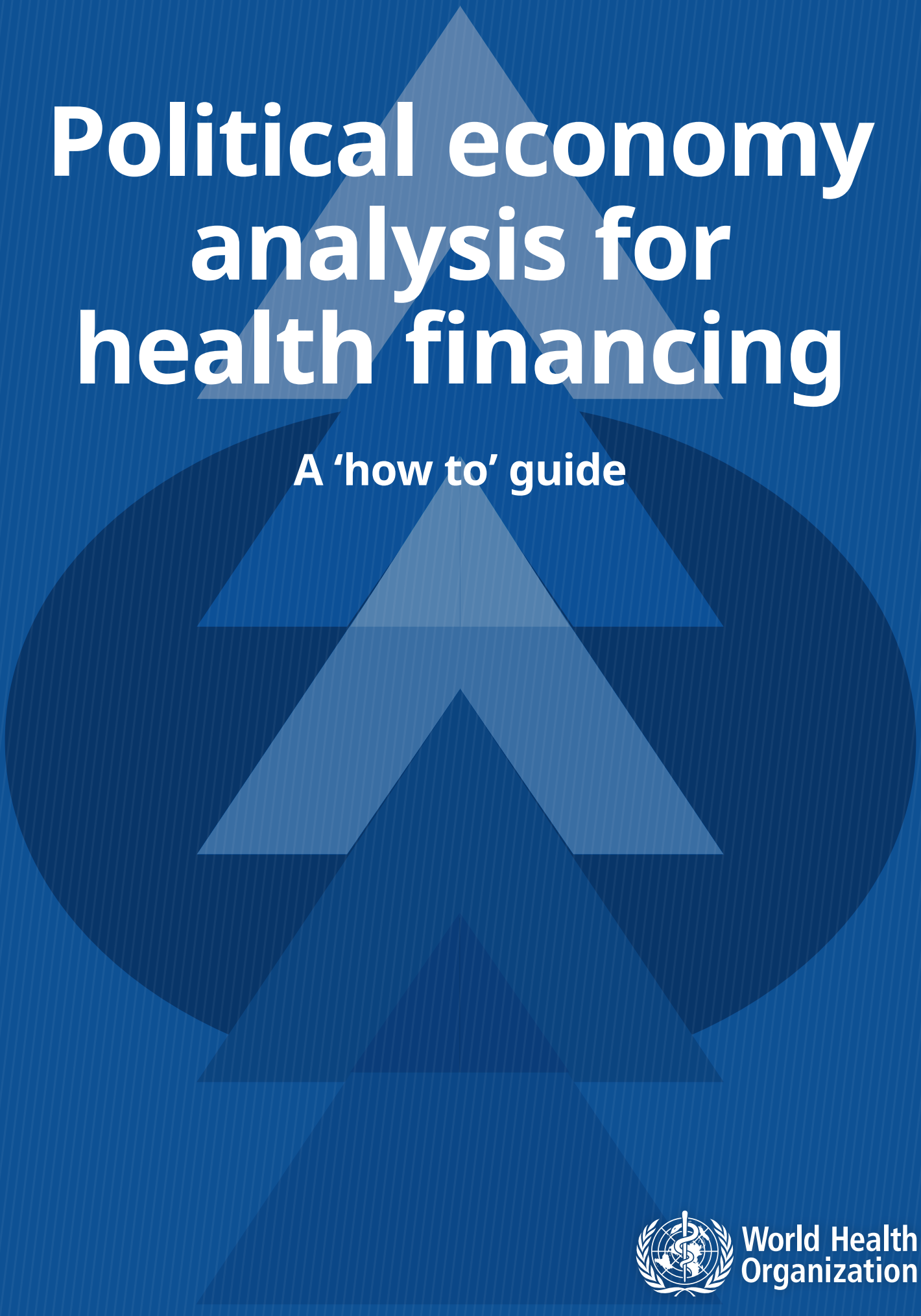
Political economy analysis for health financing

A 'how to' guide



World Health Organization

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Political economy analysis for health financing: a 'how to' guide

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Preface

This Guide is part of WHO's overall programme of work on *Political Economy of Health Financing Reform: Analysis and Strategy to Support UHC (1)*. The impetus for this work came from demands for more concrete evidence, recognition and integration of political economy issues within health financing, and overall system, reform design and implementation processes. This Guide is complementary to WHO's Health Financing Progress Matrix assessment, as well as Health Financing Strategy development guidance. In this way, it promotes an embedded political economy analysis approach that can be used in conjunction with other health financing assessments and guidance. The political economy framework can also be extended and easily adapted to broader health policy reforms.

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This document adapts material and concepts with permission, from: Reich MR, Campos PA. A Guide to Applied Political Analysis for Health Reform. Working Paper No. 1. Boston, MA: India Health Systems Reform Project at the Harvard T.H. Chan School of Public Health, August 2020. Available at: https://www.hsph.harvard.edu/india-health-systems/2020/06/01/political-analysis-guide/. Reich and Campos also provided detailed comments on drafts of the WHO guide. Readers who wish additional details on using political economy analysis for health reform can refer to the Reich-Campos document.

The guide gratefully acknowledges input received from Matt Jowett (WHO/HQ, Department of Health Financing and Economics), Alexandra Earle (WHO/HQ, Department of Health Financing and Economics), Christabel Abewe (WHO/Uganda) and Bill Savedoff (Independent Consultant), as well as participants at various events, including the Global Symposium on Health Systems Reform (2018, 2020 and 2022), the 7th Biregional Workshop on Health Financing for UHC in Asia and the Pacific (May 2023), and the Primary Health Care Regional Framework Implementation Workshop Accelerating PHC Reforms in Asia and the Pacific (September 2023). Early technical inputs are also gratefully acknowledged from Joseph Kutzin (Results for Development), Jesse B. Bump (Harvard T.H. Chan School of Public Health) and Claire Chaumont (WHO/HQ, Department of Delivery for Impact).

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Abbreviations

CHF	Community-based health insurance
CSO	Civil Society Organisation
DFID	United Kingdom's Department for International Development
DPP	Department of Policy and Planning
EDP	External development partners
FCDO	United Kingdom's Foreign, Commonwealth, and Development Office
GTZ	German Technical Cooperation
HFPM	Health financing progress matrix
ILO	International Labour Organisation
MDG	Millennium Development Goal
NESOG	Nepal society of obstetricians and gynaecologists
NGOs	Non-government organisations
NHIF	National Health Insurance Fund
NHSO	National Health Security Office
NPC	National Planning Commission
OECD	Organisation for Economic Cooperation and Development
OOP	Out-of-pocket payments
PEA	Political economy analysis
TA	Technical assistance
TRT	Thai Rak Thai Party
UHC	Universal health coverage
USAID	United States Agency for International Development
UCS	Thai Universal Coverage Scheme
WHO	World Health Organization

1. Introduction

In this section, we discuss why political economy analysis (PEA) is relevant for health financing reform and how it can be crucial in advancing related processes. This is followed by Section 2, in which we outline steps for PEA, which can be carried out in sequence or concurrently with health financing reform, depending on the circumstances.

1.1 Political economy analysis is useful to advance health financing reform

Over the past two decades, many governments have sought to promote equitable and affordable access to quality health services (i.e. universal health coverage [UHC]) by reforming their health financing policies and expanding effective coverage policies. However, broad agreement on the importance of UHC, including through a strong primary health care (PHC) foundation, has not translated easily into the design, adoption and implementation of effective health financing reforms. Health financing reform that focuses on expanding effective coverage involves complex interactions among a range of stakeholders in the health sector and beyond, with varying power and influence. Added to this are dynamic elements of the context, such as economic factors that directly impact feasible reform options. This can make reform politically contentious and difficult to move forward to adoption and implementation.

WHO's programme of work on the Political Economy of Health Financing Reform: Analysis and Strategy to Support UHC *(1)* explicitly recognizes the importance of political economy factors in influencing health financing reform trajectories. By understanding the various stakeholders involved in health financing reform, their relative power, interests and position, along with the institutions that shape the bargaining process and the related contextual and economic factors, strategies can be developed to overcome or take into account stakeholders' resistance or support. **The objective of incorporating political economy analysis in this way is to support a more strategic approach to reform as a way to increase the likelihood of effective design, adoption and implementation and ultimately progress towards UHC.**

We also acknowledge that health financing reform is often approached as part of a broader health system reform process, with particular considerations around PHC-oriented service delivery reform. In this way, the dynamics and related strategies for managing the political economy of health financing reform should not be taken in isolation from the broader reform context. While this guide focuses on the political economy aspects of health financing reform, many of the stakeholder positions, institutional context and related strategies do not only pertain to health financing. The focus on health financing reform should not be restrictive in terms of what can be included in the PEA, and other health system dimensions should be considered where relevant. In this way, this guide and related process can be used and adapted beyond health financing reform (for example, in planning task shifting in the health sector, where role changes will prompt resistance from some professional groups).

1.2 Method for development of guide

The development of this guide was iterative. It combined input from a comprehensive literature review on health financing and political economy analysis, consultation from experts and policymakers through WHO's *Political Economy of Health Financing Reform: Analysis and Strategy to Support UHC* progamme of work, and pilot application. It aligns with and adapts materials, steps and concepts from the *Guide to Applied Political Analysis for Health Reform* by Michael Reich and Paola Abril Campos (2020) *(2)*.

1.3 Use of guide

In terms of practical use, this guide lays out a structured way to organize key political economy factors to enhance the likelihood of the adoption and implementation of effective health financing reforms. It is not intended as a toolbox or comprehensive mapping of all the potential political economy factors and strategies related to health financing reform. Rather, it provides a stepwise process for analysis and structured thinking about issues related to health financing and political economy. The application of this structured analysis in the future will provide examples and evidence that can potentially be developed into a more comprehensive guide of factors and strategies conducive for implementation of UHC-oriented health financing reforms. Intended users of this guide include practitioners, policymakers, civil society and technical experts who are seeking to advance health financing reforms to move towards UHC (see more below related to change team).

In this guide, we use illustrative country case examples to demonstrate the application of this framework and approach to concrete cases. However, these are used for illustrative purposes only and are not a comprehensive assessment. While these cases can serve as a guide, each is not necessarily generalizable across countries. The annex to the guide shows these examples. We do not expect that every political economy dimension will be relevant for every reform policy. For demonstration purposes, we have provided examples of strategies identified for each stakeholder group in two contexts. The guide is meant to provide a method that can be flexibly applied and adapted by the user, based on their particular context.

1.4 Links to health financing assessment and strategy

As shown in Box 1, PEA can support specific areas of health financing reform.

Box 1. Examples of health financing reforms which PEA could support

1. Policy process and governance – such as reforms to oversight of health financing actors and institutions, or to the process for reviewing health financing performance
2. Revenue raising – such as introduction of pro-health taxes, or reforms to user fees
3. Pooling – such as increasing coverage of a scheme by expanding eligible population groups
4. Purchasing – such as changing resource allocation systems or provider payments
5. Benefits packages – such as updating and defining an essential benefits package
6. PFM – such as changing rules on how health facilities can spend and account for monies in their accounts
7. Public health functions and programmes – such as integrating functions across public health programmes to increase efficiency

1.4.1 The health financing progress matrix (HFPM)

WHO's HFPM assessment *(3)* shows where a country's health financing system currently stands relative to benchmarks for a well-performing health financing system that are aligned to UHC-objectives, and does so in a way which provides guidance on future directions. The HFPM also allows country progress to be systematically tracked over time, capturing the dynamic shifts in the policy development process, not only changes in outputs and outcomes *(3)*. This PEA guide is intended to be used alongside the HFPM process or similar health financing performance analyses and strategy development processes, to support change teams to engage in political economy thinking as they progress their technical analysis and develop recommendations. In this way, there may be specific members of the change team who engage more deeply with the political economy dynamics of the reform, or it may be necessary to incorporate political economy analysts within the change team.

- The PEA process and related output can assist with making technical recommendations more politically realistic, responsive and achievable, potentially also modifying the content (where needed, for example to make reforms more palatable), timing or sequencing of the introduction of the health financing reforms.
- The PEA can help explain why a health financing system has achieved a certain level (or not) in the HFPM assessment.
- In relation to multiple technical recommendations, PEA thinking could be used to select and sequence the most feasible options as priorities for action.

1.4.2 Health Financing Strategy Development

WHO's Guide to Developing a National Health Financing Strategy *(4)* is a reference that lays out the key technical questions and issues to be addressed through reform measures to each of the interrelated health financing functions. By embedding PEA into strategy development and implementation processes, policymakers and practitioners can devise practical and feasible policy solutions that are appropriately sequenced.

1.5 Timing of PEA

Use of this guide can occur at multiple points in time during the health financing assessment and reform process.

- It can be used in parallel to the HFPM initial assessment and should be completed ideally before the HFPM report is completed (stage 4), so that it can inform priorities for health financing strengthening.
- It can be used after the HFPM process is well underway in the case that specific health financing areas for reform have been identified, to go deeper into the political economy dynamics of specific functions.
- It can be conducted as a one-off exercise at a specific point in the process of preparing reforms, but more likely will take place over a period, with repeated discussions, reviews and iterations. The value of PEA in this context is intended to be more about supporting a way of thinking than producing formal products *per se*.
- The PEA may also be done in conjunction with the development of a health financing strategy, or related implementation plan and reviews.

While PEA can be used at different stages of the policy cycle, **the starting point for the application and use of this guide is the objectives that policymakers are trying to achieve with health financing reform or other health system reform measures** *(5–7)*. Understanding the objectives (whether they are financial protection, health outcome or citizen satisfaction related) that health financing policies and reforms seek to act upon will also help to understand the various groups that will be impacted, and how. As the technical specifications of health financing reforms are determined to improve identified objectives, PEA can be used to identify key challenges or political factors, assess policy options, and inform reform strategies (see Box 2).

Box 2. What PEA examines and why

In this box, we briefly discuss the focus of PEA and provide a framework for its application. The approach to PEA taken in this guide is not intended to represent the entire field of PEA, rather it focuses on an applied form of analysis to assist moving health financing reform forward.

Political economy aims to explain the interactions of political and economic processes in a society: the distribution of power and wealth between different groups and individuals, and the processes that create, sustain and transform these relationships over time *(8)*. PEA is an applied method to assess the political and economic dimensions of a particular policy issue or process. **More specifically, PEA is used to assess the power, interests and position of key political actors (stakeholders), as well as underlying political, economic and institutional factors of a policy issue or reform process.** It can also support the development of strategies to change the political feasibility of desired reforms. This is an activity that many (including health sector leaders) do instinctively, but this guide aims to explain the steps and thinking behind PEA more explicitly for those less familiar with them. It seeks to inform those promoting improvements in health financing in their own contexts through a step-wise approach to incorporating PEA into technical reform processes.

In the context of health financing, PEA involves a careful review of factors that determine how resources are allocated and used, including:

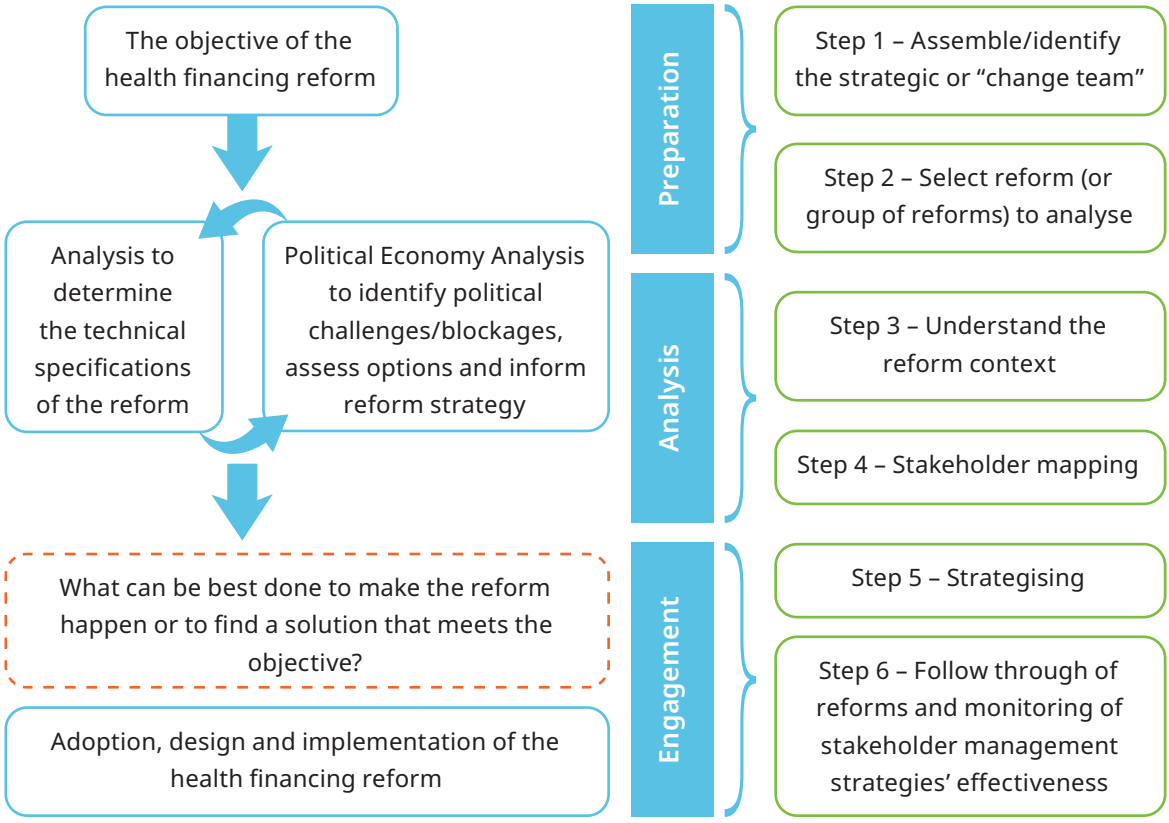
- a review of the **contextual (structural)** factors unique to each country;
- a careful assessment of relevant **stakeholders**, their **power, interests** and **position** in relation to the reform and interests in the health financing reform;
- an examination of the formal and informal **institutions** (the formal and informal processes through which deals get done or are blocked, including how ideologies are deployed and policy options framed).

These are explained further in the steps in section 2.

2. Steps of PEA

In this section, we set out six steps here, with an indication of sequence, although some of these steps may in practice run in parallel and interact (for example, selection of focal reforms and selection of the change team will need to relate to one another; the context mapping will likely influence stakeholder mapping and vice versa). These steps (in green) are mapped onto the PEA framework (Figure 1). The first two constitute a preparatory phase; the next two the analysis phase; and the final two the engagement phase.

Figure 1: PEA steps



Source: adapted from *(9)*

2.1 Step 1. Assemble/identify your strategic or 'change team'

PEA can be done by neutral experts (for example, external researchers), but in this context it is intended as a tool to support a 'change team' – people taking a role in promoting reforms that are needed to improve the health financing functions in their province, region or country. Members of the change team will therefore be to some extent self-selecting as those who are interested and active in supporting or promoting the health financing change or reform, with one or more group members active in assembling the team. They may work within the health sector or other relevant constituencies (in leadership roles). Their characteristics may be as follows:

- They will have a personal and/or professional stake in the reform.
- They need to be sufficiently informed to be able to identify and connect with key stakeholders, as well as the current distribution of power and interests – for example, having been engaged in the reforms and having observed the dynamics of the actors.
- They need to be aware of their own potential interests (reflexive, and open to discussing this within the group).
- The need to have a technical understanding of the health financing reform that is proposed and under consideration, including its coverage objectives.

Policy analysts, including in Ministries of Health and linked institutes, and policy-oriented academics may play this role effectively, as long as their personal interests and connections are considered. The group will likely be small, maybe 2-6 individuals, working as a small team, which does not need to be formalised. There may be a need to determine a primary focal point for the PEA component of the health financing reform process to ensure the output is well-incorporated, or to incorporate someone within the change team that has PEA expertise.

Approach to PEA within change team

Although documents can be consulted, these are often limited in revealing underlying interests and power. Therefore, personal knowledge, experience and interviews can be key sources for this exercise (especially for step 4, the stakeholder mapping). The team should operate with the explicit acknowledgment that controversial, difficult or challenging topics may be raised as part of the exercise. The team will need to agree on approaches to manage these sensitivities in a way that both supports the team and does not undermine the output of the exercise. Given the sensitivities around political economy dynamics, the change team also needs to enable a supportive environment that facilitates the free exchange of ideas and perspectives.

The change team may convene as a one-off to work on this exercise, or (more likely) over a period (see Timing in Section 1), in parallel to the health financing reform process to cover the analytical steps below. However, it is important to remember that, as much as PEA can be used as a formal research methodology with all the steps that a study entails (such as data collection, data analysis/synthesis, report writing), it is also a "way of thinking". We suggest some approaches and provide templates and guidance below and in the Annexes, with reference to the specific steps of the PEA that are outlined in this guide.

2.2 Step 2. Select reform (or group of reforms) to analyse

Stakeholders and interests will depend on the specifics of the reform that are under consideration. Therefore, the change team will need to pick a specific health financing functional area (see Box 1 for examples) or recommendations emerging from the HFPM (or other similar process, such as the development or revision of the Health Financing Strategy, or priority reform agenda) that are relevant for PEA application.

Approach to selecting reform(s) to analyse

When selecting a reform to analyse, the change team can consider the potential impact and/or feasibility of reforms. Criteria that can be used to select reform to analyse can consider both impact and feasibility, and include:

- Reforms which have potentially significant impact on outcomes
- Reforms which are considered as feasible to move forward, even if the potential impact is relatively marginal
- Reforms that are known to be politically triggering, difficult to move forward, and that involve multiple stakeholder groups

2.3 Step 3. Understand the reform context

Contextual and institutional factors are likely to influence reform processes and outcomes. The team should therefore think through the following context questions laid out in Table 1, which will have a direct bearing on strategies needed to enhance the chances of success of reform adoption and implementation. However, the PEA should tailor, focus and shorten this indicative list based on relevance and feasibility. These questions are given as a reference for consideration only. Background questions on economic and sector structural features are not included here as these will have been addressed already in the HFPM analysis or other health financing systems assessments.

Table 1: Context and institutional areas that may impact health financing reform and associated questions

Topic	Key questions
Financing and ownership structure	• What additional financial resources are required to develop, adopt and implement the envisaged health financing reforms? • How are changes in health financing to be funded? • What are likely to be the consequences of reform on financial incentives and control of resources in the sector?
Political factors	• What is the degree of decentralization in terms of financial and political power in relation to this policy area? • Does competition among political parties/ideologies affect the development and implementation of health financing policies? How? • What is the electoral cycle and how does that impact reform potential?
Reform 'windows'	• Are there any 'windows of opportunity'* foreseen that might facilitate the reforms (such as a likely change of leadership or government, external forces including new donor projects)? • Conversely, any clear blocking elements (such as debt crisis)?
Decision making (agenda setting, design and adoption)	• How will the reform process (at agenda setting, design, adoption and implementation stages) be managed by key stakeholders? • What fora are used for consensus building and decision-making?
Implementation	• What are likely to be the practical challenges and bottlenecks to implementation? How can these be addressed?
Accountability and oversight	• What accountability mechanisms are in place to ensure the health financing reform objectives are achieved? • To what extent do the government agencies have the technical capacity to oversee the design and implementation of the health financing reforms?
Evidence	• What role can evidence play? What kind of evidence is needed to promote these reforms? Delivered how and to whom? • Who can promote and provide the necessary evidence for the reform process? • How can this evidence be communicated to support reform objectives?
Equity	• Who bears the impact, financial costs and any potential risks of the reforms? How can negative effects be mitigated and positive ones reinforced? • Are particular groups (gender, religious, ethnic, disabled, displaced or vulnerable in other ways) included or excluded? How can they be protected and their interests promoted within the reforms?
Historical factors	• To what extent do historical factors (such as legacy of colonialism or a recent conflict) influence the acceptability and feasibility of the proposed health financing reforms?
Ideological and cultural factors	• What are the dominant societal and cultural ideologies and values, which shape views around these health financing reforms? • To what degree does the culture favour social solidarity (awareness of shared interests, objectives, standards across individuals in a society)? How much socio-ethnic fractionalization is there and how does it influence where and how health financing reform can take place?
Global factors	• To what extent will the reforms require financial or technical support from international development partners for design and implementation? • What are the predicted trends in donor resources (from those organisations which might provide support in this area)? • Can global health targets be deployed to reinforce the adoption of these reforms?

*Windows of opportunity refers to a favourable opportunity for doing something that must be seized immediately.

Approach to understanding the reform context

To collect the information, the change team can rely on personal knowledge and review of relevant documents, including government documents, technical reports, but also media reports and historical information. The change team should seek out and interview experts on the topic and experienced politicians. These are likely to be the best sources of nuanced information both for designing reforms and for packaging them in terminology that may be politically more successful.

The process can vary in length, depending on intensity: it could take a few weeks, but could also be done in a few days in an urgent situation, if all members were fully engaged and well informed. The discussion and any resultant notes should focus on the most salient issues, rather than being comprehensive.

It might be useful to review the context questions at different points in time, to assess whether some of the elements might have changed over time and how, with what implications for the health financing reform process.

As an example, a retrospective context and institutional mapping in relation to UHC reforms in United Republic of Tanzania is presented in Table 2 below.

Table 2: Context and institutional mapping in relation to UHC reforms in United Republic of Tanzania

Topic	Summary of mapping for United Republic of Tanzania
Financing and ownership structure	Dominance of the public sector as main provider of health services (73% of all facilities). However, other sectors are relevant and in particular mission hospitals in rural areas. Health financing trends suggest a declining overall prioritization to health. Under-funding, coupled with low budget execution and fragmented risk pooling and purchasing make funding for UHC reforms challenging.
Political factors	In United Republic of Tanzania decision-making is centralized, which makes actors at the central level essential and financially and politically powerful in relation to decision-making over UHC reforms. UHC is in the governing party manifesto and the President is personally engaged. This set the issue high on the agenda. The President is assumed to be a champion of the national health insurance.
Reform windows	In retrospect, the window of opportunity to implement UHC reforms envisaged in the Health Care Financing Strategy (HCFS) appears to have been prior to the 2015 elections. It could have been much easier to pass the National Health Insurance Act at that stage.
Decision making (agenda setting, design and adoption)	The Ministry of Health at central level has led the decision-making process on UHC reforms establishing the HCFS within the Health Sector Strategic Plan. In 2010, the Health Financing Unit was set up within Department of Policy and Planning (DPP) Fora were created to discuss UHC reforms, create consensus and make decisions, such as a Technical Working Group on health financing (2010) and (in 2012) an inter-ministerial steering committee (IMSC) to guide the process and get broader higher-level buy-in.
Implementation	In interviews, it emerged that leadership on implementation is seen as the main challenge for UHC reforms. Interviewees report a lack of focus, changing agendas and poor follow-up and coordination.

Topic	Summary of mapping for United Republic of Tanzania
Evidence	Evidence played a strong role in the HCFS development process, through development of options/technical paper, engagement with the experience of other countries (like Kenya and Ghana) and with technical bodies (such as WHO) for training and advice. However, difficulties were noted in moving from options papers to agreed strategies. In some instances, a large volume of evidence has been a constraint to decision-making.
Equity	Although UHC reforms aim to address exclusion, vulnerable populations, and inequity, the engagement and voice of these groups is not strong. In contrast, those with decision-making power have mixed incentives to bring in UHC reforms, which potentially threaten their own current entitlements.
Historical factors	United Republic of Tanzania offered free medical care from independence (1961) to the 1990s, when cost-sharing policies were introduced. OOP payments were soon recognised to be causing access barriers, and community-based health insurance (CHF) was introduced for the informal sector in 1996, followed by the NHIF for the formal sector in 2000. However, OOP payments remain high. Historical legacies outside the health sector also shape expectations. For example, the experience of cooperatives, their mismanagement and collapse reduces confidence in collective endeavours (such as the NHIF). The socialist legacy included the banning of the private sector between the 1970s and 1991 increases the insecurity and sense of marginalisation of the private sector currently.
Ideological and cultural factors	United Republic of Tanzania has been successful in creating a strong collective identity as a nation, which is an important basis for the solidarity required for UHC reforms such as broader risk pooling.
Global factors	United Republic of Tanzania remains reliant on donor to fund the health sector, and trends in funding has been diminishing, creating challenges for UHC reform implementation. Technical support is provided by donors, who often have their own ideological preferences for policy options (in previous health financing reforms, community health insurance was started by the World Bank and supported by the Swiss and Germans. USAID and GTZ have been supportive of insurance scheme, while DFID has been associated with removal of user fees). However, it is an achievement that the HCFS process managed to focus on health financing functions without these preconceived preferences playing out.

Note that the analysis was conducted retrospectively (looking back at reform processes that had happened, or not, in the past), rather than using the prospective approach, which is the focus of this Guide.

Acronyms in this table: CHF: Community-based Health Insurance; DFID: UK's Department for International Development; DPP: Department of Policy and Planning; GTZ: German Technical Cooperation; HCFS: Health Care Financing Strategy; IMSC: inter-ministerial steering committee; NHIF: National Health Insurance Fund; OOP: out-of-pocket payments; UHC: Universal Health Coverage; USAID: US Agency for International Development; WHO: World Health Organization

Source: *(10)*

While going through the context questions, the change team can note which elements of the context might affect the adoption and implementation of the reform, and how. Some elements might be favourable and others could represent a barrier. Some elements might be addressed/changed with appropriate strategies or with time (for example, if there is an election and a potential change in government), which are called "windows of opportunity". Whereas other elements can be more rigid and need to be navigated around. These reflections could be noted simply in text form (for example, the minutes/notes of a meeting where the change team think though the context questions), or in a table listing favourable factors, barriers, and if/how these can be addressed or changed (Annex 1). Another (complementary) option is to prepare a "strategic calendar" listing the timing of key events in the context that might be relevant in relation to the reform, such as the country's political calendar, the health sector calendar, the projects/funding cycle, etc. *(11)* (Annex 1).

2.4 Step 4. Stakeholder mapping

The fourth step involves listing the main stakeholder groups with an interest in and influence over the selected health financing reform. Table 3 lays out some common categories, grouped into six constituencies. These should be populated in relation to the planned reform under consideration, so if the function is decentralised, then actors at the local state or province level may be more relevant than at national level.

Table 3: Examples of stakeholders in health financing reform

Stakeholder groups	Example stakeholders
Interest groups	Medical associations Public/private healthcare providers Private health insurance companies Trade unions Commercial businesses Private hospital associations Disease-based organizations Industries affected by health policies (such as tobacco farmers) Organized patient groups
Bureaucracy	Ministry of Health (could have multiple factions) Ministry of Labor Ministry of Planning Other Cabinet members Social Security Institutions/National Health Insurance Funds Sub-national Minister of Health Sub-national Health Department Officials Regulatory authorities Other national or subnational departments within government with stake in health financing reform
Budget-related groups	Minister of Finance Sub-national Directors of Finance
Leadership	Head of State, President, Prime Minister, Prime Minister's Office, Office of Chief of Staff, National Congress, opposition parties
Beneficiaries	Citizens, civil society organizations, patients/carers organizations, advocacy groups
External actors	Multilateral organizations (such as The World Bank Group, World Health Organization, OECD, Gavi, Global Fund), bilateral agencies (such as USAID, FCDO, etc.)

Acronyms in this table: FCDO: UK's Foreign, Commonwealth and Development Office; OECD: Organisation for Economic Cooperation and Development; USAID: US Agency for International Development

Source: adapted from *(2,12)*

Having defined the key actors in each of these categories (focusing on influential actors rather than an exhaustive list), the next step is to consider their power in relation to the reforms (such as power to promote, power to block, power to influence others to support or not), their interest in the issue, and their position on the proposed policy *(13)*.[1] These are used as follows:

- **Power/influence** refers to the potential ability of the stakeholder or stakeholder group to affect implementation of reform.
- **Position** is whether the stakeholder or stakeholder group supports, opposes or is neutral about the reform,
- **Interest** is the stakeholder or stakeholder group's motivations and perceived impact of to their own organisation.

Table 4 provides examples and domains for each of these dimensions.

Table 4: Understanding the key dimensions in relation to stakeholder mapping

	Domains
Power / Influence	**Political authority** a. Direct: Derived from hierarchy, legal mandate, regulatory regimes b. Indirect: Ability to create incentives and constraints for other actors **Financial capacity:** Possession and control of financial resources **Technical expertise:** Technical capacity to produce, interpret and disseminate knowledge and information **Leadership** a. Ability to build partnerships, motivate other stakeholders and/or shape opinion for/against changes to status quo. b. Personal attributes of individuals within the organisation, which can include charismatic authority, personal commitment and motivation.
Position	**Degree of support or opposition** to reform expressed through use of potential power **Actions taken** to demonstrate support or opposition to reform
Interest	Extent to which **changes brought by reform are core to organisation's mission** or are a priority for organisation Perceived **impact of reform in terms of opportunities and costs** to the stakeholder (how much they benefit or lose from status quo or changes/reforms)

Source: adapted from *(13)*

Table 5 provides a set of guiding questions for the change team to assess the power, position and interest of key stakeholders or stakeholder groups that are prioritized for inclusion in the PEA.

1 Political analysis software analysis can assist analysts in organizing the data on these categories of stakeholders and in producing graphic images of the results *(14)*.

Table 5: Key questions for stakeholder mapping

	Questions
Power / Influence	• Who are the key stakeholders involved in the decision-making process for this reform? • Who are the groups that would be most adversely affected by the reform? Do they have a role or voice in the reform process? Are they represented? • Who are the primary beneficiaries of the reform? Do they have a role or voice in the reform process? Are they adequately represented? • What are their formal/informal roles and mandates in relation to the health financing reform? • To what extent is power (formal or informal) vested in the hands of specific individuals or groups in relation to this health financing reform? • What kinds of resources (such as tangible assets such as money, organization, people, votes, but also intangible ones, like information and legitimacy) does the stakeholder have access to?
Position	• Which groups or individuals are likely to support the health financing reform, which oppose it and which remain neutral? Which aspects? • What is the position that the groups or individuals have on specific aspects of the health financing reform?
Interest	• What are the stakes around the health financing reform? Who is likely to win or lose from it? • Why is a particular position taken on the health financing reform? • How much priority does the health financing reform have for them and why (consider not just material incentives and interests but also beliefs and values, for example)?

In addition to considering individual stakeholders, it is useful to consider whether there are any **alliances between them (formal or informal)** on the issue of interest, or whether these would be formed in future, as this will support your strategic thinking. For example, knowing about existing alliances or possible alliances should trigger questions like "Are there ways that the design of the reform could break up the alliance to make passage more feasible?"

Approach to stakeholder mapping

Similar to the context mapping step above, although documents can be consulted, these rarely reveal underlying interests and power, so personal knowledge, experience and interviews with selected experts can be the best source for this exercise.

Focus groups (a form of a group interview with a subset of representative stakeholders) can be an important way to incorporate the perspective of the beneficiaries of health financing reform – the people *(15)*.

Again, the stakeholder mapping can be repeated at key points in time to assess the changes in the stakeholder positioning (Annex 2) – also to monitor the effectiveness of strategies adopted by the change team (Step 6).

In practice, the mapping of actors in relation to their power, position and interest could be a "thinking out loud" process by the change team, but could also be effectively summarised in a table, such as the table in Annex 2, or the figure provided there. In general, a process of triangulation should take place, whereby there is consensus in the change team around the stakeholder mapping output. Note that:

- Where individuals are important or influential within their own offices or organisations, it may be appropriate to list them individually (and consider their influence and interests as an individual).
- Equally, where organisations or beneficiary groups are internally complex and take divergent positions on the issue of focus, different units or departments can be listed, especially when they may be influential for reform outcomes.
- Where there are divergent views on these issues, these can be noted; there are no correct answers and these considerations are in any case dynamic and contingent.

As an example, a retrospective stakeholder mapping in relation to the free maternal health care policies in Nepal is given in Table 6 below.

Table 6. Example of summary of key stakeholders' interest and power, mapped retrospectively, Nepal

Stakeholders category	Stakeholder group	Interest / Position	Power / Influence
Change team	A cohesive change team did not exist, but there was a body of experts from government entities, multilateral and bilateral agencies, CSOs & NGOs, subject experts, who individually played an influential role – having commitment and providing advice and ideas on the Aama programme (free maternity care) and driving the reform agenda, with some changes in actors over time.		
Political leaders	Maoist-led government	Highly supportive as it was a leftist party with an ideology of state-funded health care.	Highly influential as the party was in power and holding key posts (including in health)
Bureaucracy	Ministry of Health and Population	Committed but with some internal differences on political ideology, design and implementation.	Power was high as it played a key role in designing the reform agenda, leading implementation.
Budget-related groups	Ministry of Finance, National Planning Commission	• Position of the Ministry of Finance was supportive with condition that donors would fund in the initial years. • The position of NPC was supportive, with financial sustainability concerns.	• Power of Ministry of Finance was high as they set budget ceiling for health. • For NPC, influence was moderate; its main role linked to o reaching the MDG targets.
Beneficiaries	NGOs + CSOs	Supportive in advocacy for reform and political networking	Moderate power but played a critical role through advocating with policy makers and concerned stakeholders for investment in maternal health and acting as main liaison on safer motherhood.

Stakeholders category	Stakeholder group	Interest / Position	Power / Influence
External actors	Multilateral organizations	• World Bank initially concerned for financial sustainability, was pro private sector engagement but later supportive of reforms. • WHO supportive of reforms but less engaged in the process. • DFID highly supportive of the reforms. • USAID supportive of reforms with preference to onboard private sector and for micro planning at local level.	DFID moderately powerful as the funding agency and provider of key TA to the reforms. Overall high financial dependency on EDPs in health sector gives policy influence.
Interest groups	Nepal society of obstetricians and Gynecologist (NESOG); Hospital Development Board	• Hospital development board was supportive mainly in advocacy and lobbying; saw reform as revenue generating scheme for the hospitals. • NESOG was supportive of the scheme but concerned over mismatch between human resources and potential increase in workload in hospitals leading to poor quality of care and that financial incentives with poor monitoring might trigger too high caesarean section rates.	Moderate as the professional bodies advocating for quality maternity care and as provider of the care.

Acronyms in table: CSO: Civil Society Organisation; DFID: UK's Department for International Development; EDP: External development partners; MDG: Millennium Development Goal; NESOG: Nepal society of obstetricians and Gynaecologists; NGO: Non-Governmental Organisation; NPC: National Planning Commission; TA: Technical Assistance; USAID: US Agency for International Aid; WHO: World Health Organisation

Source: *(16)*

2.5 Step 5. Strategising

Having mapped the actors and considered the contextual and institutional factors that will likely be most significant for these reforms, it is now time to think through what strategies might be adopted to increase the chances of its successful introduction and maintenance. This step will take into account the positions of the stakeholders that can move the reforms forward. There are three broad areas into which the political economy-related factors (contextual factors and stakeholders) can be grouped (as outlined, for example, in *(12,16)*:

- Those that are already supportive of and conducive to the reform agenda and related objectives. These can be deployed or leveraged.
- Those that are currently opposed to, constrain or work against the reform agenda and related objectives. These can be blocked, diverted or co-opted.
- Those that are currently not involved or visible in the reform agenda and process but could become more involved to move forward reforms and related objectives.

– Those that are currently involved in the reform, but whose influence can wane over time (such as with election cycles), and therefore are of lower priority for reformers.

As noted, these can also be classified as to whether they play a more significant role in the design, agenda setting, adoption or implementation phase of the reform process.

Approach to strategising

Strategies can be **grouped by the contextual and institutional questions** (examples are provided in Table 7).

Having developed a 'long list' of strategies, those which are most feasible and potentially impactful could be selected as priorities, depending on the capacity and networks that the change team can deploy. In general, the strategies should be grounded in terms of the policy objective the change team seeks to achieve. It can also be helpful to think of the strategies as those that will affect the position, power and interest of the key stakeholders identified.

Table 7: Possible strategies, grouped thematically

Topic	Possible strategies to address these issues
Financing and ownership structure	• Making adjustments to reduce costs (such as ensuring budgets are capped, closed provider payments) • Leveraging additional support (including from international development partners, where appropriate and feasible) • Focusing on efficiency goals and their communication to stakeholders • Negotiating win/win outcomes with opponents who have influence • Making strategic concessions, if not conflicting with key objectives, to bring those potentially negatively affected on board; in many examples, this involves protecting the benefits of existing scheme members (such as in pooling reforms)
Reform 'windows'	• Identifying likely opportunities and preparing reforms in advance • Working with opposition parties, where power transfer is possible • Delaying or modifying reforms if the context is currently too hostile until a reform window opens
Historical factors	• Ensuring that the reforms address historical injustices and address/reflect national aspirations, contributing to reconciliation post-conflict and being framed in this way
Political factors	• Target reforms at relevant level that has responsibility for (and influence over) the relevant functions • Engage higher level political leadership in the policy development process, especially in centralized systems
Decision making (agenda setting, design and adoption)	• Skill advocates in the key fora to represent the case for reforms • Ensure all key stakeholders across relevant agencies are consulted and briefed on the reform goals and rationale • Increase the participation of actual and potential supporters • Create or boost networks or coalitions that increase the effectiveness of supporters • Ensure that supporters can resource their activities
Ideological and cultural factors	• Frame reforms in a manner consistent with dominant ideologies and values • Focus on elements which speak to positive values of nationhood, mutual support, equality, care for one another, protection of family

Topic	Possible strategies to address these issues
Evidence	• Ensure supporters have access to credible evidence to support the reforms • Develop evidence and related briefs which are localized and specific to likely policy-maker concerns in relation to this policy • Data should be timely and accessible and presented in a variety of fora and formats • Evidence should offer positive solutions to the policy problem
Global factors	• Supportive international development partners and civil society organizations should be mobilized to provide resource (ideological, technical, financial) to promote the reforms • Relevant global norms can be deployed, although these will need tailoring to the country's context
Accountability and oversight	• Expand spaces where supporters can influence and monitor the policy • Close-to-policy advice to support policy, design and monitoring
Implementation	• Engaging in dialogue with providers and interest groups to increase awareness of policy, its intended benefits and mobilise support • Setting up fora for regular review of policy and trouble-shooting, allowing for iteration to ensure problems are surfaced and addressed
Equity	• Ensure that vulnerable groups are represented in consultative process • Mitigate losses and take actions to buy off the 'losers' from the policy • Policy design, iteration and communication to ensure equity goals are given prominence and priority

It may also be useful to **consider strategies by stakeholder group**, as mapped in Table 3 above, which are illustrated in Box 3. Annex 3 presents a template to summarise potential strategies to be implemented for managing stakeholders according to their position.

Based on the stakeholder mapping, those with high influence over the reform are important targets, with the strategies broadly aiming to boost supporters and engage them, while neutralising opponents or shifting their position to being more favourable.

Box 3: Strategies to manage different stakeholder groups

Campos and Reich (2019) argue that, from the perspective of the "change teams", specific strategies could be devised to manage different stakeholder groups *(11)*. For each stakeholder group (Table 2), they reflect on how they interact with the policy process and which strategies might help ensuring their support (or at least reduce opposition) to the health financing reform. In their paper, they also provide detailed illustrations for each of these strategies (some examples from that and other studies are discussed in the tables below).

Managing interest groups – "Managing Outside"

Interest groups (such as professional associations, health insurance companies, hospital owners, producers of pharmaceuticals and medical technologies) often seek to influence policy to minimize their losses and maximize gains, by actively resisting or passively ignoring a policy. In such cases, the change team can design policies to counter the interest group's influence or mobilise other groups (for example, civil society or beneficiaries) in support of the reform.

Box 3: Strategies to manage different stakeholder groups, cont.

Managing bureaucracy – "Managing Within & Around"

Bureaucrats are often the key actors responsible for the adoption, design and implementation of health financing reforms. To complicate the picture, bureaucrats could be within many organisations (for example, different government agencies) and at different levels (central, decentralised and frontline). To manage the stakeholders within this group, change teams may choose to consider the critical roles of both high-ranking bureaucrats and frontline workers and invest time in finding common ground across stakeholders and in building credibility and trust, for example through bringing them together to discuss challenges and solutions that bring in their different perspectives.

Managing budget-related groups – "Managing Money"

The politics of deciding and disbursing budgets has great impacts on policy implementation. Change teams, therefore, need to develop effective strategies to create alliances with the ministry of finance and with legislative committees that oversee budget development and approval (for example, by jointly developing costed options and their budget implications).

Managing leadership – "Managing Up"

The commitment of leaders to a policy (and competence to deliver it) profoundly affect its adoption and implementation. Because of this, a change team needs to create strong and constructive relations with the top political leaders (such as the party leader and/or prime minister or Minister of Health – incumbent or likely future leaders), and call on and mobilize them in order to assure the adoption and implementation of health financing reforms.

Managing beneficiaries – "Managing Down"

For health financing reforms to be successful, the change team is advised to consider how the new policy will change existing benefits – some beneficiaries might see benefits limited or decreased and others increased. To best manage this stakeholder group, the change team should strategise to engage and build trust with beneficiaries, communicate clearly and early on with them (for example, working with the media or civil society organisations), solicit their feedback, and in some cases mobilise them into action.

Managing donors – "Managing Externally"

The influence that donors can exert on national health policy processes due to the control over funding sources or perceived stronger technical expertise creates multiple challenges but also opportunities. Change teams should manage donors in order to maximize such opportunities, for example ensuring dialogue, coordination and alignment, or leveraging external actors to provide technical analyses.

Source: adapted from *(12)*

As an illustration, two cases of health financing reform provide examples of strategies used to manage health financing reforms, by stakeholder group. The first case is Türkiye's reforms to reduce fragmentation and expand health coverage in 2002-2012 *(1, 17)* (Table 8). A study analysed how institutional blockages to the adoption of reform in Türkiye were overcome through strategies of avoidance, delay, persuasion and compromise, and overpowering *(17)*.

Table 8: Examples of stakeholder management strategies from retrospective analysis of Türkiye's health financing reforms

	Political economy factors and dynamics	Strategy used by change team	Practical actions / outcomes
Interest group politics	Opposition from the *medical association* due to concerns over pay changes	Increase provider pay to reduce opposition [*persuasion, avoidance compromise*]	Garnered sufficient support from providers to affiliate with single payer scheme and not engage in dual practice
Bureaucratic politics	Tension between *ministries and civil servants* over control of new financing scheme	Directly involve relevant ministries in the reform process early on, cede control of some aspects of purchasing function to labor ministry, link reform with other non-health reform priorities, and grandfather current civil servants into previous scheme [*delay, avoidance, persuasion and compromise*]	Built cross-governmental support for reform that was needed to overcome parliamentary and constitutional court opposition
Budget politics	Opposition from *finance authorities* based on fiscal sustainability	Link health reform to other cost-saving policies, conduct actuarial analysis to demonstrate long-term fiscal impact, and take advantage of positive macroeconomic conditions [*persuasion, compromise*]	Assuaged veto point to enable reform to move forward
Leadership politics	Highest level support and pressure for reform success from top political leaders	Strategically leverage high-level support to overcome critical opposition [*overpowering*]	Passage of key aspects of reform that would have blocked achieving intended objectives
Beneficiary politics	Concerns from *current beneficiaries of insurance schemes* about reduction in benefits and subsidization of poor AND support from *low-income/rural households*	Gradually increase benefits to align with highest level and ensure no reduction for current enrollees, and increase public satisfaction by investing in the health system [*persuasion and compromise*]	Built public satisfaction, buy-in and participation in reform agenda
External politics	Support and interest by *external partners* to provide financial and technical support	Leverage external actors to provide financial support and technical analyses to underpin reform efforts [*avoidance, persuasion*]	Provided critical resources and evidence needed to move reform forward

Source: *(17)*

A second example is the Thai Universal Coverage Scheme (UCS) reforms of 2001-2002. Retrospective analysis highlights some important strategies, including enhancing the legitimacy of the policy and changing the decision-making rules affecting it (Table 9) *(16)*.

Table 9: Examples of stakeholder management strategies from Thailand health financing reforms

Stakeholders' category	Political economy factors and dynamics	Strategies used by change team	Practical actions / outcomes
Leadership politics	Leaders of new TRT party supporting ideas for radical social reforms.	Strategically leverage high-level support from new Party leaders, and connect reform with social values supported by the Party *[overpowering, enhancing social and political legitimacy]*	UCS included in political manifesto before elections and supported after electoral win.
Beneficiary politics	Civil society organisations and NGOs were more relevant and available for mobilisation to support UHC/UCS reform because this was a period of democratisation and increasing popular participation, and there was a sense of need for financial protection	Leverage support of civil society at a time where it was increasingly relevant, and provide them with technical understanding, information and evidence *[building coalitions, increase strength of allies]*	Civil society organizations and NGOs mobilized and supported with funds and technical information to prepare their draft of National Health Security Act and gather signatures in the petition campaign.
		Create space for and allow participation of critical allies (civil society) in the reform design *[increase strength of allies]*	Active participation of civil society in designing and implementing UCS via the National Health Security Board, as well as establishment of National Health Assembly (2007).
		Design of the reform aligned with core interest of key ally (civil society) *[compromise, use of incentives]*	Pragmatic adoption of a generous benefit package in line with existing schemes and despite budgetary concerns.
Bureaucratic politics	Overall supportive of UCS, but some opposition to UCS reform from some in the Ministry of Health. Reform proposals curtailed the role and power of the Ministry of Health, and transferred functions to the NHSO	Adapt language and focus to avoid conflict and reassure stakeholder (Ministry of Health) *[persuasion, avoidance]* Include stakeholder (Ministry of Health) in dialogue structures to minimise open opposition or their working through parallel structures *[building coalitions, compromise, use of incentives]*	Change team adopted non-threatening language towards "conservatives" within the Ministry of Health and addressed their interests. For example, stressing general policy objectives while downplaying objectives that threatened or opposed conventional practices. Opponents within the Ministry of Health are included in participatory decision making so that they are 'co-opted' and their opposition is minimized

Stakeholders' category	Political economy factors and dynamics	Strategies used by change team	Practical actions / outcomes
Budget politics	New ruling party wants to stress the difference with the past and abandon patronage system for budget allocation towards a more transparent one. Leadership politics prevails over budget politics, despite financial constraints created by the economic crisis.	Preventing opponents (Ministry of Finance) from participating by referring directly to higher political levels *[overpowering]*	Bureau of Budget/Ministry of Finance is bypassed and budgetary decisions are made at higher levels by the Prime Minister and (later on) through a transparent, evidence-based and participatory process (i.e. definition of capitation levels).
		Some features of reform design in line with opponents interest (budget control) in order to minimise opposition *[compromise, use of incentives]*	Use of evidence and previous experience to design technical features of UCS so that it addressed budgetary concerns (cost containment, strategic purchasing, etc.)
External actors' politics	Varying level of support from international organisations.	Work closely with supportive external actors to mobilise them and isolate opponents within group *[increase external legitimacy, increase strength of allies]*	Change team makes use of personal links with supportive international organisations (ILO, WHO) to counter criticism and increase legitimacy of the reform. At the same time, it marginalizes opponents in the international community (World Bank).
Interest groups' politics	Opposition to the creation of UCS, in particular from medical profession and private health providers.	Include stakeholder (interest groups) in dialogue structures to minimise open opposition or their working through parallel structures *[building coalitions, compromise, use of incentives]*	Interest groups such as medical profession and private health providers are included in participatory decision making so that they are 'co-opted' and their opposition is minimized.
		Reduce influence of opponent by outpacing them and prevent/limit the possibility of their participation and opposition *[overpowering]*	Interest groups lacked power and resources of the change team and had not prepared for a long time to oppose the reform. Change team had more time to prepare and ensured rapid approval of reform, before opposition mounted or coalition of opposers formed.

Acronyms used in this table: ILO: International Labour Organisation; NGOs: Non-governmental Organisations; NHSO: National Health Security Office; TRT: Thai Rak Thai (TRT) Party; UCS: Universal Coverage Scheme; WHO: World Health Organization

Source: *(16)*

2.6 Step 6. Follow through of reforms and monitoring of stakeholder management strategies' effectiveness

Adoption of health financing reforms are generally the results of a combination of: (i) sound technical preparation, (ii) auspicious timing or being able to take advantage of windows of opportunity, and (iii) effective management of the political economy dynamics between diverse interest groups. The PEA described in this guide would support with the third point above, but in some cases also with the second, by helping identify the right timing and sequencing for reforms. It can also support necessary modifications or choices in terms of reform design features (the first point) too.

However, sustaining reforms and making their implementation effective requires that the reformers continue to monitor reform processes and outcomes and the effectiveness of their actor management strategies, and continue to adapt, technically and politically *(12)*. Contexts tend to be dynamic and problems of performance and perception need to be continually detected and responded to by the change team.

Approach to follow through and monitoring

The change team is advised to regroup periodically (the frequency and intervals of meetings and engagement will be linked to the speed and intensity of the reform process) to assess the progress of reforms against their objectives, any blockages or problems with implementation that may have come up, and how far these relate to political economy factors (those who are supporting, those who are not, why and how that is affecting the reform outcomes). Steps 3, 4 and 5 can be rapidly reviewed to identify if there have been important shifts in context or actors that would require changes to actor management strategies.

Establishing fora for regular participatory review and dialogue is one mechanism for keeping reforms on track and keeping your coalition of supporters (as illustrated by the Thai National Health Assembly, for example).

3. Conclusion

Reforms affect individuals' and groups' interests and access to resources and so create tensions and reactions at policy design, adoption and implementation stages. This is especially true of health financing reforms, and as a consequence, their success is not only related to their technical soundness but also to political considerations. Reformers therefore need to "think politically" to anticipate and strategise how to manage the reform process, including how to maximise support and ensure that groups that fear losses and have power do not block reform.

This guide aims to provide a set of steps to help reformers think through these dynamics, which interact with technical considerations in a way that may distort the reforms and their effects, if not well managed. These six steps apply to planned reforms or strengthening measures across the health financing functional areas (policy and governance of health financing, revenue raising, pooling of revenues, purchasing of health services, benefits and entitlements, public financial management, and public health functions and programmes), as well as the UHC goals.

This guide will be applied in selected country contexts and revised through use. In this way, it is considered as a living document that will be updated as it is used and applied in reform processes.

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Annexes

Annex 1 – Context mapping: templates

Contextual and institutional factors are likely to influence reform processes and outcomes and should be carefully thought through. Table 1 in the main document outlines some of the key elements that should be considered. While going through the context questions, the change team can note which elements of the context might affect the adoption and implementation of the reform, and how (favourable factors, barriers, factors that can be activated/mobilised to support the reform, and how to do so). These reflections can be noted in text form or summarised in a table such as the one below.

Table 1a: Identifying favourable factors and barriers in the context

Favourable factors to the success of the reform	Barriers to the success of the reform	Factors that can be activated/mobilized to support reform	If/how these might change or might be changed

Another (complementary) option is to prepare a "strategic calendar" listing the timing of key events in the context that might be relevant in relation to the reform, such as the country's political calendar, the health sector calendar, the projects/funding cycle, etc. The table below provides an example which can be adapted to the local context and needs.

Annex 1b: Template for a strategic calendar for health financing reforms

	Country's political calendar (elections, sessions of Parliament, Budget cycle, etc.)	Health sector's political calendar (key meetings and events, timing of National Strategies and Plans, Health Financing strategies, etc.)	Donors' calendar (for example funding cycles, renegotiation of support/ programmes, disbursement calendar, etc.)	Health financing reform's calendar (key timing, cycles and events in relation to the health financing reform of focus)	Reforms' calendar (add multiple columns to track timing of other competing reforms)
Date (in chronological order)	Add detail of event, explanation of how it might influence the feasibility of the health financing reform				
Date (in chronological order)					
Date (in chronological order)					

Source: adapted from *(11)*

Annex 2 – Stakeholder mapping: templates

As described in the main text, the fourth step of the analysis involves listing the main stakeholder groups with an interest in and influence over the selected health financing reform. Six key categories of stakeholders can be identified. Having defined the key actors in each of these categories, the next step is to consider their power in relation to the reforms, their interest in the issue, and their position on the proposed policy. The table below presents a way of summarizing these reflections on stakeholders.

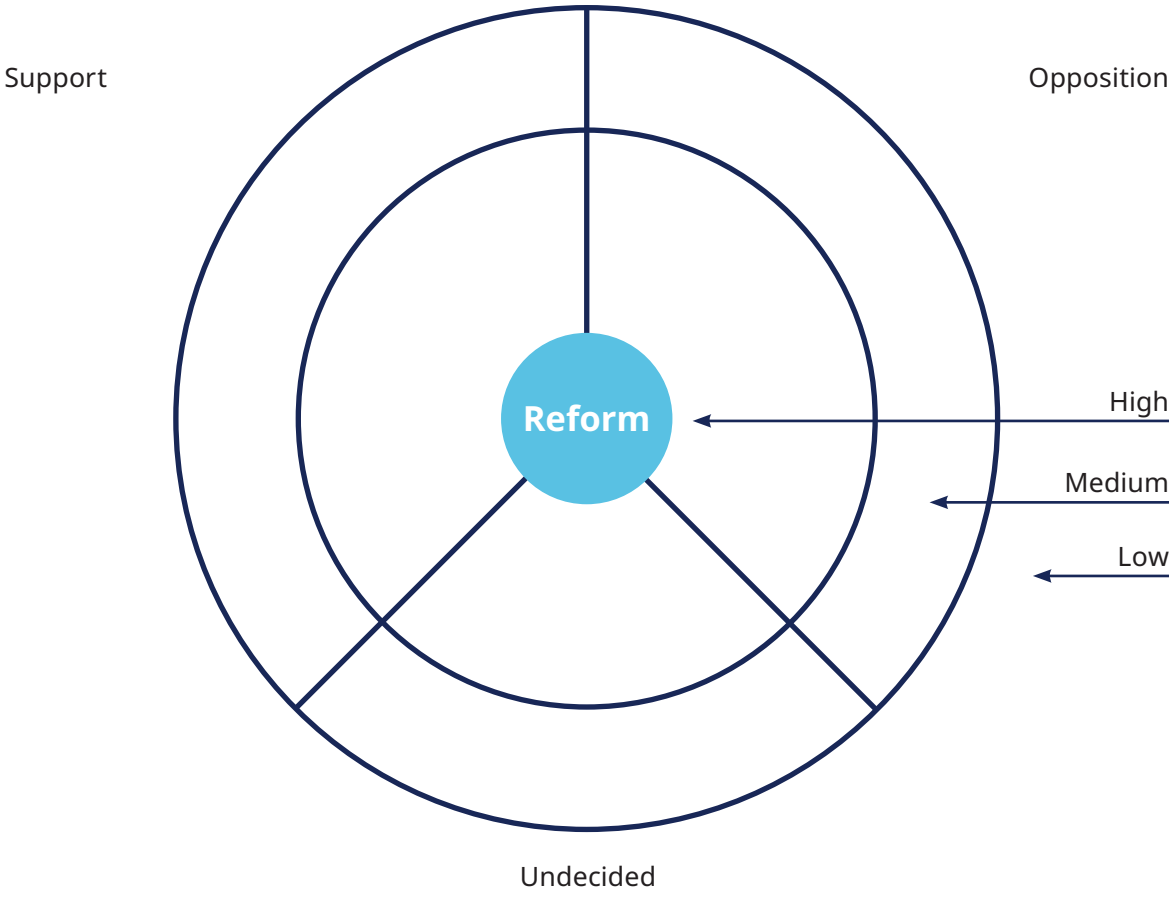
Table 2a: Stakeholder power/influence, position and interest in the reform

Stakeholders	Power/influence over the reform	Position on the reform	Interest in the reform
Interest groups			
Organisation/individual			
Organisation/individual			
Organisation/ individual			
Bureaucracy			
Organisation/individual			
Organisation/individual			
Organisation/ individual			
Budget-related groups			
Organisation/individual			
Organisation/individual			
Organisation/ individual			
Leadership			
Organisation/individual			
Organisation/ individual			
Beneficiaries			
Organisation/individual			
Organisation/ individual			
External actors			
Organisation/individual			
Organisation/ individual			

Annex 2b: Stakeholder mapping – circle of influence tool

Another way of summarizing the information is using a "circle of influence", as below *(18)*. Stakeholders (individuals, groups or by category) can be placed according to their position in relation to the selected reform: support, opposition or undecided. The circle also allows to indicate the level of influence which can be high (closer to the centre), medium or low. If there are any networks or alliances between stakeholders, these can be indicated by linking them with a broken line.

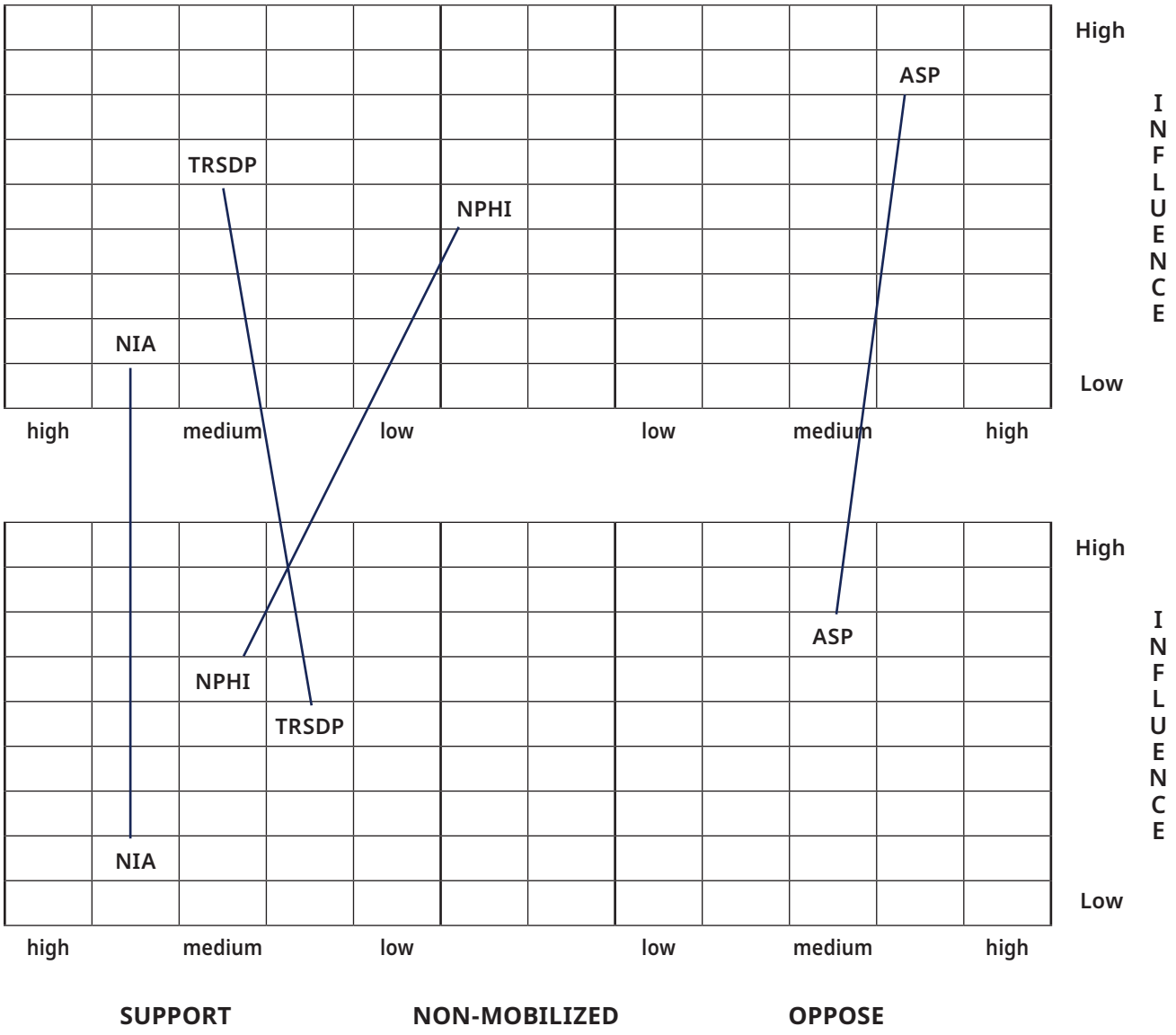
CIRCLE OF INFLUENCE GRAPHIC



Source: *(18)*

Additionally, stakeholder mapping can be repeated at key points in time to assess the changes in the stakeholder positioning. This can be done retrospectively (to look at how stakeholder position and influence has changed) or prospectively (to *predict* how they might change), as in the figure below *(19)*.

Annex 2c: Stakeholder mapping – forcefield matrix showing predicted changes in stakeholder position and influence regarding a national alcohol policy



Source: *(19)*

Annex 3 – Strategising: templates and examples

Having mapped the actors and considered the contextual and institutional factors that will likely influence the reforms, it is now time to think through what strategies might be adopted to increase the chances of its successful introduction and maintenance. Strategies can be grouped by the contextual and institutional questions or by stakeholder group (Table 7 and Box 3, in main text). Another option is to devise strategies to manage stakeholders based on their position with reference to the reform in question. The table below presents an example of this.

Table 3a: Template to summarise strategies for managing stakeholders according to their position

Stakeholders (by category or other useful grouping *(12)*)	**Position in relation to reform** (support, oppose, neutral)	**Strategy/ies to be used by change team**	**Practical actions and outcome monitoring**
Interest group politics			
Bureaucratic politics			
Budget politics			
Leadership politics			
Beneficiary politics			
External politics			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