The Use of Political Economy Analysis in Health Systems Strengthening

Information brief for donor support to complex health systems reform

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Synopsis

There is a growing recognition that political economy analysis (PEA) is an essential aspect of external donor assitance to complex health reform processes. The United States Agency for International Development (USAID)'s Vision for Health Systems Strengthening (2015–2019), for example, recognizes that "broad political economy issues often drive health systems organization, priorities, and performance" and that "health system strengthening challenges are intertwined with political and economic considerations." This information brief is for those designing and implementing health system programs to support in-country champions of health systems reforms.

This brief provides a short synthesis of findings from selected project documentation, key informant interviews (KIIs), and case studies of how PEA has been used to inform donor programming in the field of health system strengthening—from project design to implementation and adaptive management from regular monitoring and evaluation. It also summarizes how PEA can help projects be more effective by being more aware of and responsive to local political realities or thinking and working politically (TWP). The brief includes findings based on a review of 40 health systems strengthening projects and four in-depth case studies of activities supported by USAID and the U.K. Department for International Development (DFID) in Guatemala, Indonesia, Nigeria, and Pakistan.

Summary Findings[1]

Formal PEA is well recognized as a tool to help health system practitioners address complex problems.

For use in program design, the PEA process needs the following critical elements for it to suceed:

- ***Full mission buy-in from the start of the process on the scope***
- ***Systematic use and distribution of PEA findings***
- ***Participation of donor's health officers in the process of interviewing local stakeholders***
- ***Paying attention to the right timing to conduct analysis***
- ***The inclusion of country stakeholders in the discussion of PEA findings and implications***

For use in implementation, PEA is increasingly being seen as a useful tool to set a* baseline *to inform existing or new approaches in the health sector.

It is challenging, but useful, to share PEA findings with local—including government—stakeholders.

There are, as yet, only a limited number of examples where PEA has been fully embedded as part of adaptive management or learning.

More research is required on the use of PEA to better inform effective programming and achievement of health outcomes.

Introduction

Expanding access to and improving quality of priority services, tackling inequity, and achieving adequate and sustainable financing are all required to achieve UHC and are all complex and inherently political processes. Identifying potential solutions requires a nuanced understanding of the actors, institutional relationships and incentives contributing to how and why the health system works the way it does.

Political economy analysis (PEA) as a field-based methodology is increasingly being used across development/donor programming—including in health systems strengthening projects—to 1) identify political, economic, social, and cultural factors that drive or impede reforms, and 2) to design or adapt programming in accordance with findings. Multiple donors—including USAID, DFID, Australian Department of Foreign Affairs and Trade (DFAT), European Commission, World Bank, Swiss Agency for Development and Cooperation, and UNICEF—have deployed PEA to support their work in various sectors over the past 15 years. Academic institutions, think tanks, and health care practitioners have also used political economy frameworks to conduct reviews of why aspects of health systems reform were or were not successful in a given country context.

Participants at the Bellagio Workshop on Political Economy of Global Health in 2015 recognized health systems reform as "a profoundly political and economic exercise" and call for "increased use of PEA by both academic researchers and global health practitioners"[2].

This brief seeks to provide a short summary on how PEA has been utilized to identify and address political economy drivers in relation to donor-funded health systems reform activities and projects specifically over the past decade[3]. It includes views from project

[1] Findings are further detailed in the conclusion.

[2] Participants at the Bellagio Workshop on Political Economy of Global Health. 2015. "Report from Bellagio: Advancing Political Economy of Global Health to Understand and Influence the Drivers of Universal Health Coverage," *Health Systems & Reform,* 1:1, 20-21, DOI: 10.4161/23288604.2014.991221

[3] There are varying frameworks and tools for PEA in donor-driven programming. Some examples Include: USAID Applied PEA Field Guide (https://www.usaid.gov/sites/default/files/documents/2496/Applied%20PEA%20Field%20Guide%20and%20Framework%20Working%20Document%20041516.pdf); World Bank Problem-Driven Political Economy Analysis (https://elibrary.worldbank.org/doi/book/10.1596/978-1-4648-0121-1); and a DFID-sponsored Beginners Guide to Political Economy Analysis (https://www.gov.uk/government/news/nsgi-publishes-political-economy-analysis-beginners-guide).

implementers on the value of PEA to inform better health system strengthening program design and implementation. This policy brief is intended for a diverse audience of actors involved in supporting health system strengthening activities. The objectives are to improve the use of PEA to:

- Inform setting overall strategies and identifying short- to medium-term opportunities for health system reform
- Inform the design of specific health system projects or interventions, particularly those supported by external donors
- Strengthen approaches by those implementing and championing health system reforms including donors, implementing partners, and nongovernmental organizations (NGOs).

Research Methodology

Through internet research, available project information, and initial interviews, the research team identified approximately 40 donor projects or activities in the sector that appeared to be using some form of PEA as an explicit part of strategy. From this, the team selected four in-depth case studies and conducted additional KIIs with respective donor officials and project implementers involved in the respective cases to discuss how the PEA activities were conducted and garner opinions about the usefulness of PEA in the sector. The 13 KIIs included USAID staff in Washington and Guatemala, DFID staff from Nigeria, and project-based implementers in Guatemala, Pakistan, Indonesia, the United States, and the UK.

Defining PEA and TWP in Health

A 2014 survey[4] of health systems researchers and practitioners in the United States resulted in a crowd-sourced definition of PEA in the health systems field as "examining the dynamic ways in which multiple social forces underpin power relations that mediate how [health] resources are allocated and inequalities perpetuated or redressed." A 2018 HFG publication (see box) defines PEA as it relates to resource distribution and incentives that affect institutions, as well as promotes its usage.

A Definition of PEA

"PEA asks why political figures decide to raise and distribute resources in the way they do. It seeks to understand the actors who try to influence the cycle of policy development, their interests, and how they attempt to influence decisions…. And it considers how contextual factors such as election cycles and macro-fiscal trends shape the motivations and decisions of those individuals. Understanding these factors can help [Ministries of Health] enact reform in support of [Domestic Resource Mobilization]."

HFG publication "Securing Domestic Financing for Universal Health Coverage: Lessons in Process" https://www.hfgproject.org/securing-domestic-financing-universal-health-coverage-lessons-process/

By helping identify these influences—political, economic, social, and cultural—PEA supports a more politically informed approach to working, TWP, which has three core principles: strong political analysis, insight, and understanding; detailed appreciation of, and response to, the local context; and flexibility and adaptability in program design and implementation[5].

Organization of the Information Brief

This brief is organized around program cycle stages in which PEA is being utilized or implemented in health systems strengthening. This includes design (country, sector, portfolio strategies, or specific project design); implementation (which may include inception periods or baseline analysis, and day-to-day activities); and adaptive management (using monitoring, evaluation, and learning appraoches). Within each program cycle category, we highlight cases from the literature and present a sub-set of four more detailed case studies that most effectively illustrate how PEA has been or can be used to inform health systems strengthening.

[4] George Asha et al., "Exploring how political economy analysis is understood by health policy and system researchers"; SHaPeS: social science approaches for research and engagement in health policy & systems, Health Systems Global Thematic Working Group, May 18, 2014, John Hopkins University.

[5] Thinking and Working Politically Community of Practice (www.twpcommunity.org).

The categories and case studies are:

I. PEA To Support Better and Smarter Project Design.

- Case Study 1: Design in Action and Best Practices—A PEA on Reform of Tuberculosis Treatment in Ukraine (USAID).

II. PEA To Inform Implementation Baseline Analysis, Work Planning, or Shifts in Program Direction.

- Case Study 2: USAID Health and Education Policy Plus (HEP+) Project—Guatemala Municipal-level Reform PEA Activity.
- Case Study 3: Northern Nigeria—Political Economy of Health Sector Programming Through "Whole of Government" Approach.

III. PEA as an Embedded Element of Adaptive Management and Learning.

- Case Study 4: Building a Culture of Embedded PEA—Empowerment, Voice, and Accountability for Better Health and Nutrition (EVA-BHN—Pakistan.

I. PEA To Support Better and Smarter Project Design

From the donor perspective, formal PEA has been utilized with increasing frequency to inform multiyear country development strategies, design country-wide or portfolio approaches to health programming, and/or design individual health projects through requests for proposals or grants assistance. NGOs have also used PEA; for example, in 2014, in advance of designing a suite of new health programming, CARE Zambia undertook a PEA to examine health systems in the Eastern Province. However, experience shows that the quality of the process, level of donor buy-in, and integration of findings into final project designs has varied considerably.

PEA is being utilized to inform health programming in the context of USAID Country Development Cooperation Strategy (CDCS)[6] processes. In **Afghanistan,** for example, the USAID Mission recently commissioned a PEA of the health and nutrition sector to inform the development of its 2019–2023 CDCS under the USAID Leadership Management for Governance instrument. The resulting report highlights a series of key issues that USAID/Afghanistan can consider in the design of its future approach to supporting health programs, including identification of *winners and losers* as a result of proposed reforms in the health sector, spanning individual stakeholders, health, and other social sector ministries, service providers, and health beneficiaries.[7] Importantly, the PEA considers how the donor itself is an actor in the political economy with major influence over budget prioritization.

USAID's work in **Indonesia** provides an example of using PEA for project design. In 2015, USAID/Indonesia sought assistance—including from the Bureau of Global Health in Washington—to conduct a PEA related to reproductive, maternal, neonatal, and child health (RMNCH). The reasoning was to understand why Indonesia continues to struggle with high rates of infant mortality despite relatively high levels of overall capacity and a growing economy backed by decades of donor assistance in the health field. The PEA was intended to inform the design of a new RMNCH project in Indonesia, but was truncated into a two-week process during a busy period within the mission. According to stakeholder interviews, there was not full buy-in or agreement on the resulting research and recommendations. However, some of the research themes were incorporated into the subsequent project design of the USAID project (Jalin). This included identifying political feasibility of proposed interventions, identifying areas of existing political will, and using PEA at local/regional levels during implementation. Now in the first year of implementation, the Jalin project incorporates political considerations in its implementation strategy, for example, leveraging new state-sponsored minimum service standards to motivate local government actors who are responsible for delivering basic health services.

[6] A publicly available statement of the five-year strategy for bilateral development assistance in a given country.

[7] Winners as defined by those who will gain from development projects (and be the champions of it) and losers by those that will not (and possibly be the blockers of implementation).

UNICEF with DFAT in 2014–2015 conducted a PEA—*Analysis of the Political Economy of Health*[8]—to better understand the factors that have driven priority setting, planning, and resource allocation for maternal and child health in **Bangladesh, Indonesia, Philippines, and Nepal**. The comparative study asked: "if the scientific evidence base for, and cost-effectiveness and affordability of improving RMNCH have been so clear, for so long, why have so many countries failed to invest accordingly? Why, despite apparent political commitment and rhetoric, do several countries in Asia have the lowest absolute and relative levels of government expenditure on health, especially on RMNCH? How can RMNCH be prioritized and resourced?" The study was designed to inform future investments in RMNCH in Asia by UNICEF and DFAT and for consideration by other NGOs, implementers, and donors in the health field. It resulted in a brief on the PEA[9] with 10 broad recommendations for other interested donors and practitioners.

Our first case study is an early demonstration of using PEA to inform design and orientation of the existing USAID portfolio that touched on health service delivery was **A PEA on Reform of Tuberculosis Treatment in Ukraine** (see Case Study 1).

Case Study I: Design in Action and Best Practice—A PEA on Reform of Tuberculosis Treatment in Ukraine (USAID)[10]

Ukraine has the second-highest tuberculosis (TB) burden in Europe and one of the highest estimated numbers of multidrug-resistant TB cases in the world, despite significant donor support—including USAID—for TB prevention and treatment. The problems with reducing TB rates have been linked to larger health system issues, including corruption and mistrust in the health care system and outmoded service delivery in general and specific to TB. In Ukraine in 2015, the USAID Mission Health Office sought assistance to conduct a problem-driven PEA, with the core question: Why has Ukraine for years failed to adopt several reforms to its TB program despite a series of recommendations from international experts, including those included in National TB program reviews? The research was a collaborative effort with USAID/Washington governance experts and leadership and local staff from the Health Office, with support from a PEA consultant. The activity was also designed to test the emerging USAID PEA framework and field guidance subsequently released in 2016.

The PEA, which included both desk research and two weeks of KIIs in the field, focused attention on the system of informal payments and outright corruption that exists within the system of TB treatment in Ukraine and offered practical solutions that could help work within the existing political dynamics to affect change. The team closely reviewed prior assessments such as the in-depth Health Systems Assessment conducted for USAID in 2011. While the Health Systems Assessment and the PEA both identified similar systemic weaknesses, the role of the PEA—as outlined in the report—was to take this a step further to "question what set of incentives or underlying conditions contribute [to systemic inflexibility]" and link them more explicitly to necessary political reforms within and beyond the health system.

The PEA activity did not set out to inform the design of a new project per se, but the findings had implications for the implementation of multiple ongoing and emerging initiatives the mission was

[8] UNICEF. 2015. *Analysis of the political economy of health, particularly reproductive, maternal, newborn and child health, in four countries of south and east Asia.* https://www.unicef.org/videoaudio/PDFs/UNICEF_Working_Paper_on_political_economy_analysis_in_the_health_sector_-_27Aug15.pdf

[9] UNICEF. 2015. *Analysis of the political economy of health, particularly reproductive, maternal, newborn and child health, in four countries of south and east Asia.* https://www.unicef.org/videoaudio/PDFs/UNICEF_Working_Paper_on_political_economy_analysis_in_the_health_sector_-_27Aug15.pdf

[10] A summary of the PEA can be found at: https://usaidlearninglab.org/sites/default/files/resource/files/acfrogaqfoll1qnksiks540c8rjsxjpfccabcxq6t6ccysnlu0tcuiklohnknoqwer0ixjgtvca8-4o5hv6hj6xgpy4n5fortzii3sbtu0xi_24tphypofiyyqhx6gk.pdf

funding that touched on TB or rising TB rates, including the USAID Strengthening TB Control in Ukraine project (2012–2017). The study unpacked some of Soviet-legacy health care system incentive structures and highlighted areas and sources of entrenched corruption within the system. Some of the findings were utilized in discussions with the Ministry of Health and helped lead to an agreement to place a health governance advisor in the Ministry. Implicit findings in the PEA, and the direction of the thinking behind it, can also be found in the subsequently released solicitation (2017) for the Health Reform Support Project, which seeks to address "pervasive corruption in the health sector," including how corruption impacts rates of TB and concomitant burden of HIV/AIDS.

Some positive features of the PEA effort highlighted by stakeholders interviewed included:

- There was complete buy-in of the effort by the USAID Health Office leadership, who saw a clear connection between functional capacity and governance constraints and was familiar with the PEA methodology.
- The effort included local USAID staff knowledgeable of the health system and the intertwined political dynamics. This assisted the team in identifying practical recommendations and local flexibilities that, even in the absence of national-level reform, could improve TB care and treatment.
- The mission and research team looked at the mission's portfolio from multiple angles, including not only how the health-sector programming could be more politically informed, but also how existing democracy and governance programming (including civil society strengthening and anticorruption activities) could or should consider health system challenges.
- A focused PEA was designed to bring added value to other analyses and USAID research, including the previous Health Systems Assessment.

II. PEA To Inform Implementation Baseline Analysis, Work Planning, and Shifts in Program Direction

PEA is being used to help inform implementation approaches and annual work planning of projects by ensuring that the characteristics of local political systems are fully understood and taken into consideration in approaches and priority activities. This use of PEA goes hand in hand with programs in particularly volatile environments and/or working on solutions involving highly complex local systems. The types of PEA utilized include broad sector-level analyses, those that focus on particularly intractable problems, and others that focus on new or emerging opportunities, such as the role of the private sector in health service delivery.

HEP+ is a five-year global project jointly funded by USAID and the President's Emergency Plan for AIDS Relief (PEPFAR) to advance health policy priorities at global, national, and subnational levels to improve health outcomes worldwide. Individual USAID Missions in Central America, Africa, and Asia whose strategic objectives align with these goals have turned to HEP+ for support.

In **India** in 2017, the USAID HFG Project conducted a PEA of private health providers in TB treatment to develop a better understanding of how this critical group—viewed as a key element of India's national TB programs—could successfully support achieving India's goal of universal access to TB care. The analysis assessed the social, economic, and political barriers to combating TB through the lens of behaviors and incentives of patients; public and private providers; and the policy environment in which patients, public, and private providers interface. It provides a series of policy recommendations for local stakeholders, including the Ministry of Health and USAID, to consider in addressing incentives and disincentives that direct decision making by both patients and treatment providers in India. The USAID HEP+ Project has supported similar research on the role of the private sector in **Nepal and Uganda**, with the latter looking at institutions and actors influencing power and decision making in family planning and entry points for commercial expansion.

The next case study is of the **USAID/Guatemala** HEP+ Project PEA of the Prospects for Municipal

Health Insurance Schemes (see Case Study 2). It illustrates the mission's recognition of foundering political will at the national level for health financing and is an attempt to identify new and innovative financing arrangements, including through the private sector and local levels of government.

Case Study 2: USAID Health and Education Policy Plus (HEP+) Project—Guatemala Municipal-Level Reform PEA Activity

Beginning in late 2015, the HEP+ (see text box) team responded to USAID/Guatemala's request to focus on pursuing a suite of health policy reforms at the national level, including efforts to increase financial protections for health services through Guatemala's Social Security Institute. When HEP+ policy reform and health financing efforts failed to gain traction with national-level government stakeholders, including the Ministry of Health, the project team in Guatemala and the local USAID team recognized the need to adapt their management strategy. The HEP+ team's policy objective remain unchanged—support reforms to increase public sector investment in high-quality health services—but their path to achieving it would have to, at least temporarily, bypass resistance from national-level government authorities. Consequently, USAID/Guatemala encouraged the HEP+ team to explore all available sources for sustainable health financing in Guatemala beyond the Ministry of Health.

Leveraging other activities to support the ongoing decentralization of health services, the HEP+ team shifted the focus of health financing reform to the subnational level, specifically to municipalities. The HEP+ team proposed building on previous efforts to establish local health insurance programs in Villa Nueva, a large industrial municipality outside the capital. They presented Villa Nueva to USAID as a pilot for a municipal health insurance program and suggested an issue-based PEA to address questions of political viability and legality and help determine the viability of such an intervention.

A team of international and local experts in PEA, health governance, and Guatemala's health sector conducted the PEA. This included desktop research and KIIs with the Ministry of Health, Social Security Institute, public and private insurance boards, the Office of the President, the Ministry of Planning, several Villa Nueva municipal government offices, and the national association of municipalities. Access to health sector stakeholders and understanding the power dynamics among them was critical to designing strategies that could work in the political and social context. The PEA also included an analysis of the legal and regulatory framework governing municipal health insurance programs.

Findings were consolidated into a policy brief[11] that enumerated the challenges and opportunities with actionable recommednations on how to advance municipal health insurance programs in Villa Nueva and other Guatemalan municipalities. The PEA findings and an accompanying stakeholder map were shared first with USAID and later with relevant local stakeholders through a workshop to disseminate, review, and verify findings. The brief informed HEP+ technical assistance to Government of Guatemala institutions, including tools to operationalize the delegated authorities required to advance municipal health insurance programs. It also cautioned that lack of a full commitment to sector decentralization could be a hindrance.

The PEA exercise presented several adjacent benefits and possibilities for future activities, including:

- Conversations among actors involved in different facets of Guatemala's fragmented health sector who do not traditionally work together. For example, the Superintendent of Banks, whose purview includes approving/regulating insurance programs at all government levels, had not previously engaged with government authorities to discuss options for municipal health insurance.
- Testing of new ideas and suggesting approaches for health reforms and strategies to promote them. For example, it helped USAID make the case to place an embedded health advisor to sit in the Executive Secretary of the (new) President's Office.

[11] Bland, G., Peinado, L., Stewart, C. 2017. *Improving Access to Quality Healthcare*. Health Policy Plus. http://www.healthpolicyplus.com/ns/pubs/7148-7263_GuatemalaPEABriefJune.pdf

- Elections occurred following the PEA, and a new presidential administration has made highest level commitments to decentralization, which appears to be a political window for introducing or expanding subnational health financing options.
- As part of a new USAID Guatemala CDCS, the mission is considering building on the PEA with updated information and additional municipal pilots in line with the evolving process of decentralization.

The evolution in thinking on the use of PEA in project implementation for health sector programming can be tracked through DFID and other European donors over the last decade or more, as illustrated by two DFID case studies that follow of **Nigeria and Pakistan (See Section III)**. Prior to 2006, sectoral programming, including health, was largely technical in its focus with only implicit attention to political factors; PEA was confined to *governance* initiatives. DFID observed sectoral outcomes foundering in the absence of greater attention to political economy, and *pure governance* programs rarely extended major results to the social sectors, including education and health. DFID began requiring sectoral programming, including health programming in Nigeria (as a major aid recipient country), to include PEA and attention to the social and political considerations in the uptake of evidence-based social sector initiatives. The next case study focuses on the DFID Northern Nigeria Partnership for Reviving Routine Immunization in Northern Nigeria, Maternal Newborn and Child Health Initiative (PRRINN/MNCH) (see text box). It illustrates how PEA informed the direction and overall culture of the program. This case also demonstrates the bridge between initial or one-off use of PEA (used here) to ongoing applied formal and informal PEA discussed in the following case study from Pakistan.

Case Study 3: Northern Nigeria—Political Economy of Health Sector Programming

Burdened with some of the highest maternal mortality ratios and child mortality rates in the world, Northern Nigeria's efforts to improve health services had been undermined by political, structural, and institutional weaknesses at all levels of government, despite years of donor investment. In response, DFID in Nigeria sought to more closely link governance activities with sector programming with mutually reinforcing activities, termed a "whole of government" approach. A significant aspect of the DFID effort focused on **PRRINN/MNCH**[12].

PRRINN/MNCH focused on four Nigerian states with a combined population of more than 19 million. The project combined health systems strengthening—including major health financing reform—with immunization and maternal, newborn, and child health interventions.

Building on a previous power analysis mapping exercise of the political landscape, the project in 2008 undertook a more formal state-level PEA in each of the four target states. These interrogated the formal and informal power structures and incentives of local institutions and individuals and identified new ways of working. The PEA team included international experts in PEA and patronage systems and local health system experts, including the former state director of hospital management.

The primary question the project and PEA team posed was: What are the factors preventing the Nigerian government from contributing its own money to sustainably finance the health system, and how can the project/donor focus on mobilizing more domestic resources for health budgets in this environment? A related question in the PEA was: Why are existing budgets not being fully utilized in an already under-resourced environment? (Many health offices were spending only 60 percent of their allocated budget.)

[12] PRRINN/MNCH built on the platform established by the DFID-funded PRRINN project begun in 2006 with the inclusion of scope and funding Department of State of the Norwegian Government to cover the full Maternal, Newborn, and Child Health (MNCH) continuum of care in 2008, via a jointly managed project.

The resulting state-level PEAs revealed hidden areas of existing and potential corruption and rent seeking, in addition to technical constraints; they also identified opportunities for change. For example, it revealed information about the role of *informal* actors, including traditional authorities and local religious leaders and ways they might be more positive influencers on the local health system. The information informed DFID work on strengthening the budget process writ large. The PEA also had an objective to establish a baseline for tracking the political and health systems transformation related to MNCH over the course of implementation and help set parameters for project attribution. This proved difficult over the course of the project, given major economic and conflict-related shifts, including the impact of oil prices/revenue and the devastating emergence of Boko Haram in Northern Nigeria.

In the view of project implementers and relevant DFID staff interviewed, there are several lessons learned:

- The initial PEA was valuable in giving the team a deeper understanding of how the state-level budget exercise—appropriation, allocation, and budget release—happened, formally and in practice though hidden influence. It informed how the project would manage the informal processes with technical assistance to encourage state officials in the ministries of health, finance, and local government to adhere more closely to standard operating mechanisms and processes.
- The analysis helped orient the team toward what is now considered TWP. For example, in Jigawa state, the local staff became very effective in "insinuating themselves" (with due transparency) with some key Ministry of Health officials and informal decision makers. Politically astute local staff understood how and with whom to manage close working relationships, including for health budget prioritization and expenditure. Similarly, the PEA led to identifying and mobilizing religious and traditional leaders to collectively support project aims.
- However, ongoing PEA was not embedded in the project cycle as originally intended. Some stakeholders felt the promise of PEA—and the greater *whole of government* approach—did not live up to its full potential. Identified challenges included limited coordination across projects, issues of consistency, and risk aversion. PEAs were not part of logframe deliverables, leaving less incentive for DFID officers or implementers to expend the resources. There was a reluctance to actively engage Nigerian state stakeholders in reviewing PEA findings due to the fear of causing offense.
- DFID stakeholders interviewed noted that upon reflection, there was an underestimation in the effort required to apply a consistent PEA methodology across the whole of government and health sector programming, as well as to realign project-level theories of change in response to the information.

III. PEA as an Embedded Element of Adaptive Management and Learning

PEA that is rigorously incorporated into the ongoing implementation of an activity as part of an adaptive management strategy or action learning strategy is referred to as embedded, or applied, PEA. Development projects utilizing embedded PEA throughout multiple phases of a project cycle reflect a general trend away from analysis as a major enterprise done only at regular intervals (inception, annual planning) toward a more continual and iterative process. At this level, PEA often includes written products but may also use *everyday political analysis* captured by local field staff through facilitated discussions and more frequent, internal reports to drive project-level decision making and feed it into a cycle of implementation, monitoring, learning, and adaptation. The main characteristics of these projects are:

- They incorporate PEA and TWP approaches into the core of their approach; the process is ongoing—not just a one-off application or baseline study.

- They reflect a deliberate effort to work within the context of the local system and its fluid institutional, market, and policy dynamics.
- TWP approaches, including the use of formal and informal PEA, are used explicitly to inform adaptive management and responsive projects.

While it was clear that PEA is on the uptake in health programming in design and incepetion phases or donor or implementer activity, there are still few identifiable cases where it is being fully embedded in sector programming, including health. Case Study 4 illustrates a demand-side health and nutrition project that attempts to embed PEA from its inception through its implementation phase, inclusive of monitoring and learning for a highly adaptive project. The project views formal and informal PEA as a fundamental part of its implementation process, spurring ongoing dialogue among citizens, government, and health service providers to ensure that programming is responsive, with preliminary positive results linked to this approach.

Case Study 4: Building a Culture of Embedded PEA—Empowerment, Voice, and Accountability for Better Health and Nutrition (EVA-BHN—Pakistan

EVA-BHN (see textbox) is the primary demand-side element of a broader health project delivering an essential health services package. EVA-BHN targets voice and accountability and citizen advocacy within the health sector to strengthen the overall health system at the provincial, district, and community levels.

Beginning with a six-month inception period, EVA-BHN conducted a sector-wide PEA to help inform the design of the project's implementation phase.

EVA-BHN is a five-year (2014–2019), £18.85 million program funded by DFID and a major component of DFID–Pakistan's broader Provincial Health and Nutrition Programme, which aims to improve health outcomes in RMNCH and nutrition in two provinces—Punjab and Khyberpaktunwa.

The team utilized the PEA methodology, developed by DFID and refined by the Overseas Development Institute[13], to analyze actors, institutions, health sector dynamics, and incentives in focus provinces to identify opportunities and entry points for citizen-led advocacy. The PEA highlighted major contextual differences between the two focus provinces—namely, the highly centralized nature of governance in Punjab versus the fragmented, decentralized nature of governance in Khyberpaktunwa. The PEA also identified the party dynamics between the national government and Khyberpaktunwa—and informed tailored approaches to working in each province[14]. Additionally, the PEA focused on marginalized populations, citizens, powerholders, and actors not traditionally engaged in health advocacy—for example, religious leaders. Finally, the PEA, including stakeholder consultations, highlighted the importance of politics to the quality of health services and mainstreamed TWP into full project implementation.

Beyond the initial formal analysis, the project has made deliberate efforts to mainstream regular PEA into its approach to working at the district and provincial levels through facilitated, participatory processes whereby stakeholders work together to analyze the interests of local government representatives. Based on this analysis, the project supports community-led efforts to advocate for policy change and drive government action to address priority health concerns and demands (such as availability of health workers, health infrastructure, supplies and equipment)[15]. While EVA-BHN developed a tool to facilitate the district-level PEAs (focused on stakeholder analysis and analyzing local government trends), the project highlighted that the *process of engagement* through these research activities was helpful in bringing together groups who had traditionally not worked together. According to a recent Institute for Development Studies study, this embedded PEA approach is leading to accelerated achievement of results[16]. At the provincial level, EVA-BHN staff conduct rapid PEA studies and feed the

[13] See: https://www.odi.org/sites/odi.org.uk/files/odi-assets/events-documents/3797.pdf.

[14] KII with EVA-BHN implementation team.

[15] High-Quality Technical Assistance for Results (HEART). 2017. EVA-BHN Independent Assessment.

[16] Kirk, T. 2017. *A Strategic Approach to Social Accountability in Pakistan*. IDS Working Paper, Volume 2017, No 497.

information back into the project's own adaptive management processes.

EVA-BHN utilizes a continuous system of monitoring (frequent district and provincial analyses noted above) to regularly revisit its theory of change. On a semiannual basis, the project team works together in critical review sessions to review project monitoring data and the findings of district- and provincial-level PEAs to modify its approaches and activities. EVA-BHN's staff were chosen to incorporate people with backgrounds from the public and private health sectors along with experts deeply familiar with local politics and issue-based advocacy.

In the view of project implementers and available evaluation[17], there are several lessons learned:

- Regular PEA and critical review sessions cultivated a culture among the field team to promote introspective analysis and regular questioning of project assumptions. Project leadership noted that while PEA as a tool itself is very useful, it is the *process* of conducting PEA—which is a critical element of thinking and working politically—on a regular basis that helped to drive this culture.
- PEA can be used as a tool to support local stakeholders to more effectively advocate for government action in health reform. For example, EVA-BHN staff mentor local stakeholders to conduct PEA of local officials to identify entry points for their own advocacy, improving the prospect for achievement of advocacy objectives and project results.
- Conducting PEA at multiple levels of government—district and provincial—enables the project management team to view political dynamics from within multiple levels of the system and enables more politically aware and informed project design and adaptive management.

Conclusion

Most experienced health policy makers and managers have long taken political dynamics into consideration for the development of health policy and programming. Over the past decade, and with recognition of systems that are increasingly complex and adaptive, power dynamics and politics have become even more central to health systems strengthening. This short review shows that PEA helps provide an understanding of the broader context of how political and economic drivers affect the development and implementation of health policies and systems. Some practitioners feel that more rigorous PEA has the promise to help practitioners challenge or shift underlying power structures that contradict or undermine stated country health goals and policies. In conclusion:

For use in program design, the PEA process needs critical elements for it to suceed. Two-thirds of the activities examined for this research utilized PEA primarily in the design phase, but use of the findings varied considerably. Key elements for success in ensuring that PEA findings are fully utilized or integrated into design include:

- Full mission buy-in from the start of the process on the scope
- Systematic use and distribution of PEA findings
- Participation of donor's health officers in the process of interviewing local stakeholders
- Paying attention to the right timing to conduct analysis (both political timing and with regard to practical competing bureaucratic demands)
- Including country stakeholders in the discussion of PEA findings and implications

For use in implementation, PEA is increasingly being seen as a useful tool to set a baseline to inform existing or new approaches in the health sector. Particularly in DFID programming, and increasingly on USAID projects, PEA is being used

[17] Donor officials were unavailable for comment.

during the inception phase and as a research approach to help inform implementation plans and institutional targets and to test initial theories of change. It has also been used to test the viability of new ideas that emerge within the implementation of projects, such as in the case outlined regarding USAID/Guatemala's commissioning PEA research on new health insurance programs.

It is challenging, but useful, to share PEA findings with local—including government—stakeholders. Multiple key informants raised the sensitivity of PEA information as a barrier to sharing the information. In the cases where this was possible, in Ukraine and Guatemala, the PEA research produced findings that assisted USAID officials to make a case to local powers for bringing in new, influential techncial approaches. In the Pakistan EVA-BHN case, sharing of PEA information empowered local citizens' groups for health advocacy.

There are, as yet, only a limited number of examples where PEA has been fully embedded as part of adaptive management or learning. In the DFID Nigeria case discussed, PEA usage in health and other sector programming was adopted earlier, with greater investment, and with a highly integrated country portfolio. Yet even there, the donor and implementer reflected that the rigor of updating and applying the analysis fell away during implementation. Improvements can be made in how PEA information is regularly collected and operationalized in health systems projects through action learning or quality improvement cycles and participatory action research.

More research is required on the use of PEA to better inform effective programming and achievment of health outcomes. Studies are needed to look at the different programming approaches for use of PEA in the health sector, as well as comparing its use in other sectors. For example, DFID is currently conducting a multiyear Health Systems Research Initiative, which calls for more robust evidence—including on the utilization of PEA—for impact of health systems programming in low- and middle-income countries.

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