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Beyond the Travelling Model? Strategic Usage and Hybridisation of Performance-based Financing (PBF) in Health in Burundi

Keywords: performance-based financing, health policy, global health, travelling model, Burundi

Performance-based Financing (PBF) has travelled extensively in Africa. The analysis of interviews with key actors and grey literature shows that its implementation in Burundi corresponds to a strategic usage, as a tool for achieving a policy of selective free health-care. It also reinforces a technocratic elite within the Ministry of Health. Grasping such political and strategic reterritorialisation is key to comprehend global health travelling models.

Over the last two decades, Performance-Based Financing (PBF) has emerged as one of the major reforms in health financing in Africa. In this approach, which first started in Africa in the Great Lakes region, health facilities are contracted and paid according to their level of activity, defined by a series of indicators[1]. From Mozambique to Senegal, 21 African countries are currently implementing PBF projects or policies. While public health researchers fiercely debate the effects of PBF on the use and functioning of health-care services[2], much less is known of the socio-political dimension of its implementation. In order to understand PBF and its effects on the development of health policies in Africa, it is imperative to understand how what is described as the *travelling model* par excellence[3] ─in other words, an intervention defined globally and implemented locally─ is re-territorialised or vernacularized to use Sally Engle Merry's term[4]. The ambition of this article is to go beyond what Antoine Vauchez calls the circulatory prism[5], i.e. a problematisation centred on the journey of the model, and give room to the agency of national actors[6]. The study of the case of Burundi shows that the 'success' of PBF comes from its re-invention as a solution to a political issue apparently unrelated to PBF: the implementation of selective free health-care, as promised by the president of the Republic. The theoretical framework of the travelling model originally formulated by Rottenburg[7] is used as an entry point to understand how and why the PBF approach became a reality in Burundi. However, to understand the centrality of PBF in Burundi, it is necessary to also fully integrate the strategic perspective of the national actors into this framework.

The study's primary material consists of field observations conducted between 2009 and 2013, fifteen interviews conducted at that time, and seven additional interviews conducted with key actors in November 2018. These interviews with key actors (officials from different levels of the Ministry of Health, staff members of international governmental and non-governmental organisations, and donors), as well as the grey and academic literature, are analysed with particular attention to the different critical junctures of the PBF journey: pilot, scaling up[8], and national implementation phases. Extensive grey literature on Burundi and PBF had already been collected as part of a previous study[9]; the main sources are the websites of the World Bank, the NGO Cordaid (Catholic Organization for Relief and Development Aid), *Sina Health* (a health consulting firm specialised in PBF), the PBF Community of Practice, and the Ministry of Health of Burundi.

The following section locates the study within the field of research on the political economy of PBF in Africa. The paper then goes on to discuss why PBF appears to be a typical example of

1. < https://www.rbfhealth.org/projects> last accessed 24 sptember 2019.
2. S. Mayaka Manitu, B. Meessen, M. Muvudi Lushimba et J. Macq, "Le débat autour du financement basé sur la performance en Afrique subsaharienne : analyse de la nature des tensions", *Santé publique*, vol. 27, n° 1, 2015, p. 117-128.
3. P. Lavigne Delville, "Pour une socio-anthropologie de l'action publique in les pays 'sous régime d'aide'", *Anthropologie & développement*, 45, 2017, p. 33-64 ; J.-P. Olivier de Sardan, "Les modèles voyageurs à l'épreuve des contextes et des normes pratiques : le cas de la santé maternelle", in D. Pourette, C. Mattern, C. Bellas-Cabane, B. Ravololomanga (ed.), *Femmes, enfants : Anthropologie et santé à partir de Madagascar*, Paris, 2018, p. 83-100.
4. S.E. Merry, P. Levitt, "The Vernacularization of Women's Human Rights,"in S. Merry, P. Levitt. Hopgood, J. Snyder, L. Vinjamuri (ed.), *Human Rights Futures*, Cambridge, 2018, p. 213-236 ; S.E. Merry, "Transnational Human Rights and Local Activism", *American Anthroplogist*, 108, 1, 2006, p. 38-51.
5. A. Vauchez, "Le prisme circulatoire. Retour sur un leitmotiv académique", *Critique internationale*, 59, 2, 2013, p. 9
6. Their capacity to act coherently towards a chosen end. T. By Herdt and J. Bastiaensen. "L'agencéité relationnelle". *Revue Tiers Monde*, 2, 2009, pp.317-333.
7. R. Rottenburg, *Far-fetched facts: a parable of development aid* (Vol. 2). 2002. Lucius & Lucius.
8. Transition from a small-scale pilot projet to a nationwide scheme.
9. M.P. Bertone, J.-B. Falisse, G. Russo, S. Witter, "Context matters (but how and why?) A hypothesis-led literature review of performance based financing in fragile and conflict-affected health systems", *PLOS ONE*, 13, 4, 2018, p. e0195301.

travelling model, and some of the potential conceptual and heuristic difficulties associated with this approach. It is followed by an analysis of the political and strategic aspects of the implementation of PBF in Burundi. The relevance of the analytical prism and the qualification of PBF as a "travelling model" is eventually discussed.

Research on the political economy of PBF

Since the beginning of the 2000s, PBF has generated a dense academic literature that focuses mainly on the technical aspects of the approach's implementation and its effects on the quality and use of health services. As is often the case in global health, the authors include practitioners, consultants and researchers. The boundaries between these categories are sometimes blurred: some authors wear several hats, and many are entangled in various transnational networks. The last systematic review of the effects of PBF by the highly respected Cochrane Foundation was completed in 2012 and concluded that "the current evidence base is too weak to draw general conclusions"[10]. The present article focuses on a different topic: the political economy of PBF. Social science research at this level is currently structured around three main strands.

The first strand focuses on the characterisation of PBF. Even if they sometimes disagree on the most appropriate vocabulary[11], most researchers agree to reject a *minimal* definition of PBF as a simple *scheme for implementing* financial incentives for health care providers[12]. Thus, PBF must be understood as a *system*, which implies a redefinition of relationships between the actors of the health system and an overhaul of the functioning of the health facilities[13]. As the rest of this article will show, national actors in Burundi also have this broad understanding of PBF.

The second strand aims at understanding the debate on PBF in the public space and academic literature. In his doctoral thesis, Serge Mayaka Manitu documents an opposition on the interpretation of facts, which, he notes, are too often marked by individualised experiences of researchers, elevated to the rank of generalities[14]. The opposition is also ideological; it is about the neo-liberal inspiration of PBF, which is in line with *New Public Management* type of reforms, i.e. the promotion of private-sector mechanisms in the public sector. The last major confrontation on PBF took place in mid-2018 in the columns of the *British Medical Journal: Global Health*. Elisabeth Paul and her colleagues wrote a commentary calling for a questioning of the PBF approach[15], describing it as a "process controlled by international consultants and agencies to the detriment of local initiatives and ownership of stakeholders in the field". The

10. A new version is due in 2020. S. Witter, A. Fretheim, F. Kessy, A. Lindahl, “Paying for performance to improve the delivery of health interventions in low- and middle-income countries”, *Cochrane Database of Systematic Reviews*, 2, 2012

11. Different institutions call it different names. I use "performance-based financing", which is the term most commonly used in Burundi and is described by the World Bank as referring to a "financial incentive paid to health care providers” and falls within the broader category of "results-based financing” mechanisms (which may involve patients, for example). See P. Musgrove, P., *Rewards for good performance or results: a short glossary*. World Bank, Washington, DC. 2010.

12. D. Renmans, N. Holvoet, B. Criel, B. Meessen, “Performance-based financing: The same is different”, *Health Policy and Planning*, 32, 6, 2017, p. 860-868.

13. Z.C. Shroff, N. Tran, B. Meessen, M. Bigdeli, A. Ghaffar, "Taking Results-Based Financing from Scheme to System", *Health Systems & Reform*, 3, 2, 2017, p. 69-73.

14. See: S. Mayaka Manitu *et al.*, “Le débat autour…”, art. cité ; S. Mayaka Manitu, M.M. Lushimba, J. Macq, B. Meessen, “Arbitrage d’une controverse de politique de santé: Application d’une démarche délibérative au Financement basé sur la Performance en Afrique subsaharienne”, *Santé Publique*, 27, 3, 2015, p. 425-434.

15. E. Paul, L. Albert, B.N.S. Bisala, O. Bodson, E. Bonnet, P. Bossyns, S. Colombo, V. De Brouwere, A. Dumont, D.S. Eclou, K. Gyselinck, F. Hane, B. Marchal, R. Meloni, M. Noirhomme, J.-P. Noterman, G. Ooms, O.M. Samb, F. Ssengooba, L. Touré, A.-M. Turcotte-Tremblay, S. Van Belle, P. Vinard, V. Ridde, V. De Brouwere, A. Dumont, D.S. Eclou, K. Gyselinck, F. Ssengooba, L. Touré, “Performance-based financing in low-income and middle-income countries: isn’t it time for a rethink?”, *BMJ Global Health*, 3, 2018, p. e000664.

response of African experts involved in the implementation of the PBF was, among others, to point out that this criticism overlooked their role[16]. Keeping in mind this highly polarised context helps cast light on both the efforts undertaken to make the PBF model travel and the ways it has been comprehended in national spaces.
The final strand of social science research on PBF, and in particular the work of Lara Gautier[17], shows the central role of a range of individuals, international organisations, and interest groups in the global promotion of PBF. International donors are described as both the leading promoters and co-implementers of the approach[18]. Maria Paola Bertone and colleagues[19] argue that post-conflict countries seem particularly receptive to PBF, probably because they are environments frequently influenced by external actors, often open to reform, and generally inclined to rely on contract-based mechanisms (rather than interpersonal trust, which is often fragile in post-conflict situations). The present paper further develops this strand of research by integrating into it the concept of the travelling model. It studies PBF beyond its dissemination phase and opens up a new field of research that looks into context-specific strategic interplays and practices of PBF implementation.

The travel of performance-based financing

Calling PBF "a model that travels" is a given for PBF researchers, promoters, and practitioners alike. However, it is only 12 years after the first African journey of the PBF, from Rwanda to Burundi in 2005, that the concept of *travelling model* was first applied to PBF by French socio-anthropologists of development[20]. The term was then taken up by voices critical of PBF in the world of global health[21]. PBF seems, indeed, a particularly good illustration of the concept initially formulated by Richard Rottenburg in 2002[22] and developed by Jean-Pierre Olivier de Sardan[23]. Following the latter's approach, we can, first of all, distinguish a rationality, a stylised and therefore exportable explanatory mechanism: payment for the performance of health facilities, which is presented as an incentive for health facilities staff to work better. Then, there are mechanisms which are the "institutional, technical and operational" components that allow the implementation of the model, and which are, again, very visible in the case of the PBF. Without going into technical details, these include "performance indicators", "performance procurement and performance verification agencies" and a range of instruments that are presented in the procedural manual, the reference document on PBF at country level. The multiplication of trips and the identification of a "certified exemplary experience", an original *success story,* also contribute to the consolidation of the model. This is the pilot experience of

16. S. Mayaka Manitu, L. Tembey, E. Bigirimana, C.Y. Dossouvi, O. Basenya, E. Mago, P. Mushagalusa Salongo, A. Zongo, F. Verinumbe, "Towards constructive rethinking of PBF: perspectives of implementers in sub-Saharan Africa", *BMJ Global Health*, 3, 5, 2018, p. e001036.
17. L. Gautier, J. Tosun, M. De Allegri, V. Ridde, "How do diffusion entrepreneurs spread policies? Insights from performance-based financing in Sub-Saharan Africa", *World Development*, 110, 2018, p. 160-175 ; L. Gautier, V. Ridde, "Health financing policies in Sub-Saharan Africa: government ownership or donors' influence? A scoping review of policymaking processes", *Global Health Research and Policy*, 2, 1, 2017.
18. L. Gautier, V. Ridde "Health financing…", art. cité.
19. M.P. Bertone *et al.*, "Context matters.. ", art. cité.
20. P. Lavigne Delville, "Pour une socio-anthropologie de l'action publique in les pays 'sous régime d'aide'", *Anthropologie & développement*, 45, 2017, p. 33-64 ; J.-P. Olivier de Sardan, "Les modèles voyageurs à l'épreuve des contextes et des normes pratiques : le cas de la santé maternelle", in D. Pourette, C. Mattern, C. Bellas-Cabane, B. Ravololomanga (ed.), *Femmes, enfants : Anthropologie et santé à partir de Madagascar*, Paris, 2018, p. 83-100.
21. E. Paul *et al.*, "Performance-based financing…", art. cité.
22. R. Rottenburg, *Far-fetched facts: a parable of development aid* (Vol. 2). 2002. Lucius & Lucius.
23. J.-P. Olivier de Sardan"*Les modèles voyageurs…*", art. cité.

Rwanda in 2002-2005[24], and, increasingly so, the experience of Burundi. Two other significant elements also contribute to the characterisation of PBF as the travelling model par excellence. The first is the easy identification of those whom Laura Gautier and her colleagues described as the "dissemination entrepreneurs"[25], or, to use the words of a Burundi Ministry of Health official, the "PBF traders". Among these most visible promoters are institutions such as the World Bank and the Dutch NGO Cordaid, and individuals such as the authors of the *Performance-Based Financing Toolkit* published in three languages, French, English, and Spanish, by the World Bank in 2014[26]. They are fully assuming their role in promoting the model[27].

The second element is the presence of an impressive dissemination infrastructure, which has few equals in the world of global health. Early on, PBF got its own conferences (for example in Antwerp in 2006 or Bujumbura in 2009), blogs, and even courses (such as the one organised by the consultancy firm *SINA Health* since 2007)[28]. A Community of Practice (CoP) ─a group of people working together to develop solutions to problems encountered in their professional practice[29]─ was created in 2010. Three years later, it passed the 1000-member mark[30]. In addition to international consultants, the CoP includes a large number of middle and senior managers from ministries of health and NGOs who are involved in PBF implementation. It also brings together former learners of the PBF courses. It is an active network: for example, during its first year of existence, its online discussion forum saw a new topic of discussion emerging every two days[31]. Most discussions focus on technical issues of setting up PBF, PBF-related events, and training and employment opportunities. It seems that the CoP has played, and continues to play, a central role in making PBF the travelling model par excellence. Indeed, the existence of a network whose members are in regular contact ─online and at conferences─ structures and organises ideas and initiatives, creating a form of practice expected from the PBF. Bruno Meessen, one of the main facilitators of the CoP, presents it as essential to improve the mechanism and implementation of PBF, offering a space for learning and debate, returns to scale, and exchanges of experience[32], whereas Elisabeth Paul and her colleagues see it as an instrument for imposing PBF orthodoxy[33]. In any case, the CoP helps build a pool of new promoters of the model, thereby improving its life expectancy.

At the end of the travel

Using the case of PBF to highlight the existence of travelling models in global health is not very original. It may even present a danger if the analysis is limited to denouncing the apparent "cut and paste" approach of global health. The danger is that a hasty use of the vocabulary

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24. Itself inspired by schemes in Cambodia and Afghanistan. Interestingly, there are extremely few parallels, in the academic and grey literature, with the *New Public Management of* European, British but also French health systems. As is the PBF moded described in this article, the French Tariffing by Activity (T2A) is a financing system based on volume of activity rather than authorisation of expenditure.
25. L. Gautier *et al.*, "*How do diffusion…*", art. cité.
26. Fritsche, G.B., Soeters, R. and Meessen, B., 2014. *Performance-based financing toolkit*. The World Bank.
27. M.P. Bertone *et al.*, "*Context matters…*", art. cité. for a mpping of such diffusion.
28. As of 25.03.2019, nearly 80 courses had already been organised, in French and English, and the freely available training manual was nearly 246 pages long.
29. E. Wenger, et W. Snyder, W.M., Communities of practice: The organizational frontier. *Harvard business review*, *78*(1), 2000, p.139-146.
30. 2,528 members as of December 3, 2018 https://groups.google.com/d/forum/performance-based-financing.
31. 183 topics, in French and English, in one year.
32. B. Meessen, S. Kouanda, L. Musango, F. Richard, V. Ridde, A. Soucat, "Communities of practice: The missing link for knowledge management on implementation issues in low-income countries?", *Tropical Medicine and International Health*, 16, 8, 2011, p. 1007-1014.
33. E. Paul *et al.*, "Performance-based financing…", art. cité.

travelling model, focusing too much on dissemination, reduces PBF to the simple imposition of a globalised idea (promoted by experts from the North) on a population in the Global South[34], thereby denying national actors any form of agency. The balance of power is undeniable, and some cases such as Tanzania indicate a particularly coercive attitude on the part of the donors promoting the PBF[35], but this should not be an excuse for not looking closely at the realities experienced in each context. Returning to Rottenburg is useful here, as his theory of the travelling model draws on the sociology of translation and emphasises the need to pay attention to "practices, materialities, and technologies". In fact, the diffusion of the model from one context to another is less important than what comes after: "a process of translation then begins, this abstraction is rejected, augmented, altered, and/or extended. [...] A travelling model implies an interpretation of the social world, but it also provides the agency to change this world"[36]. If one agrees that there will always be a form of translation, resistance, and acculturation to the model, taking a principled normative position on the effects of PBF simply because it is derived from a circulating idea is not tenable, unless one adopts a radically essentialist view.
The reterritorialisation of the travelling model plays out in contexts that Jean-Pierre Olivier de Sardan describes as "structural" and "pragmatic". The first denotes formal and institutional adaptations: in the case of the PBF, an abundant literature documents different architectural variants of the PBF, such as the choice of certain indicators or a particular type of verification system[37]. This is what Sally Engle Merry calls the "vernacularization" of a transnational idea by *replication*: the rationality of the model remains generally unchanged, but its implementation echoes a contextualised understanding[38]. The debate in global public health on the acculturation of PBF often remains at this level[39]. However, another reterritorialization also takes place in the "pragmatic context": it plays on the normative gap, i.e., the "gap between the rules and procedures integrated" into PBF and the "rules and procedures in force"[40]. PBF leads to unanticipated adaptations. An example reported in Benin is the "seasonal" filling in of the performance registers used to define the level of performance: this filling does not occur at the time of each patient's visit but when the "season" of the performance verification comes[41].
In addition to these two contexts, Rottenburg suggests a third one, which is less often explored and which I will describe as "strategic". In this case, reterritorialisation is best understood as the strategic and legalised “hijacking” of the model to (also) resolve issues that are apparently unrelated to the issues the model was meant to resolve. It is not a departure from the rules in force, or even a perverse effect; rather, it is an open and deliberate adaptation that takes the

34. This risk is not new; it echoes the criticisms of post-development theory. See for example: J.N. Pieterse, "After post-development", *Third World Quarterly*, 21, 2, 2000, p. 175-191.
35. V. Chimhutu, M. Tjomsland, N.G. Songstad, M. Mrisho, K.M. Moland, “Introducing payment for performance in the health sector of Tanzania- the policy process”, *Globalization and Health*, 2015, p. 1-10 ; A. Barnes, G. Wallace Brown, S. Harman, *Global Politics of Health Reform in Africa: Performance, Participation, and Policy*, London, 2015.
36. M. Schnegg, T. Linke, “Travelling models of participation: Global ideas and local translations of water management in Namibia”, *International Journal of the Commons*, 10, 2, 2016, p. 803
37. D. Renmans *et al.*, “Performance-based financing…”, art. cité
38. S.E. Merry, P. Levitt, "The Vernacularization of Women's Human Rights,”in S. Merry, P. Levitt. Hopgood, J. Snyder, L. Vinjamuri (ed.), *Human Rights Futures*, Cambridge, 2018, p. 213-236 ; S.E. Merry, “Transnational Human Rights and Local Activism”, *American Anthroplogist*, 108, 1, 2006, p. 38-51.
39. L. Gautier *et al.*, “*How do diffusion entrepreneurs spread policies?...* “, art. cité ; A. Barnes *et al.*, *Global Politics…*, op. cit.
40. J.P. Olivier de Sardan, A. Diarra, M. Moha, “Travelling models and the challenge of pragmatic contexts and practical norms: The case of maternal health”, *Health Research Policy and Systems*, 15, Suppl 1, 2017.
41. E. Paul, N. Sossouhounto, D.S. Eclou, “Local stakeholders’ perceptions about the introduction of performance-based financing in Benin: a case study in two health districts”, *International Journal of Health Policy and Management*, 3, 4, 2014, p. 207-214.

model into a new territory. The case of Burundi, which I develop below, seems to be an excellent example of such strategic reterritorialisation.

PBF in Burundi: Technocrats and Politicians

Along with Rwanda[42], Burundi is often considered *the* PBF success story on the African continent. The two examples are used in efforts to disseminate the PBF model, such as the World Bank's PBF Toolkit and SINA Health's PBF training manual[43]. As a country with an economy and political regime sometimes perceived (at least until the political crisis of 2015) as less distinctively singular than those of its northern neighbour, Burundi seems to demonstrate that PBF is within reach of all countries. The analysis below will nuance this picture, suggesting that Burundi's PBF has, in fact, fundamentally reinvented itself in the context of its unique situation and historicity.

The arrival of PBF in Burundi has already been documented in other publications[44]. Strong of their experience in Rwanda, the Dutch NGOs Cordaid and HealthNet TPO suggest to experiment with PBF in 2002, and then, more substantially, from 2004. The experiment begins in three provinces in 2006 and is extended to six other provinces in 2008 (the country counted seventeen provinces at the time). It is the beginning of the structural reterritorialisation of the PBF model: the expected mechanisms and practices are adapted to the context. The process is based on a number of elements: (1) the conclusions of the General States of Health in Burundi which had proposed contracting as an option for reforming the health system, an idea developed in a workshop on contracting organised by the World Health Organization (WHO) in Bujumbura in 2006 and then in the National Health Development Plan 2006-2010; (2) study trips to Rwanda; and (3) training sessions organised by the Dutch consulting firm SINA Health[45]. Inside the Ministry of Health, PBF does not gather unanimous support. Among the objections in the different departments─positions within the Ministry do not seem to dictate views─, are questions that are still debated today (according to Ministry of Health staff): why introduce a bonus system for tasks for which civil servants are already receiving a salary? Will financial incentives not undermine the ethics and vocation of health-care staff? Between 2006 and 2009, the debate on the translation of the PBF model, or even the possibility of its travel, is in full swing. It echoes the global confrontation between, on the one hand, a public health approach implemented and thought out by doctors (often, but not always, public health doctors) and, on the other hand, an approach belonging to a generation of Ministry and NGO executives trained in health economics in Europe but also in African institutions such as the African Centre for Higher Studies in Management (CESAG) in Dakar. In 2009, an agreement is reached in the Ministry of Health: the PBF approach will be scaled up from April 2010[46]. What happened? Which sort of "translation" has taken place?

Of course, and Lara Gautier's work has already elaborated this point, "diffusion entrepreneurs" played their part. Following her typology, we can identify a *moral* argument, repeated in almost all interviews, that it would be irresponsible to continue with an "inefficient input model", i.e. financing of health facilities solely using inputs (drugs, human resources, equipment, etc.). The

42. A. Barnes *et al.*, *Global Politics…*, op. cit.

43. In its January 2019 version, Burundi is more often cited than Rwanda (40 vs 23 times).

44. E. Bigirimana, L. Ntakarutimana, J. Manirambona, O. Basenya, T. Minubona, *Le Financement Basé sur la Performance: de la phase de projet pilote à l'intégration au niveau du système de santé : Etude de cas du Burundi 2004-2014*, Anvers, 2016 ; J.-B. Falisse, J. Ndayishimiye, V. Kamenyero, M. Bossuyt, "Performance-based financing in the context of selective free health-care: An evaluation of its effects on the use of primary health-care services in Burundi using routine data", *Health Policy and Planning*, 30, 10, 2015, p. 1251-1260.

45. E. Bigirimana *et al.*, *Le Financement…*, op. cit.

46. Interview 4 (Ministry of Health executive, November 2018). The main tension was whether performance audit should be internal or external to the Ministry. Eventually, joint committees were created.

arguments of the dissemination entrepreneurs are also based on PBF *expertise*. Between 2006 and 2010, visits to pilot health facilities and graphs comparing pilot provinces and adjacent provinces that did not benefit from the approach are used to convince sceptics. It is important to note that these are not strictly speaking *scientific* arguments; the first impact studies were not published until 2014 and show a limited effect of PBF on the use of primary health care[47]. Finally, the argument is also *financial*; not all donors and potential international partners support the PBF approach from the outset ─DfID (the British *Department for International Development*) and Médecins sans Frontières, for example, are fiercely opposed to PBF─ but, by the end of 2009, the World Bank and its promises to finance the PBF throw all their weight behind PBF[48]. It is interesting to note that the market principles on which PBF is based ─among others the autonomy of management of health structures, evaluation based on indicators, and payment based on results─ have emerged almost unaltered from this first phase of reterritorialisation. At first glance, it may seem that the travel of PBF to Burundi is mainly a simple replication of the Rwandan model.
The above elements help understand why PBF was adopted and scaled up, but they explain less well how it was implemented and how, from the end of the 2000s, PBF became quite central to the Burundian health system. In 2010 and even more so in 2018, the Ministry of Health is in charge of PBF. The Burundian government, which is facing major financial problems due to the political crisis and the reduction in aid from donors such as the European Union, has committed to spending, and continues to spend, 1.4% of its GDP on PBF[49]. Why such a place? An argument that emerges from the grey literature and interviews with Ministry of Health officials is that there has been a window of opportunity, a "windfall effect" as a Ministry of Health technician explained. The set up of PBF in Burundi was the product of intense advocacy efforts by national and international actors, but the scheme has also been used by senior Ministry of Health officials to make progress on two important issues that were not strictly speaking related to PBF: the reorganisation of the Ministry of Health and the health system and, to a probably much more significant extent, the implementation of the policy of free health-care for children under five and pregnant women.

New paradigm, new elites?

The first aspect refers to the implementation of a managerial approach that benefits a series of executives with a more technocratic profile. If, as revealed in the interviews, "everyone in the ministry is interested in the possibility of improving their salary via PBF"[50], the introduction of PBF is also an opportunity to put in place new planning, monitoring and evaluation mechanisms and to systematise the identification of problems through a culture of audit at all levels, including those not (yet) under PBF. A proper understanding of the nature of these changes, and the adjustments (and circumventions) thereof, i.e. the question of reterritorialization in the pragmatic context, would require ethnographic work within the Ministry of Health, looking at practical norms. It is beyond the scope of our research. The important point, however, is not so much whether the culture of the Ministry has changed, as

47. Among others J.-B. Falisse *et al.*, "Performance-based…", art. cité et I. Bonfrer, E. Van de Poel, E. Van Doorslaer, "The effects of performance incentives on the utilization and quality of maternal and child care in Burundi", *Social Science and Medicine*, 123, 2014, p. 96-104.
48. Interview 5 (Ministry of Health executive, November 2018).
49. Ministry of Public Health, *Rapport de mise en œuvre du financement basé sur la performance associé à la gratuité des soins pour l'année 2017,* Bujumbura, 2018.
50. Interview 5 (Ministry of Health executive, November 2018).

suggested by the people we met, some authors[51] and the promoters of the PBF, but rather that PBF legitimises and strengthens certain individuals and certain departments within the Ministry. Those who control PBF dynamics ─such as the Planning Directorate and the National Contracting Policy Steering Committee set up to prepare the PBF scale-up─ gain considerable influence in the Ministry. In 2010, the latter committee is superseded by the National Technical Unit (CTN) in charge of the technical and operational implementation of the PBF. The PBF, whose ideas "infiltrate everywhere, at all levels" to use the words of an NGO representative, allows a technocratic elite, liked by the PBF's international donors and promoters for its technical competence, to assert its place in the Ministry. A similar dynamic is reported with the introduction of PBF in other African contexts[52]. If in 2010 the best experts of the PBF in Burundi include some foreigners and Burundians working for NGOs, in 2018 the landscape is much more Burundian, and almost exclusively internal to the Ministry of Health. The CTN counts among the most experienced health technicians in the country, its president is a former Minister of Health, and its vice-president is the former director-general of the National Institute of Public Health. In 2012, its other members are senior officials from the Ministry of Health ─the HIV/AIDS, Human Resources, and Health Statistics Departments─ as well as African BPF experts working for the World Bank and the Belgian Technical Cooperation[53]. Occasionally, "extended CTN" meetings are called in; they include other experts from the Ministry but also NGOs. In the field, the different structures created for the implementation of the PBF system (including its verification and planning units) recruit from within the Ministry and NGOs. A PBF-specific analytical and programmatic capacity has developed, and it has allowed the emergence of a new class of Burundian PBF experts who join the internationalised global health elite. They are co-opted in institutions that promote the PBF model such as Cordaid and the World Bank, and help the PBF travelling model continue its journey to countries such as Djibouti, Mali, Côte d'Ivoire and Chad. Perhaps more fundamentally, they are also changing the dynamics of expertise, and therefore of power, within health systems[54]. Within a few years, PBF has become an important element, not to say a cornerstone, of the Burundian health system. The consolidation of the power of this new technocracy, with a managerial orientation where the old technocracy was more medical, is however taking place in a particular strategic context, which is presented now.

Rescuing the free health-care policy

The real window of opportunity for PBF, and probably the reason why it has become so central in Burundi, is that it has allowed the Ministry of Health and the Ministry of Finance to address a thorny issue: the efficient implementation of the policy of free health-care for pregnant women and children under five years of age promised by the president of the Republic. In May 2006, the Ministry of Health public servants learnt, in the media, President Pierre Nkurunziza's decision to imminently implement free health-care, one of his electoral campaign's promises[55]. Until then, the Ministry had been opposed the idea, which was seen as the unreasonable obsession of foreign organisations present in Burundi such as MSF, DfID and the European Commission's Humanitarian Aid (ECHO). No plan for implementing selective free health-care existed, and the hastily improvised new policy had almost immediate destabilising effects on

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51. M.P. Bertone, B. Meessen, "Studying the link between institutions and health system performance: A framework and an illustration with the analysis of two performance-based financing schemes in Burundi", *Health Policy and Planning*, 28, 8, 2013, p. 847-857.
52. A. Barnes *et al.*, *Global Politics…*, op. cit.
53. Ministry of Health of Burundi, Manuel de procédures du Financement de Performance, Bujumbura, 2012.
54. Interview 7 (Ministry of Health senior official, December 2018).
55. M. Nimpagaritse, M.P. Bertone, "The sudden removal of user fees: The perspective of a frontline manager in Burundi", *Health Policy and Planning*, 26, 2, 2011.

the health system. Health facilities were severely lacking human and financial resources to meet the massively growing demand for care, and the situation became tense in many places. The system was based on fee-for-service reimbursement: every month, health facilities sent their invoices to the Ministry of Health. However, this reimbursement process soon accumulated huge delays, regularly up to one year at the beginning of the implementation of the policy, and then three to seven months afterwards (according to the Ministry of Health officials). Informal payments for supposedly free healthcare services increased. Overall, the whole health system weakened significantly, some even called it "on the verge of collapsing"[56]. The survival of the policy was, however, of major strategic importance. On the one hand, Burundi had obtained debt remission under the Heavily Indebted Poor Countries Initiative of the World Bank and the International Monetary Fund in 2006, but on the condition that it carried out ambitious health and education programmes. On the other hand, the support base of the president was in the poor and rural regions of the country, those that potentially benefited most from his selective free health-care policy. The advocates of PBF presented their scheme as a ready-made solution to this conundrum. The free health-care system in place was administratively cumbersome, to the extent that some health facilities claimed they had to hire accountants (which they could not afford to pay), and had a very lengthy disbursement procedure going all the way up to the central level of the Ministry of Finance. The PBF model, however, used a decentralised and simpler claiming and invoicing system that could be adapted to reimburse health facilities for the services they were required to provide free of charge. PBF also came with a mechanism to verify the effectiveness of the services paid for ─and reimbursement fraud was a concern for the Ministry of Health. The adaptation of the PBF model to cover free health-care is relatively simple: the "standard" PBF bonus is replaced by a larger amount of money, which includes both the PBF bonus and the reimbursement for the service provided under the free health-care policy. The scaling up of PBF, which, in fact, corresponded to the coupling of PBF with the free health-care scheme at the national level and took place only a few months before the presidential election, was led by the CTN with the support of external PBF promoters, consultants, donors and NGOs. Its effects were not long in coming: a report from the World Health Organization explains, without citing its sources or a precise period, that with PBF, the average time for reimbursement of health facilities for care provided free of charge decreased from 85 to 43 days[57]. The operation also enabled a rapprochement between the Ministry of Health and the Ministry of Finance, the body responsible for reimbursing the costs of free care that also managed the PBF funds.
It is thanks to the integration of selective free health-care, an invention that differs substantially from the Rwandan model, that the PBF travelling model becomes central and is legitimised in Burundi. It should be noted that other countries, such as Sierra Leone, are in a similar situation in 2010 with the launch of both PBF and a free health care initiatives[58], but their combination is never envisaged. Merging PBF with free health-care is not a given. It takes place in Burundi for strategic and political reasons, which are lacking in Sierra Leone (where PBF had, at the time of writing this article, largely declined). In Burundi, the strength of PBF has been to establish itself as a tool for achieving a political agenda. History seems to be repeating itself: the apparent success of PBF-free health care has led the minister's office to task the CTN, perceived as a unit of excellence, with missions that go beyond the strict framework of the PBF, to the extent that some PBF promoters are concerned that it is now too often perceived as a panacea[59]. In addition to pursuing a logic of contracting at the level of the central

56. E. Bigirimana *et al.*, *Le Financement…*, op. cit.
57. S. Sibomana, and M. Reveillon, *Burundi: Performance based financing of priority health services,* Improving Health System Efficiency series, Geneva, World Health Organization, 2015, 27.
58. M.P. Bertone *et al.*, "The bumpy trajectory… ", art. cité.
59. Maintenance 2 (Ministry of Health technician, November 2018).

administration, the CTN has been tasked with finding solutions to improve the functioning of the Health Insurance Card (CAM). The card, long moribund, was revived by Vice-President Gervais Rufyikiri in 2012 as a means for Burundians to access basic health services at no cost other than a modest annual contribution (less than two euros). This decision was not planned with the Ministry of Health, and problems soon became apparent. The similarity with the coupling of selective free health care and PBF at the end of the 2000s is striking: the PBF and its CTN, both typical technocratic objects related to “standardised” global health approaches, come to the rescue of political decisions. The CAM, like the policy of selective free health care, fits well within the global health universal health coverage agenda. However, one should not be mistaken, what is happening is not a dialogue between population, technicians and politicians: the minister, who is at the mercy of the president, exerts regalian power over the CTN in a context marked by a high turnover of civil servants (linked to the country's political instability). While the scaling up of PBF in 2010 took place in a political space that retained democratic openings, the implementation of PBF in the following years took place against the background of a populist and increasingly totalitarian regime, with an inclination towards universal health coverage. It is not a contradiction: democracy and universal health coverage are not necessarily intrinsically linked. Here we can see how, in order to impose itself in its strategic context, a global technocratic model (PBF, and more broadly the culture of audit and management) participates or is forced to participate to the legitimisation of a political regime that is less and less democratic.

Conclusion

The fundamental element of the reterritorialisation of the PBF travelling model in Burundi is its coupling with the process of reimbursement of costs related to the introduction of partial free health care. It goes hand in hand with the emergence and consolidation of a new technocratic health elite. By identifying different levels of context, but also practices and materialities, the framework of the travelling model casts light on the way PBF became central in Burundi. However, in order not to reduce our analysis of the translation of the model to its mere dissemination, we had to take the concept of the travelling model further, returning to the idea of a national context that is also eminently strategic and political. The Burundian actors of PBF talk about a "compromise adapted to the country's context while trying to preserve the fundamental principles of the approach which ensure a certain technical and financial sustainability"[60]. The tension here is between, on the one hand, the importance of maintaining the fundamentals which are synonymous with international financial support and useful inclusion in the globalised expertise of the world of global health and, on the other hand, the compromise, i.e. the need to be relevant and acceptable in the Burundian political context. The case of Burundi includes forms of replication of the Rwandan model. Still, it gains its pre-eminence by achieving what Sally Engle-Merry calls a hybridisation: with the integration of free health care, PBF becomes a truly political object, reformulated by institutions and technocratic power. This hybridisation takes place in plain daylight, in a much more visible and strategic field than that of pragmatic adaptations and practical norms. There is little doubt that the PBF model conveys rather neo-liberal ideas (such as the culture of auditing and managerial autonomy), but the debate on PBF must also integrate the possibility of the strategic hybridisation of the model. It is at this point that the ideological dimension of the PBF can be explored in practice: paradoxically, in the case of Burundi, the hybridisation of the neo-liberal principles of the PBF allows the implementation of a policy of free health care typical of a welfare state, and vice versa. Of course, even if PBF benefited the universal health coverage

60. E. Bigirimana *et al.*, *Le Financement…*, op. cit. , p. 12.

agenda in Burundi, it is also not certain that PBF was the one and only way to "save" the policy of partial free health care in this context ─but it is the one that was tried, and apparently with some success that benefited Burundians (even if the question of the sustainability of financing of free health-care comes back regularly, including at the time of writing this article).
From the moment it is accepted that PBF in Burundi is a hybridisation made of translations and reformatting, it is also clear that PBF's journey in Africa, and travelling models in general, are best understood as "a multiplicity of parallel paths, unsuccessful attempts and unexpected revivals"[61] rather than a linear succession of different stages. For example, with the recent exception of Côte d'Ivoire, no country has so far coupled PBF and free health-care ─although this is the very core of Burundi's "certified exemplary experience". The reflection carried out in this article also raises the question of what must, or can, be evaluated to account for the effects of PBF fully: the process of hybridisation, and, to some extent, the hybridised nature of PBF, are absent from current academic research that focuses on measuring the effects and on the perverse effects of PBF on the use of care and its quality.

The most interesting element of the travelling model discussed in this article is not who or what facilitates its journey. It is not even the gaps between structural and pragmatic adaptations. Instead, it is the articulation between the process of reterritorialization on the one hand, and national political and strategic interests on the other hand. The challenge for future research on PBF and other travelling models of global health in Africa and beyond, as PBF is not only an African object, will be to understand more deeply under what circumstances hybridisation does (or does not) take place. A conceptual framework that could be particularly useful comes from the political settlements theory[62], for it dissociates political (and economic) power from state or parastatal institutions and suggests studying how power, or rather powers, invest and distribute institutions, especially those associated with travelling models.

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61. A. Vauchez, "Le prisme circulatoire…", art. cité p. 13.
62. P. Behuria, L. Buur, H. Gray, "Studying political settlements in Africa", *African Affairs*, 116, 464, 2017, p. 508-525.