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EFFECTIVENESS OF PERFORMANCE APPRAISAL SYSTEM: A CASE OF THIKA COUNTY HOSPITAL

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ABSTRACT

The article seeks to appraise performance appraisal system (PAS) effectiveness in Thika county hospital in regard to adherence to standard operating guidelines and utility of PAS information. A descriptive cross-sectional research design was used.196 respondents were drawn from a population of 400 eligible participants using proportionate random sampling for staff clusters and systematic random sampling for individuals. Data was collected using a semi-structured questionnaire, Key informants interviews and focused group discussions. The response rate was 88.2 %(n=173).77.5 %(n=134) were female, 61 %(n=104) had diploma qualification as highest level of education and 71 %(n=122) were in job groups 'K' to 'N'. Regarding adherence to PAS process, 83.7 %(n=142) were not familiar with PAS policy, 71.4% (n=122) were not familiar with annual work plan, 76 %(n=130) never set plans at start of year, and 94 %(n=160) never did midyear reviews. Majority 90 %(n=155) however did end of year reviews. Majority, 80.9 %(n=140) felt due process is not followed. In exploring PAS information utility, 68.6%9(n=105) say it should improve services but currently, 83.2 %(n=144) feel it's just a routine procedure. The hospital has reward system which does not follow PAS principles. None of those scored excellent received bonus salary reward nor were there any report of sanctions. Staff development considerations are at the discretion of managers mainly considering departmental needs rather than individual development needs. Majority; 84.1 %(n=143) believe PAS has not improved hospital performance. There were no statistically significant variations across staff clusters regarding perceptions of following due process and whether PAS helps one do their job better. In conclusion, most PAS steps are missed. Either it's not a reference point for personnel decisions. The study recommends that the hospital designate office responsible for PAS, and design software to capture PAS data for reference in decision making.

KEY WORDS: *Performance Appraisal System, PAS effectiveness, PAS process, PAS utility*

INTRODUCTION

World Health Organization (2000) identified pillars for health system strengthening: service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance (stewardship).

This study explored the effectiveness of performance appraisal in Thika County hospital in Kiambu County, Kenya. It had about 400 employees, serves a population of 454, 166 people and also serves as a referral hospital for many health facilities within and outside Thika district (PPOA, 2009).

This study addresses the human resource for health pillar. At the heart of every health system, the workforce is central to advancing health. Given the acknowledged workforce crisis (shortages, maldistribution, etc) against a rising disease burden especially in developing nations, strategies to improve performance must initially focus on existing staff. Performance appraisal is one of the levers that influence performance (WHO, 2006).

Kenya had been facing malpractice in its public sector for decades. As a new government came to power in 2003, the rot and malaise in the public sector had reached crisis proportions and needed to be addressed urgently. The government introduced performance contracts and appraisals as its management tools for addressing the underperformance. These are part of the tools of the results based management (RBM) movement that gained global momentum around the early 1990s. It aims at improving service delivery through a results-oriented performance management framework (CAMPs, 2011).

Performance Appraisal (PA) has been defined as the process of determining and communicating to an employee how he or she is performing on the job and ideally establishing a plan of improvement (Byars & Rue, 2000). Performance appraisals furnish concerned authorities with information for making decisions like pay, promotion decisions, training & development, and documentation for legal purposes (Dubinsky et al., 1989).

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The government developed PAS policy and guidelines and also trained senior officers in all ministries to ensure effective implementation of the PAS.The policy provides that at the beginning of every financial year, individual employees, jointly with their supervisors shall set performance targets for the year. It directs that there be a midyear review alongside ongoing monitoring of employee performance. It also provided that excellent performance (101% score, all performance targets met and exceeded) shall be rewarded with at least one month salary, good performance attracts no specific reward while poor and very poor performance will attract sanctions. As part of the staff training and development plan, every staff member will indicate at least one professional development goal to be achieved in the reporting period as agreed with the supervisor (GOK, 2008).

Problem statement

Since 2006, employees in Thika hospital have been filling performance appraisal forms. However, responsiveness still appears a challenge, health indicators are stagnant, and there are reported difficulties with the PAS process raising concerns about effectiveness of PAS. Clients have continually reported long waits before being served. A waiting time survey in the hospital in the year 2010(not published) identified average waiting time for outpatients' clients as being two hours against the acceptable average waiting time of thirty minutes in the service charter.A staff satisfaction survey in the hospital in 2010, found that about 60 %(N=100) respondent that their workload was unreasonably high, and their pay was not contingent on performance raising questions as to what informs the individual performance target setting, and utility of the performance appraisal.Also the PAS sometimes creates problems for both management and employees; it's occasionally characterized by acrimonious exchanges between superiors and subordinates and a section of staff feel it's a bother with little value. The first national health sector strategic and investment plan (NHSSIP)) also finds weak staff performance appraisal as a challenge to health worker performance (GOK, 2012). It is this state of affairs that has provided the stimulus to explore the performance appraisal process in Thika hospital as experienced and perceived by staff.

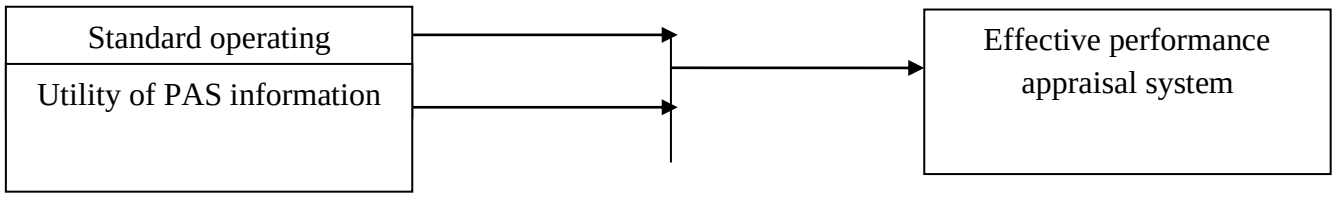
Study objectives

The general objective of this study was to explore the effectiveness of performance appraisal process in Thika hospital in regard to experiences and perceptions of staff on the essential characteristics of an effective PAS. The specific objectives include;

I. To explore adherence to national/institutional performance appraisal guidelines.
II. To determine the utility of PAS information.

Conceptual framework

The study was guided by the following conceptual framework.



Independent variables Dependent variable

METHODOLOGY

This was a descriptive cross-sectional case study. The dependent variable is effective performance appraisal. The independent variables are as follows;

Standard operating guidelines: Was measured by existence of hospital annual work plan, schedules for planning, hospital performance targets, goal alignment, schedules for performance review, clear definition of review process for everyone and appeals procedure.

Utility of PAS information: Was measured by management of PAS information, perception on the role of the PAS system, reward/sanction system in place, reports of performance based rewards, reports of underperformance addressed, and the perception of the overall impact of PAS on hospital performance.

A sample of 196 respondents was sampled from a sampling frame of 400 employees who participate in the formal performance appraisal process as per the Thika hospital annual work plan of 2012/2013. The sampling frame was stratified into the supervisory group and the operational group. The operational group was then split in two: operational clinical, and nonclinical. Proportionate stratified sampling was used to select representative units of measurement within the different strata to reduce the risks of sampling bias and sampling error and to ensure different groups in the population are adequately represented (Babbie, 1990). Systematic random sampling was used to obtain individual respondents within the three strata.

Data was collected using a semi- structured questionnaire administered to all respondents. The questionnaire entailed questions on respondent profile; PAS process guidelines, and

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utility of PAS information. Perceptions were rated on a Likert scale. Key informant interviews were conducted with the managers at the hospital level and with the human resource officials at the ministry of health to explore the PAS design and utility. Three focused group discussions were conducted; one with the operational clinical, one with operational nonclinical and one with the supervisory group.

Quantitative data has been presented in tables and graphs with frequency counts and analyzed for descriptive statistics by SPSS software. It has been analyzed by measures of central tendency (mean, mode, and median) and measures of dispersion (range, variance and standard deviation). Cross tabulation and Correlation analysis was done to determine relationships between variables. In regard to the testing of hypothesis, the perceptions were rated on a five point Likert scale (1-strongly agree, 2-agree, 3- neutral, 4-disagree, 5-Strongly disagree). Analysis was done by one way ANOVA at 5% significance level ($P<0.05$).

Qualitative data obtained through interviews and focused group discussions was recorded in a note book and categorized in particular themes reflecting the study objectives. The use of several methods is useful to allow for triangulation of the responses and minimize limitations of either method used alone.

A test-run of the designed data collection tools was done in one hospital not involved in the actual study. Revisions were then done to the tools to improve their validity and reliability. Validity was ensured by random selection of sample to reduce selection bias and both quantitative (questionnaire) and qualitative (focus group discussions and key informant interviews) approaches were combined to avoid subjectivity and the limitations of either approach alone, and to allow for triangulation which adds depth to research and help overcome personal biases. Reliability was ensured by: uniformity of data collection tools. The themes for discussion by focus group discussions were the same as the objectives of the study for all groups. All tools of data collection were thoroughly reviewed and corrected for completeness and accuracy of reporting with the research team. Reliability of test scores was done using Cronbach's alpha coefficient.

Ethical Considerations (permission to proceed)

Approval for the conduct of the study was sought from both the University's and the hospital's Research and Ethics Committees. Written consent was established from all participants to the study with the understanding that they would be at liberty to withdraw from the study at any time.

FINDINGS AND DISCUSSION

Respondent profile

The study respondents were in three categories of the clinical, the nonclinical and supervisory as presented in the table below.

Table 1: Respondent profile

Study Category	Subcategory	Frequency	Percentage	Sex	
				Female	Male
Operational	Clinical	149	86.1	121	28
	Nonclinical	15	8.7	7	8
Supervisory		09	5.2	6	3
Total		173	100	134(77.5%)	39(22.5%)

Majority, 77.5 %(n=134) were female. Among the clinical professions, nursing forms the greater portion of staff accounting for over 60% (n=104) followed by laboratory technologists 3.5% (n=6), pharmacists 3.5% (n=6) clinical officers 2.3 %(n= 4) doctors 2.3 %,(n=4) while all the other professions combined accounted for 12 % of the respondents. Most respondents 61.8 %(n=107) were within the age bracket of 35-50 years. The age brackets of 20-34 years and above 50 years had almost similar frequencies at 19.6 %(n=34) and 18.4 %(n=32) respectively. On staff education, majority had highest educational level of diploma,61%(n=104) followed by Certificate 19%(n=33), bachelors degree17%(n=29) and lastly masters degree at 3%(n=5).

Regarding designation,71%(n=122) were in job groups' K to N, followed by job groups H-J at 20.4%(n=35), A-G taking up 5.3%(n=9) and lastly job group P and above accounting for 3%(n=5). Majority 31.6 %(n=54) had served in the public service for a duration of between 20 to 29 years. Frequencies for those who had served for less than 10 years and for between 10 and 19 years were equal, each category having 29.2 %(n=50) of the respondents and finally over 30 years in service having 11.7% (n=20) of the respondents.

Adherence to procedures and guidelines

The graph below shows the distribution of responses in regard to PAS process experiences.

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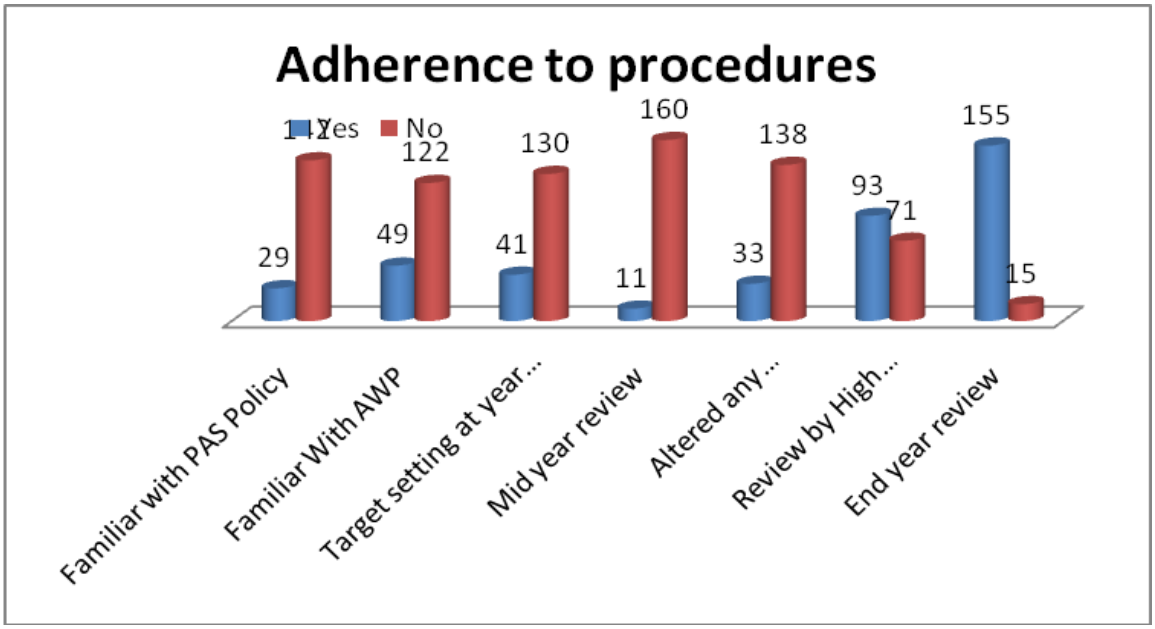


Figure 1: Experiences of adherence to procedure

The Cronbach's Alpha was 0.785 for all the seven items reflecting acceptable scale reliability levels. The graph also shows symmetrical positive correlation among all the variables except two; review by higher authority and end of year appraisal.

As to what informs the rating by supervisors,most respondents 58.1%(n=100) said they were rated on the basis of relationship with supervisor followed by job performance at 36%,(n=62).Other considerations mentioned included rank,educational level and personal lifestyle.Concerning how the process is perceived, ratings were rated on a five point Likert scale (1-Strongly agree, 2-Agree, 3-Neutral, 4-Disagree and 5-Strongly disagree) as shown in the table below. Reliability testing was done by the Cronbach's alpha coefficient which was 0.804.The responses were collapsed into positive responses having strongly agree and disagree, neutral responses and the negative responses having disagree and strongly disagree

Table 2: Perceptions on PAS process adherence

Indicator	Positive(Strongly agree and agree)%	Neutral%	Negative(Strongly disagree and agree)%
PAS process is clearly defined for everyone	29.4(n=51)	9.2(n=16)	61.3(n=106)
Individual objectives align with hospital annual work plan	46.8(n=81)	12.7(n=22)	40.4(n=70)
Appraisal ratings differentiates among various levels of performance	38.7(n=67)	4.0(n=7)	57.2(n=99)
Performance review is based on observable job behaviors.	30.6(n=53)	4.6(n=8)	64.7(n=112)
Overall performance appraisal follows due process	**15.6(n=27)**	**3.4(n=6)**	**80.9(n=140)**

Descriptive analysis show the median response was 4-disagree across all the variables except for individual performance plan alignment with hospital annual work plan which also had the modal response as 2 –agree, showing more favorable perception of individual plan alignment with hospital annual work plan. The perceptions are skewed towards the domain of unfavorable responses.

Alignment to the hospital annual work plan had more favorable perceptions 46.8 %(n=81). All the other items had majority in the unfavorable responses. However concerning the near confusing scenario whereby most staff never knew about hospital annual work plan and PAS policy, yet majority thought their performance plans were aligned to the hospital annual work plan, the FGDs revealed that staffs simply believe whether they are familiar with these documents or not they are always generally contributing to the hospitals mission as reflected in the statement below;

We do everything to support our managers and to improve the health of our people. Even if we really don't know so much about policies and plans, we know we are on focus... (Clinical staff)

It may be noted that most respondents do not participate in most of the key items in the PAS except for the end of year review. Majority too feels due process is not followed; the review is not objective and does not clearly differentiate among the various levels of performance nor is it well defined to everyone involved. These serve as disincentives to the performance appraisal in the face of expectancy theory that anticipated

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satisfaction with the process determines support for it by staff (Vroom 1964).

These findings are at variance with the expectations of both the Grote model(Grote,1996) and the kenya PAS policy (GOK,2008) that performance be rated objectively based on observable job behaviours and to accommodate contextual demands.As much as it may be expected that the process may not be entirely free from subjective tendencies(Crosby,1995),that a majority of satff feel rating performance is based upon relationship with supervisor points towards serious misgivings with the process. Such subjectivity enables a rater's personal agenda to drive the appraisal rating process(Migiro and Taderera,2010). An assessment of PAS in Public sector in South Africa and China found that the performance appraisal system can be improved through addressing the process and improving the approaches followed by the managers in daily appraisals, which can be done by following the complete process and including all the steps it involves, and by having a positive attitude towards the performance appraisal process (Xian, 2011).In lieu of this proposal, it may be inferred that Thika hospital PAS is deficient in a fundamental ingredient of PAS effectiveness; following due process.

The findings reveal a process that perhaps is not taken with the deserved seriousness. This compares with Furnham (1996) assertion that 'The organization, despite much rhetoric, does not take the whole process seriously.' These findings also agree with Stiles et al (1997) survey of three companies that revealed there was a considerable degree of managerial apathy and even skepticism about carrying out appraisal. This is further clarified by FGDs from which it was apparent that actually most appraisals were done at year end when one would set and rate objectives retrospectively all at once. One of the clinical staff noted;

'We just fill in these things during June when the year ends because they are needed in Nairobi.'

That most people don't know about the PAS policy and hospital annual work plan casts aspersions as to what informs their target setting process. It is important that the process ensures that employees understand how their personal job performance contributes to the overall performance of the company. This direct linkage helps to create team effort from shared objectives reflecting organizational goals and clarification of each member's contribution (Boice & Kleiner, 1997).

The situation was confirmed by FGD with managers when one said;

'*We are so constrained in time that we hardly get time to share, and also the staff know their individual duties.'*

Coens and Jenkins (2002) captured this kind of apathy vividly when they retorted, 'Throughout our work lives, most of us have struggled with performance appraisal. Again and again, we see supervisors procrastinate or just go through the motions, with little taken to heart.' An evaluation of PAS in the bank of Botswana found similar results that the system was inconsistent (Migiro and Taderera, 2010).An assessment of PAS in municipal government of Texas cities found that overall the cities do not consistently set, prioritize, or communicate goals to employees (Piatt le Ans, 1998). Analysis of perceptions across staff clusters in regard to following due process is shown in the table below.

Table 3: ANOVA results for perceptions across staff clusters on following due process

Overall PAS follows due process

	df	**F**	**Sig.**
Between Groups	2	1.870	.157
Within Groups	170		
Total	**172**		

The analysis found no significant variations across staff clusters in regard to perceptions on PAS following due process, $F(2,170) = 1.87$, $P<0.05$.

In regard to performance rating in the just ended financial year, majority 69.4 %(n=120) were rated at good followed by excellent at13.9 %(n=24).2.9 %(n=5) did not remember their scores. Relatively more supervisory staffs were rated excellent compared to other categories of staff as shown in the table below.

Table 4: Rating at last financial year

Rating	**Cluster Clinical**	**Supervisory**	**Non clinical**	**Total**
Excellent performance	19	4	1	24
Good performance	106	5	9	120
Fair performance	17	0	5	22
Poor performance	1	0	0	1
Don't know	1	0	0	1
Was not rated	5	0	0	5
Total	**149**	**15**	**15**	**173**

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The results show most respondents were rated as good. Though the numbers may not necessarily reflect any particular bias, from FGDs, it was established a likely tendency of rating staff fairly same and in favorable terms to avoid criticism; One of the clinical staff noted,

'*Here we are all the same, whether you work hard or otherwise, we are all good, meaning that is our score.'*

Similar sentiments are echoed by a supervisory staff who noted, in an apparent reference to staff being sacked when rated poorly.

'In fact the tool is not tailor made to rate people like nurses, and we simply rate them as a group. We also can't score someone so low; otherwise these people can deal with you and you don't want to be the reason why someone should go hungry'

PAS Information Utility

This part explored employee perceptions and experiences on how the PAS is supposed to be used, how it has been used and how it can be improved. Regarding how it has been utilized, the findings are shown in the graph below.

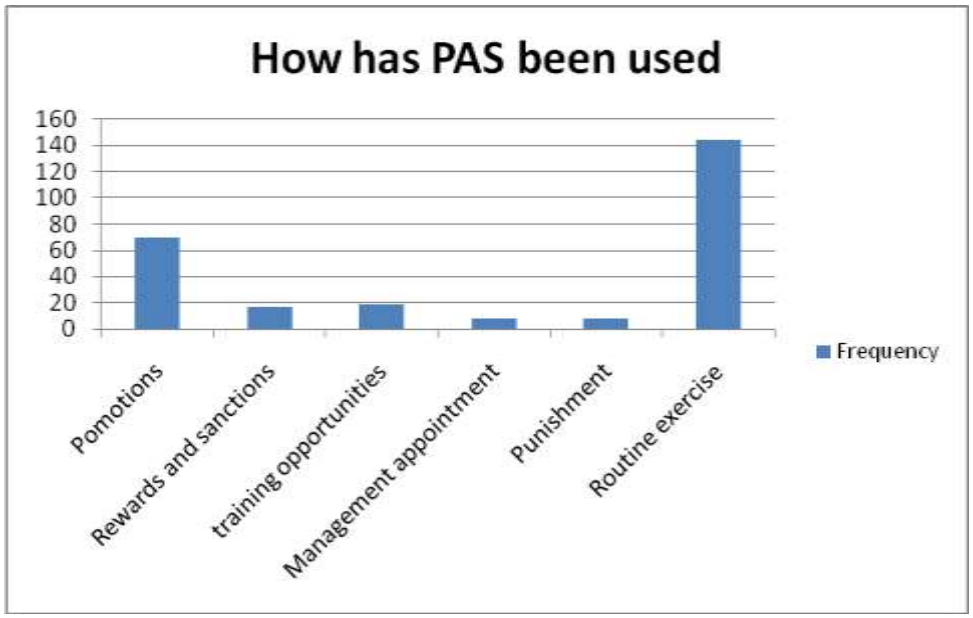


Figure 2: How PAS has been used

Most staff, 68.6% (n=105) believed PAS should be used in improving service delivery followed by rating performance, 31.4 %(n=48).Use for promotion, rewards and training attracted 13.7% 7%, and 3% of respondents respectively. However there was observed discordance between belief of how it should be used and perception of how it has actually been used with a majority 83.7% (n=144) saying it has been used merely as a routine exercise that staff engage in as a requirement of the governance system. 40.6 %(n=70) said it's used for promotions, while 11 %(n=19) said it's a basis for training opportunities.4.6% (n=8) mentioned Management appointment and staff punishment as uses of PAS.

From FGDs it was established that the use for promotions was such that when actually one was due for promotion and had signed and returned the PAS form rather than the contents as noted in the statement below during FGD;

'The appraisals only count to allow you promoted so long as you have filled them and you are due for promotion. It seems no one is interested in what is filled inside.'
(Operational clinical staff)

Some adversarial use of appraisal forms is expressed when during FGDs a clinical staff observed

'*These forms don't mean much generally, when everything is well. But let you be noted on the wrong side and the form will be retrieved from the heap, just in case you may also be a poor performer. In fact ultimately if that be the case, it's this form that will send you home…' (Clinical staff)*

This perception is affirmed by key informant interviews with ministry of health headquarters officials, who indicated that at least appraisal forms should be in one's personal file, for their promotions to be processed when due and not necessarily how they were rated in the appraisal. It was revealed that a database of appraisal forms were maintained detailing staff particulars and dates when the duly filled forms were submitted. However there was no analysis of ratings done to determine the distribution of the scores.

From the key informant interviews, it was revealed that the hospital had a reward system in place that in principle rewards performance but it was however not implemented through the

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conventional appraisal process and consequent reward system envisaged in the PAS policy. The PAS policy (GoK, 2008) provides that excellent performance should attract one month's salary as a reward. In fact not even one respondent who scored excellent as per the appraisal got any salary bonus as directed by the policy. Key informants also added that the expenditure on the hospital reward system is a matter of courage from management that has surmounted a lot of resistance from other government officials. If any of those rated as excellent on the formal appraisal received any hospital reward, it was a matter of coincidence. Some of these are captured in the frustration expressed by one clinical staff as follows

'I received an excellent score in the appraisals. I expected a salary bonus, it was nowhere, and not even a person could talk about it. It's kind of obvious it does not exist so there is no need to ask management. Then came the hospital annual award and some other people got the rewards.'

Similarly, it's clarified from key informant interviews and FGDs that the hospital annual award scheme does not directly reward the supervisory group. Asked if they got any performance based rewards, one of the supervisory noted;

'*As supervisors we don't get anything. It's to reward the other staff.'*

In regard to job improvement actions,among those who reported having had any,mostly it was through seminars and training.All supervisory staff reported having had a job improvement action.However it was clarified through key informant interviews that award of professional development actions like seminar and training opportunities was on the basis of departmental needs. Management would identify staff to develop for purposes of meeting the demands of a particular department. And opportunities too were limited and erratic as they dependent largely on partner support and sometimes on the Ministry of health headquarters. But a section of staffs think otherwise as noted during the FGDs;

'To go for a seminar here, the eye of the boss must be focused on you. How it must happen, they know better, but just know you must be in their good books.'

In response to dealing with poor performance, most respondents reported some dysfunctional strategies like transfer of staff and redeployment 79 %(N=24) and suspension 16.7 %(N=24) and only one respondent said of coaching.

In regard to perceptions on PAS utility, items explored included use of PAS as a basis for training opportunities, determination for rewards and sanctions and promotions and ultimately whether it has helped improve hospital performance.

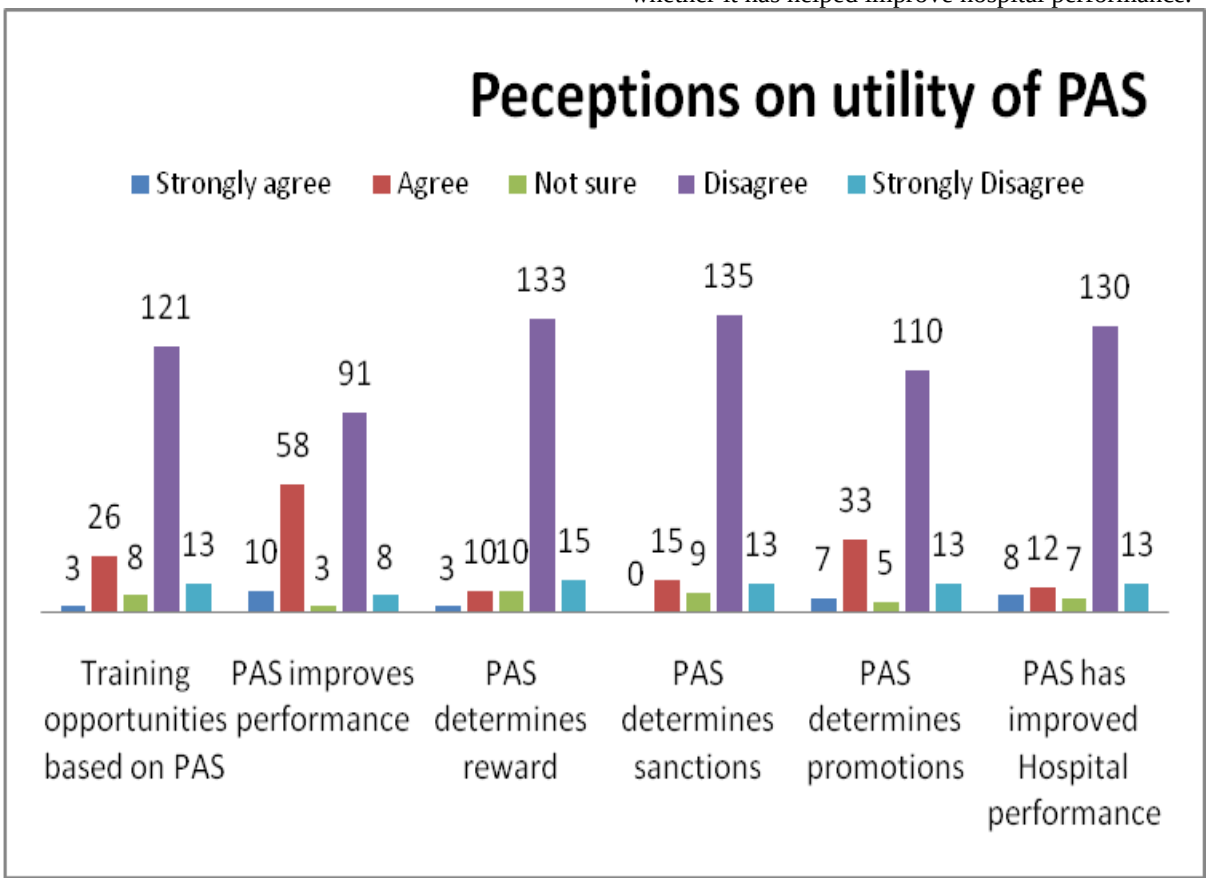


Figure 3: PAS Utility Perceptions

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The Cronbach's alpha for all the six items was 0.990 showing high internal consistency of the test scores. Most respondents, over 60% either disagree or strongly disagree with the perception of whether PAS is used for all the six domains evaluated in this study. The variables were negatively skewed; towards unfavorable responses. All the variables showed a positive symmetrical correlation. All three staff clusters had majority perceptions of disagreement in regard to PAS improving the hospitals performance as shown in the graph below.

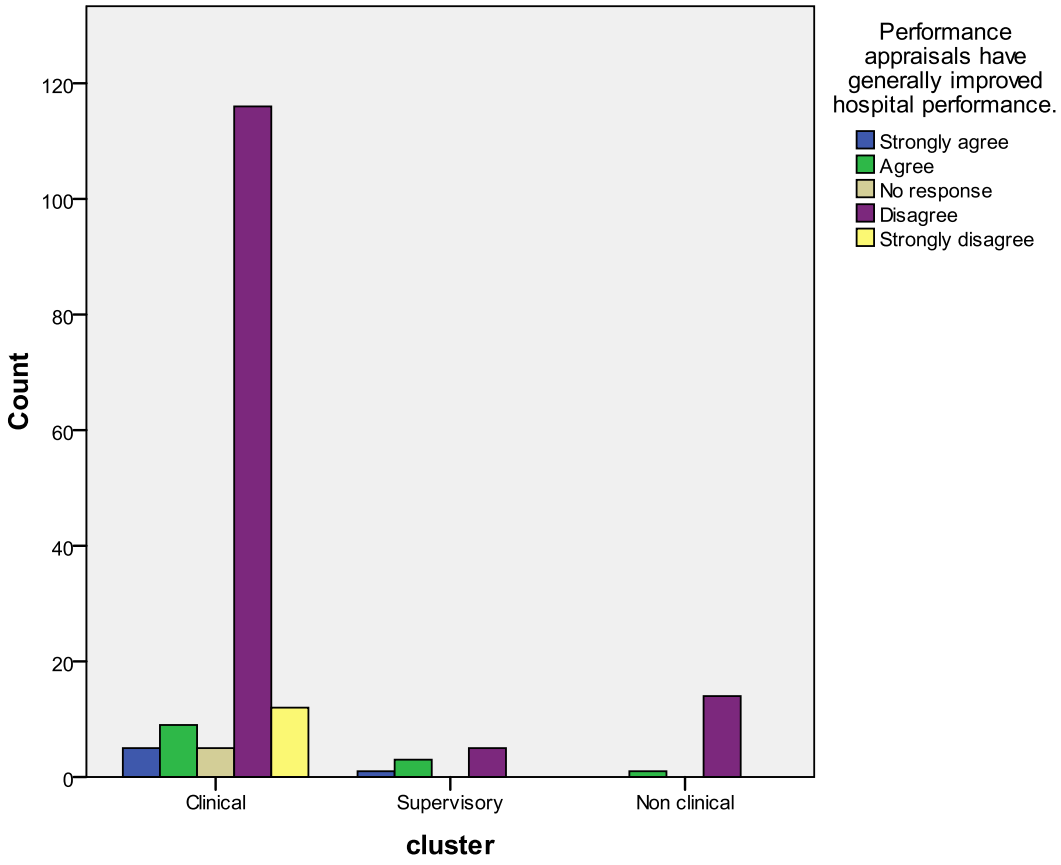


Figure 4: Perceptions on overall effect of PAS

To determine differences in perceptions across staff clusters, ANOVA was used as shown below.

Table 5: ANOVA results for perception across staff clusters on PAS information utility
Performance appraisal has generally improved hospital performance

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	5.859	2	2.930	4.510	.012
Within Groups	109.135	168	.650		
Total	**114.994**	**170**			

The analysis shows statistically significant variations across staff clusters in regard to overall effect of PAS $F(2,168)=4.510$, $P<0.05$.To determine differences between individual staff clusters, (LSD) least significant difference post hoc test was used as its less conservative.

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Table 6: Post hoc analysis of ANOVA results PAS utility
Performance appraisal has generally improved hospital performance

(I) cluster	(J) cluster	Mean Difference (I-J)	Sig.
Clinical	Supervisory	.823*	.003
	Non clinical	-.044	.842
Supervisory	Clinical	-.823*	.003
	Non clinical	-.867*	.012
Non clinical	Clinical	.044	.842
	Supervisory	**.867***	**.012**

Significant differences in perception of whether PAS has improved hospital performance were found between the supervisory and clinical and between the supervisory and the non clinical F (2,168) =4.510, P<0.05.Supervisory staff had 0.867 times and 0.823 times more favorable perceptions than clinical and nonclinical staff respectively. However there were no statistically significant differences between the clinical and nonclinical categories at the P<0.05.Favourable perceptions decline chronologically from supervisory to clinical and non clinical staff.
These results may reflect a PAS system that is isolated from other strategic human resource management practices like staff training, and motivation in terms of rewards and sanctions.

These findings agree with those of the Pakistan civil service that was not crystal clear about the purposes of PAS. In view of the Pakistan civil servants, main purpose of PAS was to support promotion decisions, which are highly dependent on appraisal reports of officers (NCGR 2008).The findings also agree with those of the evaluation of the PAS in the bank of Botswana (Migiro and Taderera, 2010) that revealed the system was used to identity employees for promotion (61%) and not used to weed out incompetent employees (78.6%) nor to determine whether the banks' policies were implemented (78.6%).

When put in the perspective of Vroom, (1964) expectancy theory which hypothesizes that individuals change their behavior according to their anticipated satisfaction in achieving certain goals and with majority of staff saying PAS has been mere routine, it may be inferred that most staff feel the PAS has little if any value and therefore are less likely to take it seriously.

These findings do not agree with those of Xian (2011) which found that the performance appraisal system in South Africa can serve as an instrument for management to determine the degrees to which programs have met their objectives and expectations. The findings also suggest divergence from distributive justice which requires that "performance appraisal ratings meet employee expectations, outcomes are based on the ratings, and outcomes meet the expectations of employees" (Bowen et al., 1999).

The PAS policy (GoK, 2008) is explicit about the consequences of PAS in terms of rewards and sanctions. It suggests bonus award of one month's basic salary for excellent performance, and cautionary letter and separation for very poor performance. From the findings, however no one got the reward despite excellent scores. None of the respondents ever reported being sanctioned. Thus the fundamental provisions of the policy in terms of PAS utility are not being implanted.

Asked to cite any improvements attributable to PAS, only 37 %(n=64) mentioned some improvements. Majority, 46 %(n=30) mentioned focus on performance. Others improvements mentioned included respect for seniors, punctuality, capacity building, improved morale and patient care.

Suggestions to improve PAS were distributed as follows were elicited through open ended questions. Most staff 47 %(n=73) felt following due process would remedy the pitfalls now bedeviling it. Other recommendations included doing rewards 19.4 %(n=30) involve staff 18 %(n=28) individualizing the process 14.2 %(n=22).Others included suggestion to train staff and give feedback.

CONCLUSIONS

The study has found that actually Performance appraisals are done in Thika county hospital. In terms of adhering to procedure; the study has established that the hospital does annual work planning but whose contents are not widely disseminated. Most staff do not undertake key ingredients to the performance appraisal process except for the end of year review. The rating is mainly in the category of good reflecting a tendency towards a favorable average. Concerning the rating criteria; there are significant undesirable considerations like relationship with supervisor influencing rating. This dents objectivity of the PAS. The perceptions on whether PAS follows due process are skewed in the domain of disapproval and symmetrically across all the three staff clusters.

Concerning PAS Utility, Staff feels it should improve performance but as it is currently, it's more a routine exercise with little utility value. It's never referred to for training opportunities, for rewards and sanctions. The hospital however is trying to reward good performance through the hospital annual award scheme that does not reflect the conventional PAS as envisaged in the PAS policy. It can thus be said that the PAS in the Thika County hospital lacks in many essential characteristics of an effective PAS process.

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RECOMMENDATIONS

The hospital should designate a responsible office in charge of the PAS process to make sure it's implemented to the fullest.

The government should involve staff both through their managers and elected representatives in the design of PAS policy. The hospital management too should involve staff at all stages of planning and give regular feedback to gauge and guide performance

The Ministry of health and the hospital management should design software to capture PAS data of all staff and refer to it for rewards, sanctions and promotions and other personnel decisions

The ministry of health should activate the reward and sanction system outlined in the PAS policy and support hospitals local complementary efforts

Recommendations for further research

A larger survey of effectiveness of PAS with more representative hospital ought to be done with a view to addressing gaps.

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