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Original Article

From Amsterdam to Bamako: a qualitative case study on diffusion entrepreneurs' contribution to performance-based financing propagation in Mali

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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' (DEs) assist with PBF pilot testing. In Mali, after participating in a first pilot PBF in 2012–13, the Ministry of Health and Public Hygiene included PBF in its national strategic plan. It piloted this strategy again in 2016–17. We investigated the interactions between foreign experts and domestic actors towards PBF diffusion in Mali from 2009 to 2018. Drawing on the framework on DEs (Gautier *et al.*, 2018), we examine the characteristics of 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 interpretive approach, this longitudinal qualitative case study analyses data from observations ($N=5$), interviews ($N=33$) and policy documentation ($N=19$). DEs framed PBF as the logical continuation of decentralization, contracting policies and existing policies. Policy emulation started with foreign DEs inspiring domestic actors' interest, and succeeded thanks to long-standing 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

Key Messages

- In African countries, pre-existing social relationships between foreign and domestic actors critically foster policy diffusion.
- The making of diffusion entrepreneurs (DEs) acting at national and subnational levels is inextricable from the diffusion of performance-based financing (PBF) in Mali.
- DEs deliberately framed PBF as matching Mali's national priorities.
- PBF pilot testing served as strategic leverage for policy learning and emulation in Mali.

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) to participate in their policy process, thereby making LMICs more likely to adopt policy innovations from outside influences. This phenomenon is referred to as policy diffusion (sometimes policy transfer; Stone, 2001). Diffusion scholars study how policies emerge in some political units and subsequently spread to other units (Tosun and Croissant, 2016). Although the role played by foreign actors in the policy process (agenda-setting through evaluation) is well documented, the literature on health policy diffusion in LMICs is still scarce (Bennett *et al.*, 2015), and tends to focus on explanatory diffusion mechanisms. In particular, the complexity of transnational networks', organisations' and individuals' influence in diffusion processes has received little attention from global health scholars (Tosun, 2017; Storeng *et al.*, 2018). It is particularly important to expand the body of knowledge exploring 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 (Sriram *et al.*, 2018). These dynamics call for the application of original approaches to make sense of the ways through which health policies diffuse across LMICs.

The present paper contributes to fill this knowledge gap, by highlighting the interactions between foreign and domestic actors engaged along the diffusion process. Investigating these relationships allows us to shed a critical eye onto government ownership since, 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, 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).

Although studies using a longitudinal perspective to analyse health policy processes in LMIC settings prove highly valuable, they are still rare (Gilson, 2012). One relevant study used a longitudinal approach to analyse health system policies evolution from the 1970s to 2003 in Ghana (Kusi-Ampofo *et al.*, 2015). The authors highlighted the roles played by multiple national and foreign actors to adopt a national health insurance scheme. PBF is a relatively recent reform: it is 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 (KR)] using a case study approach covering the 2009–18 period. We refer to these foreign and domestic actors deliberately using strategies to induce interest for the PBF in Mali as 'diffusion entrepreneurs' (DEs; Gautier *et al.*, 2018). This notion highlights why and how influential actors engage in shaping the policy diffusion process, notably through facilitating all diffusion mechanisms (including policy emulation and learning). The research question: 'How did diffusion entrepreneurs acting at multiple levels contribute to diffuse PBF in Mali from 2009 to 2018?' guided our work. Our findings underline that social interactions between DEs and key actors of the policy process proved to be instrumental in diffusing PBF. Our results not only emphasize local intermediaries' 'appropriation' of the diffusion process but also how this process empowered them to become foreign experts diffusing the policy in other countries.

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 (2009–18). 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 'DEs'), to foster health policy diffusion in developing countries.

Study setting (nature of the case)

Thanks to decentralization 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 centres).

Mali's healthcare system is characterized by a plurality of funding mechanisms, mostly focusing 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 emphasize the purchasing function of health financing. Along this exchange of ideas, and considering policy experiences from other countries, several foreign experts and national policy actors suggested the introduction of financial incentives for health providers upon the

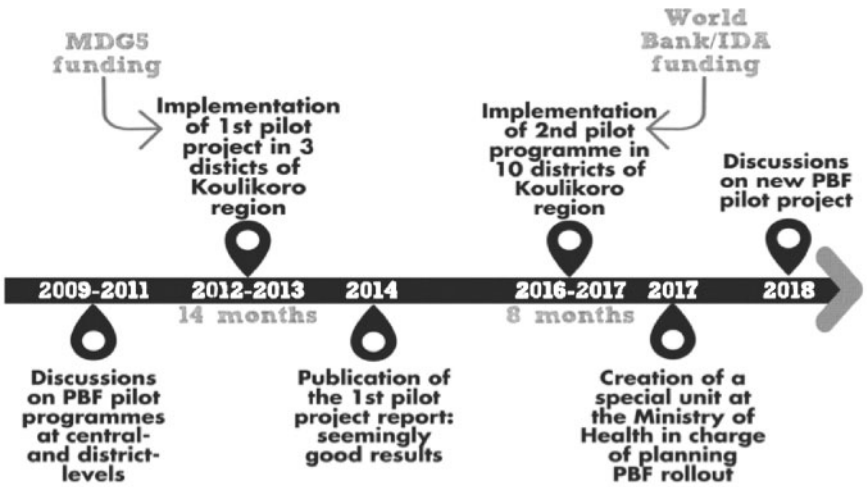

Figure 1. Key events of PBF diffusion in Mali, 2009–18.

attainment of targets, including performance contracting and PBF. Figure 1 maps out the key events of PBF diffusion. The occurrence of these events was known to the authors prior to undertaking the interviews.

In 2012, Mali's MSHP launched a first PBF project in three districts of the KR. The scheme, hereafter called the 3-HD scheme (since it covered three health districts), was designed by Dutch co-operation organizations (Seppey *et al.*, 2017). Multiple community and subnational-level actors were mobilized to fulfil 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 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 2011–17 (The World Bank, 2017). This project, hereafter referred to the 10-HD pilot, was only implemented for eight months between 2016 and 2017.

The Mali case was peculiar in several ways. First, the premises of PBF in Mali involved uncommon DEs operating in SSA, including two Dutch organizations: the Dutch development organization (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 these peculiarities, 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 summarize 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 mobilized a classic PBF 'testing package' with instrumental learning strategies (i.e. study tours; international training sessions).

Box 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 pyramid and mobilizing existing health systems institutions.
Actors and their functions:

- District health centres: provision of health services
- Community health centres: provision of health services
- Koulikoro Regional Health Office: regulation and results verification in district health centres
- DHMTs: regulation and results verification in community health centres
- City councils: purchase of health services in district health centres
- ComHAs and town councils: purchase of health services in community health centres
- Non-governmental organisations (NGOs) (e.g. Blue Star): results counter-verification
- Community-based organizations: 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 organizations including KIT, SNV and Cordaid, provided technical assistance to scheme design, contract development and advocacy at the national level.

Data collection

Guided by the framework on DEs (Gautier *et al.*, 2018), we looked for various sources of data so as to inform each of the components of the framework (see *Analytical approach* section for details). First, in order to map key events of the diffusion, and crosscheck information provided by respondents, we gathered material from key policy documents (Table 1).

Second, from January 2016 to December 2017, the first author collected data from 33 informants (Table 2). This time period was chosen because it coincided with the preparation and

Table 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 and Ghana experiences (2012)
Two manuals for PBF pilot schemes in Mali (2013; 2016)
Mali's Health and Social development plan, 2014–18 (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 capitalization 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)
Three policy briefs assessing the implementation of the second pilot project (2018)

implementation of the 10-HD project. Prior to recruiting participants, ethical approval was obtained from the ethics committees of the authors' institutes.

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 (Supplementary Appendix S1). Over the 2-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.

Analytical approach

Data were analysed using the framework on DEs. The design of this framework was directly informed by the case of PBF diffusion in SSA (Gautier *et al.*, 2018). Drawing on policy diffusion, sociology and health policy literatures, this is a unique theoretically driven framework that features the dynamic and multifaceted aspects of the political economy of PBF diffusion in African countries (Kane *et al.*, 2018). The framework highlights the constituting features and the actions carried out by multiple types of DEs (including actors from low levels of governance, such as foreign consultants) at different levels [global, continental and (sub)national] to diffuse PBF. In Table 3, definitions for each category of constituting features are provided. DEs' actions include framing the policy in ways that are politically attractive, and developing strategies to induce policy emulation (e.g. how socialization sparks interest for a policy), experimentation and learning. Table 4 describes the dimensions of the DE framework at multiple levels. For this study on PBF diffusion in Mali, we investigated the constituting features and actions of DEs at the national level.

The interview material was verbatim transcribed in French (primarily) or English. The first author coded the data using QDAMiner©. Using interpretive thematic analysis (Boyatzis, 1998), we coded the data through a deductive–inductive approach. Initial codes were based on the pre-existing theoretical construct (conceptual framework on DEs, Table 4) and additional codes were developed and integrated as we progressed through the reading. This process was intended to achieve a greater level of analytical detail and widen the interpretation of findings. This approach allowed us to identify implicit and explicit meanings emerging from the data (Peterson, 2017). An excerpt from the codebook (reviewed and approved by all authors) is available upon request.

Results

We describe who the DEs 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 article.

DEs 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 coached and worked with several Mali experts employed by another Dutch organization, 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 area. Following this experience, informants viewed these experts as forceful PBF advocates; hence, we call them Mali DEs acting at the national and subnational levels. Mali DEs also included policy-makers 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, USA, 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 the inefficiencies of health systems. Many respondents adopted foreign DEs' claims that 'everything had been tried' and appeals for new 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 emphasize the healthcare quality. In addition, on a personal level PBF projects also came in timely for these experts: in two cases, their spouse or partner was already working in the country where discussions on PBF began. The combination of favourable timing and personal motivations to link quality of care and PBF appeared to shape their commitment to advance PBF design in the late 2000s. Thus DEs also had an interest in enhancing their professional reputation by

Table 2 PBF in Mali: participants' profile

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 organization [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						

Table 3 Definitions of the DE framework's components (Gautier *et al.*, 2018)

Items	Definition
Representation systems	Representation systems are the overarching road maps that shape policy actors' understanding of the world. They provide entrepreneurs a coherent set of assumptions about the functioning of economic, political and social institutions (Gautier *et al.*, 2018).
Motivations	Entrepreneurs engage in the promotion of certain policies for certain reasons, often involving self-regarding motives as well as genuine interests in solving a given problem. The policy solution they promote for fixing the given problem is likely to align more with their own system representations than other policy alternatives (Gautier *et al.*, 2018).
DEs' resources	
Knowledge	All forms of knowledge assets (e.g. drawn from educational background, professional experience and/or training, academic evidence, lay/practice evidence, etc.)
Material	Human, equipment and financial means at hand
Social	Social capital and actors' natural ability to connect and bond with other people
Political	Actors' ability to mobilize key policy actors (e.g. building upon previous work experience/collaboration with high-level policy-makers)
Temporal	Actors' ability to find/make time, at any point in the diffusion process
DEs' types of authority	
Financial	Recognized status in the global arena that stems from the large amounts of financial resources fuelled into international development co-operation
Moral	Recognized 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, organizations with moral authority can produce norms and play a prescriptive role.
Scientific	Internationally renowned academic status combined with a recognition of the validity/utility of the claimant's perceptions of reality
Expert	Type of renown built on (typically, successful) prior professional experience in implementing a given policy and/or internationally recognized capacity to provide solutions to issues

contributing to PBF conceptualization and diffusion. Dutch experts also endeavoured to propagate their PBF model in Mali as an alternative to other organizations' models:

> *I even brought the [PBF] idea here in [Mali] […]. Why? Because I didn't want the (organisation name removed) to come in… […], with a blueprint. […] 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. European DEs were cognisant of their influence in sparking Mali DEs' international career aspirations:

> *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 the authority of DEs in Mali

Apart from the World Bank, which held critical financial authority and funded the 10-HD project in KR, material resources came from external organizations: none of the DE informants or their affiliated organizations were able to secure their own funding for implementing PBF in the country between 2009 and 2018. Foreign and national DEs' possession of knowledge, social and political resources helped them develop other critical forms of authority, notably expert and moral authorities.

Table 4 The DE framework dimensions (adapted from Gautier *et al.*, 2018, 2019)

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

First, from the beginning of the diffusion process, DE informants in Mali relied on significant knowledge resources. They had 10 or more years of experience in implementing health projects. Second, DEs had strong social resources, notably through DEs' membership to national and continental networks, including Cordaid's professional PBF network. A Dutch DE assumed that the fact that he 'knew everybody' in Mali fostered his ability to convince political actors of the relevance of PBF. Indeed, through his connections to national policy actors—starting with Mali individuals who had worked with him in the past—this DE strategically contributed to creating a national expertise pool featuring policy-makers, consultants and street-level bureaucrats that would promote the PBF policy in multiple settings.

Thanks to such assets, and building on the growing pool of Mali PBF experts, DEs endeavoured to develop a strategic apparatus to spur policy diffusion, i.e. framing the policy in politically desirable ways, inducing policy emulation and shaping policy learning and experimentation.

DE's framing of PBF in Mali

DEs framed PBF first by connecting it to their representations of the key challenges in Mali's health system (based on their worldviews and personal experience), and second by linking the core principles of the policy to past and most recent national plans. Table 5 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.

In the early 2010s, not all policy actors necessarily shared DEs' representations of the problem. For DEs, those policy actors needed to be convinced. There was a strong political consensus on decentralization and contractualization. Individual DEs engaged in repeated interactions with high-level policy-makers 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 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 problems that were put forward.

Such framing had historical precedents. In the mid-2000s, local actors in KR who were involved in the Dutch-led projects to strengthen decentralization and contractualization 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, 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 decentralization, operationalizing 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' (I40_PRIVNFP), instead of a systemic reform.

Table 5 DE's political framing of PBF at the global, continental and (sub)national levels

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 South–South-driven policies	• Accountability mechanisms (can curb corruption) • Autonomy and entrepreneurship of health providers • Introducing PBF as being inspired from peer recipient SSA countries' experience	• Health providers' autonomy (1987 Bamako Initiative) • National decentralization policy and authority transfer (*transfert de compétences*; 1993–96) • National contractualization 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

The last column is drawn from the present original research.
Source: Gautier *et al.* (2019).

Inducing policy emulation

In July 2010, a study tour was organized 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 the 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 policy-maker. 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 policy-makers' engagement was crucial. From 2010 to 2013, DEs organized regular gatherings with high-level policy-makers 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, Democratic Republic of Congo, 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 front-line 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-organized 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 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 policy-makers and street-level bureaucrats received PBF training in Benin in 2014 and 2016. The same training company, a Dutch organizational DE, trained both cohorts. Although informants were generally satisfied with the 2-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 organized courses, health systems networks' events in West Africa, or development co-operation 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 organize 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 (i.e. pooled funding from multiple donors) to the 3-HD pilot.

For Mali DEs, the results of this policy experimentation served to convince policy-makers 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 utilization (Zombré *et al.*, 2017), PBF was included in the health and social development plan for 2014–18 (Secrétariat Permanent du PRODESS, 2013).

Although the 3-HD pilot allowed for some flexibility, stricter rules of collaboration between actors were set for the 10-HD project. The project design was less government-owned than the 3-HD pilot. The MSHP and the World Bank did not appoint a project 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 (8 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 mobilizing national actors into pursuing PBF in KR and raising funds. DEs organized (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 policy-makers' 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 the 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. Our work makes three major contributions to the literature on global health policy diffusion. First, it highlights how global health systems experts from Europe or North America contribute to crafting the discourse and design of PBF in SSA. Second, it emphasizes how these foreign actors participate to 'making' African experts for the purpose of diffusing policy ideas through space and time. Third, it features their ability to strategically shape and facilitate the diffusion processes.

We reflect on this triple 'making' by highlighting the significance of their social interactions with domestic actors and putting it in perspective with current literature.

First, global-level DEs were able to frame PBF in ways that made sense to Mali political actors (1) by crafting this policy solution as being part of national priorities, and (2) by promoting a PBF scheme design 'à la malienne', thereby opening up the opportunity to adapt the policy to Mali's health system pyramid and involving community-based actors. As in previous studies on PBF, similar representation systems (drawn from a training culture in clinical and economics sciences), made key Mali actors receptive to the PBF idea (Broad, 2006; Boulenger, 2009; Soeters, 2010). As in Sierra Leone (Bertone *et al.*, 2018), many street-level bureaucrats saw PBF as having a simple 'income effect', especially during the (unsuccessful) second pilot implementation. As typical entrepreneurs (Mintrom, 1997), Foreign and Mali DEs (re)shaped the terms of the debate on PBF, strategically linking the policy idea to healthcare quality objectives, and framing it as aligning perfectly with local decentralization policies. Interestingly, despite global actors' discourse featuring PBF as a strategy to achieve Universal Health Coverage (Soucat *et al.*, 2017), in Mali such framing did not emerge from our findings.

Of course, DEs might not have the same persuasive effect without the foreign expert status. This supports the idea that foreign experts' authority is central, as this was the case of biomedical

knowledge transfer in India. 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).

A single Dutch individual (with a long history in the country) played a particularly prominent role. His actions were fostered by two main elements: (1) his personal relationships with Mali consultants and key policy actors, whom he coached to become national PBF experts; and (2) his successful framing of the diffusion process as being entirely locally owned. The Dutch DE made sure to involve these local actors in co-designing the scheme 'à la malienne', and openly called for local adaptations of the PBF scheme in Mali. In a seminal book on development co-operation, Rottenburg's (2009, p. 196) accounts of one of his main protagonists who criticized the 'blueprint approach' for constraining local ownership of the development policy under consideration, recall the Dutch DE's actions in Mali. Future studies should look into this phenomenon, which features nuanced reflections on the social interactions between foreign and LMIC actors.

Second, this case study sheds light onto the social making of African PBF experts becoming 'second-generation DEs'. Academic literature on the influence of foreign (usually North American or European) actors on health systems policy-making in SSA countries is prolific (e.g. Chimhutu *et al.*, 2015). Global health scholars often emphasize high-level policy champions in the policy process, without necessarily describing their links to foreign actors (e.g. Pelletier *et al.*, 2012). The role of development brokers (e.g. community leaders and civil society activists) in translating policy ideas locally, and their strategic use by foreign actors is also well documented (e.g. Lewis and Mosse, 2006; Merry, 2006). Yet, to our knowledge, no prior study sheds light onto the observed tendency to fuel policy ideas through country-based employees of local firms as well as street-level bureaucrats. This case study revealed that high-income country experts can influence policy diffusion by strategically creating an African expertise pool that fosters policy diffusion in multiple settings. SSA experts' interests in fulfilling career aspirations enhanced this phenomenon.

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' second-generation DEs. Pre-existing professional relationships among local and foreign actors built trust, and strongly contributed to such 'making'. Constant social interactions were at play during the 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 policy-making (Mayne *et al.*, 2018).

Interestingly, in interviews, national-level DEs tended to minimize the Dutch DE's role in both legitimizing their expertise among major global health actors involved in PBF diffusion and supporting their own actions at the country level. 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 or decolonized approaches to health policy analysis (Brady *et al.*, 2018).

Our 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 decentralization policies) to make sense to an audience of policy-makers. Our study indicates that foreign DEs in Mali did understand their audience, and successfully 'engaged with real world policymaking' through their repeated socialization with high-level policy-makers. This interaction created the conditions for the emergence of a network of PBF supporters, among MHSP officials in Bamako. DEs' ability to mobilize this network and shape the local discourse were critical self-nurturing processes, and 'galvaniz[ed] action' (as in Exworthy and Powell, 2004, p. 277). These processes led to the inclusion of PBF as policy instrument in national planning.

Third, DEs in Mali effectively shaped the policy idea and spread it country- and/or continent-wide through designing multiple diffusion activities, including shaping the discourse, training key policy and implementing actors, and offering technical assistance during pilot testing. Ettelt *et al.*'s (2015) typology suggests that pilot schemes generate policy experimentation, implementation, learning and 'demonstration'. In Mali, exposition and participation to externally funded PBF pilots served as key sources of policy learning. In the early 2010s, the perceived success of (1) Rwanda's compelling story witnessed during the study tour, and (2) the 3-HD project put together by Dutch organizations, mobilized both policy-makers and implementers. These two events enabled 'lesson-drawing' (Rose, 1991) on how PBF addresses certain health systems issues. The discourse spread by Mali experts contributed to legitimize the policy idea in the eyes of national policy-makers 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. In 2016–17, through professional and social exchanges, these experts transferred to some KR implementers their passion, knowledge and tools about PBF. 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. Thus, our findings not only concur with Ettelt *et al.*'s typology but further add that pilot testing also generates socialization between implementing actors also may spur policy emulation.

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 (2010) suggested that front-line workers' autonomy and freedom space was restricted; 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 also identified in a review of PBF in 10 LMICs (Shroff *et al.*, 2017).

This study also provided insights as to the national government's leadership in policy diffusion. In the early and mid-2010s, Dutch and Mali DEs galvanized policy-makers' interest in PBF through their multiple informal gatherings in a luxurious hotel of Mali's capital city. Participants to these meetings contributed to design the PBF 'à la malienne' scheme and became strong policy advocates. Fast forward 2017, even if the shortcomings of the second pilot project triggered doubts about the continuation of PBF in Mali (Zitti *et al.*, 2019), favourable factors sparked the government's renewed political will. When the donor's representative left, political dialogue

started between MSHP leaders and international partners to foster the design of a new PBF pilot scheme. In the meantime, following the creation by the MSHP secretary-general of a special task force responsible for planning the rollout of PBF in Mali, a prominent national DE (coached by the Dutch individual DE) became the principal advisor to the MSHP. This strategic 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'. Thus, it can be argued that in Mali, DEs were relatively successful in securing high-level policy-makers' engagement for PBF, by building on trust relationships, a shared understanding of the key issues of health systems in Mali, and creating consensus around a locally adapted PBF scheme. In comparison, the lack of such consensus in Benin, where two major DEs competed with one another over the preferred implementation modalities (Paul *et al.*, 2017), combined with failure to induce political traction, led to unsuccessful efforts to sustain PBF in that country.

Ultimately, 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 (i.e. employees from a local firm and street-level bureaucrats). This making also features a power relationship whereby local actors remain dependent on getting legitimacy and funding from foreign DE individuals and donor organizations promoting PBF.

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. Still, our findings point to opportunities for improving the framework, notably to examine more deeply dynamic power interactions among DEs, African consultants and other key actors of policy change. Adding another framework component, which would provide the list of possible forms of interaction (e.g. repeated encounters with key policy actors, modes of communication, etc.) that DEs engage in, would be useful.

There are two main limitations to this study. First, despite our endeavour to collect historical accounts of PBF (i.e. prior to 2016 when L.G. first set foot in Mali and A.C. 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 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 DEs but it also highlighted the 'co-evolution' of this making and PBF diffusion processes.

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 second-generation DEs. Further research should also investigate whether African experts can emerge without being 'groomed' or trained by foreign experts.

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).

Supplementary data

Supplementary data are available at *Health Policy and Planning* online.

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