Research Article

Why Performance-Based Financing in Chad Failed to Emerge on the National Policy Agenda

Joël Arthur Kiendrébéogo 1,*, Zubin Cyrus Shroff 2, Abdramane Berthé 1, Lamoudi Yonli 3, Mahamat Béchir 3 and Bruno Meessen 4

1Department of Public Health, Centre MURAZ, Bobo-Dioulasso, Burkina Faso
2Alliance for Health Policy and Systems Research, World Health Organization, Geneva, Switzerland
3Department of Public Health and Development, Centre de Support en Santé Internationale, N’Djamena, Chad
4Department of Public Health, Institute of Tropical Medicine, Antwerp, Belgium

Abstract—Supported by the World Bank (WB), Chad implemented a performance-based financing (PBF) scheme as a pilot, from October 2011 to May 2013. However, despite promising results and the government’s stated commitment to ensure its continuation after the World Bank’s departure, PBF failed to come onto the national policy agenda. This article aims to explain why this was the case, an especially interesting question given that several factors were favorable for project continuation. Data for this case study were collected through literature review and key informant interviews. We applied Kingdon’s agenda setting theory to explain this failure. We found that though the potential of PBF to address challenges facing the Chadian health system was confirmed by internal and external evaluations of the pilot, it failed to move from the governmental agenda to the decision agenda. The main reason was a lack of dedicated policy entrepreneurs, resulting in a weak actual ownership of the policy by national authorities and key stakeholders. We tried to understand why such policy entrepreneurs failed to emerge.

INTRODUCTION

It is common for countries to start with a pilot scheme when aiming at implementing complex interventions, 1-3 but transitioning from this pilot stage to larger scale implementation is often a critical and sensitive period. Indeed, many pilots, even when they are conclusive as far as the evidence is concerned, fail to translate into national policy. 4 Such failure occurred in Chad with a performance-based financing (PBF) strategy focusing on maternal and child health (MCH). 5

Chad has had a long-lasting problem with MCH. According to the country’s Demographic and Health Surveys, 6 the under-five mortality ratio was 194 per 1,000 live births in
1996–1997, 191 in 2004, and 133 in 2014–2015. The maternal mortality ratio, meanwhile, was 1,099 and 860 per 100,000 live births, respectively, for 2004 and for the period from 2008 to 2015. In 2011, Chad, like other countries facing similar problems with MCH, decided to experiment with a PBF strategy, with the financial and technical support of the World Bank (WB). A similar strategy has been applied in Chad’s neighboring countries, including Cameroon, the Central African Republic, and Nigeria. In the PBF strategy, health care facilities are financially rewarded for delivering specific services or tasks, with a system of inspection and auditing to ensure compliance and to raise quality where necessary. The main objective of this article is to understand why the PBF scheme in Chad failed to move from a pilot to being on the national policy agenda. Understanding this issue is crucial because it might inform the current debate about the viability and national sustainability of PBF, which is rapidly expanding in sub-Saharan Africa. This article could also be relevant for those interested in how and why pilot projects may or may not influence national policy agendas. Our article begins with a description of Kingdon’s theory, how we applied it to our case study, and our hypotheses. Then we briefly present the PBF pilot scheme in Chad. The Results section follows and thereafter we critically examine our hypotheses. We then draw larger lessons from our study in the Discussion section.

MATERIALS AND METHODS

Study Design and Theoretical Framework

We used Kingdon’s multiple streams approach to explain why PBF in Chad failed to come onto the national policy agenda after its seemingly successful pilot.

For Kingdon, an issue comes onto the policy agenda when three distinct and independent streams (problem, policy, and political streams) intersect under favorable conditions. Usually, it is a policy entrepreneur who recognizes a policy window (an opportunity for action or a given initiative) and brings these streams together.

With respect to the problem stream, Kingdon specifies that “problems are not simply the conditions or external events themselves; there is also a perceptual, interpretative element.” Mechanisms that could make some situations problematic include focusing events (e.g., epidemics or disasters), changes in indicators (e.g., a rise in a rate of mortality or morbidity), or feedback (e.g., reports, reviews, or evaluations).

The policy stream refers to concurrent existing solutions that could be used to solve the problems. It is dominated by academics, researchers, bureaucrats, and others who develop and discuss new ideas for policy makers to consider. To be workable, these solutions must be technically feasible, compatible with dominant values at the national/societal level, and capable of anticipating future obstacles or constraints. The political stream is dominated by people in or around government, including civil society organizations. It encompasses things such as the national mood, electoral politics, lobbies, and changes in government and administration. Policy entrepreneurs are advocates for proposals or for the prominence of an idea. They are people willing to invest their own resources and they can be located in any of the three streams. They might be elected officials, civil servants, lobbyists, academics, or journalists. Policy windows may be predictable or not but are scarce because they open only occasionally and for a short time. Thus, policy entrepreneurs must act rapidly; if not, the window will close and they will have to wait for the next occasion.

Kingdon points out that the word agenda can be used in many ways and could have several meanings. It is important to underscore that he makes a clear distinction between the governmental agenda, which “includes subjects to which people in and around government are paying serious attention” and the decision agenda, which includes matters subject to “authoritative decision, such as legislative enactment or presidential action.”

Our case study seeks to explain why PBF failed to move onto the decision agenda; in other words, why was it not the subject of legislative enactment or presidential action in Chad? Like the issue of long-term medical care related to the aging of the population in the United States taken as an example by Kingdon, we assume that both the problem (especially MCH issues) and the political streams in Chad were joined and thus a governmental agenda was already in place. But though the problem and/or the political streams can give rise to the governmental agenda, the coupling of all three streams is almost always needed to move onto the decision agenda (see Figure 1).

We put forth three hypotheses to explain this nonemergence. The first one is that conditions in one or more streams were unfavorable and hence there could be no coupling of the streams. The second one is that even though conditions in the streams themselves were favorable, no window of opportunity emerged. The third one is that even though a potential policy window was open, there was no suitable policy entrepreneur to take advantage of that window that existed and bring about the coupling.

In their literature review, Rawat and Morris found that Kingdon’s theory, since its release in 1984 (where it has
been applied to the health and transport sectors in the United States, has been used in various policy fields (e.g., health, transport, education, welfare, telecommunication, water, fishery, environment, energy) across all continents. Successful applications in Africa include its use to explain water and health policies. In many cases it has been refined, adapted, and even modified. Though Kingdon’s theory tries to explain why some issues come onto the agenda and others do not, few studies have actually applied it to investigate these latter cases. For example, Ridde used an extension of this theory to explain why equity was not prioritized during the implementation of the Bamako initiative in Burkina Faso. To our knowledge, this study is the first application of Kingdon’s approach to explain why a PBF policy failed to come onto a national policy agenda.

**Sampling of Survey Sites, of Participants, and Data Collection and Analysis**

We collected primary and secondary data through literature review and 20 key informant interviews (KIs), using an iterative process. Indeed, to clarify any issues during data analysis, we performed further enquiry through additional interviews and document analysis. Data were collected in the capital, N’Djamena and in four health districts: Bitkine, Ati, Koumra, and Moïssala. These were selected purposively, based on three criteria: (1) their geographical location (two in the north and two in the south); (2) their geographical accessibility; and (3) the performance they achieved after the introduction of PBF (in each region, we chose one district that performed well and one that had a poorer performance, in terms of health services utilization).

A purposive sampling technique was also used for individual key informants. They were identified in two steps. First, through a brainstorming process, the research team listed all possible actors who could have had a potential influence on the decision to implement PBF. These included (1) the highest national authorities (presidency, parliament, and national government); (2) local authorities (political, traditional, and religious); (3) health system actors at decentralized levels; (4) nongovernmental organizations (NGOs) and civil society organizations; (5) Chadian and international academics; (6) national and local media; and (7) technical and financial partners. At this stage we identified 41 people. We then sifted this first list in light of our knowledge of the country context to focus on actors that were actually involved in the implementation of the pilot or should have had a particular interest in the strategy. At this final stage, 28 respondents were targeted but we were not able to interview them all, because they were not available, could not be reached, or refused to participate in the study. Nevertheless, we had a varied profile of respondents as shown in Table 1.

**Semistructured questionnaires** were used to collect information and all interviews were conducted in French by members of the research team (J.A.K., A.B., L.Y., and M.B.) and also by two investigators recruited and trained in PBF and the objectives of the study. Interviews were conducted at respondents’ workplaces between March and July 2015. On
average, they lasted an hour and a half and were tape recorded as much as possible. In the cases where we encountered technical problems or reluctance from respondents to record, extensive notes were taken instead. Tape-recorded interviews were transcribed by a team of transcribers at the Centre de Support en Santé Internationale (CSSI) and were analyzed by the research team.

Data were analyzed manually using content analysis. We first described the pilot scheme implementation processes from start until completion. Then, guided by our hypotheses and the multiple streams approach, we tried to identify factors that could explain why PBF failed to come onto the decision agenda. Triangulation was used when analyzing data by cross-checking information from various sources: interviews, document review, and additional interviews if any.

Ethical Approval and Consent

Ethical approval for this study was obtained from the World Health Organization (WHO) Research Ethics Review Committee and permission for data collection was obtained from Chad’s Ministry of Health (MoH) and from all study participants. The objectives were explained to all respondents who signed an informed consent form before data were collected.

The PBF Pilot Scheme in Chad

Chad is a landlocked country in north-central Africa, measuring 1,284,000 km² and with more than 11 million inhabitants as of 2009. Its health system is organized following the district health system model and had, at the time of our study, 23 regions, 63 health districts, and 1,028 primary health care centers. The PBF pilot was implemented from October 2011 to May 2013 in eight health districts within four regions (two health districts per region). It was designed to be consistent with the National Health Policy 2007–2015, which identified a shortage of skilled health workers (e.g., one physician for 28,466 inhabitants or one midwife for 9,596 women of childbearing age), inadequate technical equipment, lack of infrastructure and maintenance, underfunding, and poor management and procurement of drugs, including vaccines and contraceptives, as the main challenges to the provision of health care.

PBF aimed at addressing some of these issues by improving the organization of health services and increasing accessibility and quality of care. Indicators purchased by the project mainly focused on MCH. The project covered nine district hospitals and 102 primary health centers, most of them located in rural areas. It was entrusted, after a bidding process, to a consortium consisting of a Belgian international consulting firm, Agence Européenne pour le Développement Et la Santé (AEDES), and a Chadian local NGO, CSSI. This consortium acted as a performance purchasing agency whose mission was twofold: to (1) implement the project in the pilot areas and (2) ensure a transfer of skills to the MoH. The project’s total budget was three million USD, about two USD per capita.

The pilot scheme was embedded in a larger project intended to fight AIDS: the “Projet Population et Lutte contre le SIDA” phase 2 (PPLS2). This project was funded by the WB since April 2002 and was located within the Ministry of Economics and International Cooperation. After its mid-term review in 2005, PPLS2 activities were suspended in 2006 and again from 2008 to 2010, mainly because of disagreements between Chad and the WB related to the management of the country’s oil resources. In 2010, a resumption of ties between the two parties occurred and in July additional funding, as a donation, was approved for three years to pursue PPLS2. The World Bank took this opportunity and proposed the implementation of a PBF pilot scheme as a component of PPLS2.

By the end of 2010, preparatory activities for the pilot implementation were launched. A steering committee was established by a ministerial decree of the MoH. It included most of the senior officials from the MoH, representatives from the Ministry of Economics and International Cooperation, the Ministry of Finance and Budget, the Ministry of Social Action, the PPLS2 coordinator, and technical and financial partners (WB, UNICEF, WHO, European Union, Agence Française de Développement, United Nations Population Fund). It was in charge of strategic decisions and was mandated to monitor the pilot on behalf of the Chadian government and the WB. It was also tasked with mobilizing other partners to support PBF scaling-up after the pilot stage and ensuring timely funding through the national budget. To foster country ownership of the strategy, a technical unit located within the MoH in the Direction de l’Organisation des Services de Santé (DOSS) was created by a memo in

| Interviewees                                | Number |
|---------------------------------------------|--------|
| Key informant interview (total)             | 20     |
| Ministry of Health (central level)          | 6      |
| Ministry of Health (regional chief officers) | 3      |
| Ministry of Health (medical chief officers)  | 5      |
| Ministry of Economics and International Cooperation (central level) | 1 |
| Technical and financial partners/nongovernment organizations | 5 |

**TABLE 1.** Detail of Interviewees
February 2012.\(^5\) It was to serve as the secretariat of the steering committee and was also in charge of learning from the experience and assisting the MoH to decide whether the strategy was relevant and appropriate for the health system and whether there was a need to eventually reproduce and/or roll it out. The technical unit was also supposed to collaborate with the performance purchasing agency for verification activities and to serve as the link between the MoH centralized structures and decentralized services.

**RESULTS**

**The Problem Stream**

Chad’s health system faces several challenges and its health metrics are among the worst in the world, without substantial improvement in many years. A focusing event that attracted great attention at national and international levels was a poliomyelitis outbreak including both wild poliovirus type 1 (65 cases) and wild poliovirus type 3 (three cases) in 2011\(^1\9\) [KII-10, KII-17]. This generated concern at the highest level of the state and attention was quickly extended to MCH issues (which are good indicators of the overall health of a population\(^2\0\),\(^2\1\)). Indeed, these outbreaks led the president to convene a consultation meeting on the health sector on June 24, 2011, in his office with the prime minister, the minister of health and the WHO representative. This was relayed by the local media, namely, the Tchadanthropus Cyber-Presse,\(^2\2\) which, in its Chadian press review, reported,

The President of the Republic, Deby Itno, sounds the alarm. It is unacceptable that health indicators in Chad continue to be so critical, despite the resources spent. […]

The President asked Chad’s development partners to support the Government to reverse the trends.

According to the same press release, the daily Le Progrès headlined on June 27, 2011: “A monthly meeting on health is established.” Indeed, this has taken the form of monthly meetings between the head of state, senior officials of the MoH, and major technical and financial partners every 24th of the month, to take stock of the health situation in Chad. Many senior officials from MoH confirmed the regular occurrence of these meetings.

That the health situation, especially in the area of MCH, is sometimes perceived in the country as a disgrace is evident from the statement of the first lady of the republic, during her speech at the official launching ceremony of Campaign for Accelerated Reduction of Maternal Mortality in Africa, of which she was the godmother, on December 15, 2009. “I am shocked by reading the various reports and publications on maternal and child health which show that maternal mortality is still high in Chad. (…) Dear Minister of Health, I hope that from this campaign arises another image of Chad.”\(^2\3\)

In addition, national and international agencies and NGOs contributed to getting national authorities’ attention to MCH issues. This was facilitated by the global agenda being dominated by the Millennium Development Goals and universal health coverage. Indeed, these issues are highlighted in almost all studies and documents commissioned or developed by these agencies/NGOs and related to Chad’s health or socioeconomic development situation. As a result, MCH issues were predominant in the National Health Policy 2007–2015\(^2\4\) and in the two national health strategic plans (2009–2012 and 2013–2015).\(^1\5\),\(^2\5\)

These documents reiterated the priority given to the health sector in the political agenda of the government and the PBF strategy was identified as one of the solutions to address these problems.

**The Political Stream**

Two important elements in the politics stream favoring the adoption of PBF as national policy were a growing economy and an improved national political environment. Economically, the gross domestic product growth rate increased from 1.6% per annum in 2011 to 7.2% per annum in 2012, due to increased exploitation of Chad’s oil fields.\(^2\6\) This explains the more than doubling of the health budget in five years, from 4.68% of the state’s general budget in 2008 to 9.8% in 2013,\(^1\5\) although it is still far from 15% of the Abuja target. Cooperation with donors in general improved after the resumption of ties between the country and the WB in 2010 [KII-17, KII-19]. The political environment was also more favorable, characterized by greater stability compared with previous years where the country experienced repeated armed conflicts.

Yet, there were also some hindrances in the politics stream. These include the lack of debate at the parliamentary level for the pilot adoption (as a donation, project approval by parliament was not needed, unlike for projects funded as a loan) and the high turnover of officials at the head of the MoH. With respect to the latter, it is worth noting that there were four health ministers and at least five health secretaries of state during the period 2010 to 2013. This great instability seemed to have negatively impacted the strategies’ ownership. “In the past, the senior political officials of the MoH were well involved. But because of government instability, whenever there is a change, those coming cannot get acquainted with the strategy” [KII-5]. Therefore, PBF potentially lacked support from higher level political actors such as the ministerial cabinet council or council of ministers. As Kingdon\(^8\) stated, “Not only does turnover produce new
agenda items, but it also makes it impossible to consider other items that might be thought deserving at another time."

The Policy Stream

Though there was no factual scientific evidence about the effectiveness of PBF strategy, it was seen as a potential and incipient policy to tackle MCH issues in Chad; this potential was confirmed by internal and external evaluations of the pilot.27,28 Indeed, quality of health services delivery overall was improved (e.g., through better working conditions for staff and more user-friendly health facilities), as did health facilities’ organization and management (e.g., through better planning and local health information systems).27,29

Yet, some hindrances were also present in the policy stream. It was the WB that championed PBF in Chad. Thus, this strategy was actually exogenous and completely new for many stakeholders, including senior officials of the MoH: “The strategy was completely new for us and we never heard of it before” [KII-2]. The WB was a very active broker. For instance, it funded many study tours and training workshops, organized mostly in the African Great Lakes region (Burundi, Rwanda, and the Democratic Republic of the Congo) and in Cameroon. These workshops were intended for senior officials from the MoH, the Ministry of Economics and International Cooperation, and the Ministry of Finance and Budget to get acquainted with PBF and how it has been implemented in these countries.

Despite these efforts, PBF’s exogeneity persisted. For instance, the technical assistance role was assigned to an international/national consortium (AEDES and CSSI) without a strong involvement of the MoH in the project management structure, as described below. Furthermore, the daily management of the pilot seemed inadequate to ensure a strong and inclusive national ownership of the strategy. For example, the project was managed administratively and financially within the Ministry of Economics and International Cooperation (through the PPLS2) and the MoH was in charge of its technical management [KII-2]. However, no meeting was planned or held between the two ministries to discuss project issues [KII-17, KII-19].

In addition, it was well known in advance that the WB would not extend its funding immediately after the pilot stage, which coincided with the end of the PPLS2. Hence, coordinators of PPLS2 made a plea to the government and obtained a budget line of 674 million XOF (about 1.2 million USD) to pursue the strategy. But the MoH was rather passive during this process [KII-2, KII-17, KII-19] and such a passive attitude was also observed elsewhere. For instance, the pilot was not regularly monitored by the MoH and there was a lack of strategic planning for the continuation of the strategy after this pilot stage [KII-5, KII-17, KII-19].

Another important thing to underline is the dysfunction in the working of the steering committee and the technical unit. Indeed, though the steering committee was statutorily mandated to meet once every three months, it did so only four times during the 20 months of project implementation. Donors were generally absent from these meetings, including local representatives of the WB, citing calendar conflicts or late receipt of invitation letters.27 Some criticized its seemingly top-down way of working:

... the Steering Committee, ... I’m here and I do not know them. Its members were to go down from time to time to the field, in contact with us who operate in the field, to really know our problems. [KII-9]

The technical unit within the MoH, meanwhile, held only one meeting during the whole period of project implementation.27 Its members were not diversified enough, all of them coming from the DOSS and some being very busy with other tasks or lacking technical expertise.27

The technical unit malfunctioned because its staff was not sufficiently prepared and the project was monopolized by a few. [KII-6]

In fact, the implementation of the PBF pilot scheme seemed weakly inclusive. Some key directorates at the central level of the MoH like the Direction Générale des Ressources et de la Planification, the Direction Générale de l’Action Sanitaire Régionale, and the Inspection Générale des Services de Santé (IGSS) were not part of the technical unit (which was limited to the DOSS), so their involvement remained very marginal or even zero in the case of the IGSS. Yet, the Direction Générale des Ressources et de la Planification was responsible for resource management, the Direction Générale de l’Action Sanitaire Régionale was in charge of the supervision and coordination of health regions, and the IGSS was tasked to ensure regularity and efficiency of services as well as the enforcement of regulations and ministerial directives.

It was in late 2011, early 2012. It was during the pilot phase that I heard about the strategy for the first time. Yet, as a coordinating body, our wish was to be sufficiently involved; but we felt that the project was executed by a small group of people, based on cronyism. [KII-5]
The Policy Window

For Kingdon,8 “the policy window is an opportunity for advocates of proposals to push their pet solutions.” Windows are opened, sometimes quite predictably, by events in either the problem or political streams. In Chad, the outbreak of polio virus in 2011 was a focusing event that opened a predictable policy window for advocates to propose their ideas and solutions to the head of state through the monthly meeting he began holding with senior executives from the MoH and technical and financial partners. Indeed, if the primary problem that opened this window was poliomyelitis, very quickly these meetings became concerned with all prominent health issues facing the country, including those around MCH. Furthermore, development projects and programs in Chad are very centralized because state expenses (or those made on its behalf) exceeding 50 million XOF (about 90,000 USD) must first be approved by the head of state. That this was the case for the adoption of the pilot scheme is reflected in the following quote. “The final adoption is above all a decision of the president of the republic through his advisers and collaborators” [KII-2]. In such a context where the president has a lot of power and has the final decision about almost everything, these meetings seemed the right place or forum to push PBF as a solution to the health (system) issues mentioned earlier.

Analysis of Our Hypotheses

According to Kingdon,8 a given policy arises from the coupling of the three streams brought together by policy entrepreneurs who must act when windows open. Coming back to the three research hypotheses we posed at the beginning of this study, we can rule out the two first ones. Indeed, despite some negatives discussed above, the conditions in the streams were largely favorable (conditions were framed as problems, positive factors were present in the political stream, and PBF was there as a policy solution). As we have seen above, the monthly meetings were a potential policy window. It thus appears (hypothesis three) that it was the lack of policy entrepreneurs for moving from the pilot that was the stumbling block, and this situation hampered the coupling of the PBF strategy to the problems and political streams. We seek to understand what prevented the emergence of such policy entrepreneurs.

First, we should mention the relatively noninclusive nature of implementation processes, because the pilot remained in the hands of a very small number of people within the MoH. This probably explains why there was not much advocacy for the PBF program, which, however, is essential for the emergence and institutionalization of health policies.30,31 We believe that in the interest of long-term sustainability, the involvement of stakeholders should extend beyond the MoH to include other ministries in a well-coordinated and complementary manner. Indeed, best practices recommended by PBF programs often conflict, for instance, with the rules of budgetary and financial management, procurement, and personnel management. Yet, it seems that discussions about the pilot scheme adoption were confined to bureaucratic cadres largely within the MOH and even in that case too few of them, following a top-down logic as put forth in the “silent model” of agenda setting described by Garrard.32 In this model, ministries’ technical services, experts, and lobbyists take the lead and few actors are actually involved in the process, so that public controversy is almost nonexistent. Although this is also common in many other countries, the key question remains whether this approach is relevant in Chad where national technical skills are very limited and the country is often dependent on foreign expertise, undermining the salience of this kind of agenda setting.

A second somehow linked reason was the turnover observed in the MoH with the fleeting passage of several ministers and secretaries of state, which made politicians aware of the existence of PBF while not giving them the duration of tenure long enough to enable them to go deep into the actual issues. This prevented PBF from being carried by a strong political figure in the long run. Yet, such a commitment is often decisive to put public policies on the agenda.33,34 This is particularly crucial in a “competitive” environment where many policy options exist to deal with health issues (in line with the Millennium Development Goals and universal health coverage agenda) and where potential policy entrepreneurs have a key role to play in a given policy being adopted to address the identified problem. Indeed, as Kingdon8(p142) reminds us, “The availability of a viable alternative is not a sufficient condition for a high position on a decision agenda, since many good proposals kick around the system for a long time before the lightning strikes.”

In addition, it should be recalled that the project, as a grant, did not require parliamentary approval. Debates and adoption by parliament would have greatly raised awareness and accountability about PBF in the political arena as the social legitimacy of the strategy would have increased and parliament would have examined project activities and questioned the government in case of any concerns.35 So we think that parliamentary debates would have increased the political ownership of the strategy.

A third reason was the exogenous and top-down nature of the strategy, proposed by an external actor (the WB), which acted as the policy entrepreneur for the pilot stage. PBF was completely new and unfamiliar to the country but was
implemented in a relatively hasty fashion: the additional funding by the WB was approved in July 2010, the preparatory work for project implementation occurred in late 2010, and the project itself began in October 2011. The study tours and preparatory workshops seemed to have not been sufficient to build national ownership. Furthermore, technical assistance for the implementation and strategic purchasing role were assigned to an international/national consortium, and the MoH as a whole played a rather passive role. As a result, there was a lack of internal advocates to take over the strategy when the WB left.

A fourth reason was the administrative and financial management of the project by the Ministry of Economics and International Cooperation. Indeed, this somewhat impeded PBF ownership by the MoH because the project was located outside its core structure and regular exchanges between the two ministries to discuss project issues were absent. This appeared to be due, as is often the case in many developing countries, to public service administration and management issues, including a lack of regular communication between ministries.

The last but not least important reason was the dysfunction observed within the steering committee and the technical unit, established to sustain the pilot. Indeed, the steering committee management was rather top-down and it met only four times over three years; moreover, donors usually did not attend meetings. As for the technical unit, only one directorate of the MoH was represented and staff did not always have the technical skills or the time to take up the role. It met only once in 14 months. As a result, no national body actually closely monitored and evaluated the project’s implementation. This could have limited its understanding and ownership by national actors. Yet, the steering committee and the technical unit were the key actors needed to build such ownership and it would have been natural for potential national-level policy entrepreneurship to emerge there. But these dysfunctions may have played an important role in preventing such emergence; the dysfunction in turn could also be explained by the absence of PBF champions.

Additionally, actors that were involved in the PBF implementation processes did not possess the essential qualities that policy entrepreneurs should have as put forth by Kingdon, namely, being persistent, having the right political connections, knowing how to negotiate, being listened to, and being recognized for their expertise. MoH senior officials were lacking expertise to implement the strategy, whereas the Centre de Support en Santé Internationale (the national NGO acting as a performance purchasing agency) had expertise but did not have a privileged position in the political hierarchy and had limited access to decision-making spheres. Many actors undoubtedly welcomed PBF, but it did not seem that a strong advocacy group was formed to sustain it, as was the case in Rwanda or Burundi, which were able to roll out the strategy nationwide.

To conclude, we want to stress that unlike user fee exemption policies, successful pilots are of great importance for the national policy agenda of PBF strategies (like in Rwanda or Burundi), because they provide useful lessons about design and implementation. This is probably due to the fact that PBF is a more technocratic reform with less visibility at the general population level and user fee exemptions are seen as more politically rewardable. In addition, exemption policies seem administratively simpler with no fundamental changes needed to preexisting health systems; in other words, they are a much simpler, less structural reform compared to PBF.

**DISCUSSION**

Our study highlights two kinds of policy entrepreneurship: one to introduce a pilot, which the WB did and could do more or less easily on its own, and the other of moving from pilot to policy with institutionalization into the health system, which requires greater national-level buy-in—that is, leadership—enabling people and organizations to face adaptive challenges where new learning is required—and ownership—ensuring that policies are owned and managed by nationals, with foreign inputs simply technical and advisory. Several reasons prevented this national buy-in from the MoH as discussed above.

We can draw four larger lessons from this experience in Chad and the use of Kingdon’s theory:

First, we see that the successful introduction of bold and complex interventions like PBF (most of the time as pilot schemes) often requires a significant involvement of external actors or donors (e.g., the WB), especially in donor-dependent countries like Chad. But further steps also need the active engagement of one or more policy entrepreneurs at the national level to ensure greater buy-in from domestic actors, at both political and technical levels. This was highlighted from the experience of Health Equity Funds in Cambodia, where the first pilots were initiated by international NGOs and agencies like Médecins sans Frontières, UNICEF, and WHO. But a local network including all key health actors, working under the leadership of the MoH through a sector-wide management strategy, was closely involved through ad hoc meetings, workshops, conferences, and field visits when trying to move Health Equity Funds onto the national policy agenda.

Related to that, the second lesson stresses the critical role of political ownership and technical capacity at a national
level, particularly within the MoH, as key to a policy’s sustain-ability beyond the mere availability of funds. Indeed, our study showed that PBF was introduced in an exogenous and top-down manner. The implementation and purchasing function were managed by international and nongovernmental bodies, and the MoH struggled to take the lead. The main reasons for that are outlined above.

The third lesson is the important influence of early stages on long-term processes; path dependency, in other words. Indeed, our analysis shows that the lack of capacity and ownership was a consequence of how the PBF pilot scheme was designed and implemented. It is therefore important to consider early stages and carefully reflect on the trade-off between the need for rapidity versus the time necessary to ensure a participative and inclusive process. These processes, in addition to a well-planned transfer of skills and key roles (such as the purchasing function) to governmental bodies, appear to be critical to ensuring full understanding and appropriation of PBF by national actors, thus increasing its odds of being rolled out at scale, as we see from the study on Cameroon by Sieleunou et al.43

The last and fourth lesson is about the use of Kingdon’s multiple streams approach8 in our study. We agree with Shroff et al.34 that this model allows some flexibility and must not be applied mechanically. We successfully used it to understand why a pilot scheme was not able to come onto the national policy agenda. The distinction between the governmental agenda and the decision agenda was particularly useful in this regard, but research articles do not always make a clear separation between the two. For instance, though the extension of Kingdon by Lemieux12 suggests that agenda setting involves the coupling of the problem and the political streams, no clear reference or distinction was made between the governmental and decision agendas. Another point to note is the policy window. Indeed, our study shows that the window of opportunity can be particular or atypical (the monthly health meeting in this case) in presidential or strong regimes and this matters a lot for health policy entrepreneurs’ room to maneuver, maybe even for powerful actors such as the World Bank.

We acknowledge some limitations of our study. First, some members of the research team (J.A.K. and L.Y.) were actively involved in the implementation of the PBF pilot scheme. This position as insiders may result in some subjectivity in the analysis, but this could also be an asset because issues of relevance could be more easily identified and assessed.44 However, this situation was mitigated because the other authors (Z.C.S., A.B., M.B., and B.M.), who were external actors to the country (except M.B.) and the pilot, provided critical reflections to analyses. Second, we were not able to interview all relevant stakeholders, because they were not available or reachable or they refused to participate in the study. This could have led us to miss some key elements in analyses. Third, some issues would need more in-depth analysis and may be a fruitful area for future research. For example, it would be interesting to examine the role that scientific evidence could play in an environment where many health policies are competing in the policy stream like in Chad or how these competing policies interacted with each other to influence PBFs nonemergence on the decision agenda.

CONCLUSION

Our study highlights issues that may arise in getting health policies onto decision agendas when certain prerequisites are not met. These include real national ownership through the involvement of key stakeholders. Yet, these were sorely lacking during the PBF pilot scheme implementation processes in Chad and, as a result, the strategy was not put forth by an appropriate policy entrepreneur at the right time on the decision agenda, especially in a seemingly competitive environment with other policies.

The WB was surely the policy entrepreneur that got PBF onto the governmental agenda, but on its own and in the absence of national partners and ownership, it found it difficult to actually get it on the decision agenda. Politics matters a lot and different types of policy entrepreneurship are needed at different stages of scaling-up processes, especially in the implementation of complex strategies such as PBF. Indeed, donors can be entrepreneurs at pilot stages, but when moving forward, this does not always suffice even in donor-dependent countries, and national champions are needed. Some useful lessons emerge from our case study, and taking them into account could help anticipate difficulties and thus facilitate the implementation of PBF and other health interventions in an effective and efficient way, learning that is relevant for Chad and beyond.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

J.A.K. and L.Y. were involved in the implementation of the PBF pilot scheme in Chad, funded by the World Bank, and were employees of AEDES, one of the consortium members acting as the performance purchasing agency. BM contributed to the emergence of PBF as a global health policy, through technical assistance, research and knowledge management. He is the lead facilitator of the PBF Community of Practice. He holds minority shares in Blue Square, a Belgian/
Burundian firm developing software solutions for countries implementing PBF solutions. ZCS is a staff member of the World Health Organization. He is himself alone responsible for the views expressed in the Article which do not necessarily represent the views, decisions, or policies of the World Health Organization or Taylor and Francis Group. The other authors declare that they have no competing interests.

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AUTHORS’ CONTRIBUTIONS

J.A.K. designed the study in collaboration with Z.C.S. and B.M. and with critical inputs from A.B., L.Y., and M.B. J.A.K., A.B., L.Y., and M.B. participated in data collection. J.A.K. wrote the original draft with support from Z.C.S. and B.M. All authors revised the article and contributed to analyses. All read and approved the final version.

ORCID

Joël Arthur Kiendrébéogo http://orcid.org/0000-0002-7000-3712

Mahamat Béchir http://orcid.org/0000-0002-2951-3868

REFERENCES

[1] Ssengooba F, McPake B, Palmer N. Why performance-based contracting failed in Uganda—an “open-box” evaluation of a complex health system intervention. Soc Sci Med 2012; 75 (2): 377-383.

[2] Ashir GM, Doctor HV, Afenyadu GY. Performance based financing and uptake of maternal and child health services in Yobe State, northern Nigeria. Glob J Health Sci 2013; 5(3): 34-41.

[3] Paul E, Sossouhouno N, Eclou DS. Local stakeholders’ perceptions about the introduction of performance-based financing in Benin: a case study in two health districts. Int J Health Policy Manag 2014; 3(4): 207-214.

[4] Paina L, Peters DH. Understanding pathways for scaling up health services through the lens of complex adaptive systems. Health Policy Plan 2012; 27(5): 365-373.

[5] Ministry of Planning, Economy and International Cooperation of Chad, Ministry of Public Health of Chad, World Bank, AEDES / CSSI Consortium. Manual of procedures for the implementation of results-based financing in Chad. 2011. Available at http://www.fbrtchad.org/csde/content/docs/Man uel_de_Procedures.pdf (accessed 5 July)

[6] National Institute of Statistics, Economic and Demographic Studies, Ministry of Public Health and ICF International. Demographic and Health and Multiple Indicators Survey (DHS-MICS 2014–2015). Rockville, MD: Institut National de la Statistique, des Études Économiques et Démographiques, Ministère de la Santé Publique & ICF International, 2014–2015.

[7] Musgrove P. Financial and other rewards for good performance or results: a guided tour of concepts and terms and a short glossary. 2011. Available at https://www.rbfhealth.org/sites/rbf/files/RBFglossarylongrevised_0.pdf (accessed 15 15 July)

[8] Kingdon JW. Agendas, alternatives, and public policies. 2nd ed. New York: Harper Collins; 1995.

[9] Rawat P, Morris JC. Kingdon’s “streams” model at thirty: still relevant in the 21st century? Polit Policy 2016; 44(4): 608-638.

[10] Cherlet J, Venot J-P. Structure and agency: understanding water policy changes in West Africa. Water Policy 2013; 15 (3): 479-495.

[11] Ridde V. Policy implementation in an African state: an extension of Kingdon’s multiple-streams approach. Public Adm 2009; 87(4): 938-954.

[12] Lemieux V. L’étude des politiques publiques: les acteurs et leur pouvoir [The study of public policies: the actors and their power]. 3rd ed. Quebec, Canada: Les Presses de l’Université Laval; 2009.

[13] Jones MD, Peterson HL, Pierce JJ, Herweg N, Bernal A, Raney HL, Zahariadis N. A river runs through it: a multiple streams meta-review. Policy Stud J 2016; 44(1): 13-36.

[14] Ministry of Planning, Economy and International Cooperation of Chad, National Institute of Statistics, Economic and Demographic Studies (INSEED). Second General Population and Housing Census II. 2012. Available at http://www.insedtchad.com/IMG/pdf/rappo rt_resultats_definitifs_par sous-prefecture_24_ess_33.pdf (accessed 15 July)

[15] Ministry of Public Health of Chad. National Health Development Plan II 2013–2015. 2013. Available at http://www.sante-chad.org/file/151097 (accessed 15 July)

[16] Gould JA, Winters MS. An obsolescing bargain in Chad: shifts in leverage between the government and the World Bank. Bus Polit 2007; 9(2): 1-34.

[17] Gauthier B, Wane W. Leakage of public resources in the health sector: an empirical investigation of Chad. J Afr Econ 2009; 18(1): 52-83.
[18] Winters MS, Gould JA. Betting on oil: the World Bank’s attempt to promote accountability in Chad. Glob Gov 2011; 17(2): 229-245.

[19] World Health Organization. Poliomyelitis in Chad. 2011. Available at http://www.who.int/csr/don/2011_06_10a/en/ (accessed 8 December 2016)

[20] Reidpath DD, Allotey P. Infant mortality rate as an indicator of population health. J Epidemiol Community Health 2003; 57(5): 344-346.

[21] Wilmoth J. The lifetime risk of maternal mortality: concept and measurement. Bull World Heal Organ 2009; 87(4): 256-262.

[22] Tchadanthropus Cyber-Presse. Review of the Chadian press. 2011. Available at http://forum-debat-tchadanthropus.blogspot.com/2011/07/revue-de-la-presse-tchadienne.html (accessed 5 July)

[23] Ministry of Public Health of Chad. Speech by First Lady HINDA DEBY ITNO at the launch ceremony of CARMMA. Available at http://www.sante-tchad.org/Discours-de-la-Pré-miere-Dame-HINDA-DEBY-ITNO-lors-de-la-ceremonie-du-lancement-de-la-CARMMA_a50.html (accessed 15 July)

[24] Ministry of Public Health of Chad. National Health Policy 2007–2015. Available at http://dev.tchadotheque.org/images/pdf10062013/141126704-POLITIQUE-NATIONALE-DE-SANTE-2007—2015-Septembre-2007.pdf (accessed 15 July)

[25] Ministry of Public Health of Chad. National Health Development Plan of Chad 2009–2012. 2008. Available at http://dev.tchadotheque.org/images/pdf10062013/139933392-PLAN-NATIONAL-DE-DEVELOPPEMENT-SANITAIRE-DU-TCHAD-2009-2012-TOME-1-ANALYSE-SITUATION-NELLE-OBJECTIFS-ORIENTATIONS-STRATEGIQUES-Octobre-2008.pdf (accessed 15 July)

[26] African Development Bank, Organization for Economic Cooperation and Development, United Nations Economic Development Program for Africa. Economic Outlook in Africa 2013 - Structural transformation and natural resources. 2013. Available at http://dx.doi.org/10.1787/aeo-2013-en (accessed 5 July)

[27] Kiendrébogo JA, Rusa L, Antony M, Barthès O. Capitalization of the results-based financing pilot scheme in Chad. Evaluation of implementation process. N’Djamena, Chad: Agence Européenne pour de Développement Et la Santé/Centre de Support en Santé Internationale Consortium; 2013.

[28] World Bank. Report of the evaluation of results-based pilot scheme in Chad. 2013.

[29] Kiendrébogo JA, Barthès O, Antony M, Rusa L. Piloting a performance-based financing scheme in Chad: early results and lessons learned. African Health Monitor 2015; 20: 37-42.

[30] Shiffman J. Generating political priority for maternal mortality reduction in five developing countries. Am J Public Health 2007; 97(5): 796-803.

[31] Shiffman J, Okonofua FE. The state of political priority for safe motherhood in Nigeria. BJOG 2007; 114(2): 127-133.

[32] Garraud P. National policies: developing the agenda. L’Année Sociol 1990; 40: 17-41.

[33] Shiffman J. Generating political will for safe motherhood in Indonesia. Soc Sci Med 2003; 56(6): 1197-1207.

[34] Shroff ZC, Roberts MJ, Reich MR. Agenda setting and policy adoption of India’s national health insurance scheme: Rashtriya Swasthya Bima Yojana. Health Systems & Reform 2015; 1(2): 107-118.

[35] Wang V. The accountability function of parliament in new democracies: Tanzanian perspectives. Washington, DC: World Bank Group; 2005.

[36] Toonen J, Canavan A, Vergeer P, Elovaarion R. Learning lessons on implementing performance based financing, from a multi-country evaluation. Amsterdam: KIT (Royal Tropical Institute); 2009.

[37] Ridde V. From institutionalization of user fees to their abolition in West Africa: a story of pilot projects and public policies. BMC Health Serv Res 2015; 15: 1-11.

[38] Rusa L, Schneiderman M, Fritsche G, Musango L. Rwanda: performance-based financing in the public sector. In: Performance incentives for global health: potential and pitfalls, Eichler R, Levine R, and the Performance-Based Incentives Working Group, eds. Washington, DC: Center for Global Development; 2009; 189-214.

[39] Ir P, Bigdeli M, Meessen B, Van Damme W. Translating knowledge into policy and action to promote health equity: the Health Equity Fund policy process in Cambodia 2000–2008. Health Policy 2010; 96(3): 200-209.

[40] Edmonstone JWJ. Leadership development in health care: what do we know? J Manag Med 2002; 16(1): 34-47.

[41] Costello A, Zumla A. Moving to research partnerships in developing countries. Br Med J 2000; 321(7264): 827-829.

[42] Meessen B, Soucat A, Sekabaraga C. Performance-based financing: just a donor fad or a catalyst towards comprehensive health-care reform? Bull World Health Organ 2011; 89 (2): 153-156.

[43] Sieleunou I, Turcotte-Tremblay A-M, Yumo HA, Kouokam E, Taptue Fotso J-C, Tamga DM, Ridde V. Transferring the purchasing role from international to national organizations during the scale-up phase of performance-based financing in Cameroon. Health Sys Ref 2017; 3(2): 91-104.

[44] Walt G, Shiffman J, Schneider H, Murray SF, Brugha R, Gilson L. “Doing” health policy analysis: methodological and conceptual reflections and challenges. Health Policy Plan 2008; 23(5): 308-317.

[45] Ravinet P. Fenêtre d’opportunité [Window of opportunity]. In: Dictionnaire des politiques publiques [Dictionary of public policy], Boussaguet L, Jacquot S, Ravinet P, eds. Paris, France: Presses de Sciences Po (P.F.N.S.P.); 2014; 274-282.