POLICY IMPLEMENTATION IN AN AFRICAN STATE: AN EXTENSION OF KINGDON’S MULTIPLE-STREAMS APPROACH

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Kingdon’s multiple-streams framework, which emerged in the mid-1980s, today forms one of the indispensable analytical frameworks for understanding public policy agenda-setting. However, it is only in the context of wealthy countries that this approach has been validated for setting the agenda of national and international policies. This article reports the results of empirical research in an African state studying the transferability of a threefold theoretical innovation. The question under consideration is whether the multiple-streams framework is useful for examining public policy implementation at the local level and in the context of a low income country. The research findings confirm the premise that the multiple-streams framework can be extended and can lead to the formulation of several theoretical propositions.

INTRODUCTION

John Kingdon’s multiple-streams framework, which first emerged in the mid-1980s, is considered indispensable for understanding public policy agenda-setting (Kingdon 1995). The framework’s heuristic value and related concepts are proven and have been used to study agenda-setting in health policy (Odom-Forren and Hahn 2006), international aid (Travis and Zahariadis 2002) and education (Lieberman 2002). However, it is only in the context of high income countries that it has been validated for setting the agendas of national and international policies. In this article, its transferability to the study of public policy implementation at the local level and in a low income country, Burkina Faso in West Africa is explored and after detailed analysis, several theoretical propositions are formulated.

In response to Saetren’s (2005, p. 573) observation that ‘We are not even close to a well-developed theory of policy implementation’, this paper introduces a threefold theoretical innovation. First, following Lemieux’s propositions (2002) and Zahariadis’ recommendations (1999), the multiple-streams framework has been shown to be useful for examining policy implementation. Although policy implementation has been studied for 30 years, no one has examined it using Kingdon’s framework (Pulzi and Treib 2007). Second, although American political scientists have applied the framework to national (federal) policies, this study applies it at a local level in a decentralized context, something that has been done to date in only one study in the United Kingdom (Exworthy et al. 2002). In this article, the term ‘decentralization’ refers broadly to the transfer of authority and power from higher to lower levels of government (Saltman et al. 2007) and, more specifically, to the decentralization of revenue collection through user fee schemes (out-of-pocket payment). Third, with just one recent exception (DeJaeghere et al. 2006), the framework has rarely been used in Africa. This is not surprising, since only 4 per cent of the work on policy implementation over the past 30 years has been concerned with Africa (Saetren 2005). This clearly places the article in the category of ‘reformer scholarship’,
favourably disposed towards both research on implementation and changes in theoretical approach (Lester and Goggin 1998).

THE IMPLEMENTATION GAP IN HEALTH POLICIES WITH RESPECT TO EQUITY

The empirical findings of this research concern the implementation of the Bamako Initiative (BI) health policy in Burkina Faso (Ridde 2008a). The policy was created to counteract the failure of the 1978 Alma-Ata policy on primary health care (PHC) to foster health equity (Van Lerberghe and de Brouwere 2000). It is not as yet possible to study the impact of policies on equity in health. We will thus focus on equity in utilization of services and, most of all, in access to health care for the worst-off (indigents), who have been affected the most by the introduction of user fees. The BI was formulated in 1987 in Bamako, the capital of Mali, at an international meeting of African health ministers, the United Nations Children’s Fund (UNICEF) and the World Health Organisation (WHO). Burkina Faso adopted the BI in 1987, but implementation did not begin until 1993 and, even then, in only a few districts. Its objective is to improve the quality and accessibility of health services. Decentralization takes the organization and financing of health service delivery to the local health district level. Direct payment (user fees) for health care and generic essential drugs is generalized; however, money is not forwarded to the central Public Treasury, but is retained locally and managed by village health committees, which decide on resource allocation. To avoid excluding the indigent, it was decided in 1987 to exempt them from paying user fees. However, as elsewhere in Africa, exemptions have not been applied in Burkina Faso (Gilson et al. 2000; Ridde 2007) and the indigent remain excluded. The well-known concept of the ‘implementation gap’ (Pressman and Wildavsky 1984) thus applies to this policy. Although the BI purports to promote equity of access to health care, this has not materialized. Thomas Dye (1972) correctly defined public policies as ‘anything a government chooses to do or not to do’. In this case, since equitable choices had been made in 1987, the deficiency lay rather at the implementation level. Analysts must therefore try to understand why implementation has failed.

STUDYING IMPLEMENTATION

Public policies are neither monolithic nor linear. The public policy process can be understood as consisting of several sub-processes. Since Lasswell’s famous propositions of the 1950s, numerous authors have suggested possible stages, that is, sub-processes (deLeon 1999), even if ‘stagists’ are criticized by some (Sabatier 2007). The purpose here is not to revisit this debate, discussed elsewhere (see Ridde et al. 2007), but rather to seek a heuristic breakdown – or a ‘textbook approach’ (Nakamura 1987) – to understand the BI’s implementation process, wherein the equity problem lies. Consequently, this paper is inclined towards the definitions of sub-processes proposed by two authors who are paradigmatically close. According to Kingdon (1995), public policies have four phases: agenda-setting, determining possible choices, authoritarian selection of a choice, and implementation of decisions. In Lemieux’s view (2002), there are three recurring sub-processes: agenda-setting, formulation and implementation, with evaluation being more of a meta-process. He maintains that Kingdon’s authoritarian selection stage is not a component of the public policy creation process, but is, rather, part of the official procedure which, depending on the situation, can help anticipate or endorse an emerging policy. The author shares this opinion, insofar as it is true that, in public policies supported by
the international community, these procedures are more ritual ceremonies than occasions
for intense debate. Often, the experts have already decided (Grindle and Thomas 1991).

In addition to the above, policies are not linear. Implementation often diverges from
plan. Since the 1970s, several descriptors have been applied to public policy implementa-
tion in high incomes countries, including ‘implementation politics’ (Bardach 1977), ‘crisis
of implementation’ (Mazmanian and Sabatier 1983), ‘implementation gap’ (Pressman
and Wildavsky 1984), and ‘implementation deficit’ (Blackmore 2001). Only Grindle and
Thomas (1991) have opposed this linear conception, using a dozen case studies carried
out in low income countries.

Equity in access to health care was among the original objectives of the BI policy; nothing,
however, came of it. It is therefore necessary to focus, not on the first stages of the process,
but rather on implementation. Specification of policy objectives and means is one of the
factors influencing successful implementation (Mazmanian and Sabatier 1983; Blackmore
2001). For this policy, the process of formulating and setting the agenda was largely
exogenous in origin, the end product of an international consultation process by UNICEF
and the WHO. Its content is international and homogeneous. Its initiators wanted to define,
as clearly as possible, the means for achieving the objectives, namely fee exemptions. At
the country level, implementation procedures are centrally established and district-level
authorities must conform. Having divided policy implementation heuristically into three
sub-processes, it is now important to examine how the multiple-streams approach can be
applied to the BI.

EXTENSION OF THE MULTIPLE-STREAMS FRAMEWORK

In his now-famous work, John Kingdon (1995) proposed a theoretical response to two
questions often raised by those studying public policy agenda-setting: What determines
the emergence of some ideas over others? Why are certain ideas used by governments to
formulate public policies, and not others? To answer these, Kingdon used an approach
defined by three streams. The framework was inspired by the ‘garbage can’ model, in
particular by the decision-making processes of organized anarchies, which are character-
ized by problematic preferences, unclear technology and fluid participation (Cohen et al.
1972). According to Kingdon, public policies emerge when policy entrepreneurs seize
windows of opportunity to couple a problem stream with a political stream. The policy
stream is also present, but loosely coupled with the other two. Without this coupling,
no policy can emerge. Problems remain unresolved; solutions may exist or be promoted
by stakeholders, but there is no receptivity to them. The national mood or current ideas
cannot be capitalized on because there are no recognized problems or solutions. But when
a window of opportunity appears in the problem or policy streams, a policy entrepreneur
will do everything possible to couple these streams in order for a public policy to emerge.
Problem solving is not utopian, since it requires known solutions, and so this third stream
is not negligible. Entrepreneurs may emerge from any stream, depending on the situation
and the degree to which a certain stream predominates. For Kingdon, the occurrence of a
window of opportunity in a given area may increase the probability of another window
opening in a related area. This is the concept of ‘spillovers’.

Kingdon’s framework suffers no lack of critics and supporters. He has been reproached
for not having sufficiently amplified or clarified the ‘policy stream’ concept (Exworthy
and Powell 2004). Others fault him for being too circumstantial (Howlett and Ramesh
1995), or too tied to the political system of the United States (Demers and Lemieux
The strongest criticisms, however, are from those who think the framework, which has hardly been contested, in fact cannot be contested because of its limited, or even non-existent, explanatory capacity. Falsification would be next to impossible (Ravinet 2004; Sabatier 2007). Nevertheless, critics of Sabatier (2007), for example, rarely base their criticism on empirical data and seem to have a very positivist epistemological perspective – not the approach taken in this paper.

Other authors have taken Kingdon’s framework further. Powell and Exworthy (2001) have retained the notion of streams, although applying it to the local level and transforming the content: policy, process and resource. Zahariadis (1999) extended the framework to the decision-making process. John (1998) argues that evolutionary metaphors such as Kingdon’s (Kingdon 1995) can be applied to all stages of the policy process. Lemieux (2002) extends this interpretation, suggesting that while policy formulation involves coupling the policy and political streams, implementation involves coupling the policy and problem streams. In both cases, the third (that is, politics) stream is present but loosely coupled (figure 1).

Although the scientific relevance and theoretical value of this extension have been demonstrated (Lemieux 2002), they have been empirically validated only once in Canada (Demers and Lemieux 1998). The present study goes against the ‘protracted and sterile debate about the two competing analytical paradigms labelled top-down versus bottom-up’ (Saetren 2005, p. 572). It moves away from seeing human behaviour as rational and is closer to the concept of ‘ambiguity’ adopted by some political scientists (Cohen et al. 1972; Kingdon 1995). In addition, it is closer to development anthropology’s concept of neo-interactionism (Oliver de Sardan 2005), where social actors interact with each other in a specific arena (Bailey 1969). Actors, their strategies and their margins for manoeuvre are the cornerstone of this neo-interactionism approach, in line with Strauss’ concept of negotiated order, also used in the study of public policy (Barrett 2004).

For the extension of the multiple-streams framework to be relevant to implementation, a coupling of streams must be shown to have occurred in the preceding stages (Ridde 2004). In the context of African health policies, this approach applies to the BI. Collins (1994) states that, in setting the agenda of the 1978 PHC policy, the goal of greater equity was not easy because it countered the will of certain politicians who favoured

![FIGURE 1 Extension of the multiple streams approach of Kingdon (1995) and Lemieux (2002)]
the existing system of social inequality and political domination. The presence of policy entrepreneurs was already well-established, because change was accepted to be difficult. In 1979, the government’s adoption of PHC in Burkina Faso was followed by the first national health policy. There was thus a coupling of the political (PHC) and policy (increase in vaccination and curative care coverage) streams, fostered by WHO, acting as a policy entrepreneur. Applying the streams approach to the BI, it can be demonstrated that UNICEF and WHO (policy entrepreneurs) coupled the problem stream (ineffectiveness of PHC, inequity in access to care and in financing) with the political stream (democratization, decentralization), thus initiating the process, at the end of the 1980s, of setting the BI agenda. As for policy formulation, UNICEF and WHO coupled the political stream (which remained the same) with the policy stream (generic essential drugs (GED), user fees, community management/participation). (For further details, see Ridde 2008a.)

Extension of the streams framework is therefore useful in formulating three research propositions (RP) to understand the implementation gap, that is, the failure to implement the BI’s equity component.

The equity problem stream (for example, exclusion of the indigent) has not been coupled with the policy stream (for example, user fee exemptions), because:

RP1: the absence of equity (that is, protecting access for the indigent) is not perceived as a public problem;
RP2: there has been no window of opportunity;
RP3: no policy entrepreneur has emerged to bring about the coupling.

METHODOLOGY

To study the propositions empirically, research was carried out in a health district of Burkina Faso. The methodology consisted of a case study (Yin 1994) and a socioanthropological field study. The case was an international cooperation project of a non-governmental organization (NGO) which supports the Ministry of Health’s decentralized services (District Health Team) in implementing BI policy. The case was selected, with health ministry collaboration, based on its capacity to increase understanding of the problem – that is, it was the only project of sufficient scope in the country to support a health district in following BI objectives precisely. This project began in 2001. Though some districts in the country started implementation of the BI in 1993, in this particular district, this was the first valid wide-ranging project linked to the BI that had been initiated for three years. The fieldwork for this study was carried out in 2003 over a 7-month period.

Qualitative research methods are recommended for studying public policy implementation (Rist 2000). Yin (1982) considers three research methods particularly suited for examining public policies: (1) non-structured interviews; (2) documentation study; and (3) participatory observation. Empirical data were collected using in-depth interviews (n = 24), informal interviews (n = 60), focus groups (n = 4), documentary analysis and field observation (over 7 months). Following Kingdon, Lemieux (2002) identifies four categories of stakeholders concerned with public policy, based on their expertise (specialist or non-specialist) and their position with regard to government structure (internal or external). Data were collected from stakeholders in these four categories during daily interactions, work meetings and dispensary visits, and were transcribed in the form of ethnographic field notes (Emerson et al. 1995). This enabled a profound analysis of issues around power and resource control. The selection of respondents for in-depth interviews
was carried out after 4 months in the field and meticulous identification of the most relevant interviewees. Thematic analysis was used to analyse the data (Miles and Huberman 1994).

**POLICY CONTEXT**

Although the BI was adopted at the pan-African level in 1987, it took until 1993 to implement it in Burkina Faso. Several events took place before implementation of the BI in Burkina Faso: the Benin mission (1998); operational research (1998–89); founding of a BI committee, a national secretariat, and a follow-up committee (1988); and the designation of six pilot provinces (1989–92). During a national workshop in 1992, the formulation of the BI was rendered operational with the production of the ‘BI Start-up Document’. According to the Ministry of Health, the official launch held in Kombia (one of the six pilot provinces) in October 1993 is considered the start of the BI implementation (Ridde 2007). The first training for trainers was delivered in July 1993. However, the 100 per cent devaluation of the CFA franc in January 1994 led to a reconsideration of the BI process, since the price of imported GED almost doubled. In March 1994, the ‘BI acceleration phase’ was started. This phase constituted one of the two prongs of the National Emergency Economic Program financed by the International Monetary Fund (IMF) and the World Bank (WB). The acceleration phase ended in June 1996; no evaluation followed.

In the health district, implementation started in some disorder in the 1990s. The analysis of the Ministry of Health regarding the management of drugs at the regional level was without compromise: ‘Disappearance and expiration of GED, dissemination of GED kits without auxiliary measures, health workers who were not trained in the BI, etc.’ (Ouedraogo et al. 1998, p. 17). In 1998, serious, albeit modest, developments occurred. A few members of health management committees (HMC) at the village level were trained, some GED depots were built and their management was supervised. In 2000, the first training dedicated to the BI was delivered to 19 nurses. At the beginning of 2001, the first project linked to the BI started, lasting 3 years. The overall objective of the project, as declared by the NGO, was to improve the population’s geographic and financial accessibility to GED and PHC. The NGO was to build the depots and provide them with drugs, carry out training programs, supervise and control the depots in cooperation with the district health team, and so on. The final evaluation of the project demonstrated that the actors had focused on achieving the effectiveness objectives to the detriment of equity (Ridde et al. 2005).

**FINDINGS**

Given the theoretical purpose of this article, only the empirical elements essential to a theoretical demonstration are provided. For details of the empirical data (in French), see Ridde 2007; for a peer-reviewed paper in English, see Ridde 2008a.

**The problem stream**

No empirical elements related to exclusion of the indigent population contributed to the situation’s being understood as a ‘public’ problem. Measures favouring the indigent were recognized as important at the health system’s central level in several directives targeting equity. However, these measures were not included in planning guides sent to stakeholders in outlying areas (districts, local health centres). Nor did evaluation protocols for health policy contain an indicator for access by the poorest to health care. Local planners
did not include these measures in their action plans. Student nurses did not mention this exclusion from services in their practicum reports. Health officers believe the policy has improved everyone’s access to care, including that of the indigent, yet individuals still complain about financial inequalities in access. All stakeholders recognize that direct payment excludes the poorest, yet members of the management committees and of the NGO wonder why the policy has not changed anything for those already excluded from access before it was implemented. The indigent are not included in the populations identified by public policies as most vulnerable. The definition of ‘true’ indigents is persistently subject to verbal gymnastics (Cobb and Coughlin 1998). The indigent lack a public voice. The research participants believe exclusion from care has always existed and that the indigent do not go to health centres. Compared with other stakeholders, the officers in charge and the senior administrators are very far removed from the realities of this exclusion, which have triggered neither documented incidents nor major crises. The problem of the indigent is not mentioned in professional training programmes. Neither is the subject raised during field supervision or programme evaluation. The general orientation of the prevailing value system in the local society is closer to an egalitarian view of distributive justice than to a Rawlsian view, in which the Difference Principle requires that priority be given to action favouring the most disadvantaged (Ridde 2008b).

The policy stream

Various solutions have been proposed for tackling the exclusion of the indigent from health care. According to Kingdon (1995), it is the community of specialists that debates, studies and selects solutions. One professor who teaches the BI policy components to nurses stated in his workbook that certain aspects remain unresolved, notably that of equity. In one of the professional training sessions the author attended, trainers periodically mentioned exclusion of the indigent but did not treat the issue with conviction, provoke discussion, or propose solutions. Physician planners for the health districts were explicitly instructed during training sessions to reserve resources for activities having the greatest chance of success. No solutions were offered for improving access to care. While the BI policy envisioned that exemption of the poorest would be financed through services paid for by other members of the community, central health officials gave no clear directives about allocating a percentage of user fee revenues to exemptions. In contrast, compensation for volunteer members of the management committees and health staff bonuses were easily determined. The NGO officer in charge admitted that reaching the maximum number of beneficiaries was the project’s priority, and said that solutions for eradicating exclusion would be sought once this objective had been achieved. The technical feasibility of such solutions and their appropriateness in terms of social values are far from being established. Furthermore, stakeholders anticipate responsibility for the indigent with a sense of foreboding, in that they are afraid of being invaded and bankrupted.

The political stream

The worldwide trend of privatizing health services has been heavily analysed, particularly in the context of Africa (Turshen 1999; Gilson et al. 2007). Lee and Goodman (2002) have shown how reforms in health funding in developing countries have been taken over by a ‘transnational managerial class’ that has decided, in isolation, what to promote, often to the detriment of equity. In the African context, where funding agencies are omnipresent, national and local health officials have been influenced by this regressive view. The author noticed this on numerous occasions within the Ministry of Health
and the NGO. According to those who attend international, national and local meetings where future orientations of the health system are discussed, funding agencies are no more concerned with the indigent than are other stakeholders. Adding further injury to the objective of equitable access to care, national researchers have shown that hospitals’ administrative staffs are always more concerned with financial independence (Bicaba et al. 2003). According to their research, between 1997 and 2002, only 32 women were identified as indigent in three regional hospitals and entitled to be exempted. They represent 1.6 per cent of all applied caesareans. Civil society being weak, pressure groups are rare, as is any mention of equity of access to care. The NGOs that created a committee in 1993 to monitor BI policy have never broached the subject of exclusion of the indigent. A study of the country’s independent press shows this problem is not reported in the media, either. In the newspaper most critical of the government, fewer than 1 per cent of articles in 2002 and 2003 dealt with the health system. The persons interviewed and the 2003 report of the National Ethics Committee blamed this state of affairs on politicization of the administration. All the senior health civil servants responsible for implementing the BI centrally and in outlying areas have rapidly changed posts. In public policy texts, the equity originally mentioned in the PHC strategy, and then in the BI, remains discursive in Burkina Faso. However, according to all the stakeholders interviewed, the state endeavours to meet the demands of loan/donor agencies, without really believing in equity or taking serious measures to ensure its actualization.

Windows of opportunity

In the agenda-setting, formulation and implementation of the BI policy, stakeholders have often raised the issue of equitable access to care. Access for the indigent was noted in almost all windows of opportunity occurring at the central level between 1993 and 2001. Political events (such as the annual general policy speech of the Prime Minister) were used, notably by the President, as occasions to promote the ideals of equity and justice in the society of Burkina Faso. Certain events within the health system were also used to draw the attention of senior ministry officials to the tragic consequences of inequitable access to care. In 2001 and 2003, national researchers presented their findings to these officials, reminding them of the importance of correcting this exclusion. A study of the initiation of emergency care without pre-payment (following a decision by the Prime Minister) even led these researchers to state clearly, ‘One can learn from this that the whole area of free care for the indigent has not been developed in such a way as to provide the means to facilitate implementation’ (Bicaba et al. 2003, p. 21). Kingdon (2001) acknowledged significant inertia in the public policy process but insisted ‘the process is fluid enough that there are many opportunities to advocate change’ (p. 337). In the case under study, opportunities were not lacking, but they were not grasped as a way of moving beyond discourse and problem identification.

Policy entrepreneurs

If no windows of opportunity were seized, it was partly because there were no individuals ready to couple the problem and policy streams by using their resources to promote equitable access to care. Entrepreneurs, according to Kingdon (1995), may be located in many places and in various streams. They possess three main qualities: (1) they are persistent; (2) they know how to negotiate; and (3) they are listened to and recognized for their expertise, leadership or strategic position as decision makers. They must also be ready to take action to further their ideas at opportune moments. An analysis of this study’s
findings (Ridde 2008a) clearly shows no such persons existed in the arena examined. Even if health policies are usually marked by the power of medical professionals, they did not use it in this case in favour of equity. Health workers have ‘captured’ the BI health system (Paganini 2004) and agents are more attracted by the maximization of profits than by the redistribution of revenues for the benefit of the worst-off (Tizio and Flori 1997). On a microscopic level (that is, that of a hospital) actors for social change did exist who were in favour of equity. However, within the specific context of this research, there were no individuals willing to use their resources for the benefit of the indigent, either among the four categories of stakeholders or within the three public policy streams.

**DISCUSSION: TRANSFERABILITY OF THE EXTENSION OF THE FRAMEWORK AND NEW RESEARCH PROPOSITIONS**

Before discussing the transferability of the extension of the multiple-streams framework, it is useful to revisit the research propositions formulated. As mentioned in the preliminary proposition, empirical data show no coupling of the problem and policy streams. Solutions are rare and always imprecise. Moreover, exclusion of the indigent is not sufficiently perceived as a public problem (RP1) (Ridde 2006). However, the proposition concerning windows of opportunity has not been verified (RP2). There were numerous occasions when a coupling of streams would have been possible. These were not exploited, for reasons explained elsewhere (Ridde 2008a) but summarized here,

1. an implementation process unsuited to change (parachuted, precipitous, and political);
2. a presentation and selective understanding of the policy locally that was detrimental to equity;
3. a perception by stakeholders that they could not take action (lack of technical solutions, lack of political will, centralized and under-funded health system).

The absence of a political entrepreneur is confirmed (RP3). In none of the stakeholder groups was anyone concerned about equity of access.

Thus there is a threefold explanation for the implementation gap resulting from the lack of coupling between the solution and problem streams:

1. exclusion of the indigent is not perceived as a public problem;
2. existing windows of opportunity have not been seized;
3. there are no policy entrepreneurs who favour equity.

In summary, extending the multiple-streams framework to implementation produces three research propositions, two of which are confirmed by empirical data and one which contradicts the framework. The article goes on to present a threefold theoretical innovation with regard to the multiple-streams framework.

**The framework applied to implementation**

Kingdon’s framework has been criticized, according to Zahariadis (1999), for being much more useful for understanding and explaining issues than for forecasting. Obviously, forecasting is one of the functionalities expected of a framework (Carpiano and Daley 2006; Sabatier 2007). Sabatier (2007, p. 327) even affirms, ‘The multiple-streams framework
has no explicit hypothesis’. In Canada, Demers and Lemieux (1998) have shown that this criticism is unfounded and that the framework does apply to implementation. In their study of a public policy on hospital emergency services, coupling of the policy and problem streams occurred as expected. The approach has also proved useful in the case of health policy implementation in Burkina Faso, for forecasting and for understanding and explaining the issues. In terms of forecasting, the proposition about the absence of a stream coupling was established empirically. With regard to fee exemptions for the indigent, both the scarcity of solutions and the lack of recognition of the problem were prejudicial to public policy implementation. As would be predicted by an extension of Kingdon’s framework, implementation was impossible because these two streams were never coupled. Furthermore, the framework predicts that coupling the political and problem streams could not only set the agenda for a new policy favouring equity, but also that a coupling of the policy and solution streams could result in policy reformulation. The empirical data show neither of these things happened, again confirming the framework as postulated at the beginning of this article. A first proposition about the multiple-streams framework can therefore be formulated:

P1: implementation of a public policy depends primarily on a coupling of the problem and policy streams.

A superficial reading of Kingdon’s work might lead one to believe it is the juncture of two streams, which can vary depending on the sub-processes, that explains the public policy process. Kingdon and others (Demers and Lemieux 1998; Zahariadis 1999) insist on the dual nature of this coupling and also on the importance, although of less influence, of the third stream: ‘The probability of an item rising on a decision agenda is dramatically increased if all three elements – problem, proposal, and political receptivity – are coupled in a single package’ (Kingdon 1995, p. 195). In the specific context of the Burkina Faso study, the author believes the third stream is as important as the others; the empirical data show no difference among the three streams in explaining the poor implementation. From a conceptual (and heuristic) perspective, it is easy to suggest implementation did not occur, since the solutions did not resolve the problems. However, the case study also demonstrates that the political stream did not encourage a coupling of the two other streams, leading to implementation failure. In other words, without a favourable political environment, there can be no coupling of the problem and policy streams. The case study, like many others (Turshen 1999; Lee and Goodman 2002), well demonstrates that current health reforms in low income countries in general, and in Burkina Faso in particular, are much more oriented towards sustainability and cost recovery than towards equitable access to health services. This leads to a second proposition:

P2: If implementation does result from a coupling of the problem and policy streams, it can only succeed if the political stream is favourable to it.

Whether the inverse would hold remains to be tested. Even when political orientations favour equity, solutions may not exist for the problems. Zahariadis (1999) correctly stated that, ‘Only a combination of all three streams at the same time can produce the desired outcome’ (p. 81).

It should be noted that Kingdon’s theoretical propositions concerning the problem stream have had to be complemented by other work (Rochefort and Cobb 1993; Cobb and Coughlin 1998; Houston and Richardson 2000). The author is not alone in using such theoretical triangulation (Peretz 1998). These additions have helped in understanding the
role played by 9 factors (Ridde 2006, 2008b) that determine whether social actors perceive a situation as a public problem:

1. it is recognized as important;
2. its causes are recognized;
3. its consequences are specified;
4. the populations concerned are known;
5. it is a new situation;
6. actors are close to it;
7. there are incidents, crises or symbols related to it;
8. there is feedback about it;
9. it is in step with societal values.

The framework applied at the local level
As noted by others (Exworthy et al. 2002), Kingdon’s work rests solely on federal public policy and not on local policy. Thus, the framework has focused on ‘big windows’ and not ‘little windows’, as would be required for an analysis of the implementation of decentralized public policy. The present empirical study appears to confirm the possible application of Kingdon and Lemieux’s work to the local level, that is, the ‘little windows’ (Exworthy and Powell 2004). Intuitively, there is no reason to believe this should not be possible, yet the framework has rarely been applied to the local level. Moreover, the only application of the extension of the multiple-streams framework has been limited to the study of ‘big windows’ (Demers and Lemieux 1998). Although the present case study analysed implementation of the BI at the level of a district, and not a hospital or state, there are sufficient significant empirical data (Ridde 2007) to examine these three tiers and put forward a third theoretical proposition. In Burkina Faso, implementation of the BI occurs within a health system that remains extremely centralized, despite decentralization policies. All the same, stakeholders on the periphery still have room to manoeuvre. It can, therefore, be advanced that:

P3: Peripheral implementation (‘little window’) has greater potential for success in a centralized system if the solutions to problems originate from the centre.

Thus, peripheral stakeholders, who usually follow central instructions, will have a greater tendency to implement decisions. In Burkina Faso, the central administration proposed solutions following international recommendations, but these always remained vague, more declarations of principle than operational solutions. Thus, in P3, when we use the term ‘solutions to problems’, we refer of course to a specific, technical demand in terms of process, certainly one that is much more concrete than what central planners have proposed to date. Since the central authorities and the experts from international institutions have left it to their colleagues at the local level to find concrete solutions without really supporting them, we have observed that, in a context that is still highly centralized (despite the discourse favouring decentralization), the latter have not really put much effort into providing equitable access to care. To accomplish this in such a context requires, as we will discuss below, the strength of conviction, energy and resources of a political entrepreneur to ensure that solutions see the light of day.
The key role of individual and collective entrepreneurs

The importance of policy entrepreneurs was highlighted, though negatively, something relatively rare in applications of the framework. Analysis of the empirical research data leads one to concur fully with Kingdon (1995) regarding the importance of specialists and ‘career bureaucrats’ acting within the policy stream. Individuals interviewed in this study proposed various solutions for reducing inequities in access to health care that were neither heard nor received within the general environment, much less applied. Solutions proposed by specialists or health officers are much more likely to attract the attention of senior officials than those suggested by individuals. Greater value is attributed to so-called scientific knowledge than to lay knowledge. One cannot infer much more from Kingdon’s framework and the role of stakeholders, since very few studies, if any, have looked at equitable funding and access to care.

According to Lemieux (2001), certain improvements have been made to the framework by taking into account the important role played by institutions within the policy stream. The term ‘institutions’ here is not employed with its usual acceptation in political science (for example, political regimes, electoral systems, and so on), but rather in the sense proper to the research context of international organizations (IMF, WB) and NGOs. Policy transfer in the health sector by international organizations is well documented (Walt et al. 2004). The present study has also done this, yielding a fourth proposition:

P4: When policy agenda-setting and formulation are international in origin, institutions play an essential role in the political stream of public policies.

UNICEF, WHO and the World Bank have played an essential role in BI implementation. The concept of the epistemic community, borrowed from Lee and Goodman (2002), was productive here and should be considered a complement to Kingdon’s framework.

The role of windows of opportunity

Next, we examine the hypothesis that a window of opportunity is indispensable to a coupling of the streams. Kingdon (1995) states that, during the agenda-setting stage, opportunities are situated within the problem and political streams. Consequently, by extending the framework, one would expect opportunities to be observed in the political and policy streams during the formulation stage and in the problem and policy streams during implementation. In this study, all windows of opportunity appeared essentially, if not exclusively, within the political stream. This confirms Kingdon’s hypothesis, since all the meetings and consultations that could be considered opportunities were situated within the political stream, which does not favour successful implementation. Moreover, none of the opportunities was seized. Furthermore, this study confirms Kingdon’s (1995) statement that when a window of opportunity appears, if the problem at hand is considered too complex, there will be a tendency to find solutions to other problems that are easier to resolve. In the case under study, making access more equitable by focusing on the indigent went against social norms. It is also useful to cite Rommetveit, who suggested that prime candidates for garbage cans are those issues that involve changes in normative structures – basic value-priorities in a policy’ (Zahariadis 1999). This leads to a fifth proposition:

P5: The occurrence and seizing of opportunities to find solutions to problems is a necessary, although insufficient, condition for successful implementation.
Contrary to Kingdon’s statement (1995) that windows of opportunity for coupling streams are rare, and as suggested by Zahariadis (1999), this case study displayed many such opportune moments. This conceptual difference is most likely explained by the difference in context. The policies Kingdon studied were in the context of a rich and powerful state that was not constrained by external pressure to formulate and implement particular public policies. In the case of Burkina Faso, health policies are almost always developed in response to external influences that sometimes, if not always, involve strict following of international directives. A sixth proposition can, therefore, be put forward:

P6: The more a country needs external aid to fund implementation of its public policies, the more windows of opportunity there will be for stream coupling.

As specified by Kingdon (1995) and confirmed by this study, this proposition does not imply the public policy process will unfold as expected, especially given the influence of determining factors such stakeholders’ perception of these windows and of the possibility for action. This is all the more true in a context of continued dependence on external funding.

Along the same lines, Kingdon’s (1995) propositions concerning ‘spillovers’ have not been confirmed – another part of the framework that is empirically falsifiable, thanks to this case study. The early 2000s saw numerous meetings and studies instigated by the World Bank to formulate anti-poverty policy. Countless discussions were also held on increasing equity of access to care. However, opportune moments for tackling poverty that could have created windows of opportunity for health policy were not used to advantage. No new debate on equitable access to care has arisen since those favourable circumstances evaporated. In the case under study, the World Bank is responsible for the favourable conjuncture, but many observers (Hibou 2000), consider it is not the most credible organization (for example, in terms of equity) for fostering such a transfer process. As such, a seventh proposition is useful:

P7: Spillovers within the political stream are only possible if the institutions acting as entrepreneurs and working to open new windows of opportunity share the values of established institutions.

Policy entrepreneurs favourable to equity: a valid concept on the microscopic level
As mentioned earlier, throughout the process of implementing the BI in Burkina Faso, no policy entrepreneur emerged. Part of the reason for this relates to issues of power linked to the functions of health staff and of the members of health management committees (Gilson et al. 2000; Olivier de Sardan 2005). NGOs are too dependent on donors to take alternative action and must play their cards right with ministry personnel to bring their projects to fruition and obtain new funding. WHO and UNICEF have lost their leadership roles to the WB (Ridde 2008a). Both national and local sociopolitical organizations appear to have a hierarchical nature based on consensus and social peace that does not favour the emergence of the entrepreneur (Ridde 2008b). Elected political officials have not, to date, gone beyond the discursive logic of equity. As for ‘spillovers’, the framework produced one hypothesis that was empirically falsifiable. This discussion might suggest pessimism about the transferability of the entrepreneur concept, but this suggestion is unwarranted. Analysis of empirical data shows the public policy concept of the policy entrepreneur holds true for Africa, although development anthropologists use other terms, such as
'Big Man' or 'Broker' (Bierschenk et al. 2000; Bonte et al. 2000). Given space limitations, this concept's relevance and applicability cannot be expanded upon here. It has, however, been addressed elsewhere (Ridde 2007), demonstrating that the existence of entrepreneurs working for equity in the local social context is not a theoretical illusion. Not only did these entrepreneurs exist in the region (but not the arena) where this study was carried out, but they were clearly mobilized in favour of equity of access to care for the indigent. In fact, in a hospital in the region where the research was undertaken (but that was not part of the study), two entrepreneurs succeeded in coupling the two streams in a way that expressed a major concern for making equity a reality. Unfortunately, this remains an epiphenomenon on the country scale. Two other studies have shown that the likelihood of policy entrepreneurs seeing their ideas implemented is proportional to the degree to which they are able to get the organizations with which they work to internalize them (de Leeuw 1999; Exworthy et al. 2002). This was apparently the case with the hospital in Burkina Faso.

CONCLUSION
The extension of Kingdon's multiple-streams framework (1995) has been productive in explaining the failed implementation of a health policy aiming to increase equity. To the author's knowledge, this is only the second time the framework has been validated in terms of the implementation sub-process component. It is the first time the framework has been partly validated in an African context, on the local level, and by a researcher other than the one who proposed the theoretical extension. The wishes of Sabatier (2007) or of Zahariadis (1997) regarding falsification were, on this rare occasion, taken into account, since two predictions of the framework (absence of spillover, existing windows of opportunity not seized) were not confirmed. The falsification should strengthen the framework's validity. In subsequent studies, it will be important to verify that these predictions have not been verified in other contexts or at other times. In contrast to this case study on one policy, today’s policies on development aid seem to be more intersectoral and comprehensive, allowing funding agencies to work in a more coordinated manner using sector-wide approaches. Could this have a positive effect in terms of spillover and seizing windows of opportunity? This study aims to make a modest contribution to the ‘revival’ (Barrett 2004) of implementation studies. More empirical research needs to be done, however, to validate definitively both this theoretical extension and the 7 propositions that emerged from the study. This could, for example, be equally applied in Europe. The same empirical observations in another context than Africa could thereby put this theoretical extension to a further test, since:

There is no reason to expect that local governments in European countries will be particularly resistant to problems of elite and interest groups, capture of decision-making process, lack of attention to equity, inter-jurisdictional free-riding or neglect of health promotion and public health measures. (M. Koivusalo et al. 2007, p. 201)

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