Realist evaluation in times of decolonising global health

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Abstract

Realist evaluation is a theory-driven evaluation approach inspired by scientific realism. It has become increasingly popular in the field of global health where it is often applied in low- and middle-income countries. This makes it timely to discuss realist evaluation's relationship to the emerging decolonization of global health movement. In this short perspective, we argue that the principles and practices that underpin realist evaluation have great potential to contribute to the decolonization endeavour. Both the focus on the inclusion of local stakeholders and the openness to the rival theories these stakeholders bring to the fore, are promising. However, in practice, we see that a lack of acknowledgement of power imbalances and different ontologies and an overreliance on Western-based theories thwart this potential. We therefore suggest that realist evaluations performed by external researchers, especially in the field of global health, should actively engage with issues of (power) inequities. This is not only the just thing to do, but will also contribute to a better understanding of the intervention and may facilitate the emancipation of the disenfranchised. One way of doing this is through the adoption of participatory (action) research methods, currently underused in realist evaluations. We finally give a short example of an evaluation that combines emancipatory and participatory practice development with a realist approach. The *Afya-Tek* project in Tanzania has an innovative bottom-up approach throughout the full evaluation cycle and shows the possible strength of the proposed combination to create better interventions, more empowered stakeholders, and more illuminating program theories.

Keywords: Realist evaluation, decolonization, global health, participatory action research, emancipation, power

Highlights:

- Realist evaluation (RE) shows great potential to help decolonize global health
- But, its theory-driven rationale creates obstacles for external researchers
- These can be partly overcome by an increased awareness of power imbalances
- Combining RE with participatory (action) research methods can be useful

Introduction

Since its inception, by way of the seminal work of Pawson and Tilley [1], realist evaluation (RE) has become increasingly popular in the field of global health, and health policy and systems research more specifically.[2,3] This trend can also be observed in low- and middle-income countries (LMIC), where RE faces the growing call for the decolonization of 'global health' [4-6]. This is especially the case when RE studies are done by external researchers, that is, any researcher – whether foreigner or not – who is not of or from the communities under consideration. We argue that RE's principles and practices show great potential to contribute to decolonization by involving all stakeholders and putting assumptions held by relevant local actors on an equal footing with substantive social science theories. Nevertheless, in practice, RE to a lesser extent acknowledges power imbalances, the existence of different but equivalent ontologies and/or the inadequacy of Western-based theories and concepts which may effectively thwart this potential.

In this short perspective, we show why taking these less acknowledged issues actively and critically on board of a RE is important in the light of decolonizing global health. We suggest the use of participatory (action) research methods (for formative RE), as well as ensuring an adequate recognition of power dynamics throughout the RE cycle. We end this perspective with a concise example. Although not feasible within the remits of this short paper we acknowledge the need to also scrutinize realist evaluation and its underlying philosophy themselves through the lens of decolonization.

Realist Evaluation

RE is a theory-driven evaluation approach, inspired by scientific realism and notions of deep ontology with reference to underlying (social) structures and generative (social) mechanisms.[7] The core idea of scientific realism is that a reality exists independently from our observations and knowledge about it; yet knowledge production is constrained and influenced by our social, economic and cultural position. RE aims to answer the question 'what works, for whom, in what circumstances, how and why?' by elaborating and refining program theories that explain how an intervention[1] achieved the observed outcomes. Such explanations are achieved through the identification of generative mechanisms—'underlying entities, processes, or structures which operate in particular contexts to generate outcomes of interest' (p. 368)[8]. These mechanisms generate specific outcomes in specific contexts, which is why realist evaluators use the context-mechanism-outcome configuration (CMOC) as a heuristic in the analysis and refinement of program theories.[2,9]

The RE cycle starts with the development of an initial program theory. This can be based on a variety of sources, including realist reviews, empirical studies, conceptual frameworks, policy documents, substantive theories from the social sciences, but equally assumptions held by relevant local actors and insights from local stakeholders. Subsequently, specific CMOCs are derived from this or these program theories. These are then 'tested' and refined through an iterative process of data collection, analysis and theorization. Importantly, RE is method-neutral, meaning that any data collection and analysis method appropriate to unearth and refine the proposed causal claim of the program theory can be used. One specific data collection method is the realist interviewing method, which entails a learner-teacher relationship in which the researcher explains the explanations and possible theories,

[1] In RE, the term 'intervention' is often used because of its origins in the field of evaluation. However, this should be understood as including actions, policies, programs, etc. It should also be noted that the term 'realist research' is increasingly used, in which situations are examined without referring to interventions.

after which the interviewee explains their lived experiences using these newly learned concepts and theories.[10]

Once data are collected, realist evaluators apply abductive reasoning, 'in which empirical data are re-described using theoretical concepts' [11], and retroductive theorizing, uncovering mechanisms and structures that explain an empirical observation or a phenomenon.[12] In this way, an updated program theory is created that serves as the end-product of the RE, and the starting point for a new cycle. These methods of inference imply a rather strong role for the use of pre-existing theories and concepts.

Decolonizing global health

Since RE has found quite some traction in the field of global health, notably in health policy and systems research [3], it is relevant to discuss RE in relation to the growing decolonization movement in global health.

The colonial and neo-colonial legacies imbued colonial institutions, ways of thinking and power relations into contemporary global health practices, research and evaluation. Global health interventions and evaluations are often embedded in unequal donor-recipient aid relationships, and colonial mindsets perpetuate in people's thinking about what it means to be and act as a civilized human.[4] These colonial mindsets lead to a disregard of lay knowledge from local and indigenous people[5] in favour of theories from social sciences, which are deemed universal but are based on WEIRD concepts, methodologies and ontologies (i.e. coming from people from or influenced by western, educated, industrialized, rich and democratic societies).[13] The implied hierarchy of knowledge, which disregards situated knowledge and indigenous understandings, foments the practice of helicopter science in which external researchers collect data and leave the site with little or no input in the analysis from local people or researchers, and with no credit given to the latter.[14] This is not only unfair and unjust; it is also detrimental to science and the production of knowledge. The complexities of the current global problems require nuanced solutions, which can only come from diverse knowledge bases.

Against this background, a decolonization movement emerged within global health. The movement 'fights against ingrained systems of dominance and power in the work to improve the health of populations' (p. 1)[6] and 'to remove all forms of supremacy within all spaces of global health practice, within countries, between countries, and at the global level' (p. 1627)[5]. Decolonization is a critique

of the universalization of the Eurocentric ways of being and doing.[4] As a recent editorial highlights, the "they" *who* continue to define global health research, in consequence unfortunately also determine the *what* and the *where.*[15] The process of decolonization therefore highlights power imbalances and focuses on how these are maintained or strengthened by existing structures and practices. Additionally, in the wake of this decolonization agenda, participatory research — approaches that shift the locus of power towards the local stakeholders[16] — have (rightly) gained prominence.[17] However, the participatory research process certainly is not the magical solution, as the issue is much wider than methodology alone: deeply ingrained unequal structures are at play.[18]

Realist evaluation and decolonizing global health

How does and should RE relate to this decolonization movement? Although Pawson [19] is sceptical of taking an active, normative stance towards the evaluation subject, this should not automatically imply that addressing power relations is out of bounds for realist evaluators. In the same book, Pawson [19] emphasizes the need for 'organized scepticism' (p. 107) and although he mainly focuses on colleague evaluators, he also recognizes the need for 'adversarial stakeholder participation' in the design of inquiries so that alternative theories and feared unintentional outcomes will receive equal research attention to that placed upon promised benefits' (p. 110). This points to the need to actively involve local stakeholders, including health service users, non-users, stakeholders, and local communities and seek out rival programme theories.

The importance that RE attaches to unearthing the assumptions of people involved in the funding, design, implementation, utilization and evaluation of interventions, and the method-neutral nature of RE further stimulates realist evaluators to adopt not only participatory, but also equity-sensitive and emancipatory-focused methodologies and methods. In doing so, RE enables them to tackle issues of empowerment and contribute to decolonizing global health.

However, in reality, we observe that the active involvement of and co-production of knowledge with stakeholders with less agency to improve their social status or conditions is rather absent[20], with few exceptions (see Westhorp et al. [21]). The involvement of local stakeholders is often based on practical and theoretical considerations and 'evaluator's hypotheses' (p.349) [10] rather than based on emancipatory motives. Moreover, the strong theory-driven approach in both the data collection and analysis can have implications regarding 'the influence of power imbalances, (…) (the) use of translators (…), (the) limited contextual understanding or engagement (of external researchers) and

(the identification of) appropriate programme theories reflective of the context' (p. 5).[22,23] Indeed, RE itself, as part of the larger scientific endeavour, operates against a backdrop and history of power dynamics that perpetuate a hierarchy of knowledge in which academic writing and journals are very much embedded. Although contested to an important extent by RE[24,25], this hierarchy of knowledge may prove difficult to escape from.

A similar caveat should be highlighted regarding the use of theories. Despite RE's openness to all kinds of theories, including those assumptions held by relevant local actors, evaluators often prioritize theories that are closer to their own initial ideas and lived experiences. This may be problematic as many of the substantive theories from social sciences are mainly based on studies on WEIRD people[13], making it uncertain whether their scope can be extended to other societies and cultures.[26] The issue is not that these theories might be wholly unintelligible and cannot be used, but that we might miss out on perspectives, angles and conceptualizations that are specific to the communities we are studying.

Finally, few theoretical concepts can be adequately translated between societies, given the inextricable link with languages and cultures. Cognitive science and semiotics tell us that conceptualization is firmly grounded in linguistic structure (through form-meaning pairings).[27] This inability to translate goes both ways and complicates the teacher-learner relationship in realist interviews, which may lead to 'misunderstandings'. When the existing power relationships are not accounted for, realist evaluators may not be achieving the aim of accurately answering the question 'what works, for whom, in what circumstances, how and why'.

We argue that RE principles and practices have a strong potential to contribute to the decolonization of global health through its focus on assumptions held by relevant local actors and the inclusion of different stakeholders. Yet, when power differentials are insufficiently acknowledged and not actively resolved, REs, just like any other kind of evaluation, will not only fail to fully understand how an intervention led to a specific outcome pattern, but also contribute to perpetuating inequalities.

With the decolonization agenda in mind, we therefore argue that REs, especially those in global health and performed by external researchers, should actively engage with issues of (power) inequities. Not only is this the just thing to do, analysing power also speaks to how the interaction between agency and structure is central in realist ontology and epistemology. Hence, issues of power dynamics and inequity play a critical role in explaining how and why some social phenomena or

behaviours take place or change.[28] Moreover, giving participants ownership over the research process and findings facilitates the integration of the conclusions in emancipatory actions.[20]

Given the context of unequal global structures in which REs necessarily take part, one could be sceptical about RE's potential to make large strides in the decolonization of global health. Nevertheless, it does not mean there are no ways forward. The aim henceforth should be to consistently and actively contribute to emancipation and participation in whatever way possible. One way of doing this is through the adoption of participatory (action) research methods, while bearing in mind that participation has long been a contentious issue [29] and it is important to actively revert from tokenism or instrumentalization of local stakeholders.[30] Photovoice (see Mukumbang et al. [20]) and the Community Lab of Ideas for Health (see Masunaga et al.[31]) are just two such promising methods. Another promising route, which combines emancipatory and participatory practice development with a realist approach, is discussed in the next section.

Afya-Tek: a promising example

Afya-Tek is a proof-of-concept digital health initiative in Tanzania, which is primarily based on co-creation and participatory approaches.[32] Through a locally sourced, co-created and human-centred digital health intervention (DHI), *Afya-Tek* aims to improve the continuity of care for maternal, child and adolescent health care, as well as the coordination of care between community health workers, accredited drug dispensing outlets and primary health facilities in Kibaha, Tanzania. Funded by the Swiss-based *Fondation* Botnar, and headed by the Tanzanian health consultancy group Apotheker Consultancy Limited, *Afya-Tek* is a multi-partner consortium based both in and out of Tanzania.

The primary tenet of *Afya-Tek* is that it is participatory in nature. From the use of human-centred design (HCD) to conducting formative research as a starting point for understanding the context[32] to the adoption of RE as a monitoring and evaluation methodology, *Afya-Tek* has been a bottom-up endeavour from the very beginning.

HCD is a unique approach that is both participatory and empathic in nature, which starts with the persons for whom an intervention is being designed, and ends with innovative solutions that are tailor made to suit their needs. As such all relevant stakeholders are consistently kept in the loop across the ideation, creation and implementation of any intervention.

In *Afya-Tek*, the HCD process meant that a variety of stakeholders have been consistently engaged with from project inception and co-design, through the co-creation and implementation of the DHI,

all the way to the monitoring and evaluation activities – all with the aim to eventually scale-up and integrate the intervention in the Tanzanian national digital health system. We found that HCD is especially useful for co-creating a digitized tool that is specifically tailored to and coordinated around the needs of both the health workers and the clients, consequently placing people at the centre of their care. These stakeholders have included, but are not limited to community-level "beneficiaries" and household heads; front-line health workers such as community health workers, accredited drug dispensing outlets, and health facility workers; district level health managers and supervisors; national levels of government (including ministries of health, local government, and information technology); all consortium partners and their varied expertise, as well as the funders.

Afya-Tek's continuous engagement with these various groups of relevant stakeholders allows for the organic emergence of any dominant power issues to naturally be recorded and consequently managed/neutralised if necessary. With *Afya-Tek* being the central point through which various stakeholders communicate and reflect on a common goal (improved continuity of care through a DHI), it allows for various potential instances of power and hierarchy, whether racial, social or economic, to be recognised, reflected upon, and solutions proactively and mutually agreed upon.

Additionally, within this overall participatory approach, the use of the realist approach in monitoring and evaluating the intervention has allowed us to theorise the intervention specifically within its context, making use of situated knowledge and theories. Using mixed-methods techniques, the perspectives of health workers (DHI users), patients (clients), local and national-level government partners, consortium partners, as well as that of the funders was actively pursued. This allowed us to continually and critically reflect on the various roles stakeholders inhabit and the levels of power and influence they exhibit, all within the specific contexts in which they are situated. For instance, upon critical reflection it is indicated that having Fondation Botnar (a Swiss-based philanthropic agency, whose operational viewpoint is relatively both flexible and emancipatory) as this proof-of-concept program's funder, encourages the space for the natural growth of Afya-Tek into the socio-political Tanzanian health landscape, all with the vision of long term sustainability.

In short, human-centred design and the consistent and varied stakeholder engagement helps to ensure that the digital tool is being created and implemented to be as effective and sustainable as possible. Within this, the RE component helped in developing guidance for integration, scale-up and long-term sustainability. Finally, while several challenges have been faced along the way, the flexible, human-centred, participatory and iterative nature of *Afya-Tek* has allowed for effective, real-time

problem solving and solution generation. This includes having to be realistic in what is achievable and what is not, constantly (re)evaluate based on available resources, as well as consistently being mutually inclusive in co-defining and prioritising what needs to be effectively addressed for long term success.

Conclusion

RE principles and practices have great potential to further the goal of decolonizing global health. However, it can only fulfil this potential if sufficient and critical attention is given to the strict hierarchies of knowledge that govern contemporary science and evaluation, the incorrect universalization of Eurocentric ways of doing, the relevance of different ontologies, the limited scope of commonly used WEIRD theories and concepts, and the power imbalances that exist between external researchers and research subjects. We therefore suggest that research approaches and frameworks establishing methodological congruence between emancipatory and participatory practices and RE should be considered more often. If not, RE risks to overshoot its goal of finding out 'what works, for whom, in what circumstances, how and why?' by limiting our ability to engage with and truly understand non-western, non-Eurocentric ways.

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