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Applying Political Economy Thinking to Sector Programming

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1.   PURPOSE

1.1   **This brief summarises** how the Abt Associates Governance and Development Practice (GDP) has applied Political Economy Approaches (PEA) to education and health sector programming in 13 countries in Asia, the Pacific and Africa[1]; and the key findings from these undertakings.

1.2   **While this work was supported by a number of Australian and UK Government funded programs,** and in partnership with local researchers – the authors take full responsibility for the quality of findings and approaches outlined in this paper.

2.   CONTEXT

A shifting development paradigm

2.1   T**he last two decades have seen a paradigm shift** in the development sector, away from the normative positions of the 'good governance' doctrine to 'problem-driven iterative adaptation' (PDIA)[2] and its incarnations. Proponents of the 'thinking and working politically' (TWP)[3] and 'doing development differently' (DDD)[4] approaches belong to this camp. In this vein, political-economy analysis (PEA) has become standard issue for some international development practitioners. However, the push from donors to

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[1] Papua New Guinea, Philippines, South Sudan, Mozambique, Nepal, India, Ethiopia, Tanzania, Zambia, Uganda, Malawi, Kenya, Bangladesh.

[2] Andrews, Matt, Lant Pritchett, and Michael Woolcock. *Escaping Capability Traps Through Problem Driven Iterative Adaptation (PDIA)*, WIDER Working Paper 2012/064. Helsinki: UNU-WIDER, 2012.

[3] Teskey, Graham. "Thinking and Working Politically – Are We Seeing the Emergence of a Second Orthodoxy?" White Paper. *Governance Working Paper Series.* 10 February 2017.

[4] Green, Duncan. "Doing Development Differently: Report back from two mind-blowing days at Harvard." *From Poverty to Power.* 28 October 2014.

implement programmes that are "good fit" rather than "best practice"[5] has made PEA susceptible to being bolted on to service delivery programmes to demonstrate contextual understanding, rather than thinking about how change occurs and embedding this in programme design and implementation.

2.2 **Service delivery programmes, based on overly technical diagnoses and approaches, often find it difficult to distil why change is or isn't happening**. In reality, there may be no clear technical explanation for why expected impacts are not being achieved (for example, the causes may be political in nature (see Box 1 on right), where obstacles can be intangible or hard to identify). PEA can help sector programmes understand why there are blockages to reform, the reasons for resistance to change, what those with power want (or don't want), and where positive change is emerging and why. This information allows Abt to improve programmes and ultimately achieve outcomes that are not only technically sound but also politically possible.

The 'Donor's Dilemma'

2.3 **In each of the education and health programs examined for this brief,** there was intent to improve the functionality and performance of national health or education systems (which provide services at the front line), long after donor funding had ceased. Here emerges what can be referred to as the 'donor's dilemma'. I.e. whether to intervene downstream at the point of service delivery, thereby ensuring short-term outcomes but with no guarantee of sustainability, or to invest upstream in strengthening local systems, which may deliver sustainable results, but only in the long-term?

2.4 **Why does the donor's dilemma matter for health and education programs?** The orthodox answer is that it illustrates that sustainability – the ultimate aim of donor-led development – requires trade-offs. But this is founded on the assumption that strengthening local systems will translate, at some point, into better, more sustainable outcomes for people on the ground: improving the national health and education systems (e.g. better policies for human resource planning) will lead to improvements in health and education outcomes for local populations (e.g. reduction in disease treatment and prevalence rates, improved student learning outcomes in the classroom). Where strengthened systems do not translate into better outcomes, PEA can be useful in attempting to explain why.

2.5 **In the case of the sector programs we worked with**, **PEA helps us understand the *real politick* of the government systems we are working within.** This gives a more accurate assessment of their capacity and authority to manage service delivery, the strength of pro-/anti- reform coalitions or individuals, the salience of health and education issues for those in positions of authority and control over resources, how 'institutionalised' are the formal rules of the game, and who is excluded from decision-making regarding resource allocation and access to services and why. PEA also provides evidence for developing and testing a set of sustainability indicators to better measure activities that could lead to longer-term outcomes, for example, measuring "*increased presence of support for the health reform plan amongst key powerful, pro-reform actors in government or the political elite*".

3. METHODOLOGY

3.2 **In each case, the PEA assessments** were focused on national systems, and asked: to what extent can government systems be used? What are the problems encountered when using country systems, and will they be addressed directly or worked around? The approach to 'answering' was four-fold and involved an examination of the following,: (1) organisational structures/relationships, (2) actor mapping (e.g. the strength of pro-/anti-reform individuals and coalitions), (3) Public Financial Management (PFM) systems, and (4) the integrity of procurement systems. Three sub-questions then cut across all four focus areas:

- *How personalised is the system, (i.e. what political scientists call 'clientelism')?*
- *How institutionalised (i.e. embedded) are the formal 'rules of the game'? and*

[5] Levy, Brian. "Development Trajectories: An Evolutionary Approach to Integrating Governance and Growth." *Economic Premise*. Poverty Reduction and Economic Management (PREM), World Bank, 2020.

- *How competitive and transparent is the political system?*

3.4   **Using a combination of in-house and local resources,** each assessment followed a four-stage qualitative method.

- *Stage one* involved development of a common PEA method and reporting template (see Annex 1).

- *Stage two* involved a detailed review of key literature on the health sector – including Public Expenditure and Financial Accountability (PEFA) assessments, existing analyses of political and social trends on health or education service provision, project reports and analysis from relevant donors, Non-Government Organisations (NGOs) and ministries, national budgets, and program documentation.

- *Stage three* involved semi-structured interviews and workshops with key government and non-government stakeholders. Lines of inquiry were identified prior to mobilisation and adapted by the consultant in country.

- *Stage four* involved the writing, contestation, and triangulation of findings. Consultants provided a preliminary set of recommendations and a draft report for each country. Drafts were then peer reviewed (and key assumptions tested/expanded/refined). The final reports were synthesised into abridged versions for public or private dissemination, depending on the needs of the program.

3.5 The template used to produce the PEA reports can be found at Annex 1 of this briefing note.

4   KEY MESSAGES / FINDINGS

Variation across countries

4.5   **All analyses identified the major institutional, incentive and political settlement challenges** affecting the health or education sector in the 13 countries. They also outlined the implications of these findings for each program's choice of delivery modality, budget allocations and programming.

4.6   **The 13 countries varied hugely:**

- At one end of the spectrum was South Sudan, a state only in existence since 2011 and beset by civil war; it barely functions as a state;
- At the other end of the spectrum was India, in many ways already a consolidated democracy;
- In between lie the remainder: all predominantly clientelist or patronage-based states, where votes are traded for 'cargo delivered' to client networks (sometimes government services, sometimes jobs, sometimes infrastructure);
- Using a framework developed by Brian Levy,[6] some states were identified as 'personalised competitive' – meaning that while the political system is competitive, the rules of the game have not been institutionalised and still revolve around individual political leaders and leaderships);

- Other states were classified as 'dominant discretionary' regimes (e.g. Nepal), where strong political leadership (from a party or military) has consolidated its grip on power but rules are informal and personalised.

4.3   **Despite this variation, three high-level implications** of state-level political economy for service delivery in all 13 countries emerged:

  i.   Decisions regarding the allocation of public resources are often taken for *private gain rather than public interest* – for example, the diversion of national budget away from health services and towards capital works in an MPs electorate, or the awarding of procurements to provide kick-backs to individuals;

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[6] Levy, Brian. *Working with the Grain*. New York: Oxford University Press, 2014.

ii. What may appear *formally* to be functional planning and delivery systems are used *informally but deliberately* to create rent-seeking opportunities for interest groups. These groups do not have to be elites themselves: rents can be created anywhere in a system where discretion is combined with a lack of accountability (this explains how staff in health posts can sell public drugs for their own gain); and

iii. Given the *'embeddedness'* of these political economy characteristics, there are no short-term fixes for external partners. All delivery modalities will represent a technical second (or third) best option. Moreover, every country will require its own bespoke solution.

Implications for using government systems

4.4 **When applying this analysis** to the question of whether to deliver the program interventions through government systems (with appropriate fiduciary risk measures and controls in place), the results were mixed.

- For some of the strongest performing countries – e.g. Ethiopia and Uganda — where planning and delivery systems were relatively reliable and robust (and with appropriate caution and program risk measures in place) it was assessed that the program could deliver through the government system.
- The opposite was the case in other countries (for example those experiencing live conflict) where government systems would struggle to guarantee delivery and reach, and fiduciary risks were high. A parallel delivery system was the most effective choice in this context.
- However, the majority of countries lay somewhere in the middle. In short, each required a judgement call about which government systems to use (and the nature/extent of oversight needed) and which to duplicate (procurement, delivery, staffing, finance, reporting, and so on).

Common themes

4.5 **While there was variation among the 13 countries** (i.e. in terms of ethnic heterogeneity, population and demography, governmental system [federal versus unitary], domestic resources, geography [accessibility/remoteness], and system capabilities and organisational capacity), the PEA assessments surfaced a number of recurring challenges and opportunities across both sectors, which impact the delivery of education and health services at the front line. These are grouped into eight common themes:

1: Basic services (and specific sub-sectoral issues) neglected for a reason	**All states allocated insufficient national budgets** to basic health and education services, to meet the demand of the population. This was particularly pronounced for particular sub-sectors – such as funding to address Neglected Tropical Diseases (NTD), to support teachers to deliver curricula in alternative languages of instruction, or prioritisation of critical Maternal Child Health (MCH) services.
	In some cases, this created moral hazard risks for donors where they stepped in to "fill the gap" left by the state – further incentivising governments to give low priority to address these issues.
	The demand for quality basic health and education services – especially in areas such as MCH, NTDs or educational opportunities for minority groups, disproportionately affects those experiencing the greatest forms of disadvantage (women, ethnic minorities, those living with a disability),who have the least influence to affect change in health and education policy. This further compounds the collective action challenge to increase political attention to service delivery.
2: Limited accountability	**With the exception of specific politicized issues** (e.g. funding for scholarships), all states experienced low (or non-existent) levels of state-citizen accountability, with

basic health and education outcomes rarely featuring as a political 'hot' issue for citizens or MPs during elections.

Perhaps counterintuitively, lower accountability and visibility was particularly pronounced in states that were close to reaching elimination. At such times, political leadership and public attention to the disease would often wane.

3: Pockets of pro-reform	**While there were pockets of willingness** (by individuals and coalitions) for action and reform in each country, these actors were generally not organised to advocate. There was, however, potential in many places to better organise and resource what are already promising pockets of pro-reform individuals and coalitions/networks for education or health reform advocacy. The highest performing countries in terms of health or education outcomes often had a combination of driven bureaucrats coupled with supportive (or non-interfering) ministers, often at both the national and sub-national level. This point is of significance as it demonstrates that a critical factor for health or education reform is the presence of pro-reform individuals and coalitions in positions that have authority over relevant policy and budget decisions.
4: Centre-periphery tensions	**In all states,** the national government claimed the right to set policy and strategy, while 'lower' levels of government typically had the formal *responsibility* for implementation and monitoring. In no case were appropriate levels of *financial or human resources* made available to sub-national or state governments. This analysis highlighted that decentralisation is not a panacea; issues around how incentives are patterned arise regardless of which level of government has authority over health and education policy and resources.
5: The collective action challenge	**Intra and intergovernmental coordination and effective collective action were largely absent** in all states; ministerial rivalry and infighting over prestige and resources were more common than genuine collaboration.
6: Weak capacities and capabilities	**Government bodies responsible for implementation often were ineffectively organised and** had multiple skill shortages at all levels and in all states, to differing extents.
7: Procurement and supply chains	**In some states, evidence pointed to corruption, nepotism, and the diversion of funds** at goods and service procurement points. Weak data management and monitoring within national Lower Middle Income Countries (LMICs) were also common across the 13 countries, leading to issues such as wastage. This was often due to problems of coordination between implementing organisations.
8: Village and community levels	**In many cases, the individuals who were working the hardest** (e.g. trudging through rain to villages to deliver disease information with no boots or equipment, or teachers turning up to work without having received pay for months on end) were also the most important but weakest link in the interface between the state and its citizens. All too often, frontline education and health workers were expected to perform critical community services, usually with minimal or no recompense, reward or recognition.

5   IMPLICATIONS FOR ONGOING OPERATIONS AND PROGRAMMING

Moving from 'thinking politically' to 'working politically'

5.5   **A critique often levelled at PEAs is that they are completed as a one-off exercise** and have limited impact on program activity decisions and budget allocations. In order to try and overcome this challenge, a number of additional measures are being considered by the programs featured in this study:

i.   **Investing in an ongoing understanding of the political economy of health or education sector reform:** for example, the frequent commissioning of rapid PEAs to assess change against the baseline (initial PEAs), or to deepen understanding of a specific bottleneck or challenge raised by the initial PEAs;

ii.   **Connecting political insights to program learning and adaptation:** in particular, acknowledging that TWP means not only 'thinking' politically – but also 'working' politically. To this ends some programs are supporting more frequent, informal review and reflection exercises – enabling program teams to reflect on changes in the political and operating context and how they may need to adjust activities and budgets in response.

iii.   **Valuing and measuring political and systematic change alongside change in specific service delivery targets (e.g. disease or educational attainment).** Efforts are also being made by some programs to include indicators of health or education system strength (e.g. capacity, accountability, authority, legitimacy) and political leadership / collective action for specific health or education reforms, alongside specific disease or educational attainment targets in Monitoring Evaluation and Learning plans.

iv.   **Where possible, broadening and deepening local partnerships and relationships** beyond traditional health or education actors, to ensure that those with power and influence over service delivery reform (e.g. Ministries of Finance) are engaged to support – or at least not block – the efforts of pro-reform actors.

5.6   **While these actions are modest and still at an early stage** compared to sectors and programs more familiar with TWP principles – they represent an important first step for these health and education programs to engage and adopt more politically-informed approaches to programming.

6   CONCLUSION AND RECOMMENDATIONS

6.1   **So, what does the application of PEA methods to the 13 countries reveal for health and education sector investments more broadly?** Are PEA (and TWP) methods valuable to service delivery programmes? And if so, can the PEA method simply be "transferred" from one programme to another? Or is adaptation required?

6.2   **In response to the first question, the answer is undoubtedly "yes".** Purely technical fixes to problems which are political or normative in nature will have limited impact. Health and education reform is no different. While specific elements of health and education reform are somewhat 'politics free' (e.g. selecting the most scientifically sound diagnostics and treatment plans for leishmaniosis, a parasitic disease found in the tropics, subtropics, and parts of southern Europe),change to the processes, institutions, incentives, systems and policies which shape the quality of service provision are not.

6.3   **Abt's experience has shown that PEA can help in understanding why change is or isn't happening,** where positive change is emerging and why, to better understand what those in power want (or don't want) and to ultimately improve the likelihood that interventions focused on the direct delivery of a service will be sustained by local actors after donor funding has ended.

6.4   **Yet this analysis has also revealed that there is still some way to go** in integrating both PEA and politically informed approaches to programming in service delivery sectors:

- **The theory and practice of PEA can challenge existing orthodoxies in health and education program design and delivery.** This analysis found that some practitioners remain unconvinced of the value of such analysis in health or education programmes, particularly those with a heavy clinical or learning focus. Here the focus is often on direct delivery to meet the immediate needs of those afflicted by certain diseases or struggling to achieve strong learning outcomes in the classroom. Yet such an approach does little to impact the systems and politics which shape the delivery of these services over decades, not just months or years. More effort is needed to find a common language and theoretical framework for clinical, learning, health and education systems and PEA experts that allows for both micro and macro interpretations of service delivery problems and possible solutions to be considered within a single programme.

- **PEA is an important tool in sector program design, delivery and evaluation, but it is not a panacea.** PEAs provides only one perspective on why particular populations remain underserved, or particular services remain poor, and what options external actors have to promote reform. PEAs must be understood in conjunction with other theoretical approaches and problem diagnoses, for example in health this means epidemiological assessments, supply chain analyses, health systems and PFM analyses and approaches to gender and social inclusion. A further challenge is in reconciling these different world views into a coherent and well-evidenced program design and intervention;

- **There's little point in thinking politically if you can't work politically**. There is still a tendency to separate PEAs from the program cycle: and this is not unique to health or education sector programmes. PEAs are often treated as a one-off activity conducted at design, which have little bearing on program delivery and review (selection of partners, theories of change, measurement indicators, activity design, budget allocation and so on). Part of the challenge lies in the PEA assessments themselves (PEAs can become fixated on problem definition, with less thought given to practical recommendations for health practitioners to translate this into activity design and implementation) and with the planned approach to program delivery; design is often kept separate to implementation and review. Yet global evidence suggests that in order to work politically, investment must be made to constantly assess and understand the political context in which services are being provided and ensure regular review and reflection points for political insight to be translated directly into program delivery.

- **Gender, exclusion, and inequality (GESI) need to be considered as central to how PEAs are designed and conducted – and visa-versa.** This includes in the framing of key PEA questions, how power is understood, how institutional and actor mapping is undertaken, who leads and participates in the PEA (including whose voices are *not* reflected in the PEA), and how sense-making and the communication of findings occurs. For the PEAs undertaken in these 13 case studies, separate gender, inclusion or 'leave no-one behind' analyses were conducted alongside them. While this allowed for a depth of inquiry in to both areas (GESI and PEA); there was a missed opportunity to integrate both approaches – so as to produce more politically-informed GESI, and gender informed PEA outputs. Abt GDP is currently developing a GESI responsive PEA (GRPEA) guide, which will seek to address these issues.

6.5   **Finally, as to the question of whether this tool can be transferred to other health or education sector programs – beyond those included in this analysis - In principle, there is no reason why not**. The principles and theory of the approach included here (focusing on structure, institutions and agency) is a way to understand change in any sector. Yet the true value of investing in "PEAs" will only come once they are fully integrated into the vernacular and day to day decisions of health and education program managers and their local counterparts.

Political economy analysis: *Country Name*

Purpose of this document

The purpose of this document is to summarise the major political economy issues in *(Country name)* as far as designing their relevant program is concerned. In sum: this document will advise on:

> **'to what extent do we use government systems? What are the problems using country systems, and will we seek to address them or work around them?'**

Report format

The report is in three sections. The first section is brief and introduces the specific area of focus for the Country report (as a narrower framing of the overall problem statement as noted above). Second, it assesses the Integrity and capacity of government (and where required, non-government) systems to deliver the required health or education services, and the third section draws out the implications for program design.

Section one: Introduction and scope

This section is short and succinct (1-2 paragraphs max) and explains the disease/s and part of the health system in which the country program is likely to focus – and thus the PEA has been targeted towards.

Section two: integrity and capacity of government systems

This section is in four parts: (i) relevant organisational structures and relationships among key delivery providers, (ii) roles and influence among those actors / organisations and coalitions in health or education service provision, (iii) integrity and capacity in the public financial management, and (iv) integrity and capacity in the country's medical procurement system.

(1) **Organisational structures and key inter-relationships** among health Ministries, Departments and Agencies and / or between non-government service providers and government (in instances where services are primarily delivered outside of government)	(2) **Which actors and/or coalitions have the most power and influence** over the provision of services to citizens? To what extent are they pro/anti-reform? A simple diagram / matrix will be given (see below)
(4) **Assessments on the integrity of the country's procurement systems for medical supplies** (drugs, equipment, other assets). Particular focus will be given here to the level of influence which of private interests have in drugs procurement and supply	(3) **Analysis of existing PEFA assessment/s or equivalent PFM assessments** – to what extent are the country's public financial management systems fit for purpose to deliver quality health to its citizens?

(i) Organisational structures and key relationships

Describe the key ministries, departments and agencies (including sub-national government and / or administrations) as they relate to the service delivery issue at hand, and summarise their role and formal functions

To what extent does the actual operation and functioning of these organisations deviate from how they are supposed to?

If relevant, summarise relationships with non-state providers (private and third sector)

(ii) Which actors and/or coalitions have the most power and influence?

To what extent are the services in question a major political issue in *(country name)*? How do we know?

Which are the key organisations in terms of finance, personnel / staffing, policy, drug procurement; financing?

Who are the key individuals in these MDAs? Do they exert positional and / or personal power?

What are the major sources of rent-seeking in the health or education sector generally, or for the sub-sector issue in particular? Do we know / suspect who are the winder and losers in this process?

Are drugs provided freely at the point of delivery, or do front-line providers effectively 'privatise' the supply of drugs?

How powerful are local and international pharmaceutical companies and the medical lobby in-country?

Please complete the following table:

Organisation	Primary (immediate) interest	Issues	Potential conflicts
	•	•	•
	•	•	•
	•	•	•

Please plot actors (organisations, coalitions, organisations) on this matrix, which plots the level of influence against 'for -against' reforms / interventions.
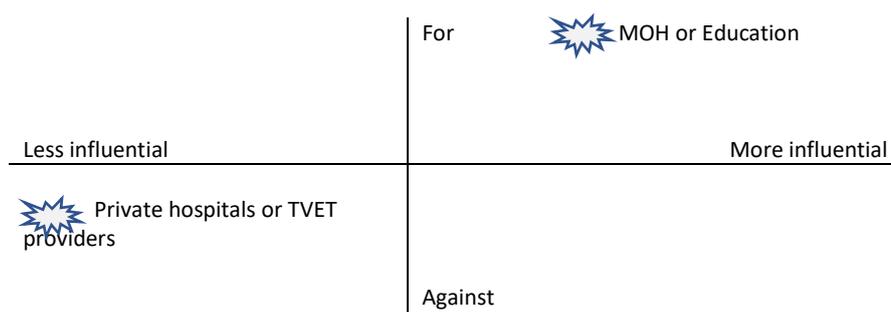
Summarise how likely each actor is to spend their political capital to make change to support the intervention

Identify what the actor/s want and what constraints they face to achieving their intentions

(iii) Assessments on the integrity of the country's procurement systems

What does the PEFA / PFM assessment tell us about strengths and weaknesses of the country's financial management system?

Which aspects of the system are most important for addressing the service delivery issues in question?

Is the government currently attempting to improve the system?

Where are the major risks?

(iv) Assessments on the integrity of the country's supply chain system for medical supplies for the selected services the country program is focusing on

What are the major strengths and weaknesses of the procurement, warehousing and distribution system from a PEA perspective?

Are there convincing moves to improve it?

To what extent does the system deliver drugs to where they are needed on time and with integrity?

Section two: Implications for Program Design

Based on the above analysis, this section identifies some high-level implications for program managers and counterparts to consider when designing their health or education interventions. The focus will be on:

(i) Possible delivery partners

Who does the program need to work with to be able to influence the problem the program is trying to overcome?

Are we actively supporting (directly or indirectly) those who we think have the ability to progress positive reform?

If not, what new or expanded relationships do we need to develop? This may include govt, non-govt, private etc; and the risks/ benefits of such partners

(ii) Possible delivery modalities

Are there particular delivery modalities which are more likely to foster political as well as technical reform in the sector in question? Think specifically here about health or education systems strengthening. Is this feasible? And if so, where in the system needs the greatest attention and why?)

What should be the role of TA as against grant support as against sector budget support?

(iii) Possible political strategies for action

Are there particular political strategies for action the program needs to design to ensure its technical interventions on health or education reform succeed?

With whom should we be working?

How can we counter any resistance?

(iv) Key program risks and assumptions

What does the political economy tell us about the level and sources of risk for this program?

Are there any political trends, key actors, coalitions or other factors identified in the analysis which lie outside the programs control but have the potential to derail the health or education reform efforts at hand?

What would be appropriate ways to mitigate risk?