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Empty rituals? A qualitative study of users' experience of monitoring & evaluation systems in HIV interventions in western India

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ABSTRACT

In global health initiatives, particularly in the context of private philanthropy and its 'business minded' approach, detailed programme data plays an increasing role in informing assessments, improvements, evaluations, and ultimately continuation or discontinuation of funds for individual programmes. The HIV/AIDS literature predominantly treats monitoring as unproblematic. However, the social science of audit and indicators emphasises the constitutive power of indicators, noting that their effects at a grassroots level are often at odds with the goals specified in policy. This paper investigates users' experiences of Monitoring and Evaluation (M&E) systems in the context of HIV interventions in western India. Six focus groups (totalling 51 participants) were held with employees of 6 different NGOs working for government or philanthropy-funded HIV interventions for sex workers in western India. Ten donor employees were interviewed. Thematic analysis was conducted. NGO employees described a major gap between what they considered their "real work" and the indicators used to monitor it. They could explain the official purposes of M&E systems in terms of programme improvement and financial accountability. More cynically, they valued M&E experience on their CVs and the rhetorical role of data in demonstrating their achievements. They believed that inappropriate and unethical means were being used to meet targets, including incentives and coercion, and criticised indicators for being misleading and inflexible. Donor employees valued the role of M&E in programme improvement, financial accountability, and professionalising NGO-donor relationships. However, they were suspicious that NGOs might be falsifying data, criticised the insensitivity of indicators, and complained that data were under-used. For its users, M& E appears an 'empty ritual', enacted because donors require it, but not put to local use. In this context, monitoring is constituted as an instrument of performance management rather than as a means of rational programme improvement.

1. Background

Recent decades have seen a rapid increase in the breadth and intensity of Monitoring and Evaluation (M&E) practices in health and development systems. For 'New Public Management', 'Results-Based Management' and 'Payment by Results', the collection of accurate monitoring data is seen as essential to the professionalisation and rationalisation of health interventions (Binnendijk, 2000; Hood, 1995). Progress towards highly-specified targets can be monitored, and good performance rewarded (Earle, 2003; Kilby, 2004). The advent of major global health initiatives funded by philanthropic organisations such as the Gates Foundation has brought a 'business minded' shift to New Public Management in the 21st century. The Gates Foundation-funded Avahan programme, for instance, emphasises its 'data driven business approach' and 'effective management model' (Avahan, 2008; Rau, 2011), in which the management of performance through the compilation of data is central.

According to evaluation literature, the major purposes of M&E are threefold: (i) assessing programme effectiveness (ii) preventing misappropriation of funds (iii) feedback and learning to improve programme performance (Green and South, 2006; Rossi et al., 2003; Shadish et al., 1991). While M&E policies presume a rational model in which accurate information leads to better performance, critics have cautioned that monitoring systems (for example using key performance indicators) should not be simply

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assumed to 'mirror' reality (Power, 1999; Strathern, 2000). Indicators are partial, capturing some aspects of reality but not others, thus leading to systematic gaps in what is recorded (Armytage, 2011; Ika & Lytvynov, 2011; Savedoff et al., 2006). More profoundly, it is argued that indicators actively construct reality. Particularly when indicators are used as a basis for performance management, those indicators come to define the problem, the role of practitioners, and the identities of the 'beneficiaries' (Erikson, 2012; Lorway and Khan, 2014; Mawdsley et al., 2005). In the interest of exploring the effects of monitoring systems at the grassroots level, this article investigates the experiences of the users of M&E systems – NGO and donor staff – charged with putting monitoring into practice.

In the HIV/AIDS literature to date, monitoring has been largely treated either as a health-systems issue (regarding HIV incidence and prevalence rates, sentinel surveillance), where the concern is whether M&E is sufficiently resourced and embedded in health systems (Peersman et al., 2009; Porter et al., 2012), or as a technical issue, where the concern is with developing the 'right' indicators and the focus is on indicators of service delivery, clinical work or behaviour change communication (Ahonkhai et al., 2012; Catumbela et al., 2013; Mannell et al., 2014) and achieving high 'data quality' (typically through web based applications with decentralised data entry) (Nash et al., 2009). Collectively, this body of work is oriented to incremental improvement of individual indicators, improvement of M&E frameworks, and the institutionalisation of M&E. There is generally little attention paid to how M&E is actually implemented at grassroots level, how it is experienced by frontline staff, or its effects at the grassroots level, despite the fact that those 'at the sharp end' of healthcare policies, who are charged with implementing them, may have important insights to contribute (Aveling et al., 2015).

The exception is a body of recent research which investigates questionable 'data quality' in routine reporting relating to HIV. For example, Kaposhi et al. found that the number of adults receiving antiretroviral therapy in the Eastern Cape, South Africa was over-reported by 36.6% on the District Health Information System, and recommended enhancing staff training, data-verification procedures, and reducing the clinical and reporting burdens on staff, to make accurate record-keeping more manageable (Kaposhi et al., 2015). Surveying the completeness and accuracy of records in a large, prevention of mother to child transmission programme in South Africa, Mate et al. found that reports submitted to the state level were only 50% complete, and accurate only 13% of the time (Mate et al., 2009). They suggest that the challenges are not only technical, but also social, highlighting the commitment of clinic staff as a key factor and therefore recommending that the collection of monitoring data be shown to be useful at a local level, so that staff have a sense of ownership and 'buy-in' to the aim of gathering accurate data. These authors did not gather data about staff perceptions, but speculate about their importance. This paper empirically investigates staff perceptions, assuming, like Mate et al. (2009), that how staff feel about their reporting activities has important implications for both staff enthusiasm and data quality.

The data for this paper are drawn from HIV interventions in a high prevalence state of western India. There is a large and growing literature evaluating HIV interventions in India, which predominantly seeks to establish whether, and to what extent, interventions have achieved positive results in terms of reducing HIV transmission or risk factors (Ng et al., 2011; Vassall et al., 2014). A smaller body of literature examines issues of process, seeking to learn lessons about programme design, mechanisms of change, and implementation (Narayanan et al., 2012; Wheeler et al., 2012).

Until the recent papers by Lorway and Khan (2014); and Biradavolu et al. (2015), however, we could find no evidence of other studies on HIV in the Indian context that had considered monitoring as an active process, constructing people and practices, rather than simply reflecting them. Lorway and Khan (2014) explore how the epidemiological categories used in HIV intervention terminology came to define new identities and new grounds of inclusion/exclusion among key populations in India. They make a compelling case that monitoring forms do not simply reflect a pre-existing reality, but construct realities. Biradavolu et al. (2015) examine the unintended consequences of a community-based monitoring system for sex worker interventions in India, finding that despite its good intentions, the system deskilled and undermined sex workers, replacing their contextually-sensitive counting systems with a less responsive universal system, thus constituting disempowered sex workers and problematic data. This article seeks to contribute to this research agenda, but with a different focus. It asks: How do the on-the-ground users of M&E systems in HIV interventions in India experience those systems? By asking this question, we seek to understand the effects of M&E practices, not in producing data, but on the everyday work and experience of running interventions.

2. Context: monitoring HIV interventions in India

At the time of the fieldwork for this study (2011–2012), the governance of the HIV response in India was undergoing a transition. Since 2003, it had been led by two agencies, working in parallel: the Indian government's National AIDS Control Organisation (NACO) and the Bill & Melinda Gates Foundation's Avahan programme. These agencies divided their responsibilities geographically, with the Avahan programme operating in certain districts in the six highest-prevalence states, while NACO was responsible for the rest. In line with international principles of 'aid effectiveness', 'harmonisation' and 'coordination', the government and philanthropy-funded programmes were closely coordinated, having similar structures in place at each administrative and geographical level (Hill et al., 2012). Both programmes employed a common operational structure of distributing funds to organisations operating at the state level, i.e. State AIDS Control Societies and international NGOs respectively. In both cases, these state level agencies managed the funding, commissioning, and evaluation of Targeted Interventions, which were sub-contracted to and implemented by local NGOs and CBOs at field level. During the fieldwork, the Avahan programme was in a transition phase, with its funding and HIV intervention programme management being handed over to the Indian Government (Rao, 2010; Sgaier et al., 2013).

The government and Avahan programmes took a common approach to intervention, with three main components. First, prevention activities took place through peer-based outreach, in which members of key populations, working as peer educators, communicated behaviour change messages and distributed condoms. Second, a medical component was provided through project-run clinics for HIV/STI testing and treatment. Finally, a 'social component' aimed at advocacy and empowerment to foster community participation and 'ownership', by promoting local leadership. Across each of these components, M&E activities were conducted, to record and evaluate each NGO's achievements in each intervention strand against targets set centrally by the funding bodies. This study was conducted in the context of Targeted Interventions for sex workers, in a 'high prevalence state' in western India.

M&E was embedded in the job descriptions and management of Targeted Interventions at all levels of programmes. We investigate "M&E" as our participants defined and experienced it. "M&E" ostensibly refers to two separate processes: monitoring (i.e. recording data about activities and outcomes), and evaluation (i.e. assessing the success of a programme in relation to its objectives by