nakuru County

The researcher sought to determine the influence of monitoring and evaluation of decentralization process on performance of HIV care and treatment program in Nakuru County. The findings resulting from the analysis are presented in Table 3.

Table 3: Influence of monitoring and evaluation of decentralization process on performance of HIV care and treatment program in Nakuru County

| | N | Min | Max | Mean | Std. |
|---|----|-----|-----|--------|---------|
| There is increased number of lower level facilities offering HIV/AIDS care and treatment | 43 | 1 | 5 | 4.5098 | .61229 |
| Significant number of the population is reached with HIV/AIDS care and treatment services. | 43 | 1 | 5 | 4.1961 | .82510 |
| The HIV care and treatment services are now convenient | 43 | 1 | 5 | 4.0196 | 1.14000 |
| There is improved waiting time. | 43 | 1 | 5 | 4.3725 | .79902 |
| Waiting time has not improved | 43 | 1 | 5 | 4.4902 | .80926 |
| HIV/AIDS care and treatment services have reached out to all populations without discrimination | 43 | 1 | 5 | 4.5098 | .80926 |

The study as shown in Table 3 revealed that there is increased number of lower level facilities offering HIV/AIDS care and treatment (mean \approx 5.00; std dev $<$ 1.000) Moreover majority of the clinicians agreed that Significant number of the population is reached with HIV/AIDS care and treatment services with a (mean \approx 4.00; std dev $<$ 1.000) The clinicians also agreed that HIV care and treatment services are now convenient with a (mean \approx 4.00; std dev $>$ 1.000. In addition majority of the clinicians agreed (mean \approx 4.00; std dev $<$ 1.000) that waiting time has not improved. Finally majority of the clinicians agreed (mean \approx 4.00; std dev $<$ 1.000) that HIV/AIDS care and treatment services have reached out to all populations without

discrimination. The standard deviation ranged between 0.61229 and 1.14000 indicating that the dispersion of the respondents from the mean was minimal. This implies that the variance of the highest respondents and the lowest respondents was small.

Influence of monitoring and evaluation of access to HIV/AIDS care and treatment program in Nakuru County

The study further sought to determine the influence of monitoring and evaluation of access to HIV/AIDS care and treatment program. Opinions are as shown in Table 4.

Table 4: Influence of monitoring and evaluation of access to HIV/AIDS care and treatment program in Nakuru County

| | N | Min | Max | Mean | Std. |
|--|----|-----|-----|--------|---------|
| Monitoring and Evaluation on HIV/AIDS program is done at facility level | 43 | 1 | 5 | 4.3333 | .90921 |
| Some patients bypass other ART sites when coming for HIV /AIDS care and treatment services | 43 | 1 | 5 | 3.8235 | .65440 |
| Services at this facility are of quality as other higher level facilities | 43 | 1 | 5 | 3.8824 | 1.30609 |
| There is budget for monitoring and evaluation of HIV/AIDS program. | 43 | 1 | 5 | 4.0588 | .98817 |
| The program's budget meets the needs of the program | 43 | 1 | 5 | 3.8627 | 1.24931 |
| There are staffs trained on monitoring and evaluation in the facility | 43 | 1 | 5 | 4.3137 | .67794 |

The findings revealed that majority of the clinicians admitted (mean \approx 4.00; std dev $<$ 1.000) that Monitoring and Evaluation on HIV/AIDS program is done at facility level. Majority of the clinicians agreed that some patients bypass other ART sites when coming for HIV /AIDS care and treatment services (mean \approx 4.00; std dev $<$ 1.000). It was also agreed (mean \approx 4.00; std dev $>$ 1.000) that Services at the facility are of quality as other higher level facilities. It was further agreed (mean \approx 4.00; std dev $<$ 1.000) that there is budget for monitoring and evaluation of HIV/AIDS program. In addition, clinicians agreed (mean \approx 4.00; std dev $>$ 1.000) that program's budget meets the needs of the program. It was further agreed (mean \approx 4.00; std dev $<$ 1.000) that there are staffs trained on monitoring and evaluation in the facility. The standard deviation ranged from 1.30609 to 0.65440 indicating that the dispersion of the respondents from the mean was moderate. This implies that the variance of the highest respondents and the lowest respondents was moderate.

CONCLUSIONS

From the findings, the researcher concluded that there is increased number of facilities offering HIV/AIDS care and treatment in line with increasing number of people living with HIV and significant number of the population is reached with HIV/AIDS care and treatment services. Further the researcher concluded that HIV care and treatment services are now convenient and waiting time has not improved. The researcher concluded that HIV/AIDS care and treatment services have reached out to all populations without discrimination.

With line with second objective, the researcher concluded that Monitoring and Evaluation on HIV/AIDS program is done at facility level. Some patients bypass other ART sites when coming for HIV /AIDS care and treatment services. The researcher concludes that services at lower level facilities are of quality as other higher level facilities. Finally on this objective the researcher concludes that there is budget for monitoring and evaluation of HIV/AIDS program and the budget meets the needs of the program.

RECOMMENDATIONS

In the light of the foregoing findings, the study recommends that;

In relation to the first objective the researcher recommends that the government should train staff on monitoring and evaluation of all HIV/AIDS care and treatment interventions so as to ensure balance in regions offering HIV/AIDS care and treatment services hence improvement in utilization of HIV/AIDS care and treatment services and improved health and survival of people living with HIV.

On monitoring and evaluation of access to HIV/AIDS care and treatment, the researcher recommends that facilities that offer all services in the same room by the same provider should integrate services so that patients are attended to by variety of providers to reduce waiting time and avoid patients travelling far bypassing facilities near their homes.

As recommendation for future studies, further studies should be done on Influence of monitoring and evaluation on performance of HIV/AIDS care and treatment program on other parts of the country since this study focused only Nakuru county.

REFERENCES

- Arnquist S. et al. 2011. HIV/AIDS in Brazil: Delivering prevention in a decentralized health system.
- Atun A. et al (2005) Analysis of how health systems context influence HIV control HIV.
- Blas, E. and M E. Limbamba. 2010. The challenge of Hospitals in Health Sector Reform.
- Center for Global Development (2011), functions of Monitoring and Evaluation.
- Donaldson, S. & Lipsey, M :Roles for Theory in contemporary Evaluation practice Developing practical knowledge, Evaluating Social Programs and problems.

- Goodman et al (1998). Identifying and defining the dimensions of community capacity to provide a basis for measurement
- Gyorkkos T. (2003). Monitoring and Evaluation of large scale Helminth control programmes. *Acta Tropic*, 86 (2):275-282
- Hutchinson, P. L., J. S. Akin, and F.Ssengooba.2002. Impact of Decentralization on Health behaviours and Health outcomes in Uganda. John Wiley & Sons, Ltd.
- Hutchinson Paul L. and Anne K. LaFond (2004) Monitoring and Evaluation of Decentralization Reforms in Developing Country Health sectors
- Jepsson and Okuonzo (2000), advantages of Decentralization.
- Maina WK. et al (2014) Utilization of Kenya AIDS Indicator Survey report.
- Nuguti O. Elizabeth (2010) Understanding Project Monitoring and Evaluation. Published by Ekon Publishers, Nairobi. Printed in Kenya
- Okwonko et al. (2014) Integrated National Guidelines for HIV prevention, treatment and care in Nigeria.
- Sydney Rosen and Fox P. (2011), Study on retention in HIV care between testing and treatment in Sub Sahara Africa.
- Uitto (2004), Monitoring functions in projects
- UNAIDS (2013)Universal access and Monitoring and Evaluation. Data use for program Improvement.
- Van Rensburg (2008) Human resource development and antiretroviral treatment in Free state province South Africa.
- WHO (2006), European response to HIV care and treatment.