Rapid Evaluation Methods in Health Systems Strengthening

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Introduction

Health systems strengthening (HSS) is widely understood to be key to achieving universal health coverage and to ensuring robust responses to health emergencies. In recent decades, global health investors have put more attention and investment towards HSS, leading to accelerated efforts to evaluate HSS policies and programs initiated by those investments. Yet, a common definition and framework for how to evaluate HSS interventions remains elusive, hampering efforts to strengthen, coordinate and amplify HSS programs.

The Health Systems Strengthening Evaluation Collaborative (HSSEC) brings together key global and national stakeholders to suggest ways to strengthen the quality of evaluations of health systems strengthening (HSS) investments in LMICs and to improve coordination across stakeholders in this space.

In this brief, we highlight available guidance on HSS rapid evaluation methods and summarize evaluation challenges and good practices.

Key objectives and methodology

The main objectives of this work were as follows:

- Compile guidance on Health System Strengthening (HSS) rapid evaluation methods and map the methods applied to various intervention/evaluation types, including new methods utilised during the Covid-19 pandemic that may be relevant to HSS evaluation, and consider the feasibility of such approaches.
- Summarise existing knowledge on specific evaluative challenges and good practice of a few methodological options and consider how they can be applied to strengthen evaluation.

This work was infomed by analysis of published and unpublished literature on the topic. The focus was on evaluations of HSS interventions described as 'rapid' and complexity sensitive with methods/ techniques that could identify emerging intermediate outcomes, causal pathways, and linkages with broader HSS outcomes. Our apprach built on, and was also informed by, other reveiws that have been carried out on the topic[1]

Overarching findings

There is a growing awarness of the need for evalution methods that are able to provide rapid 'real time' insights of HSS programming.

HSS Interventions are inherently systemic and complex. Evaluating their performance and impact needs to imbibe the complexity and dynamism of the health system, consider stakeholder inter-relationships, and inform on the systemic changes in Health Systems (HS) functions and changes in organisation and in people's relationships, roles, rules, and resources (Anwer Aqil 2017).

There is a visible need for evaluations to generate evidence for informing programmes and policy within shorter time frames. For example, during windows of opportunity and responding to health crises such as

[1] Scoping review Norman Gill 2021, systemic reviews M. McNall 2007, Cecilia Vindrola Padros 2021 and work by Tiina Pasanen 2019,

the Covid-19 pandemic, and/or have inbuilt feedback loops that support improving the intervention design and implementation for better outcomes/impact.

While there is consensus on the need for pragmatic appraches to 'speed up' the evaluative process there is not yet agreement on what exactly contitutes a 'REM approach'

The term 'rapid evaluation' is widely used for approaches that adopt pragmatic methods for the timely assessment of innovations (Norman Gill 2021). These are timely, team-led, intensive, practical, and systematic inquiries that use primarily qualitative and mixed methods requiring stakeholder participation. They are based on an iterative data collection and analysis process to report a holistic understanding of an intervention from an insider's and an outsider's perspective (M. Anker 1993) (ITECH 2008).

While there is not a consensus on the meaning of 'rapid' in rapid evaluations, our review highlights that some commen characteristics[2] (see Box 1) **There are several variants of REM that have been applied across a range of contects**

Box 1. Common chacteristics of REM

1) A shorter timescale (4 weeks to 6 months) from research design to dissemination,

2) Early/ongoing feedback or reporting of findings for continuous learning,

3) applying technology/tools and that reduce the time for data collection and analysis,

4) using less time-intensive research processes/methods, and

5) conducting data collection and analysis in parallel, eliminating transcription or the coding of qualitative data and utilising larger evaluation teams to share the workload

REM, Rapid Time Evaluations (RTE), Rapid Feedback Evaluations (RFE), and Rapid Cycle Evaluations (RCE) are broadly being considered types of REM.

The World Health Organization developed REM in the early 1990s to support programme managers to quickly identify operational issues to improve quality and process for health service delivery. RTE was developed in the late 1990s to support ongoing response during humanitarian crises working in tandem with implementation teams. RFE and RCE are more recent, supporting continuous learning and adaptability of HSS Interventions using cycles of common iterative processes (i.e., Plan-Do-Study-Act cycles), action research and developmental evaluation.

Covid-19 research has drawn upon REM with some success

COVID-19 demanded quicker implementation of new health service models, coupled with an amplified need for responsive research.

RTEs were conducted to understand the preparedness of clinical settings, communities, the responsiveness of healthcare organisations. Discrete choice experiments studied vaccine preference, utilisation & hesitancy. Mixed methods and qualitative studies were conducted on remote follow-up care for discharged patients and remote home monitoring technology such as home oximetry.

The focus was on the 'rapid' generation of evidence through review of records, analysis of large data sets from administrative and clinical data, short surveys, key informant interviews, remote data collection via telephone/online surveys, and interactive voice response.

[2] See also Norman Gill (2021) and Cecilia Vindrola Padros (2021).

The application of REM may also have been impacted by the preparedness and adaptability of researchers to rapid techniques and ethical implications of research, especially involving patients, affected facilities, and health workers.

The trend in REM is shifting towards rapid evaluations with multiple short stages with feedback loops or cycles.

These approaches are centred on stakeholder engagement and continuous learning and dissemination of findings (Cecilia Vindrola-Padros 2021). They focus on underlying causes and intervention/solution, emerging system-wide effects, causal relationships/linkage to HS outcomes and system changes needed to sustain improvement.

While promising, the use of REM as robust tool for HSS evaluaton remains largely untested and requires more dedicated expertise to develop and refine the approaches.

REM is an emerging science. There is a limited application in HSS settings and little comparative research to assess the pros and cons of rapid methodology in terms of rigour, cost, and impact (Norman Gill 2021). Regarding the determination of causality of HSS interventions, for example, it is not known if these design/methods identify where the results stand on a contribution-attribution continuum.

The application of REM is impacted by a lack of researchers with expertise and capacities in REM, including an overall shortage of health services researchers and evaluators and a lack of funding for timely applied research, such as that using routine data (Selina Rajan 2021).

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