Performance-Based Financing (PBF) in Mali: is it legitimate to speak of the emergence of a public health policy?

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We would like to thank the Canadian Institutes of Health Research, Global Affairs Canada and the International Development Research Centre, whose funds made this research possible through the Innovating for Maternal and Child Health in Africa initiative.

1. Introduction

1 In Africa, 'performance-based financing' (PBF) is an approach where 'health care providers are paid for delivering specific services, provided the services follow explicit protocols, with a system of inspection and auditing to assure compliance and to raise quality where necessary' (Musgrove, 2011, 4). Its expansion in sub-Saharan Africa has been particularly rapid (Gautier et al, 2018). In Mali, discussions of PBF have gained momentum since 2010. These have been stimulated by the increasing mobilisation of a number of actors and institutions working in the health sector who have actively supported its deployment (Gautier, 2019a).

2 The political and security crisis following the March 2012 coup d'état in Mali had an a priori limited impact on the process of setting up the country's first PBF pilot project. Indeed, Dutch donor funding for this project was never interrupted, unlike that of many other donors. However, it did result in a four-year delay to the intended launch in 2012 of a second PBF pilot project, which was funded by the World Bank as part of the Strengthening Reproductive Health Project (SRHP) (World Bank, 2017). The first pilot project, which was developed by Dutch partner organisations, was launched in three health districts in the Koulikoro region and ran for a period of 18 months

between 2012 and 2013. According to the authors of the project evaluation report (who also implemented the project), the project resulted in an increase in both service use and health coverage and an improvement in service quality (KIT/SNV, 2014). This first experiment will be referred to here as the 'first PBF project'. The second pilot project ran for eight months from July 2016 in all ten health districts of the Koulikoro region. It will be referred to as the 'second PBF project'.

3 PBF has been the subject of various research studies examining, among other things, its implementation and results in low-income countries (Gorter et al, 2013). However, the question of how it emerges has received very little research attention. A recent article has shed light on the PBF expansion process and the role of political entrepreneurs in this process in Mali (Gautier et al, 2019a). The present study forms part of this knowledge production, focusing on phenomena other than expansion. It draws on Kingdon's (1984) multiple streams theory to examine the sociopolitical and historical context of emergence. While some researchers have used this theory to explore the emergence of PBF in Africa (Sieleunou et al, 2017; Kiendrébéogo et al, 2017), there has not been sufficient attention paid to the influence of the sociopolitical context or ownership processes (Gautier and Ridde, 2017). This article therefore aims to fill this gap by answering three research questions: What forms of PBF ownership have there been in Mali? Has PBF been constructed as public policy in the health sector in Mali? Is it possible to speak of the emergence of a PBF public policy in Mali at this stage?

2. Research methods

2.1 Conceptual framework

4 A public policy can be defined as 'the outcome of activities oriented towards solving public problems within a specific environment by political actors whose interconnections are structured and evolve over time' (Lemieux, 2002, 6[1]). In political science, public policy 'agenda-setting' or 'emergence' is the process whereby a problem becomes a matter of political concern. Several models of public policy emergence have been proposed (Garraud, 1990; Lascoumes and Le Galés, 2007). Kingdon (1984) was one of the first political scientists to reflect on the subject. His theory is based on the interrelationships between three streams that structure the political sphere: the 'problem stream' (e.g. a situation that could lead to an intervention from the public authorities), the 'policy stream' (e.g. different options for solutions to the identified problem) and the 'political stream' (e.g. political climate, changes in public opinion, social movements). According to Kingdon, emergence occurs when there is a successful coupling between the problem stream and the political stream. This coupling is facilitated by two key elements, namely policy windows (favourable opportunities that bring the streams together) and the presence of policy entrepreneurs (actors who use their knowledge of the process to advance their own policy objectives).

5 In this study, we sought to use an analytical framework that would help answer our three questions concerning the emergence of PBF in the context of Mali. While Kingdon's (1984) multiple streams theory shed a lot of light on this subject, it was not able to analyse in depth the way in which social actors interact. It is important to understand the multiple forms of adjustment in the management of public action that are fostered by the plural norms characterising the development context of these

interactions, their instability and their often informal nature (Winter, 2001). The polysemic (Dartigues, 2001) notion of 'arena' is particularly useful in describing this complex reality. In the wake of Bailey's work, which approached the notion as a place of political competition (Bailey, 1971), it has been used in anthropology to aid reflection on the multi-actor context of development (Olivier de Sardan, 1995).

2.2 Data collection techniques and data analysis approaches

6 Our methodological approach was based on qualitative survey techniques, notably semi-structured interviews. Between February and August 2016, 33 interviews were conducted with a number of actors involved in the design and implementation of health policies and programmes in Mali. The interviewees came from a variety of institutions (Table 1).

Table 1. Institutions and number of interviews conducted

Institutions	Number of respondents
Direction Nationale de la Santé (DNS) and other services attached to the Ministère de la Santé	12
Strengthening Reproductive Health Project (SRHP)	1
International organisations	5
Fédération Nationale des Associations de Santé Communautaire (FENASCOM) / Association des Municipalités du Mali (AMM).	5
Former DNS managers and national executives	5
District health workers	3
Consultancy firm (CF)	2
Total	33[2]

7 The selection of respondents was based on the single criterion of contact with the first or second PBF project. The international organisations were selected from among those involved in the health sector in Mali.

3. Results

3.1 Recurring problems and multiple solutions and approaches: PBF as an alternative

The problems

8 For a social condition to become a problem, 'people must be convinced that something should be done to change it' (Kingdon, 1984, 119). There were many problems in the Malian health context at the time of the study. The following three were of particular concern to the authorities and often referred to in official documents.

Weak health indicators

9 The poor performance of the health system was a recurring concern. Access to care within a 5km radius was estimated at 58 per cent. This poor geographical coverage was combined with a low rate of curative consultations (0.43 contacts/inhabitants/year), an estimated assisted birth rate of 53.35 per cent and a family planning uptake rate of 8.8 per cent (MSHP, MSAH, MPFEF, 2015). The problems at the centre of the priorities set out in the Plan Décennal de Développement Sanitaire et Social 2014–2023 (PDDSS [ten-year health and social development plan 2014–2023]) (Ministère de la Santé, 2014) included in particular low care quality and poor service uptake.

Staff motivation and management problems

10 Low cost recovery levels associated with the mismatch between Mali's free health care policies and its health structures' profitability objectives (e.g. free artemisinin-based combination therapy vs sale of antimalarial drugs to community health centres) were an obstacle to achieving the health objectives in Mali. The PDDSS 1998–2007 evaluation report showed that 60 per cent of public employees were demotivated, with low pay being the main reason cited (Ministère de la Santé et Ministère du Développement Social, 2011).

Access to care problems

11 Despite an increase in the number of community health centres[3] as well as the development of mutual health insurance over many years and the introduction of the Assurance Maladie Obligatoire and more recently the Régime d'Assurance Médicale, Mali still had a long way to go in terms of achieving its universal health coverage objectives. The annual mutual health insurance coverage rate was still low at 4.47 per cent in 2014 (Ouattara and Ndiaye, 2017). Moreover, the poorest section of the population had no access to health services for economic reasons. For example, the high cost of emergency obstetric care had led 44 per cent of households to reduce their food consumption (Arsenault et al, 2013).

The solutions

12 From the adoption of primary health care in 1978 until the launch of the first PDDSS 20 years later, there were a succession of reforms aimed at improving health indicators in Mali. The following are among the most well known.

Payment waiver policies

13 The Bamako initiative, launched in 1987, placed a particular emphasis on cost recovery as a means of financing health facilities. Following unsatisfactory results, however, African countries tended to shift towards adopting measures to abolish them (Ridde, 2015). For example, within the space of just a few years, Mali introduced free treatment for the most common pathologies, including HIV/AIDS in 2004, caesarean sections in 2005 and malaria in 2007 (Touré, 2015). In 2005, Doctors Without Borders attempted an experiment that improved the uptake of essential services by eliminating user fees for children aged under 5 and pregnant women (Ponsar et al, 2011).

Contractual agreements, accreditation and Performance-based management

14 In 2007, the Ministère de la Santé introduced a contractual agreement scheme to reward performance, called the 'contrat de performance des hôpitaux' (hospital performance contract). However, the hospital performance evaluation report published in 2018 noted shortcomings in the following areas: the management of biomedical waste, medical fluids and vital generic tracer medicines; the organisation of emergency care; and self-assessment (MSHP, 2019).

15 The Convention d'Assistance Mutuelle (mutual assistance agreement) was another form of contractual agreement in which the Associations de Santé Communautaires (ASACOs [community health associations]) signed contracts with local authorities for public funding to implement annual action programmes in the health domain (AMM, 2016).

16 The accreditation of health facilities has been tested by some international institutions, such as the 'Kènèya Ciwara' programme implemented by the NGO CARE between 2003 and 2008 and Marie Stopes International's 'Blue Star' programme from 2012 onwards. Performance-based management is an approach that encourages programme managers to focus on opportunities rather than problems (Hadjaj-Castro and Wilbeaux, 2012). Following its adoption as a resolution in the Paris Declaration (OECD, 2008), Performance-based management has been increasingly present in the discourse, and many social and health care managers in Mali have been trained in this field. It should be noted that all these initiatives were included in the Programme de Développement Sanitaire et Social 2014–2018 (PRODESS III [health and social development programme 2014–2018]) as strategies for motivating staff (MSHP, MSAHRN, MPFEF, 2014, 98).

PBF and its added value

17 The PRODESS III addressed the relevance of PBF based on two simple questions: How can the health system do better? How can the limited resources be put to better use to promote good health? (MSHP, MSAHRN, MPFEF, 2014, 104). PBF thus presented itself as an innovation that would make better use of resources. Comparing PBF with previous approaches, our respondents highlighted its particular advantage:

'The previous strategies have had their limitations. PBF's going to improve the situation a lot now' (former national health executive).

18 For some respondents, PBF was the synthesis of all the other previous approaches:

'I think PBF combines all these experiments, accreditation, contractual agreements, all of them, when you think about it, they're all there in PBF' (human resources manager in the health sector).

The approaches

19 The health authorities in Mali adopted a number of international guidelines and introduced national strategic plans. The approaches described above were based on a whole set of proposals and recommendations.

International guidelines

20 In the wake of the structural adjustment plans that were encouraged in developing countries during the 1980s by the Bretton Woods institutions (the World Bank and the International Monetary Fund), the guiding principle for any intervention by international multilateral aid organisations is now 'good governance'. This is defined by values such as transparency, the rule of law, the participation of a plurality of actors and the fight against corruption (Baron, 2006). The focus on governance by international organisations has been more concerned with the notion of institutional efficiency and accountability to donors (Bretton Woods institutions) than with improving population participation (Boidin, 2011). Donor influence often affects national ownership, as has been demonstrated in the case of Mali in relation to the implementation of development policies (Bergamaschi, 2008). This is the context in which a large number of African countries have experimented with PBF (Turcotte-Tremblay et al, 2018).

21 The international guidelines most frequently cited by our respondents as having encouraged the adoption of PBF were the Millennium Development Goal 5 (to improve maternal health), the Paris Declaration and the Accra Agenda for Action (OECD, 2008). The latter was designed to reinforce and refine the implementation of the Paris Declaration (OECD, 2008).

National guidelines

22 PBF operates in a context of decentralisation that encourages population involvement in the local management and local ownership of public policies. In 2002, the Malian government adopted a decree setting out the responsibilities that were to be transferred by the state to local authorities in the area of health (Decree No. 02–314/P–RM of 4 June 2002). PBF was elaborated in a section of the PRODESS III entitled 'Financement des outputs' (financing of outputs), which highlighted its benefits (faster results, management autonomy, efficiency and effectiveness, etc.) and principles (pages 104–105). The team from the not-for-profit international development organisation SNV provided details of the first pilot project to the PRODESS III developers, including in particular the Cellule de Planification et de Statistique/Santé, which also benefited from the support of the Dutch Embassy. PBF was absent from other national

programmes, notably the Plan Stratégique de la Santé de la Reproduction (strategic plan for reproductive health) (Ministère de la Santé, 2013).

23 It should also be noted that the profusion of strategic documents in the health sector and particularly the overlap between the PDDSS and the PRODESS (Plan Stratégique National de la Santé de la Reproduction 2014–2018/Plan d'Action National de Planification Familiale 2014–2018[4] [national strategic plan for reproductive health 2014–2018/national family planning action plan 2014–2018]) had resulted in a 'fragmentation' or even a 'blurring' of policies.

3.2 The local PBF arena: diversity of actors and ideological variation around a collaborative project

The 'political entrepreneurs'

24 According to Kingdon (2003, 179), entrepreneurs are 'advocates who are willing to invest their resources – time, energy, reputation, money – to promote a position in return for anticipated future gain'. The expansion of PBF in Mali was mainly the work of local political entrepreneurs, supported by European experts working for Dutch organisations, including the Royal Tropical Institute (KIT) and the NGO Catholic Organisation for Relief and Development Aid (CORDAID). KIT successfully negotiated with the DNS and the Dutch embassy (donor) to use part of the funds earmarked for MDG5 to finance the first pilot project (Gautier et al, 2019a). It is worth noting that the KIT representative and the then national health executive had worked together before taking up their respective positions and therefore knew each other well:

'I worked with the head of KIT when I was still at medical school ... That also made things easier.' (former national health executive)

25 KIT and SNV joined forces by dividing up the workload. KIT took on the design and management of the project, while SNV oversaw its operationalisation in the field. Some of the European experts working for KIT sought to boost their career prospects and gain political recognition through their contribution to establishing PBF (Gautier et al, 2019a). At the end of the project in 2013, a private consultancy firm was set up, headed by a former SNV adviser who had participated in the implementation of the first PBF project. He was supported by a consultant who had been the KIT representative in the first PBF project. Following the World Bank's call for tenders for an agency to set up the second PBF project, this consultancy firm formed a consortium with KIT and CORDAID and submitted a bid. The consortium was subsequently selected to carry out the project.

PBF according to the Dutch cooperation vs PBF according to the World Bank

26 From the very first KIT-prompted discussions on PBF, there was strong demand for a PBF model adapted to the context of Mali. The first PBF project was seen as a way of testing this 'Malian-style' PBF and thus supplanting the World Bank, who some local actors had claimed wanted to trial a 'standard' and potentially unsuitable model of PBF:

> 'Instead of the Bank coming along and sewing us into a straitjacket, putting us in a straitjacket that's not meant for us, let's have a real Malian-style pilot study that takes the ASACOs into account. It won't exist anywhere else' (member of the consultancy firm).

27 This determination to adapt the project did not, however, prevent it from being perceived as an imported project:

> 'Well, that model was imported by the SNV along with the Dutch embassy, and they just explained it to us' (AMM member).

28 By defining the second PBF project as a component of the SRHP, the World Bank saw it as a way of helping to improve reproductive health indicators:

> 'By the end of the project, PBF, like the other components of the project, should be contributing to improving the reproductive health indicators.' (SRHP programme coordinator)

29 This second project was also often perceived by the respondents as not very inclusive because of the rather limited contribution made to its formulation by other stakeholders. In particular, the government was less involved in the development and management processes than it had been in the previous pilot project. The World Bank played a major role in defining the second project's content and monitoring its implementation. The drafting of the procedures manual for the project was entrusted to the aforementioned consortium (composed of Malian and Dutch actors), which was instructed not to stray from the indicators and costings set out by the World Bank. The consortium members thus participated in the implementation of this 'World Bank PBF' as subordinates, unable to influence or change anything.

Windows of opportunity opened up by financing offers and new appointments

30 Windows of opportunity here refers to the specific situations that favoured the implementation of the first and second projects. These were mainly linked to the mobilisation of donor funding. MDG5 funds were used to finance the first PBF project. The backing of PBF by a former national health executive – who later joined the minister of health's cabinet – was instrumental in securing funding for the first PBF project. The second PBF funding opportunity was the SRHP, which included a PBF component.

3.3 Emergence under duress

The limited impact of the pilot projects

31 Neither pilot project was able to demonstrate that PBF was an effective and efficient solution to the problems identified (Zombré et al, 2017; Zitti et al, 2019). The implementation periods (18 months for the first and 8 months for the second) were not long enough for those involved in the projects to get properly organised in order to deal with the many challenges. The very significant delay in the launch of the second PBF project (4 years behind schedule) had also impacted negatively on the health care staff's motivation levels:

> 'The [second pilot] project was announced how long ago and we haven't seen anything so far, I'm wondering if it's ever going to start' (health worker from one of Mali's health districts).

32 The delay was linked to a number of events, not least the security crisis in Mali. Other determining factors included staff instability and the alleged slowness of World Bank procedures. The original director of the Project Coordination Unit had also resigned, as had the firm responsible for the fiduciary management of the project. In addition, the

recruitment of an agency to implement the project was considerably delayed. Another factor was the often strained relations between one of the World Bank representatives and the bank's Malian partners, with many of the latter believing that this individual was responsible for the second pilot project's late start. Finally, the Ministère de la Santé had, since the end of the first PBF project in 2013, been headed by a string of no fewer than four ministers and general secretaries, each demonstrating a different level of commitment to PBF, resulting in a loss of acquired expertise around this solution along the way.

Poorly structured and undervalued PBF expertise

33 The number of actors with practical experience as opposed to just theoretical training in monitoring and implementing PBF projects was very limited. These individuals were attached either to the consultancy firm or to the division dealing with PBF at the DNS. The technical expertise of the consultancy firm was justifiable given its members had been involved in the implementation of the first PBF project. There had been very few initiatives since the first project had ended that were aimed at developing networking opportunities between these different actors:

> 'We haven't set up a network yet because we've been too busy, but it's only a matter of time' (member of the consultancy firm).

34 Many of the Ministère de la Santé managers who had received training for the two pilot projects had been given new assignments and were no longer in contact with any activities relating to PBF. The regional health director of Koulikoro at the time of the first project had subsequently been appointed to the nutrition division within the DNS. His planning officer had also been transferred to the DNS to lead a national programme unrelated to PBF.

Undecided or under-informed donors

35 Major donors in the health sector, including the Canadian embassy, USAID and UNICEF, participated in a number of meetings during the implementation of the first PBF project. During the first years of FBR in Mali, many technical and funding partners knew little about PBF:

> 'No, I've never heard about the pilot projects you're talking about, I don't know much about PBF' (NGO CARE International executive).

36 It is worth noting that, following the implementation of the two pilot projects, an increasing number of these partners operating in the health sector, particularly the UN agencies, became familiar with the PBF approach during their group discussions, notably thanks to a Dutch diplomat.

Lack of media coverage and politicisation

37 Apart from the launch ceremonies for the two pilot projects and the award ceremonies during the first project, PBF received only minimal media coverage:

> 'There was no publicity about it in the media. It just remained in a rather intellectual little bubble. It wasn't brought out into the open' (DNS executive).

38 There had been very little communication about the initiative, even within the Ministère de la Santé, where most of our respondents, with the exception of those

directly involved in the project, were unfamiliar with PBF. It had not even been 'reclaimed' for political purposes:

> 'The politicians have little knowledge of our health programmes let alone an initiative as low-profile as PBF.' (DNS executive)

39 It is important to stress here that this low politicisation was not unique to PBF and that it extended to many other health programmes and policies.

4. Discussion

40 The study results presented in this article suggest there has been no emergence of a PBF public policy in Mali. This can be explained by multiple constraints, including the low-level impact of local political entrepreneurs, limited windows of opportunity and insufficient interest from donors. In addition, the pilot projects were only of short duration, preventing any contribution to the policy stream. The data showed that the political entrepreneurs relied heavily on the strategy of persuasion from the outset to convince national actors to subscribe to PBF. The periodic results from the first pilot project along with its evaluation results were shared at meetings of the project steering committee, which was attached to the DNS. This 'active framing' discursive approach is often used by political entrepreneurs to persuade decision makers (Schmidt, 2002; Gautier et al, 2018). Kingdon (1984) distinguished four types of actors – managers, officials, directly involved parties, private individuals – which he grouped into two categories, namely actors within the governmental system and actors outside the governmental system. He concluded that none of these actor types dominates the emergence process and that the only category well placed to do so is that of politicians. Our results highlighted the predominant role played by three of the actor types in the deployment of PBF in Mali: (i) senior managers in the Ministère de la Santé, (ii) officials (i.e. the DNS executives) and (iii) non-governmental, directly involved parties (KIT, SNV, CF). The fourth type of actor identified by Kingdon, private individuals, who reflect public opinion and political parties, played no role. In addition, no mobilisation of civil society or political parties was observed.

41 Kingdon's theory has inspired a number of studies on public policy in West Africa. Kadio et al (2017) used the multiple streams theory to understand the emergence and formulation of a solidarity programme aimed at the poorest section of the population in Burkina Faso. Some studies have focused specifically on PBF and in particular on the question of national ownership. For example, Kiendrébéogo et al (2017) showed that there was no emergence of a PBF policy in Chad due to a lack of ownership by stakeholders and an absence of political entrepreneurs. By contrast, the emergence of PBF was made possible in Cameroon through the action of political entrepreneurs and particularly the World Bank (Siéleunou et al, 2017). Using an argument based on this same theory, Zida et al (2017) explained how the decision was taken to create two units (one of which was in charge of PBF) within Burkina Faso's Ministère de la Santé. They concluded that windows of opportunity (appointment of a new minister and administrative changes in budget allocation) had more influence than foreign actors.

42 The implementation of a public policy reveals complex relationships between the theoretical framework and practice. Based on a study of civil society in Niger, Lavigne Delville (2015) showed how the formulation of a project was marked by the ambiguity of concepts, the interplay of actors and the weight of bureaucratic mechanisms.

43 A number of authors have pointed out the limitations of the multiple streams framework (Kusi-Ampofo et al, 2015; Ridde, 2009). However, Shroff et al (2015), in their study of the health insurance model in India, highlighted the fact that Kingdon's theory is flexible and that it does not need to be mechanically applied. Generally speaking, there is little involvement from civil society and political parties in development programmes in Africa, hence the need to better contextualise the application of Kingdon's theory (Beaussier, 2017). This situation therefore calls for less focus on the role of political parties in the emergence of public policy and more on the role of political entrepreneurs. These political entrepreneurs can be likened to 'development brokers' (Olivier de Sardan, 1995) or 'knowledge brokers' (Ridde et al, 2013) because they play the role of innovation 'traffickers'. The contextual specificities of PBF implementation were addressed in a study conducted in Benin, which showed that PBF is not a rigid model and that it can adapt to the priorities of recipient governments (Paul et al, 2017). Our own results revealed that some of the political entrepreneurs chose to construct a Malian-style PBF model as the project was being set up (Gautier et al, 2019a). In contrast to the 'classic' architecture of PBF projects (Fritsche et al, 2014), the Malian model accorded the primary role to local actors – notably the ASACOs and the local administration in the health districts in question. However, the model was deployed on a rather 'top-down' basis. The dominant role of foreign actors and high-level Ministère de la Santé officials in the process did not lend itself to a true ownership of the reform by either the 'subordinates' or the beneficiaries (health workers) working in the districts (Seppey et al, 2017). Because of its resources, staff and limited duration, these actors most often perceived the PBF programme as an 'outsider's project'.

44 Our findings on the involvement of international actors and lack of ownership are similar to those presented in other studies of PBF in African countries (Gautier and Ridde, 2017). The process of the emergence of PBF has been described as nationally owned in Burundi (Falisse et al, 2012), but the pilot PBF initiatives (2006–2009) that resulted in the subsequent development of the national strategy in April 2010 were entirely led by external actors (donors and NGOs). These initiatives were launched 'with the agreement of the Ministry of Health' rather than at its behest (Falisse et al, 2012, 675). The inclusion of PBF on the political agenda was therefore clearly influenced by these external actors. Moreover, in Tanzania, the donors were patently going against the government's wishes (Chimhutu et al, 2015). Chimhutu et al's (2015) conclusion highlighted the fact that recipient governments are likely to receive more financial support if they entrust donors with the leadership of the process and control of the political agenda. This suggests not only that national government ownerships of health funding policies are very limited but that the existing system encourages state disengagement.

45 In other areas of global health, it is generally accepted that international actors (including donors) are key elements in policy making in many low- and middle-income countries (Shiffman, 2007; Gautier et al, 2019b). In these countries, complex interventions are often introduced with the close involvement of external actors (Meessen et al, 2011). However, the state's role in the emergence of public problems is decisive (Bosk and Hilgartner, 1988). In particular, research has shown that government initiatives are essential in terms of making actions visible or, conversely, 'hushing up' public policies (Hassenteufel, 2010). Even in cases where an initiative has come from abroad, the country implementing the proposed reform can take over its

ownership. For example, despite the leading role played by international actors in the introduction of Cambodia's health equity funds initiative, the fact that national actors subsequently then took over the reigns enabled its emergence (Ir et al, 2010; Van de Poel et al, 2016).

46 Sufficient support from key stakeholders (particularly national governments, decentralised public authorities, health workers, donors and aid agencies) is a prerequisite for the long-term sustainability of health funding policies in low-income countries (Kiendrébéogo and Meessen, 2019). This does not, however, generally seem to be the case. Payment exemption policies, in contrast to PBF, have always started out with strong support at the highest levels of government and are subject to extensive politicisation (Ridde and Olivier de Sardan, 2012).

47 Further research based on public policy theories would help unravel the evolving relationships between international actors and governments in the area of global health and give an indication of how these relationships influence policy making.

5. Conclusion

48 The fact that there has been no emergence as yet of a PBF public policy in the domain of health in Mali – despite the fact reflection on future projects to scale up PBF is well advanced – can be largely explained by the many constraints and the limited scope of the policy stream. The constraints have been fostered by the fact that political entrepreneurs have had little room for manoeuvre in a context offering few windows of opportunity. Beyond PBF specifically, our study returns to the question of the introduction of a global logic (PBF) into a local environment, with the whole network of relations between actors that is built up around such a process. This research reveals that the heuristic scope of a study of the dynamics associated with the emergence of a public policy is considerable when the study is founded on an interdisciplinary approach. The interdisciplinary approach adopted here, which was based on a shared reflection between political science, public health and social science, gave us an understanding of the object of study in all its complexity.

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NOTES

1. Unless otherwise indicated, this and all subsequent French quotations have been translated into English.

2. There were only three women among the 33 people interviewed. This predominance of men can be explained by the fact that not many women met our selection criteria in terms of involvement in the preparation and implementation of PBF. All the interviews were conducted by the primary author of this study. Selection was largely based on the snowball sampling method. Oral consent was obtained from each respondent prior to interview in accordance with the research protocol, which had been validated by Mali's Institut National de Recherche en Santé Publique ethics committee (Decision no 24/2015/CE–INRSP). Interviews were conducted in either French or Bambara according to the respondents' preferences. All the interviews were recorded and transcribed in full. A content analysis (Paillé and Mucchielli, 2016) was then carried out using an analytical framework based on the multiple streams theory. An analytical grid was used, and coding was done using the deductive-inductive approach. The preliminary results were presented locally on a number of occasions to discuss their relevance and plausibility.

3. According to Mali's health pyramid, community health centres represent the primary level of health care provision, while referral health centres are the secondary-level provision. All of the estimated 1,368 community health centres (MSHP, 2018) operate under the authority of the Associations de Santé Communautaire (ASACO, community health associations).
4. Ministère de la Santé (2014), Plan d'Action National de la Planification Nationale 2014–2018 (national plan of action for national planning 2014–2018) (Bamako: Ministère de la Santé).

ABSTRACTS

Performance-based financing (PBF) is just one of a number of recent experiments implemented in Mali to improve maternal and child health indicators. This article presents a qualitative study based on Kingdon's (1984) multiple streams theory and an approach inspired by development anthropology. The aim was to describe the forms of national ownership of PBF and to determine whether it is possible to speak of the emergence of a PBF public policy in Mali at this stage. The contribution of this study is both theoretical (understanding the emergence of a policy) and empirical (roles of local and international actors). The data came from 33 qualitative interviews conducted with individuals representing various institutions, notably the Ministère de la Santé. The results suggest there has been no emergence of a PBF public policy in Mali due to a myriad of constraints, including an insufficient number of political entrepreneurs, windows of opportunity and funding partners as well as the short duration of the pilot projects.

INDEX

Geographical index: Africa Sub-Saharan, Mali
Keywords: aid effectiveness, bilateral cooperation, health

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