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From ideas to policymaking: the political economy of the diffusion of performance-based financing at the global, continental, and national levels

par

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From ideas to policymaking: the political economy of the diffusion of performance-based financing at the global, continental, and national levels

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Titre

Des idées à la prise de décision : l'économie politique de la diffusion du financement basé sur la performance aux niveaux global, continental, et national

Résumé

Problématique : Le caractère polycentrique de la gouvernance de santé mondiale fait émerger depuis une vingtaine d'années des pôles d'influence politique de différents niveaux. Depuis la fin des années 2000, des acteurs influents appuient la mise en œuvre d'une réforme de financement de la santé : le financement basé sur la performance (FBP). Le FBP repose sur le transfert de ressources financières conditionnelles à la performance des prestataires de santé. En dépit d'une absence d'unanimité sur les preuves scientifiques de son efficacité, la politique a été expérimentée dans plus de 70% des 46 pays d'Afrique subsaharienne. Les projets de FBP sont promus par des réseaux d'experts transnationaux (nouveaux acteurs de la gouvernance polycentrique), financés par des bailleurs de fonds, et appuyés par des assistants techniques provenant le plus souvent d'Europe et d'Amérique du Nord. Au-delà du pouvoir financier, ces acteurs exercent d'autres formes de pouvoir moins visibles pour stimuler la diffusion de cette politique. Introduisant le concept d'"entrepreneurs de la diffusion", nous utilisons une approche d'économie politique pour comprendre les interactions sociales en jeu dans le processus de diffusion entre les acteurs agissant aux niveaux global, continental et national, ainsi que les relations de pouvoir asymétriques inhérentes à ces interactions. Pour cela, nous réalisons une étude interprétative à niveaux d'analyse imbriqués (global, continental, national).

Cadre conceptuel : Nous utilisons un cadre conceptuel interdisciplinaire empruntant aux champs des politiques publiques, des relations internationales, et de la santé mondiale. Nous analysons les caractéristiques des entrepreneurs de la diffusion – leurs systèmes de représentation (leur perception du monde et présupposés sous-jacents), ressources, types d'autorité, et motivations – et les stratégies qu'ils utilisent pour favoriser la diffusion du FBP. Ces stratégies incluent : l'ancrage idéationnel de la politique (*policy framing*), la stimulation de l'émulation par la constitution de réseaux (*policy emulation*), la conduite de l'agenda d'apprentissage sur le FBP (*policy learning*), et la fixation de standards et cadres de collaboration pour assurer une expérimentation réussie du FBP (*policy experimentation*).

Méthodologie : L'objet principal de la thèse est la diffusion du FBP en Afrique subsaharienne, qui s'articule autour d'influents « entrepreneurs de la diffusion » (cinq organisations, trois réseaux transnationaux, et plus d'une vingtaine d'individus). Trois études ont été réalisées à trois niveaux différents : niveau global (arènes politiques de santé mondiale et instituts de recherche européens), niveau continental (Afrique subsaharienne), et niveau national (cas du Mali). L'approche d'analyse est principalement qualitative : nous avons collecté des données d'entretiens approfondis (N=57), d'observations participantes (N=13) et de documents (N=41). Dans l'étude à échelle continentale, ces données qualitatives sont complétées par des analyses de réseaux sociaux et des analyses sémantiques à partir de 1 346 messages de forum. Ces données quantitatives complètent la caractérisation de l'un des réseaux transnationaux et son influence sur la diffusion du FBP.

Valeur de la recherche : Cette recherche constitue la première analyse d'économie politique détaillant des processus multiniveaux et protéiformes (discours, constitution en réseaux, et production et dissémination de multiples formes de savoirs) conduits par des acteurs influents – les entrepreneurs de la diffusion – afin de faciliter la diffusion d'une innovation politique (le FBP) dans le contexte particulier de la gouvernance polycentrique. Cette étude apporte d'importantes contributions théoriques et empiriques à la littérature. Premièrement, elle offre un cadre conceptuel novateur adapté au contexte de la santé mondiale et de la gouvernance polycentrique, qui peut être appliqué à divers types de recherche. Deuxièmement, elle fournit des analyses empiriques utiles sur les processus de gouvernance polycentrique, qui ont été jusqu'ici peu étudiés. Mettant en lumière l'exercice du pouvoir d'acteurs européens et nord-américains dans leur interaction avec des consultants et décideurs africains, cette étude ouvre également la voie à d'autres recherches, notamment sur le phénomène de fabrique d'une expertise africaine.

Mots clefs

Diffusion des politiques, Analyse d'économie politique, Financement basé sur la performance, Entrepreneurs de la diffusion, Afrique sub-Saharienne

Title

From ideas to policymaking: the political economy of the diffusion of performance-based financing at the global, continental, and national levels

Abstract

Background: Over the past 20 years, the polycentric nature of global health governance has shaped the emergence of autonomous actors with political influence at different levels. Since the late 2000s, influential policy actors have been supporting the implementation of a health financing reform: Performance-based financing (PBF). PBF relies on the transfer of financial resources conditional on the performance of health providers. In contrast to input financing systems, this mechanism focuses on achieving results based on performance targets. Despite a lack of consensus on the scientific evidence of its effectiveness, the policy has been tested in more than 70% of 46 sub-Saharan African countries. PBF projects are promoted by transnational expert networks (i.e., autonomous actors of polycentric governance), funded by donors, and supported by technical assistants, mostly coming from Europe and North America. Beyond their financial power, these actors exert other less visible forms of power to stimulate the diffusion of PBF. Introducing the concept of *diffusion entrepreneurs*, we use a political economy approach to explore the social interactions at play in the diffusion process between actors across global/continental/national levels, and the asymmetrical power relations embedded within those interactions. To do so, we carry out an interpretative study with nested analysis levels (global, continental, national).

Conceptual Framework: We use an interdisciplinary conceptual framework borrowing from the fields of public policy, international relations, and global health. We analyse the characteristics of diffusion entrepreneurs — their representation systems (their underlying assumptions about the world), resources, types of authority, and motivations — and the strategies they use to promote the diffusion of PBF. These strategies include: policy framing, stimulating emulation through policy emulation, driving the learning agenda on policy learning (FBP), and the setting of standards and frameworks of collaboration to ensure a successful experimentation of the FBP (policy experimentation).

Methods: The thesis research object is the diffusion of PBF in sub-Saharan Africa, which involves influential diffusion entrepreneurs (five organisations, three transnational networks, and about two dozen individuals). Three studies were conducted at three different levels: global level (global health policy arenas and European research institutes), continental level (sub-Saharan Africa), and national level (Mali case). The analysis approach is mainly qualitative: we collected data from in-depth interviews (N = 57), participant observations (N = 13) and documents (N = 41). In the study on continental-level diffusion, qualitative data are supplemented by social network analyses and semantic discourse analyses based on 1,346 forum posts. These quantitative data complement the characterisation of a transnational network's structure and how it influences policy diffusion.

Research value: This research is the first political economy analysis detailing multilevel and multifaceted processes (discourse, networks, and production and dissemination of multiple forms of knowledge) led by influential policy actors — diffusion entrepreneurs — to foster the expansion of a policy innovation (PBF) in the specific context of polycentric governance. This study makes important theoretical and empirical contributions to the literature. First, it offers an innovative conceptual framework adapted to the contexts of global health and polycentric governance. The framework can be applied to a variety of research designs. Second, it provides useful insights on the processes of policy diffusion in polycentric governance, thereby filling a research gap on the phenomenon of polycentrism. By highlighting European and North American actors' exercise of power in their interaction with African consultants and policymakers, this study also paves the way for future research — particularly on the phenomenon of the making of an African expertise.

Keywords

Policy Diffusion, Political Economy Analysis, Performance-Based Financing, Diffusion Entrepreneurship, Sub-Saharan Africa

Résumé détaillé en français

Introduction

Chapitre 1

Le caractère polycentrique de la gouvernance de santé mondiale fait émerger depuis une vingtaine d'années des pôles d'influence politique de différentes formes (Ostrom, 2010; Tosun, 2017). La gouvernance *polycentrique* caractérise une configuration dans laquelle plusieurs unités de gouvernement (p. ex., organisation multilatérale, Etat, ville) agissant à différents niveaux (p. ex., global, national, régional), exercent leur activité d'élaboration de normes et règles dans un domaine donné de façon largement voire totalement autonome (Ostrom, 2010). L'autonomie de ces différentes unités de gouvernement différencie la gouvernance polycentrique de la "gouvernance multiniveaux", qui reflète un système où chaque unité est imbriquée dans une structure.

La gouvernance de santé mondiale (GSM) mobilise des unités de gouvernement, notamment des acteurs internationaux publics et privés, qui exercent une influence croissante au niveau global. Parmi les acteurs publics de la GSM, on compte les organisations internationales multilatérales (du système onusien : p. ex., l'Organisation Mondiale de la Santé ; et les institutions financières internationales : p. ex., la Banque mondiale), et les organismes de coopération bilatérale (p. ex., l'Agence Française de Développement). Les acteurs privés à but non lucratif incluent quant à eux les organisations non gouvernementales (ONG), les fondations philanthropiques (p. ex., la Fondation Bill & Melinda Gates), les tin tanks (p. ex., le *Center for Global Development*) et les grands partenariats publics-privés (p. ex., le Fonds mondial de lutte contre le sida, la tuberculose et le paludisme). On compte aussi un nombre important de compagnies transnationales privées à but lucratif (p. ex., les sociétés de conseil comme *McKinsey & Company*). Ces pôles d'influence traditionnels sont largement dominés par les pays à haut revenu (Whitfield, 2009). Outre ceux-ci, de nouveaux acteurs de la GSM émergent avec le concours du polycentrisme : les réseaux transnationaux (p. ex., le réseau *Providing for Health,* P4H) et les "experts internationaux" (p. ex., économistes du développement, consultants en santé publique) qui exercent une autorité croissante dans l'arène de la GSM et auprès des décideurs nationaux sur les questions de santé

(Shiffman, 2014). Si ces nouveaux acteurs sont susceptibles d'exercer une forte influence politique, leur influence financière reste limitée comparativement à celle des acteurs traditionnels de la GSM, qui agissent pour la plupart comme bailleurs de fonds de l'aide en santé mondiale – et qui financent donc directement ou indirectement les actions de ces nouveaux acteurs. On perçoit d'emblée de nombreux enjeux de pouvoirs dans la GSM. Pour appréhender ces enjeux, l'analyse de l'économie politique (AEP, *political economy analysis* en anglais) de cette arène de gouvernance est un outil pertinent pour les chercheurs. L'AEP "concerne l'interaction des processus politiques et économiques dans un contexte donné : la répartition du pouvoir et de la richesse entre différents groupes et individus et les processus qui créent, maintiennent et transforment ces relations au fil du temps" (OECD, 2009, p. 1) (*traduction libre*). Si les appels à mobiliser l'AEP pour étudier la santé mondiale augmentent (Boidin, 2016; Participants at the Bellagio Workshop on Political Economy of Global Health, 2015), il n'existe pas à notre connaissance d'AEP appliquée au contexte polycentrique de la GSM.

Or, le mouvement pour l'atteinte de la *Couverture Santé Universelle* (CSU) accentue le caractère polycentrique de la GSM. La littérature relève en effet une multiplication d'acteurs, de réseaux, et d'experts de la GSM qui appuient – dans les discours, l'allocation d'aide en santé mondiale, et la mise à disposition d'assistance technique – le mouvement pour l'atteinte de la CSU (Brolan and Hill, 2015). Cette dernière vise à assurer à toutes les populations d'un pays un accès à des services de santé de qualité "sans avoir à redouter que le coût de ces services, au moment où ils devront y recourir, les mette en situation de difficulté financière" (OMS, 2018, p. 1). La CSU a été consacrée dans le programme de développement post-2015 comme sous-Objectif de Développement Durable (ODD) (Chapman, 2016). Dans ce cadre, l'Organisation Mondiale de la Santé (OMS) recommande d'inciter les pays à faible et à moyen revenu (PFMR) à adopter la ou les réforme(s) de financement du système de santé adaptée(s) à leurs contextes (OMS, 2018). Selon les contextes, les PFMR peuvent s'engager dans la voie de l'atteinte de la CSU en réformant les modes de financement de leur système de santé en favorisant trois dimensions d'économie de la santé : la demande de santé (c.-à-d. la couverture des besoins d'accès aux services d'une population), l'offre de santé (c.-à-d. la quantité et la qualité des services couverts), et l'équité (c.-à-d. la proportion de coûts des services couverte par l'Etat ou les régimes de protection sociale versus celle des populations ; et l'accès à toutes les populations

selon leurs besoins indépendamment des disparités socioéconomiques et culturelles). Afin d'agir sur ces dimensions, il convient de tenir compte de trois fonctions essentielles du financement des systèmes de santé (Kutzin, 2001) : la collecte des ressources financières, leur mise en commun, l'achat des services de santé (c.-à-d. le transfert des ressources mises en commun aux prestataires de services, au nom de la population pour laquelle les ressources ont été mises en commun).

Dans les pays d'Afrique sub-Saharienne, plusieurs réformes de financement de la santé ont été mises en avant par différents acteurs de la GSM, notamment les organisations internationales et les organismes de coopération bilatérale (Gautier and Ridde, 2017). Certains de ces acteurs ont eu tendance à favoriser des réformes visant à améliorer la demande de santé dans les PFMR, comme les politiques de gratuité des soins (Robert and Ridde, 2013), les mutuelles de santé (Boidin, 2015), et les transferts monétaires conditionnels (Béland et al., 2018). D'autres ont plutôt cherché à promouvoir des politiques d'amélioration de l'offre de santé par le recouvrement des coûts (Lee and Goodman, 2002) et des mesures visant à augmenter la performance des professionnels de santé (Rowe et al., 2005). Toutefois, certains acteurs de la GSM ont considéré que ces réformes avaient généré des résultats plutôt décevants. Certains ont estimé que ces réformes n'avaient pas suffisamment tenu compte de la troisième fonction du financement : celle de l'achat des services (Mathauer, 2016). En réponse à ces écueils, plusieurs acteurs de la GSM polycentrique – organisations internationales, réseaux et individus influents – ont promu la mise en œuvre d'une réforme de financement du système de santé dans les PFMR : le financement basé sur la performance (FBP) (Turcotte-Tremblay et al., 2018). Le FBP se focalise sur l'offre de santé : les prestataires de soins de santé sont financés, au moins partiellement, sur la base de leur performance. Il mobilise les théories économiques du principal-agent et du contrat. Le principal (par exemple, le ministère de la santé) conçoit un contrat formel qui incitera un agent (par exemple, un prestataire de santé) à adopter un comportement conforme à ses intérêts (Eldridge and Palmer, 2009). Cela peut être réalisé en lui offrant des avantages financiers et en établissant des procédures de suivi-évaluation de l'exécution du contrat.

À l'inverse du système de financement par les intrants (avec budget reconduit chaque année), le FBP met ainsi l'accent sur l'atteinte de résultats sur la base de cibles définies à l'avance (dans le contrat). Ces cibles correspondent à une quantité, un pourcentage de couverture, ou un score de

qualité. Elles sont liées à la prestation de services de santé qui est “achetée” par un organisme tiers. Le FBP se focalise donc sur la fonction d’achat (Soucat et al., 2017). À la fin d’une période donnée (souvent, un trimestre) au cours de laquelle la prestation a été réalisée, un système de vérification et contre-vérification se met en place afin de contrôler les résultats et opérer le versement de primes aux prestataires. Une partie de ces primes sert à réaliser des investissements dans les centres de santé, l’autre sert de surplus au salaire des agents de santé. Les primes d’investissements contribuent à susciter une autonomie décisionnelle. Lier la performance des prestataires à des primes, permettre une autonomie décisionnelle, et assurer des cycles de rétroaction plus courts sont censés motiver les agents de santé à fournir des services de meilleure qualité, rendant ainsi la prestation de services plus attrayante pour les patients et augmentant leur utilisation des services (Fritsche et al., 2014).

Le FBP a été expérimenté dans plus de 70% des 46 pays d’Afrique subsaharienne entre 2000 et 2018, en dépit d’une absence d’unanimité sur les preuves scientifiques de son efficacité (Paul et al., 2018). Comme pour plusieurs autres réformes du financement de la santé (Nabyonga-Orem et al., 2014; Ridde, 2015), la diffusion du FBP dans tous ces pays repose donc sur des processus non liés à la prise de décision fondée sur des bases factuelles (*evidence-informed policymaking*) : il est essentiel d’analyser autrement la manière dont cette politique a gagné du terrain aux niveaux global, continental et national. Les projets pilotes de FBP sont promus par des organisations internationales, des réseaux et des experts transnationaux, financés par des bailleurs de fonds internationaux (notamment à travers un fonds géré par la Banque mondiale, le *Health Results Innovation Trust Fund*, HRITF), et appuyés par des assistants techniques qui agissent à ces différents niveaux. Au-delà du pouvoir financier, ces acteurs exercent de multiples influences visant l’expansion de cette politique. Ces influences incluent : l’association stratégique du FBP à des tendances et discours populaires susceptibles de susciter l’adhésion de nombreux acteurs (*framing*), la conduite de l’agenda d’apprentissage du FBP auprès des acteurs locaux des PFMR, l’incitation à l’émulation politique en promouvant des échanges inter-pays sur le FBP, et la facilitation et le contrôle de l’expérimentation du FBP. Ces formes d’influence sont d’autant plus complexes qu’elles sont relativement peu visibles : les acteurs de la GSM promouvant cette politique s’efforcent de mettre en avant un FBP conduit et approprié par les pays (africains, en particulier) et des intermédiaires locaux, comme les praticiens africains du FBP.

Pourtant, à ce jour, il y a eu peu d'investigation empirique sur les processus de diffusion du FBP dans les PFMR (Abomo, 2018) ou sur l'économie politique de cette diffusion (Renmans et al., 2016). En outre, les AEP disponibles se sont jusqu'ici focalisées sur le niveau national, explorant les influences exercées par des acteurs extérieurs dans certains pays africains (Barnes et al., 2015; Chimhutu et al., 2015; Kiendrébéogo et al., 2017; Renmans et al., 2017a). La littérature se concentre sur les effets et les processus de mise en œuvre du FBP (Renmans et al., 2016; Witter et al., 2012; Wiysonge et al., 2017). Très souvent, l'influence des acteurs de la GSM faisant la promotion du FBP est abordée sans décortiquer ses origines, ses multiples formes de matérialisation, ou ses implications pour les PFMR.

Introduisant le concept d' "entrepreneurs de la diffusion" (ED) pour référer aux acteurs de la GSM promouvant le FBP à différents niveaux, cette thèse entend combler les lacunes de la recherche et contribuer à l'avancement des analyses de l'économie politique de la diffusion en contexte polycentrique, en explorant les caractéristiques et stratégies d'influence que les ED mobilisent pour faciliter l'expansion du FBP en Afrique. Nous nous posons la question de recherche suivante : ***Comment des acteurs politiques puissants, agissant au niveau global, ont-ils façonné la diffusion du financement basé sur la performance en Afrique subsaharienne ?***
Pour répondre à cette question, nous réalisons une étude interprétative à niveaux d'analyse imbriqués (global, continental, national) afin d'examiner l'expansion du FBP dans les pays africains et le rôle joué par les entrepreneurs de la diffusion dans cette expansion.

Ancrage théorique et méthodes

Chapitre 2 : Revue de littérature théorique et élaboration du cadre conceptuel

Le 2ème chapitre (dont le contenu a été publié dans la revue *World Development*) consiste à passer en revue la littérature théorique qui permet de construire le cadre conceptuel guidant l'analyse dans cette thèse. Dans ce chapitre, nous testons également la pertinence de ce cadre en l'utilisant pour l'analyse de la littérature sur la diffusion du FBP.

La recherche sur la diffusion des politiques est caractérisée par des modèles explicatifs cohérents qui évaluent l'importance des mécanismes de diffusion (notamment : *policy learning* et *policy*

emulation) (Tosun, 2018). Or, malgré plusieurs tentatives de “ramener les acteurs” influents dans les processus d’émergence et de diffusion politique, ces acteurs restent largement oubliés dans la littérature sur les politiques publiques, en particulier dans les études sur la diffusion (Capano et al., 2015). Nous proposons de faire progresser la littérature en introduisant le concept d’“entrepreneurs de la diffusion” (ED). Ces ED sont des individus, des réseaux et des organisations qui conçoivent une idée de politique et en font la promotion en vue de gagner de l’influence. En nous basant sur la littérature relative à la diffusion et en la reliant à des études sur la prise de décision en contexte polycentrique, nous introduisons des catégories d’analyse pour mettre en lumière les caractéristiques essentielles et les stratégies d’influence entreprises par les ED. Ces catégories forment un cadre conceptuel interdisciplinaire, empruntant aux champs de la diffusion des politiques publiques (Gilardi, 2012; Shipan and Volden, 2008), de la sociologie de l’action publique (Hassenteufel, 2008), des relations internationales (Haas, 1992), et de la santé mondiale (Shiffman, 2017).

On identifie quatre caractéristiques essentielles et inter-reliées des entrepreneurs de la diffusion en contexte de gouvernance polycentrique. Les systèmes de représentations (compréhension du monde et présupposés sous-jacents, façonnés par la culture et la formation) qui guident leur action, constituent la 1ère caractéristique. Ces représentations sous-tendent les motivations profondes (intérêts personnels, politiques et financiers) qui animent leur décision de promouvoir une politique donnée (2ème caractéristique). Deux autres types de caractéristiques essentielles découlent des conséquences de l’ouverture qui caractérise la gouvernance polycentrique. Même les acteurs provenant d’un bas niveau de gouvernance peuvent être potentiellement puissants en raison de la possibilité de diffusion verticale et de transfert ascendant. Ces nouveaux acteurs doivent lutter pour se tailler une place dans l’arène décisionnelle, en misant notamment sur les ressources (savoir, ressources matérielles, sociales, politiques et temporelles) à leur disposition (3ème caractéristique), et susciter la reconnaissance de multiples formes d’autorité (experte, scientifique, financière, morale) pour déployer leur pouvoir (4ème caractéristique). Des définitions sont fournies dans le Tableau I.

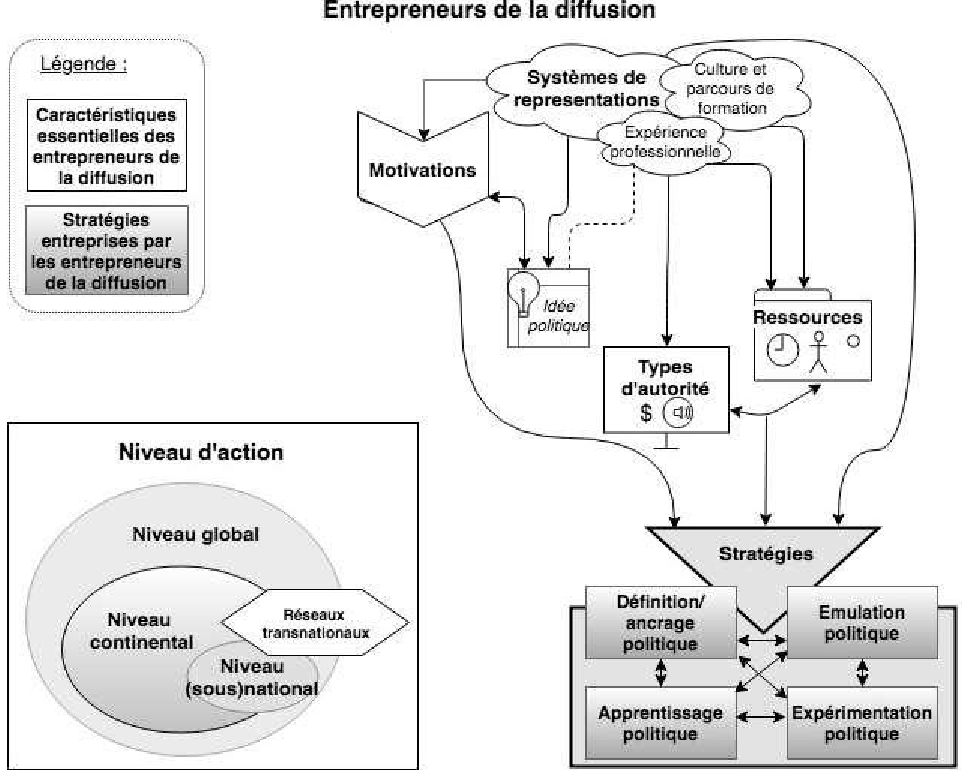
Tableau I. Définitions des types de ressources et formes d’autorité

Composantes	Définition
	Ressources
Savoir	Toute forme de savoir (p. ex., connaissances tacites, formation acquise, etc.)

Matérielles	Ressources humaines, moyens financiers et matériels à disposition
Sociales	Capital social et propension des acteurs à développer des liens avec d'autres personnes
Politiques	Propension des acteurs à mobiliser les acteurs politiques jouant un rôle clé (p. ex., décideurs)
Temporelles	Propension des acteurs à avoir/trouver du temps à dédier à la "cause" de la diffusion
Types d'autorité (reconnue et acceptée au niveau global)	
Financière	Autorité provenant de la reconnaissance du volume important d'investissement financier en faveur de l'aide au développement
Morale	Légitimité reconnue (de celui qui revendique cette forme d'autorité) du rôle de prescripteur de comportements et de producteur de normes sur la base de catégories considérées comme valides
Scientifique	Statut scientifique internationalement reconnu combiné à la reconnaissance de la validité des représentations du réel de celui qui revendique cette forme d'autorité
Experte	Renommée provenant d'expérience ultérieure d'implantation d'une politique donnée (typiquement réussie) et/ou d'une capacité reconnue à trouver des solutions à des problèmes.

C'est seulement s'ils acquièrent une forte légitimité qu'ils sont susceptibles de réussir leur entreprise de stimulation de la diffusion. Cette entreprise repose sur le développement de plusieurs stratégies. Celles-ci incluent : l'ancrage de la politique dans des orientations susceptibles de générer l'adhésion (*policy framing*), la stimulation de l'émulation par la constitution de réseaux promouvant une même politique (*policy emulation*), la conduite de l'agenda d'apprentissage sur la politique (*policy learning*), et la fixation de standards et cadres de collaboration pour assurer une expérimentation réussie de la politique (*policy experimentation*). Parfois, les ED s'organisent en réseaux informels, composés de "professionnels possédant une expertise et des compétences reconnues dans un domaine particulier" (Haas, 1992, p. 3, *traduction libre*) partageant des systèmes de représentation et des intérêts convergents. Ces réseaux contribuent à promouvoir les innovations politiques par leur pouvoir de contrôle des flux d'information et du savoir. Dans ce cas, on parle de *communautés épistémiques* transnationales (Haas, 1992).

Graphique I. Cadre conceptuel



Pour illustrer la valeur analytique du concept, nous avons effectué une revue approfondie de la littérature (scientifique et grise) sur les entrepreneurs de la diffusion (ED) du financement basé sur la performance (FBP) en Afrique subsaharienne. Nous montrons comment et pourquoi cette innovation politique récemment diffusée offre une opportunité unique pour démontrer notre concept : dans le cas du FBP, un groupe d'ED influents et fortement dédiés s'est efforcé d'accentuer la diffusion de la politique. <u>C'est grâce au caractère polycentrique de la GSM que certains d'entre eux ont pu exercer une influence sur les processus de diffusion</u>.

Notre revue a permis d'identifier qui sont les ED du FBP à l'échelle globale : cinq organisations (deux agences d'aide bilatérale, un bailleur de fonds majeur, une ONG, et une société de formation), trois réseaux transnationaux (une communauté de pratique, un réseau informel d'*alumni*, et un réseau de praticiens multipays), et une trentaine d'individus (des consultants indépendants et des chercheurs basés en Europe ou en Amérique du Nord, et des employés d'organisations internationales). Les réseaux et organisations les plus visibles sont caractérisés par une culture collective/organisationnelle ancrée dans les théories économiques néoinstitutionalistes et la "nouvelle gestion publique" qui façonnent leurs systèmes de

représentations (Broad, 2006; SinaHealth, 2019). Par exemple, la société de conseil hollandaise *SinaHealth* (acteur incontournable de la diffusion) répand, en collaboration avec d'autres sociétés de formation (béninoises et camerounaises, notamment), l'approche du FBP et ses principes fondamentaux ancrés en microéconomie (théories des contrats et des incitants). Les individus partagent également un système de représentation construit sur des formations en économie et sciences médicales (Fritsche et al., 2014). L'ensemble des ED sont mus par la nécessité d'obtenir un retour sur investissement (penchants pour l'aide basée sur les résultats et une meilleure reddition des comptes (Paul and Renmans, 2017), et par la volonté de promouvoir des approches qui semblent rompre avec l'existant (Morgan, 2010).

Au début des années 2010, les ED ont combiné leurs différentes ressources (savoir, sociales, politiques, temporelles, matérielles) et leurs autorités morales et expertes afin "d'enclencher une révolution" (Meessen, 2015). Forts de ces atouts, et naviguant dans le contexte favorable de la gouvernance polycentrique, les ED ont ainsi entrepris des actions qui s'autoalimentent afin de favoriser la diffusion du FBP. L'ancrage stratégique de la réforme FBP dans les tendances populaires de l'aide en santé (coopération Sud-Sud, efficacité de l'aide, etc.) a facilité la mise en œuvre de leurs stratégies d'émulation et d'apprentissage politique, et celles-ci ont à leur tour contribué à créer les conditions d'une expérimentation réussie du FBP dans de nombreux pays africains (Barnes et al., 2015). Au même moment (à partir de 2010), on remarque que la diffusion du FBP s'accélère en Afrique subsaharienne (Gautier et al., 2018b). Les caractéristiques essentielles des ED du FBP et leurs actions semblent donc avoir bien conduit les processus de diffusion. Le tableau II récapitule les résultats qui documentent chaque dimension du cadre sur les ED.

Entrepreneurs de la diffusion	*ED individuels (Europe et Amérique du Nord)*
Systèmes de représentations	Ancrage en économie et en sciences médicales
Motivations	Reconnaissance et visibilité accrues, retour sur investissement
Ressources	Savoir, sociales, temporelles, politiques
Autorités	D' expert, scientifique
Stratégies de définition de la politique	Association du FBP aux discours globaux dominants et/ou populaires
Stratégies pour induire l' émulation politique	Contribuer à la création d'une communauté épistémique FBP
Stratégies de conduite de l' apprentissage	Développer des standards et un guide de bonnes pratiques basé sur les expériences de FBP
Stratégies pour faciliter l' expérimenta-tion	Offre d'assistance technique aux acteurs nationaux

Tableau II. Tableau synthétique des caractéristiques essentielles et stratégies des ED du FBP (à partir de Gautier et al., 2018b)

Entrepreneurs de la diffusion	*Banque mondiale et fonds “ HRITF”*	*Communauté de Pratique du FBP*	*ONG impliquées (p. ex., Cordaid)*	*Entreprise spécialisée dans la formation au FBP*	*Autres bailleurs (p. ex., NORAD)*
Systèmes de représentations	Ancrage en économie, théorie néolibérale et nouvelle gestion	Valorisation de l' expertise du praticien	Ancrage en économie (de la santé)	Valorisation de l' expertise du praticien ; langage du secteur privé	*(pas d' information)*
Motivations	Visibilité accrue, retour sur investissement	Avancement de carrière, visibilité accrue	Visibilité accrue	Retour sur investissements, visibilité accrue	Retour sur investissements
Ressources	Matérielles, politiques, savoir	Sociales, temporelles, savoir	Savoir, politiques, sociales, temporelles	Temporelles, matérielles, sociales	Matérielles, politiques, savoir
Autorités	Financière, d' expert, morale	En quête d' autorité d' expert	D' expert	D' expert	Financière, d' expert, morale
Stratégies de définition de la politique	Association du FBP aux discours globaux dominants et/ou populaires	Présentation du FBP comme s' inspirant de l' expérience des pays pairs	Principes fondamentaux du FBP reliés aux orientations natio-nales existantes	Présentation du FBP comme s' inspirant de l' expérience des pays pairs	Association du FBP aux discours globaux dominants et/ou populaires
Stratégies pour induire l' émulation politique	Organiser des ateliers d' échange pour les expérimentateurs de projets pilotes	Création d'un forum d'échange en ligne pour les praticiens du FBP dans les PFMR	Contribuer à la création d'une communauté épistémique FBP	Contribuer à la création d'une communauté épistémique FBP	Contribuer à la création d'une communauté épistémique FBP
Stratégies de conduite de l' apprentissage	Évaluation des effets des programmes pilotes, financement / organisation de formations	Dissémination de multiples formes de savoir (forum en ligne, ateliers face-à-face, etc.)	*Pour certains:* Production et dissémination de multiples formes de savoir par la formation	Dissémination de multiples formes de savoir par la formation	Dissémination de multiples formes de savoir par la formation
Stratégies pour faciliter l' expérimentation	Financement de programmes pilotes, utilisant parfois une forme de persuasion coercitive	Mettre à disposition un pool d' experts disponibles pour aider à l' expérimentation	Participation à la mise en œuvre de projets pilotes	Offre d' assistance technique aux décideurs	Financement de programmes pilotes, utilisant parfois une forme de persuasion

Cette analyse préliminaire a fait émerger cinq propositions qui se rattachent au concept de polycentrisme (appliqué à la GSM). Ces propositions présentent également des implications majeures pour l'économie politique de la diffusion.

La première proposition suggérait qu'une condition nécessaire pour la réussite de la diffusion d'une politique donnée est que les ED réunissent leurs ressources et leurs types d'autorité (proposition 1). Il semble bien que ce soit le cas ici : la mise en commun du savoir, des ressources matérielles, sociales, politiques et temporelles des ED et le fait qu'ils bénéficiaient de multiples formes d'autorité (morale, financière, experte) ont multiplié les chances de réussite de leurs actions. Ce résultat a une implication majeure pour notre AEP de la diffusion du FBP : la mise en commun des ressources semble se faire naturellement entre acteurs déjà assez puissants. En effet, nous constatons que la réputation et la capacité des ED ont joué un rôle important dans l'issue du processus. Sans les ressources préalablement accumulées par les ED, et leur capacité à être reconnus comme des acteurs légitimes de la GSM polycentrique, il n'aurait pas été possible de mobiliser les acteurs ni les ressources financières nécessaires. On peut ainsi postuler que lorsque les systèmes de représentation et les compétences des ED s'alignent sur le contenu de la politique et lorsque celui-ci correspond aux intérêts des bailleurs, les chances de diffusion en contexte polycentrique augmentent (proposition 2).

Notre revue de littérature empirique a également révélé que les ED avaient délibérément conçu et mis en œuvre des stratégies pour favoriser la diffusion du FBP (proposition 3), notamment en le définissant de manière à susciter l'adhésion aux niveaux global, continental et national. Ceci a permis d'accroître l'impact d'autres stratégies entreprises par les ED. Non seulement ces stratégies ont contribué à étendre la diffusion, elles ont également façonné les contours de cette diffusion et de ce qui était à diffuser. En effet, il semble que seuls certains discours et certaines formes d'apprentissage (dont le contenu était très contrôlé) étaient mis en avant (Barnes et al., 2015). Ici encore s'exprime l'économie politique : c'est l'influence des ED exercée au niveau global qui permet un tel contrôle de la diffusion (proposition 4).

Le cas du FBP a également permis de faire émerger des phénomènes inexplorés. En considérant l'appareil de stratégies utilisé pour stimuler l'émulation du FBP en Afrique, ainsi que l'influence

des réseaux d'experts africains du FBP, il est possible de déduire un "effet boule de neige". Ainsi, il est probable que ces entreprises, principalement dirigées par des ED agissant au niveau global, ont contribué à la formation d'ED de FBP en Afrique opérant à leur tour dans différents pays africains (proposition 5).

Chapitre 3 : Approche de collecte et d'analyse des données

Cette thèse s'inscrit principalement dans le champ des "*public policy studies*" (Lasswell, 1970), mais elle adopte une méthode d'analyse multidisciplinaire (Engeli and Rothmayr Allison, 2014), de façon à rendre compte de la manière la plus complète possible de la complexité des processus de diffusion. Les cinq propositions présentées ci-dessus guident la conduite de cette thèse. Afin d'appréhender la validité de ces propositions, trois études ont été réalisées à trois différents niveaux : global (arènes politiques de santé mondiale et instituts de recherche européens), continental (Afrique subsaharienne), et national (cas du Mali). Premièrement, nous avons étudié la fabrique du discours sur le FBP au niveau global, et l'influence des ED dans cette fabrique. Deuxièmement, deux études ont été entreprises respectivement sur le rôle de la CoP du FBP dans la diffusion ; et l'influence des ED sur la diffusion du FBP au Mali.

La collecte de données a été principalement qualitative : nous avons recueilli des données d'observations participantes (N = 13), d'entretiens approfondis auprès de répondants (N = 57) recrutés de façon accidentelle, selon la méthode boule de neige, et par choix raisonné, et de documents sur le FBP (N = 41). Dans l'étude à échelle continentale, les données qualitatives tirées des documents et des entretiens ont été complétées par des données relationnelles de réseaux sociaux et des données textuelles de messages de forum de discussion en ligne (N = 1346). Ces données quantitatives complètent notamment la caractérisation de l'influence discursive, de l'émulation et de l'apprentissage. Le tableau III récapitule les différentes sources de données et leur rattachement aux trois études. Ce tableau montre que les données collectées auprès d'acteurs et d'organisations agissant à un niveau donné (colonne de gauche) ont pu servir à informer l'analyse de la diffusion à chacun des trois niveaux.

Tableau III. Collecte de données et correspondance avec les chapitres

Niveau de collecte des données	**Diffusion au niveau global (Chapitre 4)**	**Diffusion au niveau continental (Chapitre 5)**	**Diffusion au niveau national (Mali) (Chapitre 6)**
Global (entretiens, notes d'obs., documents)	X	X	X
Continental (entretiens, documents et messages de forum en ligne)	X	X	X
National (entretiens, notes d'obs., documents)	X	X	X
Données utilisées	57 répondants +10 séances d'observation + cinq documents institutionnels	40 répondants + 17 documents produits par la CoP sur le FBP + 1346 messages de forum	33 + répondants + 5 séances d'observation + 19 documents sur le FBP au Mali

Les entretiens ont été menés avec des informateurs considérés comme promoteurs ou praticiens du FBP (y compris des ED), des représentants de gouvernements africains, des universitaires qui étudient le FBP, et des employés d'organisations impliquées dans le FBP (y compris d'organisations agissant comme ED). Le tableau IV présente la distribution des différentes catégories de participants.

Tableau IV. Portrait récapitulatif des 57 participants aux entretiens

Affiliation institutionnelle	**Total**	**N participants dont données utilisées dans le chapitre 4**	**N participants dont données utilisées dans le chapitre 5**	**N participants dont données utilisées dans le chapitre 6**	**ED individuels ou employés d'organismes ED**
Organisation internationale [INTORG]	19	19	16	8	12
Gouvernement national (pays africains) [NATGOV]	13	13	5	10	6 (ED de seconde génération)
Institution académique dans pays africain [ACADINST_AF]	4	4	3	0	0
Institution académique dans pays européens [ACADINST_EU]	3	3	3	0	1

Consultant indépendant basé dans pays africain [INDCONS_AF]	9	9	5	9	9 (ED de seconde génération)
Consultant indépendant basé en Europe [INDCONS_EU]	1	1	0	0	1
Société privée à but lucratif [PRIVFP]	4	4	4	3	4
Société privée à but non lucratif [PRIVNFP]	3	3	3	3	3
Autre [OTHER]	1	1	1	0	0
TOTAL	**57**	**57**	**40**	**33**	**36**

Des interactions répétées avec les participants ont contribué à renforcer leur confiance envers l'intervieweuse (LG) et ont permis de recueillir des données utiles pour analyser les systèmes de représentation et les motivations des acteurs. Les données qualitatives ont été transcrites dans leur majorité par LG. LG les a ensuite codées à l'aide du logiciel QDAMiner©. Employant une démarche déducto-inductive, nous avons utilisé diverses formes d'analyse interprétative, partant des dimensions du cadre conceptuel sur les ED. Nous avons aussi laissé la possibilité à des dimensions supplémentaires d'émerger à partir des données empiriques.

Résultats

Chapitre 4 : La fabrique et la diffusion du discours sur le FBP au niveau global

Le 4ème chapitre (publié dans la revue *Globalization & Health*) a pour objectif l'analyse du discours sur le FBP au niveau global. Utilisant l'approche post-structurale de Carol Bacchi pour analyser la manière dont les politiques reflètent et donnent corps à des représentations implicites de problèmes (Bacchi, 2016), nous avons analysé les données d'entretiens réalisés auprès de 57 répondants (cf. Tableau IV), de notes d'observation participante d'ateliers sur le FBP, et de cinq documents institutionnels sur le FBP produits par des ED.

L'approche de Bacchi "*Comment le problème est-il représenté ?*" met en évidence la manière dont les politiques reflètent les problèmes qu'elles entendent résoudre et la manière dont l'action politique s'exerce par le biais de cette "problématisation" (Bacchi and Goodwin, 2016). Bacchi

part du principe que les représentations des problèmes (figurant de façon implicite dans les politiques qui se veulent des solutions à ces représentations de problèmes) reflètent les compréhensions du monde de ceux qui fabriquent les politiques. Dans l'approche, Bacchi pose ainsi la question suivante : *Quels présupposés ou hypothèses profondes (façons de concevoir les choses) sous-tendent ces représentations du "problème" ?* (traduction inspirée de celle de Quadrant Conseil, 2019). Prenant le cas du FBP, il s'agissait d'identifier les présupposés et systèmes de croyances profonds qui sous-tendent les représentations des problèmes des systèmes de santé des PFMR, et d'analyser comment ces présupposés et systèmes de croyance façonnent les discours sur le FBP au niveau global. Nous avons ainsi étudié les présupposés et systèmes de croyance des ED du FBP mais aussi ceux des non-partisans du FBP. Parmi ceux-ci, on compte certains opposants au FBP, mais aussi de nombreux observateurs. Il s'agissait notamment de mettre en exergue comment ces systèmes de représentations façonnent les discours sur le FBP au niveau global.

Nous avons ainsi mis en évidence les systèmes de représentation spécifiques des ED (agissant au niveau global) en montrant comment leurs caractéristiques culturelles et leur formation façonnaient leurs représentations sous-jacentes des problèmes. En utilisant les six premières questions de l'approche de Bacchi, nous avons pu relier de façon critique ces représentations des problèmes à leur compréhension et à leur conception du FBP comme la solution politique la plus opportune (ou la moins opportune) à ces représentations de problèmes. Plus précisément, nous avons étudié la manière dont l'utilisation des champs sémantiques – reflets des parcours des répondants – liés aux sciences de l'économie / sciences de la gestion / sciences cliniques / sciences sociales étaient présents dans les discours sur le FBP.

Nos résultats ont mis en évidence des conceptions du monde très différentes et ont relevé plusieurs limites (notamment, des enjeux laissés pour compte) aux problèmes représentés dans les discours – appelant ainsi à faire preuve de nuance. Par exemple, pendant longtemps, les questions d'équité ont été largement ignorées dans le discours sur le FBP des ED. À l'inverse, les opposants au FBP ont souvent éludé la pauvreté des conditions de travail et des salaires de la plupart des professionnels de la santé dans les PFMR. Fait important, nous avons observé que malgré une formation similaire (généralement en économie), les ED du FBP ne partageaient pas

exactement les mêmes présupposés sous-jacents. Cela a suscité des débats parmi eux. Des systèmes de représentations similaires conduiraient donc parfois à des représentations des problèmes distinctes.

Afin de répondre à la question de Bacchi: *Comment cette représentation du problème est-elle apparue ?*, nous nous sommes penchés sur les motivations des ED pour s'attaquer aux représentations des problèmes, sur leurs ressources (savoir, ressources sociales et temporelles, etc.) et les autorités (financière, morale, etc.) qu'ils exercent au niveau global. Nous avons notamment mis en lumière la manière dont les ED, malgré leurs différences de statut dans la GSM (experts individuels et communauté de pratique *versus* bailleurs de fonds majeurs), ont mis en commun leurs atouts pour augmenter leurs chances d'influencer la diffusion du FBP correspondant à leurs représentations des problèmes (proposition 1). Mobilisant les données d'entretiens, nous avons montré que les ED présentaient un ensemble complexe de motivations : une réelle volonté d'améliorer les systèmes de santé dans les PFMR, des intérêts politiques (ex : gagner de la visibilité au sein de la GSM) et des intérêts financiers. S'aligner sur le contenu d'un FBP reflétant la tendance de l'aide basée sur les résultats, populaire chez les bailleurs, leur permettrait notamment d'obtenir des opportunités de financement. Les bailleurs ont fortement soutenu la diffusion du FBP car il semblait correspondre à leur préoccupation d'un retour sur investissement. Ceci tend à valider notre 2ème proposition.

Forts de ces multiples atouts, les ED devaient trouver des moyens pertinents pour promouvoir leur discoaurs au niveau global. Nous avons utilisé ici la sixième question de Bacchi, c'est-à-dire *Comment et où ces représentations du "problème" ont été produites, diffusées et revendiquées ?*, pour illustrer les stratégies conçues et utilisées par les ED pour rendre incontournable la solution à leurs représentations de problèmes (proposition 3). Ces actions visaient notamment à i) (re)définir le FBP de façon stratégique, ii) contrôler l'agenda d'apprentissage sur le FBP, iii) définir les conditions de l'expérimentation du FBP, iv) et susciter l'émulation politique en utilisant de puissants exemples de succès du FBP pour inspirer les décideurs des PFMR.

À plusieurs reprises, nous montrons que le débat entre ED et "non-ED", mis en scène au cours des entretiens, a amené les ED à recadrer le FBP afin d'accroître sa popularité. Plusieurs répondants "non-ED" ont exprimé leur inquiétude quant au fait que le FBP représente une

innovation politique qui n'a pas résolu les problèmes structurels des systèmes de santé dans les PFMR. Au contraire, certains répondants parlaient du FBP comme d'une "*cerise sur le gâteau sans gâteau*" et/ou d'une "*réforme fragmentaire*" car cette réforme ne se focalisait que sur la rémunération des professionnels de santé. Cette critique a incité les ED à modifier progressivement leur discours en 2011-2012 (Meessen et al., 2011c). Ils ont insisté sur le fait que le FBP pourrait combler le fossé potentiel, non seulement en offrant des incitations financières aux agents de santé, mais également en augmentant la production de ressources pour permettre des améliorations de l'environnement de travail et des cycles de rétroaction plus courts. Plusieurs représentants d'ED ont aussi reconnu que le FBP devait être complété par d'autres réformes du système de santé. Certains ED ont stratégiquement défini le FBP comme une réforme systémique susceptible de servir de levier à toutes les réformes des systèmes de santé, qu'il s'agisse d'un "point d'entrée" pour l'achat stratégique, d'amélioration de la motivation des agents de santé, ou de promouvoir la populaire "révolution des données" des systèmes d'information sanitaires. En outre, les ED ont contrôlé la majeure partie de l'agenda d'apprentissage sur le FBP, en fabriquant et promouvant notamment des contenus politisés et technicisés (Gautier and Ridde, 2018) et les expériences réussies de FBP (la *success story* rwandaise, notamment). L'influence discursive des ED se manifestait donc à travers leur capacité à maîtriser les termes du débat et la circulation de savoirs sur le FBP au niveau global, ce qui tend à confirmer notre 4ème proposition.

Une stratégie a catalysé l'ensemble des trois derniers processus : l'organisation de multiples voyages d'étude dans des pays d'Afrique subsaharienne. Les stratégies des ED ont également eu un effet boule de neige, participation à la création (via de multiples formes de coaching et la formation, notamment) d'"ED de seconde génération" répandant le FBP sur le continent africain (proposition 5). Au final, cette analyse a montré qu'il est possible et pertinent d'utiliser l'approche poststructuraliste de Bacchi pour analyser les discours en santé mondiale, notamment parce qu'elle permet de dépasser les débats polarisés. Cette étude nourrit ainsi des arguments nuancés pour comprendre comment le FBP s'est diffusé dans les PFMR, tout en jetant certains doutes sur la possibilité que les acteurs locaux promouvant le FBP ne soient pas non plus façonnés par les ED agissant au niveau global.

Chapitre 5 : La diffusion du FBP au niveau continental (africain)

Pour rendre compte de la diffusion du FBP au niveau continental, nous avons réalisé une deuxième étude empirique (publié dans la revue *International Journal of Health Policy and Management*). Nous nous sommes intéressés au cas spécifique d'un entrepreneur de la diffusion qui joue un rôle de catalyseur des processus de diffusion en Afrique subsaharienne : la *Communauté de Pratique du Financement Basé sur la Performance* (CoP FBP).

Employant un devis de recherche [1] mixte convergent à dominante qualitative, nous avons documenté les attributs (correspondant aux caractéristiques essentielles de cet ED), la structure du réseau social et les stratégies mises en place par la CoP FBP pour favoriser la diffusion des politiques, à la lumière des dimensions du cadre des entrepreneurs de diffusion. Une analyse sémantique du discours du forum en ligne de la CoP a été réalisée (N=1 346 messages). Ces résultats quantitatifs ont été confrontés à une analyse thématique de données d'entretiens (N=40) et à des données extraites de la documentation clé de la CoP (note de synthèse, billets de blog, documents de travail) (N=17). Des analyses de réseaux sociaux sur la base de données relationnelles (185 contributeurs du forum en ligne, citant des membres de la CoP et des non-membres) ont été menées pour étudier en profondeur comment la structure et l'ouverture de cette communauté FBP favorisaient les processus de diffusion continentale. Nous avons ensuite employé une stratégie interactive de fusion ("*merging*") des trois corpus de résultats quantitatifs et qualitatifs (Fetters et al., 2013). Une fois cette fusion effectuée, nous avons utilisé une approche narrative pour relier l'ensemble des résultats à chaque dimension du cadre des entrepreneurs de la diffusion.

Les attributs (caractéristiques essentielles) des membres de la CoP comprenaient : des systèmes de représentation ancrés dans les sciences cliniques et économiques, et une forte motivation des membres reposant sur l'idée selon laquelle CoP améliorerait visibilité et carrière professionnelle. Les membres de la communauté semblent disposer également de ressources sociales et d'un savoir importants. Le groupe principal (*core group*) de la CoP, dominé par des membres européens, disposait en outre de ressources politiques conséquentes et d'un accès facilité aux

[1] Au Québec, l'expression "devis de recherche" est la traduction de *research design* en anglais. Cette expression, largement utilisée par les chercheurs francophones, nous semble plus pertinente que les expressions employées en France ("conception de recherche" ou "plan de recherche", par exemple).

ressources matérielles, et d'une réputation importante basée sur divers types d'autorité (experte et scientifique notamment). Plus qu'une mise en commun de ces atouts (proposition 1), l'analyse de la CoP fait ressortir la volonté affichée de ce groupe minoritaire de faire bénéficier le reste des membres de la CoP de ses avantages.

Ce groupe (dominé par des ED européens) a par ailleurs soigneusement développé des actions de diffusion visant à la fois à promouvoir les praticiens africains et un répertoire de pratiques correspondant à leur vision du FBP (proposition 3). Notamment, ce groupe a adroitement associé les principes du FBP aux problèmes majeurs des systèmes de santé en Afrique. Le large consensus dans les discussions thématiques en ligne sur le FBP a créé un fort sentiment de communauté, qui s'est en retour révélé être un terrain propice à l'émulation politique parmi les membres de la CoP. La CoP FBP a également cherché à susciter et à valoriser la production et l'échange de savoirs expérientiels sur le FBP entre les praticiens africains. Pour cette raison, et parce qu'elle a réussi à mobiliser une masse critique de praticiens du FBP, la CoP a été largement perçue comme le principal catalyseur des processus de diffusion au niveau continental. D'ailleurs, de l'avis de la majeure partie des répondants, cette communauté a joué un rôle de premier plan dans la fabrique et la promotion d'"ED de seconde génération", qui ont à leur tour participé à l'expansion du FBP sur le continent (proposition 5). C'est aussi grâce au caractère polycentrique de la GSM, que la CoP a pu exercer son influence : une gouvernance classique n'aurait pas laissé la possibilité à un "simple" réseau de praticiens de jouer un tel rôle.

La promotion d'un répertoire commun de pratiques sur le FBP a consolidé l'image d'une CoP "communauté épistémique" au sens de Haas (1992). La cohésion affichée s'est construite sur un alignement des systèmes de représentation et une convergence d'intérêts : les praticiens et leurs promoteurs européens avaient tous quelque chose à gagner dans la diffusion du FBP à travers les activités de la CoP (proposition 2). Ces activités consistaient notamment à tester des formats interactifs et ouverts (y compris à la communauté scientifique), afin d'éviter de devenir une communauté repliée sur elle-même et porteuse d'une seule et même "doctrine" (Bertone et al., 2013). Malgré les efforts déployés, un certain clivage apparaît entre la communauté scientifique, jugeant ces activités insuffisamment scientifiques, et les membres de la CoP, défendant leur savoir expérientiel parfois en éludant la validité externe de ce savoir (Gautier et al., 2019b).

En outre, les résultats de l'analyse de réseau ont montré que la communauté promue comme étant conduite par l'Afrique ne correspondait pas exactement à la structure de gouvernance réseau, largement dominée par les membres européens, bien que leur domination ait eu tendance à diminuer avec le temps. De fait, l'interaction au sein de cette communauté n'était horizontale que jusqu'à un certain point : les échanges étaient dominés par quelques européens (plus souvent cités que les africains) perçus comme les "experts originaux du FBP". Le fait que les praticiens africains soient en recherche d'opportunités pour leur carrière les plaçait souvent dans une posture d'infériorité vis-à-vis des européens. D'ailleurs, ceux-ci continuaient à avoir un accès privilégié aux organisations internationales (y compris les bailleurs de fond) les plus influentes dans la diffusion du FBP.

Pour autant, c'est l'image d'une CoP promouvant des experts africains (et leur savoir expérientiel) devenus "champions du FBP" qui a été conservée dans l'arène de la GSM. Cette image était fortement présente dans les données des entrevues. Elle a probablement été entretenue parce qu'elle servait les intérêts des promoteurs du FBP au niveau global, qui s'efforçaient de rendre la diffusion du FBP comme étant conduite par les PFMR, et qui voyaient en la CoP un "*marketplace*" opportun pour recruter des assistants techniques à l'expérimentation du FBP. Les praticiens africains sont restés, de fait, largement dépendants de financements extérieurs (pour participer aux projets pilotes de FBP). De plus, même s'ils participaient de façon importante aux activités de la CoP, les praticiens africains ont continué à avoir besoin de la validation par les "experts originaux" pour gagner en visibilité. La CoP a donc fait émerger des processus qui maintenaient les relations de pouvoir initiales.

Ainsi, malgré des intentions louables de renverser le paysage décisionnel établi (une arène de GSM dominée par des acteurs des pays à haut revenu), des personnalités influentes et des organisations internationales continuaient à guider le processus d'expérimentation, d'émulation et d'apprentissage des politiques relatives aux systèmes de santé, même si elles étaient appliquées dans les pays d'Afrique subsaharienne (proposition 4). Les processus de diffusion au niveau continental stimulés par la CoP auraient donc échoué à ébranler l'économie politique de la

diffusion du FBP, marquée par de fortes inégalités entre les acteurs des PFMR et ceux des pays à haut revenu (d'Europe et d'Amérique du Nord).

Chapitre 6 : La diffusion du FBP au Mali aux niveaux central (Bamako) et décentralisé (région de Koulikoro et ses districts)

Dans une troisième étude empirique (publié dans la revue *Health Policy and Planning*), nous nous sommes penchés sur la diffusion du FBP au niveau national, en utilisant le cas du Mali. Depuis 2009, le Mali s'est lancé dans une réflexion sur l'adoption du FBP afin d'améliorer l'utilisation et la qualité des services de santé maternelle et infantile. Entre 2009 et 2018, le pays a connu deux courtes expériences de FBP dans la région de Koulikoro, appelées "pré-pilote" et "pilote". De nombreux acteurs étrangers (d'Europe et d'Afrique) ont contribué à diffuser l'idée et les principes du FBP auprès des acteurs maliens du niveau central et de tous les niveaux de la décentralisation sanitaire. Ces acteurs étrangers participent à la création d'un noyau d'experts du FBP au Mali.

Nous avons utilisé un devis d'étude de cas qualitatif longitudinal. Le cas était la diffusion du FBP au Mali de 2009 à 2018, notamment aux niveaux central (Bamako) et décentralisé (région de Koulikoro et ses districts). Cette étude de cas était de type *instrumental* (Stake, 1995), dans le sens où les particularités de la diffusion du FBP au Mali permettent de révéler un phénomène social d'intérêt plus large, à savoir l'influence protéiforme d'acteurs agissant à plusieurs niveaux (les "entrepreneurs de la diffusion") pour faciliter l'expansion du FBP. Dans le cas malien, nous avons mis en lumière comment les entrepreneurs de la diffusion étrangers (Européens et Africains) et locaux ont influencé la diffusion du FBP dans ce pays.

L'étude de cas était rétrospective : la collecte des données s'est déroulée de janvier 2016 à novembre 2017. Elle s'appuie sur des données collectées à partir de 33 entretiens approfondis, 12 entretiens informels, cinq séances d'observation participante de réunions, et 19 documents clés sur le financement basé sur la performance (FBP) produits de 2009 à 2018. Ces données qualitatives ont été exportées dans QDAMiner© et codées selon une approche interprétative articulée autour des dimensions du cadre des entrepreneurs de la diffusion. Une synthèse a ensuite permis de rendre compte de façon empirique de chaque dimension du cadre théorique.

L'histoire de la diffusion du FBP au Mali de 2009 à 2018 s'est révélée indissociable de la fabrique et de l'action des entrepreneurs de la diffusion (ED) dans ce pays. Un ED européen, expert travaillant pour un organisme hollandais de coopération-développement en santé (le "KIT"), a joué un rôle de premier plan dans la fabrique d'ED maliens. Sur la base d'expériences de travail en commun pendant une dizaine d'années, cet expert hollandais, a développé de solides relations professionnelles avec deux experts en système de santé travaillant dans la région de Koulikoro, et un décideur partenaire de projets de développement passés (visant à consolider les mesures de décentralisation). La réputation de cet expert hollandais, son savoir et ses ressources sociales ont été mises en commun avec les ressources temporelles et politiques et l'autorité morale des acteurs maliens (proposition 1). Le succès perçu de ces projets, qui mobilisaient les prémisses du FBP (contractualisation afin d'opérationnaliser le transfert de compétences en santé), associé à un passé commun et des formations similaires en économie et gestion des services de santé, et un intérêt à faire évoluer leurs carrières respectives, ont façonné les trois ED maliens. Cette communauté malienne favorable au FBP savait en effet qu'il était dans son intérêt de faire sa promotion, étant donné les opportunités d'avancement de carrière qui devenaient possibles grâce aux larges financements disponibles pour piloter cette politique (proposition 2). Une fois considéré par l'expert hollandais comme suffisamment "prêt", l'un des ED maliens est devenu en 2017 un "ED de seconde génération", diffusant le FBP en Guinée en collaboration avec le KIT. Début 2019, les deux autres ED maliens ont également été promus en entrepreneurs de la diffusion par leur sélection récente pour participer à l'expérimentation du FBP en Mauritanie. Ce phénomène complexe d'interactions entre individus aux influences inégales que nous décrivons de façon détaillée dans le chapitre, valide à la fois nos 4ème et 5ème propositions. On retrouve ce besoin de validation par les ED "originaux" dans le chapitre précédent. La place prépondérante de l'expert hollandais dans l'ensemble des processus de diffusion reflète notamment comment le pouvoir de "simples" individus peut s'exercer dans les PFMR.

Les ED (étrangers et maliens) ont également conduit l'agenda d'apprentissage du FBP des décideurs et bureaucrates maliens au fil du temps – par de multiples formations, voyages d'études, et échanges avec des experts africains du FBP. Ils ont aussi influencé les processus d'émulation entre les acteurs en faveur du FBP, en organisant au début de la décennie 2010 des "dîners basés sur les résultats" dans un grand hôtel de Bamako pour convaincre les décideurs de

la pertinence de cette approche FBP, tout en les introduisant à ses principes et en les associant stratégiquement aux orientations nationales du pays, notamment les politiques publiques de décentralisation, contractualisation, et gestion axée sur les résultats. Les ED ont également créé et répandu l'expression FBP "*à la malienne*" afin de promouvoir un FBP adapté au contexte malien (implication des Associations de santé communautaire, mairies et conseils de cercle, etc.). C'est ce format de FBP qui a été expérimenté (financé via un résidu du fond OMD5) en 2012-2013 dans trois districts sanitaires de la région de Koulikoro. Cette expérience a participé au renforcement du noyau d'experts du FBP, mobilisant notamment les médecins-chefs de district concernés. En 2016-2017, un nouveau test du FBP (financé par la Banque mondiale à travers un projet de renforcement de la santé de la reproduction) a eu lieu, à laquelle trois des quatre ED ont activement participé en collaboration avec une ONG jouant le rôle d'un ED, Cordaid. À cette occasion, six experts africains (venant du Burundi, du Rwanda et de République Démocratique du Congo) du FBP, ayant aussi le statut d'ED, ont été mobilisés pour transmettre leur engouement et expertise aux acteurs maliens. Tous ces processus confèrent aux ED une place prépondérante, qui leur permet de diffuser leur discours et mettre en œuvre leurs stratégies favorisant l'expansion du FBP au Mali (proposition 3).

Toutefois, plusieurs freins ont participé à entraver l'action des ED au Mali. Notamment, nous avons observé peu d'interactions entre les acteurs du niveau central et ceux des niveaux décentralisés pendant l'expérimentation, notamment celle du pilote dans la région de Koulikoro. D'après les répondants, le manque de participation des acteurs du niveau central était dû à un manque de confiance et une mauvaise collaboration avec les représentants du bailleur (la Banque mondiale). Nous avons également relevé une forte perte d'expertise et d'émulation autour du FBP (anciens décideurs formés partis, turn-over important au ministère). Enfin, la discontinuité de l'expérimentation du FBP au Mali (entre les deux pilotes puis après 2017) a porté préjudice à l'engagement sur le long terme des acteurs politiques.

Au final, la diffusion du FBP au Mali a été facilitée par l'implantation de stratégies définies par les entrepreneurs de la diffusion visant à rendre le FBP politiquement pertinent. Ils ont façonné son apprentissage et suscité l'émulation auprès d'acteurs influents. Toutefois, d'importants défis freinent sa diffusion. Les architectes des futurs programmes de FBP au Mali gagneraient à tirer

des leçons de l'expérience des projets passés dans la région de Koulikoro. Il serait utile de miser sur le développement de relations de confiance entre les acteurs (p. ex. : entre bailleur et ministère de la santé). Enfin, dans le cas où la pertinence et l'efficacité du FBP font l'objet d'un consensus au sein du gouvernement malien, il conviendrait de constituer un cadre d'échanges pour que le transfert de connaissances et compétences se réalise du niveau décentralisé (qui ont expérimenté le FBP de manière effective) vers le niveau central.

Discussion *(Chapitre 7)*

Réflexions théoriques sur la pertinence du cadre conceptuel

Le concept d'"entrepreneurs de la diffusion" (ED) s'inscrit prioritairement dans le champ de la diffusion des politiques publiques. En effet, si nous apprécions les avancées de la littérature sur les mécanismes de diffusion (*policy learning* et *policy emulation*, notamment) nous avions remarqué un manque d'attention pour les acteurs de la diffusion dans ce champ de la littérature. La sociologie de l'action publique et les sciences politiques se sont révélées très utiles pour définir les dimensions d'un cadre interdisciplinaire cohérent autour de ce concept. Des politologues emploient des termes similaires, comme les "knowledge" ou "reform" entrepreneurs (Nay, 2014, 2011). Une autre littérature utile pour concevoir une approche plus centrée sur les acteurs en matière de diffusion des politiques est la littérature sur le transfert des politiques présentée par Dolowitz et Marsh (Dolowitz and Marsh, 1996) et proposée par des spécialistes de cette littérature, par exemple Stone, qui a inventé le terme d' "agents de transfert" (Stone, 2004). Cependant, nous constatons que la typologie d'agents de transfert développée par Stone est limitée par le fait que les trois catégories peuvent facilement rejoindre leurs efforts pour former des réseaux plus vastes. En outre, la catégorie "*politicians*" peut aussi entrer dans la catégorie "*ideational*". Une autre notion est celle d'"agents de changement" (*change agents*), qui découle du travail sur la diffusion de la nouvelle gestion publique (Common, 1998). En anthropologie du développement, on parle aussi de "courtiers du développement" (Olivier de Sardan and Bierschenk, 1993) qui agissent de façon stratégique en se positionnant à l'interface entre les acteurs traditionnels de l'aide au développement et les bénéficiaires dans les PFMR.

Ces différents concepts ont en commun la centralité des connaissances et des informations que les (groupes d') individus possèdent et utilisent pour faciliter le changement de politique. Ces

entrepreneurs, courtiers ou agents peuvent être efficaces à différents niveaux de gouvernement, y compris au niveau global. Nous apprécions les concepts existants, mais nous pensons également qu'il vaut la peine de poursuivre le travail conceptuel en mettant l'accent sur le contexte de diffusion des politiques et le cadre de la gouvernance polycentrique. Si on s'intéresse à la diffusion des politiques, on constate également que ces entrepreneurs/agents ne représentent pas seulement des créateurs et promoteurs de changements politiques, savoirs ou réformes institutionnelles. Armés de ressources et d'une visibilité importantes sur la scène internationale, ils sont aussi les acteurs centraux de l'expansion de ces réformes politiques dans les PFMR, et notamment en Afrique (Cliff et al., 2004; Colvin et al., 2015).

De plus, si toutes ces dénominations peuvent aussi couvrir les acteurs qui nous intéressent, elles sont le plus souvent de nature descriptive (elles s'intéressent en priorité à définir et à décrire qui sont les entrepreneurs/agents). Notre cadre propose des dimensions potentiellement plus analytiques de ces acteurs. En effet, nous suggérons que les ED recouvrent des personnalités, organisations et réseaux qui portent une idée de base, participent à développer son contenu, co-construisent la connaissance et les canaux d'apprentissage autour de cette idée politique (y compris autour de son expérimentation), définissent son ancrage politique et contrôlent les termes du débat à son sujet, et suscitent l'émulation auprès d'un nombre toujours plus important d'acteurs, se constituant ainsi en réseau(x). L'aspect analytique de l'entrepreneuriat est triple : premièrement, les manières dont ils procèdent pour développer leurs ressources et autorités et mettre en œuvre leurs stratégies pour augmenter leur impact sur la scène internationale sont des processus intéressants à analyser en soi (i.e., comment les ED deviennent *effectivement* des entrepreneurs) ; deuxièmement, l'ensemble des activités stratégiques sont mises en œuvre de façon délibérée par ces entrepreneurs pour favoriser la diffusion d'une politique donnée (objectif *intermédiaire* des ED) ; troisièmement, la mise en œuvre et les effets escomptés de cet appareil stratégique révèlent aussi des motivations/intérêts particuliers (financiers, professionnels, etc.), plus ou moins assumés par les ED (objectif *ultime* des ED).

Nous créons ce nouveau concept en ayant à l'esprit la littérature sur les communautés épistémiques (Dunlop, 2009; Haas, 2015, 1992), qui "se distingue[nt] des communautés scientifiques ordinaires […] dans la dimension normative – et politique – de leur rôle dans la

construction de savoirs légitimes et consensuels qui ne sont pas pour autant irréfutables" (Charton, 2015, p. 52). Charton poursuit en évoquant la sollicitation presque systématique, par les décideurs des PFMR, des membres de ces communautés, pour les appuyer dans leur action politique. Or, c'est ici que notre concept apporte potentiellement une plus-value par rapport à celui de Haas : on ne s'intéresse pas seulement aux organisations et réseaux, mais aussi aux individus (et à leurs trajectoires), qui exercent une influence politique directe, notamment parce qu'on leur reconnaît une légitimité propre au sein de la gouvernance polycentrique.

Outre des systèmes de représentation communs, qui orientent les motivations des ED à préconiser une politique donnée, ceux-ci doivent également posséder certaines ressources (ressources qui sont elles-mêmes façonnées par les systèmes de représentation – culture professionnelle ou institutionnelle et formation notamment) pour pouvoir influer sur la prise de décision. Ils sont aussi amenés à développer une autorité légitime afin d'être reconnus par d'autres acteurs politiques naviguant dans le contexte polycentrique. Ces atouts représentent des bases solides sur lesquelles construire des stratégies pour favoriser la diffusion de la politique de leur choix. Les actions entreprises par les ED sont aussi nourries par leurs motivations et représentations sous-jacentes. L'ensemble des catégories du cadre des ED sont ainsi de nature analytique parce qu'elles sont inter-reliées et s'alimentent entre elles. Le potentiel du cadre, qui relie de façon dynamique ces différentes catégories, est donc intéressant. De plus, malgré un accent mis sur les acteurs, le cadre des ED s'avère utile pour décrire les processus de diffusion des politiques dans l'espace (ici, les pays africains) et dans le temps (depuis la fin des années 2000).

Notre étude offre potentiellement un cadre conceptuel pertinent aux chercheurs optant pour différents devis de recherche – approche poststructuraliste (Chapitre 4), méthodes mixtes à dominante qualitative (Chapitre 5), étude de cas longitudinale (Chapitre 6). Toutefois, de façon pratique, ce qui manque peut-être, c'est une dimension qui permettrait de contextualiser la diffusion de la politique à diffuser dans un(e) pays/région donné(e). En effet, les structures historiques, culturelles, politiques et économiques peuvent ou non créer un environnement favorable à l'émergence et à la diffusion de la politique (Edwards and Di Ruggiero, 2011). Nous invitons des socio-anthropologues et des politologues à tester le cadre des ED tout en employant des approches méthodologiques différentes : il serait pertinent d'adopter une approche

prospective sur ces processus de diffusion, par une ethnographie complète dans les OI productrices et actrices de ces processus, notamment pour rendre compte des structures citées précédemment. De même, il serait intéressant d'utiliser ce cadre dans des analyses politiques comparatives approfondies entre pays.

Mise en perspective des résultats avec d'autres études empiriques

Dans le cas du FBP, on a démontré que, contrairement à ce qui pourrait se passer dans tout contexte polycentrique (donc concurrentiel), les acteurs ont eu plutôt tendance à travailler les uns avec les autres (même s'il y avait quelques voies dissidentes au modèle standard de FBP promu par la Banque mondiale, *versus* d'autres modèles de FBP potentiellement mieux contextualisés, comme le FBP *à la malienne*), créant des alliances pour avoir plus d'impact sur la diffusion de la politique. On peut ainsi parler d'une communauté épistémique de FBP assez consensuelle, composée d'ED (qui partagent un même système de représentations, forgée par une même trajectoire professionnelle, et des intérêts convergents), mais aussi de financeurs, promoteurs et praticiens africains du FBP, pour la plupart membres de la Communauté de Pratique du FBP. Sur les politiques éducatives au Sénégal, on observe un phénomène similaire, avec des acteurs sénégalais qui "ont travaillé sur les mêmes projets, ont reçu les mêmes formations à l'étranger et se sont côtoyés au sein des cabinets ou dans les services centraux des ministères" (Charton, 2015, p. 62). Ces acteurs sénégalais nourrissent des liens entre eux et forment ainsi une communauté épistémique consensuelle. Ainsi, les membres d'un réseau politique se "convertissent" à une idée politique notamment parce qu'ils partagent les mêmes cultures professionnelles, issues "des prescriptions internationales et alimenté[e]s par les expériences nationales" (Delville, 2018, p. 70).

En revanche, ce qui est spécifique au cas du FBP, c'est que les membres (locaux) de la communauté ne s'arrêtent pas à la promotion de la politique dans leur pays. Beaucoup deviennent les acteurs centraux de la diffusion dans la région, agissant comme experts internationaux du FBP sollicités pour appuyer les gouvernements de pays voisins. Ce processus a aussi été identifié dans l'étude de la diffusion des mutuelles de santé. Des auteurs relèvent une "'communauté épistémique' d'experts de la mutualité, nationaux et internationaux, dont l'appartenance ou le rôle a pu évoluer au fil du temps (agents de l'Etat, agents de la coopération, notamment d'*Abt*

Associates, consultants externes, chercheurs, etc.)" (Deville et al., 2018, p. 3). Comme dans cet exemple, la place des ED africains évolue avec le temps : de simples praticiens impliqués dans les premiers pilotes de FBP au Rwanda et au Burundi (ex : comme médecins-chef de district), ils occupent progressivement des places plus importantes au niveau institutionnel dans leur pays, et sont enfin consacrés en ED de seconde génération, agissant comme acteurs de la diffusion du FBP dans d'autres pays africains. La fabrique de ces experts traverse tous les niveaux de la hiérarchie politique (du niveau décentralisé jusqu'au niveau global) et dépasse les frontières entre administration et acteurs privés d'une part, et décideurs et experts d'autre part (Delville, 2018). Comme nous l'avons montré dans le chapitre 5, ce phénomène de fabrique d'ED de seconde génération doit aussi être envisagé dans toute sa complexité : il sert les intérêts des ED agissant au niveau global (qui promeuvent un FBP conduit par les experts africains), et ces ED permettent, dans la plupart des cas, de valider leur légitimité sur la scène de la GSM (par la formation et de multiples formes de valorisation de leur expertise), et de financer la progression de leurs carrières. Dans ce contexte, le rééquilibre des pouvoirs entre ED des pays à haut revenu et ED des PFMR est tout à fait relatif.

Bien que ces processus aient échoué à remettre en question l'économie politique de la GSM, la stratégie consistant à valoriser et passer par des intermédiaires locaux semble avoir porté ses fruits en termes de diffusion politique (Gautier et al., 2018b). Cette réflexion nous amène à suggérer une nouvelle proposition : l'ancrage politique local et la promotion de praticiens africains contribuent à la diffusion des politiques de façon plus légitime, et possiblement plus efficace, que le simple transfert de politiques Nord-Sud. De futures recherches – y compris en dehors du domaine de la santé mondiale – devraient examiner plus avant la fabrique réussie d'ED agissant aux niveaux continental et national, et le rôle joué par les ED de niveau global promouvant une politique donnée, dans cette fabrication.

Cette thèse révèle également de nombreux enjeux autour de la (co)production des savoirs, des discours et de l'expertise du FBP. La conduite d'un agenda d'apprentissage par les ED – via des guides et standards structurés, des formations internationales, des plateformes (blogs, forums) d'échanges d'expérience sur le FBP, un répertoire de pratiques cohérent (promu par la CoP FBP), et des évaluations d'impact – suggère une volonté de contrôle des flux d'information sur le FBP.

Comme dans le cas de la diffusion de la nouvelle gestion publique, un groupe d'élites a contrôlé et dirigé le flux de connaissances sur cette réforme particulière, facilitant ainsi le consensus autour de celle-ci (Common, 1998a). Or, le fait que certains ED soient à la fois promoteurs et producteurs de savoirs scientifiques et tacites sur le FBP pose des biais importants quant à la validité du savoir produit. La mise en avant d'expériences réussies de FBP, comme celle du Rwanda notamment, est utilisée à des fins d'émulation politique (voyages d'étude, article du *Lancet* érigé en *proof of concept* (Basinga et al., 2011), etc.) : on assiste à une certaine politisation des savoirs qui sert les fins de promotion et diffusion du FBP (Gautier and Ridde, 2018).

Paradoxalement, cet agenda d'apprentissage participe en même temps à la dépolitisation des savoirs sur le FBP par les experts qui en font la promotion, comme dans (Cussó and Gobin, 2008). En effet, les débats sur le FBP (dans les forums, ateliers, etc.) se concentrent sur ses aspects techniques (ex : vérification et contre-vérification, principe de séparation des fonctions) et le choix d'indicateurs quantitatifs et qualitatifs de performance, plutôt que sur la pertinence sociale et politique du dispositif. Le vaste appareil d'évaluation d'impact (conçu par la Banque mondiale) s'est d'ailleurs prioritairement attaché à analyser certains de ces indicateurs, au détriment des processus de mise en œuvre ou de la pérennisation de l'approche (IOD PARC, 2018). La méthode d'évaluation utilisée tout d'abord – les essais contrôlés randomisés – a fait l'objet de multiples critiques quant à sa validité (interne et externe) lorsqu'elle est employée pour évaluer des interventions complexes (Bédécarrats et al., 2017). Ensuite, la sélection des indicateurs à évaluer soulève l'épineux problème d' "*attribute substitution*" qui consiste à choisir ce que l'on peut mesurer (ex : taux de couverture vaccinale) au lieu d'examiner ce qui pourrait être plus significatif (ex : interactions sociales ou structures sous-jacentes) dans les sociétés (Parkhurst, 2016).

Ainsi, comme dans le cas du transfert des normes de régulation des substituts de lait maternel à l'OMS, des entreprises de politisation et de dépoliticisation du savoir coexistent (Guilbaud, 2017). La littérature sur l'assurance santé sert également de point de comparaison utile pour illustrer ce paradoxe. Le Bureau International du Travail (BIT) et la *Micro Insurance Academy* ont publié divers manuels inspirés de *success stories*, décrivant de manière détaillée comment

développer et mettre en œuvre des régimes d'assurance dans les PFMR (Dror and Jambhekar, 2015; International Labour Organization, n.d.). Ces organisations ont également apporté leur soutien à des voyages d'étude dans des pays connaissant des succès en matière d'assurance (ex : RSBY en Inde ou Asmade au Burkina Faso). Le BIT a même mis au point un guide pour l'organisation de voyages d'étude (Steinmann, 2010). Tous ces éléments soulèvent des questions cruciales concernant le rôle des appareils d'apprentissage "construits", pilotés de l'extérieur, visant officiellement à l'élaboration de politiques reposant sur des données factuelles, et appellent à des recherches plus approfondies. La diffusion des mutuelles de santé, en particulier, a généré elle aussi des tensions autour de l'influence d'acteurs extérieurs sur l'adoption de modèles prédéfinis, au Sénégal par exemple (Alenda-Demoutiez, 2017). Les dispositifs "clés en main" (comme le FBP) visant la CSU dans leur ensemble pèchent par cette vison verticale (*top-down*) de l'action publique dans les PFMR, largement dominée par les bailleurs de fonds (Boidin, 2018).

Peut-on pour autant encore affirmer que "qui paye décide" pour reprendre l'adage de l'ouvrage (Vinokur, 2007) ? Le financement du FBP, à travers le fonds HRITF (géré par la Banque mondiale) notamment, est perçu comme une condition nécessaire mais pas suffisante à la diffusion. Les ressources matérielles générées par ce vecteur ont eu pour effet principal de rendre possible la réalisation de l'agenda des ED. Mais au Mali par exemple, les ressources matérielles à elles seules n'auraient pas suffi à susciter l'émulation des acteurs. La place de l'interaction sociale, qui passe par des processus d'émulation, la (co)construction de discours et de savoirs, et une histoire commune autour de l'expérience du FBP, est centrale dans la diffusion du FBP en Afrique. Pour améliorer notre cadre conceptuel, nous pourrions nous inspirer de la sociologie relationnelle, qui aide à développer une compréhension plus dynamique et plus interactive des politiques ou interventions (Craig et al., 2018).

Au final, la diffusion du FBP mobilise des discours qui prévalent dans l'arène de la GSM, comme celui qui consacre l'idée, avancée par la Commission Macroéconomie et Santé de l'OMS, qu'investir dans la santé rapportait des bénéfices économiques (Waitzkin, 2003). Le langage économique des ED du FBP reflète comme on l'a vu dans le chapitre 4 des systèmes de représentations et une culture également ancrés en sciences économiques. Il révèle aussi une tendance des ED à considérer la prestation de soins de santé comme un "produit du marché"

plutôt que comme un bien public (Labonté and Gagnon, 2010). Cette tendance se reflète dans le framing par la Banque mondiale (conjointement avec la Fondation Rockefeller) de l'"*investment case*" pour la CSU, approuvé par de grands économistes (Summers, 2015). Or, tant que les considérations économiques continueront à dominer "en lieu et place des valeurs de solidarité et de bien commun" (Boidin, 2016), les institutions influentes (y compris les acteurs financiers) qui se réclament de ce discours resteront les acteurs privilégiés de la GSM. Ils auront tout le loisir de continuer à dessiner les contours de politiques visant la CSU qui reproduisent ce discours (comme le FBP, qui se focalise sur des indicateurs quantitatifs "rentables") et de conduire l'agenda d'apprentissage autour de ces politiques (tout en les faisant apparaître comme co-construites). Les recherches en politiques publiques transnationales qui s'intéressent à la circulation des idées dans les arènes de gouvernance globale ont donc un bel avenir devant elles (Harmer, 2011).

Réflexions personnelles

Cette section inclut plusieurs parties d'un article publié dans un hors série des *Cahiers REALISME* sur la réflexivité des jeunes chercheur.e.s en santé mondiale (Gautier, 2018).

Suite à ma formation en sciences politiques et en économie de la santé, j'ai eu plusieurs expériences de collecte de données qualitatives auprès des différentes catégories d'acteurs de la santé mondiale. Il m'est apparu important de mieux saisir la distance qui sépare les "détenteurs d'influence" de la GSM (ceux que l'on appelle aussi les *élites*) et les communautés bénéficiaires des politiques insufflés par les premiers. Dans cett thèse, je me suis intéressée aux élites : leurs trajectoires et pratiques constituaient pour moi une boîte noire que je souhaitais contribuer à ouvrir. Sans être tout à fait biographique, mon approche a donc été similaire à celle employée par Charton (Charton, 2015), qui visait à reconstituer les trajectoires professionnelles de répondants rejoignant une communauté épistémique, en insistant notamment sur les logiques de construction de carrière de ces répondants.

Afin de créer un espace d'interaction équilibré, il me fallait prendre de l'assurance et trouver des stratégies pour que la relation avant, pendant et après l'entretien avec les élites soit équilibrée et permette de générer des données exploitables, dépassant le politiquement correct. Peu de

chercheurs en sciences sociales se sont penchés sur l'équilibre des pouvoirs au sein des interactions entre jeunes chercheurs et élites, et aux phénomènes qu'ils font émerger (Maertens, 2016; Morris, 2009; Woll, 2006). Le plus souvent, la littérature se concentre sur les aspects méthodologiques (Beyers et al., 2014; Goldstein, 2002; Harvey, 2010; Leuffen, 2006). Il peut donc être pertinent de nourrir le débat par quelques réflexions sur les manières dont la collecte des données auprès des élites ont fait évoluer ma posture de jeune chercheure en santé mondiale.

Une opportunité s'est présentée : une grande messe de la recherche en santé mondiale se tenait, à laquelle participaient les élites que je souhaitais interroger. J'ai alors contacté ces personnes préalablement par courriel, les informant que je souhaitais les rencontrer après leurs sessions. J'avais conscience que ces grandes conférences constituent des espaces privilégiés de réseautage, réseautage qui se déroule pendant les pauses : ces moments libres que j'appelle des "fenêtres d'interaction *in situ*". Ces fenêtres m'ont donné la possibilité d'approcher et de planifier un entretien avec six répondants-élites.

Toutefois, il ne s'agissait que de mes premiers entretiens de thèse : mon positionnement était encore balbutiant. Il fallait, comme dans Woll (Woll, 2006), connaître les perceptions que ces élites pouvaient avoir de ma recherche, afin de pouvoir adapter mon message introductif et construire l'interaction sur une base équilibrée. J'ai donc adapté le contenu du texte d'introduction de ma recherche et transformé mon discours d'approche de façon à apparaitre comme chercheure distanciée du phénomène que j'étudiais. J'ai pu observer l'effet de ces stratégies sur mes répondants : l'équilibre dans l'interaction s'est alors construit de lui-même. On me respectait pour ma neutralité et l'intérêt que je portais au phénomène étudié. L'entretien devenait un espace créateur de données de plus en plus riches. Par la suite, la stratégie d'échantillonnage boule de neige a fonctionné à merveille : ces premiers répondants m'ont donné accès à plusieurs de leurs contacts dans ces organisations internationales. Les personnages centraux de ma recherche se voyaient rassurés par le fait que j'aie déjà rencontré un ou plusieurs de leurs proches collègues. Cette relation de confiance s'est renforcée par la suite quand j'ai continué à communiquer avec les répondants, à l'occasion notamment de séances présentielles ou notes électroniques de restitution de résultats (préliminaires ou finaux). En leur transmettant mes résultats préliminaires, je les invitais à les commenter et ne manquais pas d'inclure leurs

commentaires dans mes analyses. La plupart des 57 répondants m'ont ainsi adressé leurs félicitations pour le travail accompli, et certains ont souligné la nuance dont je faisais preuve dans mes analyses. Ces stratégies d'interaction continue avec les répondants, outre leur effet d'améliorer la crédibilité et la confirmabilité de mes résultats, ont également servi à affermir ma posture de jeune chercheure à l'aise dans l'étude des élites.

Au sein de la fenêtre d'opportunité *in situ* qui s'était offerte au départ, deux éléments ont joué un rôle majeur dans ma capacité à recruter les répondants : premièrement, dans cette conférence, il était clairement plus facile d'intercepter les personnes qui m'intéressaient parce qu'elles se trouvaient en dehors de leur espace de pouvoir habituel. Deuxièmement, le fait que les répondants me réfèrent à d'autres élites ajoutait de la crédibilité à ma stratégie d'approche : le fait d'avoir interrogé dès le départ des personnalités positionnées comme "nœuds intermédiaires" du réseau social des acteurs qui m'intéressaient a été déterminant dans mon recrutement des répondants, y compris au Mali. Finalement, à un certain moment et malgré moi, je me suis retrouvée au sein de ce réseau, ayant gagné en assurance, en expertise, et en crédibilité vis-à-vis des répondants. La véritable leçon de cette expérience est plutôt ironique : cet apprentissage de l'entrevue avec les élites n'est que le reflet de la réalité de la pratique en santé mondiale : c'est le réseau social et l'acquisition de pouvoir (savoirs, expériences, réputation/crédibilité) qui ouvrent des opportunités…

Une fois insérée dans ce réseau malgré moi, j'ai dû aussi revoir ma posture de chercheure devant la réémergence de débats polarisés sur le FBP (Paul et al., 2018), dans lesquels s'affrontaient des chercheurs "anti-FBP" et une communauté de "pro-FBP" qui avait généreusement pris le temps de participer à mes entretiens. J'estimais que la publication d'un article co-écrit par l'un de mes directeurs de thèse et des collègues remettant fortement en cause le FBP m'avait, alors que je venais de clore ma collecte, mise dans une position inconfortable. Je refusais alors de commenter le débat, affirmant que ma thèse avait pour objet l'analyse critique de la diffusion du FBP (à travers l'analyse de l'économie politique), et non du FBP lui-même, de ses points aveugles, atouts et faiblesses. On m'avait proposé de rejoindre les auteurs de cette publication, mais j'ai décliné car, au delà des préoccupations éthiques vis-à-vis de mes répondants, l'approche de publier un article mêlant plaidoyer et recherches (faites, dans leur grande majorité, par des

chercheurs du Nord) m'apparaissait problématique. Avec le recul, aujourd'hui je pense que cet article reflète aussi une économie politique de la GSM inchangée. Ce sont des chercheurs, des experts, des réseaux et des organismes basés au Nord, qui continuent à contrôler les termes du débat en santé mondiale.

J'estime ainsi que ma réponse à ce débat se situe dans la présente thèse, qui ne relève pas du plaidoyer (pour ou contre), mais qui analyse de façon nuancée des processus de diffusion qui font émerger de multiples formes d'influences, et beaucoup de déséquilibres de pouvoirs entre les acteurs. En ce qui concerne le FBP lui-même, ce qui ressort de mes analyses d'entretiens, c'est finalement un contenu assez uniforme, avec des praticiens et des promoteurs qui (re)connaissent les forces et faiblesses de cette approche. Même les répondants employés par le plus gros bailleur du FBP – dont l'approche de diffusion est critiquée dans cette thèse à bien des égards – adoptaient un discours plutôt nuancé. Malgré un évident ancrage dans les mouvances des théories néolibérales, comportementales, et de la "mise en chiffres" des prestations de santé, le FBP a au moins eu le mérite de souligner des problèmes (ex : s'assurer que l'argent parvienne effectivement au centre de santé le plus éloigné; ou saisir la complexité de la motivation des agents de santé (Lohmann et al., 2016), etc.) auxquels personne auparavant n'avait vraiment voulu s'attaquer.

Néanmoins, peu importe ce qu'on pense du FBP, car il ne disparaitra probablement pas. Les débats actuels sur le développement d'un nouveau projet de FBP avec de multiples acteurs internationaux au Mali montrent que même lorsqu'il s'arrête pendant un moment, il est susceptible de reprendre. Dans un seul pays africain (Bénin), il a disparu. Les conséquences du retrait sur la prestation de santé peuvent être négatives, mais n'est-ce pas le cas à chaque fois qu'une nouvelle intervention est introduite quelque part et disparaît (Ridde et al., 2006; Samb et al., 2013)? Il sera aussi probablement appelé différemment (à l'OMS, et au Burkina Faso, on le décrit comme un point d'entrée pour l'achat stratégique), mais il existera toujours sous une forme ou une autre. Même si les preuves scientifiques sont mitigées quant à ses effets (quoique, les devis d'étude sophistiqués choisis pour évaluer une politique aussi complexe n'aient pas été toujours pertinents : voir Gautier and Ridde, 2018) et sa mise en œuvre (quoique, nous manquons encore d'évaluations de l'implantation d'un projet de FBP non voué à l'échec dès le départ

compte tenu des circonstances de mise en œuvre, comme au Mali et au Burkina Faso). Ainsi, plus d'un an après la publication notoire de Paul et al. (2018), nous parlons toujours du FBP car il y a encore beaucoup à dire sur cette politique, tout en s'efforçant de dépasser les débats fortement politisés de 2018. Il s'agirait d'analyser cette politique avec moins de passion, plus de nuance et surtout, en restant à l'écoute des problèmes propres aux PFMR (à condition qu'ils ne soient pas non plus portés par les ED agissant au niveau global) et en les laissant faire émerger des solutions contextualisées (décolonialisées ?) pour les systèmes de santé.

Conclusion

Cette recherche constitue la première tentative d'exploration détaillée de processus multiniveaux et protéiformes (idées, savoir, réseaux) conduits par des acteurs influents – les entrepreneurs de la diffusion – afin de faciliter l'expansion d'une politique (le FBP) dans un contexte particulier : celui de la gouvernance polycentrique. Cette étude réemploie des concepts et liens déjà présents dans la littérature, et propose de nouvelles perspectives émergeant de façon empirique, ancrées dans le contexte de la santé mondiale et de la gouvernance polycentrique. Nous faisons également la démonstration que le cadre conceptuel des entrepreneurs de la diffusion est transférable au sein de différents devis de recherche. Cette thèse suggère également des pistes de recherches ambitieuses sur la fabrique des experts africains et le positionnement stratégique d'organisations et d'individus influents – consultants, chercheurs, etc. – dans la (co)production et la circulation des savoirs en santé mondiale et sur l'aide au développement de manière plus générale. Dans ces processus, la place des acteurs privés à but lucratif (ex : les sociétés de conseil et de formation) basés dans les pays à faible et moyen revenu serait très intéressante à analyser. L'étude des liens entre ces entités basées dans ces pays, et celles qui viennent des pays à haut revenu, comme ceux qui unissent des sociétés de formation au FBP africaines à l'incontournable hollandaise *SinaHealth*, serait également une piste à explorer.

Compte tenu du manque d'études sur le phénomène de polycentrisme, et de ses effets sur l'économie politique des acteurs (plus ou moins puissants) de la GSM, continuer à documenter les processus de diffusion des politiques en tenant compte de l'économie politique en présence apparaît essentiel. Pour l'avenir de la recherche sur la diffusion des politiques de santé dans le

contexte polycentrique de la GSM, il conviendrait de s'intéresser aux interactions sociales entres experts des pays à haut revenu et acteurs des pays à faible et moyen revenu, et comment celles-ci sont construites comme et révèlent (ou non) des formes plus légitimes de diffusion politique, moins verticales (*top-down*) et plus adaptées aux contextes des pays à faible et moyen revenu.

Pour cela, il pourrait s'avérer opportun d'utiliser le cas du mouvement visant la couverture santé universelle, qui continue à faire des émules dans le monde entier. Dernier cas en date (fin février 2019), le Ministre de la Santé et de l'Hygiène Publique du Mali vient d'annoncer la gratuité des soins pour les femmes enceintes, les enfants de moins de cinq ans, et les personnes âgées de plus 70 ans (Diarra, 2019). Cette annonce prometteuse révèle en fait de fortes asymétries de pouvoir, au travers desquelles les seuls acteurs américains (experts d'une ONG américaine) semblent jouer un rôle clé.

Liste d'acronymes

AEP : Analyse de l'économie politique
BIT : Bureau International du Travail
CoP : Communauté de pratique (*Community of Practice*)
CSU : Couverture santé universelle
ED : Entrepreneur(s) de la diffusion
FBP : Financement basé sur la performance
GSM : Gouvernance de santé mondiale
HRITF : *Health Results Innovation Trust Fund*
OMD : Objectif du Millénaire pour le Développement
PFMR : Pays à faible et à moyen revenu

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List of abbreviations

ASACO : Association de santé communautaire (*ComHA* in English)

BI: Bamako Initiative

CGIC: Clinique de Gestion et d'Innovation des Connaissances

ComHA(s): Community Health Association(s)

CoP: Community of Practice

DE(s): Diffusion entrepreneur(s)

DfID: United Kingdom's Department for International Development

DHMT(s): District health management team(s)

DRC: Democratic Republic of Congo

ECD : Equipe Cadre de District (i.e., *DHMT* in English)

EU: European Union

FBP: Financement basé sur la performance (i.e., *PBF* in English)

GAVI: Global Alliance for Vaccines and Immunization

GHG: Global health governance

HD: Health districts

HIC(s): High-income country(ies)

HPSR: Health Policy and Systems Research

HRITF: Health Results Innovations Trust Fund

IDA: International Development Association

IFIs: International financial institutions

ILO: International Labour Organization

KIT: Koninklijk Instituut voor de Tropen (*Royal Tropical Institute*)

KR: Koulikoro region

LMIC(s): Low- and middle-income country(ies)

MDG(s): Millennium development goal(s)

MDG5: Millennium development goal 5 to improve maternal health

MoH: Ministry of Health

MSH: Management Sciences for Health

MSHP: Ministère de la Santé et de l'Hygiène Publique (i.e., *Ministry of Health and Public Hygiene* in English)

NGO(s): Non-governmental organisation(s)

NORAD: Norwegian Agency for Development Cooperation

NPM: New public management

P4P: Pay-for-performance

PBF: Performance-based financing

PCU: Project coordination unit

PEA: Political economy analysis

PRSR : Projet de renforcement de la santé reproductive (i.e., *SRHP* in English)

RBF: Results-based financing

SDG(s): Sustainable development goal(s)

SNA: Social network analysis

SNV: Stichting Nederlandse Vrijwilligers (*Netherlands Development Organisation*)

SRHP: Strengthening reproductive health project

SSA: Sub-Saharan Africa

UHC: Universal Health Coverage

UCP : Unité de Coordination du Projet (i.e., *PCU* in English)

UN: United Nations

UNICEF: United Nations Children's Fund

USAID: United States Agency for International Development

WB: The World Bank

WHO: The World Health Organization

WPR: What's the problem represented to be

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Twenty years ago, there was a greater confidence than now that 'solutions' to health systems challenges could be found and widely implemented. The notion that it is possible, at the global level, to define policies and strategies of more or less universal relevance would be strongly contested today. (Bennett et al., 2018, p. 3)

Chapter 1. General Introduction

1.1 Foreword — Study rationale and objective

Study rationale

Power distribution between actors of global health governance has typically favoured North American and European public and private entities (Airhihenbuwa, 2006). In spite of many new categories of players joining the competitive global health arena (e.g., transnational networks), these North American and European actors have consistently been leading the diffusion of global health policies. Recently, however, calls for strengthening the leadership and participation of traditionally less powerful actors (including governments and populations receiving development assistance for health) have received more attention (Barnes et al., 2014), especially since the rhetoric of "country ownership" became mainstream in all development cooperation governance arenas (Ng and Ruger, 2011; OECD, 2005). Whether and how these calls have translated into a certain rebalance of power in global health governance remains strongly debated (Barnes et al., 2015; Buiter, 2007; Harmer, 2012; Sjöstedt, 2013).

The power dynamics in global health governance calls for original, interdisciplinary approaches to make sense of the ways through which health policies diffuse across space and time within this increasingly crowded landscape (Brown et al., 2014; Tosun, 2017). Lying at the intersection of public policy, sociology, international relations, and health policy and systems research fields, this thesis sheds a new light on the diffusion of health policies by emphasising the

interdependency of policy actors shaping the diffusion process. We unravel *how* not only international organisations', but also networks' and individuals' multiple forms of power originate and manifest. We investigate power in global health using the case of the diffusion of a health financing policy innovation — performance-based financing — in sub-Saharan Africa. Specifically, we use a political economy approach to explore the social interactions at play in the diffusion process between actors across global/continental/national levels, and the asymmetrical power relations embedded within those interactions.

The unusually fast and large expansion of performance-based financing (PBF) in sub-Saharan African countries, and the recurring debates on the relevance of diffusing PBF in this region (Manitu et al., 2015; Paul et al., 2018), make it a particularly thought-provoking study object. PBF diffusion represents an opportune research object because it mobilises a wide range of actors that are representative of the major players who typically engage in power disputes in global health governance arenas, including international donors, international non-governmental organisations, transnational networks, consultants, private companies, and developing countries' policymakers (Barnes et al., 2015).

The key policy actors forming part of our political economy analysis of PBF diffusion include: 1) dominant international organisations with strong financial power and political influence; 2) Western Europe- and North America-based individuals (and the global health transnational networks they champion) with international expertise, seeking to increase their recognition in global health political arenas — making them dependent on international organisations; and 3) individuals based in sub-Saharan Africa who may be members of transnational networks, seeking career advancement through their acquisition of international expertise — making dependent on both international organisations and North-based individuals. A large fraction of these players strategically craft the PBF policy and its diffusion in the language of "African participation" and Africa-led processes (Barnes et al., 2014).

General objective

This thesis broadly aims to contribute to the advancement of the political economy of diffusion in global health. It offers critical insights into seeming attempts to rebalance the political economy

of global health governance, whereby major global health policy actors market a policy (performance-based financing) in ways that prominently feature Africa's participation in policy diffusion efforts. This thesis questions the authenticity of such framing by analysing European and North American actors who conceived the PBF policy and strongly engaged in its diffusion, and then by unraveling their interactions with African policy actors along the diffusion process.

This introductory chapter unfolds as follows: first, we provide the general background for this doctoral research; second, we review the literature to identify the research gaps associated with our research focus — namely the political economy of global health policy processes; third, we explain how our own background connects with these concerns about power in global health and the field of health policy and systems; fourth, we describe our study object, i.e. the diffusion of performance-based financing; fifth, we present our research question and the general architecture of the thesis; and finally, we provide clarifications and definitions for key concepts used in this thesis.

1.2 Background for this research

A crowded global health governance

For the past twenty years, global health governance has significantly expanded. The Commission on Global Governance (1995), defines governance as follows:

> The sum of many ways individuals and institutions, public and private, manage their common affairs. […] It includes formal institutions and regimes empowered to enforce compliance, as well as informal arrangements that people and institutions either have agreed to or perceive to be in their interest. (Commission on Global Governance, 1995, p. 2)

Global governance involves a variety of unequally powerful actors and their interests.

In the health sector in particular, the pluralism of actors has added complexity to the policymaking landscape (Janes and Corbett, 2009), and has been challenging the role of the state as the central actor of decision-making (Boidin, 2017; Kelly, 2010). Global Health Governance (GHG) mobilises units of government, including increasingly influential global public and private actors. Among the public players in GHG are multilateral international organisations (United Nation system: e.g., the World Health Organization; international financial institutions:

e.g., the World Bank), and bilateral cooperation agencies (e.g., USAID). Private non-profit actors include non-governmental organisations (NGOs), philanthropic foundations (e.g., the Bill & Melinda Gates Foundation), think tanks (e.g., the Center for Global Development), and large public-private partnerships (e.g., the Global Fund to Fight AIDS, Tuberculosis and Malaria; and the Global Alliance for Vaccines and Immunization, GAVI). There are also many private-for-profit transnational corporations (e.g., consulting firms such as *McKinsey & Company*). These traditional actors are based in or largely dominated by high-income countries (Easterly and Pfutze, 2008; Whitfield, 2009).

Bringing in the concept of polycentric governance

The polycentric nature of GHG makes the entrance of non-traditional policy actors possible (Tosun, 2017). **Polycentric governance** is "a system of government in which many 'centres' have decision-making autonomy but adhere to an overarching set of rules to aid cooperation" (Cairney et al., 2019, p. 7). It is important to distinguish polycentric governance from multilevel governance, which conceives individual centers to be nested in a structure (Gautier et al., 2018b). In GHG, non-traditional actors include transnational networks (e.g., Providing for Health, P4H) and "international experts" (e.g., development economists, consultants in public health) who have acquired public authority in the GHG arena and in low- and middle countries (LMICs) (Shiffman, 2014; Stone, 2008). The influence of these actors involves setting the policy agenda notably by "select[ing] issues over which [they] ha[ve]it has relative control" (Cairney et al., 2019, p. 8). Crucially — and this is particularly true for non-traditional policy actors — they carefully cultivate their image.

While these new players likely have a strong political influence, their financial influence remains limited compared to that of traditional GHG players, who for the most part act as donors of global health assistance — and who fund directly or indirectly the actions of these new actors. Conversely, traditional policy actors need the political support of influential networks and individuals to enhance their legitimacy on the GHG arena, and fuel powerful ideas in territories where their image is perhaps not the strongest. Some global health networks (e.g., *Roll Back Malaria*) are even governed by traditional GHG actors because this model serves their interest to expand outreach (Shiffman, 2017).

Because of the interdependency between traditional and non-traditional actors, GHG is an "interdependent system of relations" (Ostrom et al., 1961, p. 831). GHG actors' governing takes place through shaping policies, norms, reports, goals — such as the *Millennium Development Goals* and the *Sustainable Development Goals* — in the context of a distance sovereignty.

Such a crowded and complex GHG configuration raises questions about the position occupied by developing nation-states and the potential for voicing their own issues and concerns. The distance and number of intermediaries between offices in Washington DC and LMICs' ministries of health — not to speak of isolated health centers in Sahel villages — continues to enlarge (Suárez-Herrera, 2012).

A political economy analysis of polycentric GHG

Many reflections on power emerge spontaneously from describing polycentric GHG. It is possible to spot political and financial inequalities between LMIC policymakers and multilateral international organisations (who exert a strong normative authority through their shaping of global policies); and between transnational networks and individual experts on the one hand, and donors on the other hand.

To shed light on these issues, the political economy analysis of the GHG is a relevant tool for researchers. Political economy analysis (PEA) is "concerned with the interaction 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" (OECD, 2009, p. 1). While the body of literature on global health using PEA has increased in recent years (Boidin, 2016; Participants at the Bellagio Workshop on Political Economy of Global Health, 2015), to our knowledge no PEA has focused specifically the polycentric context of GHG.

PEA is, first and foremost, about studying power. We utilise the following definition for power: "the production, in and through social relations, of effects that shape the capacities of actors to determine their circumstances and fate" (Barnett and Duvall, 2005, p. 39). These authors identify

four main forms of power in global politics as outlined in Barnett and Duvall (2005): *compulsory power*, i.e. power as relations of interaction of (direct) control by one actor over another, such as modern slavery; *institutional power*, i.e. how dominant actors exercise (indirect) control over others through institutional arrangements that may include the use of rewards and punishment[2]; *structural power*, i.e. how actors define themselves in relationship to others, "in ways that enhance the capacities of some and limit those of others" (Shiffman, 2014, p. 297); and *productive power*, i.e. how actors "create meaning, particularly through the use of categories that lead [them] to think about the world in some ways but not others" (*ibid.*). Another widely accepted taxonomy of power in social sciences is Lukes', whose work highlights a three-dimensional approach to power: decision-making power, non-decision-making power, and ideological power (Lukes, 2005). However, many scholars agree that both of these taxonomies of power only feature the idea of *power over* others, in the sense that a dominant actor's actions affect the ability of other actors to control the conditions of their own actions (Haugaard, 2012). According to many analysts, the idea of *power to* do something (e.g., referring to actors' ownership of key resources or capital; Bourdieu, 1986) enabling them to exert power) is lacking. Power to is critical because it is premised on power *over*. Thus *power to* is central to the study of GHG from a political economy analysis perspective.

We found Barnett and Duvall's taxonomy of power useful for a PEA of polycentric GHG because, unlike other existing typologies (including Lukes' as described above and Nye's soft and hard power; Nye, 1990), it sets **actors' interactions** at the core by asking how power gets limited or enhanced through relations with others. On the one hand, both compulsory and institutional forms of power are typically at play in the unequal relationship between high-income countries (HICs) acting as donors funding global health interventions, and LMIC recipients. Sometimes, the donor may use an intermediary such as a consulting firm, a NGO, or a multilateral agency: the control exerted on recipients of funding is in this case indirect. Direct control involves, for instance, donors requesting recipients to draft financial accountability reports and have their modes of governance systematically audited (Shutt, 2012). Indirect control

[2] A useful example of institutional power might be the case of dominant actors (e.g., international donors) setting the political agenda of global institutions, who implement it in ways that benefit or impair other, dominated actors. These institutions *mediate* between the dominant and dominated actors.

includes donors' setting of disbursement targets to intermediaries (Barakat, 2009; Jones, 2012). These examples represent aid instruments of performance measurement (e.g., as detailed in Robinson, 2007) whereby donors exert compulsory and institutional forms of power over other actors, possibly coercively penalising those who do not live up to expectations (Wenar, 2006). On the other hand, both structural and productive forms of power are reflected in the common situation of international consultants coming as advisors to LMIC governments to shape future national policies that respond to their institutions' or own worldviews and problem representations (Cohen, 1992; Olivier de Sardan, 2011; Shiffman, 2014). Setting this typology in global health, Shiffman (2014) emphasises that GHG actors providing technical assistance to LMIC governments features a double assumption that is taken for granted in GHG: 1) the claimed expertise is based on the assumption that LMIC governments actually need their support on particular health topic (structural power); and 2) the exercise of this expertise conveys the assumption that "particular categories [used] to think about health" are valid (productive power). The second assumption reflects the central role of ideas, which "shape our understanding of policy problems, anchor our preferences, express our goals, and inject a sense of purpose to political debate" (Koon et al., 2016). There is a need to construe what ideas shape GHG actors' problem representations because their productive power originates from ideas. While there is a growing body of knowledge that explores how international organisations "actively mobilise their persuasive powers to (re)shape policy preferences, policy agendas, […] and knowledge paradigms" (Fergusson and Yeates, 2014, p. 440), the role played by non-traditional GHG actors is overlooked.

The advice and policy responses provided by GHG actors ought to be understood in the context of these multiple forms of power. Such power is also featured in the concept of "cultural hegemony" (Gramsci, 1985; Lash, 2007). These authors have showed how the system of values and beliefs of those with more institutional and compulsory power ends up shaping mainstream views of what matters — mainstream *norms*. This concept can be used to describe the aforementioned GHG actors, the majority being from Europe and North America. They dominate GHG for two interrelated reasons: 1) their institutional domination within the international organisations' system (Easterly and Pfutze, 2008), and 2) their perpetuation of aid dependency, which reduces the bargaining power of LMICs governments in the international arena and at

home, when making policies in their own countries (Kelly, 2010). Both of these reasons — which reflect compulsory, institutional, and structural forms of power — shape their cultural hegemony. In this thesis, this hegemony is conceived as a continuum: GHG actors need to have compulsory and institutional forms of power (e.g., through funding), and develop a legitimate expertise (structural power), in order to fuel their productive power (e.g., problem representations featured in policies and norms that are promoted).

A study at the intersection of the foundational fields of public policy and health policy and systems research

This thesis primarily draws on the fields of public policy research and health policy and systems research. We accept Birkland's definition of a public policy:

> A statement by government of what it intends to do […], made in response to a problem. […] A policy is ultimately made by governments, even if the ideas from outside government or through the interaction of government and non-governmental actors. (Birkland, 2014, pp. 8–9)

The relationships among GHG actors and between them and LMIC governments draw attention to the ways the former may frame, push forward public policies, and ultimately convince the latter to adopt these policies (Cox, 1987), such as policies reintroducing user fees for patients in LMICs (Lee and Goodman, 2002).

The dynamic and relational process described in the previous paragraph features the field of policy diffusion, which is central to this doctoral thesis. Policy diffusion scholars study how policies emerge in some political units and subsequently spread to other units (Tosun and Croissant, 2016). Along with policy diffusion, it is possible to identify three sister literatures: lesson-drawing (Rose, 1993), policy transfer (Evans, 2004), and policy convergence (Drezner, 2001). Lesson-drawing scholars study the circumstances and the extent to which an effective programme or policy may be transferred to another setting (Rose, 1991). Related to lesson-drawing is the field of policy transfer. Originally conceptualised by Dolowitz & Marsh (1996), policy transfer is broadly concerned with unraveling the processes through which policy transfers from one country to another (Dolowitz and Marsh, 1996). Lastly, policy convergence is a research strand that looks at "the tendency of policies to grow more alike, in the form of increasing similarity in structures, processes, and performances" (Drezner, 2001, p. 53). In this thesis, we choose policy diffusion as the foundational field because, as compared to these other

strands of literature, the body of diffusion studies features a coherent and consistent explanatory framework that stresses the importance of various "diffusion mechanisms" (Shipan and Volden, 2008), including policy emulation (i.e., how the adoption of a policy by a — generally reputable — neighbour or similar setting inspires policy actors in other settings to also adopt it) and policy learning (i.e., how information or experience from a setting is used to inform policymaking in other settings). However, empirical research on the diffusion of health policies in LMICs has thus far remained limited (Bennett et al., 2015).

Furthermore, by highlighting the importance of external shocks and "critical junctures" in policymaking, public policy theories — and the diffusion literature in particular (Capano et al., 2015) — have tended to overlook the role played by actors and their capacity to influence the policy process (Hassenteufel and Zittoun, 2017). Possibly as a result, a large fraction of the public policy literature has addressed power issues in a fragmented fashion: each school of thought promotes its own interpretation of power and who may own it (Alasuutari and Qadir, 2014), while the ideational side of power relations is largely overlooked (Béland et al., 2016).

To initiate investigations on how global actors fuel their power in policymaking (especially in LMICs), the field of health policy and systems research (HPSR) is another useful reference (Bennett et al., 2011). HPSR is a research field that "seeks to understand and improve […] how different actors interact in the policy and implementation processes to contribute to [health] policy outcomes" (Alliance for Health Policy and Systems Research, n.d.). Unlike policy diffusion, HPSR is sector-specific, i.e. it is primarily concerned with health issues. The specificity of HPSR scholars is that they are particularly keen on engaging with multiple disciplinary perspectives and theoretical approaches in political and social sciences (Jones, 2018). Despite a growing momentum for HPSR, health sector policy processes — and analyses of power exerted through these processes — do not yet receive adequate research attention (Ghaffar et al., 2016; Lewis, 2006). The bulk of the HPSR literature describes health policymaking in LMICs as a four-part, descriptive, linear process that hardly features power: 1) agenda-setting (or "emergence"); 2) formulation; 3) implementation; and 4) monitoring and evaluation (Stone, 2008). However, in this research, as in others (Lemieux, 2002; Monnier, 1992), we reject the policy cycle approach in favour of a model that would "describe how people interact in their

policymaking environment" (Cairney et al., 2019, p. 6). In addition, there is limited consensus among HPSR scholars on the definition of PEA (George et al., 2014). According to a survey, the most frequent defining components mentioned by HPSR respondents was the fact that PEA was interdisciplinary by nature, and that it entailed an analysis of power dynamics (*ibid*.). The HPSR literature analysing power dynamics in relation to global health policymaking is relatively sparse, since few HPSR authors explicitly refer to PEA to describe their research approach.

Based on these prior observations, we endeavoured to review the literature featuring analyses of global health power dynamics across public policy and HPSR fields. In the next section, we present the results of this review, which specifically looks at power interactions between influential GHG actors as they endeavour to diffuse a given health policy, and LMICs' governments. By doing so, we also highlight the knowledge gaps that sparked the development of this thesis.

1.3 Literature review on the state of knowledge about the issue

Looking at papers published over the past 15 years and located at the intersection of HPSR and public policy literatures, we identify three key areas of study: 1) the state of the current empirical literature at the crossroad between HPSR and policy diffusion fields, and where research gaps remain; 2) how the empirical HPSR literature (including political economy analyses) features donors' influence in policymaking; and 3) how HPSR literature analyses domestic actors' leadership in policymaking and their micro-level interactions with external actors. In each thematic area, we looked for illustrations of the forms of power identified above, in order to feature key analytical elements of political economy. Building on identified research gaps, we then describe the study object and present the research question guiding this PhD thesis.

State of the literature located at the intersection of HPSR and policy diffusion fields

Without going into the specifics of policy diffusion (which we do in the next chapter), we attempt to provide a research snapshot of the literature published over the past 15 years, which features two major fields of interest in this thesis: policy diffusion and HPSR. To avoid excluding potentially relevant literatures, we conceive policy diffusion as an umbrella field, which also

encompasses lesson-drawing (Rose, 1993), policy transfer (Evans, 2004), and policy convergence (Drezner, 2001) literatures. We chose policy diffusion as an umbrella field, because, as compared these other strands of literature, the body of diffusion studies features a coherent explanatory framework that stresses the importance of various “diffusion mechanisms” (Shipan and Volden, 2008), including policy emulation (i.e., how the adoption of a policy by a — generally reputable — neighbour or similar setting inspires policy actors in other settings to also adopt it); and policy learning (i.e., how information or experience from a setting is used to inform policymaking in other settings). Our rationale for choosing the policy diffusion strand of literature is further explained in the next chapter.

Most HPSR authors studying health policy change in LMICs using policy diffusion analytical approaches tend to use the concept policy transfer more often than other commonly used public policy literatures in HPSR (as described in Bennett et al., 2015; Bissell et al., 2011; Cliff et al., 2004; Colvin et al., 2015; Gilson and Raphaely, 2008; Guilbaud, 2017; Ngoasong, 2011; Ogden and Walt, 2003). These authors also refer to a commonly accepted definition of policy transfer (Dolowitz and Marsh, 1996, 2000). One author uses policy transfer and policy diffusion interchangeably (Cherrier, 2016), and two others referred to policy diffusion literature (Ski, 2016; Weyland, 2005). While other authors do not make specific reference to any of these strands of literature, they do look at how policies emerging from elsewhere are adopted in multiple settings.

Authors using the policy transfer literature prominently look at traditional GHG actors’ influence on policy diffusion. Most of this literature refers to structural and compulsory forms of power, without making explicit links to existing power typologies. Newman et al. (2006) compile multiple diffusion modalities: consensus on problem definition; dissemination of GHG expert evidence (WHO’s); uptake of evidence regionally-generated; and financial and technical support “from reputable and respected institutions in drafting new policies and planning for implementation” (Newman et al., 2006, p. 462). Thus all forms of power except productive power are investigated. In Shiffman’s empirical study of a maternal policy named the “safe motherhood initiative” in five countries (Shiffman, 2007), we found an interesting typology of the modes of influence exerted by transnational actors in the diffusion process: norm promotion, and resource provision — which refers to productive and compulsory forms of power. At the

domestic level, local actors engaged in enhancing the cohesion of the policy community, and were stimulated by policy entrepreneurs' actions. There was no mention of structural or institutional forms of power.

Both Shiffman and Newman et al. mention activities promoted by GHG actors to foster policy learning, either through their productive power (e.g., producing norms matching their policy orientations and representation systems) or structural power (e.g., disseminating policy knowledge in multiple arenas). Besides these authors, several other papers reference the influence of activities to foster policy learning, coordinated and/or funded by major GHG players, and designed to foster diffusion (Cherrier, 2016; Cliff et al., 2004; Guilbaud, 2017; Ogden and Walt, 2003; Ski, 2016). In this literature, GHG networks and institutions invite countries to learn scientific evidence about the policy, and acquire policy knowledge through workshops, training, guidelines, and, increasingly, "study tours" whereby country delegates visit other countries to observe their experience with social reforms. Several authors report on the ways GHG actors design these learning activities, and the extent of their uptake by LMIC policy actors (Cherrier, 2016; Cliff et al., 2004). Guilbaud (2017) highlights the potential politicisation of knowledge, which manifests when there is an implicit or explicit push for the policy solutions preferred by GHG actors. In studying the diffusion of pension reforms in Latin America, Weyland (2005) questions the ability of policy actors to "process the relevant information in a systematic, unbiased way" (Weyland, 2005, p. 263). GHG actors who develop learning strategies have seldom considered these possible biases (Hanefeld and Walt, 2015). This feature of productive power was thus under-documented.

Some authors look at the influence of socialisation (e.g. based on interpersonal communications and pre-existing friendships professional relationships) on policy diffusion (Cherrier, 2016; Cliff et al., 2004). Such relations informed the development of coalitions whereby individuals connect (i.e. because they share a common belief system and interests) and gather efforts and knowledge to actively advocate for a given policy. For instance, Cliff and colleagues highlight how European experts who had gained respect from both global and local actors through long-stranding and regular social interactions in their work, were successful in "mobiliz[ing] resources so that collective action can be orchestrated towards the solution of common problems" in

Mozambique (Cliff et al., 2004, p. 46). Authors describe that the compulsory and structural power of GHG actors was somehow “smoothened” through this socialisation, thereby making the transfer of infectious diseases management techniques in this country less top-down than in other settings. However, there is no mention of how their productive power (in particular, of their embedded representations systems) translated in this socialisation.

Other authors specifically study the influence of transnational networks in policy diffusion (Ngoasong, 2011; Shiffman et al., 2016). Ngoasong (2011) employs the concept of “transcalar networks” to explain how the transfer and implementation of HIV policies was shaped by the action of civil society organisations and external donors in Cameroon. While his paper provides useful empirical details, it does not offer new taxonomies or frameworks to analyse networks. Shiffman and colleagues (2016) draw two useful conditions for the effectiveness of transnational networks in raising key issues on the political agenda of GHG: 1) a “compelling” framing of the issue is constructed by members of the issue’s network(s), which share a common understanding of the problem, possible solutions, and “convincing reasons to act”, and 2) the ability of networks’ members to find an adequate “balance” between a focused framing and sustaining a broad coalition that appealed to a wide range of people, including non-health actors and civil society organisations (Shiffman et al., 2016). However, these two conditions may be more relevant for informing analyses on transnational networks (including outside the purview of policy diffusion) that mobilise around key problematic thematic or neglected areas (e.g., climate change), rather than those interested in fostering structural reforms (e.g., health systems reforms). Our review showed that the first category of transnational networks has received much more scholar attention than the second. Further research is needed on policy networks advocating for health systems reforms in LMICs.

An insightful paper offers an interactive model (drawn from the diffusion and transfer literatures) with a wide range of learning, emulation, and communication processes depicting how actors and networks’ proceed to transfer policies at multiple levels and across policy stages (Bissell et al., 2011, p. 1143). Crucially, the model features actors and networks’ resources (human, financial, political, technical, and social resources). While authors also mention power, they do not expand

on this feature. Their model does not include a critical form of power — productive power — or the role of ideas in the diffusion process.

This review showed that there is limited HPSR literature analysing policy diffusion or transfer of policies in LMICs. Most authors also remained primarily loyal to the policy cycle model. Although none of the papers meaningfully analysed the multiple forms of power, one paper pinpointed the importance of GHG actors and networks' resources in the diffusion process (Bissell et al., 2011). Furthermore, this review brought out interesting diffusion processes that feature both productive and structural forms of power — norm promotion and socialisation, in particular. These processes ought to be further investigated.

How does GHG actors' power operate in their attempts to influence policymaking in LMICs?

In order to grasp the state of knowledge about the power of GHG in global health, we also reviewed their influence on health decision-making in LMICs. We analysed selected papers in light of the four types of power defined above: compulsory, institutional, structural, and productive. For efficiency purposes, and as in Shiffman (2014), we merged compulsory and institutional forms of power into the single category of "financial power".

As in most reviews of HPSR literature analysing policy processes (Gilson and Raphaely, 2008), most of the relevant papers featured the health policy triangle (Walt and Gilson, 1994) or Kingdon's multiple streams approach (Kingdon, 2003).

Many studies feature the financial power of traditional GHG actors, featuring both bilateral and multilateral agencies (Basaza et al., 2013a; Chimhutu et al., 2015; Chirwa et al., 2013; Dodd and Olivé, 2011; Falisse et al., 2012; Fischer and Strandberg-Larsen, 2016; Fox et al., 2014; Gilson et al., 2012; Haq et al., 2017; Khan et al., 2017; Khim et al., 2017; Koduah et al., 2015; Masiye et al., 2010; Meessen et al., 2011; Moat and Abelson, 2011; Olivier de Sardan and Ridde, 2012; Paul et al., 2014; Parkhurst and Vulimiri, 2013; Pedregal et al., 2015; Renmans et al., 2016; Ridde et al., 2011, 2012; Shiffman, 2007; Storeng and Béhague, 2014; Torbica et al., 2014; Witter et al., 2013; Zulu et al., 2013). However, few of these authors describe in detail the ways

this material type of influence operates, or refer to the differential degree of negotiation happening between donors and recipient countries (Dodd and Olivé, 2011; Khan et al., 2017; Koduah et al., 2015; Pedregal et al., 2015).

Many authors also refer to structural power, featuring the expertise of GHG actors (deemed legitimate) playing an influential role in LMICs' policymaking (Agyepong and Adjei, 2008; Basaza et al., 2013a; Dodd and Olivé, 2011; Eboko, 2005; Koduah et al., 2015; Lapping et al., 2012; Nay, 2012; Ngoasong, 2011; Parkhurst and Vulimiri, 2013; Pedregal et al., 2015; Robert and Ridde, 2013; Shearer, 2015; Storeng and Béhague, 2014; Zulu et al., 2013). A notable illustration is found in Basaza et al.'s (2013) analysis of the national health insurance scheme (NHIS) policy in Uganda. They describe the influence of the transnational network P4H "work[ing] through the [Ministry of Health] to provide technical support for the NHIS design process as well as implement criteria and strategies" (Basaza et al., 2013a, p. 8). Similarly, drawing on our own original reflections (Sieleunou et al., 2017), authors studying policymaking on performance-based financing describe "a group of policy entrepreneurs from [a major GHG player], through numerous forms of influence (financial, ideational, network and knowledge-based) and building on several ongoing reforms, collaborated with senior government officials to place the PBF program on the agenda" (Sieleunou et al., 2017, p. 1).

Yet, the role of GHG actors' productive power, by fuelling their ideas and assumptions about the world (Eboko, 2005; Nay, 2012; Robert and Ridde, 2013; Shearer, 2015; Storeng and Béhague, 2014), is less frequently mentioned. Robert and Ridde (2013) mention both productive and structural powers as driving the change in the course of health financing policies: "the production and dissemination of scientific evidence on [health care] user fees and the influence of some networks of actors in global health have contributed to [changing the discourse]". Another paper also highlights the discursive influence of scientific and experts' evidence produced and disseminated by donors (Nabyonga-Orem et al., 2014). We further noted that only one paper looks at productive power, i.e. investigating *how*, in order to match with GHG donors' interests, policy advocates' activities "contributed to narrowing the terms of debate about maternal health by restricting the kinds of arguments and forms of evidence that "count" as authoritative" (Storeng and Béhague, 2014, p. 271). HPSR academics ought to shed more light on GHG actors'

productive power, and especially disentangle its origins and multiple manifestations. We ought to address this critical gap in the literature.

LMIC policy actors' leadership in policymaking and their interactions with donors

Mirroring the perspective from the previous section (looking at donors' influence), here we analyse the path of domestic actors identifying with a given policy idea introduced by external actors, and taking the lead in pushing it forward in order to secure policy adoption.

Several authors (Agyepong and Adjei, 2008; Kadio et al., 2017; Onoka et al., 2015; Ridde et al., 2011; Thomas and Gilson, 2004; Torbica et al., 2014) describe the complex processes through which national actors go through to "shap[e] a coherent social policy in a low-income country heavily dependent on international aid" (Pedregal et al., 2015, p. 171). For example, in Cambodia these authors look at how ideas on health sector reform were mobilised by governmental actors to (incrementally) orient the policy debate and formulation (Pedregal et al., 2015). Personal trajectories of LMIC policy leaders (e.g., their training and professional experience) and how those contributed to shape their interest in pushing forward a given health policy were only featured in one paper (Kadio et al., 2017).

We found little insight about the ways these national actors were organised and the extent to which they identified with a policy that had emerged externally. In Kadio et al. (2017) there are detailed accounts into how national actors identify with universal health coverage policies, but the authors do not report on any interaction with external players. Questions remained about local actors' re-framing of externally-driven policies to match national discourses. This gap might be due to methodological challenges: policymakers may not be keen on providing insights on sensitive processes. Whether and how some local actors manage to convince high-level policy actors into policy adoption, therefore, represents an avenue for research.

We noted that governments' interactions with external players do not necessarily undermine government's ownership of policymaking processes. There are reports of these actors working "hand-in-hand" towards policy adoption in policy emergence and formulation phases (Gautier and Ridde, 2017, p. 12), particularly on user-fee removal policies (Meessen et al., 2011; Olivier

de Sardan and Ridde, 2012). Exposition to evidence promoted by GHG players also contributes to shape policymakers' decision-making (Nabyonga-Orem et al., 2014). Yet, apart from institutional meetings and international workshops (Sieleunou et al., 2017), detailed accounts of how social interactions between these unequal players manifest (perhaps even prior to policy emergence) and how these interactions subsequently model policy diffusion in LMICs remain to be unravelled.

Four conclusive remarks on the three literature reviews

The first concluding remark is that, while we found accounts of multiple forms of power (compulsory, institutional, structural, and productive) in the HPSR literature, the emphasis has been set on financial and structural forms of power. While acknowledging the significance of financial and structural forms of power in HPSR — and their implications for policy actors' interactions in the GHG arena — this thesis intends to feature the origins and modalities of productive power more prominently than in previous works.

Second, in studying health policy diffusion in LMICs, authors also failed to look simultaneously at global-level and national-level policymaking while maintaining analytical depth, and overlooked regional and continental processes. In this regard, transnational networks — which can transcend levels of policy influence — provide crucial, yet under-documented, analytical objects.

Third, there is a paucity of literature describing how (sub)national actors are empowered, and what strategies they undertake to foster the spread of a policy idea in their country.

Fourth, we need to develop and test empirically a comprehensive conceptual framework, drawn from the policy literature, which would reflect the different forms of power deployed by GHG actors; and study how they empower their actions to foster policy diffusion, while also taking into consideration the various levels of governance in which policy actors evolve.

1.4 How my interdisciplinary background connects with these concerns about power in global health and the field of health policy and systems research

[Note: In order to link my personal research interests and background to this doctoral experience, I turn to employing first-person pronouns in this section]

By nature, the field of HPSR is interdisciplinary (Robert and Ridde, 2016), blending economics, sociology, anthropology, political science, public health, and epidemiology. Taken together, these disciplines "draw a comprehensive picture of how health systems respond and adapt to health policies, and how health policies can shape − and be shaped by − health systems and the broader determinants of health" (Alliance for Health Policy and Systems Research, n.d.). My personal background lies at the intersection of these fields: training in political studies as initial background (including both sociology and political science), completing a master's in health economics and management (which also included epidemiology courses), enrolling in a PhD programme in public health (in Montreal) and economics (in Paris), and attending several anthropology courses and seminars since 2013 (at EHESS in Paris, and at University of Montreal). I define myself as an interdisciplinary PhD candidate, navigating in the burgeoning field of HPSR, and endeavouring to expand it.

In this PhD thesis, I use concepts and approaches anchored in this interdisciplinary perspective, and while it should be read as rooted in foundational research fields (e.g., public policy and HPSR), it does not fall under any specific discipline. Interdisciplinary involves a connection or integration of different disciplines, in the perspective of complementarity (for example, borrowing "disciplinary" elements as theories or methods specific to another discipline). In this thesis, we engage in "theoretical interdisciplinarity", whereby the theories and perspectives of one discipline contribute to conceptual frameworks and issues of another, in view of improving the understanding of a research object (Thompson Klein, 2011). As in Jones (2018), this theoretical interdisciplinarity means that I take into account both the characteristics of founding research fields — public policy and HPSR — and the research object (performance-based financing) and bring them into the conceptual framework for this thesis. For instance, I need to make sense of key public policy concepts — i.e., diffusion, polycentrism — while accounting for the political economy of global health governance in the case of performance-based financing. I

also need to ensure that the conceptual framework and each of its dimensions remain coherent with my ontological and epistemological stance (Jones, 2018).

This interdisciplinary endeavour is challenging. Indeed, the interdisciplinary definition bears a number of ontological and epistemological disputes that I tried to make sense of along the course of my doctoral studies. Positivism and post-positivism[3] serve as the typical foundation for the larger part of economic thinking and quantitative public health research including epidemiology. While I was being exposed to health economics and epidemiology (and their underlying representations of the world and ontology), I developed a specific interest in public health financing reforms in LMICs. Such interest emerged nearly 10 years ago, in December 2009, as I was attending for the first time "health financing in LMICs" lectures given by Dr Alain Letourmy at Paris-Dauphine University, as part of a broader course on macroeconomics of health. Ironically, the lecturer had a specific focus on health financing reforms in Mali — *mutuelles*. In the descriptions of the Mali case and the theoretical background on health financing reforms, my accounts are partly drawn from that lecture and Letourmy's literature more broadly.

With time, these quantitatively-oriented representations of health, being objectively measurable, gave way to a stronger inclination to critical thinking about health and health systems, and the multiple meanings of discourse (i.e., involving many subjectivities). I thus discarded positivist and post-positivist stances. My professional experience and academic training in development and health anthropology both shaped such inclination. Being a junior development aid officer in Burkina Faso and then at UNAIDS' headquarters, I got exposed to the many issues associated with global health standards, their local adaptation and ownership (Ancelovici and Jenson, 2012; Booth, 2012; Esser, 2014); the politics of *evidence-based medicine* (Brives et al., 2016; Timmermans and Berg, 2010), and the politics of aid in general (Ferguson, 1990; Mosse, 2013).

[3] Positivism is a philosophy of science that assumes a specific ontological perspective of the reality: that what we see is what it is. From this standpoint, observing the nature is "true knowledge". Postpositivism challenges the traditional notion of "the absolute truth of knowledge", by recognising that claims of knowledge when studying the behavior and actions of humans cannot be held as the absolute truth. Postpositivism still draws from a deterministic philosophy in which causes determine effects (Creswell, 2014). Postposivists scholars produce knowledge through observation (e.g., through experiments) and measurement of an "objective" reality.

My starting epistemological stance is that of an interpretivist. I attempt to understand the meanings of thinking of GHG actors and how those shape their actions. I emphasise the *productive* form of power. I draw from idealist philosophy applied to global health (Béland and Cox, 2010; Harmer, 2011), which suggests that ideas structure our understanding of the reality, and construct our identities and interests. I also recognize the importance of constitutive logics, which derive from poststructuralism applied to the study of policy discourse (Bacchi, 2016). Within constitutive logics, ideas provide the discursive conditions of the possible manifestation of a phenomenon of interest (Gofas and Hay, 2010). In other words, social and policy objects, subjects, and problems are shaped or constituted through discourse (Bacchi, 2009). Yet, I concur with Hay (2002) and Marsh (2009) that compulsory and institutional forms of power (including interests, and the availability of financial resources — a critical feature in the diffusion of global health policies) also play a role. This reflection, which is embedded in the description of the framework on diffusion entrepreneurs (Chapter 2) draws from social constructivism (Hay, 2002), which is acknowledged as a sister approach of interpretivism (Denzin and Lincoln, 2011). I start from the idea that reality is socially constructed and multiple (relative to *scales* and *levels* of analysis, see above), and thus engages in a qualitative approach, using poststructural discourse analysis and interpretive case study analysis, to make sense of this multiple, socially-constructed reality (Chapter 3). Unlike quantitative research that typically seeks to demonstrate causal patterns that can be representative of a single "objective" reality, qualitative research explains complex, context-bound phenomena while acknowledging diverse people (including the researcher)'s values and beliefs of these phenomena (thus reflecting the multiple and socially-constructed reality). Still, I do not completely reject quantitative research tools, since they can help qualitative researchers make sense of large textual or relational data (as in Chapter 5). In this thesis, these quantitative instruments represent appropriate support tools to further inform actors' discourse and actions. In Chapter 5, I specifically look at a transnational network's discourse and (governance) structure.

This qualitative-dominant research primarily builds on public policy theories. Perhaps owing to the fact that global health academics are often trained in public health, they have been using traditional state-centric approaches to policy analysis with a positivist or post-positivist epistemology as a backdrop. As Stoeva puts it, the global health literature "does not reflect

critically on this choice of […] framework, or the implications for the resulting analysis" (Stoeva, 2016, p. 101). I argue that this feature risks eluding other political, social, and economic transnational dynamics. Borrowing from research in public policy may be useful since academics in these fields analyse global health politics at more levels of analysis than just the national/state level. However, these scholars lack specialist knowledge and competent understanding of public health matters (Jones et al., 2017; Stoeva, 2016). Therefore, interdisciplinary researchers trained in both political studies and public health with an international perspective would be well equipped for filling this literature gap (Robert and Ridde, 2016). Moreover, political scientists and public health academics share a common interest for unpacking power in health politics and the roles played by knowledge in policymaking. The present thesis attempts to mobilise both areas of interest, using the empirical backdrop of the performance-based financing health policy in the context of a growingly complex global health governance.

1.5 Study object: the diffusion of performance-based financing in Africa

The unequal distribution of power among GHG actors evolving in polycentric arenas coincides with the rise of Universal Health Coverage (UHC) as a global overarching objective attempting to shape health sector reform in LMICs (Lancet, 2016). The movement has raised even more attention since its endorsement as sub-goal 3.8 of the Sustainable Development Goals (Ghebreyesus, 2017). Even though conceptual clarity on UHC is lacking — UHC mobilises the combination of legal, public health, humanitarian, and economics perspectives (Abiiro and De Allegri, 2015) — the promise of UHC has attracted unprecedented (financial) resources globally, regionally, nationally, and particularly on the African continent. The roots of the UHC movement may be traced back to Alma Ata's 1978 declaration coined to the Health for All catchphrase, which acknowledges people's fundamental right to health (Ooms et al., 2014). Yet, the polycentric nature of global health governance and the growth of non-state actors (including from the private sector) have spurred alternative discourses on UHC. The "race" to achieve UHC (Horton, 2018) involves multiple transnational actors with competing political agendas, which seldom view UHC as a public good (Stuckler et al., 2010). In fact, Clark notes that "most [UHC] reports fail to emphasise the importance of public health services, instead focusing on cost-

effectiveness and efficiency" (Clark, 2014, p. 3). This reflects a broader tendency among international players to craft health systems reforms like UHC in the economics language and logic.

In the case of UHC, the World Health Organization (WHO) recommends that LMICs adopt the health system financing reform(s) adapted to their needs and contexts (WHO, 2017). Depending on their aspirations, LMICs can embark on the path to UHC by reforming the financing structures of their health system, i.e. by promoting three dimensions of health economics: demand for health (i.e., coverage of population's access to service needs), supply for health (i.e., quantity and quality of services covered), and health equity (i.e., proportion of costs of services covered by the state or social protection schemes *versus* those covered by populations, and access granted to all people in a society regardless of their socio-economic and cultural differences).

Since then, several reforms have been put forward by various GHG actors, including international organisations and bilateral cooperation agencies (Gautier and Ridde, 2017). Some have tended to favour reforms to improve the demand for health in LMICs, such as user-fee exemption policies (Robert and Ridde, 2013), community-based insurance and *mutuelles de santé* (Boidin, 2015), and conditional cash transfers (Béland et al., 2018). The first two sets of reforms aimed to improve financial protection for healthcare users. Others have sought to promote policies to improve health service provision (Lee and Goodman, 2002), for example through instruments to increase the performance of health professionals (Rowe et al., 2005). However, some GHG players considered that these reforms had generated rather disappointing results. Some have argued that these reforms have not sufficiently addressed the purchase of health services (Mathauer, 2016). Several actors of polycentric GHG — international organisations, networks and influential individuals — have promoted the implementation of a reform that would address health service purchasing in LMICs, and most particularly on the African continent: performance-based financing (PBF) (Turcotte-Tremblay et al., 2018).

Performance-Based Financing in sub-Saharan Africa

[NB: This section (except Box 1.1 and up to Figure 1.2) is extracted from the fourth part, i.e. "**4. Performance-based financing in sub-Saharan Africa**", of the first thesis paper featured in Chapter 2 (Gautier et al., 2018b)]

Healthcare financing reforms have traditionally been dominated by economists and therefore are rooted in economic frames and theories. Shaped by these frames, several experts and international organisations operating at the global and national scales have strived to influence healthcare financing policymaking in sub-Saharan African countries (Gautier and Ridde, 2017; Lee and Goodman, 2002). They have notably attempted to reform the three main functions of a healthcare financing system: collecting revenues to finance and deliver health services, pooling health funds and sharing risks, and purchasing health services (Kutzin, 2001). For instance, in the 1980s, the controversial user fees reform addressed the collection and pooling functions of the healthcare financing system in LMICs (Lee and Goodman, 2002).

Performance-based financing (PBF) addresses the purchasing function of the equation (Soucat et al., 2017). PBF builds on the tradition of economic theory. It specifically mobilises principal-agent theory whereby a principal (e.g., the Ministry of Health) designs a formal contract that will motivate an agent (e.g., health provider) to behave in a way that serves the principal's interest (Eldridge and Palmer, 2009). This may be achieved by offering financial rewards to the agent and setting "procedures for monitoring and reviewing contract performance" (Manongi et al., 2014, p. 2).

The predecessor of PBF was called "performance contracting" (Mills et al., 2000). It was first tested in pilot programmes implemented in Afghanistan, Cambodia, and Haiti as early as the late 1990s. In the mid-2000s, performance-based contracting was introduced in Rwanda with an apparent success (Abbott et al., 2017). A few key individuals involved in these initial programmes have contributed to stabilising the definition of the dominant PBF model as it is diffused today in Sub-Saharan Africa (Fritsche et al., 2014). [Some of them specifically worked towards a better theoretical anchoring of PBF in microeconomics and new institutional economics (Box 1.1)].

[Box 1.1 The theoretical foundation of performance-based financing]

Participating in the premises of PBF led two individual "DEs-to-be" to pursue academic training in (health) economics (Boulenger, 2009; Fritsche et al., 2014; Soeters, 2010). Their own doctoral theses represented the "theoretical foundations" of PBF. Both started from the assumption of a rational *homo economicus* and adopted neoclassical approaches (Moxon et al., 2015) to understand institutions and human behaviours in the context of health service provision. By doing so, they separated themselves from heterodox economics and those who assume that humans are guided by a *bounded rationality* (Simon, 1962).

One of these two individuals primarily drew insights from the new institutional economics school of thought, applying the concept of "institutional arrangements" to health systems (Meessen, 2009), and testing the theory of property rights (which served as the basis for principal-agent theory) (Barzel, 1997). Principally, this institutional approach meant to conceptualise health systems as "institutional arrangements whose main purpose is to co-ordinate economic agents involved in the production of health outcomes" (Bertone and Meessen, 2013, p. 849), e.g., by setting incentives to health providers. For more details about how these theoretical approaches have been articulated with PBF, see Bertone and Meessen (2013) and the paragraphs above this box.

The other individual primarily built on microeconomics theories, including public choice theory (Tullock, 2017) to explain the behaviours of health providers. Coherent with such underpinning, his works prominently featured incentive theory and contract theory, offering a theoretical explanation for how PBF operates. These theories are explained in a comprehensive PBF manual used during training courses provided by the SinaHealth company in sub-Saharan countries (SinaHealth, 2019).

These two individuals co-edited the "PBF Toolkit" (Fritsche et al., 2014), which offers the most comprehensive and widely referenced definition of PBF. This manual features a common theoretical foundation in mainstream economics that gives prominence to the usefulness of incentives in health systems.

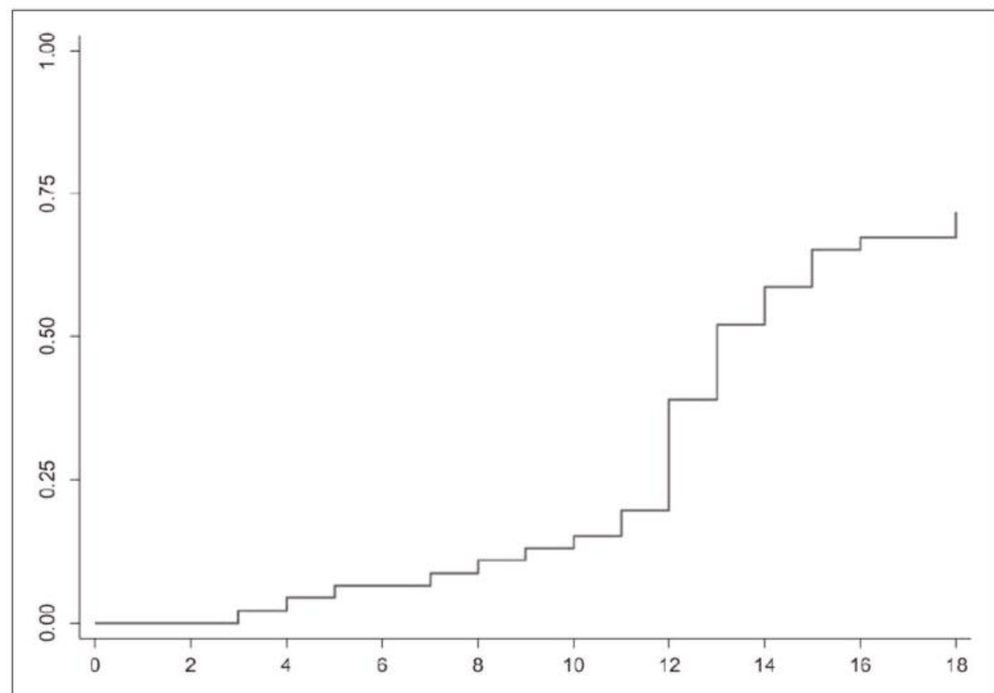
PBF is a policy innovation, whereby healthcare providers are, at least partially, funded on the basis of their performance. PBF therefore suggests a shift from an input-based purchasing model to an output-based approach that involves systematic verification and counter-verification. Linking providers' performance to payments and enabling autonomy in decision-making is supposed to stimulate health workers' motivation to provide better quality healthcare services, thereby rendering service provision more appealing to patients and increasing their utilisation of health services (Fritsche et al., 2014).

Despite mixed scientific evidence on its effects (Das et al., 2016; Witter et al., 2012), several international organisations (multilateral and bilateral donors, and NGOs) have significantly invested in PBF such as the World Bank, USAID, and more recently also GAVI and the Global Fund (see Gergen et al. 2017). Pilot PBF programmes in Sub-Saharan Africa are promoted, designed, funded, implemented, and evaluated by a few of these organisations (Gautier and Ridde, 2017). Experimenting with PBF in Sub-Saharan Africa has involved a lot of technical assistance (often provided by key individuals involved in the first PBF schemes implemented in Afghanistan, Cambodia, and Rwanda), PBF training across countries, and learning lessons from other PBF pilot schemes. This movement spurred the development of networks of PBF practitioners. These networks were set to channel certain information on PBF and to develop a sense of community.

These financial, technical, and social investments in PBF appear to have been successful. While in 2006, there were only four out of 46 countries in Sub-Saharan Africa that piloted PBF (8.7%), in 2017 this figure had jumped to 32 countries (71.7%) (Gergen et al., 2017; SinaHealth, 2017; The World Bank, 2015). Therefore, in less than ten years, PBF spread across more than two thirds of the region, whether as pilot programme or nation-wide policy. Figure [1.1] presents the Kaplan-Meier failure function to illustrate the adoption of this reform over time. Starting slowly, the slope of the adoption curve becomes very steep 12 years after beginning of our observation, suggesting that the greatest number of new adoptions happened around that point in time. At the end of the observation period, more than two thirds of the countries had adopted PBF. This diffusion speed is possibly one of the highest in the history of HCF reforms (Nolan and Turbat,

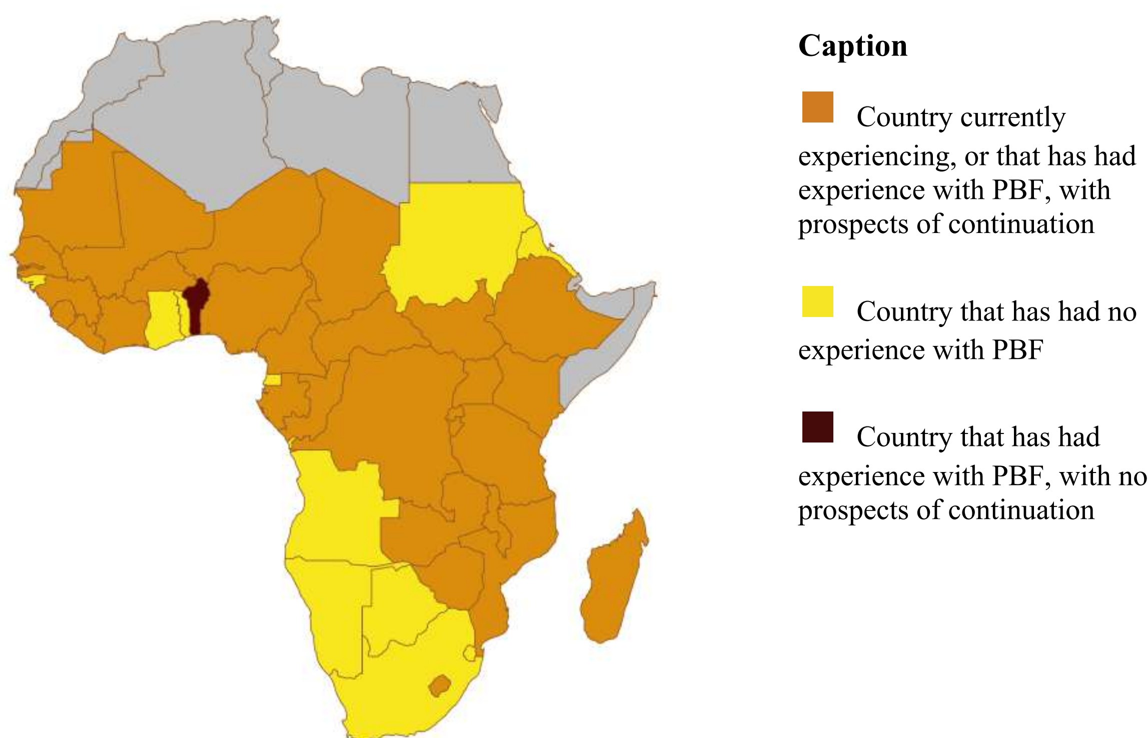
1995). We investigate whether and how successful diffusion entrepreneurs have shaped this pattern of 'explosive' diffusion (Figures [1.1 & 1.2]).

[Figure 1.1] Kaplan-Meier Plot for PBF Diffusion, 2000-2017



Note: Own elaboration. This figure draws on empirical information for 46 sub-Saharan African countries. See also Gergen et al. (2017) for additional information.

Figure 1.2 PBF policy experience in sub-Saharan Africa, as of December 2018 (Own elaboration, based on Gergen et al., 2017 and SINAHealth's country webpage)



The story of the diffusion of PBF in SSA started in the Great Lake region, with initial pilot experiences in Rwanda (in the early 2000s), and then in Uganda, Democratic Republic of Congo (DRC), and Burundi along the mid-2000s. From the late 2000s, the policy started to expand much faster (see Figure 1.1) and in all SSA regions except Southern Africa. Despite donors' multiple attempts to introduce it in South Africa, political authorities have always rejected the implementation of health PBF pilot schemes (Barnes et al., 2015). These authors assert that the government's ability to resist donors' push was "linked to South Africa having a stronger economy and a less externally reliant health system" (Barnes et al., 2015, p. 50). As for other countries of that region (Botswana, Angola, eSwatini, and Namibia), donors may have decided to shift their priority to other countries given that these countries' populations are lower than those already experiencing PBF (i.e., donors may believe that their weight is less important), and their economy is generally stronger than those countries. However, this is our own conjecture and should thus be considered with much caution.

Rationale for selecting the study object

As in the case of other health financing reforms that spread on the continent (Nabyonga-Orem et al., 2014; Ridde, 2015), the widespread diffusion of PBF in Africa is based on processes that are not linked to evidence-informed policymaking: it is essential to analyse the ways in which this policy has gained ground through other modalities, and looking at global, continental, national, and subnational levels. Major GHG policy actors promote PBF pilot projects, including: international organisations, networks, and transnational experts who act at these different levels. Thus, if the claims in favour of developing PBF in Africa are to be gauged, it is critical to assess not only PBF implementation and impacts, but also the processes by which this policy has acquired legitimacy worldwide, continent-wide, and nation-wide.

To date, there has been little empirical investigation into PBF diffusion processes in LMICs (Abomo, 2018) or the political economy of its diffusion (Renmans et al., 2016). The literature focuses on the effects and implementation processes of PBF (Renmans et al., 2016; Ridde et al., 2017; Witter et al., 2012; Wiysonge et al., 2017). One large study looks at the modalities of scale-up of PBF from pilot to a national policy in multiple LMICs (Shroff et al., 2017), but does not emphasise policy or political processes. The only available political economy analyses of PBF have focused on the national level, exploring influences from external actors in single African countries (Chimhutu et al., 2015; Kiendrébéogo et al., 2017; Renmans et al., 2017a). Only one book by Barnes et al. (Barnes et al., 2015) took a regional perspective, looking at PBF political processes exclusively in English-speaking countries, i.e., South Africa, Tanzania, and Zambia. In these works, the multiple forms of power of GHG actors promoting PBF are discussed without deconstructing their origins, manifestations, or implications for LMICs and policy actors.

The case of PBF, a relatively recent health financing reform, offers an interesting research opportunity in that it involves a variety of powerful global health organisations, networks, and individuals who are not only promoting PBF in SSA countries, but also shaping and fostering its diffusion. Unraveling these processes explains how these powerful actors influence national policy actors to secure PBF policymaking — including through promoting SSA consultants.

1.6 Research question and architecture of the thesis

This thesis aims to fill the research gaps identified above, and to contribute to the advancement of the political economy of diffusion in a polycentric context. Specifically, this doctoral research offers critical insights into seeming attempts to rebalance the political economy of global health governance, whereby a policy (performance-based financing) is marketed by major policy actors in ways that prominently feature Africa's participation in policy diffusion efforts (policy framing, emulation, experimentation, and learning). In other words, the diffusion process of that policy is framed as rebalancing the political economy of GHG. Drawing on a theoretical literature review (Chapter 2), this thesis also advances the state of public policy and global health academic fields by introducing the concept of *diffusion entrepreneurs* to refer to these GHG policy actors promoting PBF at different levels and explicitly or implicitly aiming to facilitate its diffusion by tapping into their multiple forms of power.

We highlight diffusion entrepreneurs' *constitutive features* and *actions* to foster policy diffusion. Their constitutive features include two parts: their representation systems and motivations, which unravel how their assumptions about the world shape their vision of global health problems and policy solutions; and their (political, social, material, temporal, knowledge) resources and types of authority (moral, financial, expert, scientific authority). We conceive diffusion entrepreneurs' resources as *power-to* (i.e., ability) and types of authority as *power-over* other actors (who recognise diffusion entrepreneurs' authority), which feature the Barnett and Duvall's four forms of power — compulsory, institutional, structural, and productive power (see Chapter 3 for details). Through using their resources and types of authority, diffusion entrepreneurs (featuring a coherent set of representations and motivations) are empowered to develop an apparatus of actions that shape policy diffusion in LMICs. These actions aim at framing the policy in ways that make sense to a wide audience, and fostering policy emulation, experimentation, and learning. We attempt to understand not only how interactions among diffusion entrepreneurs and with SSA policy actors are conceptually inherent to these actions (i.e., to portray an Africa-owned diffusion process that would rebalance the political economy), but also how these interactions generate multiple phenomena that mitigate, empower, or strengthen these diffusion efforts. We do so by looking at macro-level relationships (e.g., between international

organisations acting as diffusion entrepreneurs and LMIC governments), meso-level exchanges (e.g., between networks and private organisations active on the African continent), and micro-level interactions (e.g., between European individual diffusion entrepreneurs and SSA national actors).

The following research question guides our analysis: **How did powerful global policy actors shape the diffusion of performance-based financing in sub-Saharan Africa?** Subsidiary research questions include: 1) What are the constitutive features of these powerful global policy actors, what drives them to foster policy diffusion, and which actions do they take to fulfil their goals?; 2) How and why do they strategically engage with African actors to foster policy diffusion?; and 3) Did the shaping of an apparently unusual political economy of PBF diffusion in sub-Saharan Africa genuinely translate into an Africa-led diffusion process? To answer these questions, we perform a theoretical literature review to develop and test a conceptual framework on diffusion entrepreneurs; and an interpretative study with nested analysis levels (global, continental, national) to examine the expansion of PBF in African countries and the roles played by diffusion entrepreneurs in this expansion. Each of our empirical studies (Chapters 4 to 6) applies the framework at distinct analysis levels: the first study focuses on the global level, the second on the continental level, and the third on the national level.

In the next chapter (Chapter 2), we offer the theoretical underpinnings of this thesis, which gives rise to a comprehensive conceptual framework. We also tentatively apply the framework using literature on PBF.

In Chapter 3, we provide methodological details (including the study setting and approaches to data collection and analysis) and ethical considerations. We explain how three embedded empirical studies — focusing respectively on the diffusion at the global, continental, and national levels — enable us to fulfil our research objective. We also provide details about the techniques and strategies used to approach research participants, and our knowledge translation activities.

In Chapter 4, we present the first embedded empirical study of this thesis, which critically unravels the global discourse of PBF — emphasising how it reflects diffusion entrepreneurs' constituting features and their actions at the global level.

In Chapter 5, we introduce the second empirical study, which focuses on the diffusion of PBF at the continental level, featuring the PBF Community of Practice as a catalyst for these diffusion processes in sub-Saharan Africa.

In Chapter 6, we present the third empirical study, which features a case study on the diffusion of PBF in Mali, highlighting the roles played by diffusion entrepreneurs acting at the national and subnational levels.

In Chapter 7, we reflect on the relevance of our conceptual framework, provide a thorough discussion of the results of the three embedded studies, and offer some reflexive considerations drawn from the thesis experience. We suggest future research areas and possible methodological approaches in studying the political economy of global health policy diffusion in LMICs.

The final chapter offers brief concluding remarks and ways forward in studying the political economy of global health more broadly.

1.7 Definitions of key concepts and rationale for using certain designations

As with Koch and Weingart (2016), we are concerned about using terminology that might reproduce hierarchical configuration and inequalities between actors that are featured in our doctoral research. Yet, power asymmetries are an integral part of the context we are studied, and as such, replacing high-income countries and donors or *foreign policy actors*, and low- and middle-income countries and recipients or *national policy actors* with alternative terms has so far not been convincing (Koch and Weingart, 2016). For instance, the use of the word *partners* may mask persisting dependencies between actors (Gautier et al., 2018a), instead of highlighting them. Thus, despite the political limitations of this designation, we refer to countries based in the

"Global South" as low- and middle-income countries (LMICs). In this thesis, this expression is only employed for practical purposes; by no means it is used for reflecting or perpetuating paternalistic or postcolonialist forms of dominance. We distinguish these countries from other countries of interest in this thesis: Western European and North American countries are referred to as high-income countries (HICs).

As a major concept of this thesis, we accept the following definition of policy diffusion: "[the] flow or movement from a source to an adopter, paradigmatically via communication and influence" (Strang and Soule, 1998, p. 266). We attempt to establish a holistic picture of diffusion processes across multiple scales and levels of analysis. In the context of this thesis, *scales* refer to the spatial and jurisdictional dimensions used to study the travel of policy ideas (Cash et al., 2006). The spatial dimension refers to geographical territory. In this thesis, the spatial scale is divided into different *levels* (i.e., units of analysis located at different positions of this scale): the global, the continental (the sub-Saharan African continent), the national (specific African countries, e.g., Mali), and the subnational (e.g., a region of Mali). The jurisdictional dimension investigated in this thesis covers individual units of government acting more or less autonomously in the polycentric setting: towns or cities, districts, "régions" or provinces, nations (foreign or homeland), and international organisations with linkages between them created by constitutional, legal, and/or statutory means (*ibid.*).

We use the term *power* in its complex, multifaceted definition, drawing from the work of Barnett and Duvall while acknowledging its limitations, as shown above. We conceive diffusion entrepreneurs' resources as *power-to*, and types of authority (see Chapter 2 for more details) as *power-over*, which feature Barnett and Duvall's four forms of power: compulsory, institutional, structural, and productive power. Through using their resources and types of authority, diffusion entrepreneurs attempt to influence LMIC actors and policymaking.

We use Birkland's definition of a public policy (see above) throughout the text. We also consider that the making of public policies "results partly from a sustainability process, notably through actions implemented as pilot project" (Ridde, 2015, p. 1). Thus, even though PBF is most often a pilot project experimented in LMICs, as in Gautier & Ridde (2017); in this thesis, we describe

and analyse PBF as a public policy since governments from sub-Saharan countries have participated in the implementation (by providing the available human and material resources) and demonstrated political will for pursuing PBF and making it a countrywide public policy, as in Rwanda, Burundi, and Cameroon. In addition, since we are looking at the political economy of PBF diffusion, it might be useful to clarify the distinction between policy and politics. For Lemieux, politics is not only constituted by ideas emerging in public opinion; it is also shaped by dominant actors and it typically reflects their interests (Lemieux, 2002). The divergent interests between public opinion and dominant actors make politics a constantly contested field. Policies (like PBF) emerge in this conflicting landscape: they represent the representation systems and interests of particular groups who managed to set their views (of a problem) high on the political agenda of governments. This thesis specifically looks at the politics behind the rapid and wide expansion of the PBF policy.

We apply the following definition of knowledge — another key concept in this thesis: "knowledge consists of truths and beliefs, perspectives and concepts, judgements and expectations, methodologies and know-how" (Wiig, 1993). This inclusive definition is adequate: it refrains from featuring a normative dimension (e.g., implying there is a hierarchy between what can be considered knowledge and what cannot), and instead emphasises the social nature of knowledge. We prefer this term to that of *evidence*, which is highly politicised and normative (i.e., different types of evidence may be hierarchised). With this context, we posit that learning processes based on knowledge includes generating, disseminating, and/or (mis)using knowledge towards influencing policymaking.

Chapter 2. Theoretical underpinning, elaboration and testing of the conceptual framework

Article 1: How do diffusion entrepreneurs spread policies? Insights from performance-based financing in Sub-Saharan Africa

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How do diffusion entrepreneurs spread policies? Insights from performance-based financing in Sub-Saharan Africa

Highlights

- Global health evolves in a context of polycentric governance.
- In polycentric contexts, diverse actors influence policymaking at multiple levels.
- We tap into diffusion studies to introduce the notion of "diffusion entrepreneurs".
- Diffusion entrepreneurs expand their influence by developing a coherent set of features.
- The case of performance-based financing (PBF) illustrates our conceptual argument.
- Diffusion entrepreneurs' features fostered the spread of PBF in Sub-Saharan Africa.

Abstract

There has been growing interest in the diffusion of policy innovations across countries. Research on policy diffusion is characterised by coherent explanatory models that assess the importance of diffusion mechanisms. This study takes a different perspective on diffusion studies and advances public policy literature by introducing the concept of "diffusion entrepreneurs". These entrepreneurs represent (groups of) individuals, networks, and organisations promoting a certain policy innovation with a view to gain influence. First, drawing from the diffusion literature and linking it to studies investigating policy diffusion in polycentric contexts, we introduce analytical categories to study diffusion entrepreneurs' key features and actions. Second, to illustrate the analytical value of the concept, we conduct an in-depth analysis of the literature on the diffusion entrepreneurs of health performance-based financing (PBF) in Sub-Saharan Africa. We show how and why this recently diffused policy innovation provides a unique case for demonstrating our conceptual notion: in PBF, a nexus of strongly dedicated diffusion entrepreneurs have strived to induce policy diffusion. Specifically, we explore how the features of PBF diffusion entrepreneurs and their actions affect the outcomes of diffusion processes. Lastly, we reflect on the relevance of our conceptual propositions and offer practical insights to guide future investigations.

Keywords: policy diffusion, diffusion entrepreneurs, global health, performance-based financing, Sub-Saharan Africa

1. Introduction

For the past 30 years, globalisation has changed the policymaking landscape, prompting the development of polycentric governance. Polycentrism refers to having multiple governing authorities at different scales, which are mostly or completely independent when making norms and rules within a specific domain (e.g., Ostrom, 2010). The autonomy of individual units of government (e.g., multilateral organisation, country, city, etc.) is what differentiates polycentric governance from another prominent form of governance, that is, multilevel governance, which conceives the individual units to be nested in a structure. The growth in polycentrism raises questions about how policies emerge in some units and subsequently spread to other units, which is the main analytical interest of diffusion research. To date, public policy research on diffusion has concentrated on the so-called "diffusion mechanisms" but has paid less attention to the role of actors in facilitating or impeding diffusion (Capano, Howlett, & Ramesh, 2015; Tosun & Croissant, 2016). Considering that one of the dimensions of international development cooperation relates to the spreading of policy innovations, this gap in policy diffusion research also imposes a limitation on analysis related to development (Burns, Krott, Sayadyan, & Giessen, 2017; Rahman & Giessen, 2017; Rahman & Tosun, 2018).

To advance both public policy literature and development studies, we explore the characteristics and strategies of "diffusion entrepreneurs" and how these affect the outcomes of diffusion processes. We provide a theoretical framework on the critical features of diffusion entrepreneurs and on the way they develop and support an apparatus that aims at fostering diffusion globally, continentally, and nationally. The present study lays each component of the theoretical framework and based on secondary data to assess its relevance, points to several entry points for further empirical research.

There are several thematic or geographical contexts in which we can observe polycentric governance. For example, in the past few years, the literature on climate politics has increasingly recognised polycentric governance as a useful analytical lens (e.g., Morrison et al., 2017). Within this literature, the term polycentric systems is oftentimes used to refer to subnational units such as policy experiments at the level of cities (e.g., Hoffmann, 2011). Focusing on the subnational level and on the allocation of natural resources aligns particularly well with polycentric governance as

put forth by Ostrom (2010). However, we witness that polycentric systems comprise all levels of government, including the international one, and a wide range of policy areas.

In this study, we are interested in international development cooperation for pursuing public health in low- and middle-income countries — especially in Sub-Saharan Africa — and non-governmental actors that form part of this polycentric governance arrangement (see Tosun 2017). Given the characteristics of this governance system, we expect to gain new insights on the conditions for policy diffusion.

The remainder of this article unfolds as follows. First, we review the main lines of existing theory regarding policy diffusion and introduce the concept of diffusion entrepreneurs with a view to move away from the dominant mechanism perspective. Second, we outline our own conceptualisation, which possesses two features: i) the concept of diffusion entrepreneurs and ii) the emerging system of polycentric governance. Third, in preparation for the plausibility probe of our concept, we explain our rationale for case selection, showing how and why a recently diffused reform — performance-based financing (PBF) — represents an insightful case for probing the plausibility of our theoretical framework. Fourth, based on secondary data extracted from a literature review, we illustrate the relevance of the framework and offer practical insights to guide future empirical investigations. The final section offers some concluding remarks and suggestions for future research.

2. The mechanism perspective on policy diffusion

In this article, we attempt to make a conceptual contribution to diffusion research. To this end, we first summarise the theoretical building blocks of diffusion research, which we take as the point of departure. Second, we outline the strengths and limitations of the theoretical approaches to policy diffusion.

2.1 Theoretical building blocks of policy diffusion research

Policy diffusion can be defined as a situation in which policies in one unit are influenced by policies in other units (Maggetti & Gilardi, 2016). Originally drawn from the management literature and the pioneering work by Rogers (1962), the concept of diffusion was increasingly

adopted by the various subdisciplines of political science in order to study the spread of innovations. Early research on policy diffusion research was done mostly in the context of the United States of America and focused on diffusion at the subnational level (Gray, 1973; Walker, 1969). The analytical perspective quickly as moved beyond the United States, so that diffusion research now covers many different world regions such as Latin America (Weyland, 2005, 2009) or the members of the Organisation for Economic Cooperation and Development (e.g., Jahn, 2006) as well as offers insights from a global comparison of countries (Schmidt & Fleig, 2018).

Policy diffusion research is characterised by remarkably coherent explanatory framework that stresses the importance of various *mechanisms* "that cause a policy to spread from one government to another" (Shipan & Volden, 2008, p. 841). Among those, learning, emulation, and competition stand out (Goertz, 2006; Maggetti & Gilardi, 2016). *Learning* is conceived as a process in which information or experience from other units is used to inform policymaking. Some studies make explicit the assumptions on which their reasoning around learning rests, whereas other remain silent about it. In this context, Meseguer (2006), for instance calls for differentiating between bounded learning (which rests on the assumption of bounded rationality) and rational learning (which assumes full rationality) (see also Weyland, 2009). This distinction is important since learning is not necessarily a fully rational mechanism of diffusion, which, however, makes it difficult to differentiate it from the second diffusion mechanism: emulation (Meseguer, 2005).

Following Maggetti and Gilardi (2016), *emulation* can be conceived as a process of copying the policies adopted by other units as well as the adoption of policies that are socially valued and therefore increase the legitimacy of policies concerned. The similarity between learning and emulation also becomes apparent by the fact that both diffusion mechanisms are associated with the concept of epistemic communities (Haas, 1992). These transnational networks of "professionals with recognized expertise and competence in a particular domain" (Haas, 1992, p. 3) help to promote policy innovations by their power to control knowledge and information flows. These features and activities of epistemic communities can help to influence both emulation (see, e.g., Gilardi & Fueglister, 2008) and learning (e.g., Dunlop, 2009). The difficulty

of disentangling the individual diffusion mechanisms is one of the criticisms raised in the pertinent literature (Shipan & Volden, 2008).

Competition concerns economic competition between units and discerns how competitive pressure affects policy diffusion. From this perspective, competition is either conceived as a response to negative policy externalities created by others or as the process of adopting policies after a shift in the incentives of adopters caused by direct competitors (Maggetti and Gilardi 2016). The theoretical arguments vary along the dimension of whether diffusion by competition requires the existence of asymmetries in economic power or not. Studies concentrating on the diffusion of policies that originate from the United States and/or the European Union tend to make this assumption of economic power asymmetries (e.g., Buttel, 2000; Damro, 2012), whereas other approaches consider diffusion by competition to be a strategic situation among equal players (e.g., Baybeck, Berry, & Siegel, 2011)

Most studies conceive diffusion processes to be induced by one or a combination of these three mechanisms. Yet this list is not exhaustive. Coercion is the most frequent mechanism added to this list, yet it is highly contested: some authors regard it to align with the logic of diffusion (e.g., Dobbin, Simmons, & Garrett, 2007), whilst other stress that diffusion is a phenomenon that refers to strictly voluntary behaviour (e.g., Maggetti and Gilardi 2016). Regardless of the exact number and types of mechanisms, the key message we wish to convey is that policy diffusion research has embraced the mechanism-based approach. Consequently, any conceptual contribution to this literature must position itself regarding that approach and explain how it seeks to further the state of research.

2.2 Strengths and limitations of the theoretical approaches to policy diffusion

The coherent conceptual approach to the study of policy diffusion has produced something one can only rarely observe in scholarship: cumulative research where the individual contributions liaise with one another. Regardless of the type of policy analysed, individual literature strands relate to one another and allow drawing comparative insights. As a result, when inspecting the literature, we can get a sense of the policy domains where learning, emulation, competition, or all of these mechanisms are at work. Furthermore, as policy diffusion literature matured, researchers

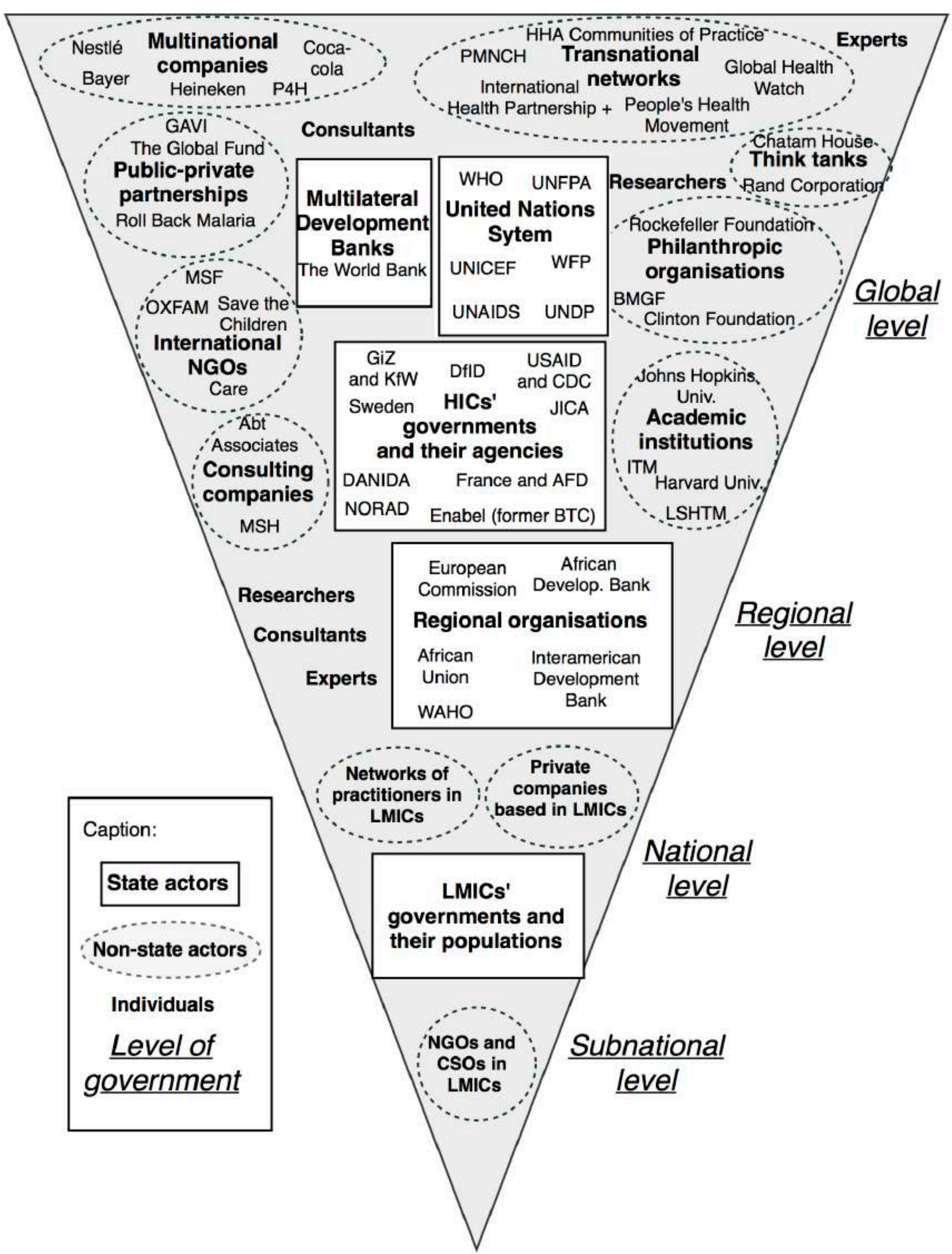
using explanatory models became increasingly aware of the need to identify and test the importance of domestic-level variables such as the countries' political regimes, level of socio-economic development, and a whole battery of variables relating to politics (Obinger, Schmitt, & Starke, 2013). From this, it follows that we can formulate expectations regarding the relevance of not only diffusion mechanisms, but also domestic-level variables that are likely to trigger or hamper the adoption of policy innovations.

The conceptual coherence of the mechanism-based approach to the study of policy diffusion also represents the main limitation of this scholarship. Any deviation from this established way of thinking about diffusion is likely to arouse scepticism, which prevents innovative conceptualisations. Some observers such as Howlett and Rayner (2008) argue that policy diffusion studies would benefit from taking one step back and developing a more refined understanding of what exactly they expect to diffuse.

Our take on existing literature is that the mechanism perspective complicates the empirical testing of the drivers of policy diffusion. The logic is compelling that learning, emulation and/or competition drive the adoption of policy innovations, but this perspective leaves unconsidered the role of actors as well as their (strategic) interactions. This limitation stems from the empirical approach most policy diffusion studies adopt: they compare a great number of jurisdictions over a sufficiently long period. The need to collect longitudinal data requires the adoption of pragmatic approaches to the measurement of the key variables. At that level of measurement, it is difficult if not impossible to pay attention to the role of (groups of) actors. Yet we argue that if we want to advance the state of public policy research, we should rather embrace the perspective of actors and improve our knowledge of *how* they matter for policy diffusion.

We believe that the adoption of such a perspective also better reflects the emergence of polycentric governance in policy domains that require international coordination and cooperation just as climate change governance or global health governance (e.g., Jordan et al., 2015; Shiffman et al., 2016; Tosun, 2017). Reflecting the transition from international health to global health (Brown, Cueto, & Fee, 2006), global health governance represents a vivid illustration of such polycentrism (see Figure [2.1]).

[Figure 2.1] The global health ecosystem



Note: This graph presents the main categories of global health governance actors. “Borders” between global and international levels of government may vary with context. Category names are specified in bold.
Categories may represent organisations, networks, or individuals. In each category, a few examples of actors are provided; those represent autonomous units of governing authority, exerting influence on decision-making at multiple scales. Consultants, experts, and researchers represent individual units, typically offering political advocacy, technical and/or evaluation assistance to low- and middle-income countries.

Abbreviations [in Figure 2.1]:

AFD = French development agency
BMGF = Bill & Melinda Gates Foundation
BTC = Belgian technical cooperation
BRICS = Brazil, Russia, India, China, and South Africa
CSOs = Civil Society Organisations
CDC = U.S. Centers for Disease Control and Prevention
DANIDA = Danish International Development Agency
DfID = U.K.'s Department for International Development
Enabel = Belgian Development Agency
GiZ = German Agency for Development Cooperation
HHA = Harmonization for Health in Africa
HICs = High-Income Countries
ITM = Institute of Tropical Medicine (Antwerp)
JICA = Japan International Cooperation Agency
KfW = German Development Bank
LMICs = Low- and Middle-Income countries
LSHTM = London School of Hygiene and Tropical Medicines
MSF = Médecins Sans Frontières
MSH = Management Sciences for Health
NGOs = Non-governmental organisations
NORAD = Norwegian Agency for Development Cooperation
P4H = Partnership for health
PMNCH = Partnership for Maternal, Newborn and Child Health
UNAIDS = Joint United Nations Programme on HIV/AIDS
UNDP = United Nations Development Program
UNICEF = United Nations Children's Fund
UNFPA = United Nations Population Fund
USAID = U.S. Agency for International Development
WAHO = West African Health Organisation
WHO = World Health Organization
WPF = World Food Program

Global health governance involves not only state actors — which are typically at the center of diffusion research —but also a wide range of non-state actors that operate at different scales (i.e., global, continental, or country scale). Organisations, networks, and individuals (e.g., intergovernmental organisations like The World Health Organization, government agencies like USAID, NGOs like *Médecins sans Frontières*, transnational networks like the People's Health Movement, and individual experts) exert an autonomous influence on health systems policymaking in countries with limited resources (Hoffman, Cole, & Pearcey, 2015). A first step for adjusting policy diffusion research to the new appearance of global governance is to invest in our understanding of how actors can become diffusion entrepreneurs.

3. The concept of diffusion entrepreneurs

Policy diffusion scholars have started investigating other aspects of diffusion processes, which correspond more to the meaning of the term 'mechanism' in the strict sense (i.e., a *causal*

mechanism) than in the usage of the classic approaches to studying policy diffusion. A case in point is the recent interest in the importance of framing for the success of policy diffusion (see Gilardi, Shipan, & Wueest, 2017). Framing is typically addressed by research interested in political agenda setting, that is, the process of placing an issue on the agenda and thereby prioritising some problems over others (Jones & Baumgartner, 2005). Framing activities are carried out by political actors, (scientific) experts or the media to present policy alternatives "in ways that could increase their popular support" (Béland, 2005, p. 2). In this context, Fergusson and Yeates (2014, p. 440) point out that international organisations can also attempt to (re-)shape policy preferences by disseminating knowledge. However, scholarship has mostly paid enhanced attention to the role of the media for framing through the use of whole "framing packages" in order to sponsor certain policy images. The sponsorship involves a number of "tangible activities as speech making, interviews with journalists, advertising, article and pamphlet writing, and the filing of legal briefs to promote a preferred package" (Gamson & Modigliani, 1989, p. 6).

As the above discussion shows, the role of actors is better understood both theoretically and empirically in literature strands that do not address policy diffusion. This also becomes apparent in the literature on the multiple streams framework, which assign the concept of 'policy entrepreneurs' a prominent role. According to Kingdon (2003, p. 179), policy entrepreneurs facilitate agenda setting and subsequent policy change by investing their resources to further a goal for anticipated future benefits (Herweg, Zahariadis, & Zohlnhöfer, 2017). Another literature that is helpful for devising a more actor-centered approach to policy diffusion is the literature on policy transfer as put forward by Dolowitz and Marsh (1996) and advanced by scholars, for instance, Stone (2004), who coined the term 'transfer agents'. A third notion — along with policy entrepreneurs and transfer agents — is 'change agent', which can be traced back to the work on the diffusion of New Public Management (Common, 1998, p. 447). According to Common, an elite group, which controlled and directed the flow of knowledge about this particular reform, facilitated the diffusion process. These three notions have in common the centrality of knowledge and information that (groups of) individuals possess and utilise in order to facilitate policy change. These entrepreneurs or agents can be based and effective at different levels of government, including the international one (Haas, 1992).

We appreciate the already existing concepts, but we also think that it is worth continuing the conceptual work by focusing on a policy diffusion context. To this end, we introduce the concept of "diffusion entrepreneurs" (DEs), which we conceive to be (groups of) individuals, networks and organisations (Stone, 2001), who seek to promote a certain policy with a view to gain influence. They therefore develop strategies to shape the perception of a policy innovation and to maximise its diffusion through adoption. Political actors "make sense of ideas by interpreting them through […] available social, psychological and cultural concepts, axioms and principles" (Koon, Hawkins, & Mayhew, 2016, p. 3). Supporting policy ideas therefore supposes that there is a match between policy ideas and diffusion entrepreneurs' understanding of the world, abilities and interests (Hassenteufel, 2008).

The starting point of our conceptualisation is Hassenteufel's (2008) elaboration on the drivers of public policy. This classification intends to capture interactions between different policy actors. Hassenteufel alludes to *resources* that actors may have at hand, *representation systems* in which they believe, which guide their pursued *interests* and ensuing *strategies*. This classification system builds on the premise of policymaking in 'closed' political systems, that is, where domestic actors interact with one another. We claim that this classification system can inform a conceptual framework on diffusion entrepreneurs, which rests on the contrary premise, that is, the existence of political systems that are 'open' to policy ideas originating from elsewhere. When assuming openness in political systems, we must also recognise that there is competition between DEs that seek to promote policy ideas. This notion resembles the logic of interest group competition in pluralist systems of interest representation (Gilens & Page, 2014). However, openness can manifest itself in different ways and the point of departure of this study is that policymaking increasingly occurs in a polycentric context, which effectively means that there is enhanced competition over influence among wannabe DEs acting at different governance levels. From this, two things follow. One is that because of polycentricism DEs originating from even low governance level can be potentially powerful because of the possibility of vertical diffusion and upscaling. Another consequence is that the enhanced competition makes it necessary for potential DEs to possess certain characteristics in order to unfold their power, and in particular, characteristics enabling them to develop a legitimate authority that can be acknowledged by other policy actors navigating in their polycentric context. DEs are able to tap into such authority for

influencing policymaking. Therefore we suggest a fourth characteristic — authority. Building on the classification by Hassenteufel (2008) presented above and extending it by conceptual elements put forth by Lemieux (2002) and Shiffman (2014), we contend that DEs expand their power by developing a coherent set of features, including i) representation systems, ii) interests, iii) resources, iv) authority, and v) strategies. Of these features, the fourth one, authority, stems from the works of Lemieux (2003) and Shiffman (2014) and represents a valuable complement as we will show later in this section.

Representation systems — also known as paradigms (Hall, 1993) — describe the "overarching road maps" that shape policy actors' understanding of the world (Hickey, Lavers, Niño-Zarazúa, & Seekings, 2018, p. 7). Representation systems provide entrepreneurs a coherent set of assumptions about the functioning of economic, political and social institutions (Béland, 2005, p. 8). Therefore, representation systems shape the entrepreneurs' definitions of problems and preferred policy choices. This concept ties in nicely with the literature on problem definition and agenda building (Elder & Cobb, 1984; Rochefort & Cobb, 1994). Global health scholars who have attempted to describe such representation systems tend to focus on individual characteristics of entrepreneurs including ideological predisposition, personal history, and training (Grindle & Thomas, 1989; Reich, 1995).

The second critical feature, entrepreneurs' motivations for pursuing policy diffusion, relates back to the notion of representation systems. Typically, entrepreneurs engage in the promotion of certain policy alternative in the hope that they will serve their own interests (Weyland, 2005, p. 263). This does not preclude that the entrepreneurs are also interested in solving a given problem, but the policy solution they promote for fixing the given problem is likely to align more with their interests than other policy alternatives (Cherrier, 2016).

An entrepreneur's resources represent critical assets to promote a policy innovation, which include material, political, social, temporal, and knowledge resources (Hassenteufel, 2008, pp. 105—106). An entrepreneur may have multiple resources. Material resources include financial, human, and logistical resources. Political resources are acquired through democratic representativeness and access to influential political actors. Social resources are about the social

recognition and ability to socialise. Temporal resources relate to the amount of time a given policy actor may dedicate to policy promotion. Lastly, knowledge resources encompass scientific evidence, policy documentation, as well as technical and practical know-how typically stemming from one's training background (*ibid*). Knowledge resources are paramount to developing policy preferences. Indeed, diffusion entrepreneurs will tend to favour a policy idea because it represents a policy solution that matches their knowledge resources.

Besides these resources, Lemieux (2003) and Shiffman (2014) emphasise entrepreneurs' need to assert a legitimate authority, based on their (recognised) status and/or their exerting normative power in polycentric governance settings. We distinguish four types of authority: financial, expert, scientific, or moral (see Table [2.1]), which, just like resources, are not mutually exclusive.

Financial authority is the classic form of authority next to moral authority and supposes a recognised status in the global arena mostly stemming from the large amounts of financial resources fuelled into international development cooperation (Shiffman, 2014). Expert authority may be achieved when entrepreneurs pursue an internationally-recognised status of expertise, mainly through mobilising knowledge, social, and temporal resources (Grundmann, 2017). Actors with financial or expert authority may lack normative power[4], whereas scientific and moral authorities combine both normative and statutory powers[5]. A claimant's scientific authority involves both building international renown (status) (Bijker, Bal, & Hendriks, 2009) and putting forward the validity or utility of the claimant's "definition, description or explanation of reality" (Gieryn & Figert, 1986, p. 67) which secures a legitimate normative power. The last type of authority refers to moral authority. According to Shiffman, moral authority stems, first from the status of the claimant *vis-à-vis* those whose behaviour they seek to shape, and second, from the validity of the categories that the claimant uses to express the needed political changes (Shiffman, 2014, p. 297). From these valid categories, actors with moral authority can legitimately produce and disseminate norms.

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[4] Understood as: the acquired power to produce norms, e.g., the World Health Organization.

[5] Understood as: acquired status providing a certain sense of authoriy, e.g., renown/reputation for having a large professional experience.

[Table 2.1] Diffusion entrepreneurs' authority for successful policy diffusion

	Authority			
Examples of diffusion entrepreneurs	**Moral authority**	**Financial authority**	**Expert authority**	**Scientific authority**
Intergovernmental organisations	X	(X)	X	
Philanthropic foundations		X	(X)	
National governments	X	(X)		
International scientists			(X)	X
International consultants			X	(X)

Note: X = the *typical* authority that diffusion entrepreneurs possess and mobilise; (X) = the *potential* authority that diffusion entrepreneurs possess and mobilise.

Table [2.1] gives an overview of some exemplary DEs' sources of authority as discussed in the relevant literature. Intergovernmental organisations may enjoy both moral and expert authorities given their legitimate political status and their normative power (Shiffman, 2014). Philanthropic foundations — whose positioning has acquired considerable legitimacy in international development cooperation due to their contribution to development aid — possess financial authority (Harman, 2016). Some scientists may acquire scientific authority by securing an international reputation, and by expanding their scientific credibility (Bijker et al., 2009). The main asset of international consultants with decades of experience is their temporal resources: this may allow them to build international renown, thereby granting them expert authority (Grundmann, 2017).

Entrepreneurs do not possess all types of resources and authority. For this reason, they may be inclined to build alliances with strategic partners — with whom they share similar representation systems — in order to increase their chances of policy diffusion (Bernstein, 2011). Building from this, we posit that policy diffusion will be facilitated when actors enjoying different categories of authority and resources amalgamate their efforts (conceptual proposition1) [6].

We now turn to the final feature of entrepreneurs that can transform them into promoters of policy diffusion, namely their strategies. Despite the previous features, entrepreneurs' strategies should depend on their representation systems, interests, resources, and/or authority. We posit

[6] See Chapter 3 for further explanation of the term "proposition".

that polycentric regimes offer DEs an apparatus of strategies they can apply to shape diffusion processes. At the same time, however, polycentric governance offers this opportunity structure to a great number of potential DEs, which leads to enhanced competition over influence. Drawing on the instructive literature on problem definition and agenda building, we expect DEs to conceive and use strategies that spread a certain discourse around the policy innovation that corresponds to their representations of the policy. Such discourse is spread through strategies to frame the policy in such a way that increases political buy-in, stimulates policy learning and emulation among future (and expected) policy adopters, and creates the conditions of successful policy experimentation. Thus, we argue that successful DEs engage in strategies to frame the policy and shape experimentation, learning and emulation (conceptual proposition 2). The timing and sequence of these strategies can vary, but for a DE to be successful and to ensure the spread of a policy innovation, all four types of strategies need to be applied given the enhanced competition among DEs in polycentric systems. Table [2.2] outlines illustrations for these strategies that may be developed in this particular context. These analytical categories are designed to apply to any context. Yet as outlined above, DEs may conceive strategies in a more deliberate manner when they evolve in polycentric contexts.

[Table 2.2] Examples of strategies designed by DEs to foster policy diffusion in the context of international development cooperation

Strategies to frame the policy	Strategies to shape experimentation	Strategies to shape learning	Strategies to shape emulation
Linking the core principles of the policy innovation to existing global orientations	Defining rules of collaboration between actors in the testing of a policy innovation	Sharing the results of evaluations of pilot programmes testing the policy innovation	Creating an online exchange forum for “pilot programme experimenters” across beneficiary countries
Introducing the policy innovation as being inspired from peer recipient countries’ experience	Bringing an international technical assistant into a country’s government to assist with the implementation of a pilot programme offered by a donor	Developing and disseminating a standardised guide based on the lessons learnt from testing the policy innovation	Organising study tours and workshops to build a community of programme experimenters

In the following sections, we illustrate these analytical categories using the case of health performance-based financing in Sub-Saharan Africa, which represents a typical example of policy diffusion in polycentric governance.

4. Performance-based financing in Sub-Saharan Africa [in Chapter 1]

5. Plausibility probe of the concept on diffusion entrepreneurs

In this section, we apply the components of our conceptual framework on diffusion entrepreneurs to the adoption of PBF by countries in Sub-Saharan Africa in order to probe its plausibility and to formulate empirical propositions subsequently.

5.1 Methodological considerations

The database for the plausibility probe is a literature review of peer-reviewed and grey literature on PBF and diffusion entrepreneurs, published in English or French from January 2000 to December 2017. We included both peer-reviewed and grey literatures because we wanted to incorporate documents from the main organisations involved in PBF, as well as blog entries from key individuals involved in PBF promotion. Portuguese was excluded because the documents produced on the Mozambican experience (Mozambique being the only African Lusophone country implementing PBF) were also available in English. Table [2.3] provides an overview of the review and selection process.

[Table 2.3] Overview of the literature review and selection process

Selection process	Peer-reviewed literature	Grey literature
English language	-Web of Science (Medline, Science Citation Index Expanded, Social Sciences Citation Index, Arts & Humanities Citation Index): for search on performance-based financing in Africa, from 2000 to 2017 inclusive. -Scopus database: for search on international organisations promoting development reforms, from 2000 to 2017 inclusive.	-Blog entries and reports from "Health financing in Africa" webplatform: http://www.healthfinancingafrica.org -PBF generic training manuals -Research syntheses, reports, blog entries from the World Bank's *Results-Based Financing (RBF) Health* webplatform: http://www.rbfhealth.org -World Bank's Independent Working Group's website: http://ieg.worldbankgroup.org -World Bank publications (i.e., annual *World Development Reports* and books on health financing) -NORAD website: https://www.norad.no/en/front/ -DfID website: https://www.gov.uk/government/organisations/department-for-international-development -USAID website: https://www.usaid.gov -SINAHealth website: http://www.sina-health.com -Cordaid website: https://www.cordaid.org/en/

French language	CAIRN database (for both searches)	-French content in blog entries from "Harmonization for Health in Africa" webplatform
Search terms	-Web of Science: (Subsaharan-Africa OR African country OR [list of 46 country names]) AND (Performance-based financing OR pay-for-performance OR pay* for performance OR performance-based incentives OR results-based financing) -Scopus: TITLE-ABS-KEY ("international organisation*" OR "international financial institution*" OR "aid agenc*" OR "World Bank") AND TITLE-ABS-KEY (policymaking OR "policy agenda" OR decision-making OR governance) AND (economics OR financing OR incentive*) AND (development OR health OR education) AND (LIMIT-TO (SUBJAREA, "SOCI")) AND (LIMIT-TO (DOCTYPE, "ar"))	-Google Books: Africa AND "global health" AND ("health policy" or "health reform*") AND ("international organisation*" OR "international financial institution*" OR "World Bank") -Google.com: searching for online transcripts of interviews given by individual DEs: "[Names of six individual DEs] AND interview*"
Publication type	Commentary, review, original research paper with content related to PBF policy diffusion in any of the 46 countries and/or diffusion entrepreneurs	Content related to PBF policy diffusion in any of the 46 countries and/or diffusion entrepreneurs
Selection of documents	-Web of Science: 21 papers (out of 141 results) selected (N=21) -Scopus: 23 papers (out of 414 results) selected (N=23) -Cairn: 6 papers (out of 41 results) selected on PBF; 18 papers (out of 106 results) selected on international organisations promoting development reforms (N=24)	-Three books were found through Google Books (out of 189 results) (N=3) -PBF generic training manuals (N=3) -Blog entries from "Harmonization for Health in Africa" (N=7) -Reports from "Harmonization for Health in Africa" (N=2) -Blog entries from the *Results-Based Financing (RBF) Health* webplatform (N=5) -Reports from rom the *Results-Based Financing (RBF) Health* webplatform (N=3) -Reports from international organisations funding PBF (N=4) -Report from the World Bank's Independent Working Group (N=1) -World Bank's official publications (N=5) -Webpages and reports from institutional websites (N=10) -Online transcripts of interviews (N=3)
N of selected documents	68	46
Grand Total	**114**	

We extracted secondary data from 114 documents to portray DEs' representation systems, motivations, resources, authority, and strategies. First, we posit that a necessary condition for successful policy diffusion is that diffusion entrepreneurs pool their types of authority and resources (theoretical proposition 1). Second, keeping the opportunity structure provided by

polycentric governance in mind, we outline the development of some of diffusion entrepreneurs' strategies to impact policy framing, experimentation, learning and emulation (theoretical proposition 2).

5.2 PBF diffusion entrepreneurs' representation systems and motivations

There are three main categories of policy entrepreneurs seeking to diffuse PBF globally. First, there are individuals, such as independent consultants and scholars based in Europe or North America, and employees of international organisations. Second, several diffusion entrepreneurs are state organisations like international organisations (e.g., The World Bank, the United States Agency for International Development, USAID) and non-state organisations, like NGOs (e.g., Cordaid). Third, there are networks, such as the PBF community of practice, and the network of pilot programme implementers generated by World Bank-led activities. Using the literature presented in Table [2.4], we identify DEs' representation systems and motivations (i.e., the first component of our framework).

[Table 2.4] Overview of the literature used to unveil DEs' representation systems and motivations

Type of documents	Used to illustrate DEs' representation systems	Used to illustrate DEs' motivations
Peer-reviewed articles	Broad, 2006 Broad, 2007 Meessen *et al.,* 2011	Grittner, 2013 Loevinsohn & Harding, 2005 Meessen *et al.,* 2011 Paul & Renmans, 2017 Soeters & Griffiths, 2003 Turcotte-Tremblay *et al.*, 2016
Independent Working Group report	Schneider, 2014	
Books	Barnes et al., 2015	Lee *et al.*, 2002
Generic Training Manual	Fritsche *et al.*, 2014	Fritsche *et al.*, 2014
Interviews transcripts available on public websites	Boulenger, 2009 GPOBA, 2016 Soeters, 2010	
World Bank publications	Friedman & Scheffler, 2016	Jamison *et al.*, 2006 (chapter by Schieber *et al.*, 2006) The World Bank, 2003
"Harmonization for Health in Africa" blog entries and reports		Communities of Practice & World Health Organization, 2016 Mathauer, 2016
"Results-Based Financing Health" blog entries and reports	Morgan, 2010	Vledder, 2013

First, thanks to the literature, we are able to unravel the representation systems of two main types of DEs: international organisations (in particular, the World Bank), whose systems are shaped by an institutional culture, and individuals (consultants, academics and employees of international organisations), whose systems build on their professional and educational backgrounds.
The World Bank, which has promoted the vast majority of healthcare financing reforms, has an institutional culture rooted in economic theory (Broad, 2006). Consistent with this culture, the World Bank primarily employs economists (Broad, 2007). Such culture has led World Bank to develop a coherent set of assumptions based on economic theories about what the issues in world development are (e.g., health providers lacking individual incentives to provide quality healthcare services) and how they may be solved (e.g., offering financial rewards to health providers based on their performance) (Friedman & Scheffler, 2016). A reform like PBF, which builds on economic theory, therefore naturally appeals to the World Bank (Schneider, 2014). Thus it comes as no surprise that the World Bank is one of the main promoters of PBF in low- and middle-income countries (Barnes, Brown, & Harman, 2015).

Concomitantly, several individuals at a lower governance level have emerged as DEs wishing to upscale their experience with a policy that they envisioned as powerful. In a major reference manual on PBF, we find that these individuals have in common a training background in economics and/or healthcare financing (Fritsche et al., 2014, p. xix). Individual DEs also have had an extensive experience working in the private non-for-profit sector in low- and middle-income countries (Boulenger, 2009; GPOBA, 2016; Soeters, 2010). In particular, these individuals have been keen on adapting private sector arrangements — such as contracting — to public health systems in Afghanistan and Cambodia (Loevinsohn & Harding, 2005; Soeters & Griffiths, 2003). These policy experiences of contracting-in and contracting-out preceded PBF (Fritsche et al., 2014). Building on these experiences, individual DEs notably developed strong assumptions about the usefulness of adapting private sectors arrangements into the public sector (Meessen, Soucat, & Sekabaraga, 2011). These experiences shaped their representations of healthcare financing issues and the possible remedies to these (e.g., Boulenger, 2009; Soeters, 2010). Therefore, such personal features — a background in economics and extensive experience in adapting contracting arrangements to public health systems — have contributed to shape a representation system anchored in economics theory and private sector structures' adaptation to

public services. The theoretical underpinning of PBF directly builds on this ideology (Fritsche et al., 2014).

Second, in the case of PBF, DEs' motivations are three-fold. Their first motive relies on a genuine attempt to solving multiple issues impeding the utilisation of health services by African populations (Turcotte-Tremblay, Spagnolo, De Allegri, & Ridde, 2016). Donors and international organisations promoting past healthcare financing reforms (e.g. health insurance) had strived to solve issues such as suboptimal quality of healthcare and low motivation of health workers, by modifying collection and pooling functions (Lee & Goodman, 2002; Schieber, Baeza, Kress, & Maier, 2006). The purchasing function had been largely overlooked, even though it has been considered a critical feature of functioning healthcare financing systems, particularly for ensuring better quality at lower costs (Mathauer, 2016). For these reasons, several international organisations and individuals expressed interests in conceiving reforms that would emphasise modifying the purchasing function (Communities of Practice HHA & World Health Organization, 2016). Therefore, for many DEs, PBF represented a timely and promising shift: Morgan asserts that "[t]he strength of [individual DEs'] commitment is borne out of careers spent looking for solutions to seemingly intractable health woes and inequities in poor countries, and many disappointments with traditional approaches along the way" (Morgan, 2010).

DEs' second motive reflects clear self-regarding interests for yielding fast results (Vledder, 2013) in response to the relative failure of past healthcare financing policies. The policies aiming at changing pooling and collection functions which were implemented in the 1990s-2000s involved highly complex, time-consuming processes (Lee & Goodman, 2002; Schieber et al., 2006). In the 2000s, several donors and international organisations had developed a certain fatigue from the lack of results (e.g., The World Bank, 2003). For many donors and international organisations, this feeling translated into the need to deliver faster results. According to its international advocates, PBF precisely delivered fast results: "the available evidence suggests that the performance-based payment created opportunities to quickly improve the delivery of healthcare services" (Grittner, 2013). For diffusion entrepreneurs, PBF thus aligned well with donors and international organisations' wish to produce fast results, thereby representing a welcomed alternative policy that would quickly demonstrate efficiency (Fritsche et al., 2014).

DEs' third motive for promoting PBF relates to donors' own self-regarding interests. Typically, DEs (in particular, those who are not representing donors) look for financial support to promote their policy idea and the "package" of activities that goes with it (see below in 5.3): aligning with donors' interests is of strategic importance to them. Donors are mainly interested in fulfilling their results-orientation agenda, which involves favouring interventions which activities can be easily tracked (Paul & Renmans, 2017, p. 2). In this respect, they perceived PBF as a desirable reform — as compared to other healthcare financing reforms — because it entails the development of systematic, transparent, and retraceable reporting of activities (Fritsche et al., 2014). Indeed, for donors, unlike alternative reforms such as health insurance or user fee exemption, one of the core values of PBF is that it leads to better accountability (Meessen, Soucat, et al., 2011).

5.3 Joining diffusion entrepreneurs' resources to foster the diffusion of PBF

Given the polycentric nature of global health governance (Shiffman, 2017) and the enhanced competition among policy actors, diffusion entrepreneurs need to possess certain assets in order to influence policymaking. In particular, they need to develop a legitimate authority that can be acknowledged by other policy actors navigating in their polycentric context. This establishes solid grounds on which to build strategies to foster the diffusion of their preferred policy — in this case, PBF. It is therefore critical for DEs to accumulate relevant resources and authorities: these will assert their influence. Using the literature presented in Table [2.5], we identify DEs' resources and authorities, and we explore the relevance of theoretical proposition 1, i.e. that a necessary condition for diffusing a given policy is that DEs pool their resources and types of authority.

First, DEs can tap into different resources. Large international organisations, such as USAID and the World Bank involved in diffusing the PBF idea benefit from favourable assets in global governance arenas. Being both large aid donors, the World Bank and USAID have important material resources (Gergen et al., 2017). The World Bank possesses robust political resources based on its intergovernmental structure (Kwakwa, 2017). Besides, based on the World Bank's institutional culture rooted in economics, it developed strong knowledge resources in economics. Thus, the World Bank, which conceives of itself as a "knowledge bank" (Wagstaff, 2012), can be

further portrayed as an "economic knowledge bank" given its established experience in the field. For instance, Schneider reports that almost half of the World Bank's health operations support countries in improving the three functions of healthcare financing, and that the purchasing function has recently taken a prominent role (Schneider, 2014, p. 1). In other words, PBF can be conceived of as a *natural* application of an international economic organisation's core business.

[Table 2.5] Overview of the literature used to unveil DEs' resources and authorities

Types of documents	Used to illustrate DEs' resources	Used to illustrate DEs' authorities
Peer-reviewed articles	Gergen *et al.*, 2017	Hout, 2012 De Francesco, 2014 Yanguas & Hulme, 2015
Independent Working Group report	Schneider, 2014	
Reports from international organisations funding PBF		Norwegian Agency for Development Cooperation, 2012
Generic Training Manual	Fritsche *et al.*, 2014 SinaHealth, 2017	Fritsche *et al.*, 2014
Interviews transcripts available on public websites	Soeters, 2010	
World Bank publications and blog entries	Wagstaff, 2012 Kwakwa, 2017	
"Harmonization for Health in Africa" blog entries and reports	Meessen, 2015	Fritche, 2013 Meessen, 2015
"Results-Based Financing Health" blog entries	Morgan, 2010 RBF Health, 2016	

Individuals' training in (health) economics and professional experience with the predecessors of PBF have shaped DEs' knowledge resources in health financing in low- and middle-income countries (Fritsche et al., 2014, p. xix; Schneider, 2014). Besides knowledge resources, through their extensive experience as policy advisors or consultants in low- and middle-income countries, these individuals developed strong social and political resources (*ibid.*). Some of them also had temporal resources. For instance, in the mid-2000s, an independent consultant strongly involved in PBF promotion dedicated large amounts of temporal resources (Soeters, 2010). The PBF networks' resources (fairly high political, knowledge, and social resources) primarily rely on those of their respective leaders, who happened to be DEs. For instance, prior to joining the PBF

Community of Practice (CoP), many practitioners involved in PBF policy implementation on the African continent (i.e., the target audience of these networks) had (regularly) met with individual DEs leading this network (Meessen, 2015a; Morgan, 2010). The social interactions among DEs are also critical: practitioners following a seminal PBF course organised by a training company led by an individual DE were invited by the latter to join the CoP (SinaHealth, 2017b). Conversely, members of the CoP's online forum promote these courses (e.g., van Heteren, 2017). This mutual feeding serves to enhance the network's attractiveness.

Material resources specifically directed at the diffusion of PBF came through the establishment of a multi-donor trust fund in late 2007. Under the leadership of several Norwegian officials and employees at the World Bank (among them, a few individual DEs), the *Health Results Innovations Trust Fund* (HRITF) was created. Administered by the World Bank, the HRITF raised funds from the Norwegian and British development agencies (RBF Health, 2016). At the end of 2016, this multi-donor fund's had committed US$385.6 million matched to US$2.0 billion in financing from the World Bank's International Development Assistance (*ibid.*). The readiness of these material resources, which were made available to DEs, made it possible to operationalise DEs' policy agenda. DEs were financially empowered to build a global community, create and disseminate knowledge, and experiment PBF in many places (Norwegian Agency for Development Cooperation, 2012).

Second, PBF DEs have multiple types of authorities helping them exerting a significant influence for policy diffusion. In global health governance, the reputation of organisational DEs is established from a long time. To start with, their expert authority stems from the global recognition of their leading status (e.g., international organisations following the World Bank's new governance approaches to development; Hout, 2012). These organisations "establish their authority through their roles as advisors, experts, or solution providers" (De Francesco, 2016, p. 355). Moreover, their moral authority is built on their long-term normative involvement in low- and middle-income countries (Yanguas & Hulme, 2015). Coincidentally, individual DEs' decades of professional experience of collaboration with the highest-levels of policymaking in low- and middle-income countries build their expert authority on the multiple fora of global

health governance (Fritsche, 2013; Fritsche et al., 2014, p. xix). Expert authority is also a critical feature of the PBF Community of Practice (Meessen, 2015a).

Many individual DEs know each other from past PBF experiences in Asia and Eastern Africa (Morgan, 2010). Besides, collaboration links were established from 2010 with the World Bank and the CoP (*ibid.*). At that point, DEs embraced the same cause, i.e., to "put PBF at the heart of health systems and… trigger a revolution" (Meessen, 2015a). Long-lasting relationships and repeated interactions between DEs naturally led them to join resources and authorities towards realising this common enterprise. Therefore, around 2010, DEs combined large material resources with social, knowledge, political, and temporal resources, as well as their moral and expert authorities. Concurrently, starting from 2010, the diffusion curve of PBF fastens, as shown in Figure 2.1. Thus, the combination of DEs' resources and authorities could indeed represent a necessary condition for fostering diffusion.

5.4 Strategies developed by PBF diffusion entrepreneurs

After securing the mobilisation of funding and critical human resources assets, the DEs' next step is to take concrete actions. Using the literature as shown in Table [2.6], we assess the relevance of theoretical proposition 2, i.e., that DEs deliberately develop an apparatus of strategies to frame the PBF policy in a way that increases global, regional, and national buy-in, which thereby stimulates policy emulation and learning, and creates the conditions of successful PBF experimentations.

[Table 2.6] Overview of the literature used to unveil DEs' strategies

Types of documents	Used to illustrate DEs' strategies
Peer-reviewed articles	Barnes *et al.*, 2014 Bertone *et al.*, 2013 Chimhutu *et al.*, 2015 Gautier & Ridde, 2017 Kiendrébéogo *et al.*, 2017 Low-Beer *et al.*, 2007 Mayaka Manitu *et al.*, 2015 Meessen *et al.*, 2011 Sieleunou *et al.*, 2017 Tosun, 2017

Independent Working Group report	Schneider, 2014
Resources found on institutional websites of organisations contributing to PBF training and/or implementation	Humuza et al., 2016 Van de Looij, 2009 SinaHealth, 2013 SinaHealth, 2017a
Generic Training Manual	Fritsche *et al.*, 2014 SinaHealth, 2017b
Books	Barnes et al., 2015
World Bank publications and blog entries	The World Bank, 2014 The World Bank, 2015
"Harmonization for Health in Africa" blog entries and reports	Meessen, 2015a Meessen, 2015b Ntakarutimana, 2014
"Results-Based Financing Health" blog entries	Morgan, 2010

First, DEs use rhetoric strategies in order to frame PBF in such a way that it appears desirable regarding its costs and benefits. We can witness two ways in which PBF has been framed in the international discourse. The first refers to local ownership and frames PBF as an idea originating from African countries (Barnes, Brown, Harman, & Papamichail, 2014, p. 24; Mayaka Manitu, 2015), i.e. being "locally owned" and Africa-led. A study reveals that organisational diffusion entrepreneurs "suggested that African countries had been clearly demanding such an intervention within health systems for a long time" (Barnes et al., 2015, p. 40). Rwanda's success story served as a crucial ingredient building the Africa-led framing of PBF: DEs in general were keen on citing Rwanda as "the key originator of PBF as a tool of health reform in Africa" (*ibid*). The second type of discourse is that of "good governance" for accountability is inherent to PBF: providers cannot get their rewards if the assigned tasks have not been verified and counter-verified. Besides increasing accountability towards African countries' civil society, PBF would increase accountability to external funders by allowing the emergence of better aid-tracking systems. Barnes et al. report that PBF was thus framed as an instrument to "help curb corruption" (Barnes et al., 2015, p. 37). In an attempt to synthesise both discourses, DEs support a set of "best practices" that have emerged in a participatory fashion, to guide African practitioners in their implementation of PBF accountability mechanisms (SinaHealth, 2017b). This corresponds to the so-called "learning-by-doing" approach to PBF that DEs actively promote (Low-Beer et al., 2007). The *best practices* discourse also matches the logic of standardising key successful experiences of PBF in Africa. Correspondingly, with the development of study tours, PBF was

crafted in the language of South-South learning, whereby "flagship countries" became the success stories from which any other country could learn (Barnes et al., 2015).

Second, in concordance with the framing of an Africa-led policy, DEs have strived to develop and expand a global PBF community, notably by bringing together the national actors involved in PBF experimentation in African countries. DEs' main strategy to spur emulation involves creating networks channelling selected information on PBF, which often reflect individuals' and organisations' positioning (e.g., see Barnes et al., 2015) and developing their sense of belonging to a community. These networks greatly benefited from the facilitating opportunity structure of polycentrism. Indeed, the prescribed participatory feature of polycentric governance creates the conditions for the emergence of networks acting as independent decision-making authorities at multiple scales (Tosun, 2017). Examples of these networks include the World Bank-led PBF community and the PBF community of practice (CoP). The HRITF has sparked the development of a World Bank PBF community of implementers and evaluators of HRITF-funded projects (Barnes et al., 2015). Consolidating this network, the World Bank has been organising annual gatherings where PBF practitioners from recipient countries and World Bank researchers exchanged lessons learnt from PBF pilot schemes implementation and share initial results of pilots' impact evaluations.

Another vocal, "practice-based" PBF network emerged: the PBF *Community of Practice* (CoP). The target audience of this network is mostly African individuals (experts, consultants, and civil servants) who have been implementing PBF as a pilot scheme or a nation-wide policy (Morgan, 2010). In addition, The CoP has an online forum and two blogs where members share their lessons learnt on a variety of PBF topics. Members also strive to defend PBF when they sense it is under attack (Meessen, 2015a). Besides, as shown above, many of the CoP members are alumni of a training company providing regular training sessions on PBF in African countries (SinaHealth, 2017a). This history helps consolidate PBF practitioners' sense of belonging to a community (SinaHealth, 2013), thereby reinforcing policy emulation. Importantly, for both the World Bank-led network and the CoP, PBF pioneers in Sub-Saharan Africa (Rwanda and Burundi) served as strong sources of emulation, particularly for national actors (Kiendrébéogo et al., 2017). This produced two effects. First, a wave of study tours to Rwanda and Burundi was

funded by organisational DEs (The World Bank, 2014). Second, PBF practitioners from pioneering countries became active members of the CoP, in an attempt to increase the visibility and credibility of their expertise (e.g., on Rwandan experts, see Humuza et al., 2016), and seize job opportunities advertised through the CoP (Meessen, 2015b; Meessen, Kouanda, et al., 2011). Such jobs opportunities lead these CoP members to become technical assistants in other countries experimenting PBF, thereby transferring their practical knowledge of PBF (e.g., Ntakarutimana, 2014). Study tours and the construction of an African PBF expertise therefore foster policy emulation.

Third, based on their framing of PBF as a set of best practices, DEs develop strategies to induce certain forms of (technical) learning among national policymakers through the production and diffusion of PBF documentation. Seminal examples of the deliberate shaping of policy learning include the HRITF's official learning strategy (The World Bank, 2016) and the CoP's vision relying on valuing, producing, and disseminating practice-based types of knowledge on PBF experimentation in African countries (Bertone et al., 2013; Meessen, Kouanda, et al., 2011). Networks and organisational DEs thereby shaped a certain form of learning, which tends to take "a 'how-to' technical approach to PBF, offering practitioners a clear guide as to how PBF can be implemented and adapted to different country contexts" (Barnes et al., 2015, p. 20). DEs promoted technical knowledge on PBF, which was disseminated across Africa through intensive training (Kiendrébéogo et al., 2017). Organisational DEs supported the training of national African actors both financially and technically (The World Bank, 2015; van de Looij, 2009). Building from the pioneering PBF experiences of Burundi and Rwanda, several training manuals were developed. Those include the aforementioned PBF Toolkit (Fritsche et al., 2014) and the course manual developed by the private company which specialises in PBF training (SinaHealth, 2017b). This technical approach to policy learning, however, failed to question the appropriateness of the PBF model itself. In fact, some voice concerns that such training might promote a "one-size-fits-all" approach to PBF (Barnes et al., 2015). Besides, as stated above, each pilot programme executed through HRITF required the implementation of an impact evaluation (Schneider, 2014). This generated a collection of costly (e.g. at least US$2 million for the impact evaluation in Burkina Faso) and complex randomised studies measuring the impact of PBF. There have been concerns as to the objectivity of the evidence generated by these

evaluations, given that the same organisation has been involved in advocacy, technical assistance, funding, and evaluation (Gautier & Ridde, 2017). The extent to which these strategies effectively fostered policy learning in the original sense — i.e., using information or experience from other units for better-informed policymaking, therefore remains questionable. Indeed, in several countries (e.g., Benin, Cameroon) "decisions were made to scale up regardless of weak, inconclusive, or incomplete pilot results" (Schneider 2014, 55). These strategies may therefore merely represent additional attempts to induce policy emulation, whereby countries adopt a blueprint inspired from pioneering countries' experience with PBF.

Fourth, strategies to stimulate national adoption at the national level mainly involve offering a PBF 'testing package' including health sector financing, technical assistance, and trainings to governments showing interest in testing PBF (Schneider, 2014). The 'testing package' is also offered to countries not showing interest: there have been instances where cooperation became coercion (Chimhutu, Tjomsland, Songstad, Mrisho, & Moland, 2015, p. 5). Employees of international organisations predesign pilot programmes and set the rules of collaboration between a wide range of actors, including health authorities, NGOs, technical assistants, and the donor(s). DEs also engage in informal strategies, such as lobbying key country officials in view of making them policy champions, as in Cameroon where World Bank employees deliberately looked for national leaders championing PBF (Sieleunou et al., 2017).

These developments tend to confirm that despite the enhanced competition among DEs in polycentric systems, DEs have successfully fostered PBF diffusion through their framing of the PBF policy and their shaping of policy emulation and experimentation (theoretical proposition 2). Given the technical approach to PBF adopted by DEs in their production and knowledge, and the potential biases surrounding the evidence that they generated, DEs' strategies for ensuring policy learning in fact only may have reinforced policy emulation.

Table [2.7] summarises the insights from our application of framework to PBF, which we discuss in the next section.

[Table 2.7] Framework categories tentatively applied to PBF

Diffusion entrepreneurs	Individual DEs based in Europe and North America	The World Bank and HRITF	Community of Practice	NGOs involved in PBF (e.g., Cordaid)	Private company specialised in PBF training	Other donors (e.g., Norwegian development agency)
Representation system	Embedded in (health) economics	Embedded in economics	Valuing practice-based expertise	*(to be completed)*	Valuing practice-based expertise, private-for-profit logic	*(to be completed)*
Motivations	*(to be completed)*	Increased recognition, return on investment	Career advancement for its members *(to be completed)*	*(to be completed)*	Return on investment *(to be completed)*	Return on investment
Resources	Knowledge, social, temporal, political	Material, political, knowledge	Social, knowledge, temporal	Knowledge, political, social, temporal	Temporal, material, social	Material, political, knowledge
Authority	Expert (primarily), scientific	Financial, expert, moral	In search of expert authority	Expert	Expert	Financial, expert, moral
Strategies to frame the policy	Linking PBF to prevailing global discourses	Linking PBF to prevailing global discourses	Introducing PBF as being inspired from peer countries' experience	Linking the core principles of PBF to existing national orientations	*(to be completed)*	Linking PBF to prevailing global discourses
Strategies to shape emulation	Making of a PBF community *(to be completed)*	Organising workshops for pilot programme experimenters	Creating an online exchange forum for PBF implementers across African countries	Contributing to the making of a PBF community	Contributing to the making of a PBF community	Contributing to the making of a PBF community
Strategies to shape learning	Developing a best practices guide based on lessons learnt from testing PBF	Evaluating the effects of pilot programmes, funding/organising trainings and study tours	Dissemination of multiple forms of knowledge (through online forum, face-to-face workshops, etc.)	*Some of them:* production and dissemination of multiple forms of knowledge through training, etc.	Production and dissemination of knowledge through training	Production and dissemination of multiple forms of knowledge through training
Strategies to shape experimentation	Provision of funding and technical assistance to national actors	Funding and co-implementing PBF pilot programmes	*(to be completed)*	Participating in the implementation of pilot programmes	Provision of technical assistance to national actors	Funding pilot programmes, sometimes using a coercive form of persuasion

Note: The mention "*to be completed*" implies that the authors will carry out empirical investigations to fill in missing information in this table.

5.5 Insights obtained from the analysis and way forward

Based on theoretical reflections, we reflected on the logical consistency of theoretical propositions 1 and 2 using secondary data from various literatures. Our analysis revealed DE largely dominates the results: The World Bank. This may be due to the fact that other organisational DEs are less visible in the available literature.

The idea that a critical condition for a given policy to successfully diffuse is that DEs join their resources and types of authority (theoretical proposition 1) is backed by our preliminary analysis. From this analysis we can draw a first proposition to be studied empirically, which postulates that the merging of resources and types of authority increases the likelihood for a policy innovation to diffuse.

Our preliminary investigation indicated that in the case at hand, DEs have purportedly undertaken strategies to shape policy diffusion (theoretical proposition 2), namely through framing the PBF policy in ways that increase global, regional, and national buy-in, which contributed to stimulate policy emulation and some forms of policy learning, and created the conditions of successful PBF experimentations. Therefore, we can draw a second empirical proposition, which postulates the following: the strategic use of policy frames increases the likelihood for a policy innovation to diffuse.

Overall, policy diffusion in the case of PBF was greatly facilitated by polycentrism. The polycentric nature of governance amplified possibilities for DEs to spread PBF, by opening up an avenue of opportunities for influence — of networks and individual experts, in particular — in ways that would have been inconceivable before. Therefore, a third empirical proposition contends that increasingly polycentric governance arrangements foster the diffusion of policy innovations.

When moving forward with these three empirical propositions, qualitative data will be collected from key informant interviews and observation of PBF-related meetings and workshops. First, the influence of DEs in global-level diffusion of PBF will be investigated. Second, two case

studies will be undertaken respectively on the CoP and in Mali to explore the contribution of DEs to the diffusion of PBF at continental and national levels. Interviews will be conducted with key informants considered experts of PBF (including individual DEs), African government officials, academics studying PBF, employees of organisations involved in PBF (including organisational DEs), and members of PBF networks. Repeated interactions with interviewees will help build their trust towards the interviewer and will likely enable to elicit useful data to analyse the actors' belief systems and motivations.

The PBF case also enabled to unravel unexplored patterns, which might open the door to additional investigations. First, considering the apparatus of strategies used to stimulate emulation for PBF in Africa, as well as the influence of networks of African PBF experts, it is possible to infer a 'DE snowball effect'. In other words, it is likely that these enterprises, mostly led by Europe-based or United States-based DEs, have contributed towards the establishment of African DEs of PBF operating in different African countries. Empirical research is needed for offering a hard test of this reasoning. Drawing from this, we can postulate the 'DE snowball effect' hypothesis. We also find that diffusion entrepreneurs' training or institutional background, and their abilities, mattered for the outcome of the diffusion process. Without DEs' resources, it would have been neither possible to harness actors' mobilisation around an active network (such as the CoP), nor to raise the necessary financial resources around the World Bank-coordinated HRITF. Nor would it have been possible to bring the PBF community together, i.e. all the actors that promote, implement, or evaluate the approach. Building from this, another hypothesis can be postulated: when DEs' representation systems and skillsets align with the policy content and when the latter matches donors' interests, this increases the likelihood of the diffusion. We invite future qualitative and quantitative research to test these two additional hypotheses.

6. Conclusion

This article introduces the concept of diffusion entrepreneurs who, in spite of several attempts to "bring back the actors", have remained a sort of forgotten link in public policy analysis, including in diffusion studies (Capano et al., 2015). This study unfolds the critical features of diffusion entrepreneurs and their strategies in a polycentric context. The polycentric nature of global governance has, in particular, greatly expanded the participation of lower-level of decision

making bodies (e.g., transnational policy networks). The growth of their opportunities for influence has, in turn, facilitated the diffusion of policies. In traditional global governance, where large international organisations dominated, such diffusion entrepreneurs would arguably not have had as much success.

Therefore our framework, which offers a compelling description of diffusion entrepreneurs' representation systems, motivations, resources, authorities, and strategies, provides valuable analytical categories to public policy analysts whose empirical data reflects polycentrism. Those with a specific interest in global health and other international development sectors will find in the present study some of the critical dimensions to account for when analysing the diffusion, in countries with limited resources, of policies actively promoted by multiple organisations, networks, and individuals.

To illustrate the concept of diffusion entrepreneurs, we relied on the case of PBF in Sub-Saharan Africa. Based on findings from a literature review and the depth of information obtained thanks to this promising framework, we were able to demonstrate that our analytical categories offer critical insights to the case of performance-based financing diffusion in Sub-Saharan Africa. First, DEs' merging of their resources and types of authority has increased the chances of PBF diffusion. Second, in the case of PBF, we showed that DEs have deliberately undertaken strategies to shape policy diffusion: framing the PBF policy in certain ways has contributed to stimulating policy emulation and facilitated PBF experimentations. DEs' strategies to spur policy learning revealed more complex processes. While DEs crafted PBF in the language of *best practices* and *learning-by-doing*, we find that it is *a certain type* of policy learning that has been induced by DEs. In the end, this enterprise may only contribute to reinforce emulation among people who were already convinced of the value of PBF. Qualitative empirical data will be helpful to further investigate this issue.

In turn, learning about diffusion entrepreneurs through the lens of PBF offered unexplored patterns in the policy diffusion body of knowledge. Building on these unexplored patterns, we have offered two additional hypotheses that could be empirically tested in future (quantitative or qualitative) research. The first posits a DE snowball effect across multiple scales, and the second

postulates that the alignment of the policy content to DEs' representation systems and resources, and to donors' interests, increases the likelihood of policy diffusion.

Lastly, PBF diffusion is still ongoing in the African continent, and there are critical issues as to the sustainability of the diffusion model. Future investigations will be needed to understand the possible trajectories that PBF will take in the future in Sub-Saharan Africa.

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Chapter 3. Research propositions and methodological considerations

This interdisciplinary thesis is initially enshrined in the field of "public policy studies" (Lasswell, 1970) and health systems and policy research (HPSR), but adopts a multidisciplinary analytical approach (Engeli and Rothmayr Allison, 2014), to account for the complexity of the diffusion process in the most comprehensive way possible.

Among the multiple hypotheses and propositions offered in the second chapter (which can be tested by quantitative and qualitative researchers), we draw five *propositions* to guide the conduct of this thesis (see subsection 3.1 below). The use of this term is coherent with our epistemological stance (see Chapter 1), since we adopt a qualitative-dominant approach to data collection and analysis. We use propositions rather than cause-and-effect relationships (Deslauriers and Kérisit, 1997, p. 95) or hypotheses to be tested and verified. As in Ridde, 2005, we use these *propositions* as starting points for our empirical qualitative research.

These propositions feature multiple forms of power of diffusion entrepreneurs. First, they include diffusion entrepreneurs' resources, which represent the *power-to* do things, e.g. enabling them to attract other actors and build their loyalty, which is something that will be useful in subsequent actions (e.g., constitute policy networks). Second, they feature diffusion entrepreneurs' types of authority, which are considered legitimate within the policy arena they evolve in (i.e., based on the recognition of their status). These types of authority illustrate *power-over* other actors. Their types of authority feature compulsory, institutional, structural, and productive forms of power (Barnett and Duvall, 2005). Diffusion entrepreneurs' power thus translates into abilities and the exercise of legitimate types of authority. This dual power creates the conditions for the development of an apparatus of strategies aimed at enhancing policy diffusion. Their influence, in turn, would transpire through their success in effectively fostering policy diffusion.

In this chapter, we outline the five propositions and offer some conceptual clarifications on the framework on diffusion entrepreneurs; present the three empirical studies (research design, object, and setting); provide details of how we completed data collection and analysis, and how ethical issues were addressed; report on our knowledge translation activities; and offer some personal reflections on the challenges and opportunities with data collection, analysis, and translation.

3.1 Propositions guiding the research

In Chapter 2, we suggested that a necessary condition for the successful dissemination of a given policy is that DEs pool their resources and types of authority. This strategy seems to be the case for performance-based financing (PBF). The DEs increased their chances of successful actions by pooling their knowledge, material, social, political, and temporal resources; and by benefiting from multiple forms of authority (moral, financial, scientific, expert). Diffusion entrepreneurs' resources feature power-to do things, while their authority enables them to exert power-over other actors (see Table 3.1).

Table 3.1. Definitions of resources and types of authority, and linkage to forms of power (Gautier et al., 2018b)

Items	**Definition**	**Power-to do what? Structural, institutional, scientific, or expert forms of power-over others?**
	<u>*Resources*</u>	
Knowledge	All forms of knowledge assets (e.g., drawn from educational background, professional experience and/or training, academic evidence, lay/practice evidence, etc.)	Gives them power as they communicate with others, especially if they are evolving in an environment that values their knowledge (of a specific issue/ policy)
Material	Human, equipment and financial means at hand	Empowers actors to realise their policy objectives and/or motivations
Social	Social capital and actors' natural ability to connect and bond with other people	Gives them power as they communicate with actors previously known, especially useful for persuasion
Political	Actors' ability to mobilise key policy actors (e.g., building upon previous work experience/collaboration with high-level policymakers)	Gives them power as they communicate with high-level / strategic policy actors previously known, especially useful for persuasion

<table>
<tr><td>Temporal</td><td>Actors’ ability to find/make time, at any point in the diffusion process</td><td>Enables for time flexibility to fulfil pre-set objectives; provides the possibility to dedicate time to a cause</td></tr>
<tr><td colspan="3"><u>Types of authority (statutory power — i.e., internationally-recognised power over others)</u></td></tr>
<tr><td>Financial</td><td>Recognised status in the global arena, that stems from the large amounts of financial resources fuelled into international development cooperation</td><td>Compulsory power (e.g., of donors) over less dominant actors</td></tr>
<tr><td>Moral</td><td>Recognised and legitimate status in the global arena to shape behaviours, and validity of the categories “that the claimant uses to express the needed political changes” (Gautier et al., 2018, p.164). Typically, organisations with moral authority can produce norms and play a prescriptive role.</td><td rowspan="2">Institutional power (e.g., of donors or academic institutions) and productive power (e.g., fuelling problem representations through discourse) over less dominant actors. Actors with any of these forms of power can also produce norms that are internationally recognised

*May also exert structural power over others recognising their leadership and experience in dealing with a particular issue</td></tr>
<tr><td>Scientific</td><td>Internationally-renowned academic status combined with a recognition of the validity/utility of the claimant’s perceptions of reality</td></tr>
<tr><td>Expert</td><td>Type of renown built on (typically, successful) prior professional experience in implementing a given policy and/or internationally-recognised capacity to provide solutions to issues</td><td>Structural power of experts over actors not (yet) considered “experts” of a given issue/policy</td></tr>
</table>

This preliminary finding (drawn from testing our conceptual framework, see Chapter 2) has a major implication for the present political economy analysis (PEA) of PBF diffusion: the pooling of resources (i.e., power-to) and types of authority (i.e., power-over) seems to be a natural inclination for these already powerful actors. Indeed, in the second chapter, there were some strong indications that DEs’ pre-established reputation, based on their compulsory, institutional, structural, and productive power over other actors, played a significant role in the outcome of the process. Using empirical data, we will examine the idea that without the resources previously accumulated by the DEs, and their capacity to be recognised as legitimate actors of the polycentric GHG, represent necessary conditions to mobilise all the actors and the necessary financial resources (<u>proposition 1</u>). Furthermore, we suggest that when the systems of representation and the competences of DEs are aligned with the content of the policy, and when it matches the interests of donors exerting compulsory and institutional forms of power, the chances of diffusion in a polycentric context increase (<u>proposition 2</u>).

Our review of the empirical literature also revealed that DEs had deliberately designed and implemented strategies to foster PBF diffusion (proposition 3), including framing it in ways that both feature their productive power, and encourage adherence to global, continental, and (sub)national levels. Such framing has increased the impact of other strategies undertaken by DEs (to foster policy emulation, learning, and experimentation of PBF). Not only did these strategies help promulgate to a wider audience, they also shaped the contours of the diffusion, and what was to be diffused. It seems that only certain discourses and forms of learning (whose content was highly controlled, and featured DEs' expertise prominently) were put forward (Barnes et al., 2015). This feature illustrates the political economy of the diffusion: the structural and productive influence of DEs at the global level allows for controlling of the diffusion (proposition 4).

The case of PBF has also brought to light unexplored phenomena. Considering the policy apparatus used to stimulate PBF emulation in Africa, as well as the growing structural influence of African PBF expert networks, it is possible to infer a DE "snowball effect". Thus, it is likely that these enterprises led by powerful DEs acting at the global level, have contributed to the making and empowerment of second generation DEs in Africa, in turn operating in different African countries (proposition 5).

Using the conceptual framework defined in Chapter 2, and featured in Figure 3.1, we attempt to test these propositions. Each framework dimension connects to another. Each dimension also reinforces one another in a dynamic fashion. For example, on the figure, the strategies to foster policy framing, emulation, learning, and experimentation are feeding each other.

Figure 3.1 Conceptual framework on diffusion entrepreneurs (Source: Gautier al., 2018b)

3.2 Three empirical studies: choice of design, study object, and setting

In order to gauge the reliability of these propositions, three empirical studies, including two qualitative research studies, and one qualitative-dominant mixed-method study were carried out at three different levels (i.e., one level per study): global (political arenas of global health and European research institutes), continental (sub-Saharan Africa), and national (case of Mali). Each study addresses these five propositions.

Global-level research study

First, we intended to unravel the global-level discursive processes that shaped the diffusion of PBF in sub-Saharan Africa. To do this, we studied the construction of the PBF discourse and the influence of global-level DEs in this enterprise, using a poststructural approach to discourse

analysis (Bacchi and Goodwin, 2016). For this analysis, there was no single setting. We attempted to cover the multiple locations of the policy's original design, development, funding, and promotion. We included major organisations involved in promoting, implementing, and/or funding PBF; individual European and North American DEs who helped design the policy in the 2000s; and transnational networks who contributed to develop knowledge on the policy and promote its practitioners.

Among the organisational DEs promoting, implementing, or funding PBF, many are international organisations and NGOs involved in development cooperation for decades. Other organisational DEs include private-for-profit actors (consulting and training companies, mainly) whose business in development cooperation — and health — is relatively recent. As highlighted in the first chapter, the participation of all of these GHG actors in the development cooperation in health features multiple forms of power, among themselves and with recipient/beneficiary/partner governments. This study highlights how they use power to influence the diffusion of PBF.

Continental-level research study

Second, a qualitative-dominant mixed-method study was carried out on the role of a transnational network — the *Performance-Based Financing Community of Practice* — in the expansion of the PBF policy idea at the continental level. Mixed method research is rapidly expanding in HPSR (De Allegri et al., 2018). It refers to the "combination of quantitative and qualitative methods of data collection and analysis within a single research effort with the aim of counteracting the weaknesses and building on the strengths of the single quantitative and qualitative approaches" (*ibid.*, p. 446). In this study, consistent with our theoretical underpinning and epistemological stance (see Chapters 1 and 2), we adopt an approach that primarily relies on a qualitative perspective of the research process, while accepting that the addition of quantitative approaches will benefit the present doctoral research (Venkatesh et al., 2016).

This analysis featured sub-Saharan Africa, which is the poorest region of the world, home to more than half of the extreme poor (The World Bank, 2018a). Sub-Saharan populations suffer the double burden of communicable and non-communicable diseases. The average life expectancy at birth (60.39 years) of all 46 countries is also among the lowest in the world (The World Bank,

2018b). This context has sparked a wide number of global initiatives to help curb the health trends in these countries. Designed by high-income country institutions, most of these initiatives pursued fast health gains: an objective that did not necessarily match governments' long-term policy orientations or their effort to harmonise and sustain achievements (Mwisongo and Nabyonga-Orem, 2016).

There is a wide literature exploring the political economy of development aid in single sub-Saharan African (SSA) countries (Bergamaschi, 2014; Ferguson, 1990; Masaki, 2018). There is less empirical evidence of continent-wide or region-wide political economy analyses (Bräutigam and Knack, 2004; Whitfield, 2008). In this second study, we investigated the processes through which multicountry African practitioners come to identify with a health policy (PBF) and participate in its expansion in their home country and other SSA countries. We studied the influence of European and North American individuals in shaping these processes.

(sub)National-level study setting

Third, using a qualitative case study approach featuring interpretive analysis, we explored the influence of DEs on the diffusion of PBF in Mali, at both the national and subnational levels, from 2009 to 2018 (i.e. over a 10-year timespan).

Mali, a country prone to political and military instability, also faces multiple health challenges. The last Demographic Health Survey (2012-2013) pinpointed a high maternal mortality ratio, i.e. 368 deaths per 100,000 live births (Cellule de Planification et de Statistique (CPS/SSDSPF) et al., 2014). It also underlined that 56 out of 1000 children die before their first birthday, and 95 out of 1000 children do not celebrate their fifth birthday (*ibid.*). Mali's health system follows a classic pyramidal model (i.e., city hospitals providing tertiary care, reference district health centers providing secondary care, and community health centers providing primary care). The health system pyramid also features the various levels of decentralisation. The latter was continuously enhanced through the 2000s, with national strategic plans and decrees specifying the roles and responsibilities at each level — regional health directorates (in charge of administrative and technical support to health districts teams), the mayors of districts' capitals (in

charge of managing reference health centres), and Community Health Associations (ComHA, in charge of managing community health centers) (OMS AFRO, 2005).

Notably, Mali is the country of the birth of the Bamako Initiative (BI). The Initiative was endorsed under the auspices of major global health organisations in 1987. The goals of BI were akin to those of PBF, namely to improve access and quality of healthcare services in LMICs through increased community participation and decentralisation of health decision-making and financing (Ridde, 2015). Four main orientations were promoted in the BI: community participation in management and financing of healthcare at all levels; developing and implementing self-financing mechanisms for ensuring healthcare delivery at the district level; decentralisation of health decision making and financing; and continuous provision of essential drugs (Hardon, 1990; Ridde, 2004a). Concurrently, in the mid-1980s, international financial institutions (IFIs) were initiating their loans conditional to the implementation structural adjustment programs in LMICs (Kentikelenis et al., 2015; White, 1996). For African countries, this meant the state's disengagement from health, education, and social services (Loewenson, 1993). According to the economist Brunet-Jailly (Brunet-Jailly, 1992), Malian public authorities negotiated the liberalisation of drugs importation and distribution in ways that exceeded the IFI's requirements, leading to an escalation of drugs' prices. With this context, and the state's financial disengagement, health districts had to find other ways to cover the costs of health service delivery. The BI officially granted the option to ask community members to pay for their own health, which was already largely occurring in Mali in the 1980s (Brunet-Jailly, 1992). This movement gave way to the general endorsement and scale-up of cost recovery, also known as the user fees policy. In Mali, this policy's endorsement was made possible for two further reasons: 1) in 1990 the government adopted a national policy (based on both Alma Ata's principles and the BI) that aimed at empowering communities in financing and managing primary health care services (Waelkens and Criel, 2007), and 2) health districts became more autonomous thanks to an effective decentralisation in the mid-1990s. Unfortunately, these measures did not reach the intended effects, and generated a lot of inequity in access to health services (Ridde, 2015).

In a continuous effort to favour community health, Mali's Mutality Act (*Loi sur la Mutualité*) in 1996 enabled it to create various *mutuelles de santé* (i.e., forms of community-based health

insurance), which have contributed to financing, provision, and access to healthcare services throughout the country. Despite their number (nearly 200 *mutuelles* as of 2013), their coverage remains low (4% of the population; Touré et al., 2014). Lastly, since 2011 healthcare services for vulnerable people are theoretically paid through a public assistance system, *Ramed* (Gouvernement de la République du Mali, 2014). However, none of these funding mechanisms achieved their coverage targets. In late February 2019, Mali's Minister of Health announced the removal of user charges for primary health care and prevention for children under five years old, pregnant women, and elderly people (over 70 years old). This announcement might trigger a wider coverage of population and increase health service utilisation (Diarra, 2019).

From the onset, Mali's health system is characterised by a plurality of funding mechanisms (OMS AFRO, 2005). Yet, in recent years, the country has seen fewer researches on health system financing compared to its neighbours (e.g., Burkina Faso and Niger; Gautier and Ridde, 2017). Mali thus represented an opportune terrain for analysing the political economy of health financing reforms, like PBF. PBF was first experimented in 2012 in three districts of the Koulikoro region. The pilot was designed and operationalised by Dutch development cooperation institutions (a public agency, and a non-for-profit company). The PBF pilot featured a design *à la malienne*, i.e. with the participation of community health centers and mayors of district capitals and villages in defining the expected results, validating the pre-agreed targets in the PBF plan, and verifying results. As part of a World Bank programme that started in 2011, a second PBF pilot project covering all 10 districts of the Koulikoro region was tested in 2016-2017. PBF was featured in national policy planning for 2014-2018 (Secrétariat Permanent du PRODESS, 2013). In early 2019, the MSHP also officially presented a plan to scale-up the policy in different regions. How the policy idea travelled through space (at the national level: in Bamako, and at the subnational levels: in three health districts, and the whole Koulikoro region) and time (from 2009 to 2018) is the object of the third empirical study.

3.3 Data collection

General overview

The data compiled for this thesis was mostly qualitative. We primarily collected data from in-depth interviews with informants (N = 57). This thesis involved elite interviewing (i.e.,

interviewing high-level policymakers, senior academics and consultants, and donor representatives): this required specific measures of control for potential biases emerging from informants' data (Natow, 2019).

First, in collecting data from informants, we sought to avoid the self-serving bias — which refers to informant's tendency to attribute positive effects and successes to their own role (Shepperd et al., 2008). Second, we attempted to mitigate the (mirroring) self-handicapping bias that occurs when informants tend to attribute negative effects and failures to external causes, outside of their control (Meyer and Turner, 2002). These two forms of bias have been identified as frequently emerging from elite interviewing, especially when there are political tensions about the phenomenon of interest (Natow, 2019). The (then) ongoing debate about PBF, as we previously showed, corresponded to such configuration.

To mitigate these potential biases, the key is to bring about a wider picture of the phenomenon under investigation (Davies, 2001). A useful tool to obtain such wider picture, as Natow (2019) indicates, is triangulation. In our research, triangulation served to enhance the confirmability of the data collected from elite informants. Thus, in order to crosscheck and cross-validate interview data, we also collected data from participant observation sessions (N = 13), and key documents on PBF (N = 41).

In the qualitative-dominant mixed method study (Johnson et al., 2007) exploring diffusion at continental level, qualitative data from documents and interviews were supplemented by relational data and textual data extracted from online discussion forum messages (N = 1,346). Relational data were generated through identifying links between authors of messages and people quoted in those messages; they were brought together in an adjacency matrix (see Chapter 5 for details). Textual data was comprised of the content of those forum messages. This quantitative dataset was analysed through a semantic discourse analysis (using QDAMiner©) and social network analysis (generated through R), both using descriptive statistics. These quantitative analyses were intended to complement the characterisation of the CoP's constitutive features, its structural and productive forms of power, and how it fosters policy emulation and learning. Table 3.2 summarises the different sources of data and their relationship to the three studies. This table

shows that the data collected from actors and organisations acting at a given level (left column) could be used to inform the analysis of the diffusion at each of the three levels.

Table 3.2 Data collection and papers' correspondence

Data collection level	**Global-level diffusion (Chapter 4)**	**Continental-level diffusion (Chapter 5)**	**National-level diffusion in Mali (Chapter 6)**
Global (interviews, observation notes, documents)	X	X	X
Continental (interviews, documents and online forum messages)	X	X	X
National and subnational (interviews, observation notes, and documents)	X	X	X
Total	57 informants +10 observation sessions + five PBF institutional documents	40 informants + 17 documents produced by the PBF CoP + 1,346 forum posts	33 + informants + 5 observation sessions + 19 documents on PBF in Mali

Saturation was achieved through recognising that no new insights were emerging from the collected data (Saunders et al., 2018).

Collecting interview data

The sampling method of interview participants was primarily purposive (i.e., based on the position held by potential participants; Palinkas et al., 2015), and secondarily done using a snowball approach (i.e., through a previous interviewee; Noy, 2008). External diversification was emphasised in order to make sure visions of different categories of actors were well represented (Pires, 2007).

Five categories of participants were recruited in conferences and workshops, by email, or through a contact person: 1) representatives of international organisations and members of networks advocating for PBF; 2) PBF experts from African countries; 3) senior officials of the Ministry of Health and Public Hygiene in Mali; 4) health managers and health workers involved in PBF implementation in Mali; and 5) staff working in country offices of at least two other donors involved in health in Mali. We identified these categories through prior mapping (Gautier et al.,

2018b), and through participating in a research launch workshop in Bamako in January 2016. For clarity, and because several informants were falling into more than one category (among the five presented above), we further classified each informant into eight types: 1) international organisations; 2) national government; 3) academic institution based in African countries; 4) academic institution based in European countries; 5) independent consultants based in African countries; 6) independent consultant based in European countries; 7) private-for-profit company; and 8) private-non-for-profit company (see Table 3.3).

We recruited participants electronically (after prior contact directly or via a resource person) or by chance during meetings with people corresponding to relevant profiles. Three main semi-structured interview guides were used according to the category of participants (Appendices G to K). These interview guides featured the dimensions of the conceptual framework. In Appendix C we review the framework dimensions featured in interview questions and the items we analysed from interview respondents' data. Table 3.3 presents the distribution of the different categories of participants.

Table 3.3 Overview of informants and inclusion of their data in each study

Affiliation	To-tal	Nb of participants whose data were used in Chapter 4	Nb of participants whose data were used in Chapter 5	Nb of participants whose data were used in Chapter 6	Individual DEs or employees of organisational DEs
International Organisation [INTORG]	19	19	16	8	12
National Government (African countries) [NATGOV]	13	13	5	10	6 (2nd generation DEs)
Academic Institution based in African countries [ACADINST_AF]	4	4	3	0	0
Academic Institution based in European countries [ACADINST_EU]	3	3	3	0	1
Independent Consultant based in African countries [INDCONS_AF]	9	9	5	9	9 (2nd generation DEs)

Independent Consultant based in European countries [INDCONS_EU]	1	1	0	0	1
Private-for-profit Company [PRIVFP]	4	4	4	3	4
Private Non-for-profit Company [PRIVNFP]	3	3	3	3	3
Other [OTHER]	1	1	1	0	0
TOTAL	**57**	**57**	**40**	**33**	**36**

NB: The categories between brackets are used consistently throughout the presentation of results in each empirical study, in relation to informants and their quotes. The numbers associated with each informant's quote are also used consistently.

The formal 57 interviews took place from November 2016 to November 2017. Out of 57 interviews, 44 were conducted face-to-face. Face-to-face interviews were done in the professional settings of the informants (in Bamako, Dioila, Paris, or Antwerp), or in the margins of conferences and meetings (in Vancouver, Antwerp, or Bamako).

Repeated social interactions with research participants helped to build their confidence in the interviewer and provided useful data to analyse actors' representation systems and motivations (see details below). In addition, over this time period, the interviewer had multiple interviews with several key informants so as to crosscheck emerging findings.

Collecting data from conferences, meetings and workshops on PBF

Although I did not use an ethnographic approach to data collection[7], I contend with ethnographers that using in-depth interviews combined with participation observation allows for higher levels of analytic granularity and provides in-depth empirical insights, especially relevant in the field of international development (Vrasti, 2008). In the context of this thesis, participant observation enabled to 1) approach potential research participants (e.g., during coffee breaks), and 2) both observe and interact with potential and already-recruited research participants in their natural setting, e.g. in routine meetings. Pouliot argues that it is difficult to engage in participant observation in international organisation contexts, because of secrecy and closed-door

[7] This section is writen in first person to describe the specific process of the doctoral researcher.

negotiations (Pouliot, 2010). A possible solution to address this issue would be to carry out interviews with different categories of actors in order to capture the essence of the policymaking process at different levels and reflecting multiple perspectives (Hoyle, 1998), thus preparing for meaningful, and perhaps more specific types of observations, whereby dimensions emerging from interview data can be further unravelled through observation.

When asked to introduce myself, I would explicitly state that I was a researcher observing the meeting/workshop. Thus, I carried out overt participant observation of conference sessions, meetings, webinars, and workshops on PBF. My participation was unobtrusive, meaning that I attempted to avoid "contaminating the research setting", i.e. I refrained from showing to meeting/workshop attendants that I was taking notes of their discussions or acting different in any way (Baker, 2006). In total, I attended 13 events that connected with the research object (the diffusion of PBF in sub-Saharan Africa). Table 3.4 outlines the details of these events. Among those events, five took place online. Since online events offer limited opportunities for witnessing social interactions, observing webinars or online TedX videos do not yield the same amount of empirical details as meetings, conferences, and workshops. As a result, the depth of analysis of observation notes taken during online events is necessarily more limited than face-to-face events.

Table 3.4 PBF events included in data collection

#	Event details	Date	Chapter relevance
1	*RBF Health* Webinar on performance-based financing (PBF) and quality of care	September 2015	Chapter 4
2	*RBF Health* Webinar on PBF outcomes in Nigeria	November 2015	Chapter 4
3	Research programme launch workshop in Bamako (Mali)	January 2016	Chapters 4 and 6
4	Health Systems Global (HSG) session on performance-based financing and results-based financing, Vancouver (Canada)	November 2016	Chapter 4
5	Health Systems Global (HSG) session on performance-based financing, Vancouver (Canada)	November 2016	Chapter 4
6	Post-HSG session on performance-based financing, Montreal (Canada)	November 2016	Chapter 4
7	Online TedX video on curing health systems (featuring PBF in Rwanda)	January 2017	Chapter 4
8	CoP webinar on scaling-up PBF	January 2017	Chapter 4
9	Workshop in Bamako (Mali) on PBF organised by the World Bank country office and the Ministry of Health and Public Hygiene	February 2017	Chapter 6
10	Meeting in Kati (Mali) on PBF organised by the Ministry of Health and Public Hygiene	February 2017	Chapter 6
11	Meeting in Bamako (Mali) on PBF organised by the Ministry of	March 2017	Chapter 6

	Health and Public Hygiene		
12	Meeting in Bamako (Mali) of the health sector coordination unit (featuring most international health donors)	March 2017	Chapters 4 and 6
13	CoP webinar on PBF and quality of care	July 2017	Chapter 4

I participated in each of these events. I systematically took observation notes and transcribed them the same day or the day after.

Collecting data from policy documentation

Policy documentation was collected for analysis, to use as support tools to cross-validate key informant transcripts and participatory observation notes. The content of a total of 41 key documents on PBF were included (Appendix B). The details of these documents may be found in each empirical study featured in the following chapters. Three categories of documents were included: 1) five reference manuals and position papers by major organisational DEs (informing the analysis of the DEs' discourse of PBF at the global level in the fourth chapter); 2) 14 blog posts on PBF directly related to the PBF CoP and three other documents produced by the CoP (i.e., informing the analysis of the CoP's contribution to continental diffusion processes in Africa in Chapter 5); and 3) 19 policy documents on PBF in Mali (i.e., for Chapter 6).

3.4 Data analysis

I transcribed most interview data (32/57 interviews) in English or French, depending on the language in which the interview had been conducted. Three transcribers — one from an English-speaking country, and two from a French-speaking country, transcribed the remaining interview data. I carefully reviewed each transcription through cross-validating the transcribed data with audio records.

I coded in English all interview and meeting/conference observation transcriptions using QDAMiner© software. Using interpretative thematic analysis (Boyatzis, 1998), I adopted a deductive-inductive analytical approach: I applied a pre-existing theoretical construct (our conceptual framework on diffusion entrepreneurs, see Figure 3.1) to analyse data deductively; inductive aspects emerging as I processed the data were used in order to achieve a better level of

detail (Gale et al., 2013) and widen the interpretation of findings. An excerpt from the codebook is provided in Appendix L.

Triangulation took place after all datasets were analysed separately. I listed the findings from each dataset and considered where findings from each method converged, offered complementary information on the same issue, or where they appeared to be contradictory (Farmer et al., 2006). Indeed I concurred with O'Cathain et al. (2010) that "[e]xplicitly looking for disagreements between findings from different methods is an important part of this process. […] Exploration of any apparent "inter-method discrepancy" may lead to a better understanding of the research question" (O'Cathain et al., 2010, p. 2). More details about the methods used for each empirical study are provided in the next chapters.

Lastly, the dissemination of preliminary results offered multiple opportunities to discuss the data with Mali research participants, the donor community in Mali, and African colleagues. I also engaged in disseminating preliminary results to each participant by email, and asked for their feedback and comments. More than half of them replied with encouragements, and a few of them made useful comments, including some nuances to several pre-analyses that I drawn. I decided to include these valuable comments in the analysis. These activities (also detailed below in 3.6) largely contributed to enhance the confirmability and reliability of the results.

3.5 Ethical considerations

Prior to collecting the data, we submitted the thesis research proposal to two ethical review boards: University of Montreal's *Comité d'éthique de la recherche en santé*, and Mali's *Comité d'Éthique de l'Institut National de Recherche en Santé Publique*. Ethical approval was first obtained from the *Comité d'Éthique de l'Institut National de Recherche en Santé Publique* (17/2016/CE-INRSP), and then from the *Comité d'éthique de la recherche en santé* (Certificate 16-153-CERES-D). The certificates are available in Appendix A.

Prior to their participation, all research participants received detailed information about this project. During the interviews, the interviewer (LG) was careful to observe any sign expressing

participants' discomfort. We made sure that the mode of communication was adequate to the context in which the interview took place, taking into account the norms and hierarchies relative to each category of participants. Finally, we encoded any identifying data during transcriptions. Signed consent was received from every participant in person, and we obtained electronically signed and scanned consent forms for those with whom interviews were conducted over the telephone or via Skype.

3.6 Knowledge dissemination and translation strategies

Knowledge translation is defined by the Canadian Institutes of Health Research as "a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically-sound application of knowledge to improve the health, provide more effective health services and products and strengthen the health care system" (Strauss et al., 2013, p. 2). The role of doctoral students in knowledge translation is often overlooked (Younas and Porr, 2019), including in global health (Walker et al., 2006). Yet, their participation to the "knowledge-to-action" movement is likely to bring up interesting developments, especially given their regular exposure to practice settings along the course of their research, including prior to data collection as they familiarise with future potential participants (which we did in Mali, by joining a research launch workshop in January 2016 and conducting several informal discussions with individual participants). In this thesis, we conceive knowledge translation as both a methodological and ethical dimension, through operationalising the notion of reciprocity — i.e., by sharing results with research participants after having taken up their time — and valuing their inputs along the analytical process. Doctoral students and their supervisors also typically engage in collaborations with organisations (e.g., this was the case for the study on the PBF CoP: we regularly communicated with its members and its main facilitator, and we had them contribute to the methods and findings), and can serve as knowledge brokers through building connexions and collaborations with practice settings (Thompson and Schwartz Barcott, 2019).

Thus, an important part of this thesis process involved 1) developing a knowledge dissemination and transfer plan from the initial steps of the research (including in the research proposal); and 2) engaging in social interaction with participants and the wider audience (composed of

international development experts, scholars, and students) to transfer them our main findings along the course of the research. We outline the key strategies, target audience, and content of this research on Table 3.5.

Table 3.5 Knowledge dissemination and translation strategies (completed or planned)

What	State of the knowledge on PBF in LMICs and in Mali	Research approach, methodology and preliminary conceptual framework	Research findings, in French
When	January 2016	Before starting data collection in Mali: January 2017.	During and after completing data collection: March-April 2017; August 2017; January/ February 2019 (status: completed)
Target	*Mali-based research team; participants of a research program workshop launch in Bamako, Mali*	*Mali-based research team*	*National policymakers, other Mali stakeholders, and representatives of donors' country offices*
Dissemination strategies	Two policy briefs reviewing the state of the knowledge on PBF in LMICS (1) and in Mali (2)	Presentation of research tools and approach, feedback sought on appropriateness	*Informal debriefing sessions organised by LG in Bamako, with emphasis on research findings *Preliminary research findings dissemination note (in French) sent to all participants by email (August 2017) *Policy brief on the diffusion of PBF in Mali (January 2019) disseminated during a research workshop in Bamako in Feb. 2019
Translation strategies	Policy briefs were discussed and commented during the workshop; participants contributed to revising and finalising them	N/A	Participants were able to discuss and contribute to research findings
Impact	Familiarisation with the research environment; establishment of preliminary contacts with potential informants Skill development: Learning how to develop a policy brief	Validation of conceptual framework and data collection tools	Integration of informants' contributions and inputs into the analysis; response to comments made on the policy brief.

What	Research findings and conceptual framework, in French	Research findings, in English or French	Conceptual framework, analytical approach, and research findings	Innovative methods used
When	Before completing analysis: October 2017 and 2018; July 2017. (status: completed)	Before completing analysis: July-August 2017.	After analysis, during thesis writing, and after thesis	After thesis submission (status: planned)
Target	*Continental stakeholders (in particular, members of the PBF CoP)*	*International organisations*	*Researchers*	*Students*
Dissemination strategies	*Formal and informal debriefing and results dissemination sessions with CoP members in Antwerp (October 2017; October 2018) *Preliminary research findings dissemination note (in French) sent to all participants (July	Preliminary research findings dissemination note (in English or French) sent to all participants by email (July-August 2017)	*At least four scientific publications, including one in open access journal *One IHP blog on the global discourse of performance-	Organisation of research and training seminars at Université de Montréal and Université Paris-Diderot
Translation strategies	In small groups, participants were able to discuss and contribute to research methods and findings	Participants were able to discuss and contribute to research findings	Using lay language, attempting to explain the dimensions of the DE framework, Bacchi's poststructural approach to	Drawing lessons learnt on the use of Bacchi's approach, applying network analysis and semantic discourse analysis
Impact	Integration of informants' contribution's to methods; integration into the analysis of inputs and comments made on findings dissemination note	Integration of informants' contributions and inputs into the analysis	Skill development: vulgarisation exercise (blog) Knowledge exchanges on methods and approaches used with participants to	*To be determined*

3.7 Reflexive considerations

[Note: several sections of the text below are extracted from a manuscript published in a special issue of Cahiers REALISME on reflexive practice in global health research (Gautier, 2018). I personally translated the content from French to English]

Approaching and recruiting "elite" participants

When embarking on the doctoral adventure, I did not know exactly what my thesis topic was going to be, let alone what categories of informants I would have to collect data from. Global health is such a cross-cutting field of study that it involves a multitude of categories of actors, from indigents in the communities, to heads of UN agencies, health workers, managers of NGOs and philanthropic foundations, departmental executives and many others (Kickbusch and Szabo, 2014). Such complexity must be understood and embraced when you start a doctoral thesis in global health. This also implies being able to give up on certain categories of actors from whom we will not be able to collect data. It will be impossible to reach a sufficient level of detail and granularity if we decide to talk with representatives from all these categories.

My initial training in political science has fuelled my fascination with power issues at the highest level of decision-making, at the national level as well as at the global level. Actors with political influence include donor representatives, senior executives of international organisations, and policy makers in developing countries. These influencers are often referred to as elites — a term I use in this reflective analysis.

Global health governance features multiple forms of power at the global level, including compulsory (i.e., mainly financial), structural, and productive power. Global health donors' exercise of these forms of power is consubstantial to country's national policymaking. In addition, these multiple forms of power have a significant impact on the health of people in developing countries, because decision-making remains highly centralised — there are only a few isolated cases of successful and genuine bottom-up approaches. In fact, global health probably represents the political space where the distance between top and bottom is greatest. Suarez-Herrera (Suárez-Herrera, 2012) described "paradoxical spaces of local sub-order, well-defined geographical entities, such as cities/towns, and overall supraterritorial order, in extremely distant

places”. This reading informed my understanding of global health policies, which are emerging and implemented precisely within these paradoxical spaces and extremely far apart. These reflections led me to question the processes through which these policies, which often appear disconnected from local practices and needs, driven by global actors, were spread across space and time.

To better understand this distance, it seemed essential to explore what drives the elites. After my training, I had several qualitative data collection experiences with these actors. The elite interview is interesting for three reasons: it often arouses strong emotions among researchers (e.g., frustration for not being able to recruit informants; or for not being able to elicit insightful discussions on the phenomenon of interest); it involves the deployment of specific strategies to access informants; and it sometimes creates an unexpected balance in the interaction. Few social scientists have examined the balance of power in interactions between young researchers and elites, and the phenomena that emerge from these interactions (Maertens, 2016; Morris, 2009; Woll, 2006). In most cases, the literature focuses on methodological aspects (Beyers et al., 2014; Goldstein, 2002; Harvey, 2010; Leuffen, 2006). It seemed appropriate to feed the debate with some reflections from my own experience.

However, somewhat disappointed by prior data collection experiences with elites in 2010 and again in 2012-13, I wanted to try to interview other categories of actors further down the chain of influence. I conducted qualitative data collection with program managers and health professionals based in Nunavik (Northern Quebec), and then in Western Côte d’Ivoire with members of “vulnerable” communities located at countries severely affected by the Ebola virus disease. This last experience — interviews and focus groups in the communities — was much more exciting for the young researcher that I was. People would always greet me with a warm welcome, participants were fully available, and most importantly, they showed gratitude that one was “(finally) interested in them”. Surely I was not fooled: this largely idealised appreciation of course masked the reality of the circumstances of my interaction with them. Being a white researcher (McIntosh, 1992) sent to these remote villages in western Côte d'Ivoire was, of course, influencing such warm welcome. I myself was exerting a form of power over my informants.

Such power had an impact on my relationship with them and in turn on the validity of the data collected. I realised that this type of interaction in the practice of research did not suit me either.

For collecting PhD thesis data, I returned to political elites. There, the multiple forms of power that manifest in social interaction seemed to balance one another. However, I must admit that I still somehow missed how easy it was to get access to communities and the feeling of always being well received. But I had to keep a pragmatic methodological choice: I could not interview all the categories of actors without losing granularity. I opted for focusing on these "high-ranking" influencers working behind the scenes and fond of informal conversations, because their personal and practical trajectories were always for me a kind of black box that I intended to help open up. Learning from my past experiences, I knew that I needed to gain more confidence and find strategies to safeguard that the relationship before, during, and after the elite interview.

An opportunity presented itself: a major gathering of global health systems research was taking place, so I took the opportunity to approach the elites I intended to interview, including representatives of donors and international organisations who attended this event. I sent them an email a week in advance giving them the outline of my research project and informing them that I wanted to meet them after their session. I was aware that these major conferences are privileged spaces for networking. Such networking typically takes place during coffee and lunch breaks. I call these moments "*in situ* windows of interaction". Despite the narrowness of the window (some of my "targets" only stayed for one day), I knew I would have a chance to schedule an interview with each of them. This is precisely what happened: they (six in total) all responded favourably. I was able to meet them to schedule an interview during these *in situ* windows of interaction. In addition, they were outside their usual professional setting: this probably made them more relaxed. With some of them, I managed to elicit less political correctness than in the discourse used by other informants located in their usual professional environment.

Establishing and maintaining trust with informants

However, these were only my first thesis interviews: I was still stammering in the process. During interviews, some informants remained suspicious. As Woll (2006) identified, I needed to grasp the perceptions that these elites could have of my research, in order to be able to adapt my

introductory message and build the interaction on a balanced basis. I adapted the content of the introductory text of my research and altered my approach speech so as to appear as a researcher completely distanced from the phenomenon I was studying. In addition, during the interview I sometimes asked my questions in ways that could lead the informants' response: I always seem to have a clear idea of what was going to be said to me. Over time, I began to feel that, in formulating my questions, I was prompting certain answers, thus introducing a bias in the social interaction. I learned to distance myself from some preconceptions (and sometimes even passing off as naive) by reformulating some questions. I was able to observe the effect of all these strategies on my informants: a new equilibrium in the interaction subsequently built on its own. I was respected for my neutrality and my interest in the phenomenon studied. Some informants even mentioned their wish to write on their trajectory within the phenomenon I was studying, and seemed pleased that someone was interested. The interview became a space of mutual interest, generating considerable amounts of data.

Thereafter, the snowball sampling strategy worked perfectly well: the first informants gave me access to several of their contacts in these international organisations. The fact that I had already met and questioned one or more of their close colleagues reassured the core participants of my research. I heard that people were saying: "You can talk to Lara, she is okay" — which suggested I had convinced them of the neutrality I tried to convey *vis-à-vis* the phenomenon. This stepping-stone was a crucial step in my data collection. Pursuing my research in Mali, I continued to reap the benefits: the introduction by these first responders further facilitated discussions with representatives of donors, international organisations, and national decision-makers in that country as well.

This trust relationship with informants also got reinforced later on when I continued to communicate with them after data collection. I engaged in face-to-face and electronic results dissemination. I sent a synthesis of my main preliminary findings in English and French in August 2017. I sent them my first empirical paper and a policy brief on the Mali case study in January 2019 (Gautier et al., 2019a). As I was communicating my preliminary results, I invited them to comment on those results. I made sure to include their comments in my subsequent analyses. Most of the 57 respondents congratulated me for the work done, and some of them

highlighted the nuance I was demonstrating in my analyses. These continuous interaction strategies with informants not only enhanced the credibility and confirmability of my results (Thomas and Magilvy, 2011), but also strengthened my position as a young researcher comfortable with interacting with elites as research objects.

If I were to do again, I would invest more time in interview practice with the various categories of elites before starting the official data collection. It is in this way that one builds self-confidence and develops a certain comfort in dialoguing with elites. I would recommend doing more pilot interviews with all categories of informants (depending on the levels of analysis and in terms of profile: decision-maker / donor / ...). Above all, interview practice with these different categories is what allowed me to gain confidence in approaching and conducting interviews with elites.

Use of reflexive tools during data collection and analysis

To achieve credibility within the research community, every researcher ought to exhibit transparency and reflexivity (Yin, 2011). My positioning in favour of a more balanced relationship between donor and recipient countries conditioned my research interest, and it also enabled me to complete this thesis. I attempted to put it aside throughout data collection, in order to ensure objectivity during my interaction with informants and during observation sessions.

As I collected data from informants and observation sessions, I also systematically took notes. In addition to this, I also kept a personal journal in which I regularly wrote my reflections during data collection and analysis. In this journal, I reported on the interviewing process, on the challenges (including some personal frustrations), opportunities (e.g., access to a new informant) arising in that process, and on potential areas for comparison (e.g., informants highlighting a similar issue) and differences. The journal critically offered the opportunity to draw pre-interpretive thoughts as data collection was occurring. These measures — interview notes and personal journal — also enabled me to generate additional questions of interest, which I could use in subsequent interviews (as in Jones, 2018). Therefore these reflexive tools were instrumental in ensuring the credibility of my findings. However, as a Western researcher I still represent a certain discourse (Wetherell, 2001), and this discourse inevitably transpires in this

thesis, even though I made sure to integrate my African colleagues' inputs, as well as contributions from participants after results dissemination.

Chapter 4. The diffusion of performance-based financing at the global level

Article 2. How is the discourse of performance-based financing shaped at the global level? A poststructural analysis

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How is the discourse of performance-based financing shaped at the global level? A poststructural analysis

Abstract

Background: Performance-based financing (PBF) in low- and middle-income settings has diffused at an unusually rapid pace. While many studies have looked at PBF implementation processes and effects, there is an empirical research gap investigating the ways PBF has diffused. Discursive processes are paramount elements of policy diffusion because they explain the origins of essential elements of the political debate on PBF. Using Bacchi's poststructural approach that emphasises problem representations embedded in the discourse, the present study analyses the construction of the global discourse on PBF.

Methods: A rich corpus of qualitative data (57 in-depth interviews and 10 observation notes) was collected. The transcribed material was coded using QDAMiner©. Codes were assembled to populate analytical categories informed by the framework on diffusion entrepeneurs and Bacchi's poststructural approach.

Results: Our results feature problem representations shaped and spread by PBF global diffusion entrepreneurs. We explain how these representations reflected diffusion entrepreneurs' own belief systems and interests, and conflicted with those of non-diffusion entrepreneurs. This research also reveals the specific strategies global diffusion entrepreneurs engaged in to effectively diffuse PBF, through reflecting problem representations based on the discourse on PBF, and inducing certain forms of policy experimentation, emulation, and learning.

Conclusions: Bacchi's poststructural approach is useful to analyse the construction of global health problem representations and the strategies set by global diffusion entrepreneurs to spread these representations. Future research is needed to investigate the belief systems, motivations, resources, and strategies of actors that shape the construction of global health discourses.

Keywords: global discourse, performance-based financing, diffusion entrepreneurs, poststructural analysis

The greatest challenge to any thinker is stating the problem in a way that will allow a solution.
— Bertrand Russell

Background

The beginning of the millennium saw the rise of Universal Health Coverage (UHC) as an overarching objective shaping health sector reform in low- and middle-income countries (LMICs). Since then, strategies to increase coverage and access to quality health services have been (re)framed by international actors as being part of a global movement towards achieving UHC. Performance-based financing (PBF), a health systems reform that shifts from an input-based to an output-based purchasing approach, provides a classic example of continuous "reframing". As of June 2017, no less than 32 out of 46 (71,7%) sub-Saharan African (SSA) countries utilised PBF (Gautier et al., 2018).

If the claims in favour of developing PBF in Africa are to be gauged, it is critical to assess not only PBF implementation processes and effects (Das et al., 2016; Witter et al., 2012; Wiysonge et al., 2017), but also it gained traction at a global, continental, and national level. To date, there has not been any empirical investigation on policy diffusion processes at the global level. PBF evolves in global governance characterised by increasing polycentrism, whereby international institutions (i.e., multilateral donors, bilateral donors, United Nations agencies, and non-governmental organisations (NGOs)), networks, and key individuals represent political units exerting power. At the global level, the discourses produced by actors of polycentric governance — cannot be overlooked. Building on the notion of "diffusion entrepreneurs" (i.e., collective and individual actors actively promoting a global policy) and on our prior work having developed a framework specific to PBF diffusion entrepreneurs (Gautier et al., 2018), we investigate the content (*what*) of their discourses and *how* these discourses matter for global diffusion.

We understand discourse as "a dynamic form of social practice which shapes the social world including identities, social relations and understandings of the world" (Jørgensen and Phillips, 2002). The literature on the shaping of global health discourses is expanding (Harmer, 2011; McDougall, 2016; Noy, 2017; Storeng and Béhague, 2016), yet few empirical papers have addressed health financing strategies, and even fewer have used a framework encompassing

polycentrism as a starting point for analysis. A well-known example is Lee & Goodman's description of a powerful "global elite" made of a wide array of actors who backed the introduction of user fees in LMICs (Lee and Goodman, 2002, p. 103). A recent book (Barnes et al., 2014) analyses the discourse that transpires from the contents of a major PBF web platform, but this analysis only reflects the views of the people behind that specific platform. The deep-rooted processes that shape diffusion entrepreneurs' representations of global health financing issues and how these representations specifically mould the global discourse on PBF remain to be unravelled.

In this paper, we examine the content of the discourse on PBF and how it is brought about in the global health arena, emphasising the contribution made by diffusion entrepreneurs acting at the global level.

Methods

1. Theoretical underpinnings

Diffusion entrepreneurs' framework

In polycentric governance, various units of governing authorities (including networks and individuals at the lowest level of governance) influence global policymaking (Tosun, 2017). Diffusion entrepreneurs (DEs) represent those units of governing authorities acting to spur the diffusion of their favoured policies. DEs are shaped by representation systems that reflect their individual or collective culture. These ideational representations influence their career choices and ensure motivation to support a particular policy (Weyland, 2005). Once DEs acquire sufficient (financial, expert, social, etc.) resources and statutory authority on the global arena, their voice is bound to have a significant echo (Gautier et al., 2018).

In our prior work, we identified PBF DEs (Gautier et al., 2018). At the global level, they include a wide range of individuals (academics, experts, consultants, and employees of international organisations), international organisations (i.e., NGOs, bilateral development agencies, and a multilateral development bank), and transnational networks particularly active in SSA. Also in our prior work, we proposed that order to foster PBF diffusion worldwide, DEs deliberately engage in specific strategies to frame the PBF policy in certain ways, to stimulate policy

emulation, to shape certain forms of policy learning, and to facilitate policy experimentation (Gautier et al., 2018).

Bacchi's poststructural approach

Several interpretivists (e.g., Kingdon (Kingdon, 2003), Rochefort & Cobb (Rochefort and Cobb, 1994), etc.) and critical realists (e.g., Pawson & Tilley, 2004) have been interested in the way(s) in which policies are defined and framed, often specifically investigating how the discourse on given policies is produced. There are two shortcomings to these approaches (Bacchi, 2016). First, both lack a reflection on how contexts, subjects (e.g., targeted populations), and problems are conceptualised. For instance, in his discussion of problem definition and framing, Kingdon leaves ambiguous the contested nature of problems reaching the political agenda (Kingdon, 2003). Second, critical realists and interpretivists neither question the representation systems reflected in problem definition nor the nature of knowledge produced (and/or used) to define and frame policies.

Poststructuralists (e.g., Bacchi) argue that social actors ought to be understood to be "in continual formation" and therefore "form part of what must be 'interpreted' rather than the starting point of interpretation" (Bacchi, 2016). Bacchi's conceptual framing, aka "*What's the problem represented to be?"* (WPR), starts with a postulation and identifies the problem representation implicit within it. Bacchi's approach is rooted in Foucaud-inspired concept of 'governing'. She suggests that governing "takes place through the formation of 'problems', that is, through problematisation" (Bacchi, 2016, p. 12). Governing units not only incorporate classic political actors (government, political parties etc.), but also units at lower levels of policymaking—experts and professionals (Bacchi, 2016). For Bacchi, these new governing units bring new questions to policy analysis: their discourse produces problems within the policy solutions they advocate for (Reekie, 1994). She suggests analysing the process of "problematisation" to reflect upon the overall shaping of policies, in order to identify what this process encompasses as well as what it overlooks (Table [4.1]). Bacchi describes WPR as a poststructural approach in the sense that "'subjects,' or 'problems' that form the basis of policy analysis are understood as shaped, or constituted, through practices" (Bacchi, 2016). Bacchi does not entirely reject previous works: she simply suggests to dig deeper into the context surrounding definition and framing of policies

(i.e., how representations affect this context, or how context affects representations). Bacchi's framework incorporates a few dimensions (e.g., categories of problem definitions) that several interpretivists looked into in greater detail (e.g., Rochefort and Cobb, 1994).

[Table 4.1]. Bacchi's WPR approach (Adapted from [Bacchi and Goodwin, 2016a])

Question #	Question title	Explanation
WPR Q. #1	What's the problem represented to be in a specific policy or policies?	If a government proposes to do something, what is it hoping to change? And, hence, what does it produce as the 'problem'? Here, considering policy 'objects' and 'subjects' (i.e., people who become problematised)
WPR Q. #2	What deep-seated presuppositions or assumptions underlie this representation of the "problem" (problem representation)?	Looking into representation systems embedded in the discourse
WPR Q. #3	How has this representation of the "problem" come about?	Analysing power relationships, the role of conflicting ideologies, disrupting the assumption that what *is* reflects what *has to be*
WPR Q. #4	What is left unproblematic in this problem representation? Where are the silences? Can the "problem" be conceptualised differently?	Identifying what has been overlooked and looking at the implications of these silences
WPR Q. #5	What effects (discursive, subjectification, lived) are produced by this representation of the "problem"?	Identifying the perceived effects of the problem representation
WPR Q. #6	How and where has this representation of the "problem" been produced, disseminated and defended? How has it been and/or how can it be disrupted and replaced?	Identifying the governing knowledges, sites, institutions, and networks involved in the problem representation

While we find the WPR approach helpful in our research on the global PBF discourses, we explicitly distinguish Bacchi's and the criticism on which it builds of other policy analysts, from our conceptual framework on DEs. The starting assumption of this empirical study is that PBF discursively emerged as a policy innovation that encompassed certain problem representations. We propose that the problematisation process reflects the interference and influence of powerful actors — global DEs. DEs are governing units evolving in polycentric governance (Bacchi, 2016): their nature and characteristics as much as their discourse (Gautier et al., 2018) ought to

be interpreted. Our approach includes (and interprets) global DEs as producers of problem representations in the global health arena.

2. Analytical framework

Our results are charted using DEs' framework dimensions, while the WPR approach provides analytical categories to critically reflect on and further unpack the results. Thus, Bacchi's six exploratory questions are brought into diffusion entrepreneurs' key characteristics and strategies (detailed in Gautier et al., 2018) (Table [4.2]). We also use Rochefort and Cobb's 'categories of problem definition claims' (outlined below in Table [4.2]), as they fall under the scope of Bacchi's first question.

[Table 4.2]: Analytical framework (adapted to analyse the global discourse on PBF)

<table>
<tr><th colspan="2">1. Describing the discourse on PBF as a policy solution</th></tr>
<tr><td colspan="2">Describing PBF policy representations, by comparing PBF definitions across four generic manuals (Fritsche et al., 2014; SinaHealth, 2019; The AIDSTAR-Two Project, 2011; Toonen et al., 2012) and one institutional position paper (Cordaid, 2015) developed by organisational diffusion entrepreneurs, and definitions provided by diffusion entrepreneurs in interviews.</td></tr>
<tr><th colspan="2">2. Describe WHAT is promoted, i.e. PBF problem representations</th></tr>
<tr><th>DEs' theoretical framework dimensions</th><th>Bacchi's WPR questions</th></tr>
<tr><td>DEs' representation systems and how they are reflected in PBF problem representations</td><td>WPR Q. #1: What is the problem represented to be in the PBF policy?
• Causality: selectively identifying the causal patterns leading to the problem, including culpabilising those considered responsible
• Severity: "how serious a problem and its consequences are taken to be" (Rochefort and Cobb, 1994)
• Proximity: characterising the issue in a way that appeals to personal experience/emotions or concerns a matter that feels close to home
• Problem populations: characterising groups and individuals affected by the problem

WPR Q. #2: What deep-seated presuppositions or assumptions underlie this representation of the problem?
Describing how DEs' representation systems, i.e. DEs' personal, collective, and institutional cultures that are reflected in their assumptions about the world, shape these problem representations.</td></tr>
<tr><td>DEs' motivations to deal with the problem; resources at hand (i.e., knowledge, financial, social, political and temporal resources), and capacity to</td><td>WPR Q. #3: How has this representation of the problem come about?
Attempting to answer this question using empirical</td></tr>
</table>

<table>
<tr><td>demonstrate authority at the global level. Four types of authority are distinguished (Gautier et al., 2018):
• Financial authority supposes a recognised status in the global arena mostly stemming from the large amounts of financial resources fuelled into international development cooperation
• Expert authority may be achieved when entrepreneurs pursue an internationally-recognised status of expertise, mainly through mobilising knowledge, social, and temporal resources
• Scientific authority involves both building international renown and putting forward the validity or utility of the claimant's "definition, description or explanation of reality" (Gieryn and Figert, 1986) which secures a legitimate normative power
• Moral authority stems from the status of the claimant vis-à-vis those whose behaviour they seek to shape, and from the validity of the categories that the claimant uses to express the needed political changes (Shiffman, 2014, p. 297)</td><td>data on DEs' motivations to fuel their problem representations, DEs' resources at hand, and DEs' types of authority.</td></tr>
<tr><td>N/A</td><td>WPR Q. #4: What is left unproblematic in this problem representation?
Attempting to answer this question using empirical data: critically reflecting on DEs' representations of what PBF is supposed to solve, and looking into the criticism expressed by several key informants towards DEs' discourse</td></tr>
<tr><td>N/A</td><td>WPR Q. #5: What effects (discursive, subjectification, lived) are produced by this representation of the problem?
Attempting to answer this question using empirical data, looking at DE's representation of what PBF is supposed to solve, identifying the perceived discursive effects, and the "subjectification" (i.e. the making and unmaking "subjects" (Bacchi and Goodwin, 2016a)) that is operated by DEs

NB. We do not consider the "lived effects", since the policy considered here can hardly bear an impact on life or death — at least not in the sense Bacchi conceives this analytical subcategory.</td></tr>
<tr><td colspan="2">3. Analyse HOW PBF policy and problem representations are promoted by diffusion entrepreneurs</td></tr>
<tr><td>How do DEs link PBF to common popular frames (policy framing), which in turn creates the conditions of successful pilot programmes (policy experimentation), appeals to a sense of community (policy emulation); and gets fuelled through multiple forms of knowledge (policy learning)?</td><td>WPR Q. #6: How and where has this representation of the « problem » been produced, disseminated and defended?
Investigating how problem representations are defended by DEs</td></tr>
</table>

3. Data collection

From November 2016 to November 2017, the first author collected data from informants (N=57) through in-depth interviews via a snowball sampling approach, and from participant observation in PBF-related international workshops, webinars, and meetings (N=10). Key informants primarily included DEs intervening at the global level that were identified through prior mapping (Gautier et al., 2018), i.e. employees of international organisations and NGOs involved in PBF promotion; academics; international experts; and facilitators of PBF transnational networks. We also interviewed "non-DE" informants, i.e. people who are not proponents of PBF, yet were acknowledged as PBF experts at the global level (e.g., academics) and/or who have been directly interacting with DEs along the course of their career or as collaborators involved in PBF training, pilot scheme experimentation, and evaluation of PBF schemes (e.g., employees of international organisations, SSA policymakers, and SSA consultants involved in PBF experimentation). SSA informants were included to provide additional insights into the activities undertaken by global DEs. All interviewees were approached by email. The first participants were recruited on-site during a major global health systems event (Gautier, 2018). The first author carried out all interviews in English or French. Interview guides included 25 open-ended questions approaching various themes reflected in the DE framework (Supplementary File 1). Two questions prompted respondents to quote PBF reference documents and resource persons. All participants read a detailed information sheet and provided their written consent prior to the interview. Ethical approval was obtained from University of Montreal's *Comité d'éthique de la recherche en santé*.

To increase confirmability, we carried out two triangulation exercises. First, to verify or complement material, we undertook additional interviews with seven key DE informants previously interviewed. Second, in August 2017, after verbatim transcriptions were completed (by the first author aided by three research assistants), we electronically sent all the participants a two-page description of preliminary results. Complements sent by participants in response to that email were subsequently added to the corresponding transcriptions. Saturation was achieved through recognising that no new data was emerging in the interviews (Saunders et al., 2018).

Table [4.3] provides details of the 57 respondents. Among the 57 key informants, 35 were individual DEs (promoting PBF as individual entrepreneurs, speaking on their own) and/or

operational employees of organisational DEs (i.e., transnational networks, NGOs, or international organisations). The majority of them were medical doctors (N=20), public health (N=15) or health economics (N=2) specialists, and economists (N=10).

[Table 4.3] Participants' general characteristics

Current affiliation (N=57)		Main educational background (N=57)		Years of experience in international development, all but "NATGOV" cat. (N=44)		Gender (N=57)	
International organisation [INTORG]	19	**Medical sciences**	33	**< 10 years**	6	**Male**	45
National Government (SSA countries) [NATGOV]	13	**Economics**	15	**> 10 years < 20 years**	27	**Female**	12
Independent consultant [INDCONS]	10	**Other social sciences**	4	**> 20 years**	11		
Academic Institution [ACADINST]	7	**Other health sciences**	4				
Private for profit [PRIVFP]	4						
Private non-for-profit [PRIVNFP]	3						
Other [OTHER]	1						

4. Data analysis

Using a primarily deductive approach, the material was coded by the first author using QDAMiner©. Codes were assembled to populate analytical categories, which consisted of the abovementioned dimensions integrating the DE framework and Bacchi's six WPR questions. We allowed additional subdimensions to emerge from the data in an inductive fashion. Based on five interview transcripts, a preliminary codebook was shared with co-authors of this paper and subsequently adjusted before continuing the coding process (Saldana, 2015). All analytical thoughts were brought into QDAMiner© via the memo feature, and were used to further reflect on the data analysis (Given, 2008).

Results

Findings are presented as follows: first, we report on the ways the global definitions of PBF reflect DEs' representation systems; second, we show how the problematisation of PBF brings about DEs' motivations, resources, and authority; and third, we describe the strategies developed by DEs to promote these problem representations.

1. How DEs' representation systems are reflected in the definition of performance-based financing (PBF) as a policy solution

Informants quoted five key reference documents (including four generic manuals and one PBF position paper) on PBF (Cordaid, 2015; Fritsche et al., 2014; SinaHealth, 2019; The AIDSTAR-Two Project, 2011; Toonen et al., 2012), which also happened to be developed by organisational DEs. We interviewed at least one representative of each of these organisational DEs. We extracted the definitions used in these five documents (Table [4.4]).

[Table 4.4] PBF definitions contained in reference documents and corresponding language categories

Source	*Definition*	*Main keywords and their language categories*			
		Economic sciences language	*Management sciences language*	*Clinical language*	*Social sciences & humanities language*
The World Bank's Performance-based financing Toolkit (2013) (Fritsche et al., 2014)	"PBF targets health facilities with a fee-for-service (conditional on quality) payment mechanism. […] PBF involves contracts with individual health facilities, whether public or private […]. PBF is done through a 'contracting-in' approach: PBF is put onto existing public and private health systems with a significant involvement of nonstarter actors".	*Conditionality (incentive theory) *Contract (contract theory)		*Quality of care	*Health systems reform
SinaHealth coursebook (2016) (SinaHealth, 2019)	"Performance-based financing is a systems reform approach, which offers an answer to the 'how' of achieving Universal Health Coverage and the Sustainable Development Goals 2015-2030. Unlike other financing mechanisms, PBF proposes a hierarchy whereby the delivery of quality services comes first, followed by the efficient use of scarce public resources and only then equity	*Service delivery *Efficiency *Financing mechanism		*Quality of care	*Systems reform *Equity and financial access

	and financial access".				
PBF Handbook by Management Sciences for Health (MSH) and USAID (2011) (The AIDSTAR-Two Project, 2011)	"PBF is the transfer of money or material goods from a funder or other supporter to a recipient, conditional on the recipient taking a measurable action or achieving a predetermined performance target. […] PBF shifts most financial risk from the funder to the recipient: payment (or sometimes the 'performance incentive' portion of the payment) is received when—or withheld until—results or actions are verified by the funder. […] [T]he funder links incentives to the recipient's achievement of predetermined results. Recipients include institutions and/or individuals; in a health program, supply-side recipients might be service-providing institutions (clinic, hospital) and/or health care providers at any level".	*Conditionality (incentive theory) *Money transfer *Incentives *Service delivery *Measurable action/target			
Royal Institute of Tropical Medicine (KIT) booklet (2011) (Toonen et al., 2012)	"We use 'performance' in terms of productivity (number of outputs, rather than attaining targets or coverage of certain priority programmes) and of quality of care as perceived by the patient as well as by professionals. […] RBF, PBF, P4P or 'achat de performance' all aim at motivating healthcare workers to perform better. To achieve this, one can stimulate both their intrinsic motivators […], as well as their extrinsic motivators such as financial incentives".	*Production of healthcare *Incentives *Motivation	*Outputs	*Quality of care	
Cordaid position paper (2015) (Cordaid, 2015)	"Results Based Financing [RBF] is a system strengthening approach that introduces checks and balances along the service delivery chain, encouraging better governance, transparence and enhanced accountability. It achieves this by linking payments directly to performance. Contrary to traditional input funding, service providers […] receive their payment on the basis of agreed indicators and verified output. […] They are autonomous in	*Conditionality (incentive theory) *Measurable action/target *Motivation *Service delivery	*Governance, transparence and accountability *Autonomy *Entrepreneur-ship *Verification of outputs (output evaluation)	*Quality of care	*System strengthening approach

	how they spend the funds in order to achieve their own aims […]. RBF motivates service providers to deliver more services of higher quality and promotes entrepreneurship”.				

NB: Some DEs, such as Cordaid, used the expression “results-based financing (RBF)” for what is generally referred to as performance-based financing (PBF). Usually, PBF is encompassed in RBF, as it represents a supply-side type of RBF (Musgrove, 2011). Other DEs use the expression “pay[ing] for performance (P4P)”.

Table [4.4] highlights the focus on the supply-side of the health financing equation. It illustrates the high prevalence of economic language in PBF definitions used in reference documentation produced by organisational DEs, and referred to by DE informants. This depiction is consistent with DEs’ discourse when they described PBF during interviews:

> *It came about as an innovative financing, right? I mean, a lot of inputs financing has been done, and continues to be done, and the thinking is that… motivation and focusing on results, might bring about change… and the performance of the system. And… the tools […] are… Tools that could… make the system more effective and efficient. And dynamise how people look at health services and delivery of services.* (I53_INTORG)

DEs defined PBF using an *instrumental orientation*, by emphasising a logical course of action to achieve outcomes or “results”, rather than the means of implementation (Rochefort and Cobb, 1994). Informants described this feature as a major innovation, since input-based financing was, by contrast, directed primarily to means of implementation (e.g., training). According to DEs, PBF emerged as an innovative policy solution that offered opportunities for creativity and transformative practices in health facilities, thanks to enhanced motivation and autonomy. Thus, PBF was initially brought up with much enthusiasm, sometimes described as a “*magic bullet*” (I02_INTORG) that would solve a wide range of health system issues (see section 2).

The economic wording highlighted in Table [4.4] reflects the idea that DEs shared the same economic language. Both DE and non-DE respondents referred to DEs’ training background in (health) economics, which spurred an early interest in applying economic concepts to health systems. Such background would lead them to be “*in complete agreement with the logic of tools and approaches*” brought by PBF (I23a_ INDCONS). Thus, notions embedded in PBF such as separation of functions and contracting, which borrowed from economic theories (i.e., contract,

incentive, and principal-agent theories), were comprehensible to DEs trained in economics. However, we noted some emerging differences of ideological positioning between informants who acted as DEs: some favoured institutional arrangements, while others preferred private sector principles (e.g., PBF enabling an increased competition between providers). Thus DEs bought into different economic cultures, and did not necessarily agree on the specifics of how to yield the best possible efficiency. As for organisational DEs, an institutional culture rooted in economic tradition appears to have shaped their worldview:

> *The World Bank was very interested. I think… the market thinking, fitted...with their ideology.* (I04_PRIVNFP)

Such economic background shaped DEs' assumptions about the world. According to non-DE respondents, economists are, by nature, willing to quantify complex phenomena: PBF precisely matches this representation as it prominently features quantitative indicators and payment-by-result. Yet for non-DEs, it is problematic to have performance measured by single indicators that are supposed to capture performance on complex health system process, such as those related to HIV or maternal care. Non-DEs also suggested that economists' representations of healthcare are driven by a tendency to set a price on anything deemed valuable. For non-DEs, this tendency involves philosophical challenges as much as practical challenges: can one claim, "*being able to objectively transform [health issues] into numbers*"? (I34_ACADINST).

Besides economics, many interviewees mentioned a PBF anchor in management sciences, and in particular in relation to new public management (NPM). Indeed PBF entails a stronger accountability at all levels of health system management. DE respondents suggested that PBF was conceived as a way to critically curb corruption in African countries. This worldview emphasising accountability and transparency was described in contrast with traditional ways of managing development efforts.

The clinical discourse, apart from quality of care (which does come as central in DEs' language), was less prominent. Several non-DE clinicians criticised PBF for being unsustainable and creating inequitable access to healthcare, because health workers would be more likely to work where they can earn more.

Other non-DE respondents used the above-mentioned arguments to criticise PBF — lack of sustainability and risks of unintended consequences for health equity. The debate on health workers' motivation, mostly brought up by non-DEs, was a case in point. For DEs, improving staff pay through financial incentives would lead to better retention of health workers. Non-DEs voiced concerns about PBF being a piecemeal reform that was just about "*paying [health workers] through incentives*" (I05_INTORG), and offered supportive supervision and/or salaries of health workers' increase as alternative policy solutions (I31_ACADINST). This criticism prompted DEs to shift the discourse. DEs thus emphasised the fact that PBF could close the *can do-will do* gap, not only through provision of financial incentives, but also by increasing resource generation to enable better performance through work environment improvements and closer performance feedback cycles. In general, the debate between "pro-PBF" and "anti-PBF" communities led DEs to reframe PBF as being more comprehensive than pay-for-performance. DEs crafted PBF as system-oriented reform, which could serve as a "*cloth-hanger*" to leverage other reforms (I16b_ INTORG).

2. **How are DEs' characteristics reflected in the problematisation of PBF?**

What are the problems represented to be in performance-based financing?

DEs highlighted a number of health systems problems in LMICs that PBF intends to solve. Table [4.5] outlines DEs' representations of the problems as they appear in key documentation produced organisational DEs.

[Table 4.5] DEs' representations of the problems (based on definitions extracted from Cordaid, 2015; Fritsche et al., 2014; SinaHealth, 2019; The AIDSTAR-Two Project, 2011; Toonen et al., 2012)

Represented problems that PBF intends to solve	Related quotes
1. Input-based financing systems with passive strategic function causing public service ineffectiveness and inefficiency)	*Let's no longer speak about how many health facilities are being built, how many staffs are being trained […]. Because [ministries of finance in LMICs] have been putting a lot of money into... into input-based financing for a long time and not necessarily seen results thereafter.* (I03_INTORG)
2. Lack of accountability of public health spending	*You cannot ask somebody to manage something like… two billions, three billions as incomes… to put that in a system; and believe that he will do that… properly… No! He must live… And… He injects the 2 billions… without earning anything from those 2 billions. Well: I do not think that in…*

	in-in-in other… in any other country this can work out, when you know that he gets paid 200,000 francs. What do… What do you expect? (laughs). While if… based on his efficacy to inject the two billions in the health system, there was something… formal, clear… [that enabled him to keep some money for himself] I am sure he would… he would be eager to do his job properly. (I49_NATGOV)
3. Unmotivated and underperforming health workers	*In most African countries, people... people are not... well paid. I think that... with the salaries that people... the remuneration must get to a fair value. And... in... in this [PBF] system, it's well-known: if you work better, you'll get more bonuses. So your work is recognised in value.* (I41_NATGOV)
4. Highly centralised decision-making (i.e., for health planning and management)	*A big problem in [African] countries that I've seen… is that they are all centralised: you want something, you have to go to the ministry of health, and talk to the director… of procurement, et cetera… to get a status quo. For me, I think it's scandalous; we must stop, we must completely change.* (I33_INTORG)
5. Underperforming monitoring systems	*I think information and transparency is something that's extremely important. Hum… Again, taking a context like [country name removed] where there is no health information system, it just doesn't exist: they've tried a thousand times, through a dozen of different ways, and it just never gets up and running.* (I08_INTORG)

These problems often directly appealed to a strong sensation of *proximity* relating to DEs' own personal experience:

> *So I was working at the ministry [of Health]. […] I knew very well that... we had a lot of losses, we were buying communication equipment, printing a lot of things… and […] this was getting... dusty, so money was being wasted.* (I54_INDCONS)

For some employees of organisational DEs, the sense of proximity also owed to the wave of market-oriented reforms in high-income countries that aimed at cost containment, including pay-for-performance reforms. This movement, being high on the agenda in several European countries, was embraced by several non-profit organisations working in LMICs. However, the sense of *severity* was particularly linked to African contexts, where the under-utilisation of healthcare services and the suboptimal quality of healthcare service delivery were described as salient.

These representations of health systems problems related to a number of selective *causal* patterns, which mostly featured economic frames and, in particular, related to efficiency and governance. For DE respondents, the lack of decentralisation (of decision-making) was considered the main cause for absenteeism and suboptimal service delivery in general. DEs suggested that centralised decision-making in African countries was obfuscating the swift transfer of financial resources to health facilities.

At peripheral level, and in facilities in particular, centralisation was perceived (by both DEs and non-DEs) as a demotivating factor as it removed the ability to make independent decisions. In addition, informants frequently mentioned inadequate work environment as a key determinant of low motivation. For DEs, healthcare human resources' critically lacked financial incentives to do their job adequately. According to DE respondents, the combination of poor salaries and working conditions drives low motivation, leading to inefficiency and poor governance. Poor governance was illustrated by suboptimal data reporting (e.g., inaccurate patients' records). Participants expressed the need to break away from this form of "*business as usual*" (I03_INTORG). Many interviewees suggested that health workers should be held accountable towards the health system; while others mentioned the need to be accountable toward African populations. Two *problem populations* emerge from this discourse: first, African people, who suffer from being underserved and getting poor services; and second, health workers, who may be represented either as executioners or victims of an inefficient system that underpays them.

What deep-seated presuppositions or assumptions underlie these representations of the problems?

As said above, DEs share the same broad values owing to economic-oriented assumptions, which shaped their world representations. However, individual DEs' personal history specifically shaped their problem representations. For instance, a respondent cited his experience in Mozambique, at the time of the Marxist-Leninist regime, where, in opposition to that model he "*realised the importance of market mechanisms*" (I10a_PRIVFP). Several individual DEs were cognisant of this shaping process, willingly admitting that their own assumptions of the world, mainly driven by their personal history, shaped their inclination to promoting PBF. Their history influenced their solution-oriented framing of public health issues:

> *So I'm pretty transparent: I'll say, I'm a political entrepreneur, I want to have an impact, and so I work on solutions. That's the first thing: I do not see myself as working on problems, […] I like to have an application, telling myself: it can have an impact, it can help solve a problem.* (I19a_ACADINST)

Several individual DEs could explicitly recall how they sought economic degrees to make sense of their personal experiences, enabling them to tie their policy solution (PBF) to economic concepts.

How have these representations of the problems come about?

First, the perception that "nothing else works", which built on DEs' assessment that these problems of health service ineffectiveness and inefficiency, and low utilisation of healthcare services in general, were not adequately dealt with through the existing policies (e.g., health insurance), is likely to have won the global arena's opinion. This widespread perception led several big global health players to look for an effective catalyst for change, which PBF was — at least on paper — bringing about. Non-DEs described PBF as a policy solution that rapidly spread on a deserted, yet fertile, field owing to the "*paucity of public health innovations*" and the relative failure of existing policies (I34_ACADINST).

Second, DEs' problem representations gained traction because DEs benefited from a worldwide reputation built on recognised skillset and authority: their discourse was deemed credible. All DE informants had 10 years or more experience in international development when they started working on PBF. Their professional seniority enabled them to develop critical knowledge, social, and political resources. Such resources also secured easy access to political leaders. These resources, combined with an expert and/or scientific authority, provided individual DEs with credibility on the global arena. Organisational DEs were perceived as possessing strong moral, expert, and financial authority, making them *"recognised and respected international agencies"* (I31_ ACADINST).

When individual DEs lacked a type of resource (e.g., temporal resources), informants asserted that they could tap into other resources categories (e.g., knowledge resources) to enhance their credibility and thus widen their influence. In addition, many DEs (including our interviewees) personally knew each other. Some worked side-by-side in various settings, most often on the occasion of PBF (or performance contracting) experimentation in Haiti, Afghanistan, Cambodia, and later on in SSA countries. In the beginning of the 2010s, joining all types of resources, a "*network of PBF experts and consultants*" (I04_PRIVNFP) regularly met. Connections between respondents appeared clearly: DE informants could name at least two individual DEs from outside their organisation, and also mentioned an organisational DE distinct from their own organisation. Many respondents (N=30) also claimed being members of a transnational network

acting as DE. Due to close affiliations, DEs' viewpoints about the inefficiencies and poor governance they perceived as hampering the health system could be easily spread.

Third, informants referred to a general trend towards increasing efficiency at the global level, due to perceived insufficient gains in health. Hence the 'output-based aid' trend became popular among donors. PBF was seen as an opportunity for them to (finally) spend money that served "*to buy deliveries and vaccinations, antenatal care visits, et cetera"* (I02_INTORG). The 2004 World Bank Report on service delivery was also mentioned as playing an instrumental role in setting the stage for such representations of the problem to emerge. The report's emphasis on service delivery was directly linked to the reflection about LMIC public systems' accountability.

Hence, the discourses on efficiency and on the possibility to enhance efficiency through improved purchasing came about. These discourses found an echo in organisational and individual DEs who were depending on donor funding. DEs expressed strong assumptions about the legitimacy of the results-based language. Based on the powerful "value for money" token, a DE informant said that, "*any institution would be sensitive to this language"*. (I36_PRIVFP). Indeed, these economic-driven representations provided them the opportunity to reinstate their position as global health leaders:

> *At a certain point 10 years ago… […] Their [the World Bank's] own projects were so… hopeless, in a way, and so disappointing […], that when they discovered PBF… […] they realised: well this may be a very good thing to regain initiative in the public health… sphere.* (I10a_PRIVFP)

Promoting a policy that carried these economic-driven representations was expected to serve DEs' interests by enhancing their visibility in a global health systems arena increasingly leaning towards better efficiency. Employees of organisational DEs also had "*incentives to get in that business*" given that PBF had a "*high visibility*" inside their organisations and that they could "*get extra money to implement the [PBF] project and make the whole health project more successful*" (I16a_INTORG). Several individual DEs were aware of the need to position oneself within the global health arena. For several interviewees, DEs had genuine motivations to solve public problems, so that they could say that they had "*brought something important for the system*" (I34_ACADINST).

What is left unproblematic in these problems representations?

Both DEs and non-DEs identified areas left unproblematic in PBF problem representations. For non-DEs, economic- and managerial-oriented representations left out key issues that mobilise other types of worldviews, which relate to systemic approaches. First, there was a perceived lack of consideration for broader systems reforms. Non-DEs suggested that by introducing PBF as a "magic bullet", policy reform might draw attention to secondary issues, such as provider incentives, instead of addressing more fundamental problems, such as the need to reform public service in LMICs. An interviewee (I18_INTORG) metaphorically spoke of DEs' promoting "*icing on the cake with no cake*", with healthcare services not yet structured to be able to integrate such reform. Other — less critical — informants (including several employees of organisational DEs) perceived PBF as an instrument that needed to be complemented with more systemic reforms, such as social health insurance. On the contrary, individual DE respondents (and at least one DE reference document: SinaHealth, 2019) tended to present PBF as the primary system to put in place before engaging in additional reforms.

Second, non-DEs feared that by framing the issues of suboptimal quality and use of healthcare services exclusively from the supply-side perspective, PBF promoters would overlook population's demand for quality healthcare. For instance, equity concerns were only raised by four DE informants, and among those, one of them asserted that equity should only come after "*mak[ing] sure there are enough resources in the health centers*" for healthcare service delivery (I10b_PRIVFP). Some DEs portrayed non-DEs — at least those prioritising equity — as "idealists", as they were eluding the major issue of availability of resources.

What effects (discursive, subjectification) are produced by these representations of the problems?

For Bacchi, "some problem representations create difficulties for members of social groups more so than for members of other groups" (Bacchi, 2009, p. 15), i.e. they produce discursive effects that could be potentially harmful. Non-DEs emphasised how health system ineffectiveness — postulated by DEs — combined with overlooking systemic issues had critical implications for populations. Furthermore, non-DE respondents pointed to risks of echoing these discourses in an environment where basic structures and resources are lacking. These informants could often

substantiate allegations of perverse effects with concrete examples, such as health workers' gaming observed in several countries experimenting PBF.

Problem representations also produce subjectification of those who are considered agents of the problems. In the case of PBF, these are health workers and bureaucrats working under centralised input-based financing systems. Subjectification of health workers was identified in problem representations conveyed by both DEs and non-DEs. DEs produced a discourse of "responsibilised subjects" able to develop a sense of entrepreneurship to ensure quality service delivery. Coherent with Bacchi's assessment, health workers would not automatically develop entrepreneurial subjectivities. However, the continual linking of healthcare practice to a simple managerial activity whereby health workers are supposed to attract patients, reflected DEs' intention to induce such "paradigm shift". Non-DE respondents argued that the strong (individual) accountability that was attached to these subjects might have diverted attention from more structural factors that critically shape the delivery of healthcare services. Besides, such subjectification could be frustrating for health workers evolving in complex environments because of a limited control over other parameters. For DE informants, such discourse was counter-productive because it tended to convey an image of passive health workers.

For DE informants, the key to improve salary and working conditions was to introduce incentives. Non-DEs often criticised this form of financial motivation: for them, developing this form of extrinsic motivation was reducing health workers to venal subjects. In turn, DEs portrayed non-DEs as overlooking the contexts where health workers were evolving, i.e. earning very little. In fact, non-DE respondents also voiced a number of discourses about health workers that conveyed strong values about human motivation, whereby altruistism would be opposed to financial gain-orientated behaviours:

> *Basically, there's intrinsic motivation: it's good, it's altruistic, it's 'cool'... And extrinsic motivation: it's bad... [...] Well, I find this is an ultra-binary vision of how an individual works!* (I20a_INTORG)

In sum, both DEs and non-DEs produced simplistic discourses that tended to reduce these subjects to binary categories. It often seemed that both groups were building their discourse (and,

in some ways, their identity) in opposition to the problem representations conveyed by the other group.

3. How do diffusion entrepreneurs promote PBF?

Diffusion entrepreneurs engaged in an apparatus of strategies to foster the production and diffusion of their representations. To do this, they needed funding. In the case of PBF, funding primarily came from bilateral donors (NORAD and UK's Department for International Development), and the World Bank. These efforts were catalysed within the Health Results Innovation Trust Fund (HRITF). Individual leadership was critical to harness financial resources. For NORAD, a special advisor to the prime minister of Norway, who had previously worked at GAVI, had been "*very interested in looking further into the performance-based financing aspect*" of that institution, whose funding was based on performance. Soon after that, "*he got involved with the World Bank*" which was building a proposal on performance- and results-based financing, and NORAD came on board (I13_INTORG). All respondents referred to a single World Bank employee, a former Task Team Leader in an African country that pioneered the approach who had "*lobbied successfully for creating this HRITF within the Bank*" (I16a_INTORG).

Framing politically legitimate solutions to problem representations

First, DEs framed problem representations described above by strategically linking each constructed problem to popular and trendy solutions in global health and international development. Those matched PBF inherent principles (see Table [4.6]), but they also came as responses to criticism arising from non-DEs (e.g. on the motivation debate). Initially, some actors were reluctant to embark on PBF; this reluctance decreased through the (re)emphasis of some problem representations, such as passive purchasing function (see point 1, Table [4.6]). As such, PBF moved from passive to active purchasing. When the concept of "strategic purchasing" came into the debate in late 2016, PBF offered to operationalise that concept:

> *Moving towards strategic… more strategic purchasing we think is associated with better… results. And… really the key thing that we're looking for I think in this [strategic purchasing] agenda is how all the… energy and movement around… PBF can be used to trigger that, in the system.* (O4_International conference)

PBF thus got linked to strategic purchasing, reportedly thanks to internal framing activities done by individual DEs within the World Health Organization. Strategic purchasing had (re)gained traction: organisations that had been reluctant were now eager to start supporting PBF. The international community saw introducing strategic purchasing as a systemic reform, and therefore it represented a more palatable idea.

[Table 4.6] Constructed problem with corresponding ideas and respondents' quotes

Constructed problem	Popular concepts or paradigms to help solve the problem	Related quotes
1. Input-based financing systems with passive strategic function causing public service ineffectiveness and inefficiency	Renewed public management structures; strategic purchasing through output-based financing	*It is about public financing, it is a matter of giving back power to the state or more capacity to negotiate with the state […] It is about making the public system effective and I have this intimate personal conviction that public systems effectiveness is the best defense of their... sustainability: um, that ineffective public systems will eventually disappear.* (I17_TANSCO) *Still, I think [PBF] is a reflection on strategic purchasing issues, and it's still something important, and something positive for us... […] In the mechanism we say uh, here: the health service is supposed uh to provide such service, uh... at such a price, for such volume and uh... and he is paid according to what he actually does and not uh... something more random.* (I18_INTORG)
2a. Lack of accountability of public health spending	Output-based aid and better aid-tracking systems	*Donors tried several approaches: providing direct funding, relying on input-based financing that is, offering training, training people for... for inputs, uh... without really knowing whether these trainings are used, what is the use of all these books, what is the use of all these documents, et cetera… So we had... we were a little… about to falter, with a funding approach… that did not provide any result.* (I34_ACADINST)
2b. Lack of accountability of public health spending	Separation of (purchaser-provider) functions	*The implicit recommendation to African countries is that they can proceed towards universal coverage on the basis of the existing model: a national health service characterized by the State fulfilling all the roles: owner, employer, supplier, purchaser, regulator, administrator… A system in which health facilities are public administrations receiving their resources through line item budgets, often even "in kind". It is precisely this status quo that PBF champions are challenging.* (I19) [NB: This quote is extracted from a blog entry posted by I19 and referred to by the key informant himself during the interview I19a_ACADINST]
3. Unmotivated and	Setting (financial)	*Of course, PBF brings staff motivation and we also*

underperforming health workers	incentives for health workers attached to performance indicators, and reinforcing supervision	*often observe a change of behaviour on the part of the staff, who dev… almost develop a spirit of entrepreneurship; so they try to imagine strategies to receive more patients, and improve the quality of services […]. So there's a certain emulation, bringing in a spirit of entrepreneurship, and leadership, to attract more patients and to improve the quality of services.* (I55_NATGOV)
4. Highly centralised countries	Enhancing providers' autonomy	*That's autonomy for health centers at the primary level, […] instead of sending funding and controlling everything that practitioners can do with this money… even if in the cabinets there are far too many medicines of one kind, while it doesn't meet the needs. And then it's recognising the... value in the system of health providers, and allowing them to... […] feel valued.* (I25_INTORG)
5. Underperforming monitoring systems	Effective health information systems; data for decision making	*This is the first time that anybody has an information about… (chuckles) you know… whether it'd be the quality, the quantity, the financing of services… hum… and that is a whole kind of cultural (pause) change where people are actually understanding what's going on. Hum… and that does contribute to making informed decision-making. Hum… we can track how well certain services are… hum… improving in terms of quantity and quality, where we couldn't before.* (I08_INTORG)

Second, embracing concerns for country ownership and aid effectiveness, DEs framed PBF as a participatory, LMIC-driven strategy. This strategy included promoting a set of best practices which emerged from decades of PBF experimentations that each country needed to adapt to their own context(s). DEs thus crafted PBF as an adaptive reform yielding much support from LMIC governments. On the African continent, DEs specifically framed PBF as being led by African practitioners. Such framing enhanced legitimacy to PBF in SSA countries.

Shaping the ways to experiment PBF

Principally, donor money served to fund PBF pilot schemes across LMICs. As with most donor-funded programmes, it required strategies to ensure successful pilot scheme implementation, including setting rules of collaboration between actors. Non-DEs specifically discussed the operating rules of the World Bank/HRITF-funded pilot projects. They reported that a first strategy for these DEs was to design a standardised PBF model with a very structured set of guidelines for institutional collaboration and pilot project planning

According to an interviewee working for a NGO acting as DE, diffusing a PBF "blueprint" was important in order to make sure "*the power of the message*" would not be lost (I04_ PRIVNFP). Several interviewees noted a number of management, financial, and human resource constraints set by organisational DEs. In Box [4.1], we report on the specific testing package of World Bank/HRITF-funded schemes.

[Box 4.1] Typical PBF pilot testing package, World Bank/HRITF-funded schemes

World Bank- and HRITF-funded schemes are typically implemented in the following stages:

1. Setting an independent project management unit at the central level
2. Drafting a PBF manual in collaboration with the Ministry of Health (i.e., operating procedures for contract agreements, including specifying PBF indicators and how rewards are calculated and distributed)
3. Arranging two competitive calls for tenders: 1) between private companies willing to act as purchasing agency or "contract development and verification agency"; 2) between private companies willing to act as fiduciary agency
4. Introducing a strict separation of functions through contracting the selected purchasing agency or "contract development and verification agency"
5. Training the multiple actors (i.e., regulator; purchaser; payer; healthcare providers) involved in the pilot scheme
6. Setting a steering committee at the government level and (possibly) a PBF unit within the Ministry of Health
7. Launching the pilot scheme in selected health districts
8. Ensuring smooth operationalization of pilot scheme (i.e., completion of contract agreements, verification, counter-verification, regular meetings of the steering committee)
9. Evaluating the pilot scheme (e.g., through a formal impact evaluation).

Source: Data aggregated from 57 interview transcripts and 10 observation notes

With such a high amount of donor control, informants highlighted issues of ownership that ought to be resolved. Implementers needed to involve government officials, to trigger the change of culture that PBF required, but that was often challenging:

> *[…] Consultants... do not sufficiently integrate people at the Ministry of Health, government officials. Even if they try to integrate them… some will continue to do business as usual.* (I25_INTORG)

Other interviewees expressed concerns about lack of government ownership. Concurrent strategies to secure ownership at ministerial level were developed when initiating pilot schemes. To achieve this, informants mentioned setting a PBF unit inside the ministry of health (MoH).

Engaging the MoH was often considered insufficient. Interviewees representing organisational DEs emphasised the need to seek political dialogue directly with the ministry of finances rather than exclusively with the MoH.

According to DEs, government ownership also depended on identifying and promoting a "policy champion" who understood the complexities linked to PBF implementation and advocated for the policy solution. Sometimes, however, donors' promotion of policy champions was controversial at country level because the donors' choice was not deemed legitimate by governments. This discrepancy was considered a major hampering factor to successful pilot implementation. Complementary to that strategy was the provision of adequate and sustained technical assistance, i.e. coaching local champions and implementing teams. Several DE informants were mindful of their coaching role, arguing that it was a necessary step for local actors' complete understanding of PBF.

Spurring emulation around PBF

Among LMICs piloting PBF, "flagship countries" like Rwanda served as a source of emulation. Indeed, according to DE informants, these countries successfully experimented and scaled-up PBF, and became success stories that inspired others. In many African countries, respondents noted that the Rwandan model was a source of inspiration for setting indicators and scheme architecture. An interviewee described a situation whereby an African country's leader was very keen on scaling-up PBF at the national level, simply building on the Rwandan model and without piloting PBF at a smaller scale. Several interviewees, including DEs, worried about a somewhat "overconfidence" in the Rwanda model.

This emulation process was also driven by an organisational DE "*which operated as a travel agency*" (I40_PRIVNFP), as it funded and promoted multiple study tours to Rwanda and, later, to Burundi (which was also featured as a PBF "success story") and other countries. Study tours (ranging from three days to a full week) were a key ingredient of policy emulation, and it usefully matched the framing of an Africa-driven policy. From the end of the 2000s, delegations — made of senior officials and sometimes health workers — from various SSA countries about to experiment pilot schemes traveled to other countries to get to know their respective PBF models.

These delegations were typically enthusiastic when coming back to their home country. The study tours enabled them to "get a sense of reality" as to how PBF could be (successfully) implemented:

> *It's really putting people in... situations where they can face concrete examples, in situations where they can... get inspired, mirror themselves!* (I46_INDCONS)

Despite such enthusiasm, other government officials voiced concerns about the need to contextualise the PBF model to country needs (e.g., in Cameroon and in Mali). The contribution of PBF study tours to policy diffusion was often alluded to with caution.

Besides study tours, DEs involved in the implementation of these schemes engaged in a number of peer-to-peer exchange gatherings, which also reinforced the African framing of PBF. DEs convened international gatherings whereby PBF implementers from African countries and other LMICs interact for a week. On these occasions, participants were encouraged to engage in socialisation activities and create connections — along the course of their PBF experience. Thus, there is a combination of genuine, spontaneous emulation (e.g., country teams communicating with each other on programme implementation components), and an explicit push by DEs to spur inter-country exchanges across the continent (e.g., a World Bank employee sending country teams to visit PBF units in other countries and "importing" Rwandan consultants to other countries) in order to subsequently copy certain features of a PBF scheme in some country and paste it in another country.

Study tour after study tour, gathering after gathering, the "community" of PBF experts expanded, building a group of "second phase-DEs":

> *You had a nucleus of people ten years ago that taught PBF and now you have… a sea of people who are experts and who are providing the support […]* (I53_INTORG)

Many informants indicated that this global community was leading PBF diffusion. Organisational DEs developed their own communities (thereby acting as network DEs): the *Results-Based Financing Health* community, managed by The World Bank and funded through the HRITF; and Cordaid's *Multi-country PBF network*. An additional prominent network DE also spurred emulation among PBF practitioners: the *PBF Community of Practice*. Members of this network described a strong sense of belonging to this community.

Some non-DE respondents, however, questioned the idea of a genuine community of PBF implementers. They described the emulation processes as being artificially induced by external actors, and organisational DEs acting at the global level. Some non-DEs spoke of a certain pressure to go on study tours and attend international workshops. A respondent compared these strategies to a form of "*evangelism*", by "*appeal[ing] to the feeling of belonging to a network*" (I51_ACADINST).

Controlling and disseminating PBF learning

Probably the most important strategy coined to favour PBF global diffusion was the development of an apparatus of learning strategies attached to PBF experimentation, which explicitly portrayed PBF as a "learning-by-doing" reform. This apparatus was developed by DEs — from initial training to results dissemination. It ensured a continuous control of the policy learning generated by the early PBF pilots. Different learning modalities were included: implementers and policymakers participated in PBF training sessions, accessed continuously updated implementation manuals, and were exposed to (scientific and experiential) knowledge on pilot schemes in various workshops, online fora, and publications.

The first major strategy of the learning apparatus was the development, funding, and promotion of international training sessions followed by cascade training at country level. For the World Bank, training represented a "*fundamental*" strategy to diffuse PBF, to "*ensure we had a critical mass... of people… in every country"* (I20a_INTORG). This method was done to facilitate country's engagement in the approach. Providers of PBF training in SSA include public organisations, private companies, and not-for-profit organisations. The company *SinaHealth* was prominently featured in interviews (see Figure [4.1] for details):

> *And… I have to say [name of SinaHealth's head removed] also has done a lot of trainings […], a lot of workshops: two-week drill down on PBF. A lot of policymakers passed through his classes. And… these are very dense courses […]. You know, like forty-five people in a place for twelve days and you hammer them and they walk out of it with a better understanding of what it is.* (I16a_INTORG)

This quote suggests very intense training sessions whereby trainees are presented with an undisputable policy solution (PBF). Trainers reportedly reviewed the theoretical underpinning and practical dimensions of PBF, emphasising a set of "*best practices*". If 80% of these best

practices got "*applied correctly*", it was assumed that PBF would "*always work*" (I10a_PRIVFP). Independent of funding, almost all African pilot implementers received SinaHealth training: donors believed in the company's capacity to train African nationals. Even projects not funded by the World Bank/HRITF got exposed to SinaHealth training sessions. Yet none of the interviewed DEs working at the global level seemed to have participated in a PBF training session. They preferred to "*learn from the field*" and/or "*team up with people that know on how this works*" (I03_INTORG). Interviewees noted that after receiving training, trainees often joined the PBF Community of Practice (CoP) thereby building "fraternity" between SinaHealth and the CoP (I06_TANSCO). Therefore, training also reinforced emulation.

[Figure 4.1] SinaHealth Company: a bit of history

Legend: *Source: I10a,b,c_PRIVFP.*

The second strategy involved the development of reference tools. As previously mentioned, organisational DEs developed their own PBF manuals detailing the specifics of their preferred PBF model. These practitioners' guides were continuously updated to ensure incremental policy learning. Interviewees cited the World Bank's PBF Toolkit in particular. However, some respondents expressed concern that it was used as a prescriptive tool because it was "*written by*

three advocates" (I11_INTORG). Six respondents referred to it as "the PBF Bible", and one raised concerns over "*following a recipe… without thinking*" (I51_ACADINST).

The third strategy, the "learning-by-doing" mantra, guided the funding and production of multiple types of knowledge on PBF experimentations. The most well-known type of knowledge was scientific impact evaluation. Building on Rwanda's "*really famous*" study published in the *Lancet* (I02_INTORG), also considered the "*proof of concept*" for PBF (I19_ACADINST), the learning apparatus of the HRITF prominently featured impact evaluations using quasi-experimental designs. These preferred methods aligned with DEs' economic-oriented representation systems. The two donors of the HRITF, building on long tradition in evaluation, explicitly requested this feature in view of building a "*global evidence base*" on PBF (I13_INTORG). The focus on impact evaluation at the HRITF motivated the development of parallel impact evaluations by other organisational DEs, such as USAID. Global DEs conceded that the results of these evaluations were not very impressive:

> *The impact evaluations? They're not — to be honest — they're not that convincing, at least, there's some strong elements… but they are not completely convincing.* (I13_INTORG)

At the World Bank, there was a certain tension between PBF advocates and researchers, the latter acknowledging that their organisation was "*obviously promoting PBF*" (I11_INTORG). These researchers reported pressure to generate positive results. DE respondents indicated that the reasons for mixed results owed to the methods chosen to evaluate the scheme, or to the variations in PBF scheme designs, i.e., if a PBF scheme was flawed, it could not yield positive results. Still, there was consensus among respondents that those mixed results should serve as lessons for improving PBF schemes. However, the mixed nature of the results seemed to have low visibility in SSA. After a presentation describing some of these results in a meeting taking place in an African city, one participant said:

> *I do not understand these results you are presenting; if the World Bank promotes this strategy, it means it has been proven. After all, it's an international institution that is behind it!* (O2_International conference)

The same positive bias emerged from several interviews with African respondents.

Before publication, preliminary results were typically shared by those who mandated the impact evaluations in the countries where the research has been done, using a "*participatory approach where... once some initial results… are put together, we kind of present this, [asking]: do you understand why, what's causing these results?*" (I08_INTORG). In spite of this approach, results uptake by policymakers was considered quite limited: respondents acknowledging that decisions to scale-up the PBF approach were often decided before research results were made available, or in spite of them. According to an interviewee, this could be explained by a mismatch between government's interests — looking for policy relevance — and academics wishing to "*publish some nice papers*" (I05_INTORG). Outside the World Bank/HRITF, criticism arouse from many informants, including several individual DEs, who pointed to the risks of overlooking non-quantifiable effects of PBF. Several DEs linked to the main organisation reasserted the need to expand rigorous evidence, while acknowledging that it was also important to account for operational and qualitative data. According to DEs, this aspect got integrated in HRITF-funded impact evaluations from 2013 onwards, which sometimes included a qualitative component.

Impact evaluation results were shared with implementers of PBF pilot schemes and policymakers in international workshops and conferences. Respondents specifically referred to the World Bank/HRITF's learning and knowledge exchange workshops. With time, these yearly workshops became opportune for sharing another type of knowledge, i.e. experiential knowledge on PBF. Hence workshops also included peer-to-peer exchanges between PBF pracititioners. While some DEs promoted the image of participatory workshops (e.g., giving voice to practitioners), other DEs suggested that the World Bank was deliberately controlling the content disseminated in these workshops, thus allowing little space for alternative views:

> *Over time there's been a bit more opening to other organisations to participate [in these workshops] but… it has been really a Bank-centered thing, from the start. I think the concern is there are already so many […] people involved, that everybody feels a bit dissatisfied… that they didn't get exactly what they wanted… out of it. So by opening up even more, maybe… they won't be able to control at all what… […] what is discussed during these [workshops].* (I08_INTORG _211116)

According to interviewees, the PBF CoP developed more horizontal (and possibly less controllable) forms of knowledge, building on experience and not only academic studies. CoP

facilitators searched for participatory formats to disseminate knowledge, notably through developing an online forum and blog entries on implementation challenges, and organising face-to-face workshops:

> *In fact, the CoP gives meaning, it gives... a validation... in the sense: "I'm not alone in doing what I'm doing". [...] And in those workshops, you try to create collective enthusiasm.* (I19a_ACADINST)

The CoP's strategies emphasised the feeling of emulation: learning processes reinforcing emulation.

Discussion

Our study analyses the problem representations (re)shaped and spread by PBF diffusion entrepreneurs at the global level, and how these representations reflected DEs' own belief systems and interests, often in contrast with non-DEs' representations. Our study examines the specific strategies DEs engaged in to effectively diffuse PBF, through framing the PBF discourse and inducing certain forms of policy experimentation, emulation, and learning.

Results from our empirical analysis concur with our first and second propositions formulated on the basis of a literature review on PBF, namely "the merging of resources and types of authority" and "the strategic use of policy frames" increase the likelihood for a policy innovation to diffuse (Gautier et al., 2018). This analysis is congruent with previous empirical studies on PBF: Barnes et al. argued that these actors have combined a wide range of resources and implemented strategies to shape the direction of the diffusion (Barnes et al., 2015). Yet, the present study revealed that a key ingredient was necessary to achieve this: long-established trust between DEs. Existing relationships between DEs enabled them to rely on each other's resources and authority, and pool their efforts towards their common project — diffusing PBF. This postulation is consistent with multiple studies on the diffusion of information in international development, which feature the prominent role of social relationships in leveraging knowledge into action (Georgalakis et al., 2017).

Barnes et al. described PBF DEs' representations systems and motivations as homogenous (Barnes et al., 2015). While we found similar representation systems (around economics), there were differences across individual DEs in favoured economics schools of thoughts. Notably, not all of them advocated for healthcare providers' competition. However, DEs did agree on certain fundamentals — the usefulness of bringing in economic concepts to public health provision. This was a key facilitating factor for DEs. In particular, as featured in previous works (Laurell and Arellano, 1996; Moon and Ooms, 2017; Ruger, 2005), the economic-oriented language reflects the World Bank's continued inclination to view healthcare provision as a "market commodity" rather than a public good (Labonté and Gagnon, 2010). This inclination is reflected in their coframing (together with the Rockefeller Foundation) of the "investment case" for UHC, which has been endorsed by prominent economists (Summers, 2015). Many global actors have bought into the idea that investing in health yields economic returns — an idea pushed forward by the WHO Commission on Macroeconomics and Health (Waitzkin, 2003).

The economic culture was shared by many DEs, and it critically oriented their views about the ways global development could be achieved. Works on the diffusion of new public management (NPM) drew similar conclusions (Common, 1998a, 1998b; Sarker, 2006). NPM represented a policy innovation that got diffused by external actors in many LMICs by mobilising an apparatus of strategies. Like NPM, PBF offers a typical example "where there is general agreement on the cause and effects of managerial techniques by a community of 'experts'" (Common, 1998b, p. 447). In fact, communication theory contends that it is easier for policy advocates to communicate with people who share "similar frames of reference" (Maybin, 2016).

The rhetoric strategies developed by both DEs and non-DEs showed that discourse is a process by which actors provide "interpretive frameworks that give definition to [their] values and preferences and thus make political interests actionable" (Carstensen and Schmidt, 2016). This process entailed simplistic subjectifications as well as overlooking critical issues on both sides. We also found that DEs' interests were not only political (i.e., gaining visibility and/or boosting career and reputation on the global arena), but also financial (i.e., pursuing donors' favoured output-based aid "trend"). Pursuing donors' interest in measuring aid effects also aligns with what we could call a generalised trend towards "quantifying results". The latter is also reflected

in the broader *Sustainable Development Goals'* agenda with its focus on metrics and innovative financing mechanisms. This trend illustrates the spread of both a "performance ideology" and audit culture that previous studies have identified (Heilbrunn, 2004; Shore and Wright, 2015). PBF matched this global push for performance, by featuring effectiveness and accountability as the key to solve the represented problems. These keywords found a particular echo across SSA for two interrelated reasons: 1) the relative hopelessness that the health status of this specific region was eliciting among the international community; 2) the need for bold, transformative policy ideas that could reverse the tendency (and achieve results similar to those of other regions). PBF three key features gave hope for promising results: an output-based approach breaking away from business-as-usual funding systems; new forms of financial incentives to increase health workers' motivation; enhanced autonomy at facility- and decentralised-levels.

Our empirical proposition postulating that "increasingly polycentric governance arrangements foster the diffusion of policy innovations" (Gautier et al., 2018) is relevant. Indeed, the PBF global community — DEs — included transnational networks as well as many individuals (experts and consultants) who exercised crucial governing power. This level of involvement was made possible by the polycentric nature of global health governance, which enables the participation of a wider range of actors to policymaking. These results are consistent with Lee & Goodman who highlighted that the health financing global elite had "come to dominate policy discussions through their control of financial resources and […] control of the terms of the debate through expert knowledge, support of research, and occupation of key nodes in the global policy network" (Lee and Goodman, 2002, p. 103). On the diffusion of NPM, Common identified the same pattern (Common, 1998b, p. 447). The specificity of PBF is that the rapid expansion of this transnational community yielded a generation of individuals, i.e. Africa-based experts who bought into the PBF solution and diffused it across the continent, hence becoming "2nd phase DEs".

Our study concurs with others that the discourses produced by powerful and highly-motivated global actors have legitimising effects on the policy they intend to promote (Hay, 2002; Marsh, 2009). Indeed, DEs appeared to be successful because they had influence on the global arena (based on their reputation) and the financial authority to spread such discourses. Consistent with

Cairney's recent work on policy entrepreneurs, "our" DEs achieved this "through using persuasive stories […] combining facts with values and emotional appeals (with heroes and morals), engaging in coalitions and networks to establish trust in the messenger" (Cairney, 2018). Heroes were health providers or populations, and morals revolved around blaming the system not conducive of quality services provision (i.e., with health workers trapped inside the can-do will-do gap).

Coalitions and networks were made up of those transnational communities that developed both informally (e.g., among international experts) and formally (e.g., the CoP), as the result of deliberate strategies initiated by the above-mentioned global elite. These communities benefitted from resources and authorities (based on the reputation and expertise of high-profile individual and organisational DEs) that enhanced their credibility in the global arena. Did these transnational communities also enjoy legitimacy to exert power based on inclusive and transparent processes (i.e., "input legitimacy"; Shiffman, 2017)? Their transparency was not optimal (e.g., debates often silencing key issues), but improved with time (e.g., acknowledgment of mixed results yielded by PBF pilots). As for inclusiveness, even if most individual and organisational DEs came from high-income countries, the strong participation of African practitioners in these communities appears to have mitigated concerns for the lack of voices from LMICs. However, the representativeness of "ordinary people" by these African practitioners can be questioned. This feature needs to be further explored by future empirical research, also because the above-mentioned global elite has been largely shaping the debate.

Our findings showed that the idea of introducing individual incentives leads to the production of subjects (e.g., entrepreneurs), as Bacchi would say. Referring to a 2001 study on students' repayment of their loans, she asserts that "the practice of repayment based on salaries" renders students — now appealed to financial gain — "governable" [46]. A similar reasoning could apply to the practice of providing financial awards based on performance — it could be simply an attempt to render them more governable. We also identified a number of representations silenced in the PBF policy as promoted by DEs: equity was seldom mentioned, as well as health providers' accountability to SSA populations (as opposed to accountability to donors or government authorities). This concurs with available literature on PBF, which explicitly calls for

accounting for equity when designing and evaluating PBF projects (Ridde et al., 2018), and for questioning the effectiveness of PBF community verification procedures (Turcotte-Tremblay et al., 2017).

Pilot programmes of PBF in SSA are promoted, designed, funded, implemented, and evaluated by international institutions (Gautier and Ridde, 2017). PBF pilot packages were primarily promoted by these actors, with local implementers enjoying limited ability to manipulate and/or control the intervention. This factor caused multiple ownership concerns, as previous studies also have shown (Gautier and Ridde, 2017; Paul et al., 2014). This feature is, however, not specific to PBF — this issue has been observed in many donor-driven pilot programmes. What made experimenting PBF so distinct was the sustained in-country coaching and technical assistance provided by foreign individuals, and the heavy reliance on policy champions who could understand the complexities of PBF and successfully advocate it in their respective countries. The Cameroon case is salient (Sieleunou et al., 2017).

The HRITF's idea of looking at the effects PBF generates, while financially investing in this reform, can be initially lauded. However, the narrow focus on quantitative impact evaluations, and the potential tension between advocates and researchers employed by the organisation which mandated these evaluations are problematic (Gautier and Ridde, 2018). These features could suggest an intention to control the discourse on PBF. In addition, the large investments in impact evaluations have yielded mixed results. These results are consistent with results presented in published systematic reviews (Das et al., 2016; Witter et al., 2012; Wiysonge et al., 2017). Interestingly, while the mixed nature of results was acknowledged by global DEs, informants from SSA frequently demonstrated a positive bias towards the impact of PBF. The discrepancy is most likely owed to barriers in access to information. This gap might also reflect a social desirability bias; perhaps those respondents had no interest in admitting that results were mostly mixed, possibly due to the fact that their job depended on the continuation of PBF in their respective countries. More generally speaking, the political economy of development aid projects, whereby national actors embrace donors' projects to secure additional funding for their respective countries (Gautier and Ridde, 2017), may lead SSA policymakers to adopt a cautious political correctness *vis-à-vis* PBF. This pattern has been demonstrated in a seminal book about

national actors' perceptions of donor-driven development projects in Sahel (Naudet, 1999). In addition, there was a low uptake of PBF research results by SSA policymakers. Congruent with Schneider [45], respondents conceded that results from scientific evaluations were not used by policymakers to inform their decisions regarding the alteration, scale-up, or stopping of PBF. This concession concurs with the lack of political consideration of results even when emerging from clinical studies, such as those conducted on pre-exposure prophylaxis to prevent HIV infections. It was often implemented in many countries including in SSA (Mugo et al., 2016) despite inconclusive evidence (Gray and Wawer, 2013). Similar patterns were observed about the national roll-up of *Revenu de Solidarité Active* in France (L'Horty, 2009). These comparisons suggest that policy is often indifferent to scientific evidence (Lewis, 2007).

In addition to producing impact evaluations, DEs organised international gatherings, study tours, and training contents that diffused tacit knowledge on PBF. Rather than actual policy learning (i.e., "information or experience from other units for better-informed policymaking" (Gautier et al., 2018)), such activities achieved more policy emulation, whereby event participants developed, through sharing this tacit knowledge, a common interest to implement PBF, and a depoliticised, primarily technical language about PBF. Indeed, countries were prompted by donors to reproduce features of schemes inspired from elsewhere. Similar patterns have been observed on the diffusion of health microinsurance: recognised global institutions such as the International Labour Organization (ILO) and Micro Insurance Academy publicised a variety of handbooks inspired from reputable success stories, which described in great detail how to develop and implement "standard" insurance schemes in LMICs (Dror and Jambhekar, 2015; International Labour Organization, n.d.). These organisations also supported study tours to countries that had insurance success stories (e.g., RSBY in India, and Asmade in Burkina Faso). ILO even developed a guide for organising study tours (Steinmann, 2010). All of these elements bring up critical issues about the role of externally driven, "constructed" learning apparatus officially aiming at evidence-informed policymaking, and call for further investigation.

Applying Bacchi's approach to the PBF case was both enriching and challenging. On the one hand, her dimensions on the subjectification produced by discourse, and omissions in problem representations, were particularly useful and relevant to our empirical results. On the other hand, we faced a challenge: Bacchi shifted from policy representations to problem representations

analysis, which entailed quite a different standpoint. We described the shaping and ensuing promotion of problem representations. We also demonstrated how DEs strategically framed problem representations as opportunely and comprehensively addressed by PBF and its core principles. However, our analysis of DEs' other strategies emphasised representations directly related to PBF, because we aimed at unraveling DEs' controlling of policy experimentation, emulation, and learning. Besides, applying Bacchi to interview data, which featured contrast between two groups (DEs and non-DEs) considered as a separate set of respondents/representations involved somehow departing from Bacchi's original intention: Bacchi's framework usually applies to textual data, irrespective of who produces them. However, given the nature of the current debate on PBF, which features a high polarisation (Paul et al., 2018), it was relevant to analyse the contrasts across representations on both sides.

Like Bacchi, Naudet suggests that policy solutions typically precede problem definition in SSA contexts (Naudet, 1999). Naudet showed that donors' (development or disbursement) objectives, and the political instruments at hand, often determine needs' assessment (and thus problems identification). In the case of PBF, we observed that DEs deliberately implemented strategies to emphasise certain problem representations in ways that were politically opportune (e.g., input-based systems fatigue), and linked PBF to popular frames (e.g., country ownership) so as to (re)assert the legitimacy of their policy solution in a contested landscape. Our study thus reveals a more complex pattern than that of Naudet's, in which the policy solution constantly evolves and adapts to align with the broader development debates occurring on the global arena. The opportunistic linking of PBF and strategic purchasing was a case in point, whereby DEs succeeded in reframing PBF in a way that attracted more buy-in within the global health arena.

For the sociologist of science Callon, "*translation*" is the dynamic process by which actors initially different, end up (by negotiation or conviction) entering into a dialogue around a common representation of a problem (Lavigne Delville, 2013). Callon suggests that solution promoters, who engage in problematisation like DEs, seek actors who may have an interest in getting on the case, and try to convince them that the promoted problem representations make sense. To achieve this, promoters develop "a set of actions by which a group of promoters strives to impose and stabilise the identity of the other actors that it has defined by its problematisation",

i.e. "*interessement*" (Callon, 1986). Interessement is based on a certain assumption of what the actors are, want to engage, and associate with: this involves establishing relationships with them. Thus, in the same fashion PBF DEs develop strategies, promoters diffuse their problem representations through multiplying social interactions: meetings, etc. On these occasions, promoters continuously have to negotiate, persuade, and reformulate their argument to adapt to potentially interested actors, who are themselves in constant evolution (Lavigne Delville, 2013). When the interessement scheme succeeds, problematisation gets validated. This outcome is precisely what happened when PBF got reframed as a key strategy to switch from passive to (active) strategic purchasing.

Our study employed a strong theoretically-informed approach to analyse a rich corpus of qualitative data. Repeated interactions with interviewees (cross-checking information through additional interviews, and letting participants comment on the study's preliminary results) enhanced our results' credibility. The detailed description of the methods used to collect and analyse data provides a strong dependability[8]. We ensured transferability through a detailed description of participants' characteristics: other researchers may use similar inclusion criteria in order to reproduce this research in other settings and on another topic related to international development. In short, our results' confirmability is high (Thomas and Magilvy, 2011).

The main limitation of this study is that respondents from international organisations (in particular, one organisation: the World Bank) dominate the sampling. While this one-sidedness suggests that they represent the most obvious promoters of PBF, non-profit organisations also played a crucial role in PBF global diffusion. Three of our respondents had moved from NGOs to international organisations at the time we analysed their interview transcripts.

Conclusion

Bacchi's poststructural approach proved useful to analyse the construction of global health problem representations and the strategies set by global diffusion entrepreneurs to spread these representations and shape the discourse. The diffusion of PBF has benefited from problem

[8] Dependability relates to the quality of the description of the study design, data collection, and data analysis/interpretation processes. This is useful to other qualitative researchers willing to reproduce the same type of research.

representations and policy frames that were cleverly and strategically implemented by global diffusion entrepreneurs, sometimes in reaction to criticism expressed by other academics and international organisations. Future research is needed to further analyse the role played by global diffusion entrepreneurs in creating and promoting "2nd phase DEs", i.e. African experts who diffused the PBF solution across the African continent and at country level. Further assessment of the policy indifference to research results in Africa is also critical. Other authors ought to study additional global development policies to investigate the motivations and strategies that influence policy diffusion.

List of abbreviations

DE(s): Diffusion entrepreneur(s)
GAVI: Global Alliance for Vaccines and Immunization
HRITF: Health Results Innovation Trust Fund
ILO: International Labour Organization
LMIC(s): Low- and middle-income country(ies)
MoH: Ministry of health
NGO(s): Non-governmental organisation(s)
NORAD: Norwegian Agency for Development Cooperation
NPM: New public management
PBF: Performance-based financing
SSA: Sub-Saharan Africa
UHC: Universal Health Coverage
WHO: World Health Organization
WPR: What's the problem represented to be

Declarations

Ethics approval and consent to participate

Prior to responding to the interviewer's questions, all participants read a detailed information sheet and provided their written consent. Ethical approval was obtained from University of Montreal's *Comate d'éthique de la recherche en santé* (Certificate 16-153-CERES-D).

Consent for publication

All authors provide their consent for publication. Written informed consent was obtained from the participants for publication of their individual details and accompanying images in this manuscript. The consent form is held by the authors and is available for review by the Editor-in-Chief.

Availability of data and material

The codebook is available upon request to the authors.

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Authors' contributions

All authors contributed to the design of the research. The first author (LG) collected the qualitative data, transcribed verbatim about half of it (i.e., 27 interviews and 10 observation sessions), and translated relevant coded contents from French to English. LG also analysed the data, and drafted the first version of this paper. MDA & VR aided in data analysis. All authors contributed to the writing of the manuscript and have read and approved the final manuscript.

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Chapter 5. The diffusion of performance-based financing at the continental level

Paper title: Transnational Networks' Contribution to Health Policy Diffusion: A Mixed Method Study of the Performance-Based Financing Community of Practice in Africa

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Transnational Networks' Contribution to Health Policy Diffusion: A Mixed Method Study of the Performance-Based Financing Community of Practice in Africa

Research Highlights

- The role of transnational policy networks such as communities of practice (CoP) in diffusing health systems reforms has been seldom investigated
- The Performance-Based Financing CoP was one of the major catalysts of relevant policy diffusion processes on the African continent
- Using innovative tools to make sense of large textual and relational data helped unravel the attributes and structures of global health policy networks and their influence in policy diffusion

Abstract

Background: Transnational networks such as Communities of Practice (CoP) are flourishing, yet their role in diffusing health systems reforms has been seldom investigated. Over the past decade, performance-based financing (PBF) has rapidly spread in Africa. This study explores how, through the PBF Community of Practice's attributes, structure, and strategies, PBF diffusion was fostered in sub-Saharan Africa.

Methods: Informed by the diffusion entrepreneurs' framework dimensions, we used a mixed methods convergent design to investigate how the attributes, structure, and strategies of this community fostered the diffusion of PBF. The quantitative strand of work included firstly a semantic discourse analysis of textual data extracted from CoP's online discussion forum (n=1,346 posts). Secondly, the relational data extracted from these 1,346 forum posts was examined using social network analysis. We confronted these quantitative results with a thematic analysis of qualitative interviews (n=40) and data extracted from the CoP's key documentation (n=17).

Results: CoP members' attributes included: representation systems anchored in clinical and economic sciences, strong expectations that the CoP would boost professional visibility and

career, and significant health systems knowledge and social resources. The CoP's core group, dominated by high-income country members, critically matched PBF principles to major health systems issues in Africa. The broad consensus in online PBF thematic discussions created a strong sense of community, a breeding ground for emulation among CoP members. The CoPs also sought to produce and promote experiential knowledge exchanges about PBF amongst African practitioners. Findings from network analyses showed that the promoted Africa-driven community was led by high-income country members, although their prominence tended to decrease with time.

Discussion: This empirical research highlighted some of the constituting features, structure, and strategies of policy networks in influencing health policy diffusion. Despite good intentions to disrupt the established governance landscape, influential actors coming from high-income countries continued to drive the framing, and shaped health systems policy experimentation, emulation, and learning in African countries.

Conclusion: Beyond mere knowledge exchange platforms, communities of practice can act as meaningful transnational policy networks pursuing the diffusion of health systems reforms, such as PBF.

Keywords: Transnational Policy Networks, Communities of Practice, Social Network Analysis, Semantic Analysis, Performance-Based Financing, Sub-Saharan Africa

[I]t is hard to bite the hand that feeds; especially when that hand has paid for your airline ticket and is feeding you a three course dinner at a five star hotel. While it is important to have a seat at the table, that table is not an even one and power asymmetries perpetuate.

(Thompson, 2019)

Introduction

Global health governance is characterised by polycentrism. This feature enables transnational networks to gain influence in global health policymaking (Shiffman, 2016). However, the role of networks in diffusing health systems reforms has been seldom investigated (Blanchet & James, 2012). Communities of Practice (CoPs) are "groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly" (Wenger, 2011, p. 1). CoPs are usually defined as "knowledge networks" as they strive to create and translate multiple forms of knowledge (Hildreth & Kimble, 2004). They represent an important global health platform because of their potential to mobilise people's knowledge from multiple sectors in view of supporting health systems reforms' implementation (Meessen et al., 2011). CoPs are interactive and inclusive networks: they organise face-to-face and online discussion fora for health practitioners, policymakers, researchers, and multilateral agencies (Bertone et al., 2013).

CoPs have flourished in the past 15 years; several of them have strived to develop a "repertoire of resources" for health systems financing reforms. While CoPs' primary aim remains to foster knowledge exchange, some CoPs (like many other transnational actors) have served to promote the diffusion of health systems financing reforms in sub-Saharan Africa (SSA) (Gautier et al., 2019a; Lee & Goodman, 2002). As they engage in "regular communication and frequent exchange of information", thus leading to "the establishment of stable relationships […] and to the coordination of their mutual interests" (Adam & Kriesi, 2007, p. 129), CoPs may also become policy networks aiming to spread policy ideas in multiple locations (Stone, 2008).

Building on two main strands of public policy literature, policy diffusion (Shipan and Volden, 2008) and "*sociologie de l'action publique*" (Hassenteufel, 2008), the framework previously developed by Gautier et al. (2018) helps to critically unravel the multiple features of those

transnational influential actors who strive to foster policy diffusion in LMICs, aka "diffusion entrepreneurs" (Gautier et al., 2018). DEs, including transnational networks, organisations (e.g. aid donors), and individuals (e.g. consultants), act in polycentric contexts: they may operate as autonomous units of political authority. Fuelling political influence into multiple units of governance, policy networks are salient illustrations of the DE concept.

Performance-based financing (PBF) has spread in sub-Saharan Africa very rapidly (Gautier et al., 2018). PBF is a health financing reform suggesting a shift from the traditional input-based transfer of financial resources for service provision to an output-based approach conditional on providers' performance. PBF diffusion has been fostered by a wide range of DEs (Gautier et al., 2018). Global DEs endeavoured to create fora to bring pilot PBF experimenters together. Notable among these fora was the PBF Community of Practice (PBF CoP) (Gautier et al., 2019a). This CoP emerged in 2010 as the practitioners' alternative to existing knowledge exchange networks, including the World Bank-led Interagency Working Group on Results-Based Financing (The World Bank, 2010). Using the example of the PBF CoP, this study aims to expand the literature characterising transnational policy networks and their influence on policy diffusion. In this study, we focus on the CoP's "diffusionist" function, notwithstanding that we also recognize and value its knowledge transfer function.

This study aims to expand the literature characterising transnational policy networks and their influence on policy diffusion. Specifically, we endeavour to unravel the constituting features of the CoP PBF and its interconnected strategies to shape PBF policy diffusion in SSA.

Methods

Policy networks may be investigated by looking at their attributes, structure and agency (Adam & Kriesi, 2007). We unravel the CoP's attributes by looking at its constituting features, and its structure (i.e. its governance) and agency by looking at its interconnected strategies. We followed Adam & Kriesi (2007)'s advice to study policy networks using mixed methods. We employed a qualitative-dominant approach (rooted in the social constructivist paradigm), relying on a concurrent quantitative and qualitative analyses (Creswell & Clark, 2011) to unravel the CoP's attributes (i.e. constituting features), structure and strategies.

First, to unpack one of the CoP's main attributes (its representation systems) and its strategies to frame PBF, we performed a quantitative semantic discourse analysis (Van Dijk, 1985) of the topical content of the CoP's online forum. The term "topical" was used to refer to content from discussion threads that related to PBF experience (i.e. institutional processes, funding, implementation, or evaluation) or theories. Archives of the discussion forum from January 2010 until September 2016, in both English and French, were screened for topical content. 1,346 messages (344 threads) were extracted. Data was coded using major semantic categories (see Appendix 5.1 and 5.2 for details) relating to the anchor disciplines of PBF (e.g. economics, management, clinical, social) which emerged from prior analysis of PBF DEs' discourse (i.e. in Gautier et al., 2019a). Words and expressions pertaining to key semantic fields were listed *a priori*, and any sentence containing these words/expressions was automatically coded using the software QDAMiner©. We used the software's coding retrieval and statistical features (on code frequencies, percentage coverage of coded words, etc.), including graphic representations, to produce the results.

Second, we performed a social network analysis (SNA) to investigate the CoP's structure (Wasserman & Faust, 1994). We used SNA to analyse communication ties joining members to each other, as well as the ties joining members to non-members. These ties featured members' citations of other persons (both members and non-members). Our goal was to visualise the CoP's network structure in terms of policy emulation (e.g. is it a cohesive community?) and learning (e.g. who cites who, and what does it say about the type of knowledge being shared and the community's openness?). We made the following analytical assumptions: citing someone was conceived as a proxy for both policy emulation (i.e. explicitly recognising that this person is part of the same policy community) and policy learning (i.e. explicitly recognising that this person's contribution expands PBF knowledge).
Based on the selected topical discussion threads, anonymous identifiers of forum contributors (n=186) citing CoP members and non-members were extracted using Excel. This means that our analysis focuses on a CoP active group (see Table 5.1) rather than the whole community: the SNA only features 287 members (out of more than 2000 members). Several CoP members commented on study in design in 2016, on preliminary results presented in a professional

meeting in 2017, and on final results in a conference in 2018. Their suggestion to split the data into two sections (from 2010 to 2012; and from 2013 to 2016) was applied so as to observe evolution patterns. This feature added to the credibility of our analysis, and confirmed social acceptance of our results among the CoP. We converted relational data to an adjacency matrix and brought it into R. We obtained undirected and directed graphic representations to inform policy emulation and policy learning, respectively. For the undirected network representation, we hypothesised a strongly connected network. For the directed network representation, we hypothesised a high number of citations among CoP members.

Table 5.1. Definitions of study participants included in quantitative analyses

Denomination	Definition
CoP members	All members registered on the CoP's online forum from 2010 to 2016 (N = 2,000+)
CoP active members	CoP members registered on the CoP's online forum and who posted at least one message in topical discussion threads (i.e., on PBF experience or theories) from 2010 to 2016 (N = 287)
CoP's core group	The core group represents the six CoP members (among which two were from SSA countries) who launched the CoP in early 2010. Their assignment was "to coordinate the CoP and boost its development", and responsibility was "to identify new objectives and launch new initiatives" (Core group, 2010, p. 8). (N = 6)
CoP's facilitating team	One of the core members (aka "main facilitator", from a high-income country) and three additional members (from SSA) moderating and initiating discussion threads (N = 4)

Third, we collected qualitative data: in-depth interviews (N=40) and documents on the CoP (N=17). Documents included: 14 key blogs on the PBF CoP, two meeting reports produced by the CoP, and one concept note on the CoP (all purposely selected to as information-rich in relation to the CoP key features and/or debates among members). Interviews with informants (i.e. PBF experts members of the CoP, as well as PBF experts knowledgeable about the CoP but non-members) were carried out from November 2016 to July 2017 in situ or by phone, in English or French (Table 5.2). Interview guides included 20 open-ended questions informed by the framework dimensions (see Appendices). Snowball sampling was the preferred strategy, given that CoP members and PBF experts frequently interacted with each other.

Table 5.2 Participants' general characteristics

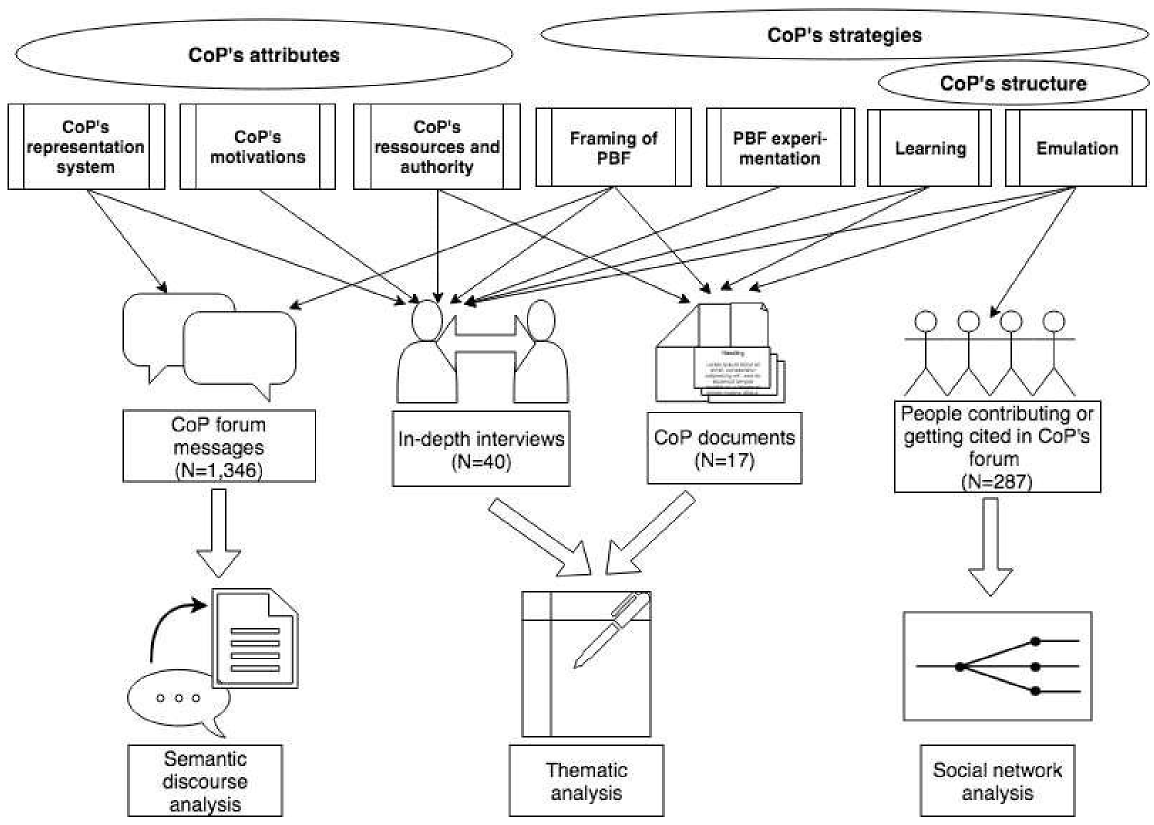
Current affiliation (N=40)		Main educational background (N=40)		Years of experience in international development, all excluding "NATGOV" cat. (N=35)		CoP membership (N=40)	
International organisation [INTORG]	16	Medical sciences	21	< 10 years	6	Yes	30
National government (SSA countries) [NATGOV]	5	Economics	11	> 10 years < 20 years	20	No	10
Academic institution in SSA countries [ACADINST_AF]	3	Other social sciences	4	> 20 years	9		
Academic institution in Europe [ACADINST_EU]	2	Other health sciences	4				
Independent consultant based in SSA [INDCONS_AF]	5						
Private for profit [PRIVFP]	4						
Private not-for-profit [PRIVNFP]	4						
Other [OTHER]	1						

NB: Each column ought to be read independently from another.

The DE framework (Gautier et al., 2018) offers analytical categories to explore the constituting features and strategies of DEs to diffuse policies. DEs share common representation systems (i.e. cultural backgrounds rooted in underlying assumptions about the world and its issues) that match the core ideas of the favoured policy, and common interests (which may be personal and/or societal) to spur diffusion (Hassenteufel, 2008). Thanks to available knowledge, political, material, temporal, and social resources, DEs acquire authority in global policymaking arenas. These constituting features enable them to design strategies to frame the policy in attractive ways, induce policy emulation (e.g. how socialisation sparks interest for a policy), and shape policy experimentation and learning (e.g. sharing policy knowledge across different settings). These strategies are interconnected: they may feed each other to further policy diffusion. For example, a common attractive framing fosters policy emulation among actors. Examples and details of DEs' constituting features and strategies are provided in Gautier *et al.* (2018).

Interview transcripts and CoP-related documents were coded using QDAMiner©. We applied a prominently deductive approach based on the DE framework dimensions. All authors reviewed and approved a preliminary codebook prior to completing the coding. Thematic analysis was subsequently applied to the coded data. Figure 5.1 shows how each dimension of the DE framework connects to the different datasets and analyses. Upon completion of analysis, using an interactive strategy of merging (Fetters, Curry, & Creswell, 2013), we brought the sets of quantitative and qualitative findings together through a combined analysis.

Figure 5.1 Correspondence matrix between DE framework dimensions, quantitative and qualitative datasets, and analyses



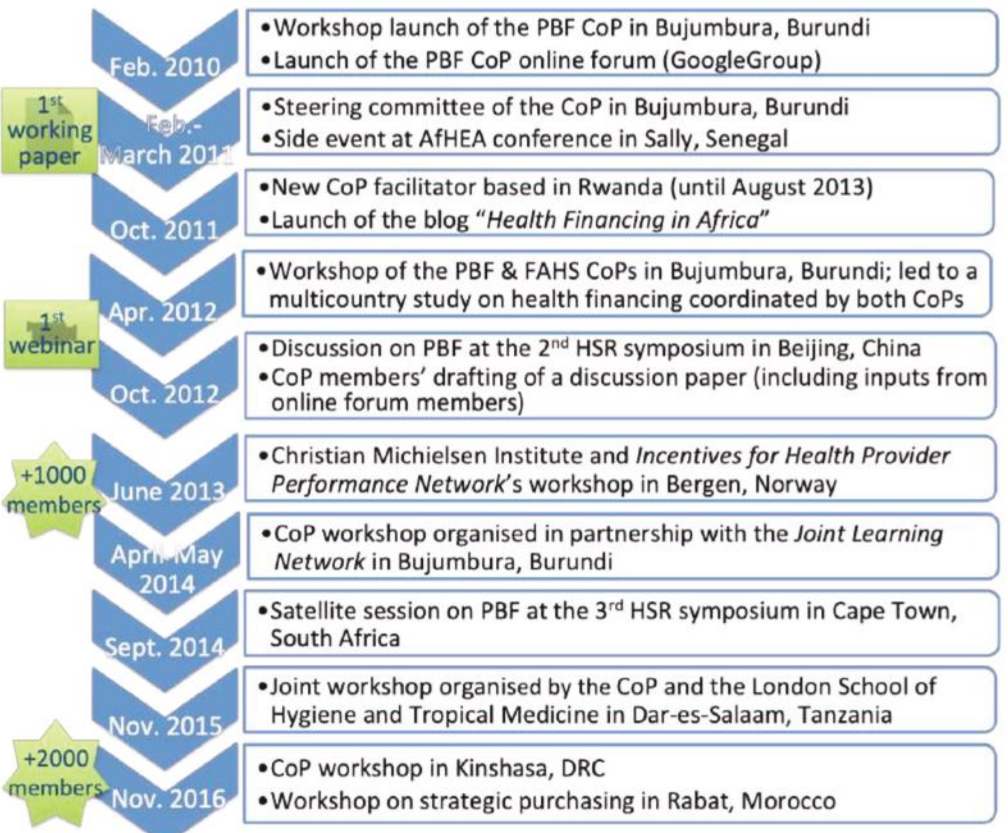
For each of the DE framework dimensions outlined in Figure 5.1, we compared and synthesised the related qualitative and/or quantitative findings on the CoP's attributes (i.e. representation systems, motivations, resources and authority), its network structure, and strategies (i.e. for inducing PBF framing, policy experimentation, and emulation and learning). In the results section, we employ a narrative approach whereby findings are presented along each dimension of the framework.

Results

1. History of the PBF CoP

By the end of 2016, most of the CoP's 2,000+ members were Africa-based consultants, health workers, and policymakers (CoPs facilitation team, 2017). Figure 5.2 represents the evolution of the CoP PBF, featuring major events and face-to face or online activities in which the CoP played a leading or influential role.

Figure 5.2 Overview of the PBF CoP's milestones and activities, 2010-2016



Note: AfHEA= African Health Economics Association; CoP = Community of Practice; FAHS = Financial Access to Health Services; HSR = Health Systems Research; PBF = Performance-based financing

Among the CoP's key events, the main facilitator (coming from a high-income country, HIC) asserted that the founding moment was the 2010 founding workshop in Bujumbura:

> *Everything's there actually, in this workshop. The whole concept is there. [...] How... we put African experts forward, [...] the joint organisation with the Ministry of Health with a very open model, putting forward young researchers... So, actually... we're breaking with conventions. [...]*

This founding workshop is one of the best representations of what we wanted. (I19a_ACADINST_EU)

The founding workshop notably gathered the CoP six core group members (i.e., the CoP inner circle, of which four members came from high-income countries). For the core group, such "breaking of conventions" involved diversifying knowledge exchange formats and convening hybrid types of workshops, gathering academics, development experts, and practitioners. The Bujumbura and Dar-Es-Salaam events in 2014-2015 were typical examples of such workshops, jointly organised with other institutions and featuring strong CoP participation.

The CoP's online forum was created shortly after the founding workshop. The number of members soon exploded (see Figure 5.2), thereby contributing to the expansion of its influence. Many informants from major global health organisations recognised this influence. Table 5.3 includes information about the PBF topical discussions on the forum, including on participation, response rate, number and nature of citations, and members' influence.

Table 5.3 Information about the PBF CoP online forum participation, 2010-2016

Participation	287 CoP members posting in topical discussions	**68.1% (LMICs)** **66.2% (SSA)**
Citations in 1,346 topical posts	Among those citing (N=186): 63.9% cite >1 person 49.5% get cited	Among those cited (N=215): 81.9% (CoP members) vs. 18.1% (non-members) **52.6% (LMICs)** **51.2% (SSA)**
Star influencers (N=2, among which the main facilitator)	Among those posting (N=287) Posted 15+ topics and got answers at least 12 times	**0% (LMICs/SSA)** 100% individual DEs
Influential members (N=10)	Among those posting (N=287) Posted at least 5+ topics and got answers at least 3 times	**50% (LMICs/SSA)** 80% individual DEs

Notes: Non-member: someone outside of the CoP network.

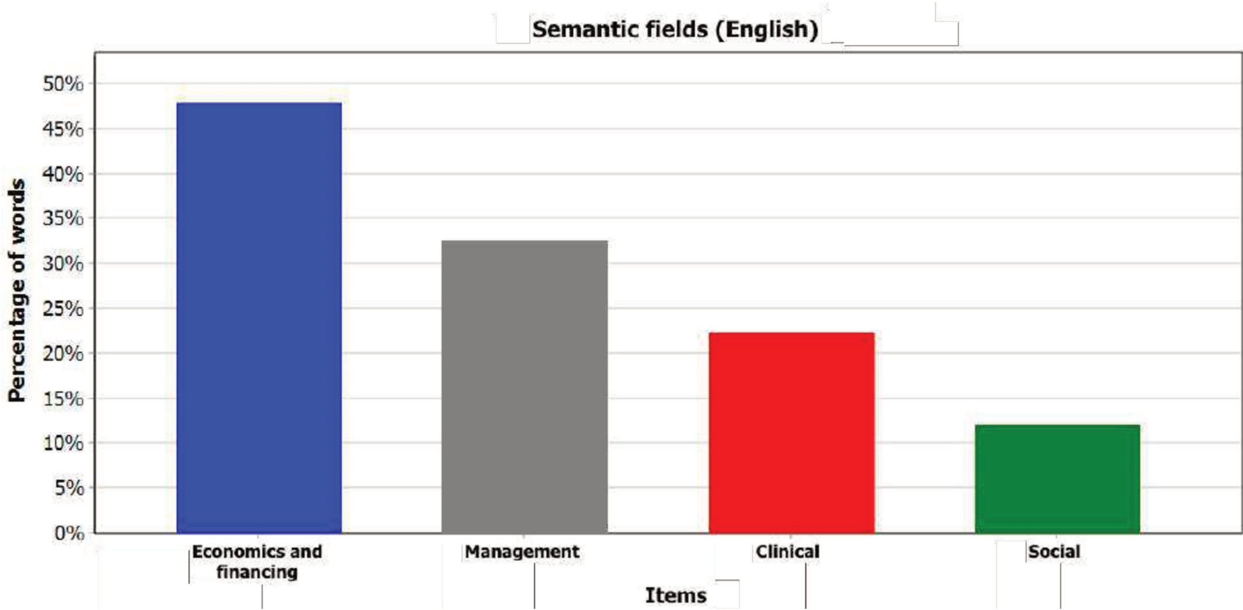
Abbreviations: LMICs = Low- and Middle-Income Countries; SSA = Sub-Saharan Africa

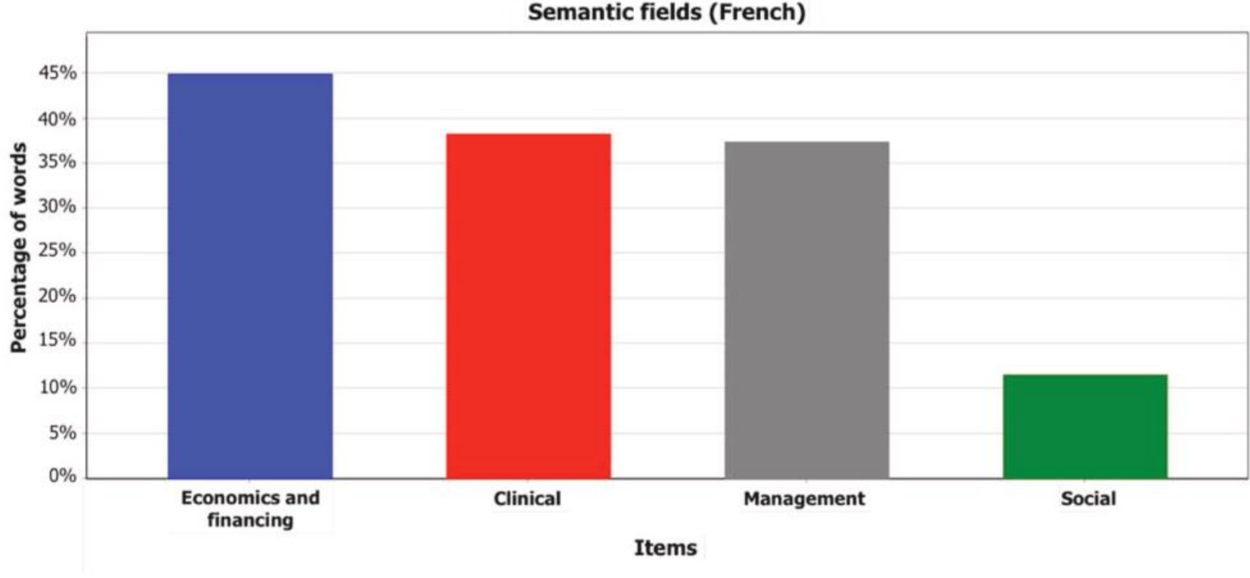
2. The CoP's attributes, structure, and strategies to induce policy diffusion

2.1 The CoP's attributes: representation systems

The CoP members' representation system transpired through the discourse (i.e. choice of words, expressions, and metaphors to describe and/or comment on PBF discussion topics) used in online discussions. The prominence of economics and health/clinical semantic fields (Figures 5.3 and 5.4) reflected CoP member interview informants' training, i.e. in economics and later specialising in health (especially for English-speaking members), or in health/clinical sciences complemented with a degree in economics (especially for French-speaking members). The "economics/financing" semantic field dominated both English and French discussions. Social sciences and social themes were less prominent. Influential members were keen on developing a PBF language that spoke to the CoP members' training background.

Figures 5.3 & 5.4. Major semantic fields in English and French discussion threads





Based on interview data, we found that core group members shared a same history (e.g., participating in initial PBF pilot scheme implementation), and additional members' had been exposed to core members during training (in Europe) or pilot scheme experimentation. This shaped a common language. Informants mentioned that from the beginning of the CoP's activities, people's background was indeed fundamental to developing the "idea of a club". This feature might explain the discussions of problem representations using a common professional jargon on the online forum.

This analysis thus points to a rather cohesive community of economists, health workers and managers.

2.2 The CoP's attributes: motivations behind the promotion of PBF

Analyses of interviews with core members and documents enabled us to identify two key interests in mobilising this community, which are intertwined with interests for promoting PBF: 1) gaining political influence and market space on the global health policymaking arena by fostering a legitimate discourse shaped by hundreds of LMIC/African practitioners; 2) consolidating the body of tacit knowledge on first-hand PBF experiences to build a shared repertoire of resources that would inform the development of PBF definitions and standards (e.g., Fritsche et al., 2014) highlighting that PBF is indeed a key policy solution.

The first motivation translated into the CoP's positioning, i.e. putting SSA practitioners and their discourse forward. Informants belonging to international organisations perceived this endeavour as laudable and successful:

> *For me, well, [the CoP] was effective in the sense that today, finally, what I see is that it's often much more... African practitioners who work on PBF than... those from the World Bank...* (I20a_INTORG)

SSA practitioners in turn reported that they had a lot to gain from promoting PBF through their participation in the CoP, notably because it enabled them to expand their professional career by acquiring skills and through wider visibility in the global health financing arena.

The CoP also offered opportunities for SSA members to share ideas for local adaptation of PBF (e.g., those featured in the CoP's Working Papers). However, one CoP member considered that for the core group, the priority agenda remained that of promoting a PBF standard definition:

> *In the definition of a CoP […] there's an important component, which is the strive* (pause) *to find local definitions, local solutions. Yet, in* (name removed) *his slides, you won't see this part of the definition. […] I don't know [why]. But when you look at how he understands PBF, for him it was never intended as a tool to invent local solutions.* (I34_ACADINST_AF)

This informant highlights the CoP's inner tension, i.e. promoting local solutions vs. standard definitions. According to I34, the idea of upholding and advertising a community of local practitioners did not involve going as far as to promote local solutions for health systems that the latter could come up with.

2.3 The CoP's attributes: resources and authority

One of the major strengths of the CoP network was that the core group members had very strong social resources, which enabled them to build personal relationships with health financing experts from LMICs. Even prior to launching the CoP, core group members had met at conferences, on the ground of pilot programs, or in academic settings in Europe.

Besides social resources, core group members also enjoyed crucial political resources: they had often previously interacted with influential politicians. This facilitated access to them. Core group members also had extensive knowledge resources, which they readily transmitted to CoP members. Informants notably asserted the CoP's effective contribution to the emergence of

"*African champions […] who have become leaders in PBF, […] providing the technical support and knowledge around PBF from within their countries*" (I53_INTORG). Many member and non-member respondents highlighted the capacity of the CoP's most influential members (mostly coming from high-income countries, HICs) to inspire and "mould" SSA PBF experts. Using the CoP, the core group coached SSA experts, to the point that the latter have reportedly "*overcome the masters*" (I53_INTORG).

These resources and prior work experience prompted core members to gain prestige, which helped them exert expert and scientific authority on the global arena. To realise its ambitious agenda, the CoP also needed some material resources. Across the years, the facilitation team secured occasional funding from The World Bank, the African Development Bank, and the Rockefeller Foundation. A Norwegian Institute, Cordaid, and a consulting company also financially contributed to specific CoP activities.

2.4 The CoP's strategic framing of PBF

One of the explicit goals of the CoP was to formulate a clear vision and definition of PBF:

> *"We need to define better what we mean by this 'PBF' approach. The experience that we developed in Rwanda, whose lessons are being applied to Burundi, and to Zambia […]. This is the story. It needs to be written up."* (I16, forum post)

This was made possible through the sharing of common problem representations structured by initial training (see above) and, according to most informants, SinaHealth's company training courses — which almost all SSA members completed prior to joining the CoP. Concurrently, in members' posts, PBF was mentioned in relation to health planning and financing, increasing efficiency of public spending, and autonomy of health providers. Influential CoP members developed a specific PBF jargon shaped by these semantic fields (e.g. "purchasing agency"), and used words pertaining to the private sector (e.g. "business plan"). Such shared repertoire (a key ingredient in the CoP's success) using a very specific technical language shaped a strong collective identity. Some informants portrayed this repertoire as having normative overtones, while others, more critical, depicted it as a "doctrine".

PBF made sense for SSA practitioners because it matched their representation systems: a lot of them considered that in the *status quo* (i.e. input-based financing) "*money was being wasted*" (I54_INDCONS_AF). The situation called for alternative ways of acting:

> *[PBF] creates a spirit of entrepreneurship... People start... thinking out of the box, people stop thinking under the usual constraints […] So it's a real paradigm shift.* (I26_INDCONS_AF)

CoP members thus portrayed PBF thus as both a revolutionary and pragmatic solution. Such depiction may also explain the wide consensus in online discussions. Dissonance across members emerged only in three discussions: once about user-fee exemptions, once about privatisation of drug provision, and once about health managers' spirit of entrepreneurship. This framing also contributed to the portrayal of PBF as a legitimate solution because it had been co-produced and propelled by SSA practitioners, who represented, as shown in Table 5.3, two-thirds of CoP participants. In coherence with the core group's first motivation outlined above, the co-production of PBF framing thus appeared to have a legitimising effect – for the CoP and for PBF itself. However, some interviewees voiced concerns as to whether co-production actually took place. The PBF definitions referred to by SSA members typically were those developed by non-SSA members.

2.5 The CoP's strategic contribution to policy experimentation

The first challenge in PBF diffusion was "*to provide governments and their partners with the appropriate technical assistance*" (Core group, 2010, p. 2). While agreeing that PBF "*was going to be something very big*" that would "*conquer the continent*" (I19a_ACADINST_EU) global experts in the late 2000s expressed concern that capacities were lacking in SSA. The CoP emerged as a tool to create an enabling environment for smooth policy experimentation:

> *The CoP was a strategy for me to... reinforce technical capabilities. […] Strengthen the quantity [of African experts]... and make sure these experts are real experts.* (I19a_ACADINST_EU)

First, the CoP's depoliticised and "Africa-led" framing of PBF nicely matched this endeavour: by bringing together a critical mass of well-trained SSA practitioners, the CoP offered international organisations (funding PBF pilot programmes), NGOs and companies (implementing pilot programmes), a pool of SSA experts to tap into:

> *[The CoP] was a big vehicle to make sure […] that … you had a roster of people who were involved in PBF projects or interventions who could potentially be… further … trained and coached… to become the experts they have become!* (I53_INTORG)

The CoP's facilitation team even started linking job announcers to SSA PBF experts. Soon, the CoP became the indispensable "*market place*" (I19a_ACADINST_EU) for PBF experimentation, since it enabled consulting companies to post their call for tenders and job offers, while encouraging SSA members to apply. These jobs were typically located in PBF experimentation settings. The CoP thus directly contributed to exporting practitioners to other SSA countries. This pattern further expanded through the action of a separate, yet connected entity: SinaHealth's training company and its alumni network (reportedly also influencing continental diffusion processes). The latter trained multiple waves of country teams starting to implement PBF. At the end of each two-week course, alumni would systematically be invited to join the CoP. The training score was used to "vouch" for CoP members' expertise in their job applications. Informants described the following sequence: people were trained by SinaHealth, joined the CoP, engaged in knowledge exchanges and study tours, gained visibility, and started diffusing the above-mentioned repertory of practices. Such repertory was primarily shaped by 1st generation DEs, i.e. CoP members from HICs (including SinaHealth's head) on PBF in other experimentation settings. This sequence is referred to as the "2nd generation DE" phenomenon.

Second, through the online forum and other CoP activities, CoP members facing challenges in introducing and/or implementing PBF were provided technical advice and guidance. The CoP was indeed perceived as a highly relevant tool for fostering policy experimentation, by supporting PBF practitioners' work and career advancement across the continent. This network thus represented a strong catalyst for diffusion processes through its multifaceted support of policy experimentation.

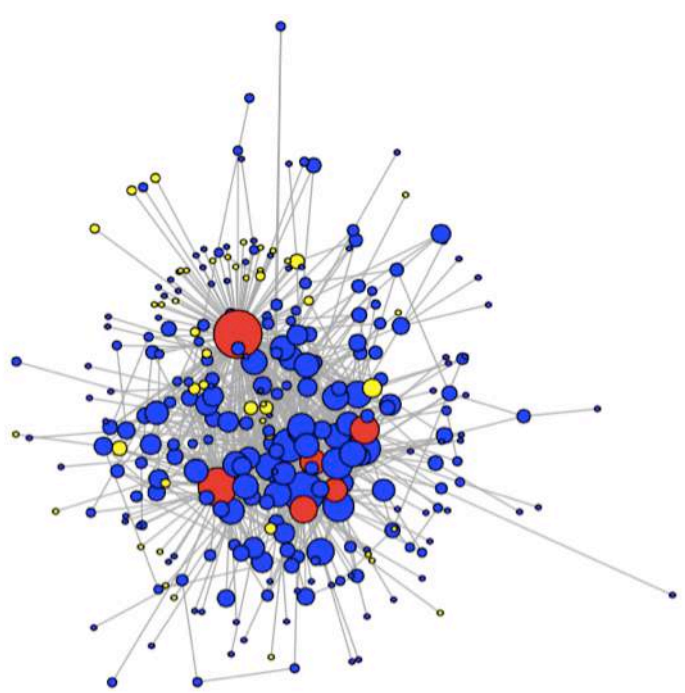
2.6 CoP's structure and strategic inducing of policy emulation

One of the explicit strategies developed by global DEs was to create fora to bring pilot PBF experimenters together (Gautier et al., 2019a). This process naturally attached social value to the tested policy, thus increasing the legitimacy of PBF and inducing policy emulation. The CoP was considered one of the major catalysts of inter-country exchanges for PBF practitioners. It represented an instrument deliberately projected to induce emulation. Yet, endogenous processes occurring within the CoP reinforced policy emulation as well. Specifically, the cohesive structure

of the CoP network and the nature of social interactions among members featured a strong sense of belonging to the CoP.

CoP members' cohesion primarily built on a shared appreciation that PBF was to be promoted. This was made possible by implementing emulation strategies. The CoP endeavoured to spark "*collective enthusiasm*" (I19a_ACADINST_EU) by creating multiple avenues for practitioners to share their experiences and socialise with one another. The CoP notably supported study tours for members to engage in inter-country exchanges, thereby fostering network cohesion. The SNA provides a rich visualisation of the network's cohesive structure. The giant size of the strong component (Figure 5.5) shows that the CoP is indeed a highly connected network. Core group members are featured in red; non-members (i.e. cited external people) in yellow.

Figure 5.5 Unoriented weighted representation of the CoP thematic discussions' SNA, 2010-16



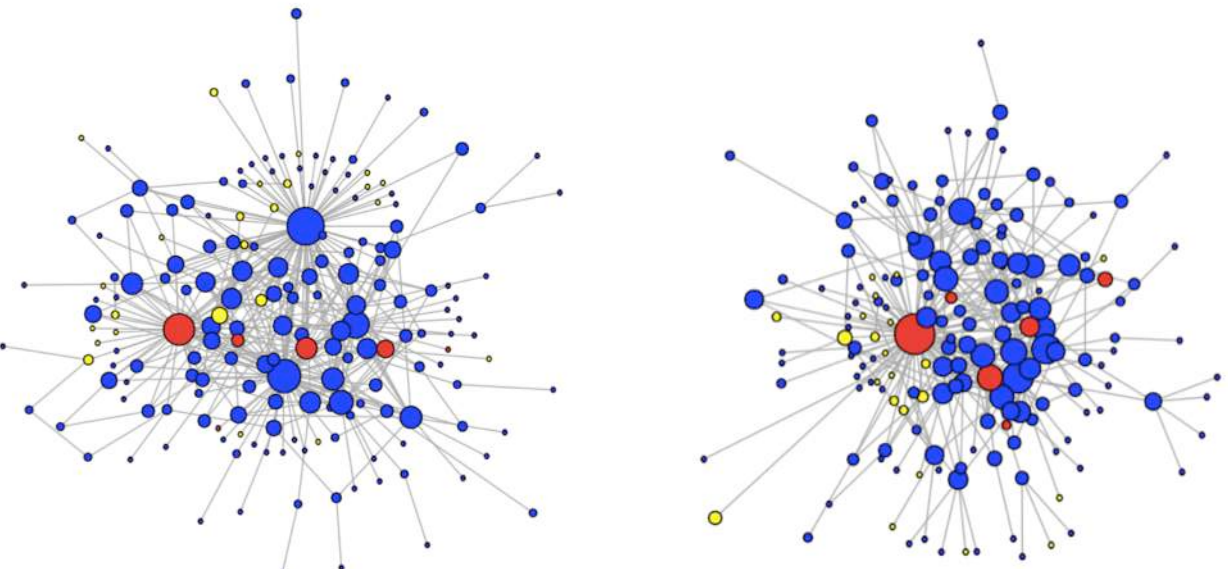
The network's global clustering coefficient is 0.098. This coefficient means that, on average, there is a nearly 10% chance that two individuals, who are citing or cited by a common individual, are also connected to each other. This coefficient can be considered average (Watts and Strogatz, 1998). More salient is the average path length of the network (i.e. the mean shortest paths between all pairs of nodes) of 2.82, which suggests that the CoP is a "small world", i.e. with fewer than three people separating each node. We tested the clustering coefficient and

average path length of the CoP network against those of 1,000 random networks (using Erdös-Rényi's model) and found that the CoP network indeed qualifies as a "small world" (Watts and Strogatz, 1998). This analysis of participation in the CoP topical forum discussions confirms the community's strong cohesion.

Figures 5.6 and 5.7 illustrate the evolution of the network structure over time. Average path length was shorter in earlier years (2.78) compared to more recent ones (3.06). The global clustering coefficients are constant through time (10.8%). This temporal analysis shows that the network was more active and more cohesive in the early years than it was in its last three years, as confirmed by the informants' general perception. For example, members sharing their emotions on the forum (e.g. following the death of a fellow member) occurred more often in 2010-2012.

Figure 5.6 Unoriented weighted representation of the CoP online thematic discussions' SNA, 2010-12

Figure 5.7 Unoriented weighted representation of the CoP online thematic discussions' SNA, 2013-16



The SNA also enabled us to visualise members' influence (Figure 5.5), measured by weighted degree centralisation (size of the nodes is proportional to weighted degree centralisation values). The member with the highest weighted degree (also the one that is represented as the largest circle) was the CoP main facilitator (352). Interestingly, although he was not a core group member, the individual with the second highest weighted degree was SinaHealth's head (160). These two highest degree nodes remained constant over time. This is coherent with qualitative

findings, which highlight a consistent cross-fertilisation among the two major PBF networks in SSA. In fact, several informants suggested that the influence on diffusion of SinaHealth's network and the CoP would be very difficult to disentangle, given their very close interaction.

Still, when looking at influence in terms of generating inspiration and career aspirations for SSA individuals (e.g., to become development cooperation consultants or employees of international organisations), the CoP was mentioned more often than the training company. Policy emulation inferred from the CoP's activities built on a strong community feeling emerging from the solidary nature of members' interactions. Informants reiterated the CoP's instrumental role in harnessing a critical mass of practitioners sharing and supporting the same policy idea:

> *One of the major forces [of networks] is that very quickly you have a large number of people who seem to support the same concept.* (I34_ACADINST_AF)

Core group informants portrayed the CoP as a community that "*enabled [isolated members] to gather together and identify with it*" (I17a_PRIVFP). For a CoP member in a given SSA country, the fact that "*dozens of other*" CoP members were available at country level to support him indeed had a de-isolating effect. This would in turn foster policy diffusion: local policymakers — whom CoP members were reportedly socialising with — would be keener on listening to a policy idea when it was supported by numerous trusted people.

Some informants, however, voiced concerns that policy emulation across experts was not exactly Africa-owned, but rather relying on and still building on "white" expertise. The branded "horizontal" nature of the CoP was questioned:

> *There's a gradient of tacit authority that lies between the actors who manage this platform [who are white and perceived as renowned] and the others who are at the bottom... So even if we say 'horizontality', there are always people who are at the top, and people who are at the bottom, in search of resources, […] opportunities and so on…* (I34_ACADINST_AF)

2.7 The CoP's structure and strategic shaping of policy learning

The specific purpose of the CoP was to secure the lessons learnt from past PBF experiences, e.g. by designing best practices material (Core group, 2010, p. 1). This lay knowledge was generated and shared through multiple interactive activities (including an online forum on best practices, an online readers' club, face-to-face workshops) and using various formats (blogging, working papers, webinars, scientific papers). Using the online forum or blog posts, members shared

success stories from PBF country experiences in SSA countries (Rwanda, Burundi…) and even outside SSA. This encouraged many other members to replicate and/or build on the ingredients that were successful in a different geographical context.

Among the various learning activities, informants tended to agree that face-to-face activities were the most powerful learning tool. According to one of the facilitators, the CoP did not manage the entire learning process of its members aspiring to become international experts. Still, the community represented a space to support the global push for PBF, and legitimised the learning venture of its proponents.

By valuing lay knowledge, the core group shaped an action-oriented type of learning agenda, so as to support each phase of PBF policy experimentation, from small-scale pilot to national rollout. This form of agenda was preferred to an academic learning agenda:

> *If […] I was always saying: "Science says, science says... the evidence is not there" — you see, if I had a very... very firm, very rigorous speech, I think that... that would frustrate... […] people... So you have to leave space for enthusiasm, for passion... […] and there's a margin of... error, eh?* (I19a_ACADINST_EU)

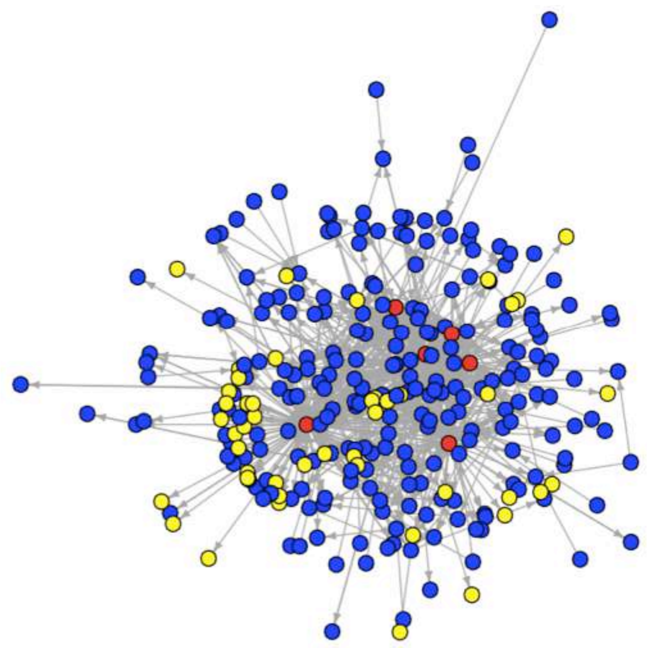
Coincidentally, some informants feared that there was not enough "quality control" of the validity of knowledge that was shared. The main facilitator reckoned he lacked time to perform quality control. In fact we noted that in the forum, CoP members rarely pointed to academic papers to contradict or nuance a practitioner's argument that might be considered scientifically invalid by researchers. The fact that many SSA practitioners were expecting to gain professional recognition (from some of the CoP funders) from participating in CoP activities, is likely to have influenced the nature of their contribution. However, the funders' participation in the online forum was considered fairly low — aside from posting job announcements.

Core group informants also emphasised the idea that technology advancements and ability to travel more easily across countries were enabling factors for implementing the learning agenda. Putting forward local practitioners translated into the CoP's processes through citing someone else during face-to-face workshops and in online activities. These activities were indeed made possible by technology and globalisation. Contributions to the CoP online forum may have served as a proxy for personal influence, because it would give visibility to individuals. In this

context, citing someone else represented an implicit recognition of that person's contribution to policy learning on PBF. Using SNA enabled to visualise who cited whom and who got cited by whom, i.e. using the "oriented" modality. In Figure 5.8 arrows feature the direction of the links (citing or getting cited).

Of those cited (N=215), 18.1% were non-members (and 43.5% of those are only cited by the facilitators). As explained above, the main facilitator strategically conceived a hybrid model of face-to-face workshops, gathering both academics and SSA practitioners (see examples in Figure 5.2) and engaged himself and fellow CoP members in regular blogging, to "*build bridges with the outside*" and "*impede some sort of complacency*" (I19c_ACADINST_EU). Despite these efforts, SNA results indicated that the CoP remained a mostly inward-looking learning community. Besides, most commonly cited non-members are authors of academic papers highlighting mixed evidence on PBF (e.g., Kalk, 2011). Non-members' authoring papers featuring positive evidence about PBF were also cited in forum discussions, but their mention induced shorter debates (hence, a lesser number of citations). This result might reflect limited openness to PBF criticism and a tendency towards confirmation bias. Concurrently, several interviewees mentioned that a common defensive tone was often used in online posts in reaction to externally-voiced criticism of PBF (including in scientific publications) and the CoP process itself.

Figure 5.8. Oriented unweighted representation of the CoP online thematic discussions' SNA, 2010-16



Looking at the number of citations from 2010 to 2016, we found that SSA members represented only 41.5% of the total number of citations, while they posted 66.2% of the total number of online messages. This would mean that SSA members do not get cited as much as they participate. If we consider that someone being cited means that he/she has knowledge influence, then HIC individuals are the ones driving the learning agenda. None of the authors of a scientific discussion paper (Witter et al., 2013) which was — amongst others — fed by comments from CoP members and discussions during Bergen's workshop (Figure 5.2), was based in SSA. Still, analyses of cited people over time enabled us to nuance influence patterns between HICs and LMICs (mostly SSA). The number of citations of LMIC/SSA members (of the total number of citations) increased from 34.6% to 52.1%, indicating a growing African ownership of policy learning.

Lastly, CoP's empowering SSA expertise sparked similar autonomous processes in other major PBF actors such as the World Bank. Several informants from that organisation indeed acknowledged being inspired by the CoP's model for promoting practitioners and having them travel throughout the continent. This soft influence also contributed to the portrayal of the CoP as the catalyst DE in SSA, and enhanced policy learning. The most salient illustration was the development of a culture of "importing-exporting" SSA experts for the purpose of helping a country team learn from the expertise of a foreign consultant. The World Bank's participation in the making of 2nd-wave DEs served to increase the chances of success of a PBF pilot programme.

Discussion

This paper makes a unique contribution to the literature on transnational networks by looking at CoPs as actors of policy diffusion rather than mere knowledge exchange networks. It offers in-depth and nuanced accounts of how the CoP became the catalyst for PBF diffusion processes in SSA. Drawing on our analysis of its attributes, structure and strategies, four key findings illustrate how the CoP reached this status: first, through implementing its agenda to define and disseminate a common repertory of PBF practices framed as country-driven and appropriated by SSA practitioners; second through its multifaceted support for policy experimentation and learning; third through its perceived capacity to spark policy emulation and empower career advancement for SSA experts; and fourth through its model of promoting practitioners and

having them travel throughout the continent. This soft influence fostered major actors' recognition of the CoP as one of the main catalysts for DEs in SSA in the mid-2010s. We discuss our findings in light of existing literature on policy networks.

A hierarchical or horizontal network?

The CoP operationalised its vision of a horizontal network through the development of multiple participatory and interactive learning activities. Yet this was not enough to change the governance structure of the network. Characterising a policy network involves looking at the "distribution of capabilities over the set of actors" within the network (Adam & Kriesi, p. 133-4). Our analysis of the CoP's resources and authority suggested that the most influential CoP members (mostly from HICs) were the leading actors fostering diffusion processes. Building on their initial PBF experience, they designed a learning agenda that strategically co-developed lay knowledge featuring and acknowledging the (African) context within which policymaking occurs, as in (Keck & Sikkink, 1999).

Following Adam & Kriesi's typology, the CoP fell under the category of a "hierarchical cooperation" type of network, i.e. cooperation "conducted under conditions significantly different from those obtaining among actors all of whom are more or less equally powerful" (Adam & Kriesi, 2007, p. 135). This unequal distribution of power was also featured in the SNA results. The promoted SSA-driven community did not match the network's structure, which was dominated by HIC individuals. In addition, our results indicated an imperfect co-production of knowledge whereby academic PBF definitions for instance continued to be led by HIC members. The difficulty of engaging participants from low-income settings in knowledge co-production has been noted earlier a typical challenge of North/South collaborations (Djenontin & Meadow, 2018).

Still, temporal analyses highlighted a growing SSA influence in knowledge exchanges. This indicates that the CoP's governance allowed for a much better representation of LMICs than global policymaking arenas (Sheikh et al., 2016). Thus, in terms of inclusiveness (Shiffman, 2017), the intense participation of SSA practitioners in the CoP was one of the strongest legitimating factors contributing to PBF diffusion, because it proved that voices from LMICs

were actively supportive of PBF. Yet, as identified in Gautier *et al.* (2019a), it is unlikely that CoP members, being mostly health practitioners, international consultants, and national policymakers, could be deemed legitimate representatives of SSA populations.

Disrupting the political economy of global health policymaking?

CoP's core members endeavoured to break with conventions and used the CoP's image – promoting SSA practitioners and their framing of PBF – to disrupt hierarchies in the political economy of global health policymaking. The CoP thus offered an opportunity to gain political influence within the global policymaking arena, largely dominated by HIC actors (international organisations and the scientific community). Yet, according to most informants, the net beneficiaries of this particular endeavour were the most influential members, mostly coming from HICs. Ironically, the CoP contributed to legitimising PBF at the global level and with external audiences, precisely because it represented the voice of SSA practitioners.

The assumption that major "stakeholders are more likely to interact with actors who are perceived as influential—independent of their beliefs—than with actors who are perceived as not influential" (Weible, 2005, p. 462) might be a barrier to the impact of policy networks with horizontal modes of operation. In other words, dominant organisations and individuals would be keener on listening and negotiating with peer-dominant HIC individuals.

Moreover, the ways the CoP effectively participated in PBF African experts' empowerment were unclear. In fact, most SSA practitioners remained dependent on individual experts from HICs for professional and reputational recognition, and on funders (e.g., PBF donors) for job opportunities and financial sustainability. This feature reflects the persistence of socio-historical structures and representation systems that continue to value the "white expert" above the local expert. The recent migration of the CoP to Collectivity's webplatform may offer more diverse opportunities for experts to engage in a more decentralised governance of the community.

A complex set of motivations

Like PBF DEs in Mali, members of the CoP pursued both 'genuine' interests in learning how to improve health system reforms' design and implementation, and self-regarding motives (Gautier

et al., 2019b). Furthermore, the cohesive nature of the network indicated the development of an *organised interest structure* (as in Schneider, 1992) whereby despite HIC members' prominence and their interests, SSA CoP members could also make some gains from supporting the policy idea (PBF).

HIC members' motivations were salient: by driving the learning agenda and dominating the development of PBF definitions, standards, and best practice guides, they would obtain strong visibility in the global arena. They would also benefit from the perceived legitimacy attached to the "African CoP". SSA members' gains could be reputational/political (expanding visibility/influence in home country), financial (higher salaries), and professional (career advancement and knowledge/skills expansion). As in the case of German corporate networks, it might have been "easier" for SSA practitioners to let individual DEs take control, so that they would be "relieve[d]… of the difficult task of finding compromise between divergent and perhaps conflicting interest perceptions" (Streeck, 1983, p. 270) within the CoP, and with a wider audience that debated PBF.

In line with Adam & Kreisi's assumption, the incentives and resources that the CoP provided for group formation, and the perceived high salience and positive effects of PBF on the field (e.g., Shen et al., 2017), were also likely to foster the CoP's influence.

An epistemic community with strongly intertwined characteristics

Similar training backgrounds and a common history (e.g., attending SinaHealth courses) consolidated SSA CoP members' sense of belonging to a community, thereby reinforcing policy emulation and spurring a shared identity: being PBF practitioners. The CoP was indeed portrayed as a transnational community of "professionals with recognized expertise and competence in a particular domain" (Haas, 1992, p. 3). Hence, it would qualify as an "epistemic community" despite its hierarchical configuration. The sense of fraternity also built on citations in forum messages: members citing fellow CoP members created a sense of being part of the same policy community.

Moving past a mere analysis of the CoP's structure, interests, ideas, power, and strategies, we tried to unravel the ways these features are intertwined to foster diffusion. Shiffman suggested looking at how "historical precedent and structural forces interact with individual and organisational agency" (Shiffman, 2016, p. i2) to advance policy diffusion. The CoP's interaction with other PBF DEs (e.g., SinaHealth, The World Bank), and the fact that its most influential members were individual DEs who had worked together in the past, significantly contributed towards fostering the impact and perceived legitimacy of the CoP.

A normative inward-looking community?

The norms promoted through a shared language and positioning towards PBF had both positive and negative implications for the policy network.

First, although the CoP had a great diversity of participants in terms of position/institutional affiliation, the fact that they shared a similar training background and PBF experience made them more likely to welcome and participate in internally generated knowledge (i.e. lay knowledge shared by fellow CoP members) than externally generated knowledge. Our findings were thus consistent with the hypothesis that nodes in a community were more likely to connect to other members of the same community than to nodes in other communities. This is coherent with findings about the structure of health policy networks in Burkina Faso (Shearer et al., 2018), which showed that strong cohesion and shared norms are often considered barriers to innovation.

Second, such homogeneity in turn implied that internal knowledge would be less likely to be contested than evidence produced by non-members. Bertone et al. (2013) pointed to the risk that CoP members "overestimate" the external validity of their lay knowledge. Despite the facilitating team's efforts to open up debates (e.g., through inviting academics to CoP workshops), we found evidence that CoP members sometimes used a prescriptive tone in knowledge exchanges. This tone may also have to do with members being cognisant that their contribution to CoP activities might generate career opportunities offered by CoP partners.

Third, in the early years of the CoP, promoting practitioners' lay knowledge on PBF involved opposing it to academic evidence. Interestingly, members' cohesion built on this defensive

language; and this in turn consolidated a sense of community. Members' efforts to legitimise lay knowledge also involved opportunistic citing of academic evidence on PBF produced by fellow members. Thus, policy learning was featured through members' citations: citing fellow members involved recognising that this person's contribution expanded PBF knowledge.

Fostering policy emulation rather than actual diffusion?

In this study, policy emulation was featured though multiple illustrations. Our results shed light on both the strong community feeling emerging from participation in the PBF CoP online forum, and the "mass effect" that led to de-isolating its members.

The CoP model primarily relied on the transfer of technical expertise from North to South and replicated by SSA practitioners. This included agreeing on a common framing of PBF (i.e. an Africa-driven policy solution), facilitating policy experimentation (e.g. developing PBF best practices guides), and fostering policy learning (by promoting inter-country and peer-to-peer lay knowledge exchanges). All these activities were intended by global diffusion entrepreneurs to facilitate PBF diffusion in SSA countries, while promoting, coaching, and creating African experts. Some of these reportedly turned into leaders "*overcoming their [white] masters*", engaged to diffuse PBF in their home country and beyond. As an illustration, one very active CoP member (from Rwanda) founded their own consulting company to provide advice to pilot implementation teams across the continent. This major spill-over effect, namely the making of 2nd wave DEs, both reflected and reinforced policy emulation, with 1st wave DEs (from HICs) inspiring and grooming SSA DEs.

Global health scholars, including those who studied PBF policymaking processes, frequently referred to "national champions" and "policy entrepreneurs" (Kiendrébéogo et al., 2017; Shiffman, 2007; Sieleunou et al., 2017) to represent local actors who help diffuse a given policy. The category of "2nd wave DEs" that emerged from our data is distinct in the sense that these actors were initially coached by HIC individuals with whom they had worked or interacted in the past (e.g., in training/academic settings). First generation DEs carefully "chose" these SSA practitioners (who may be consultants, street-level bureaucrats, or policymakers) and endeavoured to propel their career to the next level, provided that the latter have proven expertise in the promoted policy and willingness to support it at home.

However, at country level 2nd-wave DEs were at times limited, notably in terms of influencing national policymakers. Two reasons may explain their limited action. First, as indicated above they might have been perceived as less credible or renowned than their white peers. Second, they remained vulnerable to political turnover which involved either a shift in policy priorities or a more limited access to the new minister of health and his/her advisors. CoP's framing of PBF, and shaping of PBF learning and experimentation thus effectively contributed to policy emulation across SSA, rather than policy diffusion.

Study strengths and limitations

The context of increasing polycentrism in global governance makes it critical to shed light on the role(s) played by new transnational actors, such as policy networks including CoPs. This empirical research enabled us to identify the critical dimensions of CoPs facilitating the diffusion of health system reforms in polycentric governance. Semantic discourse and social network analyses helped to unfold networks' characteristics, i.e. their constituting features (nature), structure, and strategic actions (agency). To explore these intertwined characteristics of transnational networks in global health policymaking, further mixed method research combining such innovative tools data is needed.

Our research also had several limitations. Our quantitative analysis focused on a CoP active group featuring 287 members rather than the entire community. Our (retrospective) approach also included little observation of the CoP's activities. In addition, the categories we used for the semantic analysis coding was derived from a previous publication: this may have introduced a confirmation bias. Lastly, despite the use of two quantitative analytical tools, it was often difficult to disentangle the CoP's influence from that of other PBF collective DEs in SSA.

Conclusion

Our research brought to light the main attributes, structure, and strategies of a policy network — the PBF community of practice — that appeared to catalyse continental efforts towards PBF diffusion in sub-Saharan Africa. This study also showed that, despite good intentions to disrupt the established policymaking landscape, influential individuals and organisations from high-

income countries continue to drive the framing and shaping of health systems policy experimentation, emulation and learning agenda, even if these are implemented in sub-Saharan African countries.

Our results also shed light on the complex social phenomenon of influential diffusion entrepreneurs' making of "2nd wave diffusion entrepreneurs" based in SSA. This thought-provoking phenomenon, which goes well beyond the mere identification of national "policy champions" in LMICs, calls for future research related to other global health policies.

List of abbreviations

CoP(s): Community/ies of practice
DE(s): Diffusion entrepreneur(s)
HIC(s): High-income country(ies)
LMIC(s): Low- and middle-income country(ies)
NGO(s): Non-governmental organisation(s)
PBF: Performance-based financing
SNA: Social network analysis
SSA: Sub-Saharan Africa
UHC: Universal Health Coverage
WHO: The World Health Organization

Declarations

Ethics approval and consent to participate

Prior to responding to the interviewer's questions, all participants read a detailed information sheet and provided their written consent. Ethical approval was obtained from the University of Montreal's *Comité d'éthique de la recherche en santé* (Certificate 16-153-CERES-D).

Consent for publication

All authors provide their consent for publication. In addition, consent for publication was included in participants' signed informed consent.

Availability of data and material

The codebook and interview guides are available upon request from the authors.

Competing interests

VR was a co-researcher on the baseline study of the impact evaluation of PBF in Burkina Faso, but has received no salary from the funding body (the World Bank) for this activity. MDA is lead researcher on several process and impact evaluations of PBF in SSA countries, but she did not receive direct payments for any of those. The funders did not take part in the preparation or publication of this manuscript. The authors have no conflicts of interest regarding the publication of this paper.

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Authors' contributions

All authors contributed to the design of the research. The first author (LG) collected the qualitative data, transcribed verbatim 27 of the 40 interviews. LG also coded and analysed the data, and drafted the first version of this paper. MDA & VR participated in several CoP events and aided in the data analysis. All authors contributed to the writing of the manuscript and have read and approved the final manuscript.

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Appendix 5.1 — Coded semantic categories (English)

Category title	Content (keywords related to category)	N hits
Economics & financing	account agenc agent allocat austerity behavi bonus capitation cash compet consumable consumer consumption contract cost demand econom efficien expenditure externalit fee financ function fund funding funds goods growth incentiv income inefficien invest liberal market maximi measur monetar money monopol neoclassic oeconom œconomi optimis optimiz paid pareto pay premium price pricing privat produc profit purchas quanti rational regulat resource revenu salar saving spending statistic subsid supply trade transfer utility value *Exclusions:* "take into account" "account[ing] for" "knowledge transfer" "policy transfer" "work transfer"	**2184**
Management	&E administrat assessment asset autonom bank budget business capital choice client coach company debt decentrali deliver enterpr entrepr governance indicator infrastructure innovat input logistic M&E manag margin NPM operating operation outcome output planning procurement property provider-purchaser provision report reporting reports responsib result sector separat sharehold split stakeholder stock supervis supplier target technolog workflow *Exclusions:* "World Bank" "German development bank" "worldbank" "the Bank" livestock (birth) deliveries "family planning" "food bank" "inputs of…" "your input" "Federal Reserve Bank" "capitalise on your…" "Health Policy and Planning"	**1306**
Clinical	abortion acute antenatal Artemisinin ARTs ARVs birth body caesarean cancer cesarian chlorine chronic clinical communicable consultation contagi contracept death diabetes diagno disease eclampsia emergency episiotom equipment fetal GPs gynaeco gyneco HIV hospital hygien ICMI immuni infecti insecticide malaria maternity matron MD medical medicine midwi morbidity mortality NCD neonatal newborn nurse nutrit obstetric oxytocin paediatri pain paramed partogra patholog patient pediatri pharmac physici PNC postnatal practition pregnan prevent primary professional quality record registers registration registries registry reproduct SBA sexual sick skilled specialist STD sterilis steriliz surgeon surger surveillance symptom TB therap treatment tuberculosis uteri uterus vaccin vital vitamin weight *Exclusions:* registration [to a conference/workshop/webinar]; *every proper name*	**918**
Social sciences	anthropol beneficiar communism context [-specific] determinis diversity equality equitable equity fragil humani justice moral network poor poverty progressive redistribut respect social society socio solidarity syndical systemic union vulnerabl welfare wellbeing	**436**
Simple buzzwords	appropriation beneficiar capacit communit corrupt coverage data domestic empower evidence HMIS invest MDG Millennium ownership participatory partner pilot program resilien responsiven SDG strengthen sustainab techno transparen UHC universal voice vulnerb	**1126**
PBF jargon	AAP -based bullet CDV contract incentiv magic p4p PBF performance portal purchasing [agency] RBF scheme separat toolkit verif	**1794**
Disagreement/conflicts	academia academic advocate advocates bias biased clash conflict critici disagree frustrated frustrating frustration idealist idealistic inacceptable inappropriate incorrect mistake opinions opponent opposing opposition paradigm polarisation polarising polarization polarizing position proponent realistic researcher scientist unhelp *Exclusions:* (population)'s frustrations (country or government)'s	**222**

	frustrations [negative sentence structure+“disagree”]	
Agreement/ sense of community	agree agreeing agreement belong belonging collegial colleague colleagues club cohesion common concur CoP “community of” dynamism exchange exchanging family friend friends group homogene homogeneity homogeneous homogenous join member members our participate team thank thanks us we *<u>*Exclusions:</u>* “UN member” “member state/s” ”community member/s” “government member/s” “district [health] team member/s” “household member/s” “district health team/s” “government team” “family planning” “family member/s” “insurance member/s” “[first author's name] and colleague/s” US[A]	**1507**
Africa	*<u>*Excluded:</u>* Central Africa South Africa	**155**
Experts	Expert	**52**
Normative tone	prescri* should “have to” “has to” must score rule norm normative normal	**365**

Appendix 5.2 — Coded semantic categories (French)

Category	Content (keywords related to category)	N hits
Economics & financing	account achat achet agenc agent allocat argent asymetr asymétri austerity austérité austerite behavi biens bonus capitation cash commerc compet compét comportement comptab compte concuren concurren consomm consumable consumer consumption contract contrat cost coût croissance demand depens dépense econom économi efficien expenditure externalit fee financ fonction fonds function fund funding funds goods growth incentiv incita income inefficien invest liberal libéral marché market maximi measur mesure monét monetar money monopol néoclassi neoclassic oeconom œconomi optimis optimiz paid paie paiement pareto paye premium price pricing prime privat prix produc profit purchas quanti rational rationnel rationel rationnel rationnal redevab regulat régulat rémuné rémunè remuner resource revenu salar saving spending statisti subsid subvent supply tarif trade transfer transfér utilité utility valeur value *<u>Exclusions:</u>* fonctionnaire “en fonction” fonctionnement “pris en compte” “tenir compte” “profiter de l'occasion” “j'en profite pour…” demander “dans la mesure du possible” compétences “compte tenu” “tout compte fait” exprimer “pour le compte de” “tout compte fait” “au fur et à mesure” “dans la mesure où” “en mesure de”	**1764**
Management	actif actionnaire active approvisio assessment asset autonom bancaire banque bilan budget business capital choice cible client coach compagnie decentrali décentrali deliver dette distribution entrepr extrant fournisseur gère géré gérer gestion gouvernance indicateur infrastructure innovat input intrant logisti M&E manag marge margin monitor NPM opérationnel outcome output planning planifi prestat procurement provider-purchaser rapport rentabilité rentable reporting responsab résultat secteur separation séparation stakeholder stock supervis supplier technolog workflow *<u>Exclusions:</u>* “Banque mondiale” “Banque africaine de développement” “banque de sang” "inputs of…" "ton/votre input" “planning familial” "sugGESTION" "sugGère" "ménaGère" "par rapport à" "rapport entre" “rapport [partagé par auteur]” "en rapport avec" "health policy and planning"	**1385**
Clinical	accouchem aigu antenatal anténatal Artemisin artémisin avorte birth body caesarean cancer cesarienne césarienne chirurg chlorine chronic chroniq clini communicable consultation contagi contracept CPN diabete diabète diagno disease dossier douleur ECD eclampsi éclampsi enceint episiotom épisiotom equipement équipement équiper équipés fetal fetus fétus GPs gynaeco gyneco gynéco HIV hôpit hopita hospital hygien hygièn hypertension ICMI immuni infantile infecti infirm insecticide malad malaria maternité matron medecin médecin médica medical medicament MEG morbidité mort neonat néonat nutrit obstetri obstétri oxytocin paludisme paramed paraméd partogra patholog patient PCIME pediatr pédiatr pharmac PNC postnatal practition pregnan prénatal prevent prévent primaire PTME qualifié qualite qualité quality record registre reproduct seringue sexual sexue skilled soins spéciali specialist STD sterilis steriliz surgeon surger surveillance symptom TB therap traitement transmissi treatment tuberculosis urgence uteri uterus vaccin VIH vital vitamin	**1445**
PBF jargon	AAP ACV CDV contract contrat d'achat FBP FBR incit mécanisme p4p PBF performance portail RBF separa sépara separe sépare toolkit verif vérif	**1550**

Buzzwords	appropriation beneficiair bénéficiair capacit communaut corromp corrupt couverture coverage CSU data domestic domestiq durab emancip émancip empower evidence HMIS invest MDG millénaire Millennium ODD OMD partenaire participatif peren péren pilot PPP renforce resilien résilien s'appropri SDG strengthen sustainab techno transparen UHC universal universel voice voix vulnerab vulnérab SIS SNIS "données probantes")	**795**
Social sciences	altrui anthropol associati beneficiair bénéficiair communism context détermini determinis diversité egalit égalit equitable équitable equite équité filet fragil humani indigen justice moral pauvre progressif progressive protection redistribut resear réseau social societé socio solidaire solidarité syndica systemiq systémiq vulnérab vulnerabl welfare wellbeing **Exclusion:* "personnalité morale"	**406**
Disagreement/Conflict	academi académi advocate advocates chercheur clash conflict conflit controvers critic critiq defend défend defens défens désaccord erreur excus frustr idealist idéalist idealists ideolo idéolo impos inacceptable inapproprié incorrect intolera intoléra opinions opposant oppose opposition paradigm plaidoy polaris positionnement promoteur provoca realism réalisme realist réalist recherche researcher scienti ("+anti" "+pro")	**319**
Agreement/sense of community	"communauté ami amis amitié bravo club cohésion collégial collégialité collègue collègues commun "communauté de »CoP d'accord d'appartenance de" dynamique dynamisme échange échanges équipe felicitations félicitations felicite félicite féliciter fraternel groupe homogène membre membres merci nos nous partagez participez rejoignez rejoins (+ "je soutiens" "je souscris") **Exclusions:* "intérêt commun" "fond commun"	**1285**
Africa	Afrique africain **Exclusions:* "Afrique du Sud" "Banque africaine de développement"	**102**
Experts	expert	**71**
Normative tone	devraient devrais devrait dois doit doivent normal normatif normative norme normes règle règles respectée respectées respecter score	**454**

Chapter 6. The diffusion of performance-based financing at the national and subnational levels

Paper title: From Amsterdam to Bamako: a qualitative case study on diffusion entrepreneurs' contribution to health policy propagation in Mali

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From Amsterdam to Bamako: a qualitative case study on diffusion entrepreneurs' contribution to health policy propagation in Mali

Abstract

For the past 15 years, several donors have promoted performance-based financing (PBF) in Africa for improving health services provision. European and African experts known as "diffusion entrepreneurs" assist with PBF pilot testing. In Mali, after participating in a first pilot PBF in 2012-2013, the Ministry of Health and Public Hygiene included PBF in its national strategic plan. It piloted this strategy again in 2016-2017. We investigated the interactions between foreign experts and domestic actors towards PBF diffusion in Mali from 2009 to 2018. Drawing on the framework on diffusion entrepreneurs (Gautier et al, 2018), we examine the characteristics of diffusion entrepreneurs (DEs) acting at the global, continental, and (sub)national levels; and their contribution to policy framing, emulation, experimentation, and learning, across locations of PBF implementation. Using an interpretative approach, this longitudinal qualitative case study analyses data from observations (N=5), interviews (N=33), and policy documents (N=19)

DEs framed PBF as the logical continuation of decentralisation, contracting policies and existing policies. Policy emulation started with foreign DEs inspiring domestic actors' interest, and succeeded thanks to longstanding relationships and work together. Learning was initiated by European DEs through training sessions and study tours outside Mali, and by African DEs transferring their passion and tacit knowledge to PBF implementers. However, the short time frame and numerous implementation gaps of the PBF pilot project led to incomplete policy learning.

Despite the many pitfalls of the region-wide pilot project, policy actors in Mali decided to pursue this policy in Mali. Future research should further investigate the making of successful African DEs by foreign DEs advocating for a given policy.

Keywords: policy diffusion, diffusion entrepreneurs, performance-based financing, Mali.

The [P]BF pilot [in Mali] was designed to support a culture shift in the public sector, moving from payment of inputs towards payment of results. There is high-level commitment of the Government to implement [P]BF progressively across all regions of Mali to reinforce [health facilities]. (The World Bank, 2017, p. 31)

Introduction

Many low- and middle-income countries (LMICs) face chronic aid dependency situations (Kirigia and Diarra-Nama, 2008). This dependency enables powerful actors (including non-governmental actors and international donors) to participate in their policymaking, thereby making LMICs more likely to adopt policy innovations from outside influences. Such process is referred to as policy diffusion (sometimes policy transfer) (Stone, 2001). The literature on health policy diffusion in LMICs is still scarce (Bennett et al., 2015); and to date, the complexity of transnational networks', organisations', and individuals' influence in diffusion processes has received little attention from global health scholars (Tosun, 2017).

The outside influence notably raises concerns in relation to government ownership as, at national level, external actors engage in piloting health system reforms that are supposed to be designed and implemented by national parties (Gautier and Ridde, 2017). Among these reforms, several donors have promoted performance-based financing (PBF) in sub-Saharan Africa (SSA), in view of improving health services provision, by enhancing health providers' autonomy and accountability. PBF is based on the transfer of financial resources contingent upon health providers' performance. The mixed evidence as to its effects has sparked some controversy (Paul et al., 2018), especially since the diffusion of PBF in SSA has been particularly fast from 2000 to 2017 (Gautier et al., 2018). In Mali, after participating in a first PBF pilot led by external actors and funding, the Ministry of Health and Public Hygiene (MSHP) engaged in scaling up this strategy in an entire region as a second pilot (Zitti et al., 2019)

While studies using a longitudinal perspective to analyse health policy processes in LMIC settings prove highly valuable, they are still rare (Gilson, 2012). The fact that PBF is a relatively recent reform makes it even more relevant to use a longitudinal approach, since we can easily perform process tracing from the introduction of the policy idea. In this study, we investigate the roles played by foreign and domestic experts in PBF diffusion at a national level (Bamako) and a

subnational level (Koulikoro region) using a case study approach covering the 2009-2018 period. We refer to these foreign and domestic actors deliberately using strategies to induce interest for the PBF in Mali as "diffusion entrepreneurs" (Gautier et al., 2018). Interactions between diffusion entrepreneurs and key policy actors of the policy process proved to be instrumental to diffusion. The research question: "*How did diffusion entrepreneurs acting at multiple levels contribute to diffuse PBF in Mali from 2009 to 2018?*" guided our work.

Methods

Study design

This is a retrospective longitudinal qualitative case study (Stake, 1995). The case is the diffusion of PBF in Mali across space (national and subnational levels) and time (2009-2018). As per Stake's typology, this case study is *instrumental* in the sense that by illustrating the case of PBF diffusion in Mali, it enables us, thanks to its contextual peculiarities, to shed light on a wider phenomenon of interest, i.e. the multifaceted influence of actors acting at multiple levels (hereby named "diffusion entrepreneurs", DEs), to foster health policy diffusion in developing countries.

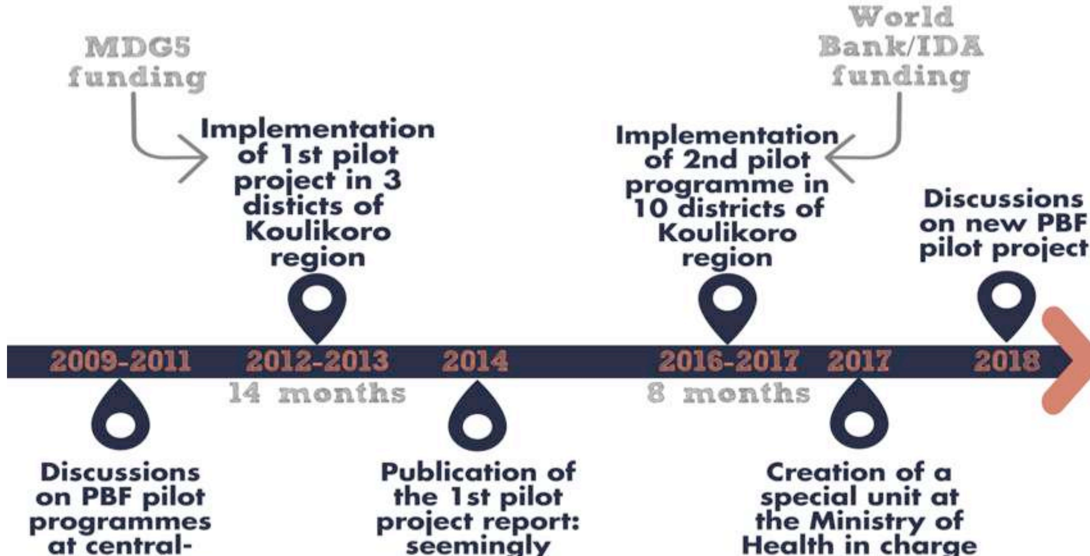
Study setting (nature of the case)

Thanks to decentralisation policies in the 1990s-2000s, health districts in Mali have become progressively more autonomous. Legislations have specified the roles and responsibilities at each level — regional health offices (in charge of administrative and technical support to districts health and management teams, DHMTs), mayors of districts' capitals (in charge of managing reference health centres), and Community Health Associations (ComHA) and villages' mayors (in charge of managing community health centers).

Mali's healthcare system is characterised by a plurality of funding mechanisms, including community-based insurance schemes. Most of these mechanisms focused on the pooling function of health financing. In the late 2000s, discussions highlighted the need to improve the quality of health service provision and to emphasise the purchasing function of health financing. Policy actors suggested the introduction of financial incentives for health providers upon attainment of pre-set targets, including performance contracting and PBF. Figure 6.1 maps out the key events

of PBF diffusion in Mali. In this study, such "diffusion events" are taken as matter of fact pre-analysis information.

Figure 6.1 Key events of PBF diffusion in Mali, 2009-2018



In 2012, Mali's MSHP launched a first PBF project in three districts of the Koulikoro region (KR). The scheme, hereafter called the 3-HD scheme (since it covered only three health districts), was designed by Dutch cooperation organisations (Seppey et al., 2017). Multiple community and subnational-level actors were mobilised to fulfill classic PBF functions (Gautier, 2016). Mali's consulting company (*Clinique de gestion et de transfert des connaissances*, CGIC) was responsible for overseeing the operations with the technical support of Dutch experts. This Mali-specific PBF design was branded "*à la malienne*" (Box 6.1).

Concurrently, as part of the World Bank's Strengthening Reproductive Health Project, the implementation of a PBF pilot scheme in all 10 KR districts was planned for 2011-2017 (The World Bank, 2017). This project, hereafter referred to the 10-HD pilot, was only implemented for eight months between 2016 and 2017.

Box 6.1 PBF *à la malienne*

What is PBF *à la malienne*?

PBF "à la malienne" refers to an approach that is adapted to Mali's context, i.e. anchored in its health system pyramid and mobilising existing health systems institutions.

Actors and their functions

- District health centers: provision of health services
- Community health centers: provision of health services
- Koulikoro Regional Health Office: regulation and results verification in district health centers
- DHTMs: regulation and results verification in community health centers
- City councils: purchase of health services in district health centers
- ComHAs and town councils: purchase of health services in community health centers
- NGOs (e.g., Blue Star): results counter-verification
- Community-based organisations: results counter-verification
- CGIC: scheme design, contract development, coaching and advocacy at local and national levels, overseeing verification and counter-verification activities

In addition to these Mali actors, Dutch organisations including KIT, SNV, and Cordaid, provided technical assistance to scheme design, contract development, and advocacy at national level.

The Mali case was unusual in several ways. First, the premises of PBF in Mali involved third-party DEs, including two Dutch organisations: the Dutch development organisation (SNV) and the Dutch's Royal Tropical Institute (KIT); and a Mali company (CGIC). These DEs designed a specific PBF scheme "à la malienne" which was not only adapted to Mali's context, but was also at odds with standard PBF design features, including separation of functions (Fritsche et al., 2014). Second, Dutch experts were the most prominent actors of the diffusion of PBF in Mali, which is not typical of the diffusion of PBF in other SSA countries, particularly in Francophone West Africa. Despite this unusualness, we argue that Mali's experience is typical of that of SSA countries exposed to PBF pilot programmes in the 2010s. Three main characteristics described by Gautier et al. (2018) can be used to summarise a standard PBF experience: first, it involved both foreign DEs and African experts; second, the diffusion was — at least partly — World Bank-funded and promoted; and third, it mobilised a classic PBF "testing package" with instrumental learning strategies (i.e., study tours; international training sessions).

Data collection

We looked for various sources of data. First, we gathered material from key policy documents (Table 6.1).

Table 6.1 Overview of policy documents included in the case study (N=19)

Documents description
KIT strategic planning for PBF in Mali (2010)
Participants' report on the study tour in Rwanda, submitted to the MHSP (2010)
KIT background document on Results-Based Financing in healthcare and the Mali & Ghana experiences (2012)
2 manuals for PBF pilot schemes in Mali (2013; 2016)
Mali's Health and Social development plan, 2014-2018 (2013)
KIT's final report on the PBF first pilot scheme in Mali (2014)
Policy brief on PBF in Mali (2016)
Participants' report on the international training course attended in Benin, submitted to the MHSP (2016)
KIT-Cordaid-CGIC Consortium's application package submitted to the World Bank in Mali (2016)
KIT-Cordaid-CGIC Consortium's final report of the PBF second pilot project in Mali (2017)
KIT-Cordaid-CGIC Consortium's capitalisation report (2017)
KIT-CGIC promotional leaflet about PBF in Mali (2017)
World Bank's report upon the completion of second pilot project (2017)
MHSP meeting minutes about pursuing PBF in KR (2017)
Policy brief on the effects on key health indicators of the first pilot project (2017)
3 policy briefs assessing the implementation of the second pilot project (2018)

Second, from January 2016 to December 2017 the first author collected data from 33 informants (Table 6.2). This time period was chosen because it coincided with the preparation and implementation of the 10-HD project. We sought purposive sampling of interview participants to include multiple categories of respondents who had been involved in PBF policy emergence and/or implementation from 2009 to 2018. The first author used a semi-structured interview guide. Over the two year-period, she had multiple interviews with seven key informants so as to offer a longitudinal perspective whilst crosschecking emerging findings. She also collected notes from participant observation of five policy meetings in Bamako. Concurrently, the second and fourth authors collected field data on this project's implementation, bringing up useful insights on diffusion as well. These features enabled us to triangulate and (in)validate emerging findings.

Table 6.2 PBF in Mali: Participants' general characteristics

Current affiliation (N=33)		Main educational background (N=33)		Years of experience (N=33)		Gender (N=33)	
Mali Government [MALIGOV]	9	**Medical sciences**	21	**< 10 years**	5	**Male**	25
International organisation [INTORG]	8	**Economics**	7	**> 10 years < 20 years**	18	**Female**	8
National independent consultant [INDCONS_MA]	4	**Other social sciences**	3	**> 20 years**	10		
International independent consultant [INDCONS_AF]	5	**Other health sciences**	2				
International-level private for profit company [PRIVFP]	3						
International-level private non-for-profit company [PRIVNFP]	3						
National Government (other country) [OTHERGOV]	1						

Analytical approach

Drawing on the framework on DEs by Gautier et al., 2018, we investigated the constituting features and the actions carried out by DEs at different levels (global, continental, national, and subnational) to diffuse PBF. DEs' actions include framing the policy in ways that are politically attractive, and developing strategies to induce emulation (e.g., how socialisation sparks interest for a policy), experimentation, and learning. Table 3 describes the dimensions of the DE framework at multiple levels. A complete overview of the framework dimensions and their definition is provided in Gautier et al., 2018.

Interview material was verbatim transcribed in French (primarily) or English. The first author coded the data using QDAMiner©. Coding relied on a deductive-inductive approach, with initial coding based on the abovementioned framework (Table 6.3, next page) and additional codes being integrated as we progressed through the reading. Findings were assessed using interpretative thematic analysis.

Table 6.3 The DE framework dimensions (Adapted from Gautier et al., 2018 and 2019)

	Diffusion entrepreneu	**Global scale**	**Continental scale**	**National scale**	**Subnational scale**
Constituting features	**Representation systems**	Training/ cultural background (e.g., economics)	Training/ background; Valuing practice-based expertise	Training/ background; Valuing practice-based expertise	Training/ background; Valuing practice-based expertise
	Motivations	Increased recognition, return on investment	Career advancement	Political popularity?	Career advancement?
	Resources	Knowledge, social, (temporal), political	Knowledge, social, (political), material	Knowledge, social, (temporal), political, material	Knowledge, social, (temporal), political
	Authority	Expert, scientific, moral, financial	Expert, scientific	Moral, expert, financial	Expert *To be completed*
Interconnected strategies to shape policy diffusion	**Framing**	Introducing the policy innovation as being inspired from peer recipient countries' experience; connecting it to common problem representations and popular frames		Linking the core principles of the policy innovation to existing national orientations	
	Experimentation	Setting rules of collaboration between actors in the testing of a policy innovation	Technical assistant brought into a country to assist with the implementation of a pilot programme	Implementing standard operating procedures from abroad	
	Emulation	Organising study tours and workshops to build a community of experimenters	Gathering experts through regional/ continental network formation	Copy-pasting policy features from abroad	
	Learning	Sharing the results of evaluations of pilot programmes testing the policy innovation Sharing lessons learnt from testing the policy innovation across countries		Establishing learning tools to translate expertise from subnational to national level Learning from implementation	

Results

We describe who the diffusion entrepreneurs acting in Mali are, and move on to analyse their constituting features and strategic actions. Findings are illustrated using verbatim quotations, translated into English (when relevant) only for the purpose of inclusion in this manuscript.

Diffusion entrepreneurs of PBF in Mali

The major DEs of PBF in Mali were individuals acting at the global level: European experts (working for KIT or the Dutch NGO Cordaid) who had been supporting health reforms in Mali and other SSA conflict-affected settings.

One of these individual DEs had worked with several Mali experts employed by another Dutch organisation, i.e. SNV in the early 2000s. These local experts played a crucial role in implementing the 3-HD pilot in 2012-13 in the same areas. Following this experience, informants viewed Mali experts as forceful PBF advocates at national and subnational levels, hence we call them Mali DEs acting at the national and subnational level. Mali DEs also included policymakers and street-level bureaucrats, who perceived PBF as the key solution. Together with PBF experts from other SSA countries ("African DEs"), foreign and Mali DEs participated to implement the 10-HD pilot in KR funded by the World Bank.

DEs' representation systems in Mali

DEs' representation systems built on a training culture rooted in medical sciences, economics, and/or management. A specific feature of Mali DEs, was that all of them but one had a medical background and had gone abroad to receive additional training in public health and/or health economics in Belgium, France, the United States of America, Benin, or Senegal.

Another key ingredient was instrumental: four of the DEs shared a common history dating back from the early 2000s. This shared experience contributed to shape common problem representations relating to inefficiencies of health systems. Many respondents adopted foreign DEs' claims that "*everything had been tried*" and appeals for "*not yet attempted*" reforms featuring contract and incentive theories (borrowing from economics and management sciences) (I43_MALIGOV).

DEs' motivations in Mali

For Dutch experts, PBF designs needed to better emphasise the healthcare quality. Opportunities to embark on PBF projects also came in timely: in two cases, Dutch DEs' spouse or partner was already working in the country where discussions on PBF began. For DE informants, the combination of favourable timing and personal motivations to link quality of care and PBF prompted their goal to advance PBF design in the late 2000s. Thus DEs also had an interest in enhancing their professional reputation by contributing to PBF conceptualisation and diffusion. Dutch experts also endeavoured to propagate their PBF model in Mali as an alternative to other organisations' models:

> *I even brought the [PBF] idea here in [Mali] and hum... […] Why? Because I didn't want the (organisation name removed) to come in... […], with a blueprint. […] I said to myself, here in Mali, there are already so many structures […] that make the system so complex, that... introducing another structure is going to make it too crowded.* (I40_PRIVNFP)

Their vision of PBF and how to introduce it at country-level was framed as differing from that of the usual PBF advocates (Gautier et al., 2018). They were particularly concerned about national ownership of the scheme, hence the branding "*à la malienne*" in the early 2010s.

Concurrently, DEs acting at continental and (sub)national levels were concerned that health systems in SSA were in such dire conditions that only the "*PBF revolution*" (I26_INDCONS_AF) could confront the status quo and improve the way systems perform. For some of these DEs, career prospects and increased salaries, as well as political recognition were also major motivators for supporting PBF, and contributed to its diffusion. European DEs were cognisant of their influence in sparking Mali DEs' international career aspirations:

> *We must also acknowledge that… In this world, PBF can make people believe: "Ah! At one point or another, I can go abroad", like we do [as foreign experts]. So if you become international technical assistant, you can... You create expectations, and I think that's what [two DEs' names] expect of me now, that I take them elsewhere.* (I40_PRIVNFP)

Resources and types of authority of DEs in Mali

From the beginning of the diffusion process, nearly all DE informants in Mali relied on significant knowledge resources. They had 10 or more years of experience in implementing health projects. Social resources were also instrumental to PBF diffusion, notably through

continental DEs' membership to African networks, including Cordaid's professional PBF network and the PBF Community of Practice. A Dutch DE assumed that the fact that he "knew everybody" in Mali helped a lot in his ability to convince local actors of the relevance of PBF. The alliance of knowledge and political resources gave way to powerful expert and moral authorities.

Apart from the World Bank, which held a critical financial authority, and funded the 10-HD project in KR, material resources came from external organisations: none of the DE informants or their affiliated organisations were able to secure their own funding for implementing PBF in the country between 2009 and 2018.

DEs' framing of PBF in Mali

DEs' acting at multiple levels framed PBF by connecting it to their problem representations (which in turn match their representation systems), and then linking the core principles of the policy to past and most recent popular orientations. Table 6.4 outlines the diverse political framing of PBF through space (columns) and time (rows). These processes tended to make the PBF solution attractive and desirable to policy actors.

Table 6.4 DEs' political framing of PBF at the global, continental, and (sub)national levels (Source: Gautier et al., 2019 & forthcoming)

Framing strategies	Global-level framing	Continental-level framing	(sub)National-level framing
Connecting PBF to common problem representations	• Inefficiencies of input-based funding • Unmotivated health providers • Substandard quality of care	• Inefficiencies of input-based funding • Money being wasted on useless material • Underpaid health providers • Corrupted health services	• Inefficiencies of input-based funding • Money being wasted on material, expensive equipment, and too much training • Underpaid, unaccountable health providers and poor working conditions
Linking PBF core principles to past or existing political orientations	• Output-based aid and accountability mechanisms • Autonomy and entrepreneurship of health providers • Country-ownership and	• Accountability mechanisms (can curb corruption) • Autonomy and entrepreneurship of health providers • Introducing PBF as	• Health providers' autonomy (1987 Bamako Initiative) • National decentralisation policy and authority transfer (*transfert de compétences*) (1993-96) • National contractualisation

	South-South-driven policies	being inspired from peer recipient SSA countries' experience	policy (2007) • Making health providers more accountable
Linking PBF core principles to recent policy orientations at the global/continental/(sub)national levels	• Strategic purchasing (output-based funding for health systems) (2016) • Increasing access to data and leveraging health information systems	• Increasing access to data and leveraging health information systems	• Accreditation and quality assurance for secondary and tertiary health providers (2012) • National policy on results-based management (2014) • Increasing access to data and leveraging health information systems

Note: The last column is drawn from the present original research.

In the early 2010s, not all policy actors necessarily shared DEs' problem representations. For DEs, those policy actors needed to be convinced. There was a strong political consensus on decentralisation and contractualisation. Individual DEs engaged in repeated interactions with high-level policymakers to show that PBF objectives were aligned to these two national health policies. The objectives of these policies were thus partly redefined to feature DEs' own problem representations. Through such strategic political linkage, many high-level Mali actors in the early 2010s were convinced of the validity of the PBF solution given the relevant problem representations.

Such framing had historical precedents. In the mid 2000s, local actors in KR who were involved in the Dutch-led projects to strengthen decentralisation and contractualisation policies, implemented authority transfer through a contracting approach. They started to use pre-PBF jargon inspired by a Dutch individual DE, including "*plan de résultats*", i.e. results plan involving verification.

From the mid-2010s, DEs also strategically tied PBF promises to more recent national policies or orientations, i.e. the government's results-based management policy, and the push to improve quality of care — which matched the government's push for providers' accreditation and quality assurance —, and leverage a "*long overdue*" health information systems reform (I36_PRIVFP_AF).

With time, whether it was framed as strengthening decentralisation, operationalising results-based management, or improving healthcare quality, most policy actors perceived PBF as a useful tool, even though they could not necessarily explain how PBF could effectively align with these national priorities. Some DEs were worried that PBF was reduced to "*just an additional stipend for people*" (I40_PRIVNFP), instead of a systemic reform.

Inducing policy emulation

In July 2010, a study tour was organised and funded by the World Bank in Rwanda. Five high-level MHSP staff participated in the study tour. Witnessing the most salient PBF success story served as a powerful tool to encourage emulation for these participants from Mali. This first exposition to PBF was instrumental in making some of MSHP staff strong PBF advocates. However, upon their return, participants deplored a lack of political commitment at the MSHP cabinet.

Concurrently, in the early 2010s strong policy emulation processes were developing between four people: a Dutch DE from KIT, two Mali experts from SNV, and a policymaker. These actors previously worked together on implementing a contracting approach, which "preceded" PBF. Building on such longstanding professional relationships, the DE from KIT mentored the three Malians to start developing a pool of Mali experts of PBF. In particular, one of them was groomed to become an African DE contributing to spreading PBF in Guinea.

Still, emulation at the highest political level needed further nudging. DEs understood that to foster the political anchoring of PBF, steering policymakers' engagement was crucial. From 2010 to 2013, DEs organised regular gatherings with high-level policymakers and experts in a trendy Bamako hotel. These "*results-based dinners*" served to make people understand PBF. Concurrently, DEs engaged in regular dissemination of the 3-HD project's early results at the National Health Planning Steering Committee. This persuasion strategy appeared successful: several influential Mali informants asserted that the PBF solution was opportune since it aligned with Mali's systemic issues. Guided by KIT experts, participants turned into "*PBF believers*" (I40_PRIVNFP).

PBF pilot projects also inspired policy emulation. The large acceptance and perceived success of the 3-HD pilot sparked interest. Many implementers of that project became Mali DEs advocating for the return of PBF until the 10-HD project's implementation. At the same time, the 3-HD pilot widened the pool of PBF experts. In order to sustain their commitment to PBF expansion, during 10-HD pilot's implementation two heads of the Consortium — both Mali DEs formerly with SNV — facilitated meetings with MSHP high-level officials who did not necessarily experience PBF "in their flesh".

Lastly, in 2016-17, the 10-HD pilot implementation involved support from technical assistants from The Netherlands, Burundi, DRC, Rwanda, and Mali. This choice was intended to facilitate the principle of communicating vessels among experts, notably across African and local settings, thereby explicitly inducing policy emulation. This endeavour was not entirely successful, reportedly due to distrust (on the Mali experts' side) and insufficient adaptation (on the African experts' side). The strong devotion to PBF of these African experts and their commitment to support PBF experimentation in KR districts, combined with their social acceptance by many frontline workers and district medical officers, prompted or strengthened the transmission of a powerful advocacy for PBF adoption in African settings, thereby also inferring policy emulation.

Policy actors' enthusiasm was not constant. During the 10-HD pilot (2016-17), policy emulation at national level was limited for two main reasons. First, poor communication hampered the smooth collaboration between implementers and the donor. Second, MHSP staff considered the financial motivation (i.e., perdiem stipends) too low to secure their engagement in PBF experimentation. Still, observation of a MSHP-organised meeting in March 2017, in the midst of a long strike of all health public officers throughout the country, indicated that many staff members *were* effectively pushing for PBF, just not "the" PBF version promoted during 10-HD pilot project implementation.

Driving policy learning

For DEs, PBF pilots represented a strategic source of policy learning. First, Mali informants reported learning from the various activities held in preparation for these pilots. These learning

activities were set up and funded by foreign DEs. MHSP high-level staff were first trained in September 2009 by the World Bank. This initial training was followed by a cascade training session gathering all regional health officers. Two additional cohorts of high-level policymakers and street-level bureaucrats received PBF training in Benin in 2014 and 2016. The same training company, a Dutch organisational DE, trained both cohorts. While informants were generally satisfied with the two-week course, many of them rejected the rigid nature of its content, which involved an explicit critique of the *à la malienne* design. Still, informants agreed that this training produced a critical mass of PBF experts in Mali. In general, exposition to global and African DEs, in the context of organised courses, health systems networks' events in West Africa, or development cooperation projects, contributed to expand PBF knowledge among Mali actors.

Second, in 2016-17, African DEs employed by Cordaid to assist with 10-HD pilot implementation, reportedly transferred their knowledge to local PBF implementers. The latter also learnt from their own PBF experience. However, the lack of interaction between them and national actors prevented the transfer of experiential knowledge. The absence of an institutional platform, enabling knowledge transfer from the subnational to the national level, was considered problematic. Besides, the frequent political turnover hampered any learning venture across decision-making units. Lastly, the Bank's inability to organise an impact evaluation led to little policy learning from the 10-HD pilot.

Shaping policy experimentation

Despite discourses featuring national ownership and PBF *à la malienne*, both policy experimentations in KR involved foreign technical assistance, and were funded only through external sources. DEs in Mali lacked resources to experiment PBF. Although the 10-HD project officially started in 2011, its implementation was delayed (The World Bank, 2017). Mali DEs pushed for implementing a "prepilot" project, i.e. the 3-HD pilot. A Mali DE's appointment in 2010 as National Health Director enabled to secure funding. His lobbying reportedly pushed the MSHP to devolve MDG5 funding to the 3-HD pilot.

For Mali DEs, the results of this policy experimentation served to convince policymakers of the value of PBF. DEs put forward positive results of 3-HD pilot, yet they achieved mixed reception.

Rather than convincing MSHP's leaders, this dissemination generated concerns about the long-term sustainability of PBF. For DE informants, some MSHP leaders influenced by former key advisors were still incompletely committed to PBF. Despite this issue, and a lack of effect of the 3-HD pilot on health services utilisation (Zombré et al., 2017), PBF was included in the health and social development plan for 2014-2018 (Secrétariat Permanent du PRODESS, 2013).

While the 3-HD pilot allowed for some flexibility, stricter rules of collaboration between actors were set for the 10-HD project. Project design was less government-owned than the 3-HD pilot. The MSHP and the World Bank did not appoint a PCU coordinator with prior PBF experience, nor did they ensure that officials following up the implementation of the 10-HD project had received PBF training. The reduced duration (eight months) of that project, the recurring misunderstandings with donor representatives who had little expertise in PBF, and the delayed or "insufficient" payments, generated disappointment for PBF DEs, and disengagement of high-level officials. These features led to incomplete implementation, making it a mostly unsuccessful pilot in KR.

As the project was closing in February 2017, an interesting process was taking place: PBF DEs were actively mobilising national actors into pursuing PBF in KR and raising funds. DEs organised (un)official meetings with MSHP leaders in Bamako and Kati and prepared the funding request to the Dutch Ambassador:

> *At the moment, I am preparing the proposal that the [MSHP's] Secretary General will hand deliver and say: "Mr Ambassador… this is what we want". […] But I keep the same approach, that is, it must be national leadership so… I'm not drafting the proposal, I'm… uh… drafting the general outline.* (I40_PRIVNFP)

Dutch DEs continued to shape Mali policymakers' engagement in PBF, especially because they had close relationships with the targeted (Dutch) funder. In March 2017, a MSHP task force was created to reflect on "*expanding PBF geographically*" (covering KR neighbouring regions), "*to all health facilities*" (including hospitals), "*and functionally*" (covering additional health indicators (I43_MALIGOV). During its first meeting, this task force laid out an action plan for pursuing and scaling-up PBF nation-wide in a sustainable fashion. Meeting participants agreed that PBF was the key mechanism to improve quality of care. This political consensus coincided in fall 2017 with a Mali DEs' nomination into MSHP's cabinet, and the setup of a new World

Bank team. These factors pushed the drafting, in mid-2018, of a third PBF pilot project covering Koulikoro, Sikasso, and Mopti regions. This multiactor project was planned by domestic and foreign DEs, in partnership with the Dutch Embassy.

Discussion

This case study offers, to our knowledge, the first longitudinal analysis (along a 10-year timespan) of PBF diffusion processes in an African country. It highlights the process through which global health systems experts from Europe or North America contribute to "making" African experts for the purpose of diffusing policy ideas through space and time. Our paper argues that African individuals' exposition to various health systems reforms and foreign experts' diffusion activities, can play a critical role in fostering emulation among local actors. We reflect on this social phenomenon, which we call the "making of 2nd-wave DEs" by putting it in perspective with current literature.

Academic literature on the influence of foreign (usually North American or European) actors on health systems policymaking in SSA countries is prolific (e.g., Chimhutu et al., 2015; Daire et al., 2018). Yet, to our knowledge, no prior study shed light onto the observed tendency to fuel this influence through country-based intermediaries. This case study revealed that high-income country experts can influence policy diffusion by deliberately and strategically contributing to creating an African expertise pool that promotes a given policy agenda at multiple levels. As were other global-level individual DEs (Gautier et al., 2019), the most influential foreign DE in Mali was aware of his role in "making" 2nd-wave DEs.

In Mali, DEs effectively appropriated the policy idea and spread it country- and/or continent-wide through discourse, training, and technical assistance. In the case of PBF in Mali, the lay knowledge, passion, and discourse spread by Mali experts contributed to legitimise the policy idea in the eyes of national policymakers and street-level bureaucrats working in multiple experimentation settings. Pushed by global-level DEs, PBF experts coming from other African countries, who had been exposed to other PBF pilot schemes and global-level DEs' diffusion activities, also played a critical role. Those we call "continental-level DEs" provided multiple forms of technical assistance and trained Mali actors in Benin: these strategies were instrumental

in diffusing PBF in Mali settings. Thus PBF's conception in Europe, experience in SSA countries, and testing in Mali involved European and SSA individuals who inspired Mali actors in multiple instances.

This study showed that the story of PBF diffusion in Mali was closely intertwined with the making of Mali DEs, acting at the national and subnational levels. This making illustrated a "push effect" (Rose, 1991, p. 14) whereby powerful actors (global-level DEs in particular and African DEs to a lesser degree) have induced the diffusion through engaging with and coaching less powerful local actors. This making also features a power relationship whereby Mali DEs remain dependent on getting legitimacy and funding from foreign DE individuals and donor organisations promoting PBF.

Pre-existing professional relationships among local and foreign actors built trust, and ultimately contributed to such "making". Constant social interactions were at play during implementation of previous development projects in KR, on the occasion of courses or training abroad, and during high-level meetings. The importance of building trust through social/professional interactions is consistent with findings from prior empirical research on PBF discourse (Gautier et al., 2019), and existing global development literature on influencing policymaking (Mayne et al., 2018).

These findings, which set communication as the core enabling factors for policy adoption, concur with recent public policy scholars' propositions (Cairney and Kwiatkowski, 2017). The authors make the case for developing a communication strategy that appeals to powerful narratives (e.g., Rwanda's success story; PBF *à la malienne*) and strategic frames (e.g., PBF anchor in decentralisation policies) to make sense to an audience of policymakers. Our study indicates that foreign DEs in Mali did understand their audience, and successfully "engaged with real world policymaking" through their repeated socialisation with high-level policymakers (*ibid*). This interaction created the conditions for the emergence of a network of PBF supporters, among MHSP officials in Bamako. DEs' ability to mobilise this network and shape the local discourse were critical self-nurturing processes, and "galvanis[ed] action" (as in Exworthy and Powell, 2004, p. 277). These processes led to the inclusion of PBF as policy instrument in national planning.

As in previous studies on PBF, similar representation systems (drawn from a training culture in clinical and economics sciences) made Mali DEs receptive to PBF and the problem representations it featured (Boulenger, 2009; Broad, 2006; Soeters, 2010). Their set of interests also featured a mix of motivations to improve health systems and career/visibility aspirations. As typical entrepreneurs (Mintrom, 1997), DEs shaped the terms of the debate on PBF. Interestingly, despite global actors' discourse featuring PBF as a strategy to achieve UHC, in Mali such framing did not emerge from informants or policy documentation. PBF was politically linked to healthcare quality objectives and was framed as aligning perfectly with local decentralisation policies. As in Sierra Leone (Bertone et al., 2018), many street-level bureaucrats saw PBF as having a simple "income effect". However, the lower and delayed financial benefits of the second pilot as compared to the first one, led to disappointment. In fact, implementation studies highlighted that KR health workers who had only experienced the second pilot, perceived PBF negatively. Even if the shortcomings of that project triggered doubts about the continuation of PBF in Mali, favourable factors have recently sparked renewed political will. Foreign and local actors appear ready to engage in another PBF experimentation covering a wider geographical area.

Once the PBF idea had been adopted, exposition to PBF pilots critically served as key sources of policy emulation and learning. In the early 2010s, the perceived success of i) Rwanda's compelling story witnessed during the study tour, and ii) the 3-HD project put together by Dutch organisations, mobilised both policymakers and implementers. These two events enabled *lesson-drawing* (Rose, 1991) on how PBF addresses certain health systems issues. In 2016-2017, through professional and social exchanges, African experts transferred to some KR implementers their passion, knowledge, and tools about PBF. Thus, our findings expand Ettelt et al.'s typology: pilot testing not only generates policy experimentation, implementation, learning, and "demonstration": the socialisation between implementing actors also may spur policy emulation (Ettelt et al., 2015).

However, this pattern may have led health workers and bureaucrats — "street-level bureaucrats"— to become street-level entrepreneurs able to open local windows and thus

influence national agenda-setting (as in Petchey et al., 2008). Lipsky suggested that frontline workers' autonomy and freedom space was restricted (Lipsky, 2010); so that they could hardly "move within policy frames imposed upon them" (Bailey et al., 2017). Yet, in the case of Mali, street-level entrepreneurs' PBF discourse is likely to have had some policy influence in the early 2010s (during and after the 3-HD pilot), especially since some of them advanced their career path along the way. However, this argument must be nuanced for two reasons: first, not all local actors appreciated PBF; and second, the lay knowledge street-level entrepreneurs had acquired did not reach the central level. Incomplete policy learning across administrative levels was identified in a review of PBF in 10 LMICs (Shroff et al., 2017).

Methodological considerations

Despite its focus on actors, the DE framework proved useful to depict policy diffusion processes across space and time. It offers a relevant analytical framework for case study researchers, including those adopting a longitudinal approach.

There are two main limitations to this study. First, despite our endeavour to collect historical accounts of PBF (i.e., prior to 2016 when LG first set foot in Mali and AC started to learn about the PBF subject), our findings may only reflect partial recollections of how PBF was diffused in the early 2010s. Second, two key actors of PBF diffusion from 2009 to 2013 could not be interviewed because they were outside of Mali and unavailable for an interview. Repeated and extensive stays in Bamako including regular interaction with informants (many of those being former colleagues of the two previously-mentioned actors) and participant observation, as well as systematic crosschecks of documentation enabled to mitigate these shortcomings.

Conclusion

Our longitudinal qualitative case study of PBF diffusion in Mali not only provided information on the wider social phenomenon of the making of local diffusion entrepreneurs, it also highlighted the "co-evolution" of this making and PBF diffusion processes. In Mali, DEs were relatively successful in securing high-level policymakers' engagement for PBF through repeated social and professional interactions.

Documenting the extent of policy diffusion across national actors is useful to those willing to invest in the policy, and ensure its ownership and sustainability in a given setting. Our findings showed that, for DEs acting at global level, using African DEs who convey a locally-owned discourse on PBF together with their lay knowledge, appears to be instrumental for increasing social acceptance of PBF locally. This conclusion brings about an empirically-driven proposition: locally-appropriated frames and Africa-grown experimentation tools contribute to policy diffusion in ways that may be considered more legitimate, and thus more effective, than straight North-South policy transfer. Future studies should further examine the making of successful 2nd wave DEs. Further research should also investigate whether African experts can emerge without being "groomed" or trained by foreign experts.

List of abbreviations

CGIC: Clinique de Gestion et d'Innovation des Connaissances
ComHA: Community Health Associations
DE(s): Diffusion entrepreneur(s)
DHMT(s): District health management team(s)
DRC: Democratic Republic of Congo
HD: Health districts
IDA: International Development Association
KIT: Koninklijk Instituut voor de Tropen (*Royal Tropical Institute*)
KR: Koulikoro region
LMIC(s): Low- and middle-income country(ies)
MSHP : Ministère de la Santé et de l'Hygiène Publique (*Ministry of Health and Public Hygiene*)
NGO(s): Non-governmental organisation(s)
PBF: Performance-based financing
PCU: Project coordination unit
SNV: Stichting Nederlandse Vrijwilligers (*Netherlands Development Organisation*)
SSA: Sub-Saharan Africa
UHC: Universal Health Coverage

USAID: United States Agency for International Development

Declarations

Ethical approval

Prior to responding to the interviewer's questions, all participants read a detailed information sheet and provided their written consent. Consent for publication was included in participants' signed informed consent. Ethical approval was obtained from Mali's *Comité d'Éthique de l'Institut National de Recherche en Santé Publique* (17/2016/CE-INRSP) and from University of Montreal's *Comité d'éthique de la recherche en santé* (Certificate 16-153-CERES-D).

Conflicts of interest

The fourth author has served as a consultant on the issue of user-fee abolition to nongovernmental organisations. The fourth author was a co-researcher on the baseline study of the impact evaluation of PBF in Burkina Faso, but has received no salary from the funding body (the World Bank) for this activity. The third author is lead researcher on several process and impact evaluations of PBF in SSA countries, but the funders did not take part in the preparation or publication of this manuscript. The authors have no conflicts of interests regarding the publication of this paper.

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Important thing in science is not so much to obtain new facts as to discover new ways of thinking about them.
— Sir William Bragg

Chapter 7. Discussion

This thesis features a unique contribution to the political economy of global health policy diffusion in the context of polycentric governance. Using an interdisciplinary conceptual framework, and applying it through a predominantly qualitative empirical approach, we depict how powerful policy actors initiated a policy idea; participated in stabilising its definition; and developed an apparatus of strategies to facilitate its diffusion through space and time, thereby realising certain personal motives. This apparatus primarily implied the empowerment and subsequent promotion of an African expertise in the field of interest.

Drawing from a comprehensive and interdisciplinary conceptual review, we created a new concept to describe and analyse these powerful policy actors: *diffusion entrepreneurs* (DEs). Providing a conceptual framework detailing the key features of these actors guided us through the application of the concept to empirical data. In this framework, power was conceived as 1) an ability (a resource) to engage in actions (i.e., *power-to*), and 2) an element illustrating authority in global governance (i.e., *power-over* other actors). We were interested in four main types of power-over: compulsory (e.g., donors' financial power over aid recipients), institutional (e.g., intermediaries with normative role such as multilateral international organisations), productive (e.g., scientists' categories perceived as internationally valid), and structural power (e.g., internationally-renowned expertise). DEs' dual power (power-to and power-over) would create the conditions for the development of an apparatus of strategies aimed at enhancing policy diffusion.

Using the case of performance-based financing (PBF), a policy that diffused across donor-dependent sub-Saharan African countries at a very rapid pace, we analysed how diffusion processes (i.e., policy framing, emulation, learning, and experimentation) operated. Several DEs were donors: they exercised compulsory and institutional forms of power in their (large) financial support of the diffusion processes and their setting of norms for policy experimentation. Other DEs were individuals and networks. These DEs' productive power operated through their (re)framing of PBF along the course of the diffusion process. DEs' structural power was illustrated in activities set to foster policy learning and policy experimentation. DEs' inducing of policy emulation featured both structural and productive forms of power, especially through their constitution in transnational networks (that in turn acted as autonomous DEs). Yet, in their endeavour to influence policy diffusion, an essential ingredient brought efforts together: their (repeated) social interactions with other DEs and with African policy actors. This feature, however, did not seem to transfer into an effective rebalance of power in favour of an African participation in global policy processes.

In this chapter, we summarise key findings drawn from our research (7.1), reflect on the relevance of our conceptual framework (7.2), bring these findings in perspective with available empirical literature, and offer some suggestions for future research (7.3). We also offer some final reflections on the ways thesis journeys shape young scholars' development (7.4).

7.1 Summary of key findings in relation to five initial propositions

Our findings shed light on the five original propositions highlighted in Chapter 3. The first suggested that a necessary condition for successful dissemination of a given policy is that DEs pool their resources (featuring power-to) and types of authority (power-over other policy actors; proposition 1). The second posited that when DEs' representation systems and competencies are aligned with the content of the policy, and when it is in the interest of funders, the chances of dissemination increase (proposition 2). The third proposition submitted that DEs deliberately design and implement strategies to promote the diffusion of PBF (proposition 3). The fourth proposition suggested that DEs' multiple forms of power exercised at the global level allow them

to control the diffusion (proposition 4). The fifth proposition offered that it is likely that strategies to foster policy diffusion, mainly led by global-level DEs, contribute to the making of PBF DEs in Africa, who in turn operate in different African countries (proposition 5).

Proposition 1: When DEs pool their resources and types of authority, the chances of dissemination increase

Empirical findings illustrate the reliability of the five propositions. First, despite initial statutory differences on the global health governance (GHG) arena (e.g., individual experts and a community of practice, versus major donors), we have highlighted the ways through which DEs have pooled their assets (resources and types of authority) to increase their chances of influencing the diffusion of the PBF policy, which matched their problem representations. In the case of the PBF CoP (Chapter 5), beyond a simple pooling of assets, our analysis highlighted the explicit wish of CoP's most influential members (coming from high-income countries and possessing strong resources and multiple types of authority) to distribute their assets (e.g., facilitating access to job opportunities) to the rest of CoP members (mostly coming from LMICs). In Mali (Chapter 6), the reputation of a global-level expert and his social and knowledge resources were pooled with the temporal and political resources and the moral authority of Mali actors to foster policy diffusion.

Proposition 2: When DEs' representation systems and motivations are aligned with the content of the policy and when the policy is framed in ways that match donors' interest, the chances of dissemination increase

Several major global donors shared a primary concern for improving aid efficiency[9] (i.e. increasing value for money; Chapters 2 and 4). This objective included donors' tendency to promote strategies to increase the accountability of aid recipients (through improved governance practices). These donors had a strong financial authority, which reflected their compulsory power. Cognisant of donors' power, and of the facilitating potential it could offer them, several

[9] Scholars have showed how this emphasis on aid efficiency and the need to address LMICs' governance issues may be problematic for a few reasons: 1) it may be misleading — there is evidence pointing to the fact that foreign aid, in fact, contributes to compromise the rule of law and state institutions (Knack and Rahman, 2004; Rajan and Subramanian, 2007), 2) it may produce unintended consequences (Merry et al., 2015), and 3) it orients financial flows towards a very limited set of "donor darling" countries (Davies and Klasen, 2019).

individual DEs strategically framed the policy in ways that matched donors' interests (e.g., PBF is considered a solution to reduce corruption in health services). Relying on the large structural power (i.e., expert authority) of these DEs, donors started to push for the diffusion of PBF since the policy seemed to reflect their concern. Several global-, continental-, and national-level policy actors subsequently realised that it was in their interest to promote PBF, given the career advancement opportunities that became possible thanks to the large funding available to pilot this policy. Besides financial and political motivations, DEs also manifested a genuine concern for improving health systems in LMICs. Their set of motivations was, therefore, quite complex. The PBF CoP's cohesion was built on an alignment of members' representation systems and a convergence of interests: African practitioners and their European promoters all had something to gain in fostering PBF diffusion through the CoP's activities (Chapter 5). In the Mali case study, the three Mali DEs were shaped by three factors: 1) the perceived success of initial performance-contracting projects, which mobilised the premises of the PBF; 2) the association with a common past and similar training in economy and management of health services; and 3) an interest in developing their respective careers (Chapter 6).

Proposition 3: DEs deliberately design and implement strategies to foster the diffusion of PBF

Once DEs with convergent interests had pooled their assets, and used their compulsory, institutional, structural and productive forms of power, DEs created strategies to brand the solution to their problem representations as being irrefutable. This strategic apparatus aimed to 1) (re)frame PBF as a politically attractive solution, 2) control the PBF learning agenda, 3) define the conditions for successful PBF experimentation, and 4) spark policy emulation through showcasing powerful success stories that could inspire LMIC policy actors. The CoP's core group (dominated by European DEs) purposefully developed diffusion activities aimed at both promoting African practitioners and a repertoire of practices matching the core group's conceptualisation of PBF. This group notably associated PBF principles with critical problem representations of health systems in sub-Saharan Africa (see Chapter 5). In Mali, the prominent positioning of Mali and European DEs enabled them to spread their PBF discourse and foster the diffusion processes (e.g., facilitating the PBF experimentation at two scales and transferring passion and expertise to high-level policy actors and decentralised actors in the Koulikoro region).

Proposition 4: DEs' exercise of multiple forms of power-over at the global level allows them to control the diffusion

Despite laudable intentions to reverse the established power imbalance on the GHG arena (an explicit concern for some European individual DEs), influential individuals from high-income countries and international organisations continued to lead the processes of policy experimentation, emulation, and learning about health systems policies in sub-Saharan African countries. DEs' discursive influence — which reflected their strong productive power — specifically manifested through their success in controlling the terms of the debate and the circulation of knowledge about PBF at the global level. Although its concrete outcomes as to policy adoption were unclear, one strategy catalysed all three processes: the organisation of multiple study tours to countries in sub-Saharan Africa. Indeed all DEs acting at global and continental levels participated to foster South-South learning on PBF. In Mali, a global-level DE's leadership was particularly instrumental in generating policy emulation at all levels and in sustaining high-level policy actors' interest for PBF. Interacting with high-level policymakers behind closed doors (e.g., in multiple face-to-face meetings, in his own words: "coaching the secretary general" in drafting a memo), this Dutch individual DE made sure to promote a Mali-ownership of the policy design and diffusion.

Proposition 5: Strategies to foster policy diffusion, mainly led by global-level DEs, likely contribute to the making of PBF DEs in sub-Saharan Africa, who in turn operate in different sub-Saharan African countries

DEs' strategies also had a snowball effect due to their participation in the creation (through multiple forms of coaching and training, in particular) of *second generation DEs* expanding the PBF policy on the African continent. Most informants felt that the PBF CoP played a leading role in the making and promotion of these second-generation DEs. In the case of Mali, once the Dutch DE considered that Mali DEs were sufficiently ready (see Chapter 6 and Gautier et al., 2019b for details), Mali DEs became second generation DEs, contributing to diffusing PBF in Guinea (in 2017-2018) and in Mauritania (starting from 2019) in collaboration with global development organisations. In both Chapters 5 and 6, we uncovered the African experts' need for validation by

the original DEs. In Chapter 6, we provided a detailed analysis of this complex phenomenon of interactions between structurally unequal individuals (European DEs vs. Mali DEs).

7.2 Reflections on the relevance of our conceptual framework

Building on existing conceptual notions and taxonomies from HPSR and public policy studies, we designed, tested (i.e., checked for the framework's reliability using secondary data drawn from a literature review), and empirically applied our conceptual framework on DEs in order to uncover diffusion processes at the global, continental, and national levels.

A 'bricolage' framework for health policy and systems research?

Denzin and Lincoln describe qualitative researchers as "bricoleur[s] and quilt-maker[s]" (Denzin and Lincoln, 2008, p. 5). Authors using and expanding the concept of the bricoleur-researcher explicitly refer to Lévi-Strauss's metaphor of the *bricoleur*, who, unlike the engineer who must follow pre-set tools and rules in their production, may have more flexibility in using the tools and materials at hand (Lévi-Strauss, 1966). Bricoleur-researchers create bricolage, that is, a coherent, pieced-together set of representations and perspectives that reflects a particular phenomenon of interest in original or innovative ways (Denzin and Lincoln, 2008). Scholars contend that researchers adopting the bricolage approach can embrace a multiplicity of research paradigms and political dimensions through their own enquiry (Berry, 2004; Rogers, 2012). *Interpretive bricoleurs* — such as myself — may be theoretical and/or methodological bricoleurs (Denzin and Lincoln, 2008). In this thesis, I engage in both: I develop a theoretical bricolage framework, and a methodological bricolage (whereby different forms of data and analytical approaches inform my study object).

A *bricolage framework* refers to a configuration wherein qualitative researchers build and combine mixed frameworks drawing on multiple theories and/or conceptual frameworks, and use the outcome to analyse and/or interpret their data. In health research, this bricolage requires synthesising existing frameworks, and yielding theoretical insights at meta-level in order to build a framework that is transferable across contexts (Booth and Carroll, 2015). As a matter of fact,

health policy and systems research (HPSR) qualitative scholars frequently apply bricolage type frameworks to analyse policy processes in LMICs (e.g., Hercot et al., 2011; Jones et al., 2017; Koduah et al., 2016; Legido-Quigley et al., 2018; Moat and Abelson, 2011; Parkhurst and Vulimiri, 2013; Pillay and Skordis-Worrall, 2013). The DE framework, presented in Chapter 2 and graphically represented in Chapter 3, can be described as a bricolage framework that primarily draws from public policy and HPSR scholars.

The evolution of HPSR theoretical literature features three key major contributions. First, the most frequently used and enduring framework in HPSR is Walt & Gilson's policy triangle (Walt and Gilson, 1994). Scholars acknowledged it as a major contribution to HPSR in that it draws attention to the neglect of actors and context in health policy analysis in LMICs (Hill, 2011). Second, another major HPSR scholar identified the importance of transnational networks and non-linear policy processes (Reich, 1995). Reich highlighted that agenda-setting for child health policies resulted from "deliberate and sustained strategies by the United Nations Children's Fund (UNICEF) and its supporters, rather than a balanced assessment of all priorities" (Hill, 2011, p. 600). Reich also acknowledged the importance of policy actors' status and power in transnational policy networks. Third, the dynamic evolution of GHG and growing interconnections between traditional and non-traditional GHG actors uncover complex forms of influence (Buse and Walt, 2000) and engender the polycentric nature of GHG (Tosun, 2017).

Despite these major contributions, the larger part of HPSR literature overlooked ideational processes and forms of influence (Koon et al., 2016). In addition, because Walt & Gilson's framework emerged in the early 1990s (which featured a very different GHG landscape), it does not meaningfully feature dynamic interactions between actors and processes (Jones et al., 2017). Thus, while we acknowledge and build on the heritage of health policy analysis theoretical literature, we are also cognisant of its limitations, and offer our own theoretical contribution.

We reflect the ideational dimension in our conceptual framework, through DEs' policy framing, representation systems, knowledge resources, and moral and expert types of authority. Our framework builds on Reich's three empirically-drawn notions. First, our *diffusion entrepreneur* concept includes transnational policy networks. Second, the framework components explicitly

recognise policy actors' powerful assets, through two taxonomies: one that concerns their resources and another one regarding their types of authority. Third, building on Reich's foundational findings about child health policy agenda-setting, our conceptual framework also prominently features DEs' deliberate strategies to frame the preferred policy in order to gain political leverage and to facilitate policy emulation, learning, and experimentation. Coincidentally, in recent public policy studies featuring the polycentric context of global development governance, authors concur that political economy analysis requires to one to identify "strategies that actors employ within and through their social relations rather than one that emphasises top-down singular modes of coercion" (Ouma and Adésínà, 2018, p. 7).

Our framework also builds on public policy literatures. It features the concept of polycentrism. The latter was originally designed by political scientist Ostrom (Ostrom et al., 1961), before expanding in the policy diffusion literature (Ouma and Adésínà, 2018; Tosun, 2018, 2017). The taxonomies used to describe resources and types of authority come from the field of sociology of public action (Hassenteufel, 2008) — a subfield public policy studies (Zittoun, 2017), and global heath political scientists (Shiffman, 2014), respectively. Lastly, the strategic apparatus components build on the policy framing literature (Koon et al., 2016) and policy diffusion mechanisms (Dobbin et al., 2007). We propose to build a framework that would advance both the HPSR and public policy literatures.

Choosing and adapting items from elsewhere to construct a full-fledged framework require coherency and making sure that each dimension has its own relevance. In line with our original anchor in public policy studies, we choose policy theorist Majone's categories for assessing the coherence and relevance of our framework dimensions. According to Majone, "an adequate theory of policy development requires that attention be paid to ideas, theories, and arguments as well as to technology, economics, and politics" (Majone, 1989, p. 166). By linking each of these dimensions in relation to our conceptual framework (Table 7.1), we submit that the latter does indeed feature an "adequate theory of policy development" (*ibid.*).

Table 7.1 Majone's dimensions applied to DE framework dimensions

Majone's core "attention" dimensions	Corresponding DE framework dimension

Ideas	DEs' representation systems; policy framing
Theories	DEs' representation systems featuring (institutional) economics and new public management theories; fundamental principles of the proposed policy
Arguments	DEs' motivations, policy framing, policy learning
Technology	DEs' strategies to foster policy emulation (e.g., study tours), learning (e.g., creating online exchange fora), and experimentation (e.g., toolkits and manuals featuring policy best practices)
Economics	DEs' resources (power-to); DEs' financial authority (compulsory power-over others)
Politics	DEs' motivations; DEs' types of authority (institutional, productive, and structural forms of power-over others); policy framing

Other HPSR and global development scholars have developed bricolage frameworks featuring policy diffusion or transfer (Bissell et al., 2011; Jones et al., 2012). These frameworks may be applied to policymaking in polycentric settings. Adapted from the foundational works by Rogers (1995) and Dolowitz & Marsh (1996), Bissell et al.'s conceptual framework represents a thorough capture of health policy transfer processes. It covers a wide spectrum of dimensions (i.e., context, resources, policy stages, modes of communication, global to local interfaces, and degrees of transfer). However, power in the interactions between actors and networks appears slightly diluted. Policy actors' motivations to engage in policy transfer, and their representation systems, are two dimensions critically missing from the framework.

The framework by Jones et al. (2012) aims to guide the analysis of interactions between knowledge, policy and power in global development. It features actors' interests, values, and beliefs — these dimensions directly link to our representation systems and motivations. However, we find that Jones et al.'s framework features knowledge prominently, and the power dimensions (which appears only under the broad category of political context) tends to get diluted. Crucially, policy actors' resources (power-to) and types of authority (power-over) on the GHG arena are key aspects to understand what knowledge is featured in the policy, how it may be interpreted by major GHG actors and LMIC practitioners, how it gets promoted and put forward (framing), and eventually how it may be integrated by LMIC policymakers. Unlike in Jones et al. (2012) we note that this process is not only political; it also features a mixture of recognition of the skills/expertise of these global experts, and local actors' feelings towards these internationally renowned actors. For example, if local and foreign policy actors have known each other for a long time, they develop trust relationships and may even share the same interests, leading to

policy alliances that transcend borders and foster diffusion. Through forging alliances, foreign policy actors also stimulate policy emulation, which is much stronger than just transferring knowledge, because it features social interactions between actors. This feature is the second major innovative contribution to the existing literature.

Building on these key dimensions featuring ideas and social interaction in policy diffusion, we turn to reflecting on the relevance of introducing a new and original concept — that of *diffusion entrepreneur*.

Why introducing a new concept?

The concept of *diffusion entrepreneur* (DE) is anchored in the field of the public policy diffusion. While we valued the progress and coherence of the body of knowledge on mechanisms of diffusion — policy learning and policy emulation or "socialisation", in particular — (Dobbin et al., 2007) there is a lack of attention for the policy actors of the diffusion in this field of the literature (Obinger et al., 2013). Other research fields (e.g., sociology of public action; Hassenteufel, 2008) proved very helpful in defining the dimensions of a coherent interdisciplinary framework around this concept. DEs are "individuals, networks, and organisations, who seek to promote a certain policy with a view to gain influence […] [and] therefore develop strategies to shape the perception of a policy innovation and to maximise its diffusion" (Gautier et al., 2018b, p. 162). Our definition matches Daigneault and Jacob's fundamental condition demonstrating the soundness of concepts (a minimal definition, i.e. focusing on direct and necessary attributes that suffice to define the concept; Daigneault and Jacob, 2012), since it features key attributes (who we are talking about and what their interest is). Intentionally, our definition does not feature the particular thematic area in which we apply this concept (global health), thereby leaving open the possible domains for utilisation, and suggesting the potential universality of the DE concept. Still, questions can be raised as to the opportunity and relevance of adding yet another concept to describe policy actors in the context of global governance. We attempt to answer these questions by reviewing the main existing terminologies.

Our concept primarily recalls the one derived from Kingdon's multiple-stream approach, namely *policy entrepreneurs* (Kingdon, 1993). Policy entrepreneurs are defined as "advocates who are

willing to invest their resources — time, energy, reputation, money — to promote a position in return for anticipated future gain in the form of material, purposive, or solidary benefits" (Kingdon, 2003, p. 179). Policy entrepreneurs may be bureaucrats, academics, journalists, representatives of interest groups, or parliamentarians. They may qualify as policy entrepreneurs as long as they are perceived at the ones who "push their proposals […] in order to find broad support among the members of the policy community" (Herweg et al., 2017, p. 34). Kingdon's work has attracted a lot of attention from ideational scholars because it features the promotion of policy actors' underlying values and worldviews (Béland, 2015). Yet public policy analysts tend to agree that the concept is under-theorised (Clausen, 2014; Lynggaard, 2006, p. 67). Kingdon's concept and multiple-stream approach was initially developed to study policymaking at the national level, and in a very specific context: a high-income country (United States). Yet Kingdon's work has been widely used to describe policymaking occurring in LMICs (which often also feature global-level actors), which raised some criticism as to the alleged "universality" of the concept (Kane, 2016).

In fact, among HPSR authors applying it to explain health policy processes in LMICs (Kiendrébéogo et al., 2017; Koduah et al., 2015; Kusi-Ampofo et al., 2015; Mauti et al., 2019; Nay, 2012; Parkhurst and Vulimiri, 2013; Ridde, 2009; Shearer, 2015; Sieleunou et al., 2017), some recognise the limitations of Kingdon's concept and approach by highlighting its "Western-centric" features (Kusi-Ampofo et al., 2015; Mauti et al., 2019; Ridde, 2009). On the contrary, our own DE concept emerges from the study of power in polycentric global governance (using the case of PBF), and goes well beyond the Western world. Some scholars discussing the multiple-stream approach, which prominently features the actions made by policy entrepreneurs, argue that it overlooks group and network power dynamics (Clarke et al., 2016; John, 2013). This is particularly problematic if one considers the importance of networks in polycentric governance: networks are prominently featured within the key attributes of our concept (see above). For all of these reasons, we chose not to apply this concept to the study of the diffusion of global health policies. Finally, scholars criticise the fact that the motivations (or "interests") of policy entrepreneurs are eluded in Kingdon's work and its subsequent applications (Clausen, 2014; Hyndman, 2017). One of the key dimensions of DEs (featured in the framework) is precisely about DEs' motivations, which crucially guide DEs' actions. In general, our DE

concept and accompanying framework provide a useful heuristic approach to describing DEs, something that was missing in Kingdon's conceptualisation of policy entrepreneurs.

Another similar concept to our *diffusion entrepreneurs*, is Haas's concept of *epistemic communities* (Dunlop, 2009; Haas, 2015, 1992), especially as it has been widely applied in studies of global development policymaking. Epistemic communities "differ from ordinary scientific communities [...] in the normative — and political — dimension of their role in the construction of legitimate and consensual knowledge that is yet possible to refute" (Charton, 2015, p. 52; personal translation). Charton goes on to mention LMIC decision-makers' almost systematic calling of members of these communities, to support them in their political action. This is where the DE concept potentially adds value compared to Haas: we are not only interested in organisations and networks, but also in individuals (and their personal/professional trajectories), who exert power because they are recognised as having their own legitimacy in polycentric governance. Even though individual leaders may be members or leaders of epistemic communities (and policy networks), we argue that they have, on their own, an important role in the diffusion process (Hogan, 2006).

The policy transfer literature is also useful for conceptualising a more actor-centered approach to policy adoption in multiple settings (Dolowitz and Marsh, 1996). The authors defined the policy transfer as "a process in which knowledge about policies, administrative arrangements, institutions etc. in one time and/or place is used in the development of policies, administrative arrangements and institutions in another time and/or place" (Dolowitz and Marsh, 1996, p. 343). Policy transfer scholars frequently used Kingdon's policy entrepreneurs. Others coined the term *transfer agents* operating in global governance according to three modes of policy transfer: 1) ideational; 2) institutional; and 3) networks (Stone, 2004, p. 562). However, actors in these three categories may easily join their efforts to form larger networks. In addition, items in the institutional category can also be reflected in the ideational category. Yet according to Barnett and Duvall, effective taxonomies of policy actors must try to "derive critical, mutually exclusive, and exhaustive distinctions" (Barnett and Duvall, 2005, p. 43).

While we find the policy transfer literature useful to describe policy actors (as compared to the policy diffusion literature), we note a lack of in-depth look into how they get convinced by a policy idea and take it through a diffusion process. We argue that policy transfer may be included in the broader category of knowledge transfer. Conceptual distinctions between those two fields are indeed difficult to establish, since the original definition of policy transfer features knowledge as the core item that gets transferred (Dolowitz and Marsh, 1996, p. 343). Stone, for instance, reproduces this confusion when speaking of "the role of international actors in policy/knowledge transfer processes (Stone, 2004, p. 545). This is all the more relevant in the context of influential knowledge-based policy actors developing their structural and productive forms of power through designing and disseminating norms (King and McGrath, 2004; Tomlinson and Harrison, 2018). The knowledge transfer literature has developed the concept of *knowledge brokers* (Lomas, 1997), which refers to middlemen engaged in facilitating the understanding of knowledge they acquired, through interactions with the general population or a specific targeted audience. Building from this, evidence-informed policymaking scholars distinguish *issue advocates* from *honest knowledge brokers* (Oliver and Cairney, 2019). Even though some individuals did engage in knowledge brokering activities, these did not always feature the entire evidence base (as we showed in Chapter 5), which is a condition for being an honest broker (*ibid.*). Given their motivations, DEs would more likely fall under the issue advocates category, but this choice would entail conceptual difficulties in separating them from academic activists, who, based on their research, engage in recommending specific policy options for bringing about social change (Martin, 2009). Indeed, DEs are not all researchers. Coincidentally, in our conceptualisation of policy diffusion in polycentric contexts, not only norms and knowledge spread to other countries: problem representations (which reflect underlying belief systems that feature specific perceptions of the world and the reality, rather than actual knowledge), financial flows, and even policy advocates themselves are travelling.

Building on the notion of brokers, development anthropology scholars conceptualised the idea of *development brokers* (Lewis and Mosse, 2006; Olivier de Sardan and Bierschenk, 1993), which offers some very insightful dimensions for development scholars. Development brokers are strategic intermediaries (usually, development experts) who mediate by connecting development policy actors sharing mutual interests in policy implementation (e.g., yielding benefits from the

policy implementation). Brokers' role is instrumental in seeking acceptable policy solutions between different policy actors pursuing different objectives, but possibly developing an interest in collaborating with each other (Ségalini, 2014). Nay and Smith (2002) emphasise the social enterprise within brokers' strategic mediation activities, as they are striving to create networks and communities. The concept is also useful to analyse strategies to depoliticise policy ideas (Diallo, 2012), and brokers' ability to call upon and rely on development experts originally coming from the (developing) country of interest, and thus considered more legitimate (Ségalini, 2014). However, international relations and public policy scholars have so far paid limited attention to the concept (with a few notable — mainly French — exceptions: Nay and Smith, 2002; Ridde, 2004b; Ségalini, 2014), possibly because it comes from a distinct discipline anchoring. Ridde (2004) emphasises the role of local development brokers who define populations' needs, adapt their discourse to match that of the donors, and even engage in aid capture — to fulfill political or material objectives. This empirically-driven definition partly resonated with some findings of our research, especially those related to African DEs pursuing career advancement, which clearly included material motives. However, the *aid capture* phenomenon was less salient, possibly because donor-favoured tendencies are increasingly diversified and fast-evolving (Goetz and Patz, 2017; Parks, 2008). On the contrary, in the case of PBF, we perceived a certain vulnerability of African experts depending on a fluctuating and often unpredictable donor funding (Martinez-Alvarez et al., 2017). To summarise, while we appreciate the value of the concept, we think it needs nuancing and conceptual anchoring: for instance, and unlike in the case of the DE framework, there is no taxonomy of the processes they intend to shape (e.g., policy learning). In this regard, policy diffusion mechanisms do provide useful and conceptually coherent categories. In addition, analyses of development brokers emphasise problem representations, but not the brokers' own representation systems. This feature is a central feature of our framework.

Lastly, policy diffusion analysts (Mintrom and Vergari, 1998; Smith et al., 2014; Weyland, 2009) have reviewed the role(s) played by formal institutions in diffusing policies, but less that of individual or non-formal organisations. Still, Common (1998a) described how two individuals travelled to diffuse NPM. According to Common, the elite was successful in "control[ing] and direct[ing] the flow of knowledge about government reform" (Common, 1998a, p. 447).

Diffusion analysts such as Common and Strang and Soule have looked into *change agents* (Common, 1998b; Strang and Soule, 1998). Change agents diffuse policies by using "coercive mandates" or "cheerleading", and often "a complex balance of the two" (Strang and Soule, 1998, p. 271). As they are conceived as "external sources", these scholars separate their actions from adopters' influence (considered internal). However, we posited in this research that what these authors call external actors may in fact take deliberate actions to influence adopters. These adopters can get influenced because external actors represent prestigious "central actors" (Strang and Soule, 1998, p. 274), or because the social ties between adopters are enhanced by external actors. Other political scientists interested in global policymaking use similar terms, such as "*knowledge*" or "*reform*" entrepreneurs (Nay, 2014, 2011). These different concepts have in common the centrality of knowledge and information that (groups of) individuals possess and use to facilitate policy change at different levels of government, including at the global level. While these denominations may also cover the actors we are interested in, they are mostly of a descriptive, a-theoretical nature (they are primarily interested in defining and describing who the entrepreneurs/agents are).

We, therefore, believe that it is worth expanding existing conceptual work by emphasising the context of global policy diffusion and the polycentric governance framework (see Chapter 2). We suggest that these entrepreneurs/agents are not only creators and promoters of political changes, knowledge, or institutional reforms; but also active architects of the diffusion (through their development of a strategic apparatus) because they have clear interests in diffusion outcomes. The analytical aspect of entrepreneurship is threefold. Firstly, the ways in which they develop their resources and authorities and implement their strategies to increase their impact on the global arena help to understand how DEs effectively develop their "*entrepreneurial leadership*" (Riddell-Dixon, 2005, p. 1068). The notion of entrepreneurial leadership[10] refers to the ability to sell creative ideas to others, e.g. through networks. Creativity refers here to entrepreneurs' innovative thinking as to how to deal with policy problems (e.g., engineering a policy solution). Secondly, these entrepreneurs implement a wide array of strategic activities (e.g., policy framing, valuing lay knowledge on PBF, and sharing selected PBF evidence in multiple fora) so as to

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[10] The concept of *entrepreneurial leadership* was initially developed by Young (Young, 1991).

effectively foster the diffusion of a given policy matching their representation systems (DEs' *intermediate* objective). They may express their creativity through this second process as well, through coming up with new ways to diffuse their ideas (e.g., finding interactive formats to disseminate and promote lay knowledge). Thirdly, the implementation and the expected effects of this strategic apparatus also reveal particular motivations/interests (financial, professional, etc.) more or less explicitly acknowledged by DEs (DEs' *ultimate* objective). Importantly, the notion of polycentrism (i.e., the recognition that political influence comes from various autonomous units) functions as a key enabler in the realisation of their entrepreneurial potential. In Table 7.2, we record the key existing concepts, their authors, the main attributes and analytical value, and what the DE concept and framework will allow for in comparison.

Table 7.2 Summary of concepts referring to influential policy actors evolving in (or studied in the context of) global governance

Concepts	**Authors**	**Main attributes**	**Analytical value**	**What the DE concept and framework bring**
Policy entrepreneurs	J. Kingdon (1993)	Originally encompassed individuals, but later expanded to organisations	Entrepreneurship in the ability to *couple* streams towards policy agenda-setting in timely manner (e.g., using *windows of opportunity*)	DE concept is explicitly applied to the context of global governance and LMIC policymaking; it expands to networks; framework features overlooked dimension: motivation
Epistemic communities	P. Haas (1992)	"Network of professionals with recognized expertise and competence in a particular domain and an authoritative claim to policy-relevant knowledge within that domain" (Haas, 1992, p. 3). Emphasis on belief systems (e.g., shared causal beliefs and shared notions of validity), expert authority and competences	Concept explicitly applied to the context of global governance; experts sharing a common belief systems guiding the formation of communities; features power relations	DE concept expands to individuals; framework offers taxonomies of resources and types of authority, and a typology of processes that influential policy actors seek to shape
Transfer agents	D. Stone	Encompasses:	Takes the policy	DE framework features

	(2004)	individuals, organisations (including non-state actors), and transnational networks. Soft policy transfer (e.g., of norms) vs. hard policy transfer	transfer literature away from "methodological nationalism" (Stone, 2004); prominently features the role of transnational networks; offers a typology of modes of policy transfer: 1) ideational, 2) institutional, 3) networks	overlooked dimensions: representation systems and motivations; taxonomies provide mutually exclusive distinctions; transnational networks identified not only as a *vehicle* (Stone, 2004) for policy transfer but an actor of such transfer
Knowledge brokers (including: "honest brokers" and "issue activists")	J. Lomas (1997) and widely expanded by other authors	Encompasses: countries, organisations, networks, individuals. Possession of knowledge as key enabling factor	Offers various taxonomies of knowledge brokering	DE framework goes beyond knowledge transfer; offers taxonomies of resources and types of authority
Development brokers	J-P. Olivier de Sardan & T. Bierschenk (1993)	Encompasses: individuals and organisations.	Informs empirical findings; features power relations	Conceptual underpinning; offers taxonomies of resources and types of authority; typology of strategies
Change agents	D. Strang & S.A. Soule (1998)	Encompasses: countries, organisations, individuals Difference between "external actors" and "central actors" bound to adopt a given policy. Possession and control of knowledge as key enabling factor	Informs empirical findings; features power relations	Actors not only creators and promoters of political changes, but also active architects of the diffusion
Knowledge/ reform entrepreneurs	O. Nay (2011, 2014)	Possession and control of knowledge and information as key enabling factor to shape policy change	Informs empirical findings; features power relations	Conceptual underpinning; goes beyond knowledge transfer; entrepreneurs not only creators and promoters of knowledge or institutional reforms, but also active architects of the diffusion

Main value of the DE framework: the analytical potential of interactive dimensions

In addition to featuring ideational concepts (which encompasses influential policy actors' multiple forms of power) and social interaction, the dynamic interrelation between all framework components (featured in Figure 3.1, Chapter 3) indicates the analytical potential of the framework.

Besides sharing similar representation systems that guide DEs' motivations to advocate a particular policy, DEs must also obtain or develop certain resources (resources that are themselves shaped by representation systems — featuring professional or institutional culture in particular) to influence decision-making. Multiple types of resources are important to secure the success of DEs' actions. Among those, social resources are key. Social resources draw on the notion of social capital. This expression originates from economics and sociology (Bourdieu, 1986), and has been widely used by political scientists (Svendsen and Svendsen, 2009). It builds on the reflection that social networks play a crucial role in shaping personal and collective trajectories; and as such, they can be considered critical assets empowering people. Our empirical findings indicate that strategies fostering policy emulation would not have been effective without DEs' having a strong social capital. The latter enabled them to build alliances at the global level, create advocacy networks at the continental level, and build political momentum at national level.

DEs also need to develop legitimate forms of authority (financial / scientific / expert / moral) in order to be recognised by other major political actors navigating in the polycentric context of global governance. These assets represent a solid foundation on which they can build strategies to strengthen the diffusion of their preferred policy. DEs' motivations and representations nourish the actions they take. They convey an initial policy idea, participate to developing its content, co-build knowledge and learning agendas about this policy idea (including around its experimentation), frame it in ways that are politically attractive, and encourage policy emulation from a growing number of actors. These processes are dynamic: one does not precede the other (i.e., there do not represent incremental stages). They reinforce one another: when a particular diffusion process takes shape, it naturally produces phenomena that foster other diffusion processes. In addition, strategies implemented to foster policy diffusion (policy framing as well as actions that induce policy emulation and certain forms of policy learning and experimentation)

may facilitate different diffusion processes at the same time (e.g., impacting both policy learning and policy emulation). All categories of the DE framework are thus analytical by nature because they are interrelated. Such interrelation reflects the (largely informal) interdependency among the policy actors of polycentric governance. The potential of the framework, which dynamically links these different categories, is promising. Moreover, despite an emphasis on actors, the DE framework is useful for describing the processes of policy diffusion through space (i.e., geographic levels) and time (since the end of the 2000s).

Limitations of the DE framework

Our study offers a conceptual framework that is adapted to a variety of research approaches: poststructural policy analysis (Chapter 4), qualitative-dominant mixed methods (Chapter 5), and longitudinal case study (Chapter 6). Global policy scholars wishing to reconstruct policy diffusion processes may therefore find it useful. Yet, by focusing on DEs as key agents of the diffusion, our framework inevitably falls in the category of actor-centered policy frameworks (Hassenteufel and Zittoun, 2014), which may lead to overlooking the policy content as well as the wider environment in which policy changes take place. We showed how Bacchi's poststructuralist approach (Bacchi, 2009) could be both useful to inform the policy content and coherent with our framework dimensions. Still, what may be missing is a contextualised description of the policy that gets diffused in a given country/region. Indeed, historical, cultural, political and economic structures may or may not create an environment conducive to the emergence and diffusion of politics (Edwards and Di Ruggiero, 2011). Building on this, we could have developed an additional dimension, which would feature these four types of structures that shape a policy's environment.

Set in the scope of a political economy analysis, the DE framework could have built on existing actor-centered power frameworks (Krott et al., 2014). Building on Dahl's definition of power (Dahl, 1957), they suggested the following theoretical proposition: "actor-centred power is a social relationship in which actor A alters the behaviour of actor B without recognising B's will" (Krott et al., 2014, p. 37). From the onset, we perceived this representation of power interaction as too restrictive. In the case of global health governance (GHG), *hard* power (or coercion) is still occurring but scholars tend to agree that it is no longer the main form of interaction between

actors. In actor-centered power frameworks, *soft* forms of power (e.g., productive power) seemed to be diluted. In the DE framework, the two dimensions featuring power — resources and types of authority — refer to both *hard* and *soft* forms of power. The taxonomies enable us to describe the types of resources and authority at the disposal of DEs. However, in doing so, we may have reduced the possibility to examine more deeply dynamic power interactions between DEs, policymakers, African consultants, and other key actors of policy change. To foresee this issue, we could have developed another framework component, which would have provided the list of possible forms of interaction (e.g., repeated encounters with key policy actors, modes of communication, etc.) that DEs engage in, in order to foster diffusion processes. Even though we were able to provide insights on this very matter through our empirical analysis, conceptualising from the onset the forms of interactions would have possibly enabled us to explain in a more detailed fashion how power operated.

For various practical reasons (temporal and material resources, amongst others), we applied our framework exclusively using a retrospective study design. Although we had originally planned to spend large amounts of time observing day-to-day activities towards fostering policy diffusion in Mali, we did not obtain access to a relevant organisation in Bamako to carry out this long-time data collection plan. We underestimated the time it would take to win informants' trust, which would subsequently secure openings in observation sites. Employing it using a prospective approach would have certainly opened up for additional dimensions and/or deepening or refining certain components of the framework.

Ideas for improving and advancing the DE framework

We invite socio-anthropologists and political scientists to test the DE framework while using different research designs and methodological approaches. For instance, it would be relevant to adopt a prospective approach to these diffusion processes. Ethnography is an adequate research tool to carry out a prospective study of diffusion processes. We invite other scholars (in particular, those in anthropology) to apply our framework using an ethnography approach by, for example, observing an international organisation that produces and fuels these processes, especially to account for the aforementioned structures. Similarly, it would be interesting to use this framework towards in-depth comparative policy analyses across countries.

Our framework prominently features multiple forms of power (through resources and types of authority, and through the multiple interactions occurring in implementing DEs' strategies). Yet, reflecting on the provocative title of a book on the global diffusion of education policies (Vinokur, 2007), can we still say that the "who pays decides" axiom is true? In the present study, policy funding, through the HRITF fund (managed by the World Bank) in particular, is a necessary but not sufficient condition for policy diffusion. The material resources generated though this institutional arrangement had one key effect: making possible the realisation of DEs' agenda. However, in Mali, for example, material resources alone would not have been enough to spark emulation of policy actors. The significance of social interaction, which involves intangible emulation processes, the (co)construction of discourse and knowledge, and a common history around the experience of PBF, proved central to the diffusion of PBF in Africa. To improve the DE framework, it would be relevant to draw on relational sociology, which may help develop an even more dynamic and interactive understanding of policies or interventions (Craig et al., 2018). In future studies, scholars could try to incorporate relational sociology concepts into our own framework dimensions.

7.3 Empirical implications of this thesis' findings

Our political economy analysis of the spread of the PBF policy idea in African countries highlighted that power is operated through repeated social interactions between key individuals (e.g., European individual DEs and African experts and policymakers) to achieve policy diffusion. First, through DEs' compulsory (i.e., financial authority), structural (i.e., expert authority), and productive (i.e., featuring moral and scientific authorities) forms of power they were able to shape a consensual, primarily technical political agenda comprising the problem definition and a (seemingly) promising solution (Chapter 4). Second, through their structural and productive power, global-level DEs contributed to policy emulation through framing the diffusion as being Africa-led and instigating a PBF epistemic community promoting African experts (Chapter 5). The latter subsequently became key actors of the diffusion on the continent. Third, DEs' control of policy learning and experimentation influenced the preferences of African

high-level policy actors towards the idea of PBF, at both national and subnational levels (Chapter 6). We discuss the key findings of this doctoral research in light of three strands of empirical literatures: 1) the literature on polycentric governance; 2) the literature on development experts; and 3) the literature on knowledge politicisation and depoliticisation, which highlights the (mis)uses of the contested PBF evidence base, as well as the many issues associated with the *evidence-informed policymaking* prescription. In discussing these three strands of work, we identify several knowledge gaps that future empirical studies could fill.

Power relations in polycentric governance

Our empirical results showed that, unlike what might happen in another polycentric setting featuring strong competition between actors (Held et al., 2019; Ostrom et al., 1961), PBF DEs tended to collaborate with each other, even if there were some dissonance as to the standard PBF model promoted by the World Bank versus other more carefully contextualised PBF models (such as the PBF scheme design *à la malienne* promoted by a Dutch DE). DEs created alliances to have more impact on the dissemination of the policy. We can thus speak of a fairly consensual epistemic PBF community, composed of DEs (who share very similar systems of representations, forged by the same professional trajectory, as well as convergent interests), but also of African promoters and practitioners of PBF (who for the most part were members of the PBF *Community of Practice*, CoP).

In a recent paper on multiple health topics (i.e., HIV, antimicrobial resistance, and the control of Ebola Virus Disease epidemics), Held and colleagues highlighted the dissonance among the diverse actors of polycentric GHG (Held et al., 2019). For example, authors identified strongly competing discourses (e.g., human rights-based approach versus disease prevention or human security approaches) in the response to HIV/AIDS and the 2014 Ebola outbreak. The authors explained this disagreement by a lack of shared understandings about what health is and how it should be governed among actors of polycentric GHG. The rise of conflicting views might also reflect the crisis nature of these issues (e.g., an epidemic outbreak), and the prominence of influential GHG actors (e.g., UNAIDS and *Médecins sans Frontières*) whose discourses were contradicting those of local discourses. In short, these cases on the response to HIV and the Ebola outbreak featured a clash between LMICs' (populations or governments) voices and global-level

dominant voices. This response was quite different in the case of PBF, which epistemic community featured a convergence of interests and problems representations, and a broad consensus on the choice of (economic) approaches to deal with the problems across LMICs and dominant GHG actors.

At the same time, and as we assumed in this thesis, informants considered that polycentrism was "making global health governance more inclusive, allowing new voices and perspectives to influence the agenda of countries and multilateral institutions, but also the way in which challenges are framed" (Held et al., 2019, p. 10). Yet this thesis' findings call for nuancing this argument about such inclusiveness: while new individual and network actors did gain power in the GHG arena, most of them already belonged to those dominating this arena. Reflecting on the roles played by transnational networks and individual experts in shaping PBF diffusion processes, our work has attempted to shed a critical light on this very aspect, taking into consideration the political economy of GHG.

The specificity of polycentric governance lies in the prominence of transnational networks and individual experts exerting a governing power at multiple scales as autonomous units. These actors may thus foster international policy prescriptions designed by powerful actors (Castells, 2011; Mosse and Lewis, 2005), notably through their transcending boundaries (e.g., using information and communication technologies available to everyone, at any time; McGrath and King, 2004) and emulating experts across many LMIC settings. Transnational networks mobilise a wide range of non-state actors, among which private-for-profit consulting firms that evolve in different — if not inexistent — models of accountability and governance (Bäckstrand, 2008; Duffield, 2002; Mosse and Lewis, 2005). Shiffman analysed the question of global health networks' legitimacy by emphasising two categories: *input* and *output* legitimacy (Shiffman, 2017). Input legitimacy refers to the inclusive, transparent, and participatory governance structure of networks. Output legitimacy represents their performance: how they effectively managed to raise (neglected) issues on the GHG agenda.

In the case of PBF transnational networks, output legitimacy is fairly high: their concerns about the neglect of the purchasing function in health financing were successfully brought forward on

the GHG agenda (Soucat et al., 2017). In this thesis, we also discussed the mixed input legitimacy of the global PBF community, and the PBF CoP in Chapters 4 and 5, respectively. To summarise, our analyses questioned the transparency of their advocacy processes (e.g., their discourse featuring selected health systems issues but silencing others), and the genuineness of inclusive representation (e.g., bringing forward African practitioners but maintaining them in multiple forms of dependency). This issue is coherent with literature analysing global environment networks, which also features a limited input legitimacy owing to the low representation of LMIC actors (Oosterveer, 2018). This study and others (Oosterveer, 2015) suggested that transnational policy actors were more likely to rely on their output legitimacy (featuring effectiveness and performance) rather than their input legitimacy.

Although Shiffman's typology encompassed power relations between LMIC and high-income actors, it possibly overlooked the issue brought up by anthropologists: how transnational policy networks actually contribute to foster the influence of private sector actors on the GHG arena. Private sectors' engagement in GHG has received research attention over the past decade (Richter, 2014; Rushton and Williams, 2011), with many development experts and researchers advocating for regulating such engagement. The recent movement within the HPSR community towards including private sector actors in UHC policy discussions (Bloom, 2018), calls for making sure that the many UHC networks (such as P4P and the *Joint Learning Network*) do not prominently feature private-for-profit frames about UHC.

Although we did not emphasise this feature in our three studies, the prominence of private actors, including NGOs, consulting firms (e.g., contracted to participate to PBF experimentation in African countries), and training companies in the diffusion of PBF in sub-Saharan Africa emerged at all levels — global, continental, and national. Their participation in diffusion processes conveyed the institutional power of donors (since all these private actors received funding from the latter), while also featuring their own productive power very clearly. For instance, Cordaid's and KIT's adaptive PBF models (Cordaid, 2017; Toonen et al., 2012) differed significantly from that of the World Bank, and these non-profit organisations made sure that their visions were taken into consideration in PBF pilot testing in African countries (even though the money came from the Bank). SinaHealth's coursebook illustrated strong statements

about introducing economic competition in health systems and removing public sector monopolies in healthcare delivery (SinaHealth, 2019). Some CoP members (who had received SinaHealth training) made explicit reference to these private sector assumptions in the PBF CoP's online discussion forum. Thus, private sector frames travelled through the multiple diffusion fora and certainly shaped some African DEs' discourse. Future studies are needed on the involvement of private sector actors in global health policy diffusion, especially when these actors are for-profit companies: their participation places health equity at stake (Basu et al., 2012; McIntyre, 2010).

Future global policy scholars should also study the claims of an increasing "inclusiveness" through polycentric governance, by critically analysing the many implications of transnational networks and experts' growing influence for global and national policymaking. In particular, questions as to whether polycentric governance actually participates to shifting trends of power imbalance between traditionally dominant GHG actors and LMIC actors would be worth asking.

Development experts in the making

Our study revealed that PBF diffusion processes contributed to the making of African experts, and this peculiarity in turn strengthened the diffusion. This phenomenon emerged empirically from our findings, along the course of data collection. For this reason, it was not possible to perform a fine-grained analysis of these African experts and their personal aspirations. In this subsection, we summarise our own findings in relation to this phenomenon, offer comparative insights with available literature, and invite scholars to further investigate the making of development experts.

In the present research, individual DEs acting at global-level effectively sought influence at the continental and (sub)national levels (i.e., on the African continent and at country-level). Their reputable expert authority — featuring a strong structural power — facilitated such enterprise. Our studies of PBF diffusion on the African continent and in Mali (Chapters 5 and 6) showed that European experts could influence policy diffusion by deliberately and strategically contributing to creating an African expertise pool that promotes their policy agenda at multiple levels. This in turn enhanced global-level DEs' visibility and legitimacy on the global arena, as they could

appear as promoting African experts, and it also contributed to foster their framing of an Africa-led policy diffusion (Chapter 5).

Many anthropologists and political scientists have analysed the role of development experts in shaping LMICs policymaking processes (Charton, 2017; Cohen, 1992; Jampy, 2012; Lewis and Mosse, 2006; Mosse, 2013; Ségalini, 2014). This literature points to the prominence of development experts' power. Already in the early 1990s, Cohen had underlined the compulsory, structural, and productive forms of power yielded by foreign economic policy advisors in Kenya, not only towards influencing policymaking, but also shaping the political economy of Kenyan advisors' training (Cohen, 1992). Yet, not only economic but also social policies are "internationalised through donor knowledge systems that emphasise the universal over the contextual […] [and] ignores national frameworks" (Mosse and Lewis, 2005, p. 6). With this background, one might question how these policies may be effectively and uncontestably transferred to LMIC settings.

The answer lies in the institutional and structural power of individual development experts, who are acting on behalf of donors (through formal contractual arrangements, for instance) and/or seek to match their interests (Gautier et al., 2019a), and their ability to articulate these donor knowledge systems to more acceptable discourses. Foreign experts' own social, knowledge, and political resources help in the process (see Chapter 6). In the case of Mali, the fact that a Dutch DE "knew everybody" and had acquired a certain reputation among high-level policy actors played a decisive role in his successful persuasion of the relevance of PBF as a policy solution to existing problems in Mali. Global-level individual DEs need to be able to shape the PBF discourse in ways that made sense to LMIC political actors, notably by crafting this policy solution as being part of national frameworks and priorities. Of course, they might not have the same persuasive effect without the foreign expert status. This supports the idea that foreign experts' structural power is central, as this was the case of biomedical knowledge transfer in India. HPSR scholars highlighted that "foreign stakeholders may be perceived as technically superior, and further, due to complicated histories of science, colonialism, and postcolonialism, could have their ideas received more favorably" (Sriram et al., 2018, p. 4).

The individual Dutch DE in Mali was aware of his role in "making" Mali DEs. Yet, in interviews national-level DEs tended to minimise the Dutch DE's role in both legitimising their expertise among major GHG actors involved in PBF diffusion, and supporting their own actions at country level (in pilot project experimentation, for instance). The complexity of the relationship between first-generation DEs (i.e., European/North American DEs who participated to promote African experts) and local DEs, would gain from further analysis featuring postcolonial (Rottenburg, 2009a) or decolonised approaches to HPSR (Brady et al., 2018; Collectif, 2017).

Further, the authority of global-level experts was not uncontested. The Mali study also featured the significance of person-dependent processes that obstructed the success of the 10-HD PBF pilot scheme in 2016-17. The "person-dependent" phenomenon in successful implementation of externally-driven projects or policies has been identified in other studies of the health policymaking process in LMICs (Husain et al., 2007). In Mali, the funder's representative in charge of coordinating the project and delivering financial orders hampered the diffusion process during policy experimentation in multiple instances. For example, African experts were not able to fully engage in their role as DEs transferring their expertise and passion to decentralised actors in Koulikoro districts, because the funder's representative did not make financial and material means available to them. Furthermore, the funder's representative's poor leadership and cooperation with MSHP officials, posed serious threats to the continuation of the policy. As soon as a new team joined the donor's country office, the relationship with high-level policymakers from the MSHP and with other partners was restored. This feature gave way to the design of a multi-regional pilot scheme featuring multiple international partners, the local consulting firm, and the MSHP.

The Mali study also provided insights as to national government's implication and leadership in policy diffusion in the context of polycentric governance. In the early and mid-2010s, what appeared to be a successful PBF experimentation in Koulikoro region attracted the attention of high-level policy officials in Bamako. Dutch and Mali DEs further galvanised policymakers' interest in PBF through their multiple informal gatherings in a luxurious hotel of Mali's capital city. Participants to these meetings designed and stabilised the PBF design *à la malienne*. Fast forward 2017, when the funders' representative withdrew (as we saw above), Dutch DEs

facilitated some of the political processes between MSHP leaders and international partners to foster the design of the aforementioned multi-regional PBF scheme. In the meantime, high-level political leadership in favour of PBF was being fostered in Bamako. In March 2017, the secretary-general of the MSHP created a special task force located at the MSHP, responsible for planning the rollout of PBF in Mali. During these task force's meetings, participants contended that PBF was the key mechanism to improve quality of care. A few months later, in October 2017, a prominent national DE (coached by a Dutch individual DE, and strongly involved in the first and second pilot schemes) became the principal advisor to the MSHP. This positioning led to a political consensus in February 2019, when a major high-level meeting on a new health systems reform recommended "the scale-up of PBF". There are two fundamental elements with government involvement: policymakers' frequent and repeated interactions with DEs, and the strategic positioning of an individual DE inside the MSHP. As we saw in Chapter 6, the first of these elements sets communication as the core enabling factor for policy acceptance among policymakers (Cairney and Kwiatkowski, 2017). These authors invite policy proponents to develop a communication strategy, featuring powerful narratives and strategic frames. The second element is conjectural and much less controllable. However, investing time in coaching high-level public officials to become policy experts might be a promising strategy for DEs.

A common background and/or professional history between PBF experts proved instrumental in shaping a cohesive pool of experts who became the key actors of the diffusion in African countries. On educational policies in Senegal, Charton (2015) observed a similar phenomenon whereby system representations of African experts were shaped by professional experience in education policies. Senegalese actors "worked on the same projects, received the same training abroad and worked together in ministerial cabinets or in ministries' central administration" (Charton, 2015, p. 62) (our own translation), thereby cultivating links between them and forming a consensual epistemic community. Studying access to drinking water in Benin and Burkina Faso, Delville (2018) identified a similar pattern. The members of a policy network converted to a political idea in particular because they shared the same professional cultures, resulting from "international prescriptions and fostered by national experiences" (Delville, 2018, p. 70) (our own translation). This phenomenon thus repeated in various African contexts. We would be interested in further research on the ways development cooperation actors — and the policies they promote — facilitate the formation of such epistemic communities throughout the world.

Compared to these works, what was specific to the case of PBF — and what makes our research contribution unique — was that the (local) members of the community did not only promote the policy in their country, but also became the central actors of policy diffusion in sub-Saharan Africa, acting as PBF international experts solicited to support the governments of neighbouring countries. This process has been concurrently identified in studies of the diffusion of *mutuelles de santé*. Authors note an "epistemic community" of mutuality experts, national and international, whose membership or role has evolved over time (agents of the State, agents of cooperation, including *Abt Associates*, external consultants, researchers, etc; Deville et al., 2018, p. 3) (our own translation). As in this example (which does not include in-depth explanations about these actors' motivations and the ways their roles evolved), African DEs' position evolved over time: from simple practitioners involved in the first PBF pilots in Rwanda and Burundi (e.g., as district chief medical officers), they gradually occupied more important positions in their country, and finally got promoted to second-generation DEs, acting as entrepreneurs of the diffusion of PBF on the whole continent. The making of these experts involves all levels of the political hierarchy (from the decentralised to the global level) and transcends borders between public and private actors on the one hand, and decision makers and experts on the other (Delville, 2018). As we showed in Chapter 5, this phenomenon of the making of second-generation DEs must also be considered in all its complexity and nuance: it serves global-level DEs' interests (i.e., their framing of a PBF policy led by African experts), and these global-level DEs are those who, in most cases, validate their legitimacy on the GHG arena (through training and multiple forms of expertise promotion), and who finance their career advancement. In this context, the actual redistribution of power between high-income countries DEs and DEs from LMICs appears to be quite limited.

The idea, promoted by many global-level DEs, that PBF diffusion empowers second-generation DEs', can also be challenged (as we highlighted in Chapter 5). Some of the global-level individual DEs were genuinely concerned with promoting African experts' creative ideas for adapting or enhancing PBF design characteristics (e.g., the SinaHealth coursebook (SinaHealth, 2019) features some of the home-grown ideas and technical instruments to implement PBF and acknowledges the names of those who participated to expand the "best practices" of PBF). Yet, in

electronic exchanges in January 2019 with a European individual DE (upon commenting on my second publication), it became clear that the core fundamentals of PBF had precedence over such local adaptations:

> [Participants of the PBF courses] must first understand the underlying theories and best practices and then try to adapt them as best as possible to the local circumstances. Yet, that also means that there can never be circumstances in which monopolies are acceptable, or that we ignore the private sector, or do away with the importance of competition for contracts, etc. These are simply hard economic laws on how to use scarce resources in an efficient manner. That understanding can sometimes be very painful for those who have to live with the daily reality of mismanagement of the health system in several countries. My experience is also that those who (diplomatically) follow that advice have a bright future and I mentioned the names of some. (I10d_PRIVFP)

Similarly, in chapter 5 we highlighted that "the idea of upholding and advertising a community of local practitioners did not involve going as far as to promote or value local solutions for health systems that the latter could come up with" (Gautier et al., 2020). Promoting a repertoire of practices on PBF that featured "the masters'" own representation systems was perceived as more important than effectively empowering African PBF experts. This view is coherent with findings of a large research on the "delusion of knowledge transfer", which highlights a differentiated valuing of expert knowledge and ideas relative to policy actors' positioning in global governance (Koch and Weingart, 2016). We would be very interested in seeing future research investigating both the second-generation DE making processes and the forms of power emerging from the interaction between global- and national-level DEs in this making.

Although these processes failed to challenge the GHG political economy, global-level DEs' strategy of valuing and going through local intermediaries (i.e., individual experts and Africa-based consulting firms/training companies) to secure key high-level actors' buy-in seemed to yield positive effects in terms of policy diffusion (Gautier et al., 2018b). This reflection suggests that, from the perspective of those actively engaging in policy diffusion, the local political anchoring and the promotion of African practitioners contribute to the diffusion of the policies in a more legitimate way, and possibly more effective, than the simple North-South transfer of policies. Discursively, this legitimation process strategically matches the popular language of Africa's participation in global health policymaking (Barnes et al., 2014). Because such "local-making" is funded by GHG actors, this suggestion may illustrate the "moral resurrection of aid",

which emphasises locally-owned, participatory South-driven processes (Mosse, 2013, pp. 1–2). Future research — including outside the field of global health — should further examine the successful making of DEs acting at the continental and (sub)national levels, and the role(s) played by global-level DEs promoting a given policy in this making.

This phenomenon also matters because we observed a complex outcome of such North-South policy transfer, in terms of government ownership. In the case of Mali, Dutch individual experts' promotion of a scheme design *à la malienne* possibly opened up the opportunity to adapt the policy to Mali's health system decentralised pyramid and involving city/village mayors as well as community-based actors. Their strong reputation among high-level policy actors, also created the opportunity for a genuine political debate on the policy idea — including contestation among MSHP officials as well as among international partners. This discussion may not have happened in countries where a single (major) donor was the only promoter (Chimhutu et al., 2015; Ridde et al., 2017). Building on this, we would be interested in addressing the following question: does the diversity of influential external policy actors pushing for a specific health system reform increase the chances of inspiring a political discussion about how to better adapt this reform to the country's context, thereby enhancing government ownership?

Politicisation and depoliticisation of knowledge

This thesis revealed many issues associated with the (co)production of knowledge, discourse, and expertise of development reforms. To date, only a few global health researchers (e.g., Janes and Corbett, 2009; Storeng and Béhague, 2016) have concurred that "there has been limited attention on how financial resources used to gather evidence may have influenced its creation and presentation" (Hanefeld and Walt, 2015, p. 120). Furthermore, Parkhurst argues that the way policy actors conceive knowledge matters because it reflects their representation systems (Parkhurst, 2016). Intentionally or unintentionally, policy actors often fail to acknowledge how their own underlying assumptions (including, their understanding of causality) and motivations may affect their use and selection of knowledge. It follows that the production and dissemination of knowledge may be partial without actors necessarily realising it (Gautier and Ridde, 2018), or without actors transparently acknowledging it. Other scholars have shown how certain authors

producing evidence on PBF refrain from adequately disclosing their potential conflicts of interest (Turcotte-Tremblay et al., 2016).

All these issues pertain to the politicisation or depoliticisation of knowledge. For scholars, to politicise something is "to render it political […], to bring it in to the realm of contingency[11] and to create the possibility of subjecting it to human purpose and intention" (Hay, 2013, p. 109). On the contrary, depoliticisation encompasses "rhetorical strategies employed by *various* social actors to […] close down the appearance of an issue as being political" (Wood, 2016, p. 524). In the PBF case, diffusion mobilised discourses pertaining to certain assumptions about health service delivery and the functioning of health systems in general. In particular, we identified the prominence of the economic paradigm in DEs' discourse (Gautier et al., 2019a). For example, DEs featured the suggestion, initially advanced by the WHO Commission Macroeconomics and Health, that investing in health brings economic benefits (Waitzkin, 2003). Economic arguments typically feature a strategy of depoliticisation (Wood, 2016). The economic language was also reflected in PBF individual DEs' discourse (as stated in Chapter 4). Organisational DEs also conveyed such economic frames: in several PBF manuals (SinaHealth, 2019; Toonen et al., 2012), healthcare delivery was viewed as a market commodity rather than a public good (Labonté and Gagnon, 2010). The World Bank — a major funder of PBF diffusion — also prominently features this representation of health. In advocating for PBF, DEs thus conveyed such hegemonic discourses, either directly referring to their institution's discourse or strategically matching their discourse to major PBF funders. Thus, in the PBF case, there were both compulsory and productive forms of power associated with the production and dissemination of depoliticised discourses on PBF.

Nay also investigated this complex connection between compulsory and productive forms of power for influential development cooperation actors (Nay, 2014). The author highlighted the large financial investments for knowledge production, made by international financial institutions (such as the World Bank) over the past decade. As of 2011, almost a third of the core budget of the Bank was dedicated to this area (The World Bank, 2011). For an international organisation whose core business is about financial services, this represents an impressive share of budget.

[11] Contingency here refers to the status of being neither true (under every possible type of valuation) nor false.

Nay and Roger also argued that such a large investment serves political purposes: controlling the debates about the relevance of the Bank's development activities (Nay and Roger, 2019). In the 2011 report, the Bank regarded itself as a knowledge bank, taking the simultaneous roles of knowledge "producer" (e.g., through the activities of the Bank's Development Research Group, mostly composed of economists), "customizer", and "connector" (The World Bank, 2011). The *customizer* and *connector* roles are of particular interests for academics interested in investigating the multiple issues associated with evidence-informed policymaking. The first refers to the Bank's "combining a global perspective with deep local knowledge to support countries as they strive to improve the lives of their people […] [and] customizing the results of research in a way that is easily applied to operational work and engagement." (*ibid*., p. 13). The second refers to the Bank's "engagement with global partnerships and in South-South exchanges" and private sector actors. In other words, the Bank aims at connecting knowledge seekers and knowledge providers. This language clearly reflects the "knowledge broker" role (Meyer, 2010), but the Bank does not use this expression in the report, preferring to be referred to a *connector*. A major example of activities illustrating the Bank's connector role is their organisation and/or funding of study tours. To ensure and maximise this activity's transferability, the Bank recently developed its own guide to "design and implement study tours" (Kumar and Watkins, 2017). The possible issues associated with this form of knowledge exchange are discussed below.

The Bank's PBF learning agenda featured these three roles, through the establishment of a trust fund (the HRITF) that translated this agenda into practice. The fund featured specifically the interest of two donors primarily who promoted the PBF policy — thus illustrating their institutional power. First, these donors pushed for the design of a large PBF impact evaluation portfolio (as described below): this enterprise illustrated the *productive* role. Second, the *customizer*'s role was illustrated through the HRITF's "learning-by-doing" mantra, which involved organising multiple workshops on lessons learnt from PBF implementation and evaluation. These activities aimed to inform local implementers and policymakers, and guide them in future policymaking. Third, the coordination of various knowledge exchange platforms (e.g., through RBF Health and its blog) and the funding of multiple study tours across African countries illustrated the Bank's connector's role. The Bank's fostering of South-South knowledge exchange was identified in Basaza et al. (2013)'s investigation of social health insurance

policymaking in Uganda. The authors highlighted how the Bank's decision to fund a study tour to three East Asian Countries, participated to catalysing policy actors' engagement for this policy (Basaza et al., 2013). Outside of HPSR, studying the evolution of Senegalese experts in a changing development cooperation environment, Ségalini also reported on a study tour organised by the Bank to make sure Senegalese actors learnt the best practices for co-managing marine and coastal resources (Ségalini, 2014).

In the case of PBF, the Bank was far from being the only policy actor making strategic use of knowledge activities. Other DEs engaged in building a learning agenda on PBF, via the production and dissemination of structured guides and standards, organising international training sessions, setting up online web platforms (blogs, forums) for exchange of experience on PBF, promoting a coherent repertoire of practices (e.g., the PBF CoP's repertoire). All of these activities suggested an inclination towards controlling the information flows on PBF. As in the case of the diffusion of new public management, a group of elites had controlled and directed the flow of knowledge on this particular reform, thus facilitating consensus (Common, 1998a). Yet, the fact that some DEs were both promoters and producers of scientific and tacit knowledge on PBF posed significant biases as to the validity of the transferred knowledge (see Chapters 4 and 5). Because DEs had certain assumptions about the central role of economics theories (particularly, institutional economics) to understand how health systems work, their discourse possibly featured biases: a confirmation bias, and the cherry-picking of evidence, in particular (Parkhurst, 2016; Gautier and Ridde, 2018). The confirmation bias can be defined as: "the seeking or interpreting of evidence in ways that are partial to existing beliefs, expectations, or a hypothesis in hand" (Nickerson, 1998, p. 175). Cherry-picking of references towards sustaining evidence that make the case for a policy is another example of possible bias. In Chapters 4 and 5, we showed how several African practitioners and high-level public officials were keener on highlighting evidence in favour of PBF. In addition, while the simultaneous creation and valuing of multiple forms of knowledge (practice exchanges, blogs, workshops, online forum, etc.) possibly enhanced social cohesion of the PBF CoP, tensions between powerful expert and less powerful ones (as in Yanow, 2004), and the incomplete questioning of the validity of this expert knowledge somehow tended to undermine the significance of this transnational policy network's contribution to policy learning (see Chapter 5 and Gautier et al., 2020). This particular issue may

have a much broader implication for the political economy of policy diffusion: our findings tend to indicate that, in the presence of successful DEs who are able to largely control the spread of (certain types of) knowledge, the validity of scientific evidence is likely to only play a minor part in the diffusion process. We further address this issue below on page 248.

Other examples of activities spurring politicised policy emulation processes included: study tours to Rwanda and Burundi and the widespread dissemination of a Lancet article established as "proof of concept" (Basinga et al., 2011). Interestingly, other scholars used the same data as that of the seminal Lancet paper, only to draw different conclusions as to the effectiveness of PBF in this country (Ngo et al., 2016). Still, the strategic highlighting of successful PBF experiences, such as Rwanda's, has been used for the purpose of policy emulation. Using Rose's words, Rwanda's success story featured in this Lancet paper initially served as a powerful "symbol" to emulate others (Rose, 1991), before they could go and "see for themselves" the ways PBF was implemented in this country, and draw lessons after attending these study tours. A similar process operated in the case of Rwanda's success story in community-based health insurance (Chemouni, 2016; Lavers, 2019). An informant in Lavers' study on Ethiopia's UHC policy processes enthusiastically said: "Rwanda has already done the pilot for us! We can scale it up straight away in Ethiopia!" (Lavers, 2019). The emulating power of Rwanda's health financing success stories thus goes beyond the PBF case.

The Rwanda example features a form of knowledge politicisation that served the promotion and diffusion of PBF (Gautier and Ridde, 2018). Research on study tours has been growing over the past few years. Increasingly, learning growingly takes the shape of the so-called "study tours" whereby country delegates visit other countries to observe their experience with a global social or health reform (FHI 360, n.d.). One the one hand, so far most HPSR scholars only described study tours yet another form of South-South knowledge exchange featuring the experience of a country with a given policy (Basaza et al., 2013; Hoke et al., 2012; Olu et al., 2017). On the other hand, a few researchers like Montero have critically assessed the many underlying forms of productive and structural power emerging from study tours practice (Montero, 2017). As highlighted in Chapter 4, study tours — which are usually organised and/or funded by major development

cooperation actors — raise controversies, and their actual effects on policy diffusion are difficult to ascertain (Ségalini, 2014).

Three main categories of problems might emerge from the practice of study tours, which all feature forms of knowledge politicisation. First, the processes through which a flagship experience of country X becomes a “success story” worth transferring to countries Y and Z are often highly politicised. Indeed international organisations or NGOs pushing for these stories fail to transparently describe how and why country X experience has been selected. Second, in many instances the very international organisations (e.g., The World Bank or the ILO) are the ones shaping the ways these study tours should be conceived and implemented (Kumar and Watkins, 2017; Steinmann, 2010), thus significantly controlling the forms of social interaction occurring between LMIC policy actors, and most importantly, selecting the knowledge and discourse that may or may not be transferred to visitors. Third, the idea of getting inspiration from policy experience in neighbouring (or not so neighbouring) countries may require a lot of efforts in contextualising. Several informants from Mali and Cameroon asserted that, in the case of PBF, upon receiving feedback from study tour participants, high-level policymakers rose concerns about the relevance of adapting a PBF scheme implemented in a particular governance structure that was at odds with their own. Mali policymakers further argued that, because Rwandan policymakers had previously come to Mali to learn from Mali’s appraised decentralisation health system, they did not see why they should in turn learn from them. Going beyond policy emulation and stimulation, this last comment raises questions about study tours possibly creating situations of competition between LMICs. Additional critical studies should look into the political economy of study tours and the multiple phenomena they contribute to shape.

At the same time, the learning agenda designed by DEs also participated to depoliticising knowledge on PBF. As in Cussó and Gobin (2008), experts who promoted a certain discourse on a policy strategically participated to depoliticising it, i.e., making it the only pragmatic technical option to solve an issue. Debates on PBF (in forums, workshops, etc.) largely focused on its technical features (e.g., verification and counter-verification, principle of separation of functions) and the choice of quantitative and qualitative indicators of performance, rather than the social and political relevance of the device. As in the case of Kenya’s social protection policymaking,

global-level DEs engaged in "depoliticising the policy space" in order to "rende[r] the process technical rather than political, thereby obscuring power relations, conflicts and choices" (Ouma and Adésínà, 2018, p. 7).

In Mali, high-level policy actors and local DEs bought into global-level DEs' technical framing of PBF, which was suggested to foster the implementation of existing policy orientations (e.g., decentralisation, results-based management, and others) (see Chapter 6). Yet as we said earlier, this process did not necessarily feature global-level DEs' hegemony. First, because the main Dutch individual DE (with a long history and experience in the country) made sure to include Mali's systemic characteristics in the proposed *à la malienne* PBF scheme (designed in collaboration with employees of a local firm); and second because they let other organisational DEs debate the scheme (e.g., Cordaid and the World Bank). In a seminal book on development cooperation (Rottenburg, 2009b), Rottenburg's accounts of one of his main protagonists — the development expert Martonosi — recall the Dutch DE's actions in Mali: the author describes how Martonosi criticised the "blueprint approach" for constraining local ownership of the development policy under consideration (Rottenburg, 2009b, p. 196). As in the case of Mali, Martonosi called for a "process approach in which the model can be adapted to local circumstances and local knowledge through participation and project ownership" (*ibid*). Thus, as in Rottenburg (2009b), perhaps this technical framing did not represent "an instrument of hegemony, but rather the only code available for carrying out transcultural negotiations… under postcolonial conditions and the norm of reciprocity[12]" (Rottenburg, 2009b, p. 142). Future studies should look into this phenomenon, which features more nuanced accounts of the social interaction between powerful GHG actors and LMIC policymakers.

In addition, the large impact evaluation portfolio (mostly designed and financed by the World Bank) also prioritised the analysis of some of these indicators, to the detriment of implementation processes or the sustainability of the approach (IOD PARC, 2018). The evaluation method primarily included randomised controlled trials (RCTs). As they have been widely applied to

[12] Rottenburg understands reciprocity in the development cooperation context; i.e. a situation where an exchange happens between partners who do not have fundamental differences in their understanding of the world (even though they may have slightly distinct frames of reference; Rottenburg, 2009b, p. 193). Thus, in the present situation, the technical framing is set as the common basis for understanding each other and cooperating.

assess complex interventions, RCTs have been criticised for their insufficient (internal and external) validity (Bardet and Cussó, 2012; Bédécarrats et al., 2017; Deaton and Cartwright, 2018). Additionally, the selection of the indicators to be evaluated raised the thorny issue of "attribute substitution", which consists in choosing what can be measured (e.g., vaccination coverage rates) instead of examining what could be more significant for societies (e.g., social interactions or underlying structures; Parkhurst, 2016). Furthermore, impact evaluations typically suffer from a representative bias, whereby assumptions are derived from "perception of similarity between a given situation and a prototypical one" (Parkhurst, 2016, p. 383).

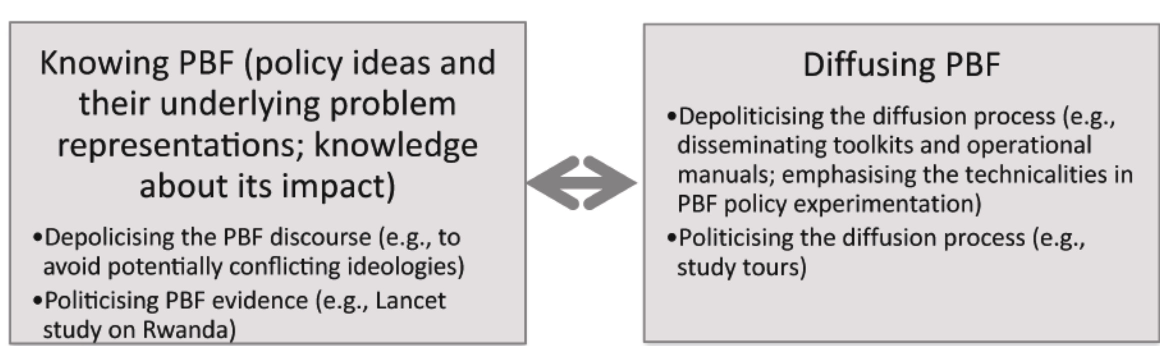
We also noted that LMIC policymakers' decisions to pursue PBF at a larger scale or at the national level were based on political considerations, rather than actual evidence as to whether it worked in the country (Gautier et al., 2019a; Schneider, 2014). Among these political considerations, donors' pressure has been highlighted in previous works (Chimhutu et al., 2015), and we demonstrated in this thesis that donors and individual DEs used their structural and productive power to influence decision-makers. This by no means reflects the sole case of PBF, as similar patterns have been identified in the case of the adoption of user-fee exemption policies (Gautier and Ridde, 2017): decisions were made hastily in the hope to win political elections. It also concurs with a recent publication analysing the scale-up of disease prevention and control policies in LMICs, in which authors assert that decisions to scale-up policies are mainly political (Abimbola et al., 2019), i.e. protecting high-income countries' security interests on the one hand, and safeguarding the rights of HIV-affected people through civil society activism on the other hand. In this case, even though each side had different representations of the problem (i.e., high-income countries perceiving the spread of HIV as a threat to their populations, versus HIV-affected population groups striving to access the best possible treatments to save their lives), these conflicting discourses somehow coalesced into the urgent need to scale-up HIV control and prevention policies in LMICs (*ibid.*).

Building on this discussion about the political use of knowledge, we argue that, beyond simply looking at whether or not policymakers utilise academic evidence, scholars should analyse the multiple biases (including cherry-picking of evidence to sustain arguments, confirmation bias, and attribute substitution as in Parkhurst, 2016) associated with evidence-informed policymaking processes, and the ways these processes contribute to shape academics' research interest. Indeed,

as in Devaux-Spatarakis' works on "experiment-based policy making" in France, there are multiple risks associated with the emphasis on policy impact and short term policy relevance (Devaux-Spatarakis, 2014), including shaping research agendas that exclusively match political demand.

The many ways through which DEs have engaged in depoliticising (i.e., rendering merely technical) and politicising (i.e., serving the particular interests of those who politicise) of PBF and its diffusion process are presented in the figure below (Figure 7.1). The figure features an interactive function whereby processes in one box feed those of the other box.

Figure 7.1 DEs' politicising and depoliticising PBF and its diffusion



Thus, the ways of "knowing PBF" (i.e. left-hand box), as they were led by DEs, bore strategic — therefore political — purposes, that ultimately served policy diffusion. In turn, diffusion processes (e.g., study tours) also contributed to further politicised PBF knowledge and shaping the PBF discourse. Dissemination activities thus represented powerful elements of politicisation. These findings concur with other authors studying social cash transfers diffusion, where they referred to workshops, study tours, and any form of dissemination activity as "weapons" fostering policy ideas (Hickey and Seekings, 2018, p. 15). As emphasised in the fourth chapter, the health insurance literature may also serve as a useful point of comparison for discussing (de)politicisation of knowledge about the policies promoted. The International Labour Organization (ILO) and the *Micro Insurance Academy* published various manuals featuring insurance success stories, and described in detail how to develop and implement insurance schemes in LMICs (Dror and Jambhekar, 2015; International Labour Organization, n.d.). Many international organisations (including ILO and the World Bank) also funded a wide range of

study tours to Rwanda (as we showed above) as well as India and Thailand (Basaza et al., 2013; Lavers, 2019). These study tours played a key role in persuading national policymakers in adopting health insurance schemes that had worked elsewhere. This norm diffusion raises crucial questions about the role of externally-driven learning agendas. In particular, the spread of *mutuelles de santé* in sub-Saharan Africa also generated tensions around the influence of external actors on the adoption of predefined models, for example in Senegal (Alenda-Demoutiez, 2017). Readymade policy schemes (such as PBF or *mutuelles*) targeting UHC as a whole feature top-down policymaking processes in LMICs. Indeed, donors continue to dominate these processes (Boidin, 2018).

This matters because GHG actors, and donors in particular, convey hegemonic economic discourses on UHC: the World Bank has been pushing for (jointly with the Rockefeller Foundation) the "investment case" for UHC. This economic framing of UHC was endorsed by leading economists (Summers, 2015). As long as economic considerations continue to dominate instead of solidarity and public good values (Boidin, 2016), influential institutions (including financial actors) who convey such hegemonic discourse, will remain the privileged actors GSM. They will have the opportunity to continue to draw the contours of UHC policies that replicate this discourse (such as PBF, which focuses on quantitative indicators) and drive the learning agenda around these policies (while making them appear as co-constructed). Transnational public policy research that addresses the flow of ideas in global governance arenas therefore has a bright future ahead of them (Harmer, 2011).

7.4 Final reflections on the PBF debate, the making of PBF discourse, and young scholar self-making

Along the doctoral research process of data collection and analysis, interactions with participants produced several phenomena that transformed my posture as a young researcher.

First, as noted in Chapter 3, I gained in confidence as I was completing data collection with elite informants. I gradually learnt how to take full advantage of the *in situ* the windows of opportunity (i.e., informal interactions in the sidelines of meetings and conferences) that

presented. Two elements played a major role in my ability to approach and recruit informants: first, in this conference, it was much easier to intercept people of interest because they were found outside their usual "arena of power" (i.e., their workplace). Secondly, informants referring me to other elites added to the credibility to my strategy: the fact that I had had initial interviews with informants positioned as "intermediate nodes" of the social network of PBF DEs was decisive in recruiting further informants. This strategy played to my advantage: this sense of trust made many informants feel comfortable with me. They were happy to talk to me about their personal stories, but also to comment and share some "juicy" details on informants that I had previously interviewed. While these details were often trivial, some of them were useful to inform the political economy of global health individuals involved in promoting PBF. These moments also served to relax the atmosphere of the interview. This phenomenon — elite informants easily opening to junior scholars — has been well documented in previous studies (Dexter, 1964; Grek, 2011; Odendahl and Shaw, 2001). In these studies, authors argue that elites feel less comfortable speaking to more senior researchers, because the latter may express more criticism towards elites' ways of doing. In other words, elite informants may perceive that there are less power issues at stake when interacting with junior researchers.

Eventually, I found myself in this PBF network, having gained in confidence, knowledge, and credibility *vis-à-vis* informants. For example, some of the African interviewees specifically asked me if I could connect them to major global-level DEs so as to obtain easy access to job opportunities. The final lesson learnt from this data collection experience is rather ironic: learning on elite interviewing simply reflects the reality of the political economy of GHG: social network and acquisition of knowledge, experiences, reputation, and legitimacy are key elements that typically open up opportunities.

Once introduced in this network, and as I was analysing interview data, I also had to reconsider my posture as young researcher facing the re-emergence of polarised debates on PBF (Ma-Nitu et al., 2018; Paul et al., 2018), in which confronted "anti-PBF" researchers and a "pro-PBF" community who had generously taken the time to answer my interview questions. As I had just completed data collection, I felt that the publication of an article co-authored by my own thesis supervisor and colleagues, which strongly questioned PBF (Paul et al., 2018), put me in an

ethically uncomfortable position. I refused to comment on the debate, saying that my thesis aimed at the critical analysis of the diffusion of PBF (through a political economy analysis), and not of PBF itself, of its blind spots, strengths, and weaknesses. Although I was offered to join the authors of this “anti-PBF manifesto”, I declined because, besides ethical obligations towards my respondents, I disagreed with the approach of publishing an article mixing political advocacy and research. In hindsight, I think this article also reflects an unchanged political economy of GHG. Academics, experts, networks, and institutions based in the North largely continue to control the terms of the global health debate.

My positioning in this debate lies in the present thesis, which does not reflect advocacy (pro- or anti-PBF), but analyses with nuance diffusion processes that feature multiple forms of influences, and many power imbalances among actors. My analyses of interviews highlight, in the end, a rather uniform content: practitioners and promoters alike acknowledged the potential of this approach as well as (at least some of) its weaknesses, during the time of the larger part of my data collection (end of 2016/beginning of 2017). Even respondents employed by the largest donor of PBF — whose diffusion approach is criticised in this thesis in many respects — adopted a rather nuanced discourse. Coincidentally, within the World Bank, staff members publicly voiced some criticism of PBF in blog entries, for instance (Loevinsohn and Nair, 2017). Despite a clear anchoring in economics and new public management theories, something many would connect to neo-liberal approaches (Auroi, 2016; Hufty, 1998), and the underlying belief in the use of metrics to improve health services, PBF had the merit of shedding light on problems (e.g.: ensuring that funds effectively reach the most remote health centers; the complexity of health workers’ motivation etc.; Lohmann et al., 2016) that no one had ever really endeavoured to tackle.

However, no matter what one thinks about PBF, and the problem representations it carries, it is now part of the current practice in many African countries where it has been piloted. The current development of a new PBF project in partnership with multiple international actors in Mali shows that even if it stops for a moment, it is likely to resume. In one single African country (Benin), it failed and disappeared. While the consequences of withdrawal on health provision may be negative, doesn’t this happen every time a new intervention, designed by external actors, is introduced somewhere and disappears (Castellanet, 2003)? The issue of sustainability — which

does require attention — is not specific to PBF (Ma-Nitu et al., 2018). It will probably be called differently (at WHO, and in Burkina Faso, it is described as an entry point for strategic purchasing), but it will always exist in one form or another. In the future, it will likely feature more prominently the shift to output-based financing (e.g., through a case-based payment system, which is already implemented in many European countries).

As we previously highlighted, scientific evidence is mixed as to the effects of PBF, yet the sophisticated study designs chosen to evaluate such a complex policy have not always been relevant (Gautier and Ridde, 2018). The literature is also mixed as to its implementation (McMahon et al., 2018; Renmans et al., 2017b; Ridde et al., 2017; Ssengooba et al., 2012). However, we are lacking thorough analyses of the implementation of a PBF project that is not bound to fail from the outset given the conditions (e.g., lack of effective decentralisation) and circumstances (e.g., very short time for preparing and implementing the scheme) in which it was tested (as in Mali and Burkina Faso). Therefore, there is still much to study about PBF in LMICs, while trying to move past the strongly politicised debates of 2018. Why not attempt to analyse PBF with less passion and more nuance, while remaining attentive to LMICs' own problem representations (provided that these too are not shaped by global DEs) and their contextualised adaptation of PBF?

Chapter 8. Conclusive remarks and ways forward

8.1 Conclusive remarks

This research represents the first political economy analysis of the diffusion of a global health policy — performance-based financing — in sub-Saharan Africa. Building on existing conceptual notions and taxonomies from HPSR and public policy studies, we designed, tested (using empirical literature), and empirically applied a conceptual framework in attempting to uncover policy diffusion in polycentric global health governance. Using a wide corpus of qualitative data, we offer an in-depth exploration of influential policy actors engaging in a wide range of processes (featuring ideas, knowledge, social interaction, and funding), to foster the travel of a health policy (performance-based financing) across the global, continental, and (sub)national levels. These actions were led by influential actors — those we call "diffusion entrepreneurs" — so as to facilitate the expansion of the policy in a particular context: that of polycentric governance. We adapted a powerful poststructural approach to analyse the global-level discourse on performance-based financing (Bacchi's approach "*What is the problem represented to be?*"). We also used innovative tools to analyse the constitutive features and governance structure of a transnational policy network, and integrated these quantitative findings with qualitative data. Lastly, we engaged in various knowledge transfer activities to sustain interactions with informants, colleagues, and researchers.

Besides adopting a comprehensive and innovative conceptual and methodological approach, this thesis makes four major contributions to the health policy and systems research and public policy strands of academic literature. First, we provide a coherent interactive 'bricolage' framework with a substantial analytical potential. Our conceptual framework adapts concepts and insights

from the available theoretical and empirical literature, and brings in new perspectives on conceptualising policy diffusion that feature polycentric global health governance. The framework is adaptable to a variety of research approaches (mixed method designs, longitudinal case study designs, etc.). We call on future research that would adapt, strengthen and continuously improve this framework.
Second, we reflect on the ideational policy research strand in our theoretical and empirical work. This attention was long overdue, since most HPSR scholars had overlooked this research field. Our conceptual framework included two ideational components: DEs' representation systems and how these shape policy framing while accounting for popular political trends (e.g., South-South learning) in order to secure a strong buy-in. In this research, ideational components proved very useful in revealing diffusion entrepreneurs' productive power.

Third, we highlighted the dynamic and complex nature of social interactions between actors of the policy process, who act at various levels of governance. To document social interactions, our framework and analysis prominently featured diffusion entrepreneurs' social resources and policy emulation processes. Our findings shed light on the fact that, in addition to financial (compulsory) power, actors' social resources and their ability to foster the phenomenon of policy emulation were other major enablers of policy diffusion.

Fourth, our research emphasised the strategic positioning of powerful organisations, networks and individuals — consultants, researchers, and so on — in the (co)production and circulation of knowledge and policies in global health and in development aid more generally. Indeed, while continuously pulling the strings, these powerful players successfully framed both the PBF policy and its diffusion as being Africa-owned and Africa-led. Such strategic positioning gave birth to the complex phenomenon of "second generation diffusion entrepreneurs", who represent African experts being empowered (by dominant actors) to become the key players of policy diffusion in multiple settings. By underlining the coevolution, social interactions, and complex relationships between European and African diffusion entrepreneurs, we were able to offer useful insights on the making of this African expertise.

Building on this, we depicted a nuanced portrait of European diffusion entrepreneurs, who despite laudable intentions to challenge the "capture" of the global health agenda by the most powerful global health governance organisations, failed to engender major shifts in power dependencies for African experts. Indeed, as long as funding and career advancement will be shaped and controlled by donors and the dominating organisations, it will be difficult to alter the status quo. This reflection applies to global health practice, but it also connects with global health research. In the sections below, we offer possible areas of research based on our findings, and we share our perspective on the future of global health policy diffusion and health policy and systems research fields.

8.2 Future areas of research

Based on knowledge gaps identified in Chapter 7, we suggest three core ideas of future research areas for scholars working at the intersection of HPSR and policy diffusion, and more broadly those who have an interest for the political economy of global governance.

First, our research suggests an ambitious research agenda on the *making of African experts*. We call on scholars to deepen the investigation of the empirical phenomenon of the *making of African experts*, especially by looking at the complex social interactions between those who empower and those who get empowered — and what are the gains at stake for both groups. This research endeavour could lead to study more broadly the claims of an increasing "inclusiveness" thanks to polycentric governance: analyses of the many implications of transnational networks and experts' growing influence for global and national policymaking would be timely. In particular, looking at what "inclusiveness" encompasses would be essential: it would be inappropriate to claim that African experts (most of them being national elite members) legitimately represent the interests of African populations in general.

Second, since the case of performance-based financing diffusion provided evidence that private sector frames increasingly orient the global health discourse, future studies are needed on the involvement of private sector actors in global health policy diffusion, especially when these

actors are for-profit companies. More specifically, we would be interested in investigations of the role(s) played by European, North American, as well as African consulting companies in the diffusion of global health policies, especially their interactions among them, and with government actors. To this end, performance-based financing (PBF) would represent an extremely relevant empirical case: a large array of consulting companies significantly invested the market of pilot scheme implementation.

Third, this political economy analysis of PBF diffusion evidenced the ways through which multiple forms of power operated in diffusion entrepreneurs' endeavour to shape and foster policy diffusion. However, further in-depth analysis of ideational forms of power — i.e., structural and productive power — in the context of global governance would be key to unravel the (discursive) influence operating between strongly dominant (e.g., donors), less dominant (e.g., North American experts), and their local partners in LMICs. In particular, it would be interesting to invest more research on global development discourse analysis, and comparing how discourses may evolve from the global to the national levels.

8.3 Reflections on the future of (global health) policy diffusion and health policy and systems research

Given the lack of studies on the phenomenon of polycentrism, and its effects on the political economy of (more or less powerful) global health governance actors, documenting the dynamic and interconnected processes of policy diffusion, remains essential. In early March 2019, the publication of a conceptual paper assessing the interactions between knowledge translation and global health governance and featuring polycentrism illustrates that the time is ripe for expanding the conceptual and empirical literature on these aspects.

However, we argue that paying lip service to the sustained power imbalance between high-income country actors dominating global health governance, and low- and middle-income country actors will not suffice to advance the literature in meaningful and adequate ways. In particular, global health scholars should be mindful to developing categories that avoid

reproducing such power imbalance or entrench actors in immutable positions. Professional and research experiences (including ethnography) in major global health international organisations should help raise awareness among future researchers, especially those interested in health policy analysis in polycentric global health governance (i.e., not only studying policy processes at the national level).

If it continues to emphasise health systems and policymaking at the national level in LMICs, the future of the health policy and systems research (HPSR) field will have to reinvent itself, featuring the #decoloniseHPSR topic much more prominently. Critically, it will have to spark LMICs' ownership of the research agenda. This will involve valuing much more prominently home-grown concepts, knowledge, and analytical lenses to study LMICs' health systems issues and complexity. This will require questioning Western-centric research standards and academic career ladders. The United Kingdom's National Institute for Health Research's recent initiative to establish equitable research partnerships between British and LMIC researchers represents an important step. However, as long as funding will be managed from donors' countries, such research partnerships will likely continue to reproduce inequalities.

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Appendices

Appendix A. Certificates of ethical approval

MINISTERE DE LA SANTE
ET DE L'HYGIENE PUBLIQUE
-=-=-=-=-=-=-
INSTITUT NATIONAL DE RECHERCHE
EN SANTE PUBLIQUE (INRSP)
BP 1771 / Tel 20 21 43 20/20 21 42 31
-=-=-=-=-=-=-
COMITE D'ETHIQUE DE L'INRSP
BP 1771/ Tél : 66 78 11 13 / 76 18 72 60
- Bamako
-=-=-=-=-=-

REPUBLIQUE DU MALI
Un Peuple – Un But – Une Foi
-=-=-=-=-=-=-

DECISION N° 24/2015 /CE-INRSP

LE PRESIDENT DU COMITE D'ETHIQUE DE L'INSTITUT NATIONAL DE RECHERCHE EN SANTE PUBLIQUE (INRSP)

Vu l'arrêté n°2013-1223/MS-SG du 03 avril 2013 portant nomination des membres du Comité d'Ethique de l'Institut National de Recherche en Santé Publique (INRSP) ;

Vu les recommandations issues de sa session ordinaire du 09 septembre 2015 relative à l'examen de **«Financement basé sur les résultats en santé maternelle et infantile et l'équité au Mali et au Burkina Faso» ;**

Vu les corrections apportées audit protocole conformément aux recommandations formulées par les membres.

DECIDE

Article 1er/ : Le protocole intitulé **«Financement basé sur les résultats en santé maternelle et infantile et l'équité au Mali et au Burkina Faso»** jugé conforme à l'éthique et aux droits humains, est approuvé par le comité d'éthique de l'Institut National de Recherche en Santé Publique (INRSP).

Article 2/ : Toute modification intervenant dans l'exécution dudit Protocole est portée à la connaissance du Comité d'Ethique de l'INRSP dans un délai maximum de quinze (15) jours.

Article 3/ : La présente décision valable pour toute la durée de l'étude, sera enregistrée et communiquée partout où besoin sera.

Bamako, le 17-09-2015

P/LE PRESIDENT DU COMITE D'ETHIQUE/P.O
LA VICE-PRESIDENTE

Ampliations :
Présidente/CE 1
Archives/CE............................1
Miseli................................ 1

INSTITUT NATIONAL DE RECHERCHE EN SANTE PUBLIQUE (I.N.R.S.P) Comité d'Ethique LE PRESIDENT

Madame SIDIBE Diaba CAMARA

MINISTERE DE LA SANTE
ET DE L'HYGIENE PUBLIQUE
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INSTITUT NATIONAL DE RECHERCHE
EN SANTE PUBLIQUE (INRSP)
BP 1771 / Tel 20 21 43 20/20 21 42 31
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COMITE D'ETHIQUE DE L'INRSP
BP 1771/ Tél : 66 76 63 37 / 76 18 72 60
- Bamako
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REPUBLIQUE DU MALI
Un Peuple – Un But – Une Foi
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DECISION N° 17/2016 /CE-INRSP

LE PRESIDENT DU COMITE D'ETHIQUE DE L'INRSP

Vu l'arrêté n°2013-1223/MS-SG du 03 avril 2013 portant nomination des membres du Comité d'Ethique de l'Institut National de Recherche en Santé Publique (INRSP) ;

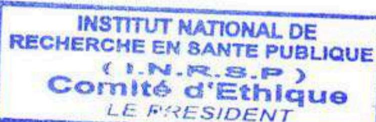
Vu la décision n°024/2015/CE-INRSP du 17 septembre 2015 relative à l'approbation du comité d'éthique ;

Vu la lettre n° L_081/MSL/2016 du 09 septembre 2016 formulée par la présidente de **MISELI** sollicitant un amendement au protocole de recherche intitulé **"Financement basé sur les résultats en santé maternelle et infantile et équité au Mali et au Burkina Faso"**, pour prendre en charge les sujets de recherche de deux (2) étudiantes inscrites à l'Université de Montréal au Canada dont les titres respectifs sont : Lara Gautier : ***"Des idées à la décision : une exploration de processus de légitimation du financement basé sur les résultats aux niveaux international, continental et national"*** et Dukuze Muziranenge Marie-Aline Brigitte : ***"Exploration des facteurs qui influencent la mise en œuvre des méthodes de sélection des ménages bénéficiaires de programmes de filets sociaux au Mali".***

Le comité d'éthique donne son avis favorable, tout en insistant sur la poursuite de l'application des recommandations de base édictées le 09 septembre 2015.

La présente décision valable pour toute la durée de la recherche, sera enregistrée et communiquée partout où besoin sera.

Bamako, le 30 septembre 2016
P/LE PRESIDENT DU COMITE D'ETHIQUE, PI
LA VICE-PRESIDENTE



Madame SIDIBE DIABA CAMARA

Ampliations :

Président /CE............	1
Archives/CE..............	1
Miseli.......................	1
Intéressées................	2

Université
de Montréal
Comité d'éthique de la recherche en santé

28 novembre 2016

Objet: Approbation éthique - « Des idées à la décision: Une exploration des processus de légitimation du financement basé sur la performance au Mali aux niveaux international, continental et national »

Mme Lara Gautier,

Le Comité d'éthique de la recherche en santé (CERES) a étudié le projet de recherche susmentionné et a délivré le certificat d'éthique demandé suite à la satisfaction des exigences précédemment émises. Vous trouverez ci-joint une copie numérisée de votre certificat; copie également envoyée à votre directeur/directrice de recherche et à la technicienne en gestion de dossiers étudiants (TGDE) de votre département.

Notez qu'il y apparaît une mention relative à un suivi annuel et que le certificat comporte une date de fin de validité. En effet, afin de répondre aux exigences éthiques en vigueur au Canada et à l'Université de Montréal, nous devons exercer un suivi annuel auprès des chercheurs et étudiants-chercheurs.

De manière à rendre ce processus le plus simple possible et afin d'en tirer pour tous le plus grand profit, nous avons élaboré un court questionnaire qui vous permettra à la fois de satisfaire aux exigences du suivi et de nous faire part de vos commentaires et de vos besoins en matière d'éthique en cours de recherche. Ce questionnaire de suivi devra être rempli annuellement jusqu'à la fin du projet et pourra nous être retourné par courriel. La validité de l'approbation éthique est conditionnelle à ce suivi. Sur réception du dernier rapport de suivi en fin de projet, votre dossier sera clos.

Il est entendu que cela ne modifie en rien l'obligation pour le chercheur, tel qu'indiqué sur le certificat d'éthique, de signaler au CERES tout incident grave dès qu'il survient ou de lui faire part de tout changement anticipé au protocole de recherche.

Nous vous prions d'agréer, Madame, l'expression de nos sentiments les meilleurs,

Dominique Langelier, présidente
Comité d'éthique de la recherche en santé (CERES)
Université de Montréal

DL/GP/gp
c.c. Gestion des certificats, BRDV
Valéry Ridde, professeur agrégé, École de santé publique - Département de médecine sociale et préventive
Manuela de Allegri, professeure, Institute of public health
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N° de certificat
16-153-CERES-D

Comité d'éthique de la recherche en santé

CERTIFICAT D'APPROBATION ÉTHIQUE

Le Comité d'éthique de la recherche en santé {CERES}, selon les procédures en vigueur, en vertu des documents qui lui ont été fournis, a examiné le projet de recherche suivant et conclu qu'il respecte les règles d'éthique énoncées dans la Politique sur la recherche avec des êtres humains *de l'Université de Montréal.*

Projet

Titre du projet	**Des idées à la décision: Une exploration des processus de légitimation du financement basé sur la performance au Mali aux niveaux international, continental et national**
Étudiante requérante	**Lara Gautier** (ND), Candidate au Ph. D. en santé publique (option santé mondiale), École de santé publique - Département de médecine sociale et réventive
Sous la direction de	Valéry Ridde, professeur agrégé, École de santé publique - Département de médecine sociale et préventive, Université de Montréal & Manuela de Allegri, professeure, Institute of public health, University of Heidelberg.

Financement

Organisme	FRQ - SC
Programme	Bourse de doctorat
Titre de l'octroi si différent	
Numéro d'octroi	200590
Chercheur principal	
No de corn te	

MODALITÉS D'APPLICATION

Tout changement anticipé au protocole de recherche doit être communiqué au CERES qui en évaluera l'impact au chapitre de l'éthique.

Toute interruption prématurée du projet ou tout incident grave doit être immédiatement signalé au CERES

Selon les règles universitaires en vigueur, un suivi annuel est minimalement exigé pour maintenir la validité de la présente approbation éthique, et ce, jusqu'à la fin du projet. Le questionnaire de suivi est d' onible sur la page web du CERES.

Domimque Langelie présidente
Comité d'éthique de a recherche en santé
Université de Montréal

28 novembre 2016
Date de délivrance

1er janvier 2019
Date de fin de validité

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Appendix B. Overview of the 41 policy documents included in this doctoral research

Documents description	Publication year
Chapter 4 – Diffusion of PBF at the global level (N=5)	
Performance-Based Financing Handbook, Management Sciences for Health (MSH) and USAID (2011)	2011
Royal Institute of Tropical Medicine (KIT) booklet	2011
The World Bank's Performance-based financing Toolkit	2014
Cordaid position paper	2015
SinaHealth coursebook (version regularly updated since 2014)	2019
Chapter 5 – Diffusion of PBF at the continental level (N=17)	
Concept Note "Managing Knowledge on Performance-Based Financing in sub-Saharan Africa. A vision for our community of practice", by Bruno Meessen and core group	2010
Blog post "Looking for Explanations", by Lindsay Morgan (*Dispatches: Stories about the development business*)	2010
Blog post "Value for Money in the health sector: not just a donor agenda", by Bruno Meessen (*Health Financing Africa: Le Blog*)	2011
Meeting report "Performance-Based Financing Community of Practice in Africa, Conference West Africa, 18 & 19 March 2011, Sally", by PBF CoP facilitators' team	2011
Blog post "An online debate on "Performance-based financing in low- and middle-income countries: still more questions than answers"", by Bruno Meessen (*Health Financing Africa: Le Blog*)	2012
Blog post "Newton's apple", by Bruno Meessen (*Health Financing Africa: Le Blog*)	2012
Blog post "Launch of a Working Group on "PBF and Equity", by Alex Ergo (*Health Financing Africa: Le Blog*)	2012
Blog post "Best wishes for 2013", by Bruno Meessen (*Health Financing Africa: Le Blog*)	2013
Blog post "Financement basé sur la Performance : compte rendu d'une conférence académique à l'Institut de Médecine Tropicale d'Anvers", by Serge Mayaka (*Health Financing Africa: Le Blog*)	2013
Blog post "Fighting input dragons: a Royal decoration for Robert Soeters", by Gyuri Fritsche (*Health Financing Africa: Le Blog*)	2013
Blog post "Results Based Financing: a new policy instrument for African governments", by Bruno Meessen (*Health Financing Africa: Le Blog*)	2013
Blog post "The Performance Based Financing Community of Practice welcomes its 1000th member", by Bruno Meessen (*Health Financing Africa: Le Blog*)	2013
Meeting report "The PBF workshop in Bergen: impressions and observations from a junior researcher", by Keovathanak Khim	2013
Blog post "Communities of Practice: A review of the year 2014", by Bruno Meessen (*Health Financing Africa: Le Blog*)	2014
Blog post "The PBF Toolkit: a neat contribution to the science of delivery", an interview of Gyuri Fritsche by Isidore Sieleunou (*Health Financing Africa:*	2014

Le Blog)	
Blog post "Health Financing in Africa - le Blog: 2014 in a glance", by Bruno Meessen (*Health Financing Africa: Le Blog*)	2015
Blog post "The Performance Based Financing Community of Practice : five years already !", by Bruno Meessen (*Health Financing Africa: Le Blog*)	2015
Chapter 6 – Diffusion of PBF in Mali (N=19)	
KIT strategic planning for PBF in Mali	2010
Participants' report on the study tour in Rwanda, submitted to the MHSP (2010)	2010
KIT background document on Results-Based Financing in healthcare and the Mali & Ghana experiences	2012
KIT-SNV Manual for PBF pilot scheme in Mali	2013
KIT-Cordaid-CGIC Manual for PBF pilot scheme in Mali	2016
Mali's Health and Social development plan, 2014-2018	2013
KIT's final report on the PBF first pilot scheme in Mali	2014
Policy brief on PBF in Mali	2016
Participants' report on the international training course attended in Benin, submitted to the MHSP	2016
KIT-Cordaid-CGIC Consortium's application package submitted to the World Bank in Mali	2016
KIT-Cordaid-CGIC Consortium's final report of the PBF second pilot project in Mali	2017
KIT-Cordaid-CGIC Consortium's capitalisation report	2017
KIT-CGIC promotional leaflet about PBF in Mali	2017
World Bank's report upon the completion of second pilot project	2017
MHSP meeting minutes about pursuing PBF in KR	2017
Policy brief on the effects on key health indicators of the first pilot project	2017
3 policy briefs assessing the implementation of the second pilot project	2018

Appendix C: Framework dimensions approaches and empirical analysis correspondence

Public policy concepts	Items analysed empirically
Representation systems and motivations to support the policy	
Focuses on intentions, ideologies, and beliefs of the policy participants as reasons for policy promotion	Cultural and training background Professional experience Dominant ideologies
Policy actors' resources and types of authority	
Focuses on social, temporal, material, knowledge, expert resources; and scientific, expert, financial, moral types of authority	Perceived power of policy actors Distribution of power across policy actors and among individuals Perceived expertise, reputation, and financial authority and how these feature compulsory, institutional, structural, productive types of power Pooling of resources and types of authority
Policy framing	
Discourse mobilisation to describe the policy	Strategic linkage to existing political orientations / objectives Reference to recent political orientations or popular global political trends
Policy emulation	
Focuses on relationships and interactions between diffusion entrepreneurs	Formal and informal social interactions between actors working together or participating together to social interactions activities related to the policy, and phenomena emerging from these interactions Network formation and cohesion
Policy learning	
Focuses on the roles played by knowledge (production & dissemination) in policy advocacy	Types of knowledge-based resources produced Types of knowledge dissemination Evidence-informed policymaking
Policy experimentation	
Focuses on rule following within a national context, i.e. arenas within which policy-making takes place (political arenas, donors' meetings…)	Coverage and duration of policy experimentation Political/administrative support/opposition Donors' support/opposition Communications between implementers, donors, and government actors

Appendix D. Recruitment template cover messages

<u>Template nb 1.</u>

Dear XX,

I am a PhD student enrolled in a joint degree between Montreal and Paris. My research is about health financing policymaking at the international, continental, and national levels. I am particularly interested in performance-based financing (PBF) in Africa. I am investigating the adoption of the PBF policy at the international, continental and national levels (in Mali), paying specific attention to policy processes – e.g., how the PBF idea emerged and how it galvanised key actors' interests. For more details, please find the synopsis of my research project attached.

Last January, I have talked to key stakeholders engaged in PBF in Bamako. I am starting to interview key stakeholders involved in PBF at the international level, in particular those involved on the African continent. I already engaged in discussions with members of the PBF Community of Practice's facilitator.

At this stage of my research, I am keen to interview with international organisations' staff members who are involved in developing PBF knowledge and resources, as well as implementing PBF pilot schemes in sub-Saharan Africa. Given your position and expertise as XX at the XX, it would be valuable to my project to speak with you about your experience of PBF.

Therefore, I would like to know if you would be available for an interview in person, during Conference XX.

If you agree to participate, we could arrange the interview at a time and place that would be most convenient to you. If you are unavailable on that occasion, we can also organise a Skype interview later on.

Looking forward to hearing from you,

Kind regards,

Lara Gautier

PhD Candidate in Global Health and Economics
School of Public Health, University of Montreal
CESSMA - Centre d'Etudes en Sciences Sociales sur les Mondes Africains, Américains et Asiatiques, Paris Diderot University-Paris 7
Tel (CA): (1) XXX-XXX-XXXX
Tel (FR): (33) X-XX-XX-XX-XX
http://www.theses.fr/en/s134742

Template nb 2.

Cher Dr XX,

Je me permets de vous contacter afin de pouvoir entamer une conversation avec vous sur la diffusion de la stratégie de financement basé sur les résultats (FBR) en Afrique.

Je suis doctorante en cotutelle internationale de thèse entre l'Université Paris-Diderot (sciences économiques) et l'Université de Montréal (santé publique). Je réalise ma thèse sur la diffusion de la politique de FBR en Afrique, à travers l'exploration d'une variété de processus agissant à la fois aux niveaux international, continental et national (en prenant pour étude de cas le Mali). Vous trouverez le résumé de mon projet de thèse en pièce-jointe.

Je suis actuellement au Mali pour une période de deux mois et demi. Avant de venir ici, j'ai interviewé plusieurs personnes ressources clés sur le FBR, y compris XX, XX, et XX – des personnes que vous connaissez certainement.

Compte tenu de votre expertise du FBR au [pays] et du rôle que vous jouez en tant qu'Assistant Contrôleur dans le district de XX dans le cadre du Projet de Renforcement de la Santé de la Reproduction (PRSR), votre contribution à mes recherches serait particulièrement valable. J'aimerais notamment vous interroger sur l'expérience du [pays] et son rôle dans la diffusion du FBR en Afrique.

Si vous êtes d'accord, et si vous avez des disponibilités dans les semaines à venir, je serais honorée de pouvoir vous rencontrer pour un entretien, à [ville] le jour où vous serez disponible, ou bien à l'occasion d'un prochain atelier sur le FBR qui se tiendra à Bamako.

Je me tiens à votre disposition pour tout renseignement complémentaire, et vous prie d'agréer, Dr XX, l'expression de mes sincères salutations.

Lara Gautier

Doctorante en cotutelle internationale de thèse
CESSMA/IRD, Université Paris Diderot-Paris 7 | Ecole de Santé Publique de l'Université de Montréal
Tel (MALI) : +223 XX XX XX XX
Tel (FR) : +33 XX XX XX XX
Tel (CAN) : +1 XXX XXX XXXX
http://www.cessma.univ-paris-diderot.fr/spip.php?article445

Appendix E. Information and Consent Form for recruiting English-speaking informants

Information and Consent Form
Individual interviews

Analysing the diffusion of performance-based financing in African countries

Principal investigator **Lara Gautier**
PhD Student, University of Montreal
Tel: +1 XXX XXX XXXX

You are invited to participate in an interview. Before agreeing to participate, the Principal investigator will read this document to you or you will be invited by her to read it thoroughly. This document presents the background of this project and the conditions of your participation. Feel free to ask the Principal investigator any questions.

Brief description of research project

I am Lara Gautier, a PhD student at Université de Montreal in Canada and Université Paris-Diderot in France. The aim of this research project is to learn about the processes that led to PBF policymaking. This doctoral project is supervised by the following senior researchers :

- Dr Valéry Ridde, Associate Professor, Department of Social and Preventive Medicine, University of Montreal, Québec, Canada
- Dr Isabelle Guérin, Associate Professor, *Centre d'Etudes en Sciences Sociales sur les Mondes Africains, Américains et Asiatiques* and *Institut de Recherche pour le Développement*, University Paris Diderot-Paris 7, France
- Dr Manuela De Allegri, Associate Professor, Institute or Public Health, Heidelberg University, Germany

Ethical clearance from *Institut National de Recherche en Santé Publique*'s Ethical Committee in Mali (17/2016/CE-INRSP) and from University of Montreal's *Comité d'éthique de la recherche en santé* (Certificate 16-153-CERES-D) was obtained in September 2016 and November 2016, respectively.

This doctoral project is part of a larger research evaluation program on "Results-based financing for equitable access to maternal and child health care in Mali and Burkina Faso". This program is run by a consortium of Mali- and Burkina Faso-based research NGOs and researchers from the University of Montreal. In Mali, this team is composed of researchers and research assistants of the NGO « MISELI » led by Dr Laurence Touré, who is also the Principal investigator of the program (see below for contact details). The program is part of the Innovating for Maternal and Child Health in Africa Initiative, a seven year, $CA36 million

multi-donor partnership funded by Global Affairs Canada, the Canadian Institutes of Health Research, and Canada's International Development Research Centre.

I have asked to interview you, because you are a key person with knowledge and insight regarding the emergence of PBF as a global health policy and I am interested in learning your opinions and personal experience regarding the PBF policy.

Participation characteristics

In total, between 40 and 50 participants will be invited to participate to an individual interview. Each interview will typically last between 40 and 60 minutes. The majority of interviews will take place in person. However, depending on participants' availability and their geographic proximity to the Principal investigator, part of the interviews will be done by phone or via Skype.

Results' dissemination

Preliminary results from individual interviews will be shared with all participants at the global and continental levels in a report that will be sent by email. Each participant will be invited to comment the report. Dissemination workshops will be organised with participants based in Mali.

Final results will be used to develop a framework on global health policymaking. We will also publish the results in a scientific journal, and disseminate them in workshops on the African continent and in international scientific conferences.

Confidentiality aspects

In order to preserve confidentiality, all names and location data collected in this study will be replaced by a code. Security measures will be taken to ensure confidentiality is preserved at each step (data collection, analysis, storage). Only the Principal investigator (Lara Gautier) will have access to identificatory data Lara Gautier's three research supervisors and the researchers affiliated to the MISELI NGO will have access to interview transcripts only after any identificatory detail has been removed.

Data will be saved for a period of seven years, after which any collected data will be destroyed.

What are the benefits and risks of your participation?

The interview will be organized in place and time that are most convenient to you. The conversation will be friendly and flexible to make it easy for you.

There are no physical risks associated with this research.
However, there might be other types of risks. The questions that will be asked to you address the topic of policymaking processes, which at times may trigger some discomfort. If you feel uncomfortable in speaking about your experience and/or touching upon a specific subject related to this research, please do not hesitate to inform the interviewer about your discomfort. You may also withdraw from the research at any time.

uncomfortable in speaking about your experience and/or touching upon a specific subject related to this research, please do not hesitate to inform the interviewer about your discomfort. You may also withdraw from the research at any time.

Please remember that there are no 'right' or 'wrong' answers to the questions that will be asked to you. The investigator will not judge your answers.

Voluntary participation and right of withdrawal

You are free to accept or refuse to participate in this research project. You can withdraw from the study at any time, without giving a reason. You simply have to notify the contact person of the research team by simple verbal notice. If you decide to refuse to participate or to withdraw, you will not loose any benefit to which you are entitled. You may also inform the Principal investigator about how to proceed with the data she collected with you: you may ask her to keep it or to destroy it. If you are an employee, your participation, refusal to participate or withdrawal will not will not result in any consequences for your employment.

Responsibility of the investigator

By agreeing to participate in this study, you do not waive any of your rights nor release the interviewer of her civil and professional responsibilities.

Resource persons

If you have questions about the research project, please contact:
Lara Gautier, PhD Student at University of Montreal
Tel: (+1) Email:
Alternatively, you may also contact:
Laurence Touré, MISELI, ilot 17, cité el-Farako, Bamako BP E5448
Tel : (+223) Email :

For any concerns about your rights or responsibilities of researchers regarding your participation in this project, you may contact the secretary of the *Institut National de Recherche en Santé Publique*'s Ethical Committee in Mali, Ms Kamissa DIAKITE.
Tel: (+223) XX XX XX XX or (+223) XX XX XX XX Email:
She speaks French and English and takes calls from 9h to 17h (local time: UTC).

Any complaints about this research can be addressed to her and will be forwarded to the ethical advisor at University of Montreal's Comité d'éthique de la recherche en santé.

Statement of Consent by the participant

I understand that I can take my time to think before giving my consent or not to participate in research.

I can ask questions to the interviewer and demand satisfactory answers.

I understand that by participating in this research project, I do not waive any of my rights nor release the interviewer from her responsibilities.

I have read this information and consent form and agree to participate in the research project.

______________________________	______________________________
First and last name of the participant (in capital letters)	Signature of participant
	Date: ______________________

Statement by the interviewer

I explained the conditions of participation in the research project to the participant. I answered to the best of my knowledge to questions and made sure that the participant had a complete understanding of the consent implications. I hereby agree to respect what was agreed to in this information and consent form.

LARA GAUTIER	______________________________
First and last name of the researcher (in capital letters)	Signature of researcher
	Date: ______________________

Appendix F. Formulaire d'information et de consentement pour les participants francophones

Formulaire d'information et de consentement
Entrevues individuelles

Analyse de la diffusion de la politique de Financement Basé sur les Résultats au Mali

Chercheure principale : **Lara Gautier**
Université de Montréal
Tel: XXX
Email : XXX

Je m'appelle Lara Gautier, je suis étudiante au doctorat à l'Université de Montréal au Canada et à l'Université Paris-Diderot en France.
Vous êtes invité à participer à une entrevue individuelle. Avant d'accepter d'y participer, veuillez prendre le temps de lire ou de vous faire lire ce document présentant les conditions de participation au projet. N'hésitez pas à poser toutes les questions que vous jugerez utiles pendant la présentation de ce document.

Brève présentation du projet de recherche

Le but de ce projet de recherche est de mieux connaître les processus qui ont mené au développement de la politique de FBR au Mali. Ce projet doctoral, dont je suis la Chercheure principale, est encadré par une équipe de supervision composée des personnes suivantes :

- Dr Valéry Ridde, Professeur agrégé, Département de Médecine Sociale et Préventive, Université de Montréal, Québec, Canada
- Dr Isabelle Guérin, Directrice de recherche, Centre d'Etudes en Sciences Sociales sur les Mondes Africains, Américains et Asiatiques et Institut de Recherche pour le Développement, Université Paris Diderot-Paris 7, France
- Dr Manuela De Allegri, Professeure agrégée, Institute or Public Health, Heidelberg University, Germany

L'approbation éthique de ce projet de recherche a été obtenue auprès du Comité d'Ethique de l'Institut National de Recherche en Santé Publique du Mali en Septembre 2016 (Décision n°17/2016/CE-INRSP), et auprès du Comité d'éthique de la recherche en santé de l'Université de Montréal en Novembre 2016 (Certificat n°16-153-CERES-D).

Cette étude fait partie d'un programme de recherche plus large intitulé : « Financement basé sur les résultats en santé maternelle et infantile et l'équité au Mali et Burkina Faso». Ce programme est mis en œuvre par une équipe composée d'ONG basées au Mali et au Burkina Faso, et de chercheurs de l'Université de Montréal. Au Mali, cette équipe est composée des chercheurs et assistants de recherche de l'ONG MISELI dirigée par le Dr Laurence Touré, qui aussi la Chercheure principale du programme (voir contact ci-dessous). Ce programme s'inscrit dans le cadre de l'initiative Innovation pour la santé des mères et des enfants d'Afrique, un projet de 36 millions de dollars canadiens sur sept ans, financé par plusieurs bailleurs de fonds dont Affaires mondiales Canada, les Instituts de recherche en santé du Canada et le Centre de recherches pour le développement international.

J'ai demandé à vous poser quelques questions parce que vous êtes une personne ressource en ce qui concerne l'émergence du FBR comme politique nationale de santé et je souhaite connaître vos opinions et expériences personnelles concernant la politique de FBR.

Nature de la participation

Au total, entre 40 et 50 participants seront invités à participer à une entrevue individuelle. Celle-ci aura une durée moyenne de 40 à 60 minutes. La majorité des entrevues auront lieu en personne. Cependant, dépendamment de la disponibilité des participants et de leur proximité géographique vis-à-vis de la Chercheure principale, une partie des entrevues se fera par téléphone ou via Skype.

Retour des résultats

Les résultats préliminaires de ces entretiens seront partagés avec les participants aux niveaux continental et international sous la forme d'un rapport écrit transmis par courriel. Chaque participant pourra commenter ce rapport. Des séances de restitution de résultats seront organisées avec les participants basés au Mali. Les résultats finaux seront utilisés afin de développer un cadre conceptuel sur le processus décisionnel en santé mondiale. Enfin, les données feront l'objet d'une publication dans une revue scientifique et de diffusion dans des ateliers et conférences scientifiques de niveau international et sur le continent africain.

Confidentialité des données

Vos informations seront rendues anonymes afin de préserver leur confidentialité. L'accès aux données audio et électroniques brutes sera limité à ma seule personne. L'équipe de supervision de l'étudiante et les chercheurs de l'ONG MISELI auront accès aux transcriptions des entrevues dont toutes les données identificatoires auront été préalablement effacées.

Des mesures de sécurité seront prises pour assurer l'anonymat des participants à chaque étape (collecte de données, analyse, stockage). Les données collectées seront conservées pendant une période de sept ans avant d'être détruites.

Avantages et risques liés à la participation

L'entrevue sera organisée en temps et lieu décidés par vous, selon vos disponibilités et contraintes personnelles. La conversation est conçue pour se dérouler de façon agréable et flexible.

Il n'y a pas de risques physiques associés à cette recherche. Cependant, il pourrait y avoir d'autres types de risques. Les questions qui seront posées abordent les différents processus d'élaboration d'une politique : en parler peut parfois déclencher un certain inconfort. Si vous vous sentez mal à l'aise en parlant de votre expérience du processus d'élaboration de la politique, n'hésitez pas à informer la personne interrogée en mentionnant votre inconfort. Vous pouvez également vous retirer de la recherche à tout moment.

Veuillez considérer qu'il n'y a pas de «bonnes» ou «mauvaises» réponses aux questions qui vous seront posées. L'enquêtrice ne jugera pas vos réponses.

Participation volontaire et droit de retrait

Vous êtes libre d'accepter ou de refuser de participer à ce projet de recherche. Vous êtes également libre de vous retirer de cette étude à n'importe quel moment, sans avoir à donner de raison. Vous avez simplement à aviser la personne ressource de l'équipe de recherche et ce, par simple avis verbal. Vous serez également libre d'informer la Chercheure Principale de votre consentement à conserver ou de votre volonté de détruire les données collectées avant votre retrait. Si vous décidez de ne pas participer ou de vous retirer, vous ne perdrez aucun avantage auquel vous avez droit. Si vous êtes un employé, votre participation, refus de participer ou retrait n'aura aucune conséquence sur votre emploi.

Responsabilité de l'équipe de recherche

En acceptant de participer à cette étude, vous ne renoncez à aucun de vos droits ni ne libérez le chercheur de ses responsabilités civiles et professionnelles.

Personnes-ressources

Si vous avez des questions sur les aspects scientifiques du projet de recherche, vous pouvez contacter :

Lara Gautier, Étudiante au doctorat à l'Université de Montréal
Téléphone : (+1) Courriel :
Laurence Touré, Professeure associée, MISELI, ilot 17, cité el-Farako, Bamako BP E5448
Téléphone : (+223) Courriel :

Pour toute préoccupation sur vos droits ou sur les responsabilités des chercheurs concernant votre participation, vous pouvez contacter la secrétaire du **Comité d'éthique de l'Institut National de Recherche en Santé Publique du Mali : Mme Kamissa DIAKITE**.
Téléphone : (+223) XX XX XX XX Courriel:

Toute plainte concernant cette recherche peut être adressée à cette personne : elle sera ensuite transmise au **Comité d'éthique de la recherche en santé de l'Université de Montréal**. Mme Diakité s'exprime en français et en anglais et prend les appels entre 9h et 17h **(heure locale : UTC).**

Déclaration du participant

Je comprends que je peux prendre mon temps pour réfléchir avant de donner mon accord ou mon désaccord à participer à la recherche.

Je peux poser des questions à l'enquêtrice et exiger des réponses satisfaisantes.

Je comprends qu'en participant à ce projet de recherche, je ne renonce à aucun de mes droits ni ne dégage l'enquêtrice de ses responsabilités.

Je comprends que les données de l'entretien feront l'objet d'un enregistrement audio.

J'ai pris connaissance de la fiche d'information et du présent formulaire de consentement, et j'accepte de participer au projet de recherche.

Prénom et nom du participant (caractères d'imprimerie)	Signature ou empreinte digitale du participant Date :

Déclaration de l'enquêtrice

J'ai expliqué les conditions de participation au projet de recherche au participant. J'ai répondu au meilleur de ma connaissance aux questions posées et me suis assuré de la compréhension du participant. Je m'engage à respecter ce qui a été convenu dans le présent formulaire d'information et de consentement.

LARA GAUTIER	
Prénom et nom du chercheur (caractères d'imprimerie)	Signature du chercheur Date :

Appendix G. Interview guide with global actors

Focus of the interview: Analysing the diffusion of performance-based financing at the global level

Archival Number			Name of Interviewee		
Position & Affiliation of Interviewee					
Name of Interviewer					
Mode of Interview			Face to face ◯ Phone ◯		
Audio recorded			Yes ◯ No ◯		
Date			DD	MM	YYYY
Start Time			End Time		

Script: *I am Lara Gautier, a PhD student at Université de Montreal in Canada and Université Paris-Diderot in France. The aim of this research project is to learn about the processes that led to PBF policy diffusion in low- and middle-income countries. This study is part of a larger research evaluation program on "Results-based financing for equitable access to maternal and child health care in Mali and Burkina Faso". This program is run by a consortium of Mali- and Burkina Faso-based research NGOs and researchers from the University of Montreal*[1].
I have asked to interview you, because you are a key person with knowledge and insight regarding the emergence of PBF as a global health policy and I am interested in learning your opinions and personal experience regarding the PBF policy.

I have reviewed the procedures for the interview during the consent process. Do you have any questions before we begin?

A. SECTION ON REPRESENTATION SYSTEMS, MOTIVATIONS AND RESOURCES

	Question	Prompts	Comments
1.	**Could you tell me a little bit about your background?**	*How did you come to your current position? What was your personal trajectory?*	
2.	**How long have you been working in this institution?**		
3.	**How do you feel about your job?**	*What would be the most fulfilling or exciting, or the most challenging or frustrating in your job?*	
4.	**How did you first hear of performance-based financing (PBF)?**		
5.	**For you, what does this global policy represent? How would you define it?**		

[1] This project is part of the Innovating for Maternal and Child Health in Africa (IMCHA) Initiative, a seven year, $CA36 million multi-donor partnership funded by Global Affairs Canada, the Canadian Institutes of Health Research, and Canada's International Development Research Centre

6. **Could you tell me a little bit about the ideas and values that are behind the development of PBF in LMICs?**

   What is the purpose of the PBF policy? What policy issues does it address?

7. **According to you, what are the possible reasons for choosing to implement this policy in many LMICs, particularly in African countries?**

8. **What do you think about the effect(s) of this policy?**

   Do you believe that this policy works well in LMICs? Why or why not?

9. **According to you, what helped the most in shaping the development of this policy?**

   What impact did this have? How much help were these facilitators?

   Facilitators might relate to:
   - Individual skills/knowledge
   - Positive evaluation
   - Political factors
   - Policy/program topic factors

B. SECTION ON STRATEGIES

10. **What types of documents are used about PBF and why do you think they are relevant resources?**

    - *Primary research studies; such as impact evaluations published in academic journals*
    - *Secondary research articles (reviews) such as systematic reviews or research summaries*
    - *Government reports or other unpublished (grey) literature, including evaluations of policies or programs from other organisations*

11. **Would you consider that evidence (any type of knowledge resources) informed the development of the PBF policy in any way? How did they?**

    What is your assessment of the importance of the contribution of knowledge resources to the development of the PBF policy overall?

12. **For instance, can you name a specific knowledge resource on PBF used in your organisation?**

    Is it commonly referred to in your organisation?

13. **Can you describe the ways these resources were used in the development of PBF in countries? What do you think about these?**

    Can you describe how research was used? Were there concerns about the use of generalised research for instance?

    NB: Generalised research might result in overconfidence in the benefit of particular initiatives

14. **Could you tell me about the consultation process with experts, reference groups or researchers to inform this policy?**

15. **Did you play a specific role in the development and/or diffusion of this global policy? If yes, what was this role about? Who did you work with?**

    NB: Understanding the role of the interviewee is very important to the validity of the interview. Was their role central, marginal, advisory? Did they produce/contribute to/direct some documents on PBF?

16. **As you may know, there is a wide range of activities for governments' representatives and local experts to familiarise with PBF. Do you know what these activities are? Can you describe them?**

    What are their objectives? To what extent do you think they contribute to policymaking in LMICs countries according to you? Could you give some examples?

17. **Have you contributed to organise one of these activities? If you have, how are government representatives selected to participate in these activities?**

18. **Could you please describe for me how these activities (e.g., workshop or study tours) take place and what their objectives may be? You may give a particular example if you wish.**

19. **In your opinion, how do training or study tours help convince national decision makers?**

20. **If not, have you organized or attended at least one special event on PBF, e.g. a conference session on PBF?**

21. **Do you follow the ongoing discussions on PBF, such as through the PBF Community of Practice or webconferences on PBF?**

    If yes, what do you think about it?
    If no, why not?
    To what extent these discussions inform countries decision makers according to you?

22. **In your opinion, what has been the response by donors and local governments to PBF?**

23. **Who else do you think it is important that we speak to (if more than one person nominated, ask interviewee to rank in order of relevance/ importance)?**

24. **Are there any resources or documents you would recommend we consider?**

25. **Is there anything you think has been missed or that you think is important for us to be aware of?**

Appendix H. Interview guide with actors based on the African continent

Focus of the interview: Assessing the diffusion of performance-based financing on the African continent

- *This interview is designed to be carried out as a friendly, open conversation about the diffusion of a global health policy in Africa: performance-based financing (PBF)*
- *The purpose is to explore how ideas (e.g., economic theories), knowledge (e.g., past and present research evidence, grey literature), and networks contributed to the development of the policy in low- and middle-income countries.*
- *The aim of the interview is to understand and accurately describe ideas and knowledge mobilisation in the development of the PBF policy.*
- *Interviews are audio recorded, unless notified otherwise by the interviewee.*
- *The structure below is a guide. The conversation might not always be this linear, however all questions ought to be addressed before the interview concludes. Interviews should take up to 1.5 hour.*
- *The prompts in italics can be used as supplementary questions but should not replace the main question they are attached to. On some instances, an interviewee might touch upon important themes: these may be re-employed by the interviewer using the interviewee's own words, in an attempt to make the interviewer talk about the mentioned theme in relation to the PBF policy process specifically.*

The Interview

Archival Number			**Name of Interviewee**		
Position & Affiliation of Interviewee					
Name of Interviewer					
Mode of Interview			Face to face ◯	Phone ◯	
Audio recorded			Yes ◯	No ◯	
Date			**DD**	**MM**	**YYYY**
Start Time			**End Time**		

I am Lara Gautier, a PhD student at Université de Montreal in Canada and Université Paris-Diderot in France. The aim of this research project is to learn about the processes that led to PBF diffusion in African countries. This study is part of a larger research evaluation program on "Results-based financing for equitable access to maternal and child health care in Mali and Burkina Faso". This program is run by a consortium of Mali- and Burkina Faso-based research NGOs and researchers from

the University of Montreal[2]. I have asked to interview you, because you are a key person with knowledge and insight regarding the emergence of PBF as a global health policy and I am interested in learning your opinions and personal experience regarding the PBF policy.
I have reviewed the procedures for the interview during the consent process. Do you have any further questions before we begin?

A. SECTION ON REPRESENTATION SYSTEMS, MOTIVATIONS AND RESOURCES

Question	Prompts	Comments
1. Could you tell me a little bit about your background?	*How did you come to your current position? What was your personal trajectory?*	
2. How long have you been working in this institution?	*What is the purpose of the PBF policy? What policy issues does it address?*	
3. How do you feel about your job?	*What would be the most fulfilling or exciting, or the most challenging or frustrating in your job?*	
4. How did you first hear of performance-based financing (PBF)?		
5. For you, what does this policy represent in African countries?		
6. According to you, what helped the most in shaping the development of this policy?	*What impact did this have? How much help were they?* Facilitators might relate to: • Individual skills/knowledge • Positive evaluations • Political factors • Policy/program topic factors	
7. Could you tell me a little bit about the ideas and values that are behind the development of PBF in Africa?	*What is the purpose of the PBF policy? What policy issues does it address?*	
8. According to you, what are the possible reasons for choosing to implement this policy in many African countries?		
9. What do you think about the effect(s) of policy?	*Do you believe that this policy works well in LMICs? Why or why not?*	

B. SECTION ON STRATEGIES

Question	Prompts	Comments
10. What types of documents are used about PBF and why do you think they are relevant resources?	• *Primary research studies; such as impact evaluations published in academic journals* • *Secondary research articles (reviews) such as systematic reviews or research summaries* • *Govt. reports or other unpublished (grey) literature, including*	

[2] This project is part of the Innovating for Maternal and Child Health in Africa (IMCHA) Initiative, a seven year, $CA36 million multi-donor partnership funded by Global Affairs Canada, the Canadian Institutes of Health Research, and Canada's International Development Research Centre

	evaluations of policies or programs from other organisations
11. How is the relevance of the research or of the methods used in impact evaluation determined?	*Was an assessment made of whether the research was:* • *Consistent with previous research?* • *Compatible with organisational values/knowledge?* • *Actionable/feasible?*
12. Would you consider that evidence (any type of knowledge resources) informed the development of the PBF policy in any way? How did they?	*What is your assessment of the importance of the contribution of knowledge resources to the development of the PBF policy overall?*
13. For instance, can you name a specific knowledge resource on PBF used in your organisation?	
14. Would you say that this knowledge was used to persuade others to a point of view or course of action?	*Can you describe how research was used?* *Which stakeholders were they trying to persuade/inform/ justify the decision to?*
15. Do you have concerns about how these resources were used in the development of PBF in countries?	*Were there any consequences of the use or non-use of these resources? Were there concerns about the use of generalised research for instance?*

"Having explored the ways knowledge was used, I would now like to talk about the other elements that may have played a role in policymaking"

16. Did you play a specific role in the development and/or diffusion of this policy on the African continent? If yes, what was this role about?	NB: Understanding the role of the interviewee is very important to the validity of the interview. Was their role central, marginal, advisory? Did they produce/contribute to/direct some documents on PBF?
17. With what type of people do you work with on PBF?	
18. Could you tell me about the consultation process with experts, reference groups or researchers to inform this policy?	
19. As you may know, the *Health Results Innovation Trust Fund* facility funds a range of activities for governments' representatives and local experts to familiarise with PBF. Do you participate in these activities? (Y/N) Why or why not?	*Did you already participate in a PBF training and/or PBF-related country visit?* *To at extent do these activities contribute to policymaking in African countries according to you? Could you give some examples?*
20. If yes, how many times have your participated in these activities?	
21. Could you please describe for me how these activities take place and what their objectives may be? You may give a particular example if you wish.	

22. **In your opinion, how do training or country visits help convince national decision makers?**
23. **Who do you approach when you need expertise on PBF? (Choice of names)**
24. **Why do you choose to approach these people in particular? Multiple answers: recognized expertise, long-time trust, relevance of advice**
25. **Who do you approach when you need advice to help convince national governments of the value of PBF? (Choice of names)**
26. **Why do you choose to approach these people in particular? Multiple answers: recognized expertise, long-time trust, usefulness of the advice to convince national decision makers**
27. **What type of advice do these resource people give you?**
28. **In your opinion, how does advice from these resource people help convince national decision makers?**
29. **In your opinion, how do these resource people influence the diffusion of the PBF policy idea on the African continent?**
30. **Is PBF in the national policy of your home country? (Y/N)**
31. **Have you contributed to organise one of these activities (Y/N)? If you have, how are government representatives selected to participate in these activities?**
32. **Why do you think these activities are popular among African participants?**
33. **Do you participate to the discussions on PBF, such as through the Community of Practice or webconferences on PBF?**

    If yes, what do you think about it?
    If no, why not?

    To what extent these discussions inform countries decision makers according to you?
34. **In your opinion, what has been the response by African governments to PBF? Why?**
35. **Who else do you think it is important that we speak to (if more than one person nominated, ask interviewee to rank in order of relevance/importance)?**
36. **Are there any resources or documents you would recommend we consider?**
37. **Is there anything you think has been missed or that you think is important for us to be aware of?**

Appendix I. Guide d'entrevue avec les acteurs du gouvernement malien

Thème de l'entrevue : Analyse de la diffusion du Financement Basé sur les Résultats au Mali

• Cette entrevue est conçue comme une conversation ouverte sur la diffusion d'une politique de santé mondiale : le financement basé sur les résultats (FBR) au Mali.
• Ces questions sont adressées au personnel du ministère de la santé, du ministère des finances, et de la direction nationale de la santé.
• Le but est d'explorer la manière dont les idées (par exemple, les théories économiques), la connaissance (par exemple, les données de recherche actuelle, la littérature grise), et la construction de consensus parmi les décideurs nationaux ont contribué au développement de la politique dans les pays à revenu faible ou intermédiaire.
• Les entrevues seront enregistrées à moins que le participant ne refuse.
• La structure ci-dessous est un guide. La conversation ne suit pas nécessairement un fil linéaire, mais toutes les questions doivent êtes abordées avant la fin de l'entrevue. La durée maximale prévue des entrevues est d'1 heure et 30 minutes.
• Les "Prompts" en italiques peuvent être utilisées comme questions complémentaires mais elles ne sont pas sensées remplacer les questions principales auxquelles elles sont rattachées. Dans certains cas, un répondant peut évoquer un thème important ou employer une expression representative d'un phénomène intéressant : ces expressions ou thèmes peuvent être réutilisées par l'enquêteur en reprenant les termes du répondant, ceci afin de l'inviter à poursuivre sa réflexion tout en replaçant la discussion autour des processus qui façonnent le FBR.

Entrevue

Numéro		**Nom du participant**		
Profession et affiliation du participant				
Nom de l'enquêteur				
Mode d'entrevue		Face à face ○	Par téléphone ○	
Enregistrement audio		Oui ○	Non ○	
Date		**JJ**	**MM**	**AAAA**
Heure de début		**Heure de fin**		

Je m'appelle Lara Gautier, je suis étudiante au doctorat à l'Université de Montréal au Canada et à l'Université Paris-Diderot en France. Le but de ce projet de recherche est de mieux connaître les processus qui ont mené au développement de la politique de FBR au Mali. Cette étude fait partie d'un programme de recherche plus large intitulé : « Financement basé sur les résultats en santé maternelle et infantile et l'équité au Mali et Burkina Faso » (ISMEA).

Ce programme est mis en œuvre par une équipe composée d'ONG de recherche basées au Mali et au Burkina Faso, et de chercheurs de l'Université de Montréal[3].
J'ai demandé à vous interroger parce que vous êtes une personne ressource en ce qui concerne la diffusion du FBR comme politique nationale de santé au Mali et je souhaite connaître vos opinions et expériences personnelles concernant la politique de FBR.
J'ai examiné les modalités de l'entrevue au cours du processus de consentement. Avez-vous d'autres questions avant de commencer ?

A. SECTION SUR LES SYSTEMES DE REPRESENTATIONS, MOTIVATIONS ET RESSOURCES

Question	Prompts	Commentaires
1. Pourriez-vous tout d'abord me parler de votre parcours ?	*Quelle a été votre trajectoire personnelle jusqu'à votre poste actuel ?*	
2. Depuis combien de temps travaillez-vous dans cette institution ?		
3. Que pensez-vous de votre poste actuel ?	*Qu'est-ce qui est selon vous le plus stimulant / le plus intéressant, ou à l'inverse le plus frustrant dans votre travail ?*	
4. Comment avez-vous entendu parler du financement basé sur les résultats (FBR) ?		
5. Quelles sont les idées et valeurs qui sous-tendent le FBR ?	*Quel est le but du FBR ? Quels problèmes politiques tente-t-il de résoudre ?*	
6. Pourquoi pensez-vous que cette politique a été choisie dans de nombreux pays africains?		
7. Estimez-vous que cette politique fonctionne bien dans les pays Africains ? Pourquoi ?		
8. Que pensez-vous du FBR tel qu'il est mis en place au Mali ?		
9. D'après vous, qu'est-ce qui a contribué le plus au développement de cette politique au Mali ?	*Quel a été l'impact de ce facteur ?* *Les facteurs facilitateurs peuvent se rapporter :* *• aux compétences individuelles / connaissances* *• aux attributs de l'équipe de décideurs* *• au contexte politique* *• au contenu de la politique elle-même* *• aux évaluations positives disponibles*	
10. Avez-vous joué un rôle spécifique dans le développement de cette politique au niveau national ? Si oui, en quoi consistait ce rôle ?	NB: Comprendre le rôle de la personne interrogée est très important pour la validité de l'entrevue. Son rôle était-il central, marginal, consultatif? A-t-il produit / contribuer à / commandé certains documents sur le FBR ?	

[3] Ce projet s'inscrit dans le cadre de l'initiative Innovation pour la santé des mères et des enfants d'Afrique (ISMEA), un projet de 36 millions de dollars canadiens sur sept ans, financé par plusieurs bailleurs de fonds dont Affaires mondiales Canada, les Instituts de recherche en santé du Canada et le Centre de recherches pour le développement international.

A présent, je vais vous poser des questions un peu plus spécifiques sur la manière dont cette politique a été développée au Mali.

B. SECTION SUR LES STRATEGIES

Question	Prompts	Commentaires
11. Comment vous-êtes vous documenté (rapports, preuves scientifiques, etc.) sur le FBR ?		
12. Est-ce que vous pensez que les ressources documentaires que vous avez utilisées ont soutenu le développement de la politique de FBR au Mali ? Pourquoi ?	*Comment évaluez-vous l'importance de la contribution des ressources documentaires à l'élaboration de la politique de FBR ?*	
13. Utilisez-vous une ressource documentaire spécifique sur le FBR ? Si oui, quelle est-elle ?	*Est-ce un outil fréquemment utilisé dans votre institution ?*	
14. Pensez-vous que ce type de ressource documentaire a été utilisé pour informer d'autres acteurs impliqués dans le processus de décision ?	*Pouvez-vous décrire comment les ressources disponibles sur le FBR ont été utilisées?* *Quels acteurs ont essayé d'informer / justifier la décision politique ?*	
15. Avez-vous des préoccupations sur la manière dont ces ressources sont utilisées dans le développement des politiques nationales ?	*Y avait-il des préoccupations au sujet de l'utilisation de la recherche généralisée par exemple ?*	Les recherches généralisées peuvent se traduire par un excès de confiance dans le bénéfice des initiatives
16. Quels problèmes locaux cette politique permet-elle de résoudre selon vous ?		
17. Quels facteurs sociopolitiques (ex. récentes réformes du système de la santé) ou évènements récents ont influencé l'émergence de la reforme selon vous ?		
18. Selon vous, quelles caractéristiques du système de santé malien ont facilité l'émergence de cette politique ?	*Le système FBR correspondait-il à d'autres politiques déjà en place ?*	
19. Y a-t-il eu des consultations avec des acteurs extérieurs au gouvernement qui ont pu contribuer à documenter cette politique ? Pourriez-vous m'en parler ?		

Question	Prompts	Commentaires
20. Quels sont les acteurs à l'origine du développement du FBR selon vous ?	*Quel(s) rôle(s) a joué chacun des acteurs ayant contribué à l'émergence de la politique (institutions internationales, consultants internationaux, acteurs nationaux, etc) ?*	
21. Les cercles ci-dessous représentent l'ensemble des participants à un événement marquant dans le processus d'intégration du FBR au sein de la politique nationale. Pourriez-vous colorier ces cercles en représentant la proportion de l'influence jouée par chaque acteur clé ? Ces cercles n'ont pas de valeur officielle et ne seront pas publiés, ne vous inquiétez pas. Coloriez simplement selon votre ressenti.		
22. Pourriez-vous décrire en quelques mots les actions entreprises par ces acteurs ?		
23. Y a-t-il eu des débats au moment de la prise de décision sur le FBR ? Sur quels sujets ont porté ces débats ?		
24. Selon vous, quelle a été la réaction des bailleurs de fonds (autres que la Banque Mondiale et la SNV) au FBR ?		
25. Avez-vous participé aux activités visant à se familiariser avec le FBR en Afrique (formation, visite d'un autre pays, etc.) ? Si oui, quelles activités avez-vous suivi ?		
26. Pourriez-vous décrire en quelques mots la manière dont ces activités se sont déroulées ? Quels étaient leurs objectifs ?		
27. Que pensez-vous que ce type d'activités ?	*Selon vous, contribuent-elles directement ou indirectement à l'élaboration des politiques ?*	
28. Pensez-vous à quelqu'un en particulier avec qui nous pourrions également avoir un entretien sur ce sujet ?		
29. Est-ce que vous souhaiteriez nous recommender des ressources ou documents complémentaires à notre discussion ?		
30. Avez-vous autre chose à ajouter sur ce sujet ?		

Appendix J. Guide d’entrevue avec les consultants et experts au Mali

Thème de l’entrevue : Analyse de la diffusion du Financement Basé sur les Résultats au Mali

• Cette entrevue est conçue comme une conversation ouverte sur la diffusion d'une politique de santé mondiale : le financement basé sur les résultats (FBR) au Mali.
• Ces questions sont adressées aux consultants de nationalité malienne.
• Le but est d’explorer la manière dont les idées (par exemple, les théories économiques) et la connaissance (par exemple, les données de recherche actuelle, la littérature grise), et la construction de consensus parmi les décideurs nationaux ont contribué au développement de la politique dans les pays à revenu faible ou intermédiaire.
• Les entrevues seront enregistrées à moins que le participant ne refuse.
• La structure ci-dessous est un guide. La conversation ne suit pas nécessairement un fil linéaire, mais toutes les questions doivent êtes abordées avant la fin de l’entrevue. La durée maximale prévue des entrevues est d’1 heure et 30 minutes.
• Les “Prompts” en italiques peuvent être utilisées comme questions complémentaires mais elles ne sont pas sensées remplacer les questions principales auxquelles elles sont rattachées. Dans certains cas, un répondant peut évoquer un thème important ou employer une expression representative d’un phénomène intéressant : ces expressions ou thèmes peuvent être réutilisées par l’enquêteur en reprenant les termes du répondant, ceci afin de l’inviter à poursuivre sa réflexion tout en replaçant la discussion autour des processus qui façonnent le FBR.

Entrevue

Numéro			**Nom du participant**		
Profession et affiliation du participant					
Nom de l’enquêteur					
Mode d’entrevue			Face à face ◯	Par téléphone ◯	
Enregistrement audio			Oui ◯	Non ◯	
Date			**JJ**	**MM**	**AAAA**
Heure de début			**Heure de fin**		

Je m’appelle Lara Gautier, je suis étudiante au doctorat à l’Université de Montréal au Canada et à l’Université Paris-Diderot en France. Le but de ce projet de recherche est de mieux connaître les processus qui ont mené au développement de la politique de FBR au Mali. Cette étude fait partie d’un programme de recherche plus large intitulé : « Financement basé sur les résultats en santé maternelle et infantile et l'équité au Mali et Burkina Faso » (ISMEA).

Ce programme est mis en œuvre par une équipe composée d'ONG de recherche basées au Mali et au Burkina Faso, et de chercheurs de l'Université de Montréal[4].
J'ai demandé à vous interroger parce que vous êtes une personne ressource en ce qui concerne la diffusion du FBR comme politique nationale de santé au Mali et je souhaite connaître vos opinions et expériences personnelles concernant la politique de FBR.
J'ai examiné les modalités de l'entrevue au cours du processus de consentement. Avez-vous d'autres questions avant de commencer ?

A. SECTION SUR LES SYSTEMES DE REPRESENTATIONS, MOTIVATIONS ET RESSOURCES

Question	Prompts	Commentaires
1. Pourriez-vous tout d'abord me parler de votre parcours ?	*Quelle a été votre trajectoire personnelle jusqu'à votre poste actuel ?*	
2. Depuis combien de temps travaillez-vous dans cette institution ?		
3. Que pensez-vous de votre poste actuel ?	*Qu'est-ce qui est selon vous le plus stimulant / le plus intéressant, ou à l'inverse le plus frustrant / le plus agaçant dans votre travail ?*	
4. Comment avez-vous entendu parler du financement basé sur les résultats (FBR) ?		
5. Quelles seraient les idées et valeurs qui sous-tendent le FBR ?	*Quel est le but du FBR ? Quels problèmes politiques tente-t-il de résoudre selon vous ?*	
6. Pourquoi pensez-vous que cette politique a été choisie dans de nombreux pays africains ?		
7. Estimez-vous que cette politique fonctionne bien dans les pays Africains ? Pourquoi ?		
8. Que pensez-vous du FBR tel qu'il est mis en place au Mali ?		
9. D'après vous, qu'est-ce qui a contribué le plus au développement de cette politique au Mali ?	*Quel a été l'impact de ce facteur ?* *Les facteurs facilitateurs peuvent se rapporter :* *• aux compétences individuelles / connaissances* *• aux attributs de l'équipe de décideurs* *• au contexte politique* *• au contenu de la politique elle-même* *• aux évaluations positives disponibles*	
10. Pensez-vous avoir joué un rôle spécifique dans le développement de cette politique au niveau national ? Si oui, pourriez-vous me décrire en quoi consistait ce rôle ?	NB: Comprendre le rôle de la personne interrogée est très important pour la validité de l'entrevue. Son rôle était-il central, marginal, consultatif? A-t-il produit / contribuer à / commandé certains documents sur le FBR ?	

[4] Ce projet s'inscrit dans le cadre de l'initiative Innovation pour la santé des mères et des enfants d'Afrique (ISMEA), un projet de 36 millions de dollars canadiens sur sept ans, financé par plusieurs bailleurs de fonds dont Affaires mondiales Canada, les Instituts de recherche en santé du Canada et le Centre de recherches pour le développement international.

B. SECTION SUR STRATEGIES

Question	Prompts
11. Avez-vous participé au programme pilote de FBR dans la region de Koulikoro ? (O/N)	
12. Qui avez-vous l'habitude d'approcher lorsque vous avez des questions techniques sur le FBR ?	
13. Pourquoi pensez-vous que cette personne (ces personnes) ressource(s) peuvent vous aider ?	
14. Quel type de conseils ces personnes ressources vous donnent-elles ?	
15. En quoi ces conseils vous aident-ils à convaincre l'ensemble des acteurs politiques ?	
16. Avez-vous participé aux activités visant à se familiariser avec le FBR en Afrique (formation, visite d'un autre pays, etc.) ? (O/N) Pourquoi avez-vous choisi d'y participer ou de ne pas y participer ?	
17. Si oui, quelles activités avez-vous suivi ? Pourriez-vous décrire en quelques mots la manière dont ces activités se sont déroulées ? Quels étaient leur(s) objectif(s) ?	
18. Que pensez-vous que ce type d'activités ?	*Selon vous, contribuent-elles directement ou indirectement à l'élaboration des politiques ?*
19. D'après vous, de quelles façons est-ce que les formations ou les visites pays aident à convaincre les décideurs nationaux ?	

A présent, je vais vous poser des questions un peu plus spécifiques sur la manière dont les ressources documentaires sur le FBR ont été utilisées au Mali.

Question	Prompts	Commentaires
20. Comment vous-êtes vous documenté (rapports, preuves scientifiques, etc.) sur le FBR ?		
21. Est-ce que vous pensez que des ressources documentaires spécifiques ont soutenu le développement de la politique de FBR au Mali ? Pourquoi ?	*Comment évaluez-vous l'importance de la contribution des ressources documentaires à l'élaboration de la politique de FBR ?*	
22. Utilisez-vous une ressource documentaire spécifique sur le FBR ? Si oui, quelle est-elle ?	*Est-ce un outil fréquemment utilisé dans votre institution ?*	
23. Avez-vous des préoccupations sur la manière dont ces ressources sont utilisées dans le développement des politiques nationales ?	*Y avait-il des préoccupations au sujet de l'utilisation de la recherche généralisée par exemple ?*	Les recherches généralisées peuvent se traduire par un excès de confiance dans le bénéfice des initiatives

Question	Prompts	Commentaires
24. Quels problèmes locaux cette politique permet-elle de résoudre selon vous ?		
25. Quels facteurs sociopolitiques (ex. récentes réformes du système de la santé) ou évènements récents peuvent avoir influencé l'émergence de cette politique selon vous ?		
26. Selon vous, quelles caractéristiques du système de santé malien ont facilité l'émergence de cette politique ?	*Le système FBR correspondait-il à d'autres politiques déjà en place ?*	
27. Quels sont les acteurs à l'origine du développement du FBR selon vous ?	*Quel(s) rôle(s) a joué chacun des acteurs ayant contribué à l'émergence de la politique (institutions internationales, consultants internationaux, acteurs nationaux, etc) ?*	
28. Les cercles ci-dessous représentent l'ensemble des participants à un événement marquant dans le processus d'intégration du FBR au sein de la politique nationale. Pourriez-vous colorier ces cercles en représentant la proportion de l'influence jouée par chaque acteur clé ? Ces cercles n'ont pas de valeur officielle et ne seront pas publiés, ne vous inquiétez pas. Coloriez simplement selon votre ressenti.		
29. Pourriez-vous décrire en quelques mots les actions entreprises par ces acteurs ?		
30. Y a-t-il eu des débats au moment de la prise de décision sur le FBR ? Sur quels sujets ont porté ces débats ?		
31. Pourriez-vous décrire la réaction des bailleurs de fonds (autres que la Banque Mondiale et la SNV) au FBR et le processus de négociation avec ces acteurs ?		
32. Pensez-vous à quelqu'un en particulier avec qui nous pourrions également avoir un entretien sur ce sujet ?		
33. Est-ce que vous souhaiteriez nous recommender des ressources ou documents complémentaires à notre discussion ?		
34. Avez-vous autre chose à ajouter sur ce sujet ?		

Appendix K. Guide d’entrevue avec les représentants des bailleurs de fonds au Mali

Thème de l’entrevue : Analyse de la diffusion du Financement Basé sur les Résultats au Mali

• Cette entrevue est conçue comme une conversation ouverte sur la diffusion d'une politique de santé mondiale : le financement basé sur les résultats (FBR)
• Ces questions sont adressées au personnel des bureaux pays des bailleurs de fonds impliqués en santé au Mali
• Le but est d’explorer la manière dont les idées (par exemple, les théories économiques) et la connaissance (par exemple, les données de recherche actuelle, la littérature grise), et la construction de consensus parmi les décideurs nationaux ont contribué au développement de la politique dans les pays à revenu faible ou intermédiaire.
• Les entrevues seront enregistrées à moins que le participant ne refuse.
• La structure ci-dessous est un guide. La conversation ne suit pas nécessairement un fil linéaire, mais toutes les questions doivent êtes abordées avant la fin de l’entrevue. La durée maximale prévue des entrevues est d’1 heure et 30 minutes.
• Les “Prompts” en italiques peuvent être utilisées comme questions complémentaires mais elles ne sont pas sensées remplacer les questions principales auxquelles elles sont rattachées. Dans certains cas, un répondant peut évoquer un thème important ou employer une expression representative d’un phénomène intéressant : ces expressions ou thèmes peuvent être réutilisées par l’enquêteur en reprenant les termes du répondant, ceci afin de l’inviter à poursuivre sa réflexion tout en replaçant la discussion autour des processus qui façonnent le FBR.

Entrevue

Numéro			**Nom du participant**			
Profession et affiliation du participant						
Nom de l’enquêteur						
Mode d’entrevue			Face à face ◯	Par téléphone ◯		
Enregistrement audio			Oui ◯	Non ◯		
Date			**JJ**	**MM**	**AAAA**	
Heure de début			**Heure de fin**			

Je m’appelle Lara Gautier, je suis étudiante au doctorat à l’Université de Montréal au Canada et à l’Université Paris-Diderot en France. Le but de ce projet de recherche est de mieux connaître les processus qui ont mené au développement de la politique de FBR au Mali. Cette étude fait partie d’un programme de recherche plus large intitulé : « Financement basé sur les résultats en santé maternelle et infantile et l'équité au Mali et Burkina Faso » (ISMEA).

Ce programme est mis en œuvre par une équipe composée d'ONG de recherche basées au Mali et au Burkina Faso, et de chercheurs de l'Université de Montréal[5].
J'ai demandé à vous interroger parce que vous êtes une personne ressource en ce qui concerne la diffusion du FBR comme politique nationale de santé au Mali et je souhaite connaître vos opinions et expériences personnelles concernant la politique de FBR.
J'ai examiné les modalités de l'entrevue au cours du processus de consentement. Avez-vous d'autres questions avant de commencer ?

A. QUESTIONS SUR LES SYSTEMES DE REPRESENTATIONS, MOTIVATIONS ET RESSOURCES

Question	Prompts	Commentaires
1. Pourriez-vous tout d'abord me parler de votre parcours ?	*Quelle a été votre trajectoire personnelle jusqu'à votre poste actuel ?*	
2. Depuis combien de temps travaillez-vous dans cette institution ?		
3. Que pensez-vous de votre poste actuel ?	*Qu'est-ce qui est selon vous le plus stimulant / le plus intéressant, ou à l'inverse le plus frustrant / le plus agaçant dans votre travail ?*	
4. Comment avez-vous entendu parler du financement basé sur les résultats (FBR) ?		
5. Pourriez-vous me parler des idées et valeurs qui sous-tendent le FBR ?	*Quel est le but du FBR ? Quels problèmes politiques tente-t-il de résoudre ?*	
6. Pourquoi pensez-vous que cette politique a été choisie dans de nombreux pays d'Afrique ?		
7. Estimez-vous que cette politique fonctionne bien dans les pays Africains ? Pourquoi ?		
8. Que pensez-vous du FBR tel qu'il est mis en place au Mali ?		
9. D'après vous, qu'est-ce qui a contribué le plus au développement de cette politique ?	*Les facteurs facilitateurs peuvent se rapporter :* *• aux compétences individuelles / connaissances* *• aux attributs de l'équipe de décideurs* *• au contexte politique* *• au contenu de la politique elle-même* *• aux évaluations positives disponibles*	
10. Avez-vous joué un rôle spécifique dans le développement de cette politique au niveau national ? Si oui, en quoi consistait ce rôle ?		

A présent, je vais vous poser des questions un peu plus spécifiques sur la manière dont cette politique a été développée au Mali.

[5] Ce projet s'inscrit dans le cadre de l'initiative Innovation pour la santé des mères et des enfants d'Afrique (ISMEA), un projet de 36 millions de dollars canadiens sur sept ans, financé par plusieurs bailleurs de fonds dont Affaires mondiales Canada, les Instituts de recherche en santé du Canada et le Centre de recherches pour le développement international.

B. SECTION SUR LES STRATEGIES

Question	Prompts	Commentaires
11. Dans votre institution, comment vous-êtes vous documenté (rapports, preuves scientifiques, etc.) sur le FBR ?		
12. Est-ce que vous pensez que les ressources documentaires que vous avez utilisées ont soutenu le développement de la politique de FBR au Mali ? Si oui, de quelles façons ?	*Comment évaluez-vous l'importance de la contribution des ressources documentaires à l'élaboration de la politique de FBR ?*	
13. Utilisez-vous une ressource documentaire spécifique sur le FBR ? Si oui, quelle est-elle ?	*Est-ce un outil fréquemment utilisé dans votre institution ?*	
14. Pensez-vous que ce type de ressource documentaire a été utilisé pour informer d'autres acteurs impliqués dans le processus de décision ?	*Pouvez-vous décrire comment les ressources disponibles sur le FBR ont été utilisées?* *Quels acteurs ont essayé d'informer / justifier la décision politique ?*	
15. Avez-vous des préoccupations sur la manière dont ces ressources sont utilisées dans le développement des politiques nationales ? Pourquoi ?	*Y avait-il des préoccupations au sujet de l'utilisation de la recherche généralisée par exemple ?*	Les recherches généralisées peuvent se traduire par un excès de confiance dans le bénéfice des initiatives
16. Connaissez-vous les activités visant à se familiariser avec le FBR en Afrique (formation, visite d'un autre pays, etc.) ? Si oui, que pensez-vous que ce type d'activités ?	*Selon vous, contribuent-elles directement ou indirectement à l'élaboration des politiques ?*	
17. Pourriez-vous décrire en quelques mots la manière dont ces activités se déroulent ? Quels est/sont leur(s) objectif(s) ?		
18. Quels problèmes locaux cette politique permet-elle de résoudre selon vous ?		
19. Quels facteurs sociopolitiques (ex. récentes réformes du système de la santé) ou évènements récents ont influencé l'émergence de la reforme selon vous ?		
20. Y a-t-il eu selon vous des consultations avec des acteurs extérieurs au gouvernement qui ont pu contribuer à documenter cette politique ? Si oui, pourriez-vous m'en parler ?		

Question	Prompts	Commentaires
21. Quels sont les acteurs à l'origine du développement du FBR selon vous ?	*Quel(s) rôle(s) a joué chacun des acteurs ayant contribué à l'émergence de la politique (institutions internationales, consultants internationaux, acteurs nationaux, etc) ?*	
22. Les cercles ci-dessous représentent l'ensemble des participants à un événement marquant dans le processus d'intégration du FBR au sein de la politique nationale. Pourriez-vous colorier ces cercles en représentant la proportion de l'influence jouée par chaque acteur clé ? Ces cercles n'ont pas de valeur officielle et ne seront pas publiés, ne vous inquiétez pas. Coloriez simplement selon votre ressenti.		
23. Pourriez-vous décrire en quelques mots les actions entreprises par ces acteurs ?		
24. Comment se sont déroulés les débats entre les différents bailleurs de fonds sur le FBR ?		
25. Pensez-vous à quelqu'un en particulier avec qui nous pourrions également avoir un entretien sur ce sujet ?		
26. Est-ce que vous souhaiteriez nous recommender des ressources ou documents complémentaires à notre discussion ?		
27. Avez-vous autre chose à ajouter sur ce sujet ?		

Appendix L. Codebook for global-level analysis

- **Background/Values**
  - **Background**
    - **Training & culture=belief system**
      - Economist
      - Anticommunist comments
      - Economics in North America
      - MD
      - IMT Alumni
      - KIT Alumni/experience
      - Health economics
      - Nurse
      - Public health
      - Tropical medicine
      - HPSR
      - Public admin and IR
      - Dutch-born=cultural background
      - Cultural background shaping representations
      - Flemish-born=cultural background
      - Knew abt the mechanism since already in Europe and in comparative h
      - US Peace Corps
      - Harvard Alumni
      - WB institutional culture=econ
    - **Prof exp & how it shapes assumptions= belief system & ideologies**
      - Cordaid exp
      - MSF exp
      - Describing job tasks
      - Prof experience shaping interest in measurement + than op training
      - Personal experience shaping pb representations
      - Valuing RCTs in IE and peer-rev publications
      - Field exp=resources and authority
      - Exp=NGOs and consulting companies=resources and authority
      - Hospital manager in Af=resources and authority
      - WB exp shaping assumptions
      - Development economics and idea of results-based aid
      - Advocacy job in international topics
      - Politician
      - Link with HD
      - Academia=prof=ressources and authority
    - **professional seniority in dev aid=authority**
      - > 10 years
      - > 20 years
    - **Prof exp in health econ=resources**
      - Hospital manager in Kenya
      - Experience in Health economics
      - AEDES exp
      - Exp in AAP
      - Technical assistant at national PBF cell
      - Prof experience shaping assumptions abt EBDM
    - **How 1st heard of PBF**
      - 'Founding fathers'
      - Asked to work on PBF for an IE
      - CERDI écon de la santé
      - KIT and Cordaid
      - Cordaid1
      - WB workshop
- **Misc on current affiliation**
  - **WB**
    - How joined the WB
    - Dev Res Group and its value
    - GFF and RBF health leader
    - Current affiliation influencing solution diffusion genesis
    - Low internal knowledge abt PBF projects
    - Being linked to the WB creates opportunities to influence policy
    - US influence on the WB
    - Limits as to what the WB can promote (EBPM)
    - Working at the but not knowing difference betw PBF and RBF
    - Distinguising researchers and practitioners' values/advocacy
    - DRG commenting onWB staff implementers
    - Criticizing 'continual under I in supervision of projects'
    - Limited knowledge abt package
    - Some WB staff critical of PBF
    - Being a researcher at the WB vs other researchers
    - Wants to do smth else than PBF
    - Criticizing GH and interdisciplinarity/MDs
    - TTLs>internal politics, access to HRITF
    - HNP dynamics>not sharing as much as used to
  - **MoH**
    - Attempt to re-appropriate the Bank's promotion?!
    - Mobilizing all energies to succeed with PBF
    - Frustration that it's going too slow at the MoH
    - Strong political will in BF?
    - High-level officials=attentism towards PBF
  - KI going in circles?
- **What's the pb & and the solution represented to be?**
  - **Problem representations**
    - **Genesis and origins**
      - Refering to WDR 2004
      - Refering to personal exp=motivations
      - NVivo='Huge demand from countries'
      - Ministers of finance keen to change
      - Nvivo='It just makes sense'
      - WB projects so hopeless!
    - **Econ frames**
      - incentives > behaviour change
      - Contract theory
      - Econ theories
      - Market-oriented concepts
      - Private sector involvement
      - Market-oriented reforms in Europe and NA
      - Budget allocation in general = crisis
      - Breaking away from input-based, produce results
      - Efficiency and governance/accountability
      - Nuancing the power of contrast betw inputs and outputs
      - Changing management practices
      - Information and monitoring/transparency
      - Need more autonomy/empowerment in HF=crisis
      - Nvivo>there's ton of money! it's not abt money
      - Local economy growth/job creation
    - **Health systems frames**
      - Need to signal priorities to the health sector, whether through PBF
      - Reference to health system in general
      - Under-utilization of services=crisis
      - Low quality=crisis
      - Coverage=crisis
      - Re-engaging HW=pb population
      - Problem population=HCF and HCW
      - Shift in power structure in HF=pb population
      - Nvivo='not seen as an adaptive tool but as a donor-funded wish'
      - Nvivo>it's a systems reform and not a tool!
      - Nvivo>if PBF is only abt complementing salaries, it's not good
    - **Other frames**
      - Mentioning what other aspects motivate HW
      - Mentioning accountability to the people
      - Psychologic frames=Not only bad effect on intrinsic motivation!
      - Data and results frames>MSF
      - Input-based not working = crisis
      - Funds not well allocated = crisis
      - Refering to humanistic frames
      - Financial incentives not transformative!
      - Addressing fraud=supportive supervision
      - Creating enabling environment=supportive supervision
      - Perdiemism
    - **Change of paradigm**
      - Budget allocation change
      - Changing the traditional discourse to HCW=pb population
      - Nvivo=Giving them more if we want them to do more

- **Expressive or instrumental orientation**
    - Expressive orientation emphasis > symbols, tools and principles
    - Instrumental orientation emphasis > results
    - Multiplicity of mechanisms
- **Africa**
    - Funds not reaching HF = crisis
    - Severity for gov'ts
    - Emphasis = problem population
    - Mentions needs of population
    - Highly hierchical, centralised countries
    - Dysfunctioning health systems in general=crisis
- **Critical dimensions on which a +change is needed**
    - Autonomy
    - Efficency
    - performance
    - governance
    - Accountability
    - participation
    - Entrepreneurship
- **What is left unproblematic & silences by promoters**
    - Equity?
    - Asking the pops what they need or want
    - Humanistic quality of care
    - What motivates HCW

Solution representations

- **GenesisPBF**
    - Donor-driven (WB KI)
    - WB-originated
    - NOT WB-originated
    - The Norwegians + The Brits
    - Two reasons=donors'interest + credible IE results
    - Trend for donors=results-based aid motivation
    - It's a trend!
    - Serving donors' interests
    - Rwanda SS
    - Great Lakes originating
    - PBF predecessors
    - Cambodia experience
    - NGOs-originated
    - Individuals traveling from Cambodia to Rwanda
    - Rwanda recovering=fertilizer for new approaches
    - Several factors explaining diffusion
    - 1st reason is availability of financial resources
    - Weight of the WB $
    - Political authority of the WB
    - WB coming with both $ and idea
    - Political popularity in Af countries
    - Nvivo='I started reading abt it and suddenly they came in Nigeria"
- **Objectives**
    - Improving end outcome = pop health
    - NVivo='The official goal' at the WB
    - Serving to solve the pb rep=focus on production and less on inputs
    - Serving to solve the pb rep=allocation
- **Motivations**
    - Valuing results-based approach
    - Nvivo='a very good thing to regain influence in PH'
    - PBF portfolio vs other policies at WB
- Generalizing at the beg of a movement=positive
- Perceptions of anti PBF representations
- KI's assessment>everything was called PBF, but key principles weren't resp
- Nvivo='a bit less of a hype now'
- 'very context-specific' solution
- Copy-paste>no!
- If the message is too context-specific, risk of losing power
- Overconfidence in Rwanda SS
- PBF as a silver(magic) bullet
- Nvivo='Lots of misunderstandings'
- Perception of gov>not embracing it
    - Perception of gov> PBF not integrated in broader system
    - Perceptions of what other donors think
    - Perception of gov> it gives them money
    - Perceptions of gov>they like it cuz it will get them results/more control
    - Perceptions of gov> no choice, lack of ownership
    - Perceptions of gov>external financing
    - Perceptions of gov> how to sustain it?
    - Innovation
    - Nvivo=It's about learning what works and doesn't
    - Continuous learning
    - Adaptation/adaptive feature
    - Nvivo=Not a book of rules (WB KI)
    - Expressing contradictory feelings towards WB
    - Very technocratic approach to health systems > gov-funded
    - Criticizing assumptions of what policymakers will think of PBF
    - PBF success depending on managerial capacities in gov
    - No WB bias to say PBF is a great thing?
    - WB staff>Not excited abt training
    - 'We don't want to hear/ read on Rwanda'
    - Nvivo='The Rwanda design was flawed'
    - Gaming but you try to reduce this
    - PBF improving data quality in countries
    - Infering a change of culture>sustainability is possible
    - Nothing new!
    - **Anti**
        - Nvivo='You can do many other things to strengthen health syst'
        - AntiPBF perceptions>fraud
        - AntiPBF perceptions>corruption
        - How it was implemented in BF>top-down, no change in power stru
        - Nvivo='You're paying extra money on top of salaries!'
        - Is it cost-efficient?
        - Is it sustainable?
- Path dependency
- High donor dependency in many Af countries

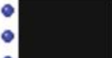
DEs' actions>Learning>Evaluation

- **Duration**
    - Timeframe Cam>2 eval 2009 and 2012
    - Timeframe Rwanda>mid-2000s
    - Timeframe Zimbabwe>2011-2014
    - Timeframe Burundi > 2006
    - Real IE in Cameroon>2012
    - Timeframe DRC> 2008-9
- **PBF IE**
    - Long process!
    - Nvivo='Really famous' Rwanda IE
    - **Donors' interest**
        - NVivo='We want to know more'
        - Nvivo='Sometimes the enthusiasm is so big'
        - Better use of $
    - **HRITF**
        - Nb of IE
        - In the HRITF package
        - Results encouraging
        - Good results
        - No slam-dunk
        - Mixed results
        - Reasons for mixed results
        - Negative results
        - No impact on some indicators
        - Ackowledgement=too much copy-paste (WB KI)
        - Learning
        - Adaptation of IE designs
        - Context-specific
        - Ppl at the WB being cautious, nuancing
        - Need to be cautious
        - Same design>same ppl working on them
        - Paternalism
        - Job at the interesection betw operations and research

    - Working with research group in learning events
    - Team work, 'bringing different parts of expertise to the table'
    - Learning from IE>interdependency w system
    - Learning>Not only focusing on the suppy-side
    - Learning from implementing a tool, not the results?!
    - HRITF wokshops on how to do IE
    - Ackoweldging limitations to own IE studies
    - Specificity of low-income settings
    - How sustainable are the results?
    - Nvivo='pilots always succeed so of course it will succeed'
  - Rwanda SS published in the Lancet
  - Rwanda and Burundi SS
  - Only knowledge abt IE
  - Uganda> did not work
  - Instrumental role of Paul Gertler
  - **Discussion abt IE relevance**
    - Metaanalysis>makes sense for quality, less for coverage
    - Results from IEs not being valued by outside academics
    - Limitations>System-type of reform>counterfactual is not HF!
    - Limitations>not grasping the change in culture
    - Hard to disentangle PBF effect from other interventions
    - RCTs first and then some qualitative...
    - 2nd generation IE with qual/MM component
    - 'Countries scaling-up w/o IE results anyway!'
    - 'Countries killing PBF w/o IE results anyway!'
    - Nvivo='It's fine that IE is not the be all and end all'
    - Debate about IEs done by WB people
    - No censorship at the Bank
    - Comparing apples and oranges
    - Designs> need to serve practice and be coconstructed
    - Designs> too complex! irrelevant from a longterm perspective
    - What really matters is how it will continue!
    - IEs are abt cost-effectiveness, not policy information
  - Nvivo='it's only experimental evidence!'
- **Other PBF eval designs**
  - Cordaid results in Cameroon=mixed
  - 1st Eval in Cameroon=not robust
  - CoP eval of Cordaid
  - Cordaid PBF programs>no rigorous IE
  - other IEs = not robust
- **Results uptake**
  - Pilot evaluation results+>continuation?
  - Power of IE results> scientific community
  - Power of IE results >'decision makers and donors won't care!'
  - Research results undervalued/no influence
  - Limited uptake of results evaluation by implementers
  - Scale-up in Zimbabwe
  - Nvivo='often politically motivated initiatives have no evidence"
  - Research culture vs advocacy culture > bias
  - No debate abt the results since the decision was made
  - WB results dissem>representing a powerful learning agenda
- Only publishing positive results
- Nvivo='introducing a culture of evaluation is risky'

DEs' actions in general

- The World Bank
- CERDI
- HealthNet TPO
- Cordaid
- Individual DEs



- SINAHealth
- Provider incentive network
- CoP
- Norad
- Nvivo=Too many opportunists!
- Relationships between indiv DEs

SinaHealth1

- SINAHealth>FR and EN
- SINAHealth>history
- Course specifications
- Also consultancy
- Constant learning and feeding process

DE's PBF models

- Tools that are used across PBF models
- USAID model> more target based
- USAID model> more individual-based
- **WB model**
  - Diffusing the WB model
  - WB blueprint
  - Internal alignment
- **Sina**
  - Score of purity
  - SINA model>developmental dynamic, practice-oriented
  - Best practices
  - National action plans get developed during the course and then sha
  - Development of standard contracts
  - Integrating the regulatory actors=sustainability
- **Cordaid model1**
  - Focus on HF autonomy
  - Cordaid model>step-by-step
  - Cordaid model
- MSH model is different

African DEs

- Rwanda and Burundi
- Study tours=PR operation for Rwanda
- Practitioners
- Motivations=after a war it makes sense

Strategies

- DE's strategies = 'academics' for making sure things have a sequence/f
- Learning + emulation = Critical elements in the diffusion
- Nvivo=training and study tours 'propagating the concept'
- WB=Funds+ability to build networks and diffuse idea
- **Semantic fields associated w PBF DEs**
  - Religion
- **Framing**
  - Ill-served/underserved populations, for DEs
  - Capacities and competencies vs. knowledge
  - South-south exchange
  - Nvivo='A broad-based health system tool'
  - Nvivo='way to revitalize a morbid health system'
  - Strategic purchasing
  - PBF promoters blaming health providers
  - Decentralization
  - Health systems reform
  - Transformation processes
  - NPM and autonomy/decentralization
  - Equity dimension in PBF
  - Value for money program
  - What's the alternative?
  - Combining with UHC and supply-side strategies
- **Emulation through workshops**
  - Workshops on sharing IE results
  - Power of workshops=Creating space for countries to share their ex
  - HRITF workshops bringing togerther implementers and researchers
  - Power of workshops=Influencing decision-makers
  - CoP workshop
  - 'Lots of WB workshops to convince countries'
  - Exchanging not only abt Rwanda!
  - Experience>becoming true believers?
  - WB-managed workshops= + control of the content
- **Emulation in general**
  - Ability of the WB to create networks
  - WB infering emulation

- Informal networks
- Formal networks
- Participation in CoP
- Perceptions CoP
- Perceptions CoP>no quality control
- Perceptions CoP>language issue
- Perceptions CoP>sharing experience
- WB spillover effect on other IOs and donors
- SINA course creating communities
- Cordaid multicountry network
- Nvivo CoP/SINA='There's a kind offraternity there'
- WB creating African experts
- Spillover even on WHO
- Probant results>spurring enthusiasm and emulation
- Perceptions CoP>exchanges can orient policy discussions at country lev
- Perceptions of all 3 main sharing exp canals for emulation

Learning all types but evaluation

- Toolkit>general
- Toolkit>a 'practitioner's guide'
- Toolkit>not all evidence-based but experience
- Toolkit>tested in DRC, success
- Nvivo WB='Not one key resource'
- IE Toolkit
- Country manuals
- SINAHealth Manual
- being asked by to join trainings
- Cordaid manual
- Cordaid learning tools more practice-based
- Nvivo='2 PBF Bibles in Africa'
- Book by Loevinsohn
- Cascade training at country-level
- Cascade training from SINA>contributing to K and policy diffusi
- Manuals vs. sharing experience=power
- HRITF gen role in learning
- HRITF workshops>learning
- HRITF workshops>lessons learnt and national action plans
- RBF seminars and webinars
- RBF website useful/online courses
- HRITF learning actions perceived as underappreciated
- High-level training
- WB funding training
- Internal WB trainings and learning from the field
- Internal Cordaid training and learning from experience
- Training of African country reps
- Training> 'not really the WB'
- Training> AEDES
- Bridging operational knowledge and decision making?
- Cordaid policy briefs
- Power of study tours in convincing decision makers
- Study tours>general
- Study tours>WB facilitating
- Study tours>1st phase of diffusion
- Study tours>followed by restitutions at country level
- Study tours>ppl participating becoming policy champions
- Study tours>criticism
- IE results but no prescriptive message
- WB staff criticism towards HRITF>not enough $ for learning
- Need to develop adaptive tools
- Learning from SINA resources
- Value of K exchanges
- Just being exposed to and
- Sharing early results with implementers, policymakers etc
- Participatory approach to results dissemination
- Internal WB papers production and dissemin°
- Online trainings vs. face2face
- RBF game
- WB staff exchanges
- Very little ownership of the definition by African nationals
- How to deal with technical challenges at country-level
- Appreciation of all 3 main experience sharing canals
- National KI>documentation through the @ and colleagues

Experimentation

- WB push in countries
- Need to have ownership at country-level
- Devloping political buy-in from the beginning
- Institutionalisation> in BF
- Project architecture at the WB
- Political economy in Zimbabwe
- Easy involvement of other donors...
- ...vs WB pushing other donors
- Dynamics with other donors depends on the context
- Need to find 'Policy champions'
- Need to have political stability
- HRITF bringing in PBF pilots in Africa
- Key individual=the director of policies and planning
- Relying on experts who have the network
- Securing implemeters' buy-in
- Fmk of cooperation with the WB
- Main challenge for national KI>high turnover!
- Creating ideal conditions for a pilot to succeed
- WB coercion
- NGOs involved
- Technicalities with other IOs

- Nvivo='They're not blinded by ideology'
- DEs' Contribution to system design
- DEs' Multiple roles in PBF training
- The WB implementers/advocates
- Nvivo='through their lived experience'
- Genesis of HRITF=Norway
- Conflicts abt PBF>general
- Conflicts abt PBF> **DE's perceptions**
- Conflicts>irritation towards academics
- Perception of trainer **DEs** > by WB staff

Appendix M. Research brief: Preliminary research findings (in English, focus on global and continental levels)

Diffusion of performance-based financing
Preliminary research findings from in-depth interviews and participant observation

Performance-based financing in Subsaharan Africa: describing diffusion entrepreneurs' characteristics and exploring their strategies to achieve policy diffusion

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Introduction: In the 2000s a healthcare financing reform was implemented in Subsaharan Africa (SSA): performance-based financing (PBF). PBF has been recently framed as a possible instrument to introduce *strategic purchasing* towards universal health coverage. It suggests a gradual shift from an input-based purchasing system to an output-based approach involving systematic verification and counter-verification. Promoters posit that this system will increase quantity and quality of services. Despite mixed scientific evidence on its effects, a wide array of actors have significantly invested in PBF, hoping to generate more knowledge on the how and why PBF may work. As of June 2017, no less than 35 out of 52 (67,3%) SSA countries have had an experience with PBF.

Aim: Using a preliminary framework outlining diffusion entrepreneurs' features and strategies, we aimed at shedding light on 1) what shaped critical diffusion entrepreneurs' engagement in PBF, and 2) how strategies to achieve PBF were developed and implemented: framing the policy in popular international discourses, generating emulation around PBF among SSA actors, producing and disseminating multiple types of knowledge, and facilitating country-level cooperation between actors.

Methods: From November 2016 to June 2017, data was collected from key informants (N=46) through in-depth interviews via a snowball approach, and from participant observation in PBF-related workshops, webinars and meetings (N=10). Key informants were: representatives of international donors, academics, African consultants, and national policymakers. Using a deductive-inductive approach whereby our framework inform the main analytical categories, data is coded using QDAMiner© and thematic analysis is subsequently applied. Ethical clearance was obtained from University of Montreal's *Comité d'éthique de la recherche en santé* in November 2016.

Preliminary results: PBF is promoted by a nexus of several individuals, networks, and institutions. We call them diffusion entrepreneurs (DEs). A common representation system and the ability to join various resources shape DEs' engagement for PBF. Individual DEs primarily include international experts who know each other from experimenting earlier (and sometimes competitive) versions of PBF (i.e. *contracting* approaches) with NGOs in Cambodia and Rwanda.
*Individual diffusion entrepreneurs share similar representation systems, from which one paradigm appears to stand out: that of new public management[1] (NPM). International organisations (e.g., The World Bank, USAID) and NGOs (e.g., Cordaid) involved in promoting and implementing PBF also share a culture rooted in NPM, whereby values such as accountability, efficiency, and value for money are promoted.
*International organisations strongly involved in diffusing the PBF idea benefited from a favourable positioning – their robust political influence in both international and domestic arenas – and an established reputation based on their status, knowledge, and long-term normative involvement in LMICs. Individual DEs pooled their complementing resources (e.g., knowledge, time, social and interpersonal skills). What was still needed was funding. Under the leadership of several Norwegian

[1] New public management (NPM) has been described as a "marriage between two opposite streams of ideas": new institutional economics and business-oriented managerialism applied to the public sector (Hood, 1991).

officials and a few World Bank employees, a multidonor trust fund was established. In late 2007, after securing financial engagement of both Norway's NORAD and UK's DfID, the fund became the *Health Results Innovations Trust Fund* (HRITF). Financial resources raised were to be used for implementing a variety of PBF-related activities.

From interview data and observation notes, we have gathered that PBF diffuses through strategies that have been planned and implemented by diffusion entrepreneurs in SSA, and driven by a financial catalyst – the HRITF. These strategies also benefit from favourable opportunity structures brought by globalisation (enhanced ways of communication, cheaper traveling, etc.). Strategies involve:

i) Ideational framing: on top of NPM, DEs mobilise popular international relations discourses, such as the ones of "governance", "local autonomy", and "best practices" to frame PBF. PBF is also anchored in the language of South-South learning, whereby flagship countries would become success stories from which other African countries could learn. In SSA countries, national promoters frame PBF as the logical continuation of existing frameworks (e.g., decentralisation) and general orientations (e.g., results-based management).

ii) Emulation: DEs' framing successfully harnessed a number of individuals around two main active PBF networks in SSA: the PBF Community of practice and the HRITF network. There are other informal and professional PBF networks built around former and current employees of consulting firms and NGOs (e.g., the "multicountry PBF network") but their actions are, as of 2017, less visible. All of these networks form what we call the "PBF community". This community is made of North-based as well as SSA-based individuals: consultants, former or current policymakers, and former or current employees of development cooperation agencies, NGOs, and international organisations. A few of these African experts participate to PBF pilot schemes in several SSA countries (Benin, Republic of the Congo, Mali, etc.) as technical assistants employed by consulting firms and NGOs. Importantly, the PBF community claims that it fosters skill development and visibility of these African PBF experts.

iii) Learning: the financial resources raised by DEs enabled to produce and disseminate multiple forms of PBF knowledge in faster ways. Typically, the development of toolkits, training manuals, blog posts builds from lessons learnt from experimenting PBF. These PBF resources gets diffused through training sessions, online and face-to-face peer-learning, study tours, and technical assistance whereby PBF experts from African flagship countries transfer their passion and expertise to other African individuals. Most of these activities were funded through the HRITF and the International Development Association. Among the domestic actors interviewed, many tended to show a strong commitment for PBF after participating to training sessions and study tours facilitated by the PBF community.
Besides, the HRITF officially has promoted a "learning-by-doing" approach. On top of the above, this implied the development of impact evaluations of each of the HRITF-funded pilot schemes. Yet, it remains unclear as to how such learning-by-doing approach (which could bring some uncertainty as to the possible outcomes of the pilot schemes) was introduced to recipient countries' representatives: national interviewees exhibited full confidence in the benefits that the PBF approach would bring to their respective countries.

iv) Cooperation in experimentation: Diffusion entrepreneurs also support PBF through policy advice and technical assistance. DEs' policy advice involved the development of consensus-building strategies (e.g., informal and regular lobbying directed at domestic actors) in order to convince policymakers of the value of PBF. Technical assistance brought together a wide range of actors: the ministry of health, decentralised authorities, health providers, NGOs, technical assistants (often: foreign consultants), and external funder(s). According to most interviewees, effective cooperation between these actors proved to be challenging, often due to a high turnover of government employees. Concerns about the institutional and financial sustainability of the approach – once donors leave – were also voiced by a number of interviewees.

Provisional conclusion: Diffusion entrepreneurs' characteristics and ability to pool their resources were instrumental in diffusing the policy in a coherent way. Without them, it would not have been possible to bring the PBF community together, i.e. all the actors that promote, implement, or evaluate the approach. In turn, without the enabling environment brought by globalisation, which increased ways of communication and possibilities of cheaper traveling, the diffusion strategies developed and implemented by DEs would not have yielded such fast results. PBF diffusion is still ongoing on the African continent, and the sustainability of the diffusion model is not ensured, given that HRITF activities will be taken over by a new financing facility that has a broader portfolio.

Appendix N. Research brief: Preliminary research findings (in French, focus on Mali)

La diffusion du Financement Basé sur la Performance au Mali
Dissémination de résultats préliminaires

La diffusion du FBP au Mali: une exploration des défis et opportunités en termes de cadrage politique, émulation, apprentissage et coopération

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Introduction
Depuis une dizaine d'années, plusieurs partenaires techniques et financiers (PTF) promeuvent le financement basé sur la performance (FBP) en Afrique, en vue d'augmenter la quantité et la qualité de la prestation de services de santé et d'améliorer l'autonomie et la responsabilité des prestataires de soins. Le FBP est basé sur le transfert de ressources financières sous réserve de l'atteinte de résultats par les prestataires de soins. Au Mali, après avoir participé à un programme FBP prépilote, le Ministère de la santé et de l'hygiène publique (MSHP) a inclus le FBP dans son plan stratégique national et s'est engagé dans une démarche régionale de cette stratégie en utilisant un financement externe et en demandant l'assistance technique d'experts provenant d'autres pays africains.

Objectif
Cette étude vise à documenter les façons dont le FBP a été graduellement diffusé à travers les acteurs nationaux du Mali (responsables de la mise en œuvre, décideurs et experts aux niveaux central et décentralisé). Nous étudions cette diffusion en analysant quatre mécanismes de diffusion: 1) le cadrage politique et idéologique du FBP, 2) l'émulation (c'est-à-dire la mobilisation et l'engagement des acteurs nationaux autour du FBP), 3) l'apprentissage dans les différents lieux de mise en œuvre du FBP (c'est-à-dire les processus mis en œuvre par les acteurs internationaux, continentaux et nationaux pour développer une « masse critique de gens formés au FBR »), et 4) la coopération entre les acteurs.

Méthodes
Pour étudier le cadrage politique, l'émulation, l'apprentissage et la coopération autour du FBP, nous avons collecté des données qualitatives de janvier à juin 2017: notes d'observation participante lors de rencontres nationales (N = 5) et entretiens approfondis (N = 27) avec des experts nationaux de FBP, des décideurs et des prestataires de soins, ainsi que des assistants techniques internationaux et des représentants de bailleurs de fonds au Mali. En utilisant l'analyse thématique, nous identifions les principaux sujets et valeurs associés au FBP au Mali, révélant ainsi comment le FBP est présenté dans le discours national, comment l'idée du FBP a fait des émules parmi les acteurs nationaux, comment l'apprentissage du FBP s'est réalisé et enfin comment ils ont coopéré avec les acteurs internationaux.
Ce projet a été approuvé par le Comité d'Éthique de l'Institut National de Recherche en Santé Publique du Mali en Septembre 2016 (17/2016/CE-INRSP).

Résultats préliminaires
Au Mali, le FBP est inscrit dans la suite logique des politiques de décentralisation et des orientations générales de la nouvelle gestion publique (gestion axée sur les résultats et contrats de performance). Pour les acteurs basés au Mali, le FBP est également conçu comme un instrument utile pour améliorer la qualité des soins et la motivation des prestataires, qui se sentent responsabilisés et

autonomisés. Ce cadrage politique et idéologique façonne l'engagement initial des acteurs nationaux dans FBP.
L'émulation s'est constituée tout d'abord par la mobilisation d'experts nationaux (formés par des experts internationaux) qui ont galvanisé l'intérêt de hauts cadres et décideurs pour le FBP à travers des rassemblements informels et formels réguliers depuis 2010. Une autre source d'émulation essentielle est l'existence de relations de confiance de longue date entre les décideurs nationaux et des experts du FBP en dehors du Mali: ceux-ci ont communiqué leur engouement pour le FBP dans le cadre de sessions de formation internationales et de cours auxquelles ont participé les acteurs maliens. L'apprentissage a été initié par des experts internationaux et africains à travers des séances de formation et des voyages d'étude à l'extérieur du Mali. Au niveau décentralisé, c'est l'interaction avec des assistants techniques africains transférant leurs connaissances et leur passion aux acteurs décentralisés impliquant FBP qui a joué un rôle clé. Cependant, en raison d'un manque d'interaction entre les décideurs décentralisés et centralisés, et d'un fort turn-over parmi les employés du MSHP et les prestataires de soins, l'apprentissage est incomplet. En outre, la coopération au cours de la mise à l'échelle régionale n'a guère fonctionné en raison d'une répétition de malentendus et d'une mauvaise communication entre le bailleur de fonds et les acteurs nationaux. Perte de temps (bureaucratie de la Banque). Par ailleurs, la multiplication de "trous" dans la continuité du FBP au Mali affecte la mobilisation autour de cette politique.

Conclusion provisoire
Documenter l'étendue de la diffusion des politiques parmi les acteurs nationaux est essentiel pour tout acteur prêt à investir dans la politique et à assurer son appropriation et sa durabilité dans un contexte donné. Les développeurs de futurs programmes FBP au Mali devraient construire un partenariat basé sur l'expérience des projets passés dans la région de Koulikoro. Il conviendrait en particulier de miser sur le développement de relations de confiance entre les acteurs (ex : entre bailleur et agence de mise en œuvre ; entre bailleur et ministère de la santé). Enfin, il serait utile de constituer un cadre d'échanges pour que le transfert de connaissances et compétences se réalise du niveau décentralisé (qui ont expérimenté le FBP de manière effective) vers le niveau central.

Appendix O. Policy briefs

Que sait-on en 2016 du financement basé sur les résultats en Afrique ?

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Cette note montre que des programmes de financement basé sur les résultats (FBR) ont été récemment implantés dans de nombreux pays africains, malgré le manque de données probantes sur leur efficacité et leur mise en œuvre.

La présente note de politique est rédigée dans le cadre conjoint de deux programmes de recherche sur le FBR au Mali et au Burkina Faso en collaboration avec Miseli et Agir.

Introduction

Présentée comme véhiculant un modèle « adaptable » à tous les pays, la couverture sanitaire universelle (CSU) émerge au début du millénaire comme politique de santé mondiale. La CSU vise à atteindre un équilibre optimal entre qualité des soins, couverture de la population, et accès aux services de santé sans risque d'appauvrissement. La CSU a été consacrée comme le sous-objectif n°3.8 des ***Objectifs de Développement Durable 2016 - 2030***. En Afrique, plusieurs stratégies de financement visant la CSU ont été mises en avant par les bailleurs de fonds internationaux, dont le financement basé sur les résultats (FBR).

Qui sont les acteurs centraux du FBR en Afrique ?

- Gouvernements des pays africains
- Fonds « *Health Results Innovation Trust Fund* » (HRITF) créé par la Banque Mondiale et réunissant un ensemble de bailleurs internationaux. Le HRITF apporte un appui financier et technique à l'élaboration, la mise en œuvre, le suivi et l'évaluation du FBR, et contribue à la production de données probantes sur le FBR
- Agences de coopération bilatérales et ONG : co-financement et appui technique à la mise en œuvre

Le FBR repose sur l'idée d'un transfert de ressources (financières et matérielles) conditionné par l'atteinte de résultats prédéfinis. Le FBR est promu par les organisations internationales comme moyen de réformer la façon dont les systèmes de santé sont planifiés, financés, coordonnés et évalués. Ces dix dernières années, le FBR s'est rapidement répandu dans d'autres pays africains et un guide mise en œuvre appelé « Boîte à Outils », a été proposé par la Banque Mondiale.

Source : Fritsche et al, 2014

Avec ce développement rapide, le FBR a tendance à être perçu dans les pays comme un nouveau programme, dont l'approche rappelle les interventions de type vertical en santé mondiale. En outre, le manque de viabilité financière des programmes de FBR peut fragiliser la durabilité du système mis en place : dans la plupart des pays, l'État ne finance le régime national de FBR qu'à hauteur d'environ 50 % (p. ex. : 52 % au Burundi d'après Falisse et al, 2014). En ce qui concerne les expériences pilotes de FBR, habituellement celles-ci sont entièrement financées par les bailleurs (Witter et al, 2013). Or il y a peu de visibilité sur l'engagement financier des bailleurs de fonds dans le financement du FBR à moyen et long terme (Kalk et al, 2010).

Fonctionnement du FBR

Le « financement basé sur les résultats » peut faire référence à plusieurs régimes de financements. Ceux-ci sont classés en deux catégories : ceux qui visent à augmenter la demande de services (pour la population), comme le « transfert monétaire conditionnel », et ceux qui visent à augmenter l'offre de services (du côté des prestataires de soins), comme la « rémunération à l'acte médical conditionnel ». Nous nous intéressons ici aux régimes de FBR centrés sur l'offre.

Ce type de FBR entend accroître la responsabilité des systèmes de santé en mettant l'accent sur les résultats (cibles de performance définies à l'avance) plutôt que sur les intrants. Un élément clé de la conception des régimes de FBR est la séparation de la fonction d'acheteur des services (ex : le Ministère de la santé) de celle de vérificateur des prestations (ex : organisme communautaire). Ce dispositif garantirait une vérification vierge de conflits d'intérêts.

Typiquement, un cycle de FBR inclut :

- la conduite d'une étude de faisabilité
- le développement d'un plan stratégique auquel sont adossés les résultats prévus en termes de performance
- la signature d'un contrat entre services de coopération technique, d'une part, formations sanitaires et autorités administratives, d'autre part
- la mise en place d'un système de restitution des résultats sous forme de rapports
- la vérification des résultats dans les formations sanitaires
- la contre-vérification par les utilisateurs de services
- le versement des sommes promises en fonction des résultats obtenus.

Les régimes de FBR se déclinent en trois grandes catégories, souvent complémentaires :

1. le FBR comme moyen de réformer le système de santé dans son ensemble (niveau national ou provincial), par la fixation d'objectifs de santé publique larges (p. ex. : nombre de médecins par habitant) qui orientent le transfert de ressources
2. le FBR comme mécanisme de paiement des formations sanitaires (niveau du district ou d'une formation sanitaire particulière), qui reçoivent des fonds en fonction de la quantité et de la qualité des services qu'elles produisent
3. le FBR comme moyen de motiver les professionnels de santé (niveau individuel) par le versement de primes conditionnées à l'atteinte d'objectifs spécifiques (p. ex. : nombre de femmes enceintes séropositives sous traitement ; meilleurs taux de satisfaction des patients quant à la qualité des soins prodigués).

Il est important de noter que les coûts du FBR ne se limitent pas au paiement des résultats obtenus. Ainsi, avant l'introduction du FBR, d'importants investissements (équipements, infrastructures, etc.) sont à réaliser. En outre, une fois le système FBR mis en place, les frais de transaction liés au versement des primes à la performance sont élevés (p. ex. : 34 % du paiement-résultat au Mali) et récurrents.

Le FBR ne peut pas à lui seul constituer la base du système de santé. Il permet d'augmenter les ressources - liées à la production des produits de services de santé - mais l'existence d'un système de santé solide est essentielle. Si les intrants de base (personnels, médicaments, vaccins) manquent, les professionnels de santé sont contraints par le système FBR de fonctionner tout en étant sans ressources nouvelles. Ce dispositif ne peut générer de bons résultats.

Études sur les effets du FBR

Les évaluations effectuées au Rwanda, pionnier de l'expérience FBR sur le continent, montrent une augmentation du recours aux accouchements assistés mais une absence d'effets sur les services de planification familiale (Fritsche et al, 2014). Une autre étude (sans groupe contrôle, donc à utiliser avec précaution) conclut à une amélioration de la qualité des césariennes, mais à une qualité inchangée des activités cliniques générales, et à une baisse de la qualité dans la gestion organisationnelle de quatre hôpitaux de district convertis au FBR (Janssen et al, 2014). En outre, le FBR n'a pas été en mesure de réduire les inégalités d'accès aux services de santé, il aurait simplement amélioré la qualité des soins reçus pour les enfants pauvres (Skiles et al, 2015).

Au Burundi, le FBR est associé à une augmentation de l'utilisation de certains soins de la mère et de l'enfant tout en n'ayant pas d'impact significatif sur les visites externes, les visites postnatales et la vaccination des enfants (Falisse et al, 2014). Une autre étude indique que le FBR est associé à une augmentation des accouchements institutionnels et des visites prénatales (Bonfrer et al, 2014a). La qualité générale des soins aurait augmenté, mais les patients eux-mêmes ne rapportent aucune amélioration. Cette étude ne démontre aucun effet du FBR sur la vaccination des nourrissons et des femmes enceintes. À l'inverse, un autre article souligne l'augmentation de la probabilité qu'un enfant soit complètement vacciné (Bonfrer et al, 2014b).

La question de l'équité d'accès aux soins est très peu prise en compte dans l'élaboration des régimes de FBR. Leurs effets sur l'équité (notamment d'accès aux soins pour les indigents) n'ont fait l'objet que d'un nombre limité d'évaluations. Celles-ci se sont focalisées sur le Burundi (Bonfrer et al, 2014b), le Rwanda (Lannes et al, 2015), et la Tanzanie (Binyaruka et al, 2015). Leurs résultats sont mitigés et tendent plutôt à montrer une absence d'effet. Des évaluations portant sur les liens entre FBR et équité sont en cours, p. ex. au Burkina Faso (Ridde et al, 2015).

Finalement, on constate un manque d'évaluations rigoureuses : la plupart des études constituent des expériences naturelles (c'est-à-dire, sans étude de référence de type « baseline » ni plan d'évaluation défini à l'avance), dont les résultats sont difficiles à évaluer du fait de l'absence de groupes contrôle auxquels comparer les effets du FBR.

Études sur la mise en œuvre du FBR

Le FBR est susceptible de produire des effets inattendus : négligence des soins non rémunérés, surcharge de travail etc. (Lannes et al, 2015). Très peu d'études portant sur la mise en œuvre ont été réalisées jusqu'à aujourd'hui. Celles-ci sont pourtant nécessaires afin de comprendre les facteurs liés au contexte qui affectent la mise en œuvre du FBR.

Au Bénin, la mise en œuvre du FBR est encore insuffisamment intégrée aux autres réformes en cours. Il apparaît que s'ils apprécient certains éléments du FBR (comme les formations), les acteurs locaux ne se sont pas encore véritablement appropriés le système (Paul et al, 2014).

L'expérience du FBR en Ouganda a quant à elle mis en évidence l'incompatibilité entre la mise en place de la vérification communautaire (et sa logique de « démocratie sanitaire ») et la logique entrepreneuriale du FBR, qui consacre les dispositifs d'incitations financières et le développement de « managers » au sein du système de santé (Ssengooba et al, 2012).

Principaux résultats des études disponibles sur le FBR

- Le FBR augmente potentiellement l'utilisation de certains services de santé maternelle et infantile.
- L'amélioration de la qualité des soins reste encore à démontrer.
- Les effets sur l'équité sont mitigés, de nouvelles évaluations sont nécessaires.
- Au niveau de la mise en œuvre, le FBR peut produire des effets inattendus si les acteurs locaux ne se sentent pas suffisamment impliqués.

Conclusion

En Afrique, on note une insuffisance de données probantes et d'évaluations indépendantes sur les effets des différentes initiatives de FBR, notamment sur l'équité. En outre, il y a peu d'études qui permettent de comprendre les enjeux de mise en œuvre, le jeu des acteurs et les stratégies d'adaptation.

Recommandations

1. Des évaluations dépassant la simple mesure de l'impact sont nécessaires, afin de comprendre plus profondément les mécanismes de causalité autour du FBR.
2. Compte tenu du manque de données probantes, il est recommandé d'agir avec plus de prudence sur l'extension progressive du FBR dans les pays africains et de poursuivre des recherches indépendantes.
3. L'implication de tous les acteurs (ministères de la santé et des finances, directions régionales, hôpitaux, professionnels de santé, etc.) dans l'élaboration et la mise en œuvre du FBR est essentielle pour s'assurer que chacun est disposé à s'adapter à la nouvelle approche.
4. Enfin, si l'approche prouve son efficacité et équité, et que les pays souhaitent maintenir les régimes de FBR sur le long terme, il est nécessaire que les gouvernements nationaux, et en particulier les ministères des finances, s'engagent durablement dans le financement.

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Le financement basé sur les résultats au Mali

L. Gautier, Université de Montréal (Canada)

Cette note de politique expose l'état actuel du financement basé sur les résultats (FBR) au Mali. Elle présente notamment la mise en œuvre et les résultats du programme pilote de FBR dans la région de Koulikoro.

La présente note de politique est rédigée dans le cadre conjoint de deux programmes de recherche sur le FBR au Mali et au Burkina Faso en collaboration avec Miseli et Agir.

Introduction

Avec un taux de mortalité néonatale pour 1 000 naissances vivantes de 37,8 et un taux de mortalité maternelle pour 100 000 naissances vivantes de 587 en 2015 (OMS, 2015), le Mali est activement engagé dans l'amélioration de la santé maternelle et néonatale.

Dès 2012, dans la perspective d'accélérer la réduction de la mortalité maternelle et néonatale, le Ministère de la Santé et de l'Hygiène Publique du Mali a mis en place un programme pilote de financement basé sur les résultats (FBR) dans trois districts sanitaires de la région de Koulikoro. Ce programme pilote, conçu et géré par l'Institut Royal des Tropiques (KIT) et opérationnalisé par la coopération néerlandaise (SNV), a démarré en octobre 2012 (Toonen et al, 2014).

La phase pilote du FBR au Mali

Acteurs

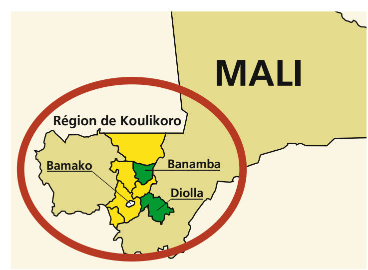
- Direction Nationale de la Santé et Direction Régionale de la Santé de Koulikoro
- Districts sanitaires, Centres de santé de Référence (CSREF) et Centres de Santé Communautaire (CSCOM)
- Institut Royal des Tropiques (KIT) basé à Amsterdam (design, stratégies, développement des instruments, gestion de projet)
- Organisation Néerlandaise de Développement (SNV) (développement des instruments, appui conseil aux acteurs sur le terrain, gestion des paiements en fonction des résultats obtenus)
- ONG (contre-vérification).

Fonctionnement

- Approche adaptée au contexte malien, reposant sur les structures et systèmes existants (« FBR à la malienne »)
- Répartition des fonds d'achat : niveau CSCOM : 60 % pour les investissements et 40 % pour les primes de personnel ; niveau CSREF : 60 % pour les primes au personnel, 40 % pour le fonctionnement et les investissements
- Vérification assurée par les services techniques de l'État avec dispositif de contre-vérification indépendant assuré par des ONG.

Mise en œuvre du programme pilote de FBR

Le programme pilote s'est déroulé durant 24 mois (8 mois de préparation, 16 mois de mise en œuvre) dans les cercles de Dioïla (districts sanitaires de Fana et Dioïla) et de Banamba (district sanitaire de Banamba). À la fin du programme, 26 CSCOM et 3 CSREF étaient couverts par le FBR.



L'une des composantes majeures de la politique sectorielle de santé au Mali est la promotion des centres de santé communautaires. Ainsi, les associations communautaires (ASACO) constituent les structures de gestion des CSCOM. Le programme pilote de FBR a donc intégré les ASACO et les communes (mairies) des trois districts à plusieurs niveaux : définition des résultats attendus (consultation au préalable des besoins et réclamations des utilisateurs de services), validation du plan de résultats (définition des objectifs à atteindre), et vérification des résultats. C'est ainsi qu'on parle d'un « FBR à la malienne ».

Résultats de la phase pilote

Selon les évaluateurs du KIT et de la SNV, le programme de FBR a généré de bons résultats dans les trois districts (voir ci-dessous). Cependant, en l'absence d'une étude de référence de type baseline à laquelle confronter les résultats de la phase pilote, et face à une méthode d'évaluation limitée (p. ex. : dans le rapport, aucune mention des modèles statistiques utilisés, aucun contrôle apparent des facteurs de confusion), il est difficile de tenir les résultats pour acquis. Enfin, le fait que l'évaluation ait été réalisée par la même équipe qui a mis en œuvre la phase pilote affaiblit la crédibilité des résultats présentés.

Évaluation de la phase pilote (mai 2014)

- Augmentation de l'utilisation des formations sanitaires pour certaines prestations concernant la santé maternelle et infantile
- Amélioration de la qualité des services, notamment grâce à la disponibilité continue des soins (ouverture 24h/24, 7j/7). Les effets sur la disponibilité de médicaments essentiels de qualité et la diminution du temps d'attente dans les formations sanitaires doivent faire l'objet d'évaluations supplémentaires
- Augmentation sensible des recettes des ASACO et rationalisation des dépenses
- Amélioration de la gouvernance : gestion plus concertée et transparente entre ASACO, communes et CSCOM
- Amélioration des performances des professionnels de santé et du travail d'équipe
- Recrutement de nouveaux agents pour améliorer la couverture géographique des aires de santé

Source : Toonen et al, 2014

Même si le contexte institutionnel de décentralisation administrative et sectorielle de la santé, propre au Mali, a été pris en compte dans la mise en œuvre du programme pilote, il semble que l'implication des acteurs maliens était insuffisante. Les évaluateurs ont ainsi reconnu l'implication indispensable de deux acteurs ayant une responsabilité importante au niveau de l'offre de soins (outre les services techniques néerlandais) : les communes et les ASACO. En outre, les questions d'équité n'ont pas été spécifiquement prises en compte dans le programme pilote.

Recommandations des évaluateurs du programme pilote

1. Afin d'assurer la viabilité financière du FBR en vue de son extension, il est recommandé de réviser la grille des paiements-résultats en fonction de l'utilisation prévue des services, et de prévoir un financement durable des coûts de transaction.
2. Des efforts sont aussi à réaliser pour le paiement à temps des achats aux prestataires.
3. Il conviendrait également d'intégrer des cibles d'équité, notamment en termes d'accès financier pour les indigents. La coopération néerlandaise recommande aux prestataires d'utiliser les surplus liés au FBR pour augmenter l'accès financier à ces groupes vulnérables.

Vers l'extension du FBR

Les bons résultats apparents ont conduit à un engagement fort des autorités nationales en faveur du FBR. Le gouvernement a ainsi décidé d'insérer le FBR dans la politique nationale : la stratégie FBR a été retenue dans le Plan Décennal de Développement Sanitaire adopté en 2014. L'expérience pilote a conduit à la mise en place d'un réseau de réflexion et de capitalisation des expériences afin de consolider le « FBR à la malienne ».

En outre, dans le cadre du programme de santé maternelle et infantile piloté par la Banque Mondiale, le gouvernement malien a décidé d'élargir l'initiative FBR à l'ensemble de la région de Koulikoro (10 districts). Cette extension vise à améliorer l'accès et l'utilisation des services de santé reproductive de qualité par les femmes en âge de procréer. L'enjeu est de réussir une articulation avec le FBR à la malienne testé avec succès dans les trois districts. Un comité de pilotage composé de sept ministères et de la société civile, ainsi qu'une unité de coordination sous la responsabilité du ministère de la santé ont été créés pour suivre la réalisation de ce programme. Des recherches sur l'émergence, la mise en oeuvre et l'efficacité de cette initiative seront assurées par une équipe de chercheurs Maliens et internationaux (Canadiens, Allemands, Français).

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http://www.equitesante.org

www.graphiquedesign-bf.com

La diffusion du financement basé sur les résultats au Mali a été facilitée par l'intervention d'" entrepreneurs de la diffusion " locaux et étrangers

Lara Gautier, Abdourahmane Coulibaly, Manuela De Allegri, Valéry Ridde

Cette note résume les résultats d'une recherche qualitative portant sur la diffusion au Mali du financement basé sur les résultats (FBR). Elle montre comment plusieurs acteurs locaux et étrangers, appelés "entrepreneurs de la diffusion" ont impulsé et/ou facilité chaque étape de la diffusion.

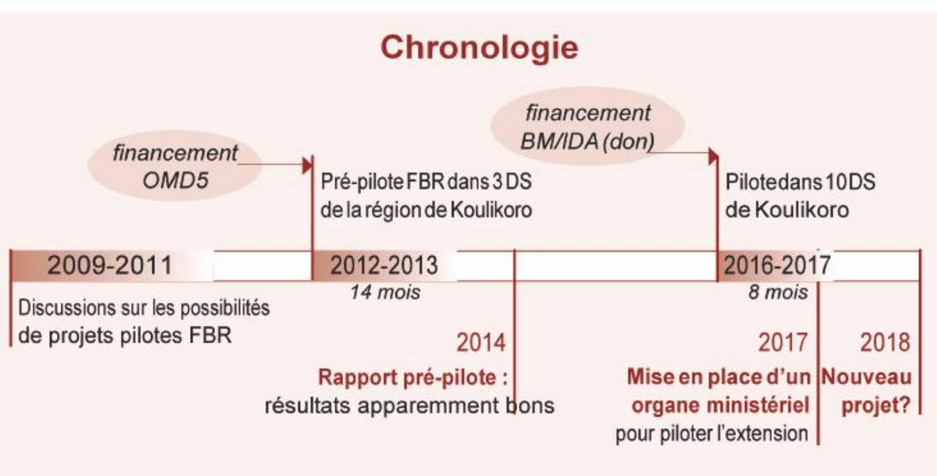
Messages clés

- L'inscription stratégique du FBR au sein des orientations nationales est impulsée par des entrepreneurs de la diffusion locaux et étrangers. Ils conduisent l'agenda d'apprentissage du FBR et suscitent l'émulation des acteurs.
- L'existence préalable de relations sociales entre les acteurs étrangers et locaux est essentielle au processus de diffusion du FBR au Mali..

Le FBR au Mali

Depuis 2009, le Mali s'est lancé dans une réflexion sur l'adoption du FBR afin d'améliorer l'utilisation et la qualité des services de santé maternelle et infantile. Entre 2009 et 2018, le pays a connu deux courtes expériences de FBR dans la région de Koulikoro, appelées « pré-pilote » et « pilote ».

De nombreux acteurs étrangers (d'Europe et d'Afrique) ont contribué à diffuser l'idée et les principes du FBR auprès des acteurs maliens du niveau central et de tous les niveaux de la décentralisation sanitaire. Ces acteurs étrangers participent à la création d'un noyau d'experts du FBR au Mali. Ces derniers deviennent des entrepreneurs de la diffusion au niveau local.



L'étude

La recherche qualitative s'est déroulée de janvier 2016 à novembre 2017. Elle s'appuie sur des données collec- tées à partir de 33 entrevues approfondies, 12 entrevues informelles, cinq séances d'observation participante de réunions, et 17 documents clés sur le financement basé sur les résultats (FBR).

La contribution des entrepreneurs de la diffusion à…

1) La définition du FBR au Mali

La motivation financière correspond au désir de réaliser son travail afin d'obtenir des primes ou son salaire.

- Ancrage des principes du FBR dans les orientations nationales : politiques publiques de décentralisation, contractualisation et gestion axée sur les résultats.
- Diffusion de l'expression « FBR à la malienne » afin de promouvoir un FBR adapté au contexte malien (implication des Associations de santé communautaire, mairies et conseils de cercle, etc.).

2) L'apprentissage et l'expérimentation du FBR

par les acteurs locaux à travers la mise en œuvre des activités interactives ci-dessous :

Un entrepreneur malien de la diffusion du FBR:

"Moi, j'étais déjà imprégné dans l'approche [FBR] [...], je trouvais que ça cadrait mieux avec ma formation de base parce que je suis un économiste de la santé."

Voyages d'études

Echange d'expériences interpays :

- Ghana-Burkina Faso-Mali (2009-2010)
- Voyage au Rwanda (2010)

Formations

- Acteurs du niveau central et régional formés (Bénin, 2014 ; 2016)
- Acteurs des niveaux décentralisés formés dans le cadre des pré-pilote et pilote (Mali, 2013 ; 2016)

Echange avec les experts

- Echanges avec les experts africains et maliens basés à Bamako et dans la région de Koulikoro (Mali, 2016-2017)

3) L'émulation entre les acteurs en faveur du FBR

- Fin des années 2000 : Initiatives de contrats de performance à Dioila, impliquant :
  - Des experts hollandais promouvant le FBR
  - Des employés maliens d'une agence de coopération + un décideur malien
- De 2010 à 2013 : Ce noyau d'experts du FBR au Mali organise des « dîners basés sur les résultats » à Bamako pour convaincre les décideurs
- Pré-pilote 2012-2013: renforcement du noyau d'experts du FBR, participation de médecins-chefs de district
- Pilote 2016-2017 : six experts africains (venant du Burundi, Rwanda et de RD Congo) du FBR transmettent leur engouement aux acteurs maliens de niveau décentralisé

Importance des liens de confiance entre les acteurs

- Histoire commune avec les experts hollandais
- Liens créés lors des formations suivies à l'étranger entre décideurs maliens & formateurs européens/africains promouvant le FBR

Freins à la diffusion du FBR au Mali

- Peu d'interaction entre les acteurs du niveau central et ceux des niveaux décentralisés pendant l'expérimentation, notamment celle du pilote dans la région de Koulikoro.
- Perte d'expertise et d'émulation FBR (anciens décideurs formés partis, turn-over important au ministère) Discontinuité de l'expérimentation du FBR au Mali (entre les deux pilotes puis après 2017)

Conclusions

La diffusion du FBR au Mali a été facilitée par l'im- plantation de stratégies définies par les entrepreneurs de la diffusion visant à rendre le FBR politiquement pertinent. Ils ont façonné son apprentissage et suscité l'émulation auprès d'acteurs influents. Toutefois, d'im- portants défis continuent à freiner sa diffusion.

Recommandations pour la suite du FBR au Mali

- Afin de renforcer l'émulation et transmettre l'apprentissage du FBR aux niveaux central et décentralisés, développer une plateforme de communication inter-institutionnelle
- À l'occasion de la préparation d'une nouvelle expérimentation du FBR, consolider la définition du FBR au Mali en réunissant l'ensemble des entrepreneurs de la diffusion et les acteurs impliqués dans le pilote FBR autour d'une concertation nationale.

Remerciements :
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Appendix P. Scientific paper published in 2018 in Sociedade e Cultura (Open Journal System)

Did the learning agenda of the World Bank-administrated Health Results Innovation Trust Fund shape politicised evidence on performance-based financing? A documentary analysis

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Abstract The World Bank, co-funded by Norway and the United Kingdom, created and managed an innovative financing mechanism, the Health Results Innovation Trust Fund (HRITF), to support performance-based financing (PBF) reforms in low- and middle-income countries. From its inception in late 2007, until the closing of fundraising in 2017, it has carried out a wide range of activities related to experimenting PBF. In conjunction with the World Bank, which positioned itself as a "learning organisation", donors have pushed the HRITF towards developing a specific learning agenda for documenting the policy impact of PBF. This learning agenda has been primarily based on impact evaluations of PBF pilot programmes. As a new body took over the HRITF's portfolio (Global Financial Facility), a documentary analysis of this learning agenda is timely.

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Building from public policy concepts that have been applied to social and health policy, and knowledge translation literature, we examine the learning agenda implemented by the HRITF over these 10 years. Our data includes documentation and publications (N=35) on HRITF and from the HRITF online platform. Results indicate that on several fronts, the HRITF shaped some form of politicised knowledge, notably in the ways country pilot grants were designed and evaluated. Some of its learning activities also provided opportunities for a transformative use of knowledge for World Bank staff as well as national implementers and policymakers. We also provide reflections about the HRITF's preferred approaches to produce knowledge and learn.

Keywords: Performance-based financing, literature review, documentary analysis, the World Bank, impact evaluation, politics of evidence.

> "There is great interest from the global community to learn more about [health results-based financing, RBF] in a short timeframe. This interest stems not only from academics' or practitioners' interest, which is clearly prevalent, but also from a need to provide evidence on RBF in order to foster donor support and country investment, at a time when several countries have to address sustainability concerns." (The World Bank, 2016a, p. 2)

Introduction

The need to develop and use knowledge on the impact of healthcare system policies is a critical strand of work of major global health organisations. A large number of these policies addressed public healthcare systems financing in low – and middle – income countries (LMICs). Indeed, for the past 20 years, many healthcare financing strategies to improve supply, demand, and access to health services have been promoted and funded by international donors. These are piloted and scaled-up in spite of uncertainty as to their impact and effects on health systems. A report by the World Health Organization (World Health Organization, 2013) on achieving universal health coverage (UHC) – which, among all these strategies, has been winning donors' attention – emphasises critical research gaps to be addressed.

Along with UHC, an approach mostly focusing on the supply-side of the healthcare financing equation was introduced: performance-based financing (PBF). PBF has been defined as a "policy innovation, whereby healthcare providers are, at least partially, funded on the basis of their performance" in attaining predefined healthcare targets (Gautier et al., 2018, p. 165). Pilot programmes of PBF have multiplied over the past fifteen years inLMICs. These programmes have been promoted, designed, funded, implemented, and evaluated by global actors (i.e., multilateral and bilateral donors, and non-governmental organisations) (Gautier; Ridde, 2017). In the mid-2000s, under the leadership of the Norwegian Agency for Development Cooperation (NORAD), the idea of a multi-donor trust fund emerged; and in December 2007, the Health Results Innovations Trust Fund (HRITF) was created. Administered by the World Bank, the HRITF's core missions were to raise funding from donors, to offer technical assistance in countries and build

their institutional capacity to scale up and sustain PBF, and to produce and disseminate "evidence-based knowledge for a successful implementation of PBF" (RBF Health, 2016a). To date, HRITF has committed 385.6 million USD for 35 RBF programmes across 29 countries (Bhandari et al., 2017). This funding was matched to US$2.0 billion provided by the International Development Assistance fund (RBF Health, 2016a). This time period coincides with assessing the ending of the HRITF portfolio – whose fundraising function has been overtaken by the Global Financial Facility (Fernandes; Sridhar, 2017). As a policy idea, a wide range of individuals have challenged PBF (Paul et al., 2018) efficient and equitable approach to improving the performance of health systems in low-income and middle-income countries (LMICs) while its (individual and collective) promoters have sought to actively defend it (e.g., MayakaManitu, 2018; VanHeteren, 2018). This paper thus provides a timely analysis of the learning agenda of one of the major PBF players – the World Bank-managed HRITF.

In global health, analyses of such learning agendas have seldom questioned the use of evidence in policymaking (Lee; Goodman, 2002). Several global health researchers concur that "there has been limited attention on how financial resources used to gather evidence may have influenced its creation and presentation" (Hanefeld; Walt, 2015, p. 120). The HRITF case is interesting because some authors have uncovered potential biases in the evaluation of performance-based financing funded by the HRITF in LMICs (Barnes et al., 2014; Ireland; Paul; Dujardin, 2011; Turcotte-Tremblay et al., 2016). The portfolio of the HRITF may also provide valuable and genuine opportunities for learning in these countries. We consider policy diffusion, research on the politics of evidence, and the knowledge translation literature to investigate the politicisation of this global health institution's learning agenda, which is administered by an international organisation (the World Bank) that refers to itself as "the knowledge bank" (Zack, 2003, p. 70). Our research investigates whether and how the learning agenda of the World Bank-administrated Health Results Innovation Trust Fund shape politicised evidence on performance-based financing. By reviewing the HRITF's documentation and publications assessing the HRITF's portfolio of activities, we aim to shed light onsome of the pitfalls as well as opportunities induced by the implementation of the HRITF's learning agenda.

Methods

i) Analytical framework

Drawing from policy diffusion, analysis of the politicisation of evidence, and the literature on knowledge translation, we build an analytical framework that guides our review of the HRITF's learning agenda.

First, the body of policy diffusion literature can be useful to analyse PBF, because pilot programmes testing this policy innovation have flourished in low- and middle-income countries, sometimes leading to national policy adoption (Sina Health, 2017).

Many countries have learnt from one another. Yet some policy diffusion analysts tell us that learning policy experience from elsewhere raises an important risk of bias (Gilardi, 2010; Weyland, 2009). Investigating the diffusion of social policies, Weyland questions the ability of policy actors to "process the relevant information in a systematic, unbiased way" (Weyland, 2005, p. 263). Instead, they tend to "rely on cognitive heuristics that make it easier to select and digest an overabundance of information but that can also distort inferences significantly" (Weyland, 2005, p. 263). Therefore, policy actors engage in selection and digestion of information based on the cognitive frames available to them.

Cognitive frames have attracted a lot of attention from other strands of public policy literature (Béland; Cox, 2010; Cairney, 2016; Nature, [s.d.]; Parkhurst, 2016b). Drawing conceptual reflections from analysing the so-called movement of "evidence-based policymaking", Parkhurst argues that on the contrary: evidence is political (Parkhurst, 2016b). Indeed, the way knowledge is conceived by policy actors matters because it reflects their belief system (Parkhurst, 2016a, p. 12). Yet policy actors tend not to consider these personal beliefs and motivations in their use and selection of knowledge. Parkhurst identifies two biases in the use of evidence in policymaking: a technical bias (i.e., political manipulation and cherry-picking of evidence) and an issue bias (i.e., in the creation of evidence and/or in the selection of the latter). As a form of technical bias, political manipulation happens when "scientific accuracy" is sacrificed when "policy decisions can determine the political or financial survival of involved actors" or where non-stateactors "produce biased evidence in their interests" (Parkhurst, 2016a, p. 9). Cherry-picking of references towards sustaining scientific evidence making the case for a policy is another example of such bias. Issue bias may arise when policy actors are "unaware how their value systems, or their group identities, bias their understandings and interpretations of evidence" (Parkhurst, 2016a, p. 11). It follows that the legitimacy induced by the production and dissemination of evidence (i.e., publishing and presenting research findings through peer-reviewed articles, reports, and policy briefs (McSween-Cadieux et al., 2017)) may be partial without actors necessarily realising it. A common bias resulting from this process is the confirmation bias, which can be defined as: "the seeking or interpreting of evidence in ways that are partial to existing beliefs, expectations, or a hypothesis in hand" (Nickerson, 1998, p. 175). Lastly, and most importantly, Parkhurst points to the (over)use of impact evaluations in policymaking arenas, which might illustrate another category of bias: that of "attribute substitution". It is about "substituting the difficult questions of what to do to make society better with more straightforward questions of what interventions produce an effect" (Parkhurst, 2016a, p. 384). In other words, attribute substitution is choosing to pursue what can be measured (e.g., incidence rates or vaccination coverage), instead of looking at what might be more significant (e.g., social interactions or underlying structures) in societies. For instance, impact evaluations typically suffer from a representative bias, which derives from "representativeness heuristic" (Gilovich; Griffin, 2002), whereby assumptions are derived from "perception of similarity between a given situation and a prototypical one" (Parkhurst, 2016a, p. 383).

Lastly, the literature on knowledge translation provides relevant analytical lens to identify valuable opportunities that learning agendas may offer. McSween-Cadieux *et al.*'s empirically-drawn framework (Mc Sween-Cadieux et al., 2017, p. 8) identified three types of knowledge use by multiple policy actors (including international actors) in Burkina Faso. The first is related to politicisation (pervasive use), while the other two are "positive" knowledge uses: conceptual use, which enabled actual learning and skill development, and instrumental use, which fostered awareness-raising and change (Mc Sween-Cadieux et al., 2017).

From these theoretical underpinnings, it is possible to draw analytical categories relating to policy actors' interaction with knowledge in global public health. Importantly, we take a different perspective from the literature that provides frameworks depicting how national policymakers interact with knowledge (e.g., Rodríguez et al., 2017). In this investigation, our study objects are not national policymakers but global actors pursuing policy diffusion. We identify four main categories of "knowledge processing": selection, digestion, production, and dissemination of knowledge. The sequencing of these four categories may vary: for instance, dissemination of knowledge may represent the first step towards using knowledge. Parkhust's categories of biases are grouped into the category of "*Persuasive use of knowledge*", while "positive" types of knowledge uses come under an umbrella named "*Transformative use of knowledge*". Building from this, we draw an analytical framework that is applied to the case at hand (Table 1).

Table 1 – Overview of the analytical framework

Knowledge processing categories	**Persuasive use of knowledge**			**Transformative use of knowledge**	
	Technical bias	***Issue bias***	***Attribute substitution***	***Adaptation***	***Skills development***
Selection of knowledge	Cherry-picking of evidence	Confirmation bias	Selecting and setting up a (closed) list of measurable indicators based on international standards	Adopting a more inclusive vision of what constitutes "robust knowledge", and considering critical feedback	Learning how to perform a critical appraisal of various types knowledge resources and identify biases
Digestion of knowledge	Cherry-picking of evidence	Confirmation bias	Simplified digestion of complex data (e.g., digesting data from narrowly defined indicators)	Acknowledging pitfalls, and taking actions to reorient practice	Learning how to interpret results from various types of knowledge resources

<table>
<tr><td>Production of knowledge</td><td>Political manipulation of evidence</td><td>Confirmation bias</td><td>Representative bias; quantitative measurements of complex phenomena (e.g., impact evaluations)</td><td rowspan="2">Filling research gaps / adopting (more) participatory research approaches</td><td>Learning how to implement impact and process evaluations</td></tr>
<tr><td>Dissemination of knowledge</td><td>N/A</td><td>Selective dissemina-tion of knowledge</td><td>Tendency to overvalue results from studies evaluating the (quantitative) impact of policy innovations</td><td>Learning how to disseminate knowledge in meaningful and attractive ways</td></tr>
</table>

Adapted from: Weyland 2005; Parkhurst 2016; Mc Sween-Cadieux et al. 2017, and authors' own propositions

ii) Data collection, extraction, and analysis

For this documentary analysis (Shaw; Elston; Abbott, 2004), we searched for two main types of data: internal resources of the HRITF, and external resources reporting on or analysing the HRITF portfolio of activities. For the former, we looked for online-available resources (including: manuals, reports, web stories, and PowerPoint presentations) extracted from the World Bank's Results-Based Financing (RBF) Health web platform (http://www.rbfhealth.org). We also searched through two main World Bank databases: the World Bank's "Open knowledge repository" database using the following search terms: "performance-based" or "results-based" or "impact evaluation", as well as the World Bank Health and Nutrition "Documents & Reports" database using search terms: "performance-based" or "results-based". We reviewed all the contents of the RBF web platform and screened for content specifically related to the learning agenda. Table 2 summarises the resources extracted.

Table 2 – Titles and sources of documentation extracted from the RBF Health and from the World Bank's website

Category	Title	Web source
Webpage	History. The Health Results Innovation Trust Fund	http://www.rbfhealth.org/mission-history
Webpage	Mission. The Health Results Innovation Trust Fund	http://www.rbfhealth.org/mission
Webpage	Country Pilot grants; Knowledge and Learning grants [screening of all grants in these two databases]	http://www.rbfhealth.org/projects
Institutional strategy	Learning Agenda for Results-Based Financing in the Health Sector: The Health Results Innovation Trust Fund Learning Strategy	https://www.rbfhealth.org/sites/rbf/files/The%20Health%20Results%20Innovation%20Trust%20Fund%20Learning%20Strategy.pdf

Progress report	Using Results-Based Financing to Achieve Maternal & Child Health: Progress Report	http://issuu.com/world.bank.publications/docs/using_results-based_financing_to_achieve_maternal_/1?e=1107022/5228184
Annual report	A Smarter Approach to Delivering More and Better Reproductive, Maternal, Newborn, and Child Health Services, Annual report 2014	http://www.rbfhealth.org/sites/rbf/files/HRITF%202014%20Annual%20Report.pdf
Progress report	Achieving Results for Women's and Children's Health, Progress report 2015	http://www.rbfhealth.org/sites/rbf/files/2015%20Progress%20Report_0.pdf
Evaluation synthesis	Completed Impact Evaluations and Emerging Lessons from the Health Results Innovation Trust Fund Learning Portfolio	https://www.rbfhealth.org/resource/completed-impact-evaluations-and-emerging-lessons-health-results-innovation-trust-fund
Evaluation synthesis	Health Results Innovation Trust Fund Qualitative Research Synthesis Report	http://www.rbfhealth.org/sites/rbf/files/Event/HRITF%20Qualitative%20Reseach%20Synthesis%20Report_March%202015%20Final.pdf
Discussion paper	Qualitative Research to Enhance the Evaluation of Results-Based Financing Programmes: The Promise and the Reality	http://www.rbfhealth.org/sites/rbf/files/Qualitative%20Research%20to%20Enhance%20the%20Evaluation%20of%20Results-Based%20Financing%20Programmes%20The%20Promise%20and%20the%20Reality_0.pdf
Discussion paper	Performance Incentives in Global Health: Potential and Pitfalls	http://documents.worldbank.org/curated/en/260981468150303844/pdf/541060BRI0RBF110Box345636B01PUBLIC1.pdf
Toolkit	Impact Evaluation in Practice Handbook	https://openknowledge.worldbank.org/bitstream/handle/10986/25030/9781464807794.pdf
Toolkit	Performance-Based Financing Toolkit	https://openknowledge.worldbank.org/handle/10986/17194
Toolkit	Health Results Innovation Trust Fund Qualitative Research Tool	http://www.rbfhealth.org/sites/rbf/files/documents/HRITF%20Qualitative%20Research%20Tool.pdf
Blog	Re-Imagining Results-Based Financing: Gearing up for the Future	http://www.rbfhealth.org/blog/re-imagining-results-based-financing-gearing-future
Blog	Knowledge and Learning Grants: Building Solid Foundations for Locally Owned RBF Programs	http://www.rbfhealth.org/resource/knowledge-and-learning-grants-building-solid-foundations-locally-owned-rbf-programs

Blog	Scaling up and integrating your Results-Based Financing scheme: a progression in four phases	http://www.rbfhealth.org/blog/scaling-and-integrating-your-results-based-financing-scheme-progression-four-phases
Blog	My learning experience: Results-Based Financing in Zimbabwe	http://www.rbfhealth.org/blog/my-learning-experience-results-based-financing-zimbabwe
Blog	We just learned a whole lot more about RBF	http://www.rbfhealth.org/blog/we-just-learned-whole-lot-more-about-rbf
Blog	Results-Based Financing Writeshop: Improving implementers' documentation and dissemination of experiences and lessons learnt	http://www.rbfhealth.org/blog/results-based-financing-writeshop-improving-implementers'-documentation-and-dissemination
Blog	Learning from Experiential Performance-Based Financing Knowledge in Burundi and Cameroon	http://www.rbfhealth.org/blog/learning-experiential-performance-based-financing-knowledge-burundi-and-cameroon
Blog	Learning in the Land of the Tango: The Annual Results and Impact Evaluation Workshop for RBF	http://www.rbfhealth.org/blog/learning-land-tango-annual-results-and-impact-evaluation-workshop-rbf
Blog	Building Performance-Based Financing Knowledge Base Key to Successful Scale-Up of Programs	http://www.rbfhealth.org/blog/building-performance-based-financing-knowledge-base-key-successful-scale-programs
Blog	Results-Based Financing: What Research Priorities Should We Address Over The Next Five Years?	http://www.rbfhealth.org/blog/results-based-financing-what-research-priorities-should-we-address-over-next-five-years
Blog	Results-Based Financing: A Proven Model for Better Maternal and Child Health	http://www.rbfhealth.org/blog/results-based-financing-proven-model-better-maternal-and-child-health-0
Blog	Perspective of an Impact Evaluation (IE) Front Line Agent: What are the Lessons Learned from the 2012 IE RBF Workshop?	http://www.rbfhealth.org/blog/perspective-impact-evaluation-ie-front-line-agent-what-are-lessons-learned-2012-ie-rbf-workshop
Blog	A Conceptual Framework for Learning About RBF Programs	http://www.rbfhealth.org/blog/conceptual-framework-learning-about-rbf-programs
Blog	"Oops! Did I Just Ruin this Impact Evaluation?" Top 5 of Mistakes and How the New Impact Evaluation Toolkit Can Help	http://www.rbfhealth.org/blog/"oops-did-i-just-ruin-impact-evaluation"-top-5-mistakes-and-how-new-impact-evaluation-toolkit
Blog	Welcome to the All Things RBF Blog!	http://www.rbfhealth.org/blog/welcome-all-things-rbf-blog

Thirty documents were selected: 15 blog posts, three annual/progress reports, four webpages, three toolkits, two discussion papers, two evaluation syntheses, and one institutional strategy. In addition to these 30 "internal" HRITF or World Bank resources, we looked for two types of documents investigating the HRITF's portfolio. First, we selected relevant documentation on the HRITF from organisations linked to the World Bank (i.e., works ordered by the World Bank, its funders, and a major main think tank that influences the institution). Those include the following, respectively: the Norwegian Agency for Development Cooperation's and United Kingdom's Department for International Development's official websites, online reports produced by the World Bank's Independent Evaluation Group, and the Center for Global Development's website. We identified four key references: an external evaluation from 2014 of the World Bank's health financing strand of work (Schneider, 2014); the Center for Global Development's special blog about the "HRITF at 10" (Bauhoff; Glassman, 2017); NORAD's formal evaluation of the HRITF (Norwegian Agency for Development Cooperation, 2012); and the United Kingdom's Department for International Development report on their involvement in results-based financing (Department for International Development, 2014).

Once we selected the data sources (35 references in total), we developed an Excel spreadsheet containing two types of entries corresponding to our analytical framework: knowledge processing stages (rows) and knowledge uses (columns). Subsequently, we extracted data related to the description of the HRITF's learning agenda. We articulated the results by knowledge processing stages based on our analytical framework, shedding light on some of the pitfalls, but also on the opportunities induced by the implementation of the HRITF's learning agenda. We discussed the results in light of 68 peer-reviewed articles addressing performance-based financing, whose search and selection process has been detailed in a separate paper (Gautier et al., 2018, p. 167).

Results

i) Overview of HRITF activities

Two countries – Norway and the United Kingdom – committed funds to the HRITF. Embracing the evidence-based policymaking injunction (Jones; Young, 2007), these two nations conditioned their financial provisions to the implementation of impact evaluations. Impact evaluations "assess the causal effects (impacts) attributable to an intervention by comparing the outcomes of interest (short, medium, or long term) with what would have happened without the program counterfactual" (Independent Evaluation Group, 2012). Since its inception, the HRITF thus had an explicit learning agenda primarily based on these impact evaluations of PBF pilot programmes (Schneider, 2014): "a well-funded impact evaluation portfolio underpins HRITF's comprehensive learning agenda" (RBF Health, 2016b). In addition to impact evaluations, there were many learning activities developed to implement the HRITF learning agenda (Table 3).

Table 3 – Activities developed to implement the HRTIF learning agenda in LMICs, 2008-2017

Goals	Pilot programme implementation	Knowledge development
Building technical capacity to implement PBF	Funding training at country-level to implement pilot programmes	Funding international training of PBF implementers and/or high-level policymakers in LMICs (NB: training provided by international firms)
Learning from PBF implementation elsewhere	Contracting with international firms or consultants from other LMICs to provide technical assistance for successful implementation	Organising and funding study tours in "success story" countries (e.g., Rwanda, Burundi, Cameroon)
Building country's technical capacity to evaluate PBF	N/A	Building capacity of countries to design, implement, and evaluate RBF programs
Expand "evidence-based" knowledge on PBF	N/A	Designing and implementing impact evaluations with quantitative components only (1st phase, from 2008 to 2012); with quantitative and qualitative components (2nd phase, from 2013 to now)
Provide visibility to the HRITF	Creating and publicising online RBF courses and the "RBF game", publishing annual reports and blogs sharing lessons from pilot experimentation	Publishing blogs, reports, and peer-reviewed articles that share impact evaluations results
Creating a community	Funding and organising international workshops for sharing lessons from pilot experimentation and impact evaluations results	

Source: Authors' compilation based on information available from the HRITF website RBF Health: www.rbfhealth.com

Thus, learning from PBF pilot programmes implementation was a critical aspect of the HRITF's learning agenda.

ii) A politicised selection of knowledge?

The second objective of the learning agenda was to "improv[e] the methods and measures used for assessing RBF (and determinants of its success)" (The World Bank, 2016a, p. 3). Measuring the effect of PBF was therefore critical. This evaluation involved first and foremost the selection of "measurable" indicators. The selection and setting of indicators in PBF represents a critical political moment: health providers get their rewards based on their commitment to achieving a number (quantity) of health services with technical quality (e.g., a qualified health staff should perform a certain number of antenatal consultations per month adequately recorded and followed-up). Since most PBF schemes initially targeted maternal and child health services, designers tended to refer to the same standardised list of indicators (e.g., Rusa et al., 2009). Besides, PBF scheme designers were already planning for impact evaluations and meta-analyses, therefore for comparability purposes, they thought it was best to harmonise lists of indicators. However, this approach resulted in attribute substitution issues. Indicators were often decided by World Bank people with their international partners (e.g., Vergeer et al., 2010), with inadequate consideration for contextual features (Paul; Sossouhounto; Eclou, 2014). At times, indicators did not match the human resources configuration of health facilities in LMICs. For instance, in Mali (The World Bank, 2017a), it is debateable to only reward deliveries assisted by qualified health workers, while birth attendants ("matrones") are in most rural facilities the only staff available to perform such task.

Besides, despite the original idea that HRITF would support results-based financing broadly, i.e. encompassing both supply-side and demand-side incentives, emphasis has been almost exclusively set on the provider. Thus, apart from a few pilot experiences (in Benin, Burkina Faso and Cameroon, for instance), indicators have eluded the inclusion of the worst-off in PBF pilot schemes (De Allegri et al., 2018; Ridde et al., 2018a, 2018b). In response to this criticism, the HRITF portfolio has paid an increased attention to equity (The World Bank, 2015). More recent pilot schemes (e.g., in the Republic of Congo and in Central African Republic) have more systematically included the targeting of vulnerable people ("indigents"). Such schemes comprise an indicator whereby providers are rewarded more if they attend indigents (who do not pay or only pay reduced user fees at the point of service).

iii) Digesting types of knowledge: unravelling the HRITF's learning-by-doing approach

The HRITF's work represents one of the most salient examples of the World Bank deliberately and expressively adopting a *learning-by-doing* approach in health. Besides the development of impact evaluations of HRITF-funded projects (included in CPGs), it also relies on developing non-scientific knowledge through the so-called "knowledge and learning grants" (KLGs) which include funding for in-country and international training and study tours to featured countries (McCune, 2014).

This learning-by-doing vision guiding the learning agenda of the HRITF mayyield transformative uses of evidence. A critical illustration of such potential transformation is the explicit goal to facilitate technical peer-to-peer dialogue across countries through funding and organising study tours (The World Bank, 2009). However, there might be concerns surrounding the "copypasting" approach that emerge: not all the activities implemented by "success story" countries like Rwanda may be adapted to other countries. This type of cherry-picking (learning only from the "best model") leads to overconfidence in a standard model that is bound to mislead country implementers, thereby inducing cognitive shortcuts. From 2015 however, the HRITF has encouraged national delegations to visit other countries that have adopted different PBF models, such as Argentina (McCune, 2015), Burundi (Idrissi; Driss, 2015), or Zimbabwe (Socorro, 2016).

The HRITF online platform (http://www.rbfhealth.org) is a resource repository that serves as the main knowledge management tool operationalising the "learning-by-doing" vision. Notably, it provides online resources for skills development, including trainings, webinars, and the "RBF game". Importantly, it includes a blog initially named "All Things RBF", which "shares stories from practitioners and implementers around the world, including project experiences and personal perspectives from subject matter experts on a range of RBF topics" (Vledder, 2012). The blog started off with overly enthusiastic language (one of the first blog posts was entitled: "Results-Based Financing: A Proven Model for Better Maternal and Child Health" (Vledder, 2013)) which appeared to convey substantial confirmation biases. Conducting a discourse analysis of the content of this blog until July 2014, some authors argued that "[n]one of the 38 blog entries […] were overtly critical or specific about potential limitations of PBF" (Barnes et al., 2014, p. 25). Gradually however, we found that the content of blog posts became more reflective and, more recently, even critical. As an illustration, the first paragraph of a blog entry (by Loevinsohn; Nair, 2017) includes the following sentences: "After more than 8 years of implementing RBF in the health sector, this narrow focus on incentives as the sole driving force for results seems too narrow. Although RBF provides a common approach to thinking about improving the quality, delivery, and coverage of essential services, it is not 'one size-fits-all' by any means".

Uncertainty as to the effectiveness of PBF (Das; Gopalan; Chandramohan, 2016; Ogundeji; Bland; Sheldon, 2016; Witter et al., 2012), raises a few concerns for policymakers' digestion of information on PBF. While World Bank staff acknowledged that evidence was mixed (Kandpal, 2016), there may have been some discrepancy in the diffusion of this information (Paul et al., 2018). Considering that policymakers in LMICs usually have to overcome technical and cognitive barriers to access to research (Hyder et al., 2011), governments with no or little experience with PBF might not have had access to such mixed evidence. This lack of informed decision making prior to engaging in pilot schemes may have led to a confirmation bias, where by government representatives expected PBF to deliver on its promises – based on the moral and financial authority of the World Bank.

iv) Producing multiple types of knowledge?

The HRITF learning agenda entailed the production of multiple types of knowledge. For instance, the RBF Health website provides a number of resources (e.g., reports, evidence syntheses, toolkits, etc.) documenting the impact of PBF. But the core learning component of the HRITF's learning agenda lied in producing impact evaluations. According to its last progress report, 33 impact evaluations were funded by HRITF across 28 countries (Health Results Innovation Trust Fund, 2016). In general, the multiple roles that HRITF, managed by the World Bank, undertook in country pilot grants (CPGs) can be problematic. Indeed, when a Task Team Leader in charge of a pilot scheme (responsible for taking decisions on disbursements, and setting the rules of collaboration for PBF pilot implementation) is also involved in the design and implementation of an impact evaluation of the same program, there is a high risk of confirmation bias. Although one of the core principles of PBF is the separation of functions, few researchers have looked into this issue (Turcotte-Tremblay et al., Forthcoming).

One could argue that concentrating on the sophisticity of impact evaluation designs and on quantitatively measurable data, has been pursued at the expense of policy relevance, leading to the phenomena of attribute substitution. Indeed, attention to operational complexities or intermediary mechanisms may be more useful to policymakers in LMICs. First, expectations about the design of complex (i.e., multi-arm and randomized) models of impact evaluations sometimes differed between the funder and governments' representatives. Some would argue that multi-arm models (applied in Burkina Faso, Cameroon, and Zambia) are "incredibly useful" means for understanding "the most cost-effective strategy to increase coverage and quality, and to establish attributable impact outcomes" (Bauhoff; Glassman, 2017, p. 2). Yet their implementation involved lengthy, heavy, and sometimes even controversial processes (Gautier et al., 2018). In Burkina Faso for instance, there was a discrepancy between what World Bank/HRITF staff wanted to undertake for the impact evaluation, and what local actors actually wished for. The design included four arms to test the impact of PBF alone versus together with other interventions (including health insurance). This testing involved developing a complicated process of randomization – in over 500 facilities – that was criticised by local actors (Ridde et al., 2017). Given the institutional orientation towards a universal health insurance scheme (*ibid.*), it might especially be counter-intuitive to ensure that one of the control groups would not implement insurance. Besides, the national user-fee exemption policy for children under five and pregnant women implemented in 2016 (Zombré; De Allegri; Ridde, 2017a) may undermine the current impact evaluation: it will be difficult to disentangle the effects of this policy from the effects of PBF. In Cameroon as well, there were complaints about the randomization process (also including four arms (De Walque; Robyn; Sorgho, 2013)): several health providers expressed a feeling of injustice (RBF Health, 2014). Second, the support provided by the HRITF included skills development in evidence-

informed policymaking: "capacity building among country teams for implementing impact evaluations" (Elridge; Tekolste, 2016, p. 3). Considering the frustrations expressed by some country representatives, assessing the effects of this approach is significant. Most importantly, making sure county teams understand that policy relevance is more critical than developing sophisticated impact evaluations designs is essential.

To date, evaluating country pilot grants (CPGs) through quantitative methods have remained the fund's priority: very few qualitative components have been included in the evaluative design. A qualitative component was added in only 13 out of these 28 countries (Cataldo; Kielmann, 2016). More importantly, one could argue that process evaluations may be missing from the picture (except for Cameroon where a process evaluation was recently published (De Allegri et al., 2018)), even though they are extremely useful to unpack the "how" – the circumstances in and conditions for which an intervention can deliver expected results. The reasons why HRITF decided not to fund more process evaluations – which could have brought critical and complementing elements to impact evaluations – may lie in the preference for quantitative measurements, which are considered "more straightforward", and above all, more controllable than qualitative inquiries.

Another issue arises with the impact evaluation strand of work: the World Bank (which coordinates the HRITF) appears to have taken a double standards approach to producing scientific knowledge on PBF. Several PBF pilot projects have been funded by the World Bank outside of the HRITF facility (e.g., in Mali and Niger (The World Bank, 2017a, 2017b)): these do not involve scientific evaluations. Generally speaking, the lack of scientific evidence coming from these countries' experience with PBF is problematic because it creates inconsistency. On the one hand, in HRITF-funded CPGs, huge amounts of money have been spent on impact evaluations [The average cost of an impact evaluation done by the World Bank is close to 1 million USD. In Guinea, an impact evaluation of performance-based incentives in education amounted to over 2 million USD (Gertler et al., 2016, p. 217).], and on the other hand, non-HRITF funded pilots have not involved any instrument to produce what is referred to as "robust evidence". It may notably create representative biases. For example, in Mali, only internal reports have been produced on the two pilot schemes implemented in the Koulikoro region (The World Bank, 2017a; Toonen et al., 2014). These pointed to positive outcomes of PBF in that region without controlling for confounding factors. However a concurrent independent investigation using a quasi-experimental design showed no effect on health utilisation (Zombré; De Allegri; Ridde, 2017b) of the first PBF experience. In addition, this research was not cited in the World Bank report that was written afterwards, which illustrates an example of cherry-picking of evidence (The World Bank, 2017a).

v) Disseminating the knowledge

In coherence with the evidence-based policymaking discourse, the underlying idea of the large impact evaluation strand of work, was that the ensuing dissemination of positive results would prompt policymaking (in favour of national scale-up, for instance).

Yet, it remains unclear as to how much actual evidence-based learning recipient countries' representatives was achieved". There are indications that this evidence-based approach to policymaking has not been very effective. In several countries (like Burkina Faso, Benin, or Argentina), "decisions were made to scale up regardless of weak, inconclusive, or incomplete pilot results" (Schneider, 2014, p. 55). One limitation for evidence-informed policymaking includes the fact that data collected by the World Bank through baseline, midline, and endline surveys for impact evaluations undergo an embargo of about two years. The idea of an "open" knowledge bank (Kiendrébéogo, 2014) providing readily available data on PBF pilot schemes is therefore misleading: if policymakers need to wait for years before independent researchers can use this data, and disseminate their own evidence, it may be more difficult for them to make informed and balanced decisions.

Besides the publication of peer-reviewed studies reporting on impact evaluation results, the learning strategy included multiple knowledge dissemination activities. HRITF-funded projects included the organisation of yearly gatherings held in multiple places across the world (e.g., in Thailand in 2011, Turkey in 2012) to disseminate early findings from impact evaluations to national actors implementing PBF pilot schemes funded by the HRITF. Soon, it became clear that these international workshops would also represent relevant fora for sharing decision makers and practitioners' lessons learnt (e.g., in Argentina in 2015, and Zimbabwe in 2016) (Kiendrébéogo, 2014). This opportunity contributed to the development of a community of PBF practitioners (Barnes; Brown; Harman, 2015). The contents of these workshops were often restricted to technical matters (e.g., McCune, 2015). However, with time genuine exchanges of lessons learnt could be shared on these occasions, including on the (not only technical) challenges posed by implementing PBF. This happened, in particular, at the last workshop held in Zimbabwe (The World Bank, 2016b). At the end of the day, actors mostly benefiting from listening to contextualised policy-related challenges (e.g., Jansen; Toonen, 2016) are likely the members of the World Bank Research Group themselves. The shift, starting from late 2012, towards including qualitative components to impact evaluations (Hasan, 2012) might have been the most salient outcome of such exchanges, thereby demonstrating adaptation on the researchers' side – in order to fill research gaps.

In many ways, the learning-by-doing approach may have pushed the HRITF along the path of a "learning organisation" (Akhnif et al., 2017), which includes and values not only scientific evidence but also practice-based expertise and participatory co-constructed knowledge. There are bold indications that the HRITF developed strong skills in meaningful and attractive ways. The recent set up of "RBF writeshops" indicates the HRITF's will to value and promote practitioners' lessons learnt, by teaching them how to document these lessons, and coaching them in developing articles on the topic of their choice (Josephson, 2017). Future research should look into the how and why the learning-by-doing approach is useful to enhance the World Bank's credibility and legitimacy in healthcare financing. Yet, ensuring constant questioning and debating of the knowledge that is produced before it gets disseminated (Health Results Innovation Trust Fund, 2016) remains critical inorder to

avoid any accusation of selective dissemination of knowledge, based on the observed World Bank's mingling of advocacy and knowledge production roles.

Discussion

A politicised learning agenda?

The most frequently cited illustrations of a politicised selection, digestion, production, and dissemination of knowledge are attribute substitution and issue biases.

First, in designing PBF schemes, risks of attribute substitution manifested in the inadequate consideration for contextual features in selecting the policy's indicators. Several papers pointed to a lack of ownership by decision makers (Chimhutu et al., 2015; Gautier; Ridde, 2017). Moreover, the direct beneficiaries of PBF, i.e. health providers at the individual or collective level, were rarely consulted to provide input to the design of PBF schemes in their country/area. In Benin, such lack of contextual consideration has caused incomplete adherence by implementers of the PBF scheme (Paul; Sossouhounto; Eclou, 2014). In Nigeria, an independent study has shown that scepticism about the adequacy of healthcare workers' assessment tools led to incomplete adherence (Ogundeji; Bland; Sheldon, 2016). Therefore, there is a need for enhanced policy relevance in countries where PBF is tested. There needs to be a more adaptive, contextualised type of assistance for designing PBF pilot schemes. At this stage, letting country representatives decide what would fit their epidemiological profile and health priorities/health system general planning would be a first step, and would comply with the Paris *Declaration on aid effectiveness* (OECD, 2005). Trying to integrate or build from previous experience(s) of PBF, even if other donors were involved, would create the conditions for more constructive collaborations with government and other international partners.

Efforts to widen the scope of indicators were not always conclusive. For instance, as indicated in the results, the HRITF portfolio started to introduce more indicators to link incentives to equity performance. Yet, as a recent paper on the Cameroon experience shows, providing higher rewards for the care of the worst-off "does not seem to be enough to effectively reach disadvantaged populations and increase care among the very poor" (De Allegri et al., 2018, p. 7). Providers get individual and collective financial rewards, while patients (including vulnerable ones) still have to pay to access health services.

The cherry-picking of the "right model" to reproduce in other LMICs also raises concerns for policymakers' digestion of knowledge. Indeed, getting primary "inspiration" from the Rwandan model (Meessen; Soucat; Sekabaraga, 2011) through funding and organising study tours and workshops in that country is problematic. In Rwanda, the "mutuelles" model has equally been copy-pasted in many other African countries, often without paying adequate attention to the peculiarities of the Rwanda contexts that made this "success" possible (Chemouni, 2018). The Rwandan experience, which served as "proof of concept" thanks to the publication of a paper in the renowned Lancet

(Basinga et al., 2011), also raises a few questions. The context of Rwanda – recovering from traumatising events under the leadership of a vocal President – is arguably very specific, with a peculiar political settlement, a complete legitimation project, and specific political ideas (Chemouni, 2018). Besides, the conclusion of the Lancet paper were partly questioned by subsequent papers (Ngo; Sherry; Bauhoff, 2016; Skiles et al., 2015) using the same Demographic Health Survey data.

Most importantly, this documentary analysis shows that the World Bank staff was involved in the promotion, design, funding, implementation (through technical assistance), and evaluation. This involvementmay have createda conflict of interest (Gautier; Ridde, 2017; Turcotte-Tremblay et al., 2016). Even though impact evaluations were designed and analysed by a different World Bank group (the Research group, whereas the Health Nutrition Population unit was in charge of pilot implementation), the same institution engaged with each of the stages (i.e. from designing pilot schemes to results dissemination). While some research may have been conduced by external parties, the relationship involved controlled research findings disclosure. This issue starts to get more research attention: authors have shown the possible pitfalls associated with such relationships (Doherty et al., 2018). As mentioned in the results section, this connection raises major risks of confirmation biases in the production of knowledge.

The initial focus on producing quantitative impact evaluations also requires commentary. The emergence of PBF coincided with the renaissance of impact evaluations using quasi-experimental research designs, which had lost credence in the 1980s (Shadish; Cook, 2009). Unlike PBF, community-based insurance schemes mainly expanded in the 1990s: there were very few impact evaluations with quasi-experimental designs published at the time, compared to recent years (Ekman, 2004; Raza et al., 2016; Spaan et al., 2012). Research trends in the 2000 decade, shaped by influential economists such as Esther Duflo, re-emphasised the value and relevance of undertaking impact evaluations to assess the effectiveness of development interventions (Duflo; Glennerster; Kremer, 2007). The main purpose of these evaluations was to draw scalable lessons from these "rigorous" impact evaluation results. Recently, there has been a lot of criticism of this movement, particularly from Nobel-prized economists (Bédécarrats; Guérin; Roubaud, 2017; Deaton; Cartwright, 2018). Critics pointed to the many pitfalls (frequently featuring representative biases) of generalising conclusions drawn from quasi-experimental evaluations, which design actually entails a necessary narrow scope of measureable effects, and which do not account for the many contexts in which the intervention takes place.

As observed in the results section, the content of HRITF's knowledge dissemination workshops were – at least initially – restricted to technical matters (e.g., McCune, 2015). This constriction tended to portray the World Bank as a mere "passive facilitator of learning in global health policy" (Barnes; Brown; Harman, 2015, p. 88). However, such passivity might hide a feature of Ferguson's "antipolitics machine" (Ferguson, 1990), whereby international organisations pursue the constant depoliticisation of complex social issues. Applying this argument to the case at hand would mean for the World Bank – and other

international actors promoting PBF – to be pursuing a strategic depoliticising of PBF-related issues, by reframing those as exclusively technical (Barnes et al., 2014, p. 23). For instance, Barnes and colleagues observe that for promoters (e.g., in Meessen; Soucat; Sekabaraga, 2011) "PBF schemes form contractual relationships rather than hierarchical ones" (Barnes et al., 2014, p. 23). However, issues of power and hierarchies in health facilities in LMICs may not be dealt with simply by issuing contracts between parties.

IIn general, what the HRITF's learning strategy reveal is that donors offered to fund the HRITF for widening the body of knowledge on PBF, without actually knowing which way it could go (Bollinger; Kruk, 2016). This outcome is coherent with the results of two Cochrane systematic reviews (Witter et al., 2012; Wiysonge et al., 2017). The 2012 review notably pointed to important concerns over the imputability of observed effects to PBF as described in the studies, i.e., whether the PBF intervention was independent of other changes occurring at the same time as the intervention, such as other policies in place or seasonal features (Witter et al., 2012).

Opportunities for transformative learning

There were many indications that the HRITF did engage in transformative use of knowledge. The inclusion of qualitative components in impact evaluation designs, as well as the implementation of writeshopsare salient examples of an authentic "learning-by-doing" approach, whereby World Bank researchers acknowledge the complex phenomena generated by PBF, and whereby PBF implementers acquire skills. Besides, the genuine peer-to-peer knowledge and practice-based exchanges created on the occasions of dissemination workshops and/or study tours equally represent positive opportunities for contextual adaptation of PBF schemes in LMICs. Pursuing the constant debating of knowledge is critical to avoid any accusation of selective dissemination of knowledge, based on the observed World Bank's mingling of advocacy and knowledge production roles.

Building on these opportunities, a few policy recommendations can improve the relevance and appropriateness of the PBF portfolio. Primarily, the GFF could learn from the several pitfalls identified in this paper and in the numerous process evaluations published by researchers independently from HRITF-funded pilot programmes (e.g., Chimhutu; Lindkvist; Lange, 2014; Feldacker et al., 2017; Ridde et al., 2017; Turcotte-Tremblay et al., 2017), so as to initiate a reflection on how to re-orient the ways schemes are designed, implemented, and evaluated in LMICs. In particular, the GFF (who has taken over the RBF portfolio) should make sure that the lack of evidence-informed policymaking, which has prevailed for now, does not perpetuate. The GFF might also capitalise on the numerous achievements of the HRITF as a participatory "learning organisation". Lastly, the possible conflict between the "advocacy role" and "knowledge-production role" of the World Bank is a critical aspect that should be further investigated with interview data.

Conclusion

This paper assesses the learning agenda of the HRITF using the available documentation on the subject. It concludes with a nuanced portrayal of the various activities undertaken by the HRITF and the World Bank to expand knowledge on the policy impacts of PBF. In the ways country pilot grants were designed and evaluated, the HRITF shaped some form of politicised knowledge. Several learning activities also provided opportunities for a transformative use of knowledge for World Bank staff as well as national implementers and policymakers.

This piece took an interdisciplinary approach (using public policy and knowledge transfer literatures) to perform a documentary analysis. The various dimensions of the analytical framework proved useful to make sense and organise the rich information extracted from the grey literature. However, the fact that we primarily relied on documents made it difficult to sustain arguments with specific examples and evidence for illustrating some of the analyticaldimensions (e.g., those in the transformative use of knowledge category). This difficulty is an important limitation of this study. An in-depth qualitative investigation including participant observation of World Bank processes and activities would provide more depth in the analysis and unpack implications for future knowledge management strategies at the World Bank. The institution would advance towards becoming a transformative learning organisation should it accept to host such research approach.

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A agenda de aprendizado do Fundo Fiduciário de Inovação em Resultados para a Saúde, administrado pelo Banco Mundial, moldou evidências politizadas sobre financiamento baseado em desempenho? Uma análise documental

Resumo

O Banco Mundial, cofinanciado pela Noruega e Reino Unido, criou e gerenciou um mecanismo inovador de financiamento, o Fundo Fiduciário para Inovação dos Resultados na Saúde (HRITF), para apoiar reformas de financiamento baseado em desempenho (FBD) em países de renda baixa e média. Desde o seu início no final de 2007, até o fechamento da captação de recursos em 2017, realizou uma ampla gama de atividades relacionadas à experimentação do FBD. Em conjunto com o Banco Mundial, que se posicionou como uma "organização que aprende", os doadores levaram o HRITF a desenvolver uma agenda de aprendizagem específica para documentar o impacto político (*policy*) do FBD. Esta agenda de aprendizado tem sido baseada principalmente em avaliações de impacto de programas pilotos de FBD. Considerando-se que um novo órgão assumiu a carteira do HRITF (*Global Financial Facility*), uma análise documental dessa agenda de aprendizado mostra-se oportuna. Tendo por base conceitos de políticas públicas aplicados à política social e de saúde, e a literatura de tradução de conhecimento, examinamos a agenda de aprendizagem implementada pelo HRITF ao longo desses 10 anos. Nossos dados incluem documentação e publicações (N = 35) sobre o HRITF e da plataforma *on-line* do HRITF. Os resultados indicam que, em várias frentes, o HRITF moldou alguma forma de conhecimento politizado, principalmente no modo como as doações para projetos pilotos foram desenhadas e avaliadas. Algumas de suas atividades de aprendizado também proporcionaram oportunidades de uso transformador do conhecimento pelos funcionários do Banco Mundial, bem como de implementadores e formuladores de políticas nacionais. Também apresentamos reflexões sobre as abordagens preferidas pelo HRITF na produção do conhecimento e aprendizado.

Palavras-chaves: Financiamento baseado em desempenho, revisão da literatura, análise documental, Banco Mundial, avaliação de impacto, política de evidência.

¿La agenda de aprendizaje del Fondo Fiduciario para la Innovación en Resultados de la Salud administrado por el Banco Mundial formuló evidencia politizada sobre el financiamiento basado en el desempeño? Un análisis documental

Resumen

El Banco Mundial, cofinanciado por Noruega y el Reino Unido, creó y administró un mecanismo de financiación innovador, el Fondo Fiduciario para la Innovación en los Resultados de la Salud (HRITF), para respaldar reformas de financiamiento basada en el desempeño (FBD) en países de ingresos bajos y medianos. Desde su inicio a fines de 2007, hasta el cierre de la recaudación de fondos en 2017, ha llevado a cabo una amplia gama de actividades relacionadas con la experimentación de FBD. Junto con el Banco Mundial, que se posicionó como una «organización de aprendizaje», los donantes han impulsado el HRITF hacia el desarrollo de una agenda de aprendizaje específica para documentar el impacto de la política del FBD. Esta agenda de aprendizaje se ha basado principalmente en evaluaciones de impacto de programas piloto de FBD. A medida que un nuevo organismo se hizo cargo de la cartera de HRITF (*Global*

Financial Facility), un análisis documental de esta agenda de aprendizaje es oportuno. A partir de los conceptos de política pública que se han aplicado a las políticas sociales y de salud, y la literatura de traducción de conocimiento, examinamos la agenda de aprendizaje implementada por HRITF durante estos 10 años. Nuestros datos incluyen documentación y publicaciones (N = 35) en HRITF y de la plataforma en línea HRITF. Los resultados indican que en varios frentes, el HRITF dio forma a algún tipo de conocimiento politizado, especialmente en la forma en que se diseñaron y evaluaron los subsidios de los países. Algunas de sus actividades de aprendizaje también brindaron oportunidades para un uso transformador del conocimiento para el personal del Banco Mundial, así como para los implementadores nacionales y los formuladores de políticas. También proporcionamos reflexiones sobre los enfoques preferidos de HRITF para producir conocimiento y aprender.

Palabras clave: Financiamiento basado en el desempeño, revisión de literatura, análisis documental, el Banco Mundial, evaluación de impacto, política de evidencia.

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Appendix Q. Blog entry published in International Health Policies in 2019

One year later… yes, we are still talking about PBF in low- and middle-income countries!

internationalhealthpolicies.org/one-year-later-yes-we-are-still-talking-about-pbf-in-low-and-middle-income-countries/

By Lara Gautier

January 18, 2019

Academic publishers' timelines are interesting. Exactly a year ago, Paul *et al.*'s paper received unprecedented attention in the global health stratosphere. Acclaimed by some, criticised by others, the paper certainly sparked much debate on the relevance of performance-based financing (PBF) in low- and middle-income countries (LMICs). This made an analysis of the PBF discourse at the global level all the more relevant – which was the exact purpose of my first empirical PhD thesis paper. The latter, co-authored by my supervisors Manuela De Allegri and Valéry Ridde, got published this Tuesday in Globalization & Health. I was asked to "put in simpler terms" the key findings of this research, so that even my grandma would understand.

Why? Well, applying Carol Bacchi's Foucault-inspired poststructural approach to analyse how policy proposals contain *within them* implicit representations of problems (I know, I've lost some of you already!) isn't exactly easy to explain in everyday language. I'll try anyway!

After a lengthy – and sometimes challenging – data collection with 57 consultants, employees of international organisations, academics, and national policymakers, I was looking for an analytical framework that could help me link the representation systems (i.e., the overarching roadmaps, paradigms, and ideologies that shape policy actors' understanding of the world) of PBF proponents and non-proponents (among them of course, some PBF opponents, but also many *wait-and-see* folks) and their shaping of the discourse of PBF at the global level. Bacchi's "*What's the problem represented to be?*" approach, which highlights how policies represent the problems they intend to address and how governing takes place through this "problematisation", came in handy: we could highlight the specific representation systems of PBF proponents and non-proponents by demonstrating how their cultural and training background features were shaping their underlying problem representations. Using the first six questions of Bacchi's approach, we could critically link these problem representations to their understanding and framing of PBF as the most (or the least) opportune policy solution to these deep-seated problem representations (*yes, I know, my grandma is now rolling her eyes*). We specifically looked at how the use of economic sciences/management sciences/clinical sciences/social sciences language categories reflected their background. The results pointed to quite different understandings of the world, and highlighted several limitations (including eluding issues left "unproblematic") of both proponents' and non-proponents' problem representations – thus calling for much nuancing. For instance, for a long time, equity issues were largely ignored in PBF proponents' discourse, while PBF opponents omitted to address the dire financial and working conditions faced by most health professionals in LMICs. Importantly, interview data also led me to realise that despite similar training (usually in economics), not all PBF proponents shared the exact same deep-seated presuppositions. This entailed numerous debates including among the most enthusiastic PBF proponents – those

we called PBF “diffusion entrepreneurs”.

In several instances, we showed that the proponent/opponent debate which transpired in interviews led these diffusion entrepreneurs (DEs) to reframe PBF so as to increase its political momentum. Several “non-DE” respondents expressed concerns that PBF represented a policy innovation that failed to address structural issues of health systems in LMICs (“*icing on the cake with no cake*”), and/or a “*piecemeal reform*”. This criticism prompted DEs to gradually shift their discourse in 2011-2012. They emphasised the fact that PBF could close the *can do-will do* gap, not only by providing financial incentives, but also by increasing resource generation to enable better performance – notably through work environment improvements and closer performance feedback cycles. A lot of the proponents gradually also acknowledged that PBF indeed needed to be supplemented by other health system reforms. Some DEs strategically framed PBF as a systemic reform with the potential to leverage all health systems reforms, be it as an “entry point” for strategic purchasing, improving health workers’ motivation, or yielding the so-called health systems “data revolution”.

Shifting the attention to strong PBF proponents, Bacchi’s third question, i.e. *How has this representation of the problem come about?*, enabled to examine DEs’ motivations to deal with the problem, their resources (i.e., knowledge, material, social, political and temporal resources), and their expert/scientific/financial/moral authority at the global level. Using interview data, we showed that DEs were driven by a complex set of motivations: a genuine interest to improve health systems in LMICs, political interests (e.g., gaining visibility on the global arena), and financial interests (e.g., matching PBF with donors’ output-based aid “trend”). We also shed light on how DEs pooled their resources and sources of authority to make an impact and spread the policy proposal that matched their problem representations, i.e. PBF.

Empowered by such resources and authorities, DEs still had to seek relevant modes of operation to boost their discourse globally. Here we used Bacchi’s sixth question, i.e., *How and where has this representation of the ‘problem’ been produced, disseminated and defended?*, to illustrate the strategies used by DEs to propel the solution to their problem representations. These strategies entailed controlling the learning agenda, shaping the rules of PBF policy experimentation, and spurring policy emulation by using powerful PBF success stories to inspire LMIC policymakers. One of the key activities catalysing these three endeavours was the organisation of multiple study tours across sub-Saharan African countries. DEs’ strategies also had a snowball effect – creating “second wave DEs” spreading PBF on the African continent. Stay tuned for my next PhD paper to get more information on this!

So yes, one year after Paul *et al.*’s notorious paper in BMJ Global Health, we’re still talking about PBF because in my personal opinion, there’s still much to say about this policy while trying to avoid the strongly politicised debates that developed last year. With less passion, more nuance, and more listening to LMICs’ own problem representations (provided that these too are not shaped by global DEs) and their contextualised adaptation of PBF maybe?

I'm guessing my grandma lies on the floor by now, out of this world. Fortunately, when she wakes up, she can read the full story in Globalization and Health!