Assessing the utility of Kingdon's multiple streams framework for studying policy implementation: a case study of mobile hospitals in Lusaka Province, Zambia

by

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DECLARATION

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously, in its entirety or in part, submitted it for obtaining any qualification.

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ABSTRACT

Despite policy implementation research being 30 years and having been analysed using various perspectives, very few have analysed it using Kingdon's (1984) multiple streams framework. Whether the framework can be applied to analyse stages of the policy process such as policy implementation has been debated in policy studies. The few studies which have applied the framework have mainly used it to analyse policy implementation from the perspective of explaining a policy implementation gap. This research uses the framework to assess its utility for furthering our understanding of policy implementation, using mobile hospitals in Lusaka Province, Zambia as a case. The study argues that the multiple streams framework in its current state does not provide an adequate lens through which to study policy implementation in this context due to its limited focus on the impact of institutional factors on policy.

Access to health care services for all is one of the main challenges facing the Zambian health system. Mobile hospitals were introduced in 2011 to help address inequities in accessing health care in rural areas. Using qualitative methodology and data collection methods such as observation, key informant in-depth interviews, and a review of several secondary sources, this dissertation sought to answer the main question, "What is the value of Kingdon's multiple streams framework for studying policy implementation?" The study found that while the framework was not comprehensively illuminating in certain aspects, it was however valuable as it brings into focus the agenda setting and policy formulation stages of the policy process when studying policy implementation which other approaches to implementation do not necessarily do. Doing so helps to provide a better understanding of policy implementation.

The study argues that a study of policy implementation using a multiple streams framework must begin by examining the political structure in which actors operate. To enable a contextualised understanding of policy implementation, the study, therefore, modified the framework by placing institutional factors at the centre of the political stream because they affect policy implementation in contexts where executive power is strong and other institutions and non-state actors are weaker. This means that the president, as head of the executive has significant impact on policy implementation, and the influence of other actors is limited. The study contributes to policy implementation literature and to debates on refining the multiple streams framework to address some of its limitations.

OPSOMMING

Ten spyte daarvan dat die implementeringsnavorsingsveld meer as 30 jaar oud is en vanuit verskeie perspektiewe al ontleed is, is min ontledings al gedoen met Kingdon (1984) se veelvoudige-strome raamwerk. Hierdie raamwerk word beskou as een van die mees invloedrykste analitiese raamwerke om kontemporêre openbare beleidsprosesse te verstaan. Of die raamwerk toegepas kan word om die fases van die beleidsproses, soos die implementering van beleid, te ontleed, is in beleidstudies bespreek. Die min studies wat die raamwerk toegepas het, het dit hoofsaaklik gebruik om implementering te analiseer vanuit die perspektief van die leemte vir die implementering van beleid. Hierdie navorsing gebruik die raamwerk om sy nut te evalueer om ons begrip van beleidsimplementering te bevorder, deur gebruik te maak van mobiele hospitale in Lusaka Provinsie, Zambië as ‘n gevallestudie. Dié studie beweer dat die veelvoudige-strome raamwerk in sy huidige toestand nie ‘n toereikende lens bied waardeur beleidsimplementering in hierdie konteks bestudeer kan word nie, as gevolg van die beperkte fokus op die impak van institusionele faktore op beleid.

Toegang tot gesondheidsorgdienste vir almal is een van die grootste uitdagings wat die Zambiese gesondheidstelsel in die gesig staar. In 2011 is mobiele hospitale dus bekendgestel om ongelykhede aan te spreek om toegang tot gesondheidsorg in landelike gebiede te kry. Deur middel van kwalitatiewe metodologie en data-insamelingsmetodes soos waarneming, in-diepte onderhoude met sleutel-informante en ‘n oorsig van verskeie sekondêre bronne, beoog die proefskrif om die hoofvraag te beantwoord: “Wat is die waarde van Kingdon se veelvoudige-strome raamwerk vir die bestudering van beleidsimplementering?” Die studie het bevind dat die raamwerk waardevol is omdat dit fokus op agenda-instelling en beleidsformuleringsstadia van die beleidsproses wanneer daar gekyk word na beleidsimplementering wat ander benaderings tot implementering nie noodwendig doen nie. Dit help om ‘n beter begrip van beleidsimplementering te gee.

Die studie beweer dat ‘n studie van beleidsimplementering deur die veelvoudige-strome raamwerk moet begin deur die hele politieke struktuur waarin akteurs werk, te ondersoek. Om sodoende ‘n meer kontekstuele begrip van beleidsimplementering moontlik te maak, het die studie die raamwerk verander deur institusionele faktore in die middel van die politieke stroom te plaas omdat dit beleidsimplementering beïnvloed in ‘n konteks waar die uitvoerende gesag sterk is terwyl ander

instansies en nie-staatsinstellings akteurs swak is. Die studie het bevind dat die president as hoof van die uitvoerende gesag in hierdie verband aansienlike impak het op beleidsimplementering en die invloed van ander akteurs word deur politiek en magsdinamika beperk. Die studie dra by tot die beleidsimplementeringsliteratuur en debatte oor die verfyning van die raamwerk om sodoende van sy beperkings aan te spreek.

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LIST OF ABBREVIATIONS

AIDS- Acquired Immune Deficiency Syndrome

ART- Anti-Retroviral Therapy

CSO- Central Statistical Office

DFID- Department for International Development

HIV- Human Immunodeficiency Virus

MDG- Millennium Development Goals

MOH- Ministry of Health

MOFNP- Ministry of Finance and National Planning

MONDP- Ministry of National Development Planning

MSF- Multiple Streams Framework

NHSP- National Health Strategic Plan

PEPFAR- President's Emergency Plan for AIDS Relief

PSRP- Poverty Reduction Strategy Paper

SAG- Sector Advisory Group

SWAp- Sector Wide Approach

UNDP- United Nations Development Programme

UNICEF- United Nations Children's Education Fund

UNFPA- United Nations Population Fund

USAID- United States Agency for International Development

SIDA- Swedish International Development Cooperation Agency

WHO- World Health Organisation

CHAPTER ONE: INTRODUCTION AND OVERVIEW

1.1 Introduction and background to the study

Addressing inequities in Zambia's health system has been on the policy agenda since 1964 when Zambia gained independence. The Zambian government made special efforts to address these inequities, including through the adoption of the primary health care approach in 1981 as articulated in the Alma Ata declaration (Kasonde and Martin, 1994:9). Zambia has followed this strategy through all the health reforms which have been implemented since 1992 (Ministry of Health, 2011:1). The vision of the reforms has been to "provide the people of Zambia with equity of access to cost-effective, quality healthcare as close to the family as possible." (Ministry of Health 2011:34). However, access to health care services for all is still one of the main challenges facing the Zambian health system. Research into this has further shown that people with the greatest need for health services are not receiving an equitable share since it is skewed in favour of the rich and people living in urban areas (Phiri and Ataguba, 2014:13).

The 1978 International Conference in Alma Ata declared and adopted primary health care as the key to the attainment of the goal of Health for All for member states of the World Health Organisation. The Declaration defines primary health care as:

> essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (WHO and UNICEF, 1978:1).

After much deliberation and consultative processes, the Ministry of Health published a document in 1980 entitled "Health by the people: implementing primary health care in Zambia", which set out detailed guidelines on implementing primary health care in the country (Kasonde and Martin, 1994:10). In 2008, Zambia joined other African countries at a conference in Ouagadougou, Burkina Faso in signing the Ouagadougou Declaration on Primary Health Care and Health Systems, which was a renewed commitment to using the primary health care approach (Saidou, 2010). The objective of the conference was to review past experiences on primary health care and redefine strategic directions to achieve health related Millennium Development Goals (MDGs) using a primary health care approach (Saidou, 2010:11).

During the official opening of the third session of the National Assembly in January 2009, President Banda announced his government's intention to introduce mobile hospitals to address inequities in the access to healthcare, mainly in rural and peri-urban areas (Banda, 2009:46). Out of a population of about 14 million people, more than half (61 percent) live in the rural areas while only 39 percent live in the urban areas (CSO, 2014:3). People in rural areas normally walk long distances to the nearest health centre, and even then, the health centre usually does not have skilled health professionals because these are skewed in favour of urban areas and more specialised hospitals. Access to health services for all is therefore one of the greatest challenges facing the Zambian health system (Ministry of Health, 2016). The decision to introduce mobile health units in Zambia was met with fierce criticism from various stakeholders, including the donor community in the country who threatened to cut funding to the Ministry of Health (Engstrand, 2013). Some criticism included bad road networks in most rural areas - which are either impassable or non-existent in the rainy season, shortage of health staff countrywide, administrative costs, and a political move to appease the rural population since general elections were approaching (Zambian Economist Online, 2009).

Many argued that it would be more beneficial in the long run if government used the money instead to improve the already existing health infrastructure. However, the Zambian government at the time argued that the concept of mobile hospitals was not very different from that of the Zambian Flying Doctor Services; only that the latter moves in the air and the former moves on land but that they both target rural and disadvantaged areas (Simbao, 2011:4). The prestigious mobile hospitals, purchased in 2010 for US$53 million through a loan from China became operational in 2011, servicing different areas and providing various kinds of services to people. One would have expected that the controversy and apathetic response from various stakeholders would have made the government to withdraw and bow to pressure to shelve the idea. However, this was not the case. Why did a heavily contested policy idea still go ahead to be implemented, even against the advice of technocrats? And given this controversy and resistance from various sectors of society, why was it deemed 'successful' even by the ones that condemned it before? These two issues contradict our understanding of the major reasons unpopular policies may not be implemented and let alone be deemed successful. This dissertation therefore explores these issues using the multiple streams framework to understand policy implementation of the mobile hospitals.

Public policy implementation is considered a very important part of the policy process (Hill and Hupe, 2002:3; Barret, 2004:253). The reason for this is that public policy has to be implemented

to have impact, as opposed to simply being adopted. Even the best-looking policy on paper is of little worth if it is not implemented. Policy implementation refers to the execution of basic policy decisions, usually incorporated in a statute but can also take the form of important executive orders or court decisions by government administrative machinery in order to achieve stated goals (Mazmanian and Sabatier, 1983:20; Howlett and Ramesh, 2003:13).

Although policy implementation studies have for a long time been characterised by debate and considered a "thing of the past", they have in the last decade emerged as current issues arousing considerable interest from many researchers (Barrett, 2004:249; O'Toole Jr, 2004:265; Saetren, 2005:560; Pulzl and Treib, 2007:90). Over the years, implementation research has been confronted by the difficulty of finding an appropriate implementation theory or framework. Top-down and bottom-up approaches have been debated, and a synthesis between the two has been proposed by many scholars (Winter, 2006:154; Pulzl and Treib, 2007:91). Other perspectives have been proposed, but no consensus has been reached on the most appropriate perspective (Barrett, 2004:255; O'Toole Jr, 2004:269). Policy implementation is therefore analysed from different perspectives.

The literature on policy implementation advances several reasons for conducting policy implementation research. In general, they can be summarised as: understanding and explaining policy success or failure; making normative policy and policy design recommendations; predicting policy outcomes; and providing a unifying approach to studying multi-actor and inter-organisational activities within politics and administration (Schofield, 2001:247). While much attention has been devoted to explaining success or failure, the findings of this research point to a common approach to studying actors and activities. The research applied Kingdon's multiple streams framework (1984) to determine its value for policy implementation studies.

The multiple streams framework is considered one of the most influential frameworks for understanding contemporary public policy processes (Walt, Shiffman, Schneider, Murray, Brugha, and Gilson, 2008:200). Despite the fact that implementation research has been done for over 30 years, and has been analysed from various perspectives, very few researchers have analysed it using Kingdon's framework (Pulzl and Treib, 2007:91; Ridde, 2009:938; Zahariadis and Exadaktylos 2016:60). As mentioned earlier, top-down, bottom-up and synthesis approaches have traditionally been used to study policy implementation. While these approaches have endeavoured to explain implementation, scholars have argued that they are inadequate, as such, an appropriate implementation framework has not yet been found (Winter,

2006). This research aims to uncover what insights Kingdon's multiple streams framework can contribute to furthering our understanding of policy implementation through a case study of mobile hospital implementation.

Kingdon's multiple streams framework which was developed for agenda setting in the United States, has been extensively applied in many countries to understand national and international policy agendas (Kendall, 2000:543). The framework is composed of three streams- problem, policy and politics streams, running independently of each other. These meet or converge at opportune times when a policy entrepreneur seizes a window of opportunity to couple the streams, hence bringing about policy change. Essentially, it is only when a prominent problem can be attached to a viable policy in line with national mood at that particular time that policies can emerge (Kingdon, 2003:165).

The multiple streams framework has also been applied to explain agenda setting and policy formulation in Africa (Ashford, 2006; Bird, Omar, Doku and Mwanza, 2011; DeJaeghere, Chapman and Mulkeen, 2006; Fourie, Perche and Schoeman, 2010; Kusi-Ampofu, 2015). While scholars such as John (2012) and Zahariadis (1999) have argued that the framework can be applied to all stages of the policy process in varying contexts, studies which have applied the framework to policy implementation in Africa are limited. Ridde (2009) is the only one so far to have done so. He applied the multiple streams framework to analyse the failure of a health policy intended to promote equity in Burkina Faso. The framework has however been applied to analyse policy implementation in mostly European countries and the United States (Lemieux, 2002; Exworthy, Berney and Powell, 2002; Exworthy and Powell, 2004; Boswell and Rodrigues, 2016; Zahariadis and Exadaktylos, 2016; Sager and Thomann, 2017).

Overall these studies show that a multiple streams framework can indeed be applicable to implementation. I discuss in detail how each of these studies applied the framework and their recommendations in Chapter Two of this dissertation. Ridde (2009) for instance demonstrated that a coupling of streams must occur in the preceding stages of policy agenda setting and policy formulation for implementation to happen. Building on insights and knowledge from all these studies, this research applies the framework to a study of health policy implementation in an African context. The aim is to assess the value of the framework for studying policy implementation using a case of mobile hospital implementation in Zambia.

However, it differs from Ridde's study (2009) in that while he uses the multiple streams framework to explain the failed implementation of a health policy aiming to increase equity at

the local level in Burkina Faso, this study does not investigate an implementation gap. Secondly, it also differs in the manner in which it applies the framework, that is, with a view to seeing what it highlights for policy implementation versus what other approaches to policy implementation highlight. I am focusing on Ridde (2009) because he is the only so far to have applied the framework in a low-income country in the African context and in health policy implementation too. The other studies mentioned have applied the framework in more developed countries.

1.2 Statement of the Problem and Research Question

Despite the government's aim to ensure equity of access to health services for all, access to health care services for all is still one of the main challenges facing the Zambian health system. With a high disease burden[1], and the majority of the people living hours away from the nearest health centre, providing healthcare is a major challenge, hence the decision by government to introduce mobile hospitals to operate in rural and peri-urban areas. The initiative was the first to have mobile health units operate at such a scale, wholly funded and implemented by government through the Ministry of Health. However, despite the criticisms against mobile hospitals (Kyambalesa, 2010), there has been limited research on the operation of the units since their implementation in 2011. Research concerning mobile hospitals in Zambia is also lacking. Besides criticism on why mobile hospitals are not appropriate for Zambia, there is very little documented about their use. The limited literature available has focused mainly on ''small scale" operations of mobile clinics offering mainly primary health care, and are run as projects by different organisations who usually receive funding from external sources.

Kingdon's (1984) framework has been used in many settings to explain agenda setting and policy formulation. However, one of its criticisms is that extensive academic debate about the framework is still missing in the literature. In addition, its value for studying policy implementation in varying contexts is not established. Some authors have proposed the application of the multiple streams framework to cover the entire policy process (John, 2012:160; Zahariadis, 1999:79). However, research utilising the framework for policy implementation, particularly in Africa are few and far between. Ridde (2009), as already

[1] Disease burden in Zambia is largely influenced by the high prevalence and impact of communicable diseases, particularly malaria (246 cases/1000 population), HIV and AIDS (14%) and Tuberculosis (408/100,000 population). There's also a high burden of Maternal, Neonatal and Child Health problems (591/100,000), and a growing problem of Non-Communicable Diseases, with cardiac diseases topping the list. (Ministry of Health, 2017:6)

mentioned, is to the researcher's knowledge the only one so far to have applied the framework to implementation in Africa. This research also applies the multiple streams framework to a case of mobile hospital implementation in Zambia's Lusaka Province. The aim is to assess what value the framework has for studying policy implementation, and to identify any insights that the framework can contribute to help understand policy implementation better in a context like Zambia.

The primary research question for this dissertation is therefore: "What is the value of using Kingdon's multiple streams framework for studying policy implementation?'' The secondary research questions that the research will seek to answer are:

i. What does implementation of mobile hospitals in Lusaka Province entail?

ii. Are there any issues in the streams that facilitated policy implementation?

iii. Are there actors/policy entrepreneurs that helped to 'couple' the streams in order for mobile hospitals to be implemented in Zambia?

1.3 The Multiple Streams Framework

As noted already, the research applied Kingdon's multiple streams framework to a case study of mobile hospital implementation in Zambia. Kingdon's framework (1984) emerged from the "garbage can model" by Cohen, March and Olsen (1972) based on organised anarchy in decision making. Kingdon (1984) noted that there were similarities between this model and the American Federal Government in that the general logic underlying implied in the garbage can model of separate streams running through the organisation, also applied to the federal government. Kingdon's model thus consists of three separate streams running through the policy making system. These are: problem, policy and political steams. Policy change happens when these independently running streams are joined together through coupling when a policy window opens, or when there is a window of opportunity. This process is usually facilitated by a policy entrepreneur who helps to bring about policy change by coupling the streams.

The policy process in general is seen as dynamic and irrational due to ambiguity and policy makers' time constraints in the real policymaking environment (Zahariadis, 2003). There is really no strict set of rules to abide by or a fixed starting point such as problems in society to be considered as the beginning of policy. Rather, solutions are usually developed independently of problems and later linked to problems by policy entrepreneurs when an opportune moment

presents itself. The policy entrepreneurs are found in many locations and include lobbyists, academics, journalists or civil servants (Kingdon, 1995:160). The people to push for an issue to be labelled as a problem do not even need to be close to the problem; they just need to be able to use their resources and time to study the system in order to bring attention to their issues (Kingdon, 1984; Zahariadis, 2003).

The framework is popular for understanding agenda setting and has been used in different contexts to explain policy change. As already noted, it has also been applied to other policy processes such as policy implementation but to a limited extent. The framework is further explained and elaborated on in the next chapter, highlighting the cases and contexts in which it has been applied and extended beyond its original development of agenda setting. I will also show how its application in this research differs from the way it has previously been used in policy implementation studies.

1.4 Rationale for the study

While some scholars have proposed that Kingdon's framework can actually be applicable to the entire policy process including implementation, very few studies have shown this, especially in Africa. As stated earlier, only Ridde (2009:938) has demonstrated the applicability of the framework to study policy implementation in Africa so far. His study however focused on explaining the implementation gap of a health policy on equity. This has been the focus of most implementation research (Hupe, 2011:64). While this research is also on health policy implementation, it is different in that it is not aimed at explaining one aspect of implementation such as an implementation gap. While in Ridde's case it is well known that the policy failed to be implemented and the investigation focused on why this was the case, this was not the case in this study. The policy related to mobile hospitals was being implemented.

In my study therefore, the aim is to assess how useful Kingdon's framework is for studying implementation in general, using the case of extending access to health services by means of mobile hospitals in Zambia's Lusaka province. The aim is not to conduct an evaluation of the policy or to investigate policy success or failure, but to determine the value of using the multiple streams framework in implementation studies in this context. The study helps to deepen our understanding of different factors responsible for implementation in a developing country context such as this one. Further, it contributes to building the multiple streams framework as has been suggested by some scholars such as (Cairney and Jones, 2016; John, 2012; Zahariadis, 1996).

In terms of access to health services, mobile hospitals are generally known for serving difficult to access sub-populations in both rural and urban areas, with cost-effective preventive approaches to healthcare (Oriol, Cote, Vavasis, Bennet, Blanc and Bennet, 2009). Despite this and the advancement in technology and health, little is documented about mobile hospitals as a way of improving access to health care beyond crisis situations, and well-integrated into the healthcare system globally (Abbasi, Mohajer and Samouei, 2016). Research concerning mobile hospitals in Zambia is also lacking. Besides criticism on why mobile hospitals were not appropriate for Zambia, there is very little documented about their use in terms of published articles. Instead there are reports such as one by Lombe (2017) who discusses the controversies surrounding the purchase of the units, and concludes that going by reports from the Ministry of Health officials, there has been appreciation for the services offered.

Since improving health care delivery is high on the development agenda of most developing countries (WHO, 2016), the research can also be useful for drawing lessons on what could work in terms of mobile hospital implementation for other developing countries with similar characteristics to Zambia. It is estimated that between 40 to 60 percent of the people living in developing countries live more than 8 km from a health care facility (Karra, Fink and Canning, 2017:821). In such cases, mobile hospitals could be useful.

1.5 Research Design and Methodology

This section introduces the research design and methodology that was used in the research, and is further discussed in much detail in Chapter Three. The research design was a single case study of mobile hospitals in Lusaka Province in Zambia. Yin (2009:10) describes a case study as "an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident." A case study was chosen as the research design as it is most suited to study in depth contemporary events whose behaviours cannot be manipulated (Yin, 2009:11; Crowe Cresswell, Robertson, Huby, Avery and Sheikh, 2011:1). It involves in-depth observation of events and interviews with people involved in these events (Crowe et al., 2011:2). The single case study here looks at the overall nature of mobile hospitals in Lusaka province, Zambia. Mills, Gabrielle and Eiden (2010:764) state that qualitative single case studies are inductive in nature in that they explore a single case to develop a rigorous theory or explanation for functions in human behaviour. The single case study here is thus suited as the study explores the implementation of mobile hospitals through the multiple streams framework to contribute to

developing the framework. This is also further explained and justified in detail in Chapter Three.

The approach to the research was qualitative, which is supported by a case study research design. Qualitative methodology involves exploring the lived social realities of informants and undertaking a comprehensive analysis of a particular problem as opposed to giving statistical descriptions of generalised ideas (Bryman, 2004:159). According to Rist (2000:1008), qualitative research methods are recommended for studying public policy implementation because of their distinctive position from which to assess the possibility of tools having the impacts intended by policy makers. He points out that this is because they are longitudinal, done in naturalistic settings, and focused on constructions of meaning developed by participants (Rist, 2000:1008). In this case, the qualitative methodology was most suitable for an in-depth study of policy implementation regarding mobile hospitals in order to assess how the multiple streams framework can further assist our understanding of policy implementation.

Data was collected using three main methods. These are: documents, semi-structured interviews, and observations. Observation in research is useful for gaining an understanding of the physical, social, and cultural, contexts in which study participants live (Crotty, 1998:5; Yanow, 2007:409). In this case, it was important to observe the mobile hospitals in the field to have a better understanding of their operations. Permission was obtained from the Ministry of Health to observe the environment in which the mobile hospitals operate. The next stage of data collection was interviews. According to Kitchin and Tate (2000:213) "interviews allow for thorough examination of experiences, feelings or opinions that closed questions could never hope to capture." Semi-structured interviews were used to allow for deeper exploration of the relevant issues. The interviews were conducted with four main categories of respondents, carefully and purposively selected on the basis of their involvement and the knowledge they were perceived to have. These categories were officials at the Ministry of Health Headquarters, officials at the Levy Mwanawasa Teaching Hospital which is also the provincial hospital and in charge of coordinating the activities of the mobile health unit in the province, frontline health workers working in the mobile hospitals, and informants from the ministry's co-operating partners.

At the beginning of the research, the exact sample size was not known, however, an adequate sample was obtained to answer the main research question. According to Marshall (1996:523), determining the size of the sample in qualitative research is often a flexible process, and he

describes an appropriate sample size for a qualitative study as one that adequately answers the research question. A sample size of 15 was obtained because saturation point was reached, that is, no new issues were emerging.

Secondary sources of data included an analysis of various documents such as official statements from the government of Zambia including presidential speeches, statutory and policy documents and others. Additional sources included material from NGOs, co-operating partners and other stakeholders working around health.

The data analysis followed qualitative data analysis methods. This consisted of identifying, coding and categorising patterns found in the data collected (Flick, 2014:173). The methods used were thematic and content analysis[2]. The data was categorised based on the research questions which were framed according to the main themes of the multiple streams framework. From this sub-themes were generated, enabling a comprehensive analysis to be done. A comprehensive account of the research design and all the methods that were employed in this research is provided in Chapter Three.

1.6 Ethical issues

The Research Ethics Committee at Stellenbosch University and the Ethics Committee that approves all research in Zambia granted ethical clearance for the study. The Ministry of Health also granted authority for staff to be interviewed and an observation of the operations of the mobile hospitals in the field. Participation in the study was purely on a voluntary basis and the objective of the study was explained to the participants before signing consent forms. All information obtained was confidential and anonymity was guaranteed.

1.7 Chapter Outline

This dissertation is made up of seven chapters. The introductory chapter has already provided a background to the study and stated the problem. It also presented the research questions and highlighted the research methodology and Kingdon's multiple streams framework.

In Chapter Two policy implementation studies and the multiple streams framework are discussed. Implementation studies are traced from the time of Pressmann and Wildasky to show how the field has evolved over three generations. The chapter also pays attention to the various

[2] Elaborated on in Chapter three

approaches which have been used to study policy implementation, noting that as useful as they are, the multiple streams framework is able to help us further our understanding of policy implementation through the comprehensive way it examines the prior processes of agenda setting and policy formulation. The chapter further demonstrates how the multiple streams framework has been applied beyond its original context and intention of agenda setting in health and transport sectors in the United States, in many different settings, countries, policy areas and policy stages such as policy implementation. It also shows how this study operationalised the framework differently from previous studies to include the influential role of institutions in understanding policy implementation.

Chapter Three discusses in detail the research design and methodology that was used for the study namely, a case study and qualitative methodology. It offers justification for each selection, including the sources of data, sampling, data collection methods and data analysis. The chapter discusses validity and reliability and includes my reflections on the fieldwork process. It also offers ethical considerations and limitations pertaining to the study.

Chapter Four contextualises political governance and health policy in Zambia. It starts with a general conceptualisation of political governance in terms of the system, Parliament, presidential powers, and the role of non-state actors in governance issues. It then discusses the health policy context in the country, emphasising primary health care as the means of delivering health services. Understanding the health system and its challenges is aimed at helping to understand the government's decision to implement mobile hospitals.

Chapter Five offers the first results. It conceptualizes and contextualises mobile hospital implementation both internationally and locally. It thus discusses the use of mobile health units across the globe and in Zambia. It describes in detail the implementation of various mobile health units across the country, and more specifically the mobile hospitals in Lusaka Province. It describes in detail their implementation in the province based on the fieldwork findings. A description of the province is also presented in this chapter to help understand the context in which the mobile hospitals operate.

Chapter Six is based on the three streams of problem, policy and politics, as well as policy entrepreneurs and policy windows which essentially make up the core elements of Kingdon's framework. The chapter aims to answer the research questions on issues that were present in the streams and whether there were policy entrepreneurs that facilitated the coupling of the streams for implementation of mobile hospitals. In the section on the problem stream, it shows

how various actors understood health policy problems in Zambia. It highlights the ways in which issues get to be recognised as problems to feature on political agendas. Similarly, the section on the policy stream shows policy alternatives suggested by actors to deal with various problems in the health sector. The political stream, adapted to incorporate institutional factors, further explores how these factors affected all the other elements in the political environment to ensure the implementation of mobile hospitals. The chapter further discusses the coupling of these streams, the opening and closing of policy windows, and the opportunities created for implementation. Further, it provides more insight into the power dynamics that exist between the executive, specifically the president, and various institutions mandated to oversee and implement policy. The chapter therefore shows how top political leaders are not only powerful agenda setters, but that they are also influential for policy implementation.

Chapter Seven is the final chapter. It summarises the dissertation and highlights its contribution to implementation literature, as well as the empirical and theoretical contributions. It also identifies the research gaps and proposes some recommendations for future research.

1.8 Conclusion

The aim of this chapter was to give a detailed introduction to the study as well as to give a brief insight into the research process. The chapter has indicated that Kingdon's multiple streams framework, despite being popular and influential in policy analysis, has been hardly been used for policy implementation, particularly in Africa. This study aims to assess whether the framework can contribute to understanding policy implementation. The chapter also highlighted that a primary healthcare approach is the underlying approach governing the health system in Zambia, whose overall goal is health care for all, and that mobile hospitals were introduced to provide health services to the disadvantaged in rural areas. The chapter also provided the rationale, the problem statement, and the research objectives. The theoretical framework as well as methodology were introduced, but will be further explained in Chapters Two and Three respectively. The next chapter reviews the literature on policy implementation and the multiple streams framework.

CHAPTER TWO: REVIEWING POLICY IMPLEMENTATION STUDIES AND THE MULTIPLE STREAMS FRAMEWORK

2.1 Introduction

The previous chapter explained the research problem and outlined the research questions for this study, with the main question being whether the multiple streams framework can be valuable for studying policy implementation. The framework which emerged in the early 1980's is one of the most widely used frameworks for analysing public policy. However, as one of the criticisms labelled against the multiple streams framework is that of limited academic debate in the literature, this chapter is important to review literature on both the use of the multiple streams framework and the field of policy implementation. In particular, reviewing how the framework has been applied across various policy areas and stages is important in helping to determine its value for policy implementation. The guiding questions of this literature review therefore are: How has the study of policy implementation evolved over the years considering the various approaches that have been used to analyse it? And; How has the multiple streams framework been applied beyond its original focus of studying agenda setting in health and transport, to other policy sectors and stages such as policy implementation? This review is important to help show how policy implementation has been analysed and further how the multiple streams framework has contributed to this analysis of policy implementation. The review essentially concludes that despite the studies that have applied the multiple streams framework to study policy implementation, very few of these have been located in the African context.

The chapter starts by providing an overview of the literature on public policy implementation. It discusses policy implementation and examines its origins and development of the field, and what research in policy implementation entails. The purpose for reviewing implementation literature is not only to help understand where we are at with regards to implementation studies as they have resurfaced in the last decade, but also to show how the multiple streams framework differs from various other approaches used to study implementation, and what insights the framework brings to policy implementation studies.

The second part of this chapter thoroughly examines the multiple streams framework including criticisms and some examples of how the framework has been applied in the United States, Europe, Asia and Africa. This is done to provide a strong theoretical grounding which is

necessary for the study as it applies the multiple streams framework to policy implementation of mobile hospitals in Lusaka Province. Thereafter, the literature regarding the application of the framework to other stages of the policy process such as decision making and implementation is reviewed. As noted earlier, the framework has been applied to policy stages beyond agenda setting, albeit to a limited extent. Reviewing the literature is important to show the conclusions drawn from studies that have applied the framework, particularly in policy implementation, and how they differ from the way this study applies it. Before concluding, the chapter reflects on the context in which a theory emerges and its applicability in a different context, taking into consideration the necessary factors such as cultural and institutional context.

2.2 Studying Policy Implementation

This section defines policy implementation and reviews the evolution of policy implementation research over three generations. It also reviews some commonly used approaches to policy implementation and how they differ from the multiple streams framework. This helps to locate the study and show the debates surrounding policy implementation such as the development of an appropriate implementation theory.

The policy process is typically regarded as a cycle with 'stages' namely, policy agenda setting, policy formulation, decision making, policy implementation and policy evaluation (Hogwood and Gunn, 1984:4; Parsons, 1995:79). While this stage framework has been criticised by many authors as being unrealistic, too rational, and not a true reflection of the policy process (Cochran, Mayer, Carr, Cayer and McKenzie, 2009:8; Jann and Wegrich, 2007:44), Hill and Hupe (2002:6) maintain that it is necessary to have a stage framework to study the policy process both analytically and heuristically. Understanding the stages framework also helps to make sense of the multi-faceted phenomena of policy processes, giving one insight on 'how to'' think about the policy process in general (Howlett, McConnell and Perl, 2016:277).

Scholars have debated extensively on what exactly policy implementation entails, when it begins, when it ends, and how many kinds there are (Brynard, 2005:650; Hill and Hupe, 2002:1). The verb implement means to carry out or accomplish something. There are many definitions of policy implementation in the literature by different scholars. O'Toole Jr (2000:266) defines policy implementation as "what develops between the establishment of an apparent intention on the part of government to do something, or stop doing something, and the ultimate impact in the world of action." Howlett and Ramesh (2003:13) contend that as part of

the policy process, policy implementation concerns how governments put policies into effect. According to Barrett (2004:253), policy implementation must be seen as a vital and continuing part of the political policy process, as opposed to regarding it as an administrative follow-on. She further argues that it should be seen as policy-action reasoning which requires negotiation and bargaining between policy makers and implementers (Barrett, 2004:253). The definition of implementation by Mazmanian and Sabatier (1983:20) seems to encompass most of what many scholars agree to be the nature of implementation:

> Implementation is the carrying out of a basic policy decision, usually incorporated in a statute but which can also take the form of important executive orders or court decisions. Ideally, that decision identifies the problem(s) to be addressed, stipulates the objective(s) to be pursued, and in a variety of ways, 'structures' the implementation process. The process normally runs through a number of stages beginning with passage of the basic statute, followed by the policy outputs (decisions) of the implementing agencies, the compliance of target groups with those decisions, the actual impacts – both intended and unintended – of those outputs, the perceived impacts of agency decisions, and finally, important revisions (or attempted revisions) in the basic statute. (1983: 20–1).

Policy implementation can also be understood as process, output and outcome (Paudel, 2009:38; Pulzl and Treib, 2007:92). While policy implementation studies have for a long time been characterised by various debates, and have been considered a 'thing of the past' they have in the last decade emerged as current issues generating considerable interest from many researchers (Barrett, 2004:249; Saetren, 2005:572). The past decade has particularly witnessed a number of scholars calling for a revival of implementation studies (Barrett, 2004: Blackmore, 2001; Cairney, 2002; O'Toole Jr, 2000; Saetren, 2005; Schofield, 2001; Schofield and Sausman, 2004). Researchers have reiterated the need to continue investing in studies of policy implementation and change processes, both empirical and conceptual**;** studies aimed at both understanding and giving explanation son the dynamics of relationship between policy and action (Barrett, 2004:260; Hill and Hupe, 2002:1; Saetren, 2005:560; Pulzl and Treib, 2007:90).

Hill and Hupe (2002:1) contend that in an era where issues of governance have taken centre stage, policy implementation research is still relevant. According to O'Toole Jr (2000:266), "implementation research concerns the development of systematic knowledge regarding what emerges, or is induced, as actors deal with a policy problem." He places the main question in

implementation research as: “What happens between the establishment of policy and its impact in the world of action?”(O’Toole Jr, 2000: 273). The study of public policy implementation is dominated by four issues namely, debates on the top-down/bottom-up approaches, efforts to back down from this debate, debates regarding the value of policy implementation research, and lastly the different methods of studying implementation. These issues are further elaborated on in section 2.2.1 below discussing the three generations of policy implementation research.

2.2.1 Generations of Implementation Studies

The literature on policy implementation classifies the development of the field over three generations, starting from the early 1970s to date. Pressman and Wildavsky (1973), regarded as the founding fathers of policy implementation research, are good examples of the first generation of studies on policy implementation which ranged from the early 1970s to the 1980s. Saetren (2014:90) however argues that policy implementation research dates back at least a decade, even before Pressman and Wildavsky’s influential publication. Even though the word implementation may not have been used often, it was the central theme in earlier work which sought to resolve issues in public administration (Hill and Hupe, 2002:18). However, it is also agreed that Pressman and Wildavsky’s work set the scene for later research in implementation as it turned the spotlight on the issues faced in the execution stage of the policy process and why policy does not always translate into the desired outcomes as outlined in the policy goals. (Hill and Hupe, 2002:18; Winter, 2006:151)

First generation scholars of implementation research actually focused most of their research on understanding what is referred to as an implementation gap or an implementation deficit (Winter, 2006:151). The aim of implementation research was to locate the reasons why policy implementation was failing, and to propose ways of increasing the policy’s chances of meeting the objectives as set out (Barrett: 2004:254). To this day, public policy implementation researchers have placed a lot emphasis on understanding implementation gaps because it is viewed as a problem which needs to be resolved (May and Winter, 2007; Schofield, 2001). Research during the first generation has been described as mainly explorative with inductive case studies seeking to generate theory (Winter, 2006:152). The assumption of the first-generation implementation scholars was that implementation would just happen when policies had been determined by authorities (Brynard, 2005:651). They underestimated the complexity of the process, which second generation scholars highlighted in their studies of policy implementation.

Second generation implementation studies started around the early 1980s. Through a number of case studies, scholars showed why policies were not always implemented as stated in policy directives (Brynard, 2009:651). They focused on variables which affect implementation either positively or negatively such as policy, organisation and people (Schofield, 2001:249). This period was also focused on theory development which the first generation had started out on (Winter, 2006:152). The period was characterised by confrontation and debates between the proponents of the top-down and bottom-up approaches about which one was the most appropriate one to analyse policy implementation.

Top-down researchers such as Pressman and Wildavsky (1973) and Mazmanian and Sabatier (1981) followed implementation through the system from the top officials down to the implementers, but with particular interest in upper level officials, while bottom-up researchers such as Lipsky (1981) placed emphasis on the role that implementers played in the implementation process. Since each approach does not take into account the part played by implementation reality that is explained by the other, a synthesis between these two approaches has been proposed by many scholars; other perspectives have also been proposed. These include backward mapping (Elmore, 1987), intergovernmental implementation (Goggin, Bowman, Lester and O'Toole, 1990), the ambiguity and conflict model (Matland, 1995), and the interactive model (Thomas and Grindle, 1990). All these approaches are further discussed in section 2.2.2 below to help determine the contribution that the multiple streams framework makes to implementation which is different from these approaches.

Needless to say, there is still no consensus on the most appropriate approach, and therefore no general implementation theory established to date (Barrett, 2004:255; O'Toole, 2004:269). The lack of an implementation theory is one of the greatest critiques of implementation research (O'Toole, 2000:265). Winter (2012:265) however argues that agreement on a common analytical and theoretical framework is untimely at this stage, and that diversity is more of a strength than a weakness. He is of the view that implementation research can be improved by "(1) accepting theoretical diversity rather than looking for one common theoretical framework and (2) developing and testing partial theories and hypotheses rather than trying to reach for utopia in constructing a general implementation theory" (Winter, 2012:265).

Third generation implementation research is regarded as having started in the early 1990s to date (Saetren, 2014:91). The distinctive feature of third generation research lies in its detailed research design (Goggin et al., 1990). Third generation scholars sought to test theories based

on more statistical research designs and comparative case-studies, which increased the number of observations (Winter, 2006:158). This is because most prior research had been dominated by single case studies (Goggin, 1986 cited in Paudel, 2009:4). Another feature of this generation is that the research design paradigm is more flexible. It does not favour any particular theoretical framework over another, rather, the aim is to move away from purely descriptive frameworks and focus more on frameworks which seek to analyse policy implementation (Saetren, 2014: 95). It attempts to incorporate the insights of both the top-down and bottom-up perspectives (Pulzl and Treib, 2007:89). The policy implementation literature shows that more progress has been achieved on methodological than theoretical fronts (Saetren, 2014:84). For instance, Saetren (2014:95) further states that a comparative approach is a feature of policy implementation studies nowadays, as is an increased use of quantitative research methods to supplement qualitative methods. Policy studies can then be argued to be more about method than theory, as it is more concerned with understanding how implementation works in general and how its prospects might be improved (Brynard, 2005:651).

While the US and countries in Western Europe moved through the various phases implementation research, African countries like South Africa for instance are still in the midst of the implementation era (Brynard, 2005). This is in part as a result of implementation problems encountered being regarded to be greater by virtue of the political and social context in which implementation occurs (Brynard, 2005:655). In line with enhancing theoretical diversity in the field of policy implementation as proposed by Winter (2012), Ridde (2009) studied implementation using a different approach altogether which differs from the direction proposed by others for moving implementation research forward such as synthesising bottom-up and top-down approaches. Rather, Ridde (2009) examined policy implementation failure from the perspective of Kingdon's multiple streams framework, which very few scholars have done in the over 30 years that the field has been studied (Pulzl and Treib, 2007:91; Ridde, 2009:938). Ridde (2009) applied the framework to examine policy the implementation gap and further formulated seven research propositions that helped to explain the implementation gap of a health policy on equity in Burkina Faso.

Despite being a single case study, this dissertation fits into the third generation of policy implementation studies through its flexible research design and focus on a theoretical framework that seeks to analyse policy implementation. The next section reviews the literature on traditional approaches to policy implementation that have been developed over the years to show their focus and explore their deficiencies. This helps to make a case for the utility of the

multiple streams framework to implementation, as to whether it offers any insight that can help take the study of implementation forward.

2.2.2 Various approaches to studying policy implementation

As discussed earlier, policy implementation research has for a long time been dominated by finding the most suitable approach for studying it. Many approaches have been developed over the years as the field continued to grow. Two schools of thought have however been prominent in explaining implementation, namely the top-down and bottom-up approaches. There are also mixed approaches aimed to synthesise these two approaches. The table below highlights the main differences between the top-down and bottom-up approaches.

Table 1: Differences between the Top-down and Bottom-up approaches to implementation

Variable	**Top-down approach**	**Bottom-up approach**
Decision-maker	Policy makers	Street-level bureaucrats
Structure	Formal	Both formal and informal
Starting point	Statutory language	Social problems
Authority	Centralisation	Decentralisation
Process	Purely administrative	Networking, including administrative
Output/Outcomes	Prescriptive	Descriptive
Discretion	Top-level bureaucrats	Street-level bureaucrats

Source: Adapted from Paudel (2009:40)

The top-down approach, for example the rational model, assumes that policy making begins from the top with specified objective and goals set out by policy makers. It thus represents the policy makers' views. It further assumes that policy makers can exercise control over both the environment and implementers (Paudel, 2009:39). Top-down scholars such as Mazmanian and Sabatier (1978) view implementation as being concerned with the extent to which the goals stipulated in an authoritative decision relate with the actions of those tasked with the implementation. The top-down approach thus places a lot of emphasis on those formally tasked with the implementation process, and on elements such as the formal organisational structure and relationships between units (Elmore, 1978:185; Winter, 2003:213). In this approach, policy

implementation begins at the top of the process, with a clear statement of the policy-maker's intent, and proceeds through a sequence of specific steps outlining implementers' roles at each level of the process.

While the top-down approach views policy makers as central actors, it has been criticised for viewing policy implementation as an entirely administrative process and not acknowledging other realities such as political influences. May (2003:224) argues that it does not acknowledge the political realities responsible for policies with several goals, vague language and complex implementation structures. The top down approach does not thoroughly examine the details of the policy process, such as how the activities of various actors actually influence the policy process or implementation. Furthermore, the top-down approach neglects the role of the actual implementers on the ground as it places policy makers at the centre with the assumption that they have full knowledge of the problems and goals (Lipsky, 1980: May, 2003:224).

The starting point for the bottom-up approach is a problem in society. Bottom-up scholars basically argue that policy is made at the bottom, and that the behaviour of individuals is paramount. Policy making and implementation is based on the formal and informal relationships which constitute the policy sub-systems (Howllet and Ramesh, 2003:190). One of the most widely cited bottom-up approaches is the street-level bureaucracy theory by Michael Lipsky (1980). Street-level bureaucrats or frontline workers are seen as having a discretionary role in the delivery of services, thus ultimately being the real policy makers. Similarly, Hull and Hjern (1978 cited in Winter, 2003:213) pay attention to the behaviour of local networks and argue that the structure of implementation at the local level is a major factor in determining success of the because on those ground adapt the policy according to their conditions. Rothstein (1998:93) argues that this control in the networks can lead to policies being captured by special interests. A major criticism of the bottom-up approach is its rejection of formal authority which contradicts the tenets of democracy since policy makers usually operate under the mandate of voters (Matland, 1995:150; Paudel, 2009:42). In addition it has been argued that not much thought has been given on how to use the discretion of street-level bureaucrats to ensure that policies are affective at that level too (Elmore, 1978 cited in Paudel, 2009:44).

Since there has been no agreement on the most suitable approach for implementation between top-down and bottom-up scholars, attempts have been made, as already mentioned, to synthesise the two and to incorporate the weaknesses and strengths overlooked by each one. The most commonly cited synthesised approaches in the literature include backward- and

forward-mapping (Elmore, 1980), the intergovernmental/conflict implementation (Goggin et al., 1990), the ambiguity and conflict model (Matland, 1995), and the interactive model (Thomas and Grindle, 1990).

According to Elmore (1980), in forward-mapping, it is assumed that policy implementation can be managed from the top through hierarchical relationships, centralised control, and authority. Policy makers need to take into consideration the incentive structure of target groups when selecting policy instruments. Forward-mapping thus entails listing detailed policy objectives and key performance indicators. Backward-mapping on the other hand views policy implementation as being based on the problem and not the objectives. It is assumed that the ability to control the problem is based on ones closeness to the problem. The closer to the problem, the better placed to act. It thus entails stating behaviours to be changed at the lowest level and the ways in which to do so. Although useful, the backward- and forward- mapping approaches have been criticised for lacking explanatory power (Matland, 1995:151).

The interactive model is provided by Thomas and Grindle (1990). In this model, the policy implementation process is seen as interactive rather than linear. The main argument is that at any given point, it is possible to alter or change a policy or idea as a result of pressure and how it is viewed. Concerned parties can mount pressure for change through means such as influencing those tasked with the implementation process which may be senior officials in government. The model has been criticised for not providing an extensive synthesis of the top-down and bottom-up approaches to analyse policy implementation (Paudel, 2009:44).

Another synthesis is provided by Goggin et al. (1990) based on the communications theory perspective of intergovernmental implementation. In this model, the major source of implementation problems are seen to be issues related to organisational management. Interpretation of messages by state level implementers are regarded as a function of the contextually different settings in which it is received. The model conceptualises intergovernmental policy implementation as the interplay between those sending the messages and those receiving them in a wider system of communication. The argument is that implementation is affected by the interaction of a number of factors from national to local levels (Winter, 2006:158). The interpretation of communication or messages from all these levels is therefore a result of all the contextually different settings in which it is received (Cline, 2000:554). Despite the synthesis, the model has been criticised for still aligning itself more to a top-down model of the process (Cline, 2000:557).

Matland (1995) develops a synthesis of the top-down approaches known as the ambiguity and conflict model. The model helps to choose which approach is more appropriate to use at any given time, depending on the characteristics of the policy in question. It focuses on how the policy makers' ambiguity and conflict level affect decision making. However, the model does not consider the level of policy discretion to be something that policy makers choose and how that may be a source of policy conflict. (Paudel, 2009:44).

All these various approaches have contributed to explaining various aspects of policy implementation, particularly the variables that might affect it. One of the main differences between the multiple streams framework and these approaches is their focus areas and how they view policy implementation. As already noted, the multiple streams framework was intended for agenda setting. However, it has been used to study policy implementation in various contexts. In the following section, I discuss the multiple streams framework, and show cases in which it has been applied. I show that despite being developed for agenda setting, it has been used in many settings and contexts including decision making and policy implementation, though to a limited extent. I also show that this application to implementation has focused mainly on explaining implementation gaps, and not necessarily on identifying the contributions that the framework makes to implementation studies. Further on in section 2.5, I examine the applicability of a foreign model to another context, taking into account such things as ideas and institutional context.

2.3 Kingdon's Multiple Streams Framework

This section reviews the framework which makes up the study. The multiple streams framework developed by Kingdon (1984) is based on the "garbage can model" of organisational behavior by Cohen et al (1972). The framework was developed to explain agenda setting. Cobb and Ross (1997:3) define agenda setting as the politics of selecting issues for active consideration. Weiss (1989:118) refers to it as the process by which some problems come to public attention at given times and places. Kingdon thus sought to answer the question "what makes people in and around government attend, at any given time, to some subject and not to others?" (Kingdon 2011:1). The framework views government as an organised anarchy made up of a system that manifests both order and disorder. At any given time, particular items on the agenda are a function of the mix of "garbage" in the can, the contents of which consist of three separate streams: problems, solutions, and politics (Zahariadis, 1999:3).

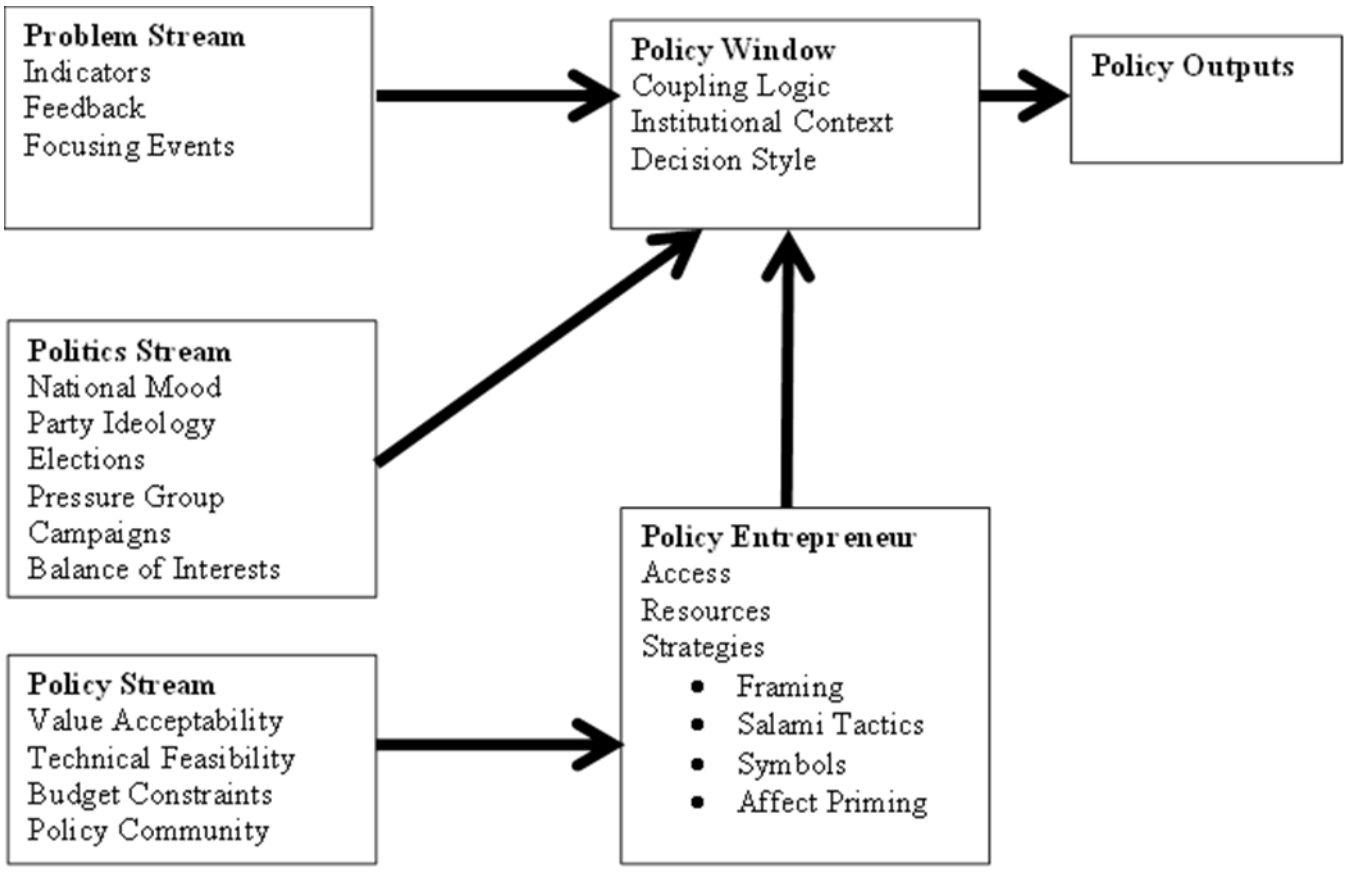
Issues are placed on the agenda when these three elements are in place: a problem is recognised, a solution is available, and the political climate makes the time right for change (Kingdon, 1995:3). Kingdon argues that these three independent streams of activities ultimately lead to the selection of one policy idea over another. He defines "agenda" as "the list of subjects or problems to which governmental officials, and people outside of government closely associated with those officials are paying some serious attention at any given time" (Kingdon, 2003:3). He distinguishes between a governmental agenda (the list of subjects that are getting attention within government) and a decision agenda (the list of subjects within the government agenda that are already up for an active decision) (Kingdon, 2003:166).

The problem stream highlights problems that need to be addressed and why they seem to occupy the attention of officials more than others Policy makers find out about these through indicators, focusing events, and feedback (Kingdon, 2003:90). Both government and non-governmental agencies usually monitor various activities. Indicators such as birth rates, income disparities, death rates, and maternal mortality rates, among many others, are used to assess the magnitude of a condition. Policy entrepreneurs in and around government constantly look out for changes in such indicators. Focusing events like a crisis, disaster or personal experiences push certain conditions to prominence and draw more attention to some conditions than others. For instance, a major accident such as a plane crash will push government to act (or appear to act) on aviation safety (Birkland, 2007:74). Another way officials learn about conditions is through feedback about the operations of existing programmes. Feedback can be received through formal monitoring and evaluation studies, or informally such as through complaints from communities.

The policy stream involves various policy proposals and alternative solutions generated for many problems. According to Kingdon (1995:117), many ideas are present, bumping into each other, circulating, combining and recombining in the garbage can. However, only a few are selected for serious consideration depending on factors such as technical feasibility, congruence with the political and social values of community members, budget constraints, public acceptability, and politicians' receptivity (Zahariadis, 2007:177). Policy proposals that appear difficult to implement are less likely to make it through this process. Solutions or policies are developed already without specific problems on hand, rather than when the right time presents itself and the policy can be attached to a problem that suits it.In fact, a policy solution designed in response to a particular problem can be attached to another problem if needed. The aims of the policy maker and the policy problems are thus considered ambiguous (Cairney and Jones, 2016:40). Figure 1 below summarises the multiple streams framework, showing the elements

in each stream, as well as the policy entrepreneurs. It is important to note that there have been some extensions to some of Kingdon's ideas, such as strategies used by policy entrepreneurs to couple streams, which Kingdon did not specify in his framework but are nonetheless included in this illustration.

Figure 1: Summary of Multiple Streams Framework



Source: Adapted from Jones, Petersen, Pierce, Herweg, Bernal, Raney and Zahariadis (2016:15)

The political stream, independent of the other two streams, also flows according to its own rules. Its dynamics rely on changes derived from the national or public mood, pressure group campaigns, elections, and elected officials (Kingdon, 2011:145). There are thus visible and invisible participants. Actors like the president and top appointees, members of the national assembly, major political parties, and many others in the political arena, are visible participants who affect the agenda (Kingdon, 1995: 199). Academics, career bureaucrats and ordinary civil servants belong to the group of invisible participants who affect the alternatives. Kingdon (2011:145) describes developments in this stream as powerful agenda setters and that consensus

is built more through bargaining rather than persuasion.

The three streams are viewed as independent, but they come together at a critical point when a window of opportunity known as a "policy window" opens. This window is open for only a short while and it is up to policy entrepreneurs to make use of these windows to attach their proposals to a problem, or to use opportunities in the political stream for instance to push for initiatives that fit in with a new administration. Kingdon (2003:179) defines policy entrepreneurs as "highly knowledgeable, committed individuals in or outside of government who are willing to invest their resources to promote a position in return for anticipated future gain in the form of material, purposive or solidarity benefits."

Kingdon's (1984) framework has been criticised on many fronts. The criticisms are discussed here to identify the weaknesses of the framework and to develop a way of addressing some of these criticisms. To begin with, the independence of the three streams has been challenged; it has been argued that too much emphasis is placed on their independence instead of their linkages (Mucciaroni, 1992: 93; Zahariadis, 1999:81). Mucciaroni (1992:93) further argues that changes in one stream can cause changes in another, and therefore the streams must be viewed as interdependent. Similarly, Sabatier (2007:332) argues that policies are not always a function of policy communities, neither are they developed independently of problems. Policy making in the policy stream is not a domain of policy specialists because politically elite participants tend to be involved in identifying both problems and solutions (Robinson and Ella, 2000). Kingdon (1984) has also been criticised for paying a lot of attention on the importance of problem definition when setting the agenda, without considering the fact that the problem is not fixed throughout and may be reframed or eventually even abandoned (Howlett et al, 2015:419).

Kingdon has also been criticised for not being specific about the streams and what exactly they entail (Howlett et al., 2016:278; Jann and Wegrich, 2017:50). For instance, Lee (2008) criticises his idea of a political stream for limiting public opinion to a role in the politics stream of public policy-making, without mentioning the role that public opinion plays in the problem and policy streams. Lee (2008) further argues that the framework limits public inputs to metrics such as national mood, vote counts, pre-election and post-election polls. Lower level bureaucrats have been known to have the capacity to influence policymaking, and this has also not been adequately accounted for in the framework. Kingdon's assertion of the limited role of the media in agenda setting has elicited further debate. It has been argued that to understand how the media influences public opinion and public policy, one must distinguish and understand the

way in which the media is produced, consumed and regulated (Banda, 2008).

The process of coupling has been criticised for depending on randomness and chance to explain the emergence or non-emergence of polices, as opposed to being a product of power or societal prejudices for example socio economic status, gender, and race that make it possible for certain kinds of coupling to occur over others (Jann and Wegrich 2007:52). In addition, Zahariadis (2014:43) argues that the process of coupling must be refined and further elaborated on by specifying for example the skills and characteristics of policy entrepreneurs to avoid generalisations in cross national environments. He therefore proposes a theory of entrepreneurship within the multiple streams framework (Zahariadis, 2014:43).

As the multiple streams framework was developed exclusively on the basis of the United States experience, it has been argued that the underlying concepts and variables may therefore not apply in certain comparative contexts such as those with limits on policy entrepreneurship, or those with a different legislative system (Beland and Howlett, 2016:224). In line with this, Odugbemi (2008) argues that the framework may not be entirely applicable to developing countries, unstable polities, or authoritarian states whose systems differ significantly from that of the United States. He argues that the policy processes in many developing countries is real anarchy at work, with violent and sudden policy reversals being predominant (Odugbemi, 2008). Kingdon's view on policy entrepreneurs and elite institutions has also been criticized for being too narrow to account for decision-making in more centralised and integrated polities which have restricted participation in policy issues, unlike the United States (Demers and Lemieux, 1998 cited in Ridde, 2009:941).

Although Sabatier (1999:266) argues that the framework cannot be used to forecast outcomes since it has no explicit hypothesis, Zahariadis (2014) disputes this claim, stating that the framework can be applicable when attempting to forecast. He demonstrates this in a case study on how national mood can shape public policy objectives in foreign policy in Greece. Ridde (2009:947) also argues that the framework was useful for forecasting, understanding, and explaining the issues related to the implementation of a health policy in Burkina Faso. In their review of the framework, Jones et al (2016:29) however note that it is not easy to produce a framework 'test' owing to the inconsistencies and incoherence of its application by various researchers. They observe that the framework's core concepts and sub-concepts are not fully incorporated by some researchers in the application of the framework. Other authors have stressed that for a Kingdon's framework to be considered both more true to empirical reality

and more useful to predict policy outcomes, it is important to determine how non-institutional actors and grassroots outsiders such as civil society can gain access to effectively influence the policy-making process (Cairney and Jones, 2016:38; Sabatier, 2007:333; Odugbemi, 2008). On a more theoretical level, the framework has been criticised for failure to develop a systematic theoretical debate (Jones et al 2016:31; Zohlnhofer, Herweg and Rub, 2015:412). It has been argued that the framework has not been modified much and academic debate on how to develop the framework further to respond to criticisms is still lacking (Zohlnhofer et al, 2015:414). Furthermore, Howlett et al (2016:279) note that the framework does not account for all the stages that policy processes and deliberations undergo, and therefore its application to other 'stages' of the policy process cannot be automatically assumed. They question whether streams may be present in the implementation process and if so, their independence (Howlett et al, 2016:279). They thus propose combining the framework with other approaches to policy making such as the advocacy coalition framework by Sabatier and Jenkins-Smith (1987), plus the traditional policy cycle approach to have a more holistic framework that takes diverse factors into account (Howlett et al, 2016:280).

A common criticism of Kingdon's multiple streams framework has also been that the role which institutions play in policy has not been sufficiently accounted for (Mucciaroni 1992; Schlager 2007; Rüb 2009). The argument is that the framework places too much emphasis on the temporal, situational, and human agency elements at the expense of the institutional context of policy decisions (Saetren, 2016). While Kingdon (1995) does discuss the role of governmental institutions and actors in the political stream and participants inside government, this institutional focus is not explicit, but implicit. This is because it is mixed in with several other ideas in a more common broad-ranging and heterogeneous concept such as the political stream (Saetren, 2016:27). Some authors have reasoned that because Kingdon (1984) focused on agenda setting, the role of institutions may not have been a factor since agenda setting is much less shaped by formal institutions (Baumgartner et al., 2009; Cairney and Heikkila, 2014). However, since the framework has been applied beyond agenda setting and beyond the United States, the role that institutions play in these later stages and contexts/systems is important to examine (Jones, 2015).

Zahariadis (2016) argues that inclusion of institutions in the framework both enriches and complicates the framework, but does not seriously alter its premise or logic. In his analysis on how institutions can be infused in the framework, he notes that thus far, there have been three ways in which this has been done, namely through arenas, institutional ambiguity, and the

duration of policy windows (Zahariadis, 2016:8). Spohr (2016) proposes to combine the multiple streams framework with historical institutionalism so as to take institutional effects into account, thus introducing path-dependency in the framework. Through case studies of labour-market reforms in the UK and Sweden, he argues that institutions are essential in all streams because they filter problems, structure policies, and influence politics (Spohr, 2016:264).

In their study on the use of earnings from lotteries to sponsor education in Tennesse and North Carolina, Ness and Misretta (2009) propose adding a ‘‘policy milieu’’ as an extra element to the multiple streams framework. This refers to the government structures and the organisational systems such as the governor’s authority and power, as well as what is described as legislative professionalism. Another author, Blankenau (2001) further contributes to the claim by showing how policy windows and institutional milieu are linked or related. He argues that veto points with larger numbers facilitate a policy window opening for a longer time so as to adopt a particular policy given the gravity and number of compromises that must be taken into account.

Zohlnhöfer et al (2015) provide a more detailed way in which institutions can be introduced into the multiple streams framework. They suggest doing so at the decision-making stage of the policy cycle, arguing that when applied at this stage, formal political institutions become more prominent than is the case in agenda setting (Zohlnhöfer et al., 2015:244). Further, when applied to settings other than the United States, institutional differences must be considered, and this could involve an adaptation of the political stream (Zahariadis, 1996: John, 2012). This adaptation would depend on the prevailing political stream in a particular context.

While authors such as Zahariadis (2003) have successfully applied the framework to decision making, Zohlnhöfer et al. (2015:249) point out that even then, institutions have still not been sufficiently considered in the framework mainly because of the way the framework has been adapted to cover decision making. They add that the proposal by Zahariadis (2003) to analytically collapse agenda setting and decision-making makes it difficult to pay sufficient attention to the role of institutions, especially at the decision-making stage where they should be prominent (Zohlnhöfer et al, 2015:250). They thus propose that in order to thoroughly account for the role of institutions in the multiple streams framework, particularly in the decision-making stage, there has to be a coupling process for the stage just as there is during agenda setting. Therefore, two coupling processes.

The main question at the decision-making stage/coupling is whether the policy entrepreneur will gain the majority consent required to get a pet project adopted, and this is precisely where institutions are needed because they define which majority would suffice and which actors would need to agree to the adoption of a policy (Béland 2005). Essentially, this means that whoever has control of the relevant political institutions has an upper hand in decision making. For instance, a united party in Parliament is able to ensure that a bill is easily adopted.

2.4 Using the multiple streams framework for policy analysis

Despite the above criticisms, the multiple streams framework has contributed both theoretically and empirically to public policy, and its applications indicate that it is influential and a flourishing field of study (Cairney and Jones, 2016:53; Jones et al, 2016:13). The framework has been applied extensively (Beland, 2016:228), and has demonstrated to be useful in explaining particularly agenda setting and policy formulation in many different settings. According to Zahariadis (2014:25), Google Scholar shows over 10,000 citations since Kingdon's seminal work in 1984, and about 1,900 peer reviewed articles mentioning or applying the framework since 2000. It has been relied upon by researchers to analyse the factors involved when governments everywhere are faced with the great task of choosing which issues to act upon, which to simply overlook, and which to put forward for consideration, given the many decisions that have to be made against limited time frames and finite resources. A number of authors in several different countries, and particularly in the more advanced western democratic countries, have used Kingdon's framework to explain how specific issues have emerged on policy agendas.

Indeed, using the multiple streams framework has become in most policy studies has become the norm (Beland and Howlett, 2016:223). The framework has been applied across national, subnational and international levels, with the United States and European countries having produced the most scholarly work using the framework in one way or another (Cairney and Jones, 2016:44). The most popular policy domains explored have been in health, environment, governance, education, and welfare (Jones et al., 2016:20). The framework has also generated useful insights for comparative research, despite the fact it was focused exclusively on the United States (Beland and Howlett, 2016:221). The following paragraphs show the various areas and contexts in which the framework has been applied to study policy making.

Ogden et al. (2003 cited in Walt et al., 2008) drew on Kingdon's ideas of policy windows to analyse how the HIV/AIDS epidemic contributed to global policy windows in their research on

tuberculosis in the United States. Also, Gosden and Beder (2001) used Kingdon's framework to examine how powerful pharmaceutical companies in the United States and Australia use public relations companies who play the role of policy entrepreneurs to manipulate public policy-making in the mental health field. In education, Young, Shepley and Song (2010) used the framework to explain how the issue of reading became prominent on the agenda of three state governments in the United States using information collected from major policy actors. Lovell (2010) also used it to come to the conclusion that school choice alternatives in the United Sates would become a policy issue in the near future. In Canada, Dattani (2010) used the framework to analyse the top health care issue on the Canadian government's agenda during a two week period in which he found that the death of a 13 year old boy due to H1N1-related illness was a significant focusing event that pushed the issue of H1N1 flu virus vaccination shortage to the top health care issue during that period.

It has also become common practice to apply Kingdon's framework to policy making at the European level (Zohlnhofer et al., 2015:414). Kingdon's framework has been widely used to study agenda setting, particularly in the European Union (EU). These studies have looked at the role that countries and EU institutions play to ensure that the issues they have an interest in end up on the EU agenda (Hix, 2002; Rasch, 2000). Pollack (2003) applied the framework to study the relevance of supranational institutions in the politics of the then European Community and the role of policy entrepreneurs in the institution. Ugland (2011) also used the framework to illustrate how policy entrepreneurs managed to draw widespread public attention to a set of problems pertaining to alcohol, health, and social welfare in Europe in order to have an alcohol policy placed on the EU political agenda.

Green-Pedersen and Wilkerson (2006) examined how the health care agenda is set amid political developments in Denmark and the United States over a period of fifty years. In analysing the contextual conditions of policy transfer of the World Health's Organisation (WHO), and the Health for All (HFA) policy initiative in Finland and Portugal, Tervonen-Gonzales and Lehto (2004) drew on Kingdon's three steams of problem, policy, and politics. Strand, Brown, Torgersen and Giaever(2009) relied on Kingdon's model, amongst others, to identify policy entrepreneurs who were responsible for developing a policy to tackle health inequalities in Norway in order to determine how the political agenda was set.

While it is mainly in the context of fairly wealthy countries that the multiple streams framework has been applied to analyse agenda setting of national and international policies (Ridde,

2009:938; Zohlnhofer et al., 2015:414), it has also been applied in Asian and African settings, although to a limited extent. Reich (1994 cited in Buse et al., 2009) illustrated how the problem of ineffective and expensive pharmaceuticals had been floating in the problem stream for some time in Bangladesh without any action from the government until a new president showed interest in acting on the problems. A group of health professionals then saw this as an opportunity to get an essential drugs policy on the public agenda and this happened when the three streams came together, resulting in far-reaching policy changes. Similarly, in Singapore, the model was used to explain how a policy window opened up to facilitate a major policy shift that changed a longstanding casino ban, thus confronting core beliefs that ran deep in Singapore's society regarding gambling. The study demonstrated that Kingdon's model was also applicable to a parliamentary system with a small core group of decision makers, such as in Singapore (Ting, 2008).

Shiffman (2007) analysed how the convergence of different developments in problem definition, politics, and policies in five developing countries (India, Indonesia, Honduras, Guatemala and Nigeria) pushed the issue of maternal mortality reduction onto the national agenda in 2005. Some of the key factors identified were that advocates were more likely to be effective in moving political elites to action if they were able to justify to policy-makers the extent of the problem and brought well-connected and influential political entrepreneurs into their circles to push the issue. Ayyar (2009) also extended and applied the ideas of policy windows to further analyse and explain general public policymaking in the Indian context and found that the framework was applicable.

Aspects of Kingdon's model were used to investigate the processes by which the universal anti-retroviral therapy policy was developed in Thailand in 2001, particularly the role played by non-state actors during the agenda setting stage (Tantivess and Walt, 2008). It was discovered that non-state networks made significant contributions at almost every stage of the policy process, despite the state being dominant in the initial stages. Yu (2003) also used the model extensively to explain why the death of a new college student was a focusing event that occupied the top governmental agenda in China in 2003.

In the African context, Ashford et al. (2006) used the model, among many others, to describe how a window of opportunity is created for policy change, thus illustrating the policy process and how to work strategically to translate knowledge into policy actions in Kenya's health sector. Inspired by Kingdon and agenda setting, Bird et al. (2011) examined why mental health

had remained a low priority on the national agenda of most African governments through comparing policies in Ghana, Uganda, South Africa and Zambia.

To assess the acceptability of strategies for increasing the supply of teachers in sub-Saharan Africa, DeJaeghere et al. (2006) relied on Kingdon's three streams to determine the most feasible and acceptable strategies. Fourie et al. (2010) also use Kingdon's framework to analyse the role of AIDS donors and civil society in the policy process of South Africa to understand the resistance of the government to the HIV epidemic. In Zambia, while studies have made reference to Kingdon, the literature so far shows limited studies that have actually applied the framework to analyse policies (Mainza, 2017). Where the framework has been used for instance, it has been used in comparative cases and also applied differently from the way that this study does. The studies have focused on agenda setting to understand why for instance mental health was not a priority (Bird et al., 2011); to analyse national sports associations response to the HIV/AIDS pandemic (Banda, 2014); and to understand the policy making process in the Southern African Development Community (SADC). These studies have either not looked at implementation or not fully incorporated all the elements of the framework.

Banda (2014) for instance utilises a number of other models apart from the MSF. These include policy network theory, global health governance approach, and the top-down and bottom-up approaches to policy implementation to draw attention to how the different associations responded to the mainstreaming of HIV/AIDS. The MSF was useful to understand why HIV/AIDS become prominent on the global and national agenda and the factors that led to policy response. The MSF was not used to analyse implementation of these responses, rather the top down and bottom-up approaches were used. Similarly, Bird et al. (2011) focus on agenda setting but do not use Kingdon's three streams comprehensively, rather, they develop three categories (legitimacy of problem, feasibility of response, support for response) to understand why mental health was a low priority in Zambia, Ghana, Kenya and South Africa.

Another study by Mainza (2017) analyses the roles of political power, media and groups in the SADC policymaking process using the MSF and thus collects data from SADC member states which includes Zambia. However, the study looks into providing insight on the obstacles to meeting SADC cooperation and integration targets. These studies help to show that this particular study is different and goes beyond how the MSF has been applied in the past in Zambia. There is also very little empirical evidence showing how the policy relating to mobile hospitals in Zambia was implemented, which literature this dissertation also contributes to.

The above scenarios indicate various ways in which the multiple streams framework has been applied to study agenda setting and policy formulation in different policy areas and contexts. This discussion was relevant to show that the framework has been applied beyond the United States to other countries and other policies besides health and transport, thus highlighting the flexibility of Kingdon's concepts. The next section discusses the debates concerning applying the framework to all stages of the policy process.

2.4.1 Debates on applying the multiple streams framework beyond agenda setting

Applications of the multiple streams framework in various contexts have shown that the framework is applicable to other contexts, and different from those for which the framework was originally developed. Kingdon (1984) initially began examining health care and transportation policies in the United States, but later extended his research to include fiscal policies for the next edition of his book (Kingdon, 1995). The focus of his work has primarily been agenda setting at the federal level. However, his work has been applied in multiple cases, some beyond his case studies as has been shown above. The applications of the framework have thus been extended in three main aspects, that is, policy areas, policy stages and units of analysis (Zohlnhofer et al., 2015:414).

Some authors have proposed the extension of the framework to cover the entire policy process (John, 2012:160; Sabatier, 1991:151; Zahariadis, 1999:79). On the other hand, some argue that the framework cannot simply be applicable to other stages of the policy process without the addition of more streams (Howlett et al., 2015:422; Howlett et al., 2016:69). In this case, Howlett et al (2015) propose adding two more streams: a process and a programme stream. However, Zahariadis (1995) suggests that applying the multiple streams framework to political systems and other stages of the policy cycle that were not the focus of Kingdon when developing his framework can be done without making significant modifications to it.

Howlett et al. (2016:280) argue that extending the framework beyond agenda-setting should be accompanied by an awareness that problem definition may not be the same throughout a policy process, thus affecting the contours and content of the order of the policy process and the outcome of the policy. However, following up on Sabatier's (1991) recommendation, Zahariadis (1992) did extend the framework to explain decision making regarding telecommunication policy in Britain and France. His work showed that the framework and the three streams could indeed be applicable to the entire policy process, beyond Kingdon's focus

on agenda setting.

Geva-May (2004) also extended the framework to cover a policy 'stage' that is usually neglected in the policy cycle, that is, policy termination. Geva-May explores the applicability of Kingdon's framework to the termination phase of the policy cycle and argues that the framework is applicable to studying policy termination since it addresses two main factors responsible for organisational stability. These factors are the existing institutional structure, and problem definition (Geva-May, 2004:330). She further points out that termination occurs when windows of opportunity open and close as the three streams converge. Since Kingdon identified two types of opportunity windows, that is, either predictable or induced windows, Geva-May (2004:323) argues that predictable windows lower the costs of termination because the termination timeline is anticipated.

2.4.2 Analysing policy implementation using multiple streams framework

In this section, I show the various ways in which the multiple streams framework has been applied to study policy implementation, what the authors concluded, and how this study differs in approach from other studies. Exworthy et al. (2002:80) suggest the need for applications of the framework at not only central levels as is usually the case, but at local levels too. Since Kingdon (2003) analysed issues at a central level to understand agenda setting and policy formulation for implementation, policy windows at the local level must be analysed (Exworthy and Powell, 2004:265). After all, politics (policy formation) and administration (implementation) are closely linked (Zahariadis, 2014:45). A few studies have thus applied the framework to study implementation (Lemieux, 2002; Exworthy and Powell, 2004; Ridde, 2009; Howlett et al, 2015; Boswell and Rodrigues, 2016; Saetren, 2016; Zahariadis, 2016; Sager and Thomann, 2017).

Exworthy et al (2002) applied Kingdon's framework in the United Kingdom to understand both policy formulation and failed implementation of a health policy, to tackle health inequalities both nationally and locally. The framework helped to understand the vertical dimension between central and local government. Using empirical evidence from three case studies, they examined how national policy became part of the local policy agenda and how that affected implementation strategies. The case studies were each focused on a health authority and its local partnership network. Their research showed that there was an implementation gap between what central government envisioned and what was happening locally. They found that national and local streams of health inequalities were partially coupled, but that policy windows

at both the national and local levels needed to be open for longer periods of time if health inequalities were to be tackled. Overall, they state that the framework was helpful to understand the way in which the policy was being implemented locally (Exworthy et al., 2002:92).

Boswell and Rodrigues (2016) applied the multiple streams framework to analyse implementation of UK targets on asylum, defence, and climate change. They state that the framework allows for policy to be treated as an exogenous variable that is developed or imposed by a central or superordinate authority, and that the way that the policy is implemented is dependent on its confluence with local or sectoral problem and politics streams (2016:508). They argue that in order to be usefully applied to explain implementation across the units or sectors approach, the framework needs further theoretical specification to better explain how policy actors construct policy problems or how such constructions are influenced by political dynamics and how such problems become attached to policies and solutions. They thus draw on organisational theory to complement the MSF to explain implementation across units. This entails focusing on the organisations in the public administration responsible for the detailed elaboration and implementation of policy. It is assumed that policy, politics and problem streams need to converge at the central or superordinate level to produce policy decisions. They argue that implementation is most affected by the actions and behaviour of actors in charge of supervising and implementing the policy, who adjust their actions and behaviours to suit political actors from the centre. This insight regarding the political pressure from the centre on organisations was also insightful for this research, to help understand not only how the centre influences the choice of policy to be implemented, but also how level of political commitment by the centre influences the implementation of policy at local level.

Using a modified and extended version of the multiple streams framework, Saetren (2016) shows how a policy entrepreneur in a cabinet position used manipulation strategies during an open window of opportunity to facilitate policy adoption and implementation of a governmental relocation programme in Norway. He modified the framework to address how variation in policy issue characteristics and designing of solutions into politically optimal ‘‘package deals’’ could affect the chances of success for policy entrepreneurs in coupling the streams. He found that there were four conditions that made the policy entrepreneur successful: institutional position, personal characteristics, an open policy window, and certain manipulation strategies. He proposes that future studies using the multiple streams framework would do well to address the missing link of the impact of institutional factors (Saetren, 2016:86).

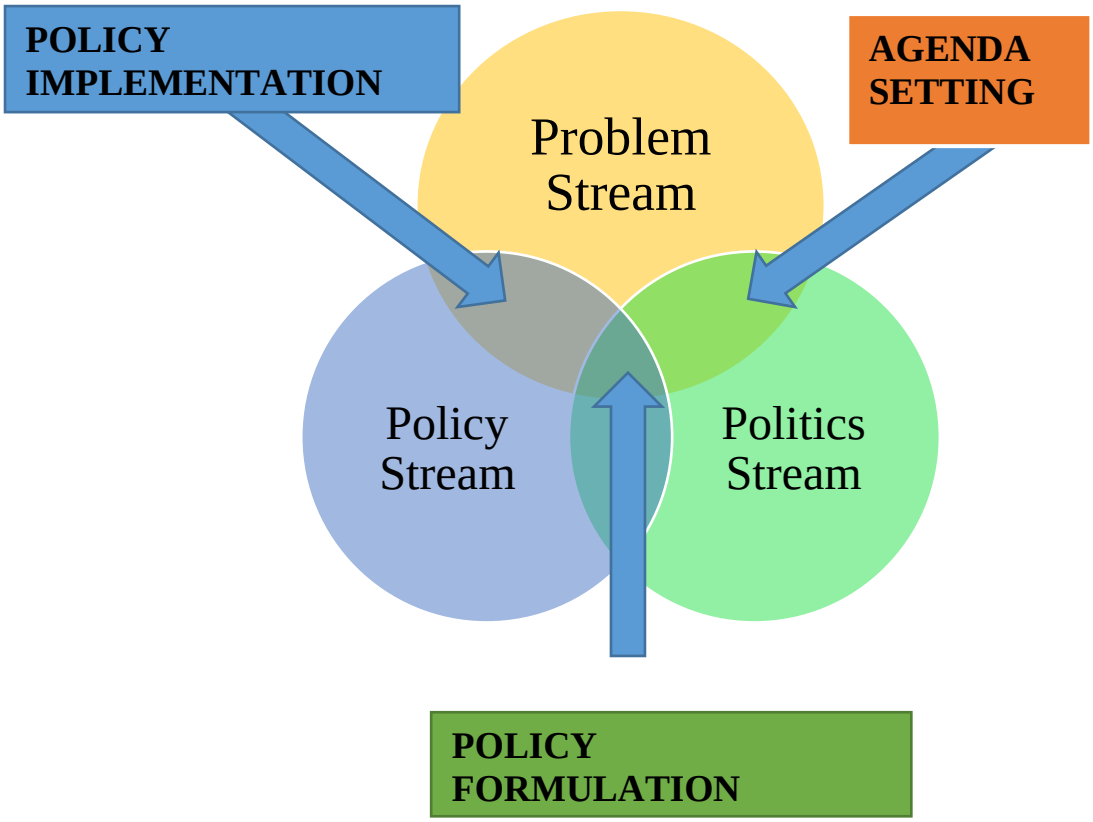
Analysing why policies adopted by a wide margin fail to be implemented, Zahariadis and Exadoktylos (2016) also extended the framework to examine the implementation of Greek higher education reform in 2011. They highlighted the role of policy entrepreneurs and the strategies used to couple the streams which help to determine implementation success or failure. These strategies used by policy entrepreneurs were not covered by Kingdon (2012) as he focused more on their attributes and skills. They concluded that when policies negatively disrupt the status quo, successful entrepreneurial strategies are usually expected to cause implementation failure under conditions of centralised monopoly, crisis, and inconsistent political communication (Zahariadis and Exadoktylos, 2016:77). They argue that implementation not only involves coupling the problem and policy streams as Ridde (2009) had concluded in his research, but may also involve decoupling the two streams.

Whereas Zahariadis and Exadaktylos (2016) focus on entrepreneurial strategies to understand implementation decisions, Sager and Thomann (2017) show that the multiple streams framework is also well placed to examine implementation decisions in federalist systems. They however refined it by including socially constructed problems and inherited policy paths to determine how the interchange of problems, politics, and inherited policy paths affect the decision by Swiss member states to enable the integration of asylum seekers into the labour market integration. Regarding the value of the framework, they conclude that in order to fully comprehend its dynamics in comparative research, historical institutionalism theory must be included because decision makers do not act randomly together with solutions, problems, and opportunities, but also in accordance with the adopted logics of the policy. (Sager and Thomann, 2017:309).

It has been proposed that with appropriate revisions and qualifications, the multiple streams framework may contribute to addressing the politics (policy formulation) administration (policy implementation) dichotomy (Skok, 1995:326; Zahariadis, 1999:89). Indeed Lemieux (2002 cited in Ridde, 2009:941) suggests that since coupling the policy and political streams leads to policy formulation, coupling the policy and problem streams should then lead to policy implementation. This interpretation was taken further by Ridde (2009:941) who demonstrated that in order to apply the multiple-streams framework to policy implementation, it must be shown that coupling of streams in the prior stages happened. According to Hill and Hupe (2007:84) implementation cannot be analysed without looking at the policy formulation process. Policy formulation and specifying objectives have an impact on implementation success or failure (Barrett 2004:253; Blackmore, 2001:146).

Figure 2 below depicts the coupling and application of the multiple streams framework. During agenda setting, the problem and politics stream are coupled while the policy stream is loosely coupled. Similarly, during policy formulation, there is a coupling of the politics and policy streams. Applying the same logic, it can be argued that an application of the framework to implementation entails a coupling of the problem and policy streams with the politics stream loosely coupled (Ridde, 2009).

Figure 2: Multiple Streams Framework showing coupling of streams in each stream



Source: Adapted from Ridde (2009:941)

Ridde (2009:938) is to my knowledge the only researcher so far to have extended Kingdon's framework to policy implementation in Africa. His work has been useful to explain the failed implementation of a health policy aimed at increasing equity (that is, protecting access for the indigent population) at the local level in Burkina Faso. He formulated three research propositions initially to understand the implementation gap. The equity problem stream (exclusion of the indigent) had not been coupled with the policy stream (user fee exemptions), because the absence of equity was not perceived as a public problem; there was no window of opportunity; and there was no policy entrepreneur who emerged to bring about the coupling. These were confirmed after the research except for the proposition concerning windows of

opportunity. Ridde (2009:947) went further and formulated seven propositions about the MSF after the research that he states may be useful when applying the framework to policy implementation. These are summarised as:

- Implementation of a public policy depends primarily on a coupling of the problem and policy streams.
- 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.
- Peripheral implementation ('little window') has greater potential for success in a centralized system if the solutions to problems originate from the centre.
- When policy agenda-setting and formulation are international in origin, institutions play an essential role in the political stream of public policies.
- The occurrence and seizing of opportunities to find solutions to problems is a necessary although insufficient, condition for successful implementation.
- 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.
- 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.

Ridde's (2009) study however mostly focused on explaining the implementation gap of this particular policy, similar to what Exworthy et al (2002) also focused on. Suffice it to say, this has been the pre-occupation of most implementation research (Winter, 2006: 151; Hupe, 2011:64).

The research that has applied the framework to policy implementation has shown that it is well suited to analyse how policies are implemented. Taking this fact into consideration, this research builds on some of the insights and knowledge produced by authors who have applied the framework to policy implementation. This includes the relevance of coupling of the problem and policy streams for implementation to occur (Ridde, 2009), the importance of a supportive political stream for implementation (Ridde, 2009), the role of policy entrepreneurs in implementation (Zahariadis and Exadotylos, 2016), the role of institutions in decision making (Zohlnhöfer et al, 2015), and the impact of political pressure from the centre on organisations (Boswell and Rodrigues, 2016).

Up to this point, this chapter has elaborated on policy implementation and the various approaches that have been used to analyse it. It has also elaborated on the multiple streams framework and how it has been used to explain the policy process in various settings, particularly agenda setting and policy formulation, and more recently, policy implementation. The literature on policy studies explains policy as often being based on one or more of three concepts: ideas, institutions, and interests (Kern, 2011:1118). Kingdon's framework is based on ideas, and to some extent interests. The following section (2.5) discusses the impact of ideas and institutions on the policy process. It also analyses the relationship between the context in which a concept or a theory emerges and the applicability and analytic power it is likely to enjoy in a quite different setting, based on the context of decoloniality and knowledge production in contemporary Africa. This discussion is important for the study because as noted already, the multiple streams framework emerged in the US, a context different from Zambia not only in terms of institutional and political attributes, but also in terms of being classified as a Western country in as far as what is considered legitimate knowledge is concerned. Therefore, the discussion helps to highlight the different analytic power that the theory may have in another context, and the way that this can be factored in contextually.

2.5 Applying 'foreign' models to other contexts and the role of ideas and institutions

While acknowledging that the MSF is rooted in universal concepts that can apply to many settings, there has been a persistent contest among contemporary scholars over what is considered legitimate knowledge. European colonizers have defined legitimate knowledge as Western knowledge, particularly European colonizers' ways of knowing, usually seen as objective and universal knowledge (Akena, 2012:600). Ted (2019) points out that because most developing nations lack theories that are developed by their own scholars, utilising theories from the western world is common but can also be quite challenging due to the differences between the environment of the theory's original development and the context in which it is being applied. Therefore, testing of these western theories must be done with consideration for cultural or situational influences. For this reason, this research recognises the importance of critically assessing how a western model like the MSF can be harmonised with the cultural values within the Zambian context.

Indeed, Mannheim (1936 cited in Akena, 2012:600) argues that western scholars delegitimisation of indigenous knowledge, means that for one to understand a social

phenomenon, such as knowledge, one must study the social circumstance within which the knowledge has been conceived and born. Examining the relationship between the individual and society thus entails studying the society and the individual to uncover the deeper meanings embedded and represented by the knowledge produced. In line with this line of thinking, this research also attempts to study the overall context in which implementation and policy formation occurs in the Zambian context, as this context is different from the US where the MSF was developed. This context also entails taking into account the cultural and institutional values unique to Zambia to help understand the knowledge that the use of the MSF in this context uncovers.

There are multiple understandings of what an institution is and how it affects the behaviour of individuals. I define the concept institution narrowly to refer primarily to the following key elements that make up the politico-administrative system: the legislature, the cabinet, ministries, and government agencies (Saetren, 2016:73). Policy becomes authoritative and widely applicable mainly through institutions (Peter, 2012:67). The common understanding about institutions is that they structure policy decisions; following the rules within a particular institutional context is a major reason for policy change. Political institutions frame and affect the behaviour of actors whose interests and aims are important for policy change. They define the allocation and exercise of political power and in so doing shape policy making mainly through restricting political actions by the operation of rules, norms, and organisational settings (Thelen and Steinmo 1992 cited in Lieberman, 2002:709).

Political actors organise themselves and act according to the rules and practices which are constructed socially, well known publicly, accepted and anticipated. Because of these established rules and practices, political institutions confer basic duties and rights, determine or shape how burdens, advantages and life-chances are distributed in society, as well as constitute authority to resolve issues and conflicts (Beland, 2016:738). Institutions are also important because they channel and shape the behaviour of participants which helps not only to determine which solutions reach the agenda (Mucciarioni 1992: 466), but also which solutions are implemented. However, some scholars like Peter (2012) argue that the role of institutions in initiating policy is overstated. He argues that institutions help to explain the variation of public policies across different countries and contexts, but they do not usually initiate policies, rather they seek to prevent change (Peter, 2012:40). While institutions do not in themselves independently influence the policy process, their operations and rules are however the result of decisions made by policy actors such as politicians or bureaucrats (Peter, 2012). He further

states that in some contexts political actors try to reform institutions in order to get more power (Peter, 2012: 41).

Since institutions influence policy-making, policy ideas matter in and beyond the agenda-setting process (Beland, 2005:1). The scholarship on ideas and policy shows that ideas can potentially come from anywhere; there are multiple sources. These sources are complex and multidimensional (Lieberman, 2002:698). For Kingdon (2003:72), to understand policy change, where the idea comes from matters less than what makes it take hold and grow. In other words, what is important is to understand what makes an idea's time to come. According to Lieberman (2002:710), an idea's time arrives not simply because the idea is compelling on its own terms, but because there is a favourable political environment. He argues that the moment a political idea meets persuasive expression in the midst of actors who are placed in institutional positions that grant them both the opportunity and motive to convert it into policy, is the time one can declare that an idea has found its time (Lieberman (2002:710).

In line with this Berman (2001:233) states that,

> …political scientists must be able to explain why some of the innumerable ideas in circulation achieve prominence in the political realm at particular moments and others not. Since no intellectual vacuum ever exists, what is really at issue here is ideational change, how individuals, groups, or societies exchange old ideas for new ones.

Lieberman (2002:700) argues it is evident that these processes happen in a way that intertwines ideas and institutions, such that both need to be taken into account when analysing political or institutional change. Consequently the relationship between policy ideas, strategic interests, timing, and political institutions is essential when it comes to making policy (Beland, 2005:10).

Although ideas can come from many sources, institutional variation among countries explains why some types of actors are more influential in certain contexts than in others in generating policy ideas (Beland, 2016). He cites France as an example where state bureaucrats and experts usually play a major role in policy proposal development compared to the United States where non-state actors such as think tanks play more of this role, partly because of the nature of the governance system involving decentralisation and pluralism Beland, 2016:231). He goes on to argue that ideas interact with institutions to influence policy change because institutions define the context within which policies are made by highlighting the actors and the policy solutions that are institutionally permissible (Beland 2016).

Studies have also shown that in contexts where decentralisation is the case, decision making is a shared responsibility (Faguet, 2011). Decentralisation can be defined as the transfer of authority and responsibility for public functions from the central government to intermediate and local governments or quasi-independent government organisations and/or the private sector.[3] For instance, in developed countries such as the United States, the decentralised nature of governance allows for other parties, institutions or organisations to be actively involved in shaping policy. On the other hand, in most developing countries, decentralisation is still a work in progress as most power and authority lies at the centre, and policy ideas more often than not emanate from there (Olum, 2014). While low levels of decentralisation are not an entirely bad thing since not all functions can be decentralised, decentralisation does however help to strengthen the capacity of institutions to make decisions and determine policy initiatives. However, even decentralised institutions in developing countries are used by some representatives to advance their personal interests because most power is still retained at the centre (Olum, 2014).

2.6 Conclusion

This chapter sought to provide a literature review of policy implementation and Kingdon's multiple streams framework. It has discussed policy implementation in general as well as implementation research and its development through three generations. The review was necessary to show the gaps in implementation studies, particularly in finding an appropriate model or approach to studying policy implementation. By using the multiple streams framework, the study hopes to make a contribution to the ongoing debate. The main focus on Kingdon's multiple streams framework was necessary to show that despite the framework having been applied in many settings, it still lacks theoretical grounding in terms of institutional focus, which gap this study contributes to filling. The review also showed that the framework is especially popular in developed countries like Canada and the United States and in European countries too but less so in Africa. The framework has only been applied in Burkina Faso, Kenya, South Africa, Uganda and Ghana. Its extension to other 'stages' of the policy process such as policy implementation has been limited, and only one empirical study in Africa has been undertaken so far. In Zambia, the framework has rarely been used.

[3] World Bank, available at http://www1.worldbank.org/publicsector/decentralization/what.htm

The review thus concludes that despite the framework being applied to study implementation in varying contexts especially in developed countries, its applications in African contexts have been limited. Secondly, where the framework has been used for implementation, most studies addressed implementation gaps or an aspect of the framework such as policy entrepreneurs. In the next chapter, I discuss the methods that were used to come to this conclusion.

CHAPTER THREE: THE RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

This chapter provides a detailed account of the approach that was used for the research. It explains the methods adopted, and justifies why these were deemed appropriate. The research design and methodology adopted for this research entailed making prudent decisions starting with choosing the site for the research to designing an appropriate research strategy for carrying out fieldwork and for analysing the data. The chapter addresses how specific techniques were used to find answers to the research questions. The chapter also discusses how the data was analysed and how ethical issues concerning the study were addressed. A reflection on the fieldwork process is also provided. Thereafter, the study limitations and issues pertaining to ensuring the accuracy of data are presented before concluding the chapter.

3.2 The Research Design

Research design according to Yin (2009:10) refers to the logical structure of any research embarked on which acts as the basis for collection, measurement and analysis of data. It is intended to deal with logical problems as opposed to logistical problems (Yin, 2009:10). A research design provides a systematic and coherent means of realising research objectives. Flick (2007:38) states that a research design has a direct impact on the concrete steps of a proposed research project and how it is conducted because it includes all the procedures relating to how research is conducted including the write-up.

Research designs are often confused with research methodology. The difference is that while a research design provides a logical structure to the research, the methodology entails the methods to be used in the data collection. In short, the research design provides a framework for the collection and analysis of data and indicates which research methods are appropriate (Walliman, 2006:42). It creates a clear idea of how the research is to proceed, specifying the data needed for the kind of enquiry to be engaged into, and how this would impact on the research interests.

The research design in this research was a single case study of the mobile hospitals in Lusaka Province in Zambia because of the need to conduct a thorough investigation of a specific case. Yin (2009:10) describes a case study as “an empirical inquiry that investigates a contemporary

phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident." Despite case studies being popular for conducting implementation research since its inception, some implementation scholars such as Goggin (1986) have argued that they do not contribute much to the development of an implementation theory, but help more in identifying implementation problems. Case studies are however useful even for theory because they can help to determine the applicability of theory outside a particular context which helps to build the theory. The case study in this research was suited as a design because it made it possible to study this case of mobile hospital implementation within its context, as in taking note of the time and place where it occurred which contributes to expanding the multiple streams framework beyond its initial development.

There are other research designs such as action research, historical studies, experimental design, cross sectional design, surveys, and longitudinal design. A case study was however chosen as the research design because it was the most suited to gain in-depth knowledge about a set of contemporary events whose characteristics could not be manipulated (Yin, 2009:11; Crowe et al., 2011:1). Since case studies involve in-depth observation of events and interviews with people involved in these events (Crowe et al., 2011:2), several events from the overall implementation process, to elections, administrative changes, and selection of alternatives, were analysed for the study.

Another reason why a case study research design was deemed appropriate for this research is because of its usefulness in a situation where not much is known about a particular issue (Bleijenbergh, 2010:62). Besides applications of Kingdon's framework to investigate policy failure in various contexts (Exworthy and Powell, 2004; Ridde, 2009; Zahariadis, 2016), there is limited research available that assesses the value of Kingdon's framework for implementation. A case study is also a useful design when testing whether a specific theory and model is applicable to phenomena in the real world (Bleijenbergh, 2010:630). In this instance, the case study was used to determine the framework's contribution to policy implementation studies, since not much information was available about the implementation of mobile hospitals in Zambia and the utility of the framework used in the study. The research question posed thus called for the need to do an in-depth study of mobile hospital implementation using the multiple streams framework.

It has been argued that a single case is enough in order to permit analytical generalization to theoretical propositions, based on real-world discovery (Fletcher and Plakoyiannaki, 201:239).

The single case as opposed to multiple or comparative case study is therefore justified by the fact that the aim of the research was not to provide an overview of the implementation of the mobile units across Zambia so as to establish similarities or differences, but rather, to simply use their implementation as a way to help determine the multiple streams framework's value for policy implementation. While there were several public health cases which could have been selected, this case, as mentioned earlier in the introductory chapter was particularly interesting in that despite being heavily contested, the policy went ahead to be implemented. This is different from some other public health initiatives in the Zambian health sector in which the government has been seen to take the advice of various experts, especially the donor community (Hanefeld, 2010; Swedlund, 2013). Therefore, part of the objective was to understand why implementation of a 'rejected' health policy idea was possible.

As single case studies also aim to shed light on a larger class of cases (Gerring, 2009:20), Lusaka Province was selected because the capital city, Lusaka is located here. Therefore, being the capital, the Ministry of Health Headquarters, the body responsible for coordinating all health policies is located here, and so are all the main offices of donor partners. While other provinces may have regional or smaller offices, the senior staff who are more involved in health policy formulation are found at the headquarters in Lusaka. And informants from these two categories (donor partners and ministry headquarters) were identified as vital for the research so as to explore the health policy formulation of mobile hospitals before even looking at their implementation. As noted in the previous chapter, it is almost impossible to study implementation without looking at the prior processes of policy agenda setting and formulation. I make further justification for the category of informants chosen for the research in section 3.4.4.

As the most populated and urbanised of the 10 provinces in Zambia, Lusaka Province can also be said to represent a model for the other provinces, particularly with reference to mobile hospital implementation. Mobile hospitals help to decongest referral hospitals and Lusaka has the largest referral hospital, catering for patients from all over the country. Lusaka Province was also the first to implement mobile hospitals when they were launched in 2011 and has therefore been implementing them longer than any other province. As such, it helps to study the implementation over a longer period of time. Therefore, a single case helps to demonstrate and analyse the topic under discussion. Zambia as a country was selected because it represents a developing country in sub-Saharan Africa. Some critics of Kingdon's framework have argued that it cannot be easily applied in most developing countries (Beland and Howlett, 2016;

Odugbemi, 2008). In addition, Zambia is one of the few developing countries implementing mobile hospitals as part of their mainstream health system; something that has not received much attention (Oriol et al., 2009) which presented an opportunity to prove or disprove the criticism.

I am aware of the criticisms labelled against case studies, the main one being the fact that because the sample size is usually small, generalizing findings to the wider population is impossible (Gerring, 2004:348; Walliman, 2006:46). Furthermore, it is argued that the case being investigated may not be representative of the larger problem (Gerring, 2004:343). However, Yin (2009:11) points out that case studies are most favourable where the aim is to gain insight into a phenomenon and not necessarily to gain representation. This is specifically what this research aims to do; to understand how the multiple streams framework as an analytical tool can help to understand policy implementation in the context of mobile hospitals.

Gerring (2004:343) also states that case studies provide a good platform from which to investigate similar cases. Since the aim is not to generalise the findings of this research, the study contributes to the debates on applying the multiple streams framework beyond agenda setting by showing its value for studying policy implementation and helping us to see the ways in which various policy actors for instance can impact policy implementation in a centralised context. The lessons observed in this case of mobile hospital implementation can also be useful for other countries with similar characteristics such as Zambia.

3.3 The Research Methodology

Silverman (2013:99) states that methodology centres on the choices made about cases to study, methods of data gathering, and forms of data analysis in planning and executing a research study. Traditionally, a distinction is made between quantitative and qualitative research methodology. These two approaches to research are differentiated mainly by their underlying assumptions regarding the main approach to collecting and analysing data (Walliman, 2006:36). The underlying epistemological difference between these two approaches have elicited debate based on the different assumptions of what constitutes reality, whether or not it is measurable, and whether subjective or objective methods should be used when seeking to understand knowledge (Newman and Benz, 1998:2)

Advocates of quantitative research techniques such as Auguste Comte, John Stuart Mill, Emile Durkheim and others argue that research must be based on a positivist approach inherent in the

natural sciences and must be objective (Bryman, 2004:19; Smith, 1983). Positivism refers to the view that knowledge in research should be gained from the 'positive' verification of observable experience and arguments are put forward in favour of the superiority of its techniques and approach (Guba and Lincoln, 1994:110; Newman and Benz, 1998:17). Researchers who support quantitative techniques argue that social science investigations should conform to such standards. This research method is claimed to be "value free" by virtue of its epistemological nature and values are regarded as confounding variables which should not be permitted in studies aimed at objectivity (Guba and Lincoln, 1994:114).

On the contrary, advocates of qualitative research techniques such as Wilhelm Wundt, Max Weber and others argue that social reality cannot be perceived in the same manner as natural science. They hold the view that what is known to be reality is socially constructed and therefore cannot be subjected to a positivist approach (Creswell, 2003). The subject of a study and the research cannot be separated (Bryman, 2004:20), which means that values are also important. Because they believe that research should be characterised by in-depth descriptions of what is being studied, qualitative techniques depend more on language and the interpretation of its meanings, and these data collection methods usually involve close human involvement and a creative process of developing theory rather than testing (Walliman, 2006:37).

The research methodology chosen for this study is qualitative which is supported by the case study research design. It entailed the use of qualitative techniques such as interviews and observations to collect data and the use of descriptive approaches to present the findings. Qualitative methodology involves exploring the lived social realities of informants and undertaking a comprehensive analysis of a particular problem as opposed to giving statistical descriptions of generalised ideas (Bryman, 2004:159). For the kind of research that this study embarked on qualitative rather than quantitative methodology was best suited because of the need to understand as opposed to measure the implementation of mobile hospitals in Lusaka Province. Exploring experiences from the perspectives of the respondents themselves increases understanding of the policy process which worked for this research since the aim was to see how the multiple streams framework can better explain policy implementation.

According to Rist (2000:1008) qualitative research methods are best suited when studying public policy implementation since they are distinctly positioned to determine that the impact that policies have are the ones envisioned by policy makers. He points out that this is because they are longitudinal, are conducted in natural environments, and are aimed at exploring the

socially constructed meanings that participants develop (Rist, 2000:1008). Since the study focused on the policy implementation of mobile hospitals, qualitative methodology was best suited s to understand implementation from the perspective of both implementers and policy makers. According to Silverman (2013:7), one of the greatest strengths of qualitative research is its ability to account for and analyse everyday societal practices and activities at length. Patton (1987:19) also describes such examination of a particular situation as "in depth, in detail and holistic[ally]". This type of comprehensiveness is what the study aimed for.

The qualitative methodology selected for this study was also determined by the theoretical framework and the research questions. Since the research aimed at assessing the utility of the multiple streams framework for policy implementation, the selected methodology was deemed best since it was adaptable to the context (which I did) and less structured. Qualitative methodology was also best suited because the methods employed allowed me to assess, explore, and explain in-depth the value of using the multiple streams framework for understanding implementation. The methods are discussed in the following section.

3.4 Sampling

A sample is a small group of members chosen from a target population. According to Babbie et al. (2008:203) a sample is "a special subset of a population observed in order to make inferences about the nature of the total population itself." Because not all members of the population can be included in research, a sample must be drawn from that population (Walliman, 2006:76). A sampling frame is a complete list of cases in a population that can be used (Walliman, 2006:76). The target population or sampling frame in this research was people involved in implementing health policy, and to some extent formulating policy related to mobile hospitals.

3.4.1 Sampling technique

Walliman (2006:77) discusses various sampling techniques in qualitative research. These include both probability and non-probability sampling techniques. While probability sampling techniques are based on selecting samples randomly, non-probability techniques do not use randomisation. Examples of probability sampling are: simple random sampling, systematic sampling, simple stratified sampling, proportional stratified sampling, cluster sampling, and multi-stage cluster sampling.

Non-probability sampling techniques on the other hand include: convenience sampling, quota sampling, theoretical sampling, purposive sampling, snowball sampling, and simple matching sampling (Walliman, 2006:79). One of the major advantages of using probability sampling is that it gives the most reliable representation of the population while non-probability sampling techniques are not usually representative (Gibson and Brown, 2009:56). Despite this, probability sampling techniques were not considered appropriate for this research because the idea was not to gain representation of the population. Non-probability techniques were deemed appropriate to produce the specific information that was required to answer the research question. Purposive sampling, theoretical sampling, and snowball sampling were therefore used to identify respondents as they were the deemed the most appropriate. As Gerring (2007:87) points out, sampling techniques such as randomization in case studies are problematic because by definition, case studies have small sample size, as such, purposive sampling is recommended. Furthermore, since qualitative sampling focuses on selecting information-rich cases for in-depth study, to enhance the richness, validity, and depth of the information, random sampling is not preferable (Mills, Durepos and Wiebe, 2010:838).

Theoretical sampling is the method used when obtaining data from a sample of the population that the researcher assumes is most knowledgeable about the topic (Gibson and Brown, 2009:56). This method was used to identify the four categories from which respondents were drawn. These included direct actors responsible for implementation of mobile hospitals, representatives from donor partners, experts, and those responsible for policy formulation. The respondents in these categories were identified from government departments, namely the Ministry of Health headquarters, the provincial hospital, civil society organisations, and international donor partners. I then used purposive sampling to identify particular informants within these organisations.

According to Babbie (2008:202), “in purposive sampling, a researcher uses his or her own judgment in the selection of sample members.” The researcher actively selects what they deem to be the most suitable sample to help provide answers to the research question (Marshall, 1996:523). The informants in this research were purposively sampled based on their involvement and knowledge of the policy making and implementation process concerning mobile hospitals. To begin with, the selection was based on my knowledge of who constituted policy actors, however, more actors were included in the research as knowledge of the context increased. This knowledge on policy actors was mainly based on prior interactions within the Ministry of Health. I sought to embrace varying perspectives as far as possible, such as

including both those in support of the policy and those who were critical of it. This was done in order to appreciate and help understand how mobile hospitals were selected at the time as a solution to help address inadequate access to health services.

Purposive sampling was thus used to identify frontline health workers and key informants in the Ministry of Health headquarters, the Levy Mwanawasa General Hospital, and among donor partners and civil society. I used my knowledge to sample informants who were more likely to provide insights and understanding to the research. While purposive sampling is known to have a higher level of subjectivity and bias compared to other non-probability sampling methods (Babbie, 2008:203), it was still the preferred method because certain information could only be possessed by certain kinds of people. I endeavoured to counter this bias by ensuring that informants were selected based on a clear criteria according to the aim of the research. Purposive sampling is also recommended in case studies in order to obtain information-rich cases (Fletcher and Plakoyiannaki, 2010:837).

Snowball sampling is a sampling technique in which subjects recommend useful potential candidates for a study (Marshall, 1996:523). This technique was used to ask informants to identify other key informants who they deemed useful to the research or who possessed some knowledge pertinent to the research. One of the main disadvantages of snowballing however, is that it may be biased, that is, informants may recommend a participant whom they know shares similar views to their own. However, to counter this, during analysis and interpretation of the data, special attention was paid to responses from informants who supported certain explanations and to those who disagreed, to help ensure that the explanations were supported by facts. In addition, triangulation of methods also helped to counter biasness. Some of the respondents were health workers. This method of sampling was also important for the research as knowledge of vital potential informants in all the categories was inadequate.

3.4.2 Choosing the Sample Size

The exact sample size was not known at the beginning of the research. However, once in the field, a total sample of fifteen was obtained in the data collection**.** According to Marshall (1996:523), determining the size of the sample in qualitative research is often a flexible process and he describes an appropriate sample size for a qualitative study as one that adequately answers the research question. In addition, Silverman (2013:148) states that sample sizes in qualitative studies, especially in case study research, are usually small but adequate enough at the same time.

A sample size of fifteen in this research is also justified by the fact that the aim was not to gain representativeness, but rather to gain deep insight into the case of mobile hospital implementation to determine the utility of the multiple streams framework for policy implementation. Bryne (2001:495) points out that understanding the purpose of the research must be a decisive factor in selecting a qualitative sample. Different numbers of participants were thus selected from each category of respondents as follows: four officials from the Ministry of Health headquarters in the mobile health services and planning departments, three officials at Levy Mwanawasa Teaching Hospital as the hospital is in charge of coordinating the mobile hospitals in the province, four frontline health workers working in the mobile hospitals and lastly, four informants from civil society and main donor partners because they play an important role in Zambia's health sector.

3.4.3 Identifying the respondents

The three officials from the Levy Mwanawasa Teaching Hospital were selected based on the criteria of who was considered better suited to help answer the research questions. Since the hospital has a limited number of management positions, selection was easy as there was not a big population to sample from. Selection was based on those officials whose offices were directly involved with the operations of the mobile hospitals. One of these was purposely selected while the other two were selected through snow ball sampling. The frontline health workers operating in the mobile hospitals were sampled based on their specialisations. The aim here was also not representation but simply to get views from the practitioners on the ground on what implementation entails, and what challenges they faced among other issues. Four were interviewed: two doctors and two nurses. Among the civil society, I purposively selected from major partners in the Ministry of the Health; in other words lead donors known to play leadership roles among other donors in their engagements with the ministry and the medical association, a key player too in health policy for mobile hospitals.

3.4.4 Justification for the category of respondents

The study aimed to select **i**nformants who interact with health policy formulation and implementation in general, and mobile hospitals in particular. These informants and the kind of information sought from them are described below.

The Zambian Ministry of Health headquarters is responsible for policy direction, monitoring and evaluation. It plays the role of being the centre and overseer of all health activities in the country. The mobile health services department is responsible for coordinating all mobile health

services which include mobile hospitals and a flying doctor service. The policy department on the other hand is responsible for ensuring that the process of policy formulation is completed and policy documents are available for the purpose of implementation. Officials from all these departments gave valuable insights on aspects of policy regarding mobile hospitals, including goals and objectives. Information relating to how mobile hospitals became a policy agenda and subsequently implemented was also obtained through these interviews.

Levy Mwanawasa Teaching Hospital is a provincial hospital and coordinates the actual implementation of mobile hospitals in the province. Interviews with officials on the implementation and logistics involved was important. Staff from the provincial general hospital were included for their views on the performance of the mobile hospitals as well as the challenges encountered.

Frontline health workers working in the mobile hospitals were interviewed to gain an understanding of what exactly implementation entails from their perspectives. They are the ones practically in charge of the actual implementation process, and are also closer to the ground so they understand the general sentiments of various users. The health workers were also expected to provide follow-up clarifications of some responses given by the officials from both the provincial hospital and the Ministry headquarters.

Donor partners are key players in Zambia's health sector. They play a huge role in supporting government health programmes both financially and through technical expertise. Some of the main multilateral partners are the World Bank, the European Union, and United Nations agencies such as the World Health Organisation and the United Nations Development Programme among others. The main bilateral partners are the Swedish International Development Agency, the Department for International Development, and the United States Agency for International Development to mention a few. Selection was made based on who was available and willing to give insights on their roles in Zambia's health policy and their views on the controversy that surrounded the purchase of mobile hospitals. Table 2 below summarises the number and kind of respondents who participated in the field work.

Table 2: Summary of respondents

Organisation/Category	**Number of informants**	**Kind of informant**
Ministry of Health Headquarters	4	High level informant- 1; Senior level informant- 1 Middle management informant- 2
Levy Mwanawasa Teaching Hospital	3	Administration- 1 Middle management policy- 1 Senior management- 1
Donor partners/Civil Society	4	Donor partners-3 Medical association- 1
Health Workers	4	Doctors- 2 Nurses- 2
Total	**15**	

3.5 Methods of data collection

Triangulation was used in collecting the data. This refers to seeking evidence from a wide range of sources and comparing the findings from these sources or methods (Neuman, 2000). Qualitative research involves the use of methods such as field interviews, open ended questions, and participant and non-participant observations. The qualitative data comprised written texts of various forms both published and unpublished, field notes, and transcribed audio and video recordings. Yin (1982 cited in Ridde, 2009:942) suggests three methods of data collection especially appropriate for examining public policies. They are: observations, semi-structured interviews (primary sources), and studying documents (a secondary source). In this research, the data was collected using these three methods. This triangulation provided a thorough exploration of the research topic and helped to ensure that valid results were obtained. The time

period for the empirical study, that is, the field work involving observation and interviews was between August and November, 2016.

3.5.1 Observation

Observation in research is useful in order to gain an understanding of the social, physical, economic and cultural contexts in which study participants live and work (Crotty, 1998:5; Yanow, 2007:409). Observation was useful to help understand the operation of the mobile hospitals. As Simons (2009:69) points out, observation is useful to understand programmes and policies through the perspectives of those who enact them. Observations can take the form of participant observer where the researcher takes part in the activities of the group, or non-participant observation where the researcher is detached from the activities of the group (Gibson and Brown, 2009:102; Walliman, 2006:95). In this research, I was a complete observer as I did not participate in anything, but merely observed the mobile hospitals in the field to get a sense of how they operate and what procedures were involved. I was able to go out and observe the mobile hospital in the field on three occasions when the mobile hospital was conducting operations in Lusaka district, between 3 and 9 October, 2016. I would arrive just after 8 in the morning and stay for about 3 hours, then leave and return late afternoon around 3pm for another 2 hours to check how the operations were going and especially how the queues were moving.

Permission was obtained from the Zambian Ministry of Health to observe the environment in which the mobile hospitals operate. Some of the areas of observation included the flow of clients to and from the mobile hospitals, the numbers of people waiting to be attended to, functional units and departments, and the general ambience. Through this exercise I gained a deeper understanding of the implementation process and some of the challenges encountered. This information was also useful during interviews with key informants as I had some prior 'first-hand' knowledge of the mobile hospital operations.

I was aware of the disadvantages of observation as a method of data collection. These include the Hawthorne effect[4] and also the bias associated with recording observations (Payne and Payne, 2004:159). However, because hospitals are by nature public institutions, it was not unusual to be a complete observer and remain 'invisible' by being ignored (Walliman, 2006:95). This minimised the Hawthorne effect since not many people, including the health workers, were aware of my presence. While permission was granted to observe the mobile

[4] Hawthorne effect refers to the tendency of people changing their behaviour when they are being observed.

hospitals in the field, I was not allowed to enter areas where patients were being treated. However, I was able to get a feel of the general operations which were peaceful and orderly despite the queues of people waiting to be attended to. The use of other methods of data collection such as in-depth interviews and document analysis also complemented my observation notes.

I designed an observation schedule[5]. Since the aim was to help understand the operation and implementation of the mobile hospitals, the schedule was designed in such a way as to provide information on an aspect of the implementation to be observed. The schedule had two columns, one indicating the criteria for observation and the other for notes on what had been observed. Some of the criteria for observation included whether all medical units/departments were operational, the numbers of people waiting to be attended to, the categories of health workers attending to patients, and the general ambience of the mobile hospitals.

3.5.2 Key informant in-depth interviews

The next stage of the data collection was interviews. According to Kitchin and Tate (2000:213) "interviews allow for thorough examination of experiences, feelings or opinions that closed questions could never hope to capture". They also provide a framework within which respondents can express their own understanding in their own terms (Patton, 2002:65). I was interested in learning about the informants experiences and opinions regarding the implementation of the mobile hospitals which helped to answer the research question. Semi-structured interviews were used to allow for a deeper exploration of the emerging issues.

Bryman (2004:468) notes that semi-structured interviews are flexible and provide interviewees with leeway in responding to questions. Because the interview guide is not strictly followed, there is room for further probing of responses and explaining particular questions to respondents. Gibson and Brown (2006:89) recommend examining the interviews immediately after they have been conducted to establish any interesting topical issues which may have emerged and are worth exploring in other interviews. I practiced this technique and was thus flexible, adding or reformulating questions for the next interviews. Generally, the average length of each interview was about 40 minutes and they all took place at the respondents respective offices. Interview appointments were made either through visits to the respective offices or via email.

[5] See attached observation schedule in appendices

The interviews were conducted with respondents from the four main categories already mentioned, namely officials at the Ministry of Health headquarters in the mobile health services department, officials at the Levy Mwanawasa Teaching Hospital, frontline health workers working in the mobile hospitals, and informants from the Ministry's donor partners. All these interviewees were important to the study because of their insights into mobile hospital implementation. The choice of the categories was informed by the desire to obtain diverse and well-informed opinions concerning the topic and research questions. This is because the mobile hospitals had received mixed reactions from various segments of the populations and it was important to explore these feelings and opinions to understand the decision to have them implemented and what alternatives could have been implemented instead.

Four different interview guides were thus developed for each category of respondents. These were pilot tested with a few colleagues to ensure that the questions were clear. Guided largely by Kingdon's multiple streams framework (Kingdon, 1995), the following themes were explored in the interviews:

(i) **Coupling of the three streams**, namely problems, policies and politics. This was important to understand the processes leading to the implementation of mobile hospitals. As discussed in the previous chapter, some writers such as Ridde (2009) have argued that application of the multiple streams framework to implementation requires a coupling of the streams to have occurred in the previous stages of the agenda setting and policy formulation. To explore coupling of the streams, interviewees for instance were asked what they considered to have captured the attention of government and the president to have mobile hospitals implemented at the time since inadequate access to health care had always been an issue.

(ii) **The role of policy entrepreneurs**. It was important to know who drove the agenda for mobile hospitals to be initiated and implemented, and if they had the same influence during the implementation.

(iii) **Operations of the mobile hospitals.** What exactly is involved, what health issues are attended to, and what is the operating schedule, the challenges encountered, among other questions.

It is recommended that when asking questions, the researcher begins with fact-based or tangible questions before asking respondents more abstract and serious questions. This is done to make respondents feel at ease. (Gibson and Brown, 2007:87; Walliman, 2006:93). I followed this method and the first questions asked were therefore background questions relating to policy

formulation before moving to more current issues. The interviews ended with the respondents being asked if they wished to highlight anything else. In so doing, and if there were issues which I had not considered relevant, they were brought forward.

The questions were as simple and clear as possible.[6] The interview questions were mainly open-ended to give the respondents an opportunity to express themselves as they wished without limitations. In certain cases, the respondents were asked to expand or motivate their responses. This helped me to gain more insight. Lewis-Beck, Bryman and Liao, (2004:1020) note that a flexible and interactive approach helps to the respondents to produce accounts of their own perceptions, interactions, perspectives, experiences, interpretations, and understandings. Some of the interviews were digitally recorded when permission was granted, and later manually transcribed. I also took notes in all the interviews. This was helpful because in some cases recording was prohibited by the interviewees. This is further highlighted in section 3.10 where I discuss the limitations.

3.5.3 Document Review

Document review refers to the process of exploring the records that individuals and organisations produce (Gibson and Brown, 2009:65). Because these records are not generated by the researcher, they are secondary sources of data. However, within a document review, a distinction is made between primary and secondary documents. The former has the character of primary data such as demographic data while the latter take the form of newspaper articles, academic work, government records, and other forms of commentary which are secondary with respect to the events and accounts with which the respondents engage and on which they report (Gibson and Brown, 2009:67; Walliman, 2009:85). A number of documents that provided a rich variety of information related to the research purpose were consulted. The main documents reviewed are listed in table 3 below.

[6] See interview guide attached in appendices

Table 3: List of the main administrative and policy documents consulted

Document	**Source**
National Health Strategic Plans (2006-10; 2011-15; 2017-21) National Health Policy Annual Health Sector Review 2012	Ministry of Health
Human Resources for Health Plans (2006-10, 2011-15, 2017)	Ministry of Health
5th, 6th and 7th National Development Plans (2006-10; 2011-15; 2017-21)	Ministry of Finance; Ministry of National Development Planning
Zambia Demographic and Health Surveys (2005, 2007)	Central Statistical Office
2010 National Census of Population and Housing	Central Statistical Office
Labour Force Study Reports (2014, 2016)	Central Statistical Office
Zambia Human Development Report (2016)	United Nations Development Programme
Parliamentary Debates and Proceedings (from 2009)	Parliament of Zambia
Presidential speeches/ Ministerial Statements (2008, 2009, 2010, 2011)	Parliament of Zambia
Constitution of the Republic of Zambia (2016)	Republic of Zambia/Government Printers

Source: Own compilation

Document reviews included official statements from the government of Zambia such as presidential speeches, and statutory and policy documents produced by the Ministry of Health. Other sources included material from NGOs, donor partners, and stakeholders working in the

health sector in Zambia, as well as print and electronic media reports. These data sources were particularly useful for understanding and writing about the background to the study, namely the challenges faced in securing access to health services, initiatives taken, and how the mobile hospitals fit in.

While document review provides a broader perspective on the topic at hand, I was aware of the disadvantages of this method right at the beginning of the research. Some of these shortfalls are: documents being limited to a historical focus, documents being biased to present a good image of the organisation, inaccuracy, (in)accessibility and general credibility (Walliman, 2006:85). To counter this, I relied on Merriam (1992 cited in Olson 2010:320) views on questions that researchers must ask in order to check the authenticity of documents. These include the history of the document, the circumstances and purpose for which it was produced and the authors information sources, and whether other documents exist that might shed additional light on the same story. The documents were thus reviewed with caution bearing this is mind, and nothing was taken at face value. Where possible, information was corroborated with other sources so as to limit bias associated with using documents as a data source.

3.6 Data Analysis

The importance of data analysis in research cannot be overstated. It essentially forms the outcome of the research (Flick, 2014:3). Analysis of the data in this research also followed qualitative analysis methods. Qualitative data analysis methods include: discourse analysis, thematic content analysis, narrative analysis, ethnographic analysis, grounded theory, and hermeneutics (Gibson and Brown, 2009:7). Data analysis in this research was done by means of thematic content analysis since the framework for the research already had five identifiable themes. These themes are problem stream, policy stream, political stream, policy windows, and policy entrepreneurs. As Jones et al. (2016:28) argues, examining all the main components of the framework comprehensively helps to produce a better test of the framework, as opposed to invoking only a few of the components. Each of these themes had specific key features as articulated by Kingdon (1995) which I further classified as sub-themes. The manner in which I proceeded for each theme is explained below.

Problem stream

Kingdon (1995) states that officials learn about problems through indicators, feedback or focusing events. In addition to this, there are certain components necessary for a situation to

become a public problem, namely: it is recognised as important, its causes are recognised, its consequences can be determined, the affected populations are known, it is new, people are close to the situation, and it is in line with the values of the society (Ridde, 2009) In view of this, the issues explored were those raised by different actors in the document reviews and in interviews on perceived problems in the health sector that needed to be addressed at the time when the mobile hospital agenda was proposed.

Policy stream

The policy stream endeavored to identify and explore the solutions that were proposed or were in place for tackling inequities in access to healthcare as articulated by various actors. It also identified the community of specialists who debated, studied and selected solutions. Furthermore, it analysed how the proposal for mobile hospitals was selected, based on factors such as value acceptability, technical feasibility, and congruence with dominant values among others (Zahariadis, 2007:177).

Political stream

The multiple streams framework was modified in the political stream to focus on the overall governance structure within which policy actors operate. The focus was mainly on institutional factors as they tend to affect all aspects of the political stream in this context. I thus analysed how institutions such as the executive impact policy, and how it affects the political environment such as legislative and administrative turnover, civil society organisations, national mood, and elections. Issues cited in relation to these sub- themes were then analysed.

Windows of opportunity

Windows of opportunity that opened, particularly in the problem and political streams and the factors that eventually led to coupling were explored based on the respondents' views and various documents reviewed. This is because events in these streams usually facilitate windows of opportunity.

Policy Entrepreneurs

Individuals and/or organisations deemed responsible for coupling the streams for agenda setting, policy formulation, and implementation were identified. These, including the activities they engaged in were analysed in relation to the policy on mobile hospital implementation.

Thematic content analysis was therefore, deemed as most suitable considering the aim of the research and the research question. It involved identifying, describing, and coding the collected data (Gibbs, 2007:38; Flick, 2014:173). It is advisable to start this process soon after data collection. Consequently, I started the analysis during the fieldwork process and transcribed the data from the interviews over a two-month period. After transcribing, the data was organised and reviewed. Units and themes were identified in each interview based on the themes that were explored. Thereafter all the units from all the interviews with similar contents were grouped according to the appropriate category.

One of the main advantages of using content analysis is that it is systematic, flexible, and helps to reduce the amount of data since the researcher needs to focus mainly on selected aspects of meaning, especially those that relate to the overall research question. (Flick, 2014:170). Because content analysis is mainly focused on description, it has been argued that the method may not be suitable for a critical analysis of data (Flick, 2014:171; Mayring, 2000). With this in mind, I was careful not to take the data for granted or at face value, rather it was critically analysed and interpreted by referring to other sources of data such as secondary sources from news articles and official documents produced by government and cooperating partners.

3.7 Ethical considerations

Ethical issues remind researchers of their roles, responsibilities, and the tenets of good research practice that must be respected while undertaking fieldwork (Bell, 1999 cited in Walliman, 2006:148). Ethical clearance from the Research Ethics Committee at Stellenbosch University as well as from an Ethics Committee which approves all research in Zambia was obtained. Furthermore, authority was also obtained from the Ministry of Health to interview staff and to observe operations of the mobile hospitals in the field. All the institutions/partners that were approached for the research granted authority, some of them in writing. These letters are attached in the appendix section of this dissertation. Suffice to say, the process of obtaining ethics approval in Zambia was not an easy one. The bureaucratic procedures involved were rather cumbersome to navigate.

Written consent was obtained from all the informants through informed consent forms which they were asked to sign at the beginning of the interviews. Consent was also sought before recording the interviews. The aim and objectives of the study were made explicit to the informants. Participation in the study was elicited purely on a voluntary basis. Confidentiality, anonymity and the right to freely withdraw from the research was guaranteed. The information

obtained from the interviews and observations was regarded as confidential and only I have access to it. It has been safely stored in a password enabled computer and is equally stored in a secure place away from all external parties. Personal identifiers in the research have either been removed or altered to protect the identity of informants. Since I transcribed all the interviews personally, confidentiality was ensured.

3.8 Reflections on the fieldwork process

According to May and Perry (2014:111), reflexivity is not a method, but a way of thinking or a critical ethos which cannot be confined to one element of the research process; it is rather an iterative and continuous element of good research practice. Gibson and Brown (2009:8) emphasise how important it is for the researcher to think critically about the research while it is in progress in such a way as to consider how their own thoughts and previous experiences could be capable of influencing the data. The term 'reflection' here therefore entails a critical evaluation of the processes which occurred prior to, during, and after the fieldwork process. It is about taking note of the different settings within which knowledge was produced in order to refrain from taking some parts of the research process for granted. This critical reflection on the process of the design, data collection, experiences in the field, and challenges faced, including how they were countered, plays a role in affecting the overall research process, validity, reliability and analysis of the findings (May and Perry, 2014:114).

While it is almost impossible to separate the researcher from the research in qualitative research, I was cautious to keep my previous experience and biases possibly retained from working in the Ministry of Health, from heavily influencing the study. I say heavily because as noted earlier, I had prior knowledge of some information which helped me do the research. But I was aware of the need to nonetheless approach the study from a 'neutral' and objective perspective with a willingness to learn from the informants. Bias towards a particular inclination or persons was avoided. I also reflected on the data by re-evaluating and taking into account the various viewpoints, multiple readings, and comparing field notes and observations with the interview transcriptions.

Unequal power relations, gender, identity, values, age or class differences can affect the validity of the data obtained (May and Perry, 2014:114; Mauthner and Doucet, 2003:417). It is therefore paramount for researchers to always reflect on how such attributes have the potential to influence their interactions with informants since it can ultimately affect the research process. By doing so, the researcher is able to analyse the dynamics and asymmetries of power and

acknowledging inherent interests at play when presenting particular versions of events (May and Perry, 2014:114). As most of my informants were high level officials such as senior directors, securing interviews were not easy, let alone conducting the interviews. This was mainly due to institutional procedures and their busy schedules. Where possible, I was referred to other people who were as knowledgeable and able to assist while in other cases, I relied on 'intermediaries' or personal contacts who assisted me to secure interviews. In other cases, I made use of gatekeepers. For example, access to informants from two donor partners was made possible by a close relation who had senior contacts within these organisations. In addition, I negotiated the power dynamics between myself and senior/high level officials by taking the interviews as encounters or meetings where we would interact and develop democratic relations to enhance openness and curiosity

I also had to negotiate notions of insider and outsider perspectives. At certain times, I was treated as an 'outsider' based on the fact that not only did I not belong in the organisations, but I was also not studying or living in Zambia. In some cases, I was treated as an insider because I am Zambian and a former employee within the health sector, and had some prior knowledge of certain issues especially in the Ministry of Health. Both of these situations were advantageous in some instances and unfavourable in others. My insider status gave me easier access to respondents in the ministry, when ideally the process to get someone to grant you an interview can be bureaucratic. In addition, some informants opened up and freely expressed their opinions regarding the mobile health units while others appeared cautious of how much information to share with an 'outsider'. I negotiated these issues by clearly explaining the aims of the research and showing them my letters of introduction and authority to proceed with the research. I explained that the data was purely for academic purposes and that total confidentiality was assured.

3.9 Validity and Reliability

Validity refers to the extent to which a measurement procedure gives correct answers (Kirk and Miller, 1986:19). It addresses the suitability of the methodology to accurately answer the research question, and the validity of the research design for the methodology, sampling, data analysis, and results (Leung, 2015:326). Reliability refers to the degree of consistency with which research results can be replicated by different researchers or the same researchers on different occasions (Gibson and Brown, 2009:59; Silverman, 2005:302).

To ensure validity, an intensive and extensive literature review to guide the development of the interview guides was conducted. Furthermore, the themes were guided by the framework used in the research which has been used and tested before by other studies. Triangulation of the data collection methods and sources also ensured that that data was supported. In addition to recording, notes were taken during the interview in order to highlight key issues and for backup to avoid any loss of data. As for reliability, I ensured that there was consistency in the interviews by approaching them in a flexible manner.

3.10 Limitations in data collection

This dissertation is based on information obtained from the opinions and perspectives of informants working in and around the health sector in Lusaka Province. The research is relevant to the specific study area where the research was conducted since knowledge obtained through qualitative research methodologies is situated and partial (Bryman, 2004:375). Therefore, the results of this research are not a representation of mobile hospital implementation in all the provinces of Zambia.

In terms of limitations related to the data collection process, I faced some difficulty in recording all the interviews as some interviewees did not want to be recorded, for security reasons they said. I therefore, had to rely on my notes and could have missed some important points. However, the use of other sources of data such as document reviews helped. While the topic itself was not sensitive, I got the sense that not many people were unwilling to discuss or divulge a lot of information. Some informants particularly from the Ministry of Health seemed rather apprehensive to answer certain questions despite total assurance of confidentiality and anonymity. In such cases, I had to either rephrase the question or skip it altogether since the respondents were within their rights to not answer questions. This apprehensiveness could perhaps be due to the fact that employees in the ministry are very cautious about what kind of information they release to outsiders as there have been incidences in the past where irregularities were exposed during research and some people lost their jobs. Nonetheless, the limitations did not hamper the data collection or analysis or negatively impact on the study.

3.11 Conclusion

The aim of this chapter was to provide a detailed explanation of the research process. It thus presented the research design and methodology used in the study. It stated that the design of this study was a case study with a qualitative methodology, and provided a sound justification

for this selection, namely that the aim of the research was not to gain representation or to generalise the findings, to gain a deep understanding of policy implementation in this context and to determine the value of the multiple streams frameworks for studying policy implementation. It described in detail the methods used to collect the data which included both primary and secondary sources, namely observations, in-depth interviews, and document analyses. A justification was also provided for the choice of the sampling techniques and the respondents. This was followed by a discussion about how the data collected was analysed for presentation. Ethical considerations and measures to ensure validity and reliability were also discussed. The following chapter contextualises political and health governance in Zambia. The aim of is to help understand the overall institutional structure within which policy actors operate. A detailed account of the health policy context underpinned by primary health care is important for the study as it provides a solid background and context to the study.

CHAPTER FOUR: CONTEXTUALISATION: POLITICAL GOVERNANCE AND HEALTH POLICY CONTEXT IN ZAMBIA

4.1 Introduction

The aim of this chapter is to provide a contextualisation of governance in Zambia in terms of politics and health. The first part of the chapter provides a country overview, looking specifically at the demographics and the economy, and ending with the political system and presidential powers. The chapter then proceeds to discuss the health policy context and the current focus on the attainment of universal health coverage using the primary health care approach. The aim of providing such backgrounds, especially the political context, is to show the overall governance and institutional structure within with policy actors operate. It is also aimed at understanding the centralised system of governance in Zambia, to show that much authority is exercised by executive powers over decision making. The context also helps to further understand the decision by government to adopt mobile hospitals as a partial approach to health service delivery in the country despite negative feedback from several stakeholders in the country. Since the selected site for this study is Lusaka Province, the chapter ends with an overview of the province, focusing on its health facilities. The aim is to provide a context and understand the geographical environment in which mobile hospitals operate and the implementation challenges encountered.

4.2 Zambia- Country Profile Overview

Zambia is a landlocked sub-Saharan country in the central southern part of Africa. It has eight neighbouring countries, namely the Democratic Republic of Congo (DRC), Malawi, Mozambique, Namibia, Tanzania, Angola, Zimbabwe and Botswana. Lusaka is the capital city and main business hub. The latest available data from 2017 projected the national population figure at 16.4 million with an estimated growth rate of 2.9 percent, of which 49.1 percent were male and 50.9 percent female (CSO, 2018:10). Life expectancy from birth in 2018 was projected at 54.6 years. Females had a higher life expectancy at birth of 56.9 years compared to 52.2 years for males (CSO, 2018:11).

Administratively, the country is divided into ten provinces and 105 districts (CSO, 2014:1). Of these provinces, two are predominantly urban, namely Lusaka and the Copperbelt provinces.

The remaining provinces—Central, Eastern, Northern, Luapula, Muchinga, North-Western, Western, and Southern—are predominantly rural (CSO, 2014:1). The major cities are Lusaka, Ndola, Kitwe, and Livingstone which is known as the tourist capital. The official language is English but there are about 70 different local languages and dialects used in different parts of the country.

In terms of economic status, it is a lower middle-income country reclassified as such in July 2011 by the World Bank[7]. It is also classified as a medium human development nation and is globally ranked 139 out of 188 countries (UNDP, 2016:32). Since 2006, the country has been implementing the 'Vision 2030' which aims at transforming it into a prosperous middle-income nation by the year 2030 (MOH, 2010:3). Earnings from copper have continued to be the country's major economic activity despite several attempts to diversify the economy. Zambia is the second largest copper producer in Africa after the Democratic Republic of Congo. Despite some improvements registered in its macro-economic performance such as an annual growth rate of 5 percent this has not translated into positive socio-economic growth for its people especially those in rural areas: 40.8 percent of the population is classified as extremely poor, 13.6 percent moderately poor and 45.6 percent as non-poor (CSO, 2010; MONDP, 2017:3). In addition, 80 percent of these live in rural areas and rely on agriculture (UNDP, 2011). According to the 2014 Labour Force Survey carried out by the Central Statistical Office (CSO, 2015:50), about 84 percent of those employed were working in the informal sector while 16 percent in the formal sector (91.2 percent for females, 75.8 percent for males). Agriculture contributes only 9 percent of GDP, despite providing employment for about 57 percent of the the labour force, mostly the small scale farmers in the rural areas (UNDP, 2016:7)

According to the 2014 Global Peace Index, the country is classified as a peaceful, stable, multiparty democracy, and the third most peaceful country in sub-Saharan Africa (Institute for Economics and Peace, 2014). It practices a presidential system of government where the president, Members of Parliament or the National Assembly and councilors are elected through a secret ballot by the people during parliamentary and presidential elections held every five years (Government of Zambia, 2016:18). There is separation of powers among the legislature, executive and judiciary. Executive power rests with the president who can be elected for a maximum of two consecutive five-year terms as the head of state, head of government, and

[7] Each year on July 1 the World Bank revises its classification of the world's economies based on estimates of Gross National Income (GNI) per capita for the previous year. Information available at https://blogs.worldbank.org/opendata/changes-country-classifications (Accessed March 6, 2018).

commander-in-chief of the armed forces (Government of Zambia, 2016:35). The main political parties are the ruling Patriotic Front (PF), the Movement for Multiparty Democracy (MMD), the United Party for National Development (UPND), the Forum for Democracy and Development (FDD), the People's Alliance for Change (PAC), and the Rainbow Party.

The first multi-party elections since the 1960s were held in 1991, ending the one-party state system which had been in place since 1972 and beginning a new era of liberal democratic principles under President Frederick Chiluba. Chiluba took over from President Kenneth Kaunda of the United National Independence Party, the founding party of new Zambia after the end of colonialism in 1964. Until recently, elections have been held under the simple majority win or first-past-the-post principle. The newly amended Constitution of Zambia Act No 2 of 2016 (Government of the Republic of Zambia, 2016) now provides that a presidential candidate shall win 50% + 1 of the votes to be declared the winner. It also provides for the vice-president to be selected through elections as a running mate of the presidential candidate. The major participants in the Zambian policy and political processes include the Executive, Members of Parliament, local councilors and the traditional village councils. Other influential actors include civil society organisations such as church mother bodies and professional bodies and industry associations (Njovu, 2012:13)

4.2.1 Parliament and Political Parties

Article 62 (1) of the amended Constitution of Zambia Act No 2 of 2016 (Government of the Republic of Zambia, 2016) establishes that the Parliament of Zambia is made up of the President and the National Assembly. The National Assembly refers to both elected and nominated Members of Parliament. There is a total of 166 Members of Parliament excluding the Speaker of the National Assembly and the Republican President. Of this total, 156 members are directly elected by the people and eight (8) nominated by the president. The current composition of the House has the governing party, Patriotic Front (PF) occupying 89 seats while the opposition parties have a combined number of 63. The rest of the 14 seats are occupied by independent candidates[8].

The PF party which was founded as a break-away party from the governing party then, Movement for Multiparty Democracy (MMD) in 2001 came to power under Michael Sata in 2011, making him the fifth republic president. The elections were widely considered free and

[8] Parliament of Zambia. Information on House representation. Available at http://www.parliament.gov.zm/ (Accessed 20 March, 2019)

fair and the smooth and peaceful shift of power was nationally and internationally accepted (Yezi, 2013:17). Despite the transition of power from MMD to the PF being peaceful, marking the first alternation of political parties since the re-instatement of multi-party democracy in 1991, there are still challenges in the democratic system. Larmer and Fraser (2007:613-614) note that "while Zambia's democracy remains partial, disciplined, and intolerant of dissent, Zambia's democratic culture in the form of public expression of popular social attitudes towards political, economic and social change is, at least in urban areas, healthily undisciplined." The PF's tenure, particularly under President Edgar Lungu has been accused of eroding democracy, undermining democratic institutions, stifling the press, weakening the judiciary, and increasing centralisation of power in the presidency (Cheeseman, 2019). Lungu narrowly won the two previous elections, a by election in 2015 after the death of Sata and a general election in 2016.

The National Assembly is a unicameral legislature which oversees the performance of executive functions by scrutinising and appropriating expenditure of public funds by state institutions, state organs, provincial and district administration, and other institutions or bodies, among other functions. Parliamentary committees are established to conduct this surveillance in order to ensure that the executive is accountable to Parliament. There are essentially three types of Parliamentary committees: Housekeeping, General Purpose and Portfolio Committees.[9] The Housekeeping Committees include committees responsible for privileges, reforms and business of the house while the General Purpose Committee includes the Public Accounts Committee, Committee on Delegated Legislation, Committee on Government Assurances and Budget Committee. Portfolio Committees on the other hand oversee the functions of the various government ministries and departments such as agriculture, health education among others.

Political parties are also free to organize themselves and contribute to the work of Parliament through parliamentary caucuses or parliamentary groups which consist of members of a particular political party in one group or caucus (Chipenzi, Kaela, Madimutsa, Momba, Mubanga, Muleya, and Musamba, 2011:44). Burnell (2002:294) however argues that the extent to which the Parliamentary Committees' activities translate into real power and influence, and what that reveals about the conduct of government is subject to the executive discretion. It has been noted that committees place more emphasis on the details of policy and especially implementation rather than being actively involved in planning, policy advice and setting priorities (Inter-Parliamentary Union, 2009:16). For example, despite analysing the budget for

[9] Parliament of Zambia. Information on committee system. Available at http://www.parliament.gov.zm/node/109 (Accessed 07 November, 2019)

the health sector and making recommendations to be read in the House, the Parliament's Committee on Health, Community Development and Social Services neither has the legal authority to change or provide input into the establishment of the health-sector ceiling nor the power to follow up on whether or not the Ministry of Health accepts their budgetary recommendations (Inter-Parliamentary Union, 2009:25).

Burnell (2002:294) further argues that although Members of Parliament have the power to initiate both private members bills and private bills (meant to promote or benefit the interests of some particular person or group, not the general benefit), in reality, the executive has monopolised the introduction of new legislation. As such, Parliament enacts rather than makes law (Inter-Parliamentary Union, 2009:14; Chipenzi et al., 2011:45). In addition, while the reports generated by the various committees may be informative, there is also the question of the information that is not revealed by these reports, especially cases where government has withheld information or where committees have not probed deeply. This information would usually be found government-commissioned reports of inquiry, whose findings are withheld by government (Burnell, 2002:294).

Article 2 of the Constitution of Zambia (Amendment) Act No. 2 of 2016 establishes that the legislative authority of the Republic is vested in and exercised by Parliament (Government of the Republic of Zambia, 2016:21). The republican president appoints his cabinet members from among the National Assembly. The front bench consists of the vice-president who leads government business in the national assembly, and cabinet ministers who are required to work as a team. This type of arrangement entails that the executive power of the president is dominant, therefore, the president and cabinet do not serve to the full satisfaction of Parliament (Burnell, 2002:292). The executive influences the Members of Parliament to speak on its behalf because of the authority it has over its appointees (Chipenzi et al., 2011:45). In addition, since the constitution provides for the president to appoint cabinet ministers from the National Assembly, it also does not stop the president from appointing opposition Members of Parliament. This act is seen as one which weakens the opposition as it undermines the members' ability to be a watchdog to the executive, to which they now belong (Burnell, 2002:294; Yezi, 2013:30). It is viewed as a calculated move by the executive to destabilize and weaken the opposition so as to have the needed numbers when it is time to pass a bill or debate a motion (Yezi, 2013:30).

For instance, between 2002 and 2003, a total of seven opposition members were appointed to cabinet positions by President Mwanawasa in a bid to increase his party's numbers in Parliament (Simutanyi, 2005:7). This was because after the 2001 general elections, his party, the MMD, was outnumbered by the opposition in Parliament. The MMD had 77 seats including the nominated members while the opposition had a combined total of 81 seats (Electoral Commission of Zambia, 2001). A strategy to appoint opposition members to the MMD was therefore effected by appointing them as deputy ministers. This strategy has continued and even subsequent presidents, namely Presidents Sata and Lungu have done the same, in an alleged effort to maintain power over the legislature and weaken the opposition parties (Yezi, 2013:31).

The role that political parties play in policy-making is usually meant to be more pronounced in Parliament. This is the arena in which they can either influence government or demonstrate their ability to offer an alternative government. However, it has also been noted that Members of Parliament are more dedicated to their respective political parties than to their constitutional mandate of law making and being a watchdog to the government (Simutanyi, 2005). While various motions and bills are presented before Parliament, most of these are voted for on party lines as opposed to doing so objectively and on merit. A good example of this is the 2016 Constitution Amendment Act No 2 which was rammed through Parliament because of the ruling party's majority. The ruling party also formed coalitions with smaller opposition parties. Many believed this was a deceptive process which chose to ignore some of the core recommendations that the people were asking for.[10] In addition, some of the appointments made by the president to constitutional offices for example are approved by Parliament based on allegiance to the appointing authority as opposed to being merit based (Ndulo, 2016).

4.2.2 Presidential Powers

The Zambian presidential powers are enshrined in the Constitution, which is the supreme law of the land. Part VII of the amended Constitution of Zambia Act No 2 of 2016 (Government of the Republic of Zambia, 2016) vests executive authority in the President of the Republic of Zambia as both head of state and commander-in-chief of the defence force. Article 91 (1) further provides that,

[10] Statement by Grand Coalition on the Campaign for a People Driven Constitution https://www.lusakatimes.com/2015/12/17/treachery-of-the-parliamentary-amendment-of-the-constitution/ (Accessed 4 April 2019).

> *[t]he executive authority of the State vests in the President and, subject to this Constitution, shall be exercised directly by the President or through public officers or other persons appointed by the President.*

The executive functions of the president are further outlined in article 91 (2), and some of them are subject to National Assembly approval such as appointments of citizens to certain high-level positions (Government of the Republic of Zambia, 2016). The functions can be summarised as making appointments, establishing governmental departments, formulating and implementing policy, initiating legislation, giving foreign policy direction, maintaining law and order, protecting and enhancing economic and social welfare.

There have been calls by many sections of society to have Zambia's presidential powers reduced in all five constitutional amendments since independence in 1964 (Masterson, 2017:1). Yezi (2013:19) notes that not much has been done to institute checks and balances, strengthen separation of powers or constrain the executive. In fact, constitutional reform and amendments of certain provisions have been a presidential election campaign issue since the return to multiparty politics in 1991. Reducing the enormous powers that the constitution confers on the president is a major reason for these reviews (Ndulo, 2016:2). Almost every aspiring presidential candidate claims they will reduce the executive powers of the president once elected but none of them has so far done so. There was hope that the most recent constitutional amendment of 2016 would achieve this. However, not much has changed except provision for the vice-president to be a running mate to the presidential candidate instead of being directly appointed by the president as the case was before.

This politicisation of the constitution and failure to make long-lasting amendments is partly because the interests of the political elite, particularly the ruling party, at each given time are placed above the interests of the general citizenry (African Peer Review Mechanism, 2013; Chipenzi et al., 2013:35). The executive powers of the president can be exercised directly or via the cabinet or any other authorised persons or service commissions appointed by the president. However, no member of the cabinet, Permanent Secretary or head of an institution directly appointed by the president can carry out any duties without express authority from the president. This is because the overall executive authority rests with the president. Furthermore, the president also has the authority to dissolve the National Assembly. Thus, unlike purely presidential systems, the two branches of executive and legislature are not mutually independent in the Zambian case (Burnell, 2002:294).

It is not surprising that the president holds so much leverage even in institutions that are supposed to oversee the general welfare and functions of various government departments, since he appoints the heads of these institutions. For instance, in the judiciary the president appoints the judges of the High Court, Supreme Court and Constitutional Court on the recommendation of the Judicial Service Commission. However, this is not strictly followed as the president holds discretion. In addition, the appointment of commissioners is also not independent since they are usually government functionaries (Ndulo, 2016:11). Therefore, even though there is separation of powers on paper, the executive arm of the government in reality exercises more influence and dominance over the legislature and the judiciary. The appointment of judges by the president for instance affects their impartiality because of allegiance to the executive. Security of tenure is also tied to the executive in a way. In addition, the president appoints the heads of what should be autonomous institutions such as the Auditor General's Office, the Drug Enforcement Commission, the Electoral Commission, and the Anti-Corruption Commission, to mention a few. This centralised nature of governance affects and undermines the operations of all these institutions. They do not enjoy autonomy and cannot be expected to be impartial or go against the appointing authority even when they are supposed to act independently, because in reality they are accountable to the president, for instance, the fact that the Auditor General's reports must first go through the president's office before reaching Parliament compromises the autonomy of the Auditor General (Inter Parliamentary Union, 2009:20).

4.2.3 Non-state actors and state relations

The discussion of non-state actors is important to provide context to the environment in which they act, as well as necessary for the discussion in the next chapters about their impact on the policy implementation of mobile hospitals. Non-state actors are defined as organised political actors who are not directly connected to the state but follow objectives that affect key state interests (Pearlman & Cunningham, 2011:3). These actors can be businesses, donor agencies, professional bodies, or civil society organisations such as trade unions or faith-based organisations. I am using the term non-state actors here loosely to mean such kind of actors. Since the trend has now moved to governance instead of government, non-state actors have been seen to play a significant role in the policy process from setting the agendas to policy evaluations. Non-state actors are able to organise the public to engage more actively in deciding and managing matters of public concern.

Kingdon (1995) places non-state actors such as interest groups as key in agenda setting in the

political stream. This hidden cluster of participants forms a loosely knit community of specialists in a particular area of interest who try out various proposals in a variety of ways through speeches, hearings, business lunches or dinner meetings, parliamentary committee hearings, and bill introductions. They affect the alternatives more than the agenda setting, perhaps because the process of generating alternatives is less visible than the process of agenda setting. Their work usually feeds into the design of alternative proposals, but they are not necessarily responsible for shifting official attention from one item to another (Kingdon, 2003:69).

Perkin and Court (2005 cited in Tantivess and Walt, 2008:325) summarise the general role of these actors in policy and development. In agenda setting, the actors help to bring issues to the attention of policy makers through such activities as advocacy campaigns, research, and the promotion of links between policy-makers and various stakeholders aiming to influence the government agenda. In formulating policy, they provide policy-makers with the evidence necessary to assess alternatives. In policy implementation, non-state actors assist governments through provision of outreach services or serving as platforms to act upon issues that have not received the necessary attention from governments (Tantivess and Walt, 2008:330). They are important because they can enable or hinder the implementation process.

The role that non-state actors play however varies depending on political contexts. In more developed countries with advanced democracies such as the United States, they serve as avenues through which citizens can directly be involved in policy formulation and implementation (Beland, 2016). This is so because policy in these societies usually result from pressure or influence exercised by various groups or associations through lobbying and persuasion. In less democratic and low-income countries, non-state actors also play a major role in lobbying and applying pressure on governments to implement certain changes (Tantiveness and Walt, 2008). However, in most cases, their participation is very much dependant on political will. While the levels of participation may vary across policy contexts, studies have shown that in most cases, participation in general for non-state actors is somewhat constrained. This is especially the case for civil society organisations that are viewed as anti-government. The capacity to be fully involved or to be seen to have a major impact is dependent on how much space they are allowed by the state or whether they have to fight for their voices to be heard.

Non-state actors have played a major role in contributing to democracy and development in Zambia. They have mobilised into coalitions and social movements in times of crisis and always

play a role at defining moments of the country's political history, such as the return to multiparty politics in 1991, or the move to stop President Chiluba's third term bid in 2001 (Chipenzi et al, 2011). However, the space for their engagement has continued to shrink instead of emerging as vibrant (Mutesa, 2009). This is because the powers and influence of the executive also somewhat extends to non-state actors, especially civil society organisations in the country. Yezi (2013) notes that post 2011 general elections, the country has experienced high levels of political intolerance and the levels of antagonism amongst the political players, civil society organizations and sections of the media is evident. The intolerance has resulted much from perceived government manoeuvres to close up space for participation especially for opposition parties, civil society and media organisations, who are denied permits for gatherings or threatened with deregistration (Yezi, 2013:30).

A vibrant civil society is a necessary ingredient for social, political and economic development (Mulonda, Kanyamuna and Kanenga, 2018:17). It has been observed through history that Zambian civil society organisations have had to constantly negotiate for civic space whenever there has been a change in government, or more precisely a change in presidency (Kaliba, 2014:6). They do not have the required political space within which to independently engage government and air their views in order to meaningfully contribute to policy. Actors who seem to be too excited or persuasive can be easily clamped down by the state (Kaliba, 2014:5).

The view that actors involved in service provision are partners, while those involved in advocacy and governance work are suspicious, not trustworthy and somewhat confrontational is one perpetuated by government (Mulonda et al, 2018:17). For example, the private media is often seen as an enemy, as are unions who demand certain rights. However, most donors are viewed as partners because of their technical and financial support in various programmes. Zambia is considered one of the major aid recipient countries in Africa (Leiderer, 2015). For a long time, multilateral donors like the International Financial Institutions (IFIs) were the most important donors. However, since the early 1990s bilateral flows from bilateral donor partners such as SIDA and USAID have more than doubled while multilateral flows from partners like the World Bank have fallen drastically, particularly since 2005 (Wild and Domingo, 2010).

The health sector in particular receives a considerable amount of aid from donors to manage various programmes (Leiderer, 2015). The donors are key stakeholders in health policy through their participation in sector advisory committees and sector wide approaches which are ways of coordinating and managing aid given to the Ministry of Health (Ministry of Health, 2011:34).

In addition, the donors and international organisations are influential especially at global level to determine health policy that countries like Zambia must implement and which at national level are dependent on funding from these oganisations (Leiderer, 2015:1426). Despite this partnership, the priorities of policy makers sometimes triumph over those of the donors, as was the case in mobile hospital implementation. Ricci (2009) notes that although transnational and non-state actors play powerful roles in global health, states are sovereign entities in the international system and remain central to national policy decision-making and implementation. The roles of donor partners in policy is explored further in Chapter Six where I discuss the elements in Kingdon's streams as observed in this study.

In terms of citizen participation, government administrative structures are highly centralised such that citizen participation in governance issues is mostly limited to elections and political parties (Kaliba, 2014:12). There is thus a lack of institutionalised mechanisms for citizen participation in decision-making processes. A direct way in which citizens can participate in governance is through submissions to parliamentary portfolio committee meetings. But this is also not effective as submissions may or may not be taken into account due to issues related to the general composition of Parliament where the ruling party has the upper hand (Burnell, 2002). Another way that citizens participate is through community radio stations which offer a platform where citizens can freely debate and discuss issues affecting the country (Yezi, 2013:20). Almost each province has a community radio station based in one or two districts although there are still many rural districts in the country which have neither access to any Zambian radio or TV nor community radio stations (Ibid). Coverage of the proceedings of the National Assembly is also made possible via a dedicated radio station, Parliament radio where citizens can follow debates.

4.3 Health Policy Context in Zambia

This section discusses the heath policy context in Zambia to provide a firm background for understanding the system within which health policy is formed and health services are delivered in the country. It is also important to understand government's justification for mobile hospitals. I begin by discussing the overall policy framework which is underpinned by the primary health care approach. Thereafter, I present a picture of what the health system looks like in terms of management and provision of health care, disease burden, financing, human resources, and access to health services. In the last section, I give a brief overview of Lusaka Province as the research site to provide a context for understanding the implementation of mobile hospitals.

4.3.1 Health Policy Framework

The process of formulating and setting the agenda in health is largely exogenous in origin, usually the end product of international agreements and processes by international organisations such as WHO and UNAIDS. These frameworks have an impact on health policy in the country for instance in terms of the way that the HIV/AIDS agenda is carried out in the country (Hanefeld, 2009). A number of other international and regional interventions have shaped the government's agenda for health, as well as elevated its importance on a par with other social sectors such as education. These include: the right to health which was included in the 1948 United Nations Declaration of Human Rights; the Millennium Development Goals of which three were directly related to health; and now the Sustainable Development Goals which have as goal number three of ensuring healthy lives and promoting the well-being for all; the United Nations General Comment 14 in 2000 which adopted the Right to the Highest Attainable Standard of Health; the 2001 Abuja declaration in which African governments pledged to achieve significant success in the health sector by increasing government funding to health to at least 15% of the national budget; and the 1978 Alma Ata Declaration on primary health care which highlighted that primary health care was essential for all individuals and all communities. The primary health care approach continues to be the adopted means of delivering health services.

While these international frameworks are important catalysts to setting the health agenda locally, it is important to adapt or domesticate the frameworks to the local context. For instance, Mukanu, Zulu, Mweemba and Mutale (2017) note that the content of the Non-Communicable Diseases (NCD) Strategic Plan 2013-2016 did not adequately address all the major NCDs that are prevalent in Zambia such as mental illness, epilepsy, eye conditions, injuries and sickle cell disease because the plan was strongly skewed towards the WHO Global Action Plan for NCDs 2013–2030 and the 4 × 4 approach.[11] This is despite the policy process being dominated by the Ministry of Health (Mukanu et al., 2017). Needless to say, the health policy making process in Zambia can be complex and highly political due to power imbalances that exist during the process (Zulu, Kinsman, Michelo and Hurtig, 2013). They point out the great influence that policy actors power or position in the political hierarchy has in shaping the policy process and

[11] The 4 × 4 approach focuses on cardiovascular diseases, cancers, diabetes and chronic respiratory conditions as the four main NCDs and also focuses on unhealthy diets, alcohol abuse, use of tobacco products and physical inactivity as the four main preventable risk factors (WHO, 2013; Mukanu et al., 2017).

details of health policy reform, even more so than their knowledge on the subject. Gilson, Doherty, Lake, McIntyre, Mwikisa and Thomas (2003) have also highlighted the important role played by key political figures such as the minister of health in the process of health policy development during a moment of major political change in Zambia by choosing which proposals to take for implementation. Buse Dickson, Gilson and Murray (2009) thus suggest that the study of health policy needs to take into account factors such as the role of the state, the interests of various actors and the manner in which they wield power, the nature of political systems and their ways for participation.

Locally, the National Health Policies and Strategies Act of 1992 provide the overall policy framework within which health services are provided (Ministry of Health, 2011:5). Other frameworks include the Poverty Reduction Strategy Paper (PRSP), the National Decentralisation Policy and other national policies, particularly the National Health Strategic Plans produced every five years in line with National Development Plans, all aimed at achieving Vision 2030. Launched in 2006, Vision 2030 is the country's first long-term plan which expresses the aspirations of the Zambian people to become a prosperous middle-income country by the year 2030 (MONDP, 2017:51). The Ministry of Health is currently implementing the National Health Strategy Plan (NHSP) 2017–2021 with a primary health care approach at the centre of its implementation. In terms of health care the overall vision, as already mentioned, is to ensure "equitable access to quality health care by all by 2030". (MOFNP, 2011:17). The mission of the Ministry of Health is thus to ensure the provision of equity of access to cost effective quality health care as close to the family as possible (Ministry of Health, 2011:2). This has been the driving force behind the health reforms which have been implemented since 1992 when restructuring in the Ministry of Health started.

The key strategies of the health reforms include separation of policy making and operations through the reduction of the Ministry of Health structure, the decentralisation of health services management to autonomous district and hospital boards, and de-linkage of health staff from civil service (Martineau and Buchan, 2000:176). Decentralisation of health services to districts and provinces is however still a work in progress as the model which was adopted was hardly sustainable in practice (Ministry of Health, 2016:67), leading to dissolution of the health boards in 2006 while decision-making was retained at the centre. Decentralisation via devolution has been proposed whereby local government authorities are given the responsibility of delivering public services in local health, among other services (Ministry of Health, 2016:11). Health is therefore managed through the Ministry of Health headquarters at the centre, Provincial Health

Offices and District Health Offices, and at province and district levels respectively as summarised in Figure 5 below even though these bodies are not empowered with full authority for decision makingHealth care is provided in five ways. The highest level is third level hospitals, followed by second level hospitals, first level hospitals, health centres and health posts. Third level hospitals are the biggest and most specialised hospitals in Zambia, covering a catchment population of 800,000 and above. Second level hospitals cater for a catchment population of between 200,000 and 800,000 and are mainly found at provincial levels. First level hospitals are found at district levels and meant to cover a population of between 80,000 and 200,000 (Ministry of Health, 2006:3). Although the population of the country is relatively small, it is geographically scattered, making delivery of equitable health services close to families a challenge (WHO, 2013:2). Table 4 below shows the number of public health facilities according to the latest available information. (Ministry of Health, 2017:11).

Table 4: Health facilities by size and type, 2016

Description	**Total Number Countrywide**
Level 3 hospitals	8
Level 2 hospitals	34
Level 1 hospitals	99
Health centres	1,839
Health posts	953
Total	**2,933**

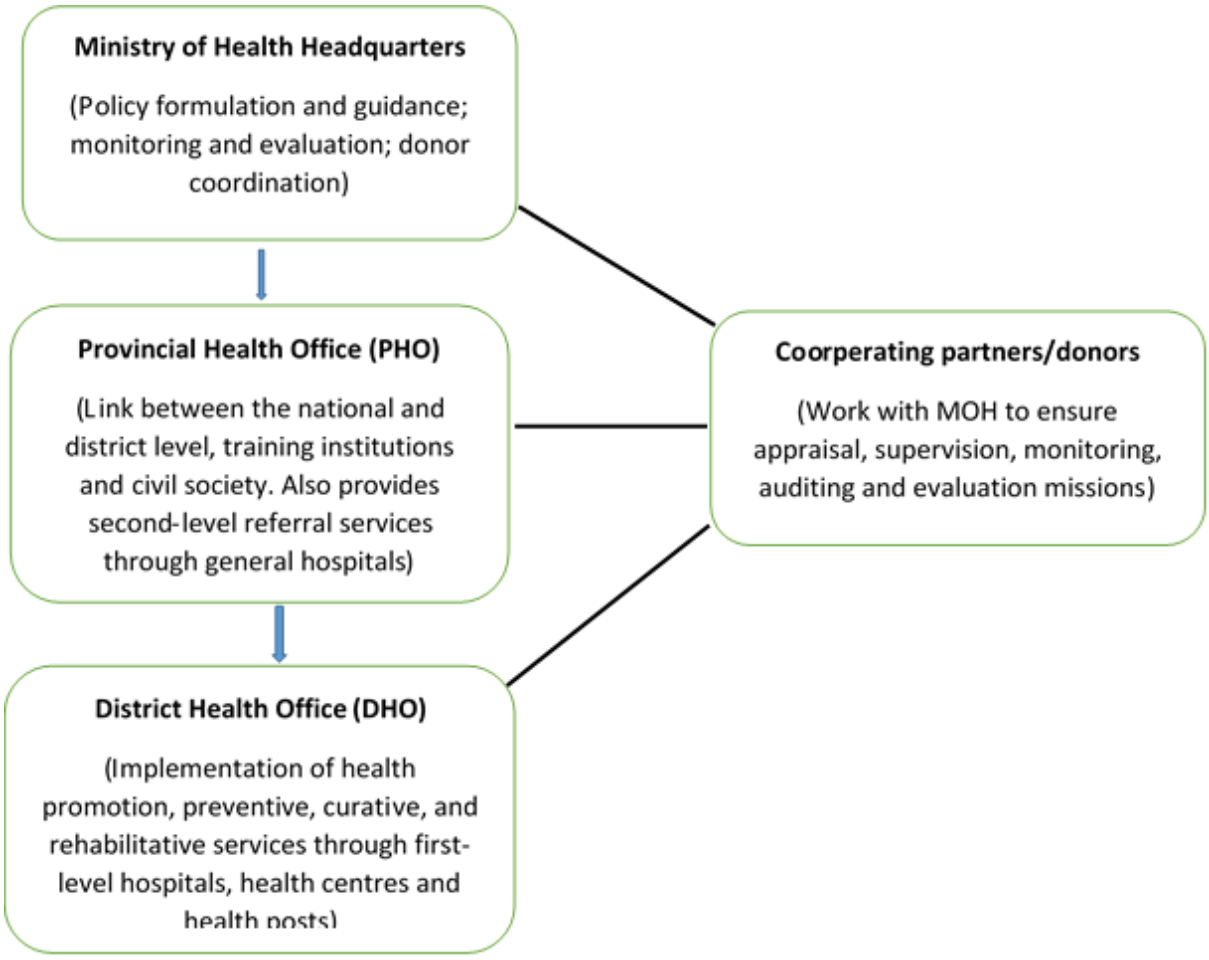
Source: MOH (2017:11)

Health care is provided by the government, private facilities, and joint efforts with other organisations such as the church. The main health care providers are public health facilities under the Ministry of Health, facilities under the Ministries of Defence and Home Affairs respectively, private facilities, non-governmental organisations (NGOs), mine hospitals and clinics, mission hospitals and clinics coordinated by the Churches Health Association of Zambia (CHAZ), and traditional healers (Ministry of Health, 2011:9). The government health facilities are still the largest providers of health care in the country despite the call for privatisation of health services by the World Bank and IMF policy proposals for developing countries in the early 1990s. The country has eight third-level hospitals, 34 second-level

hospitals, 99 first-level hospitals, 1,839 health centres, and 953 health posts. All third-level hospitals are government-owned. Of the second-level hospitals, 26 are government-owned, and eight are owned by the Churches Health Associations of Zambia (Ministry of Health, 2017:10).

Health centres are found in both urban and rural health centres. The former covers a catchment population of between 30,000 and 50,000 people while the latter serves a catchment area of 29km or a population of 10,000 people. Health posts which are at the primary levels of health care, are typically staffed by nurses and built in communities far away from health centres, and cater for a population of approximately 3,500 people. In urban areas 7,000 persons are served by each health post. Health centres, most of which are located in rural areas, form the largest number of public health facilities in the country, followed by health posts. The major activities at health centres are predominantly health promotion and disease prevention. There are some limited curative services provided, too, with complicated cases being referred to first-level district hospitals. Figure 4 below summarises the structure of the Ministry of Health. The headquarters is responsible for the overall policy formulation and coordination while the provincial and district health offices provide referral services among others. Donors provide support and oversight to the ministry in various ways.

Figure 3: Summary of the Ministry of Health Structure



Source: Ministry of Health (2016:5)

4.3.2 Health Care Financing

A trend has emerged within development assistance with the establishment of Global Health Initiatives (GHI) in order to render assistance to countries in their quest for development. These initiatives often focus on specific diseases and populations (WHO, 2008). Examples of the major GHIs in Zambia include The Global Fund to Fight AIDS, Malaria and TB (GFTAM), the Global Alliance for Vaccines and Immunisation (GAVI), the US President's Emergency Plan for AIDS Relief (PEPFAR) and the World Bank's Multi Country HIV/AIDS Programme (MAP) (Ministry of Health, 2011).

Besides domestic funding from the government, donor support to the health sector is estimated at 56 percent of the total health expenditure (Ministry of Health, 2017:75). However, it is mainly for vertical programmes such as HIV/AIDS, malaria, and TB. PEPFAR for instance is the single largest donor to the country's HIV response, contributing approximately 68 percent of HIV

funding (USAID, 2017:10). Vertical or stand-alone schemes have been criticised since they exist alongside national structures but are not integrated into them (WHO, 2008). Therefore, the Ministry has little flexibility in utilising the funds, making it impossible to fund its priorities as outlined in the health strategic plans. Scholars have highlighted how international agencies through their institutional roles, resources, and alliances shape both global and local action on health (Hanefeld, 2010; Swedlund, 2013; Gore and Parker, 2019). Like many countries dependent on donor aid, control of financial resources is the most commonly identified means by which donors influence priority setting and policy implementation in Zambia (Lundstrom, 2012; Swedlund, 2013).

The main aid formalities in the health sector can be summarised as budget support disbursed through the Ministry of Finance either as general budget support or sector budget support; off-budget or off-system project aid through vertical funds; and on-budget project aid, such as pooled funds in the form of basket funds. Donor aid in the Zambian health sector flows mainly through a sector-wide approach (SWAp), a system of coordinating and managing aid commonly used in low income countries which has been in place in Zambia since 1993 after the introduction of the health reforms (Ministry of Health, 2006). In this arrangement, there is a pooled funding mechanism whereby all donors put their money into a 'health basket', and the responsibility of using and accounting for the funds is given to the Ministry of Health. The ministry therefore has flexibility to use the funds in accordance with its priorities, mostly for district funding using separate government systems (Leiderer, 2015). The coordination of funds through SWAp has however been affected by big initiatives and vertical funds such as the Global Fund and PEPFAR, which secure major funding for the ministry but are not accounted for in the basket funding (Engstrand, 2013).

While the donors are interested in specific health issues, the funds contributed to the pool basket are not necessarily meant for any of their specific programs such as HIV/AIDS, malaria, TB, etc (Cheelo et al., 2007:30). They do however have some indirect say in how their funds will be used by influencing the priority setting in the policy meetings which they belong to, held every month. The donors are also members of the Sector Advisory Group (SAG), a high-level forum which meets twice a year to coordinate and discuss the implementation of the NHSP (Ministry of Health, 2011:34).

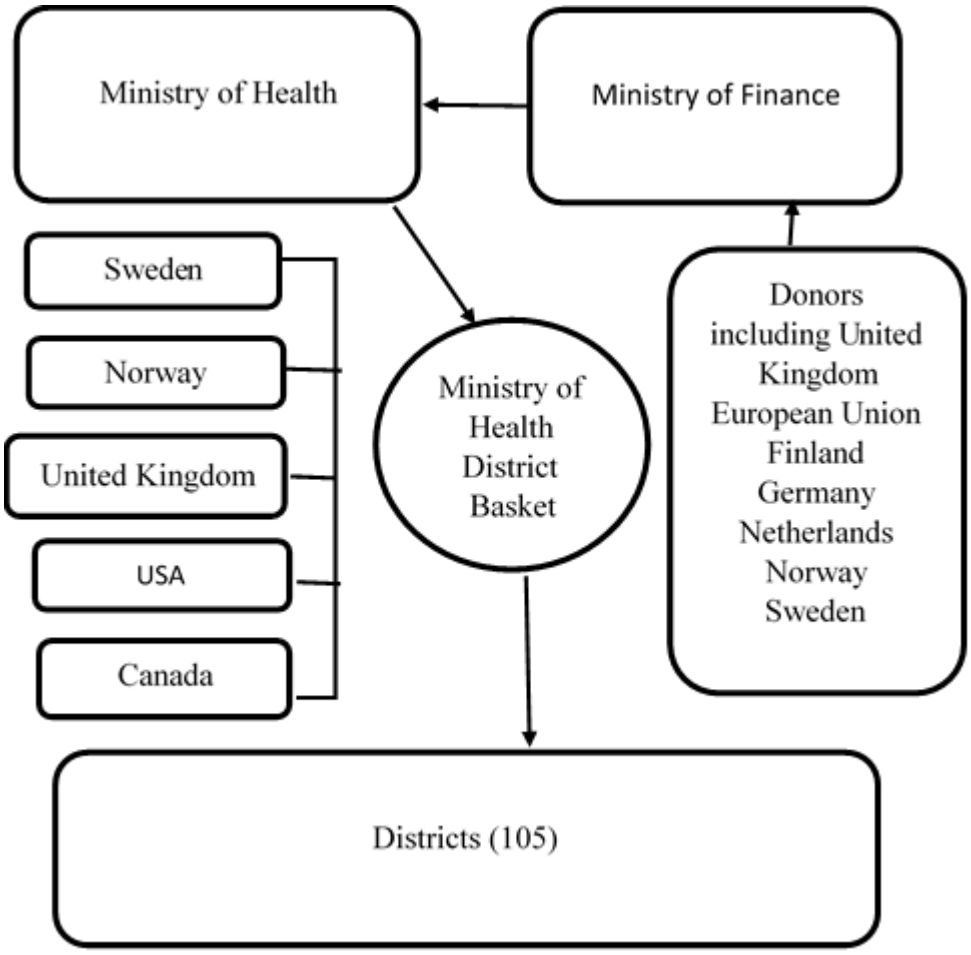
Zambia does not have a social or national health insurance scheme which means that most individual households use out of pocket expenditures to pay for health services. A National

Health Insurance (NHI) Bill is however currently being debated in Parliament and once passed may be implemented. It is envisaged that the NHI will increase the resource envelope for health and enhance universal health coverage (Ministry of Health, 2017:2). A policy report on the healthcare financing system in Zambia by international non-profit organisation Freedom to Create (2016) observed that to strengthen the overall health system, apart from developing a healthcare financing strategy outlining the challenges in financing, government must proactively enable the private sector to expand their presence, especially through participation in the NHI, devising innovative financing and care models and other public private partnership opportunities.

A key feature of the reforms since introduction in 1992 has been an introduction of user fees as a way of raising additional revenue while also instilling a sense of ownership in public health facilities by the public. The reforms were subsumed in the general economic restructuring which began in many developing countries with an emphasis on the market, including privatisation of care provision and on partially off-loading the responsibility for financing services from government to service users through direct payment or community financing schemes. The controversial introduction of user fees at all public health facilities in a bid to increase resources to the health sector and the decentralisation of health care delivery to health boards also had exemptions based on age, demographics and disease (Kamwanga et al, 2000:33; Mwanza, 2010:12). In 2006, the government abolished user fees at primary health care facilities in rural and peri-urban areas in an effort to ensure universal access to health care, especially for the poor (Masiye et al, 2008:2). In 2011 when a new government took office led by Michael Sata, it was announced that user fees had further been abolished in all health centres both rural and urban. Research shows that user fees in resource limited countries affect access to health services for the poor (Gilson et al., 2003; Masiye et al., 2008; Van Der Geest et al., 2000).

Figure 5 below gives an overview of how funds are pooled into the basket. Some donors provide budget support to the government through the Ministry of Finance which then allocates a share to the Ministry of Health for it to put into the basket. In some instances, donors also contribute directly to the basket without going through the Ministry of Finance.

Figure 5: Overview of basket funding in the health sector



Source: Adapted from Sundewall (2009:20)

4.3.3 Health Status and Disease Burden

Zambia has made significant improvements in reducing maternal and child mortality rates (MOH, 2017:2). The burden of disease is currently largely influenced by the high prevalence and impact of preventable and treatable communicable diseases, particularly malaria, HIV/AIDS, TB and STIs (MOH, 2017:7). In addition, there is a growing burden of non-communicable disease (NCD), including mental health problems, cancer diseases, trauma, sickle cell anaemia, diabetes mellitus, hypertension, cardiovascular diseases (CVDs), chronic respiratory disorders, blindness and eye refractive defects, oral health problems, and maternal and child health problems. Despite significant improvements achieved, malaria has continued to be the leading cause of mortality and morbidity in the country (MOH, 2017:7). However, there has been a reduction in malaria incidence among children under five due to the distribution of treated mosquito nets and indoor spraying (UNDP 2016:88). The HIV prevalence rate has been stabilised from 15.6 percent in 2002 to 11.6 percent in 2016 (MONDP, 2017:48).

Table 5 below highlights the ten major causes of mortality in health institutions for all ages in Zambia in 2015 according to the latest available data. Malaria and respiratory infections associated with pneumonia topped the list, while hypertension and non-infectious digestive system diseases were at the bottom.

Table 5: Ten major causes of mortality in health facilities in 2015

Disease Name	Mortality cases
Malaria	2360
Acute Respiratory Infection/pneumonia	1890
TB	1576
Anaemia	1493
Diarrhoea: non-bloody	1283
Cardiovascular	1268
Trauma	969
Severe malnutrition new case	792
Hypertension	739
Non-infectious digestive system	640

Source: MOH, 2017:7

4.3.4 Health Workforce

In the health sector the human resources for health crisis has persisted for over 20 years; numbers, utilisation of staff and morale have been major issues (MOH, 2017:1). Human resource capacity remains one of the weakest components of the health system (MOH, 2017:6). Despite some improvements since 2000, the Ministry unfortunately by the late-2000s when the mobile hospital idea was being suggested still operated under a critical shortage of staff. Rural areas were the worst off with staff population ratios almost 1:14,500 and 1:1,800 for doctors and nurses respectively, far below the WHO recommended staff population ratios of one health worker per four hundred people (1:400), with a health worker defined as a trained nurse, doctor, clinical officer, pharmacist, and laboratory, radiology and environmental technician (Tjoa, Kapihya, Libetwa, Schroder, Scott, Lee and McCathy, 2010:2).

WHO in its World Health Report (2006) recognised the general lack of human resources for health worldwide, more so in Africa in the delivery of quality health care. The Ministry of Health's Human Resources for Health Strategic Plan (2006-2010) was the first consolidated

plan to deal with the crisis in the country. The ministry and its partners resolved that a comprehensive strategy framework was needed and came up with the Human Resources for Health Planning & Development Strategy Framework in 2017 which is currently guiding interventions. According to the Ministry of Health (2017:6), there are about 1.2 physicians, nurses, and midwives per 1000 people while the minimum acceptable density threshold is 2.3 per 1000. The estimated shortage of doctors, nurses and midwives is about 14,960. However, with the projected population growth, the deficit more than doubles disproportionately to 25,849 in 2020, and 46,549 in 2035, at the current rate of human resources for health production (MOH, 2017:2).

According to the Ministry of Health (2017:1), there were 63,057 approved positions for health workers as of December 2016, but only 42,515 of these were filled, representing 67% of the approved establishment. In the same year, the ministry recruited a total of 2,071 health workers against the targeted 2,500. There was a 32% shortage or gap in health workers in 2016, a situation that is unlikely to have changed much in 2019 given the decision by government in 2018 to halt new hires due to limited funds. While government through cabinet office approves positions, the actual recruitment and filling of these positions is dependent on the availability of funds. The country's human resources profile according to the latest data available for December 2016 is summarised in Table 7 below. There is a 32 percent gap of health workers in the Ministry of Health. Dental personnel, clinical officers, laboratory personnel, doctors and midwives show a gap of more than 50 percent to be filled; the numbers are simply too few to meet the demand for health services. And most of these skilled workers are found in urban areas which means that rural areas remain disadvantaged in access to specialised care.

Table 6: Human resources for health profile-2016

HRH Cadre	**Approved Positions**	**Actual Filled**	**Gap (%)**
Doctor	3,119	1,514	51
Clinical Officer	4,883	1,814	63
Midwife	6,322	3,141	50
Nurse	18,484	11,666	37
Pharmacy	1,219	1,159	5

Radiography	542	419	23
Laboratory	2,110	921	56
Environmental	2319	1,796	23
Physiotherapy	448	432	4
Nutrition	350	202	42
Dental	908	312	66
Administration	22,353	19,254	14
Total	**63,057**	**42,630**	**32**

Source: Ministry of Health (2017:13)

4.3.5 Access to health services

Since pre-independence, the Zambian health sector has faced inequities in the provision of health care because most development and infrastructure services, including health were skewed in favour of more urban areas. Initiatives such as the introduction of the Zambia Flying Doctor Service soon after independence in 1965 were introduced to help combat disease in rural areas. Other developments in the health care system included elements of the primary health care approach such as focusing on prevention rather than cure even before the 1978 Alma-Ata Declaration (Kasonde and Martin, 1994:7). However, this conference gave direction to the process, and the government decided to adopt and start implementing the primary health care approach as the main driver of its health programmes in 1981 (Kasonde and Martin, 1994:9), and renewed this commitment at the Ouagadougou Declaration on Primary Health Care and Health Systems in 2008 (Saidou, 2010).

In line with this renewed commitment to primary health care, the government launched plans in 2011 to construct 650 more health centres across the country, to recruit more health workers for the centres, and to introduce a training programme to establish cadres of state-paid community health assistants (CHAs) (Aantjes et al., 2016:302). In addition, the government also recommitted to the Abuja declaration of spending not less than 15% of the national budget on health care. In 2011 for instance, it was one of six African countries which were meeting this (Aantjes et al., 2016:302). By 2018 however, this allocation has reduced to only 9.5% of

the national budget (MOFNP, 2018:30). Further, there are budgetary issues and irregular distribution of funds which affect access to health care (Penfold, 2015).

The major barriers to accessing health care include poor quality of health services, unavailability of medicines, financial constraints, weak outreach programmes, and long distances to health centres (Halwindi, Siziya, Magnussen and Olsen, 2013). Abolishing user fees in 2006 to reduce financial constraints was the first step in trying to attain universal coverage (Ministry of Health, 2007:10). Achieving universal health coverage is one of the sustainable development goals to be achieved by 2030 (UNDP, 2015). The goal of universal health care is "to ensure that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship."[12] While access to health care and medicines is free in public health facilities where user fees were scrapped, the low stock of medicines mean that patients are sometimes simply issued with a prescription and have to buy their own medicine (Penfold, 2015). This is not feasible for poor households and limits their access to healthcare. Research has shown that a shortage of medicines is also a major factor in determining whether or not people will go to a health facility (Chatt and Roberts, 2010:15)

Besides the inability to pay and the shortage of drugs, another barrier to accessing healthcare is the physical accessibility of health facilities. Most people live in rural areas and the distance to a health centre plays an important role in whether they are able to access health care or not. Out of a population of about 14 million people, more than half (61 percent) live in rural areas while only 39 percent live in urban areas (Central Statistical Office, 2014:3). The majority of the population live hours away from the nearest health centre and most health workers and specialists are concentrated in urban areas. Providing healthcare for all therefore remains a major challenge (Ministry of Health, 2011:12).

Because of increased costs related to transport, poor people especially struggle to access health care and medicines (Penfold, 2015). For people in rural areas travelling often takes longer per kilometer than for people living in urban areas because of poor infrastructures and lack of transport (Hortsberg and Mwikisa, 2002:72). Research has shown that distance is the main

[12] World Health Organisation note on universal health coverage. Available at http://www.who.int/healthsystems/universal_health_coverage/en/ (Accessed October 20, 2018)

barrier to accessing healthcare services in many rural areas in Zambia (Chatt and Roberts, 2010; Gabrysch et al., 2011; Hortsberg, 2003). Mobile health service provision through the use of mobile units has therefore been recommended in the rural areas where people have difficulties with mobility, to reduce cost of access to health care (Hjorstberg and Mwikisa, 2002:77). Besides mobile clinics, a flying doctor service which was established in 1965 by the government has been helping to bring health services to remote areas in the country. The services provided include treating patients on site and evacuating patients to specialised health facilities.

4.4 Lusaka Province Health Profile

This overview of Lusaka Province is aimed to give a background to the research site to understand the physical context in which mobile hospital implementation occurs. It also provides a background to the next chapter which discusses the implementation of mobile hospitals. Lusaka Province is situated in the central part of Zambia with the capital city, Lusaka within its boundaries. It is the smallest province in terms of surface area, and second to the Copperbelt province in size and population. It shares internal borders with Central, Eastern, and Southern provinces and international borders with Mozambique and Zimbabwe. According to the latest available population projection by the Central Statistical Office (2018:10), the province has a population of three million inhabitants. The province has eight Districts namely Chongwe, Shibunyunji, Kafue, Luangwa, Lusaka, Chilanga, Chirundu and Rufunsa. Chirundu and Shibunyunji are fairly new districts in the province having been formed in 2012 by the government. Shibunyunji was part of Chilanga district while Chirundu was classified as being in the Southern province. Figure 6 below shows the map of Lusaka and all the districtsA mobile hospital visits all these districts according to a schedule drawn up by the provincial hospital which coordinates all the mobile hospital activities in the province.

Lusaka Province has over 200 health facilities, including private facilities, mission hospitals, district hospitals, first level hospitals and one provincial hospital, namely the Levy Mwanawasa General Hospital (Ministry of Health, 2012) The province also houses national specialised tertiary institution hospitals such as the University Teaching Hospital, the Cancer Diseases Hospital and Chainama Hills Hospital which caters mainly to mental health patients. Within the province, there are also various government sponsored professional health training institutions such as the Dental School, the University of Zambia medical school and several

nursing schools. Despite all this the province still faces a shortage of adequate health facilities to cater for its ever-growing population, both in urban and rural districts.

Figure 6: Map of Lusaka Province and the districts in the Province

Source: CSO (2010:137).

According to the Ministry of Health (2013) report on health facilities in the country, Chilanga district has 22 health facilities but no first level hospital. Other districts only have mission hospitals which also act as district hospitals. These are Luangwa and Rufunsa districts which have nine hospitals and 16 mission health facilities respectively. Mission health facilities are supported by charity funds. Chongwe and Kafue districts have district hospitals owned by the

government. Besides this, they also have 26 government health facilities and 25 mission health facilities respectively.

Lusaka District has over 100 health facilities most of which are privately owned but no district hospital. However, there are five public health centres in high density areas which have been upgraded to first level hospitals. These are Chilenje, Kanyama, Matero, Chelstone and Chawama. There was a proposal by the Ministry of Health to demarcate the district into four zones based on these upgraded health facilities (MOH, 2015:7), but this is yet to be achieved. The zones would be run by Zonal Medical Officers who would be based at the Lusaka District Medical Office so as to improve the referral system since each zone will have a first level hospital with many other health centres in the area. This will help to decongest the two main hospitals in the province. Lusaka district currently refers patients to the University Teaching Hospital (UTH) and Levy Mwanawasa General Hospital. Figure 9 below is a map of Lusaka district, showing the various areas and townships to give an idea of the zones.

Figure 7: Map of Lusaka District

Source: CSO (2015)

4.5 Conclusion

The aim of this chapter was to contextualise Zambia's governance in terms of political power as well its health policy situation. It discussed the political system and showed how the legislature operates, including the executive functions of the president. The role of non-state actors in governance issues was also highlighted. Overall, the political governance shows a highly centralised system where the president wields a lot of power; enough to influence decisions of Parliament. In the discussion on the health policy context, the chapter showed that primary health care is the adopted means of delivering health services in which universal health coverage is the goal. It showed how the health system is managed as well as the challenges faced such as ensuring access to health services, and a lack of human resources for health and the high disease burden. This discussion was necessary to provide a background to help understand government's justification for implementing mobile hospitals amid strong

criticisms from various stakeholders. An overview of the research site, Lusaka province was also provided to help understand the health challenges faced in the province and to provide a background for the next chapter which contextualises mobile hospital implementation in the province.

CHAPTER FIVE: IMPLEMENTING MOBILE HEALTH UNITS: CONTEXTUALISATION BOTH INTERNATIONALLY AND LOCALLY

5.1 Introduction

The previous chapter noted that access to health services is one of the major challenges facing the Zambian health system and that mobile health service provision has been recommended as one way to address the barriers associated with this. This chapter builds on this discussion by contextualising the use of mobile health units as a means to provide health services not only in Zambia, but also in various countries and contexts across the globe. It is important for the study to understand what mobile health units are and how they function as a means of providing health services. It is also important to show that despite their use in many settings, there are limited cases where they are being used the way that Zambia is. This is by going beyond providing primary health care to include secondary care, as well as being integrated in the overall health system as another way of providing health services. Therefore, the aim is to provide an answer to the first sub research question posed, namely to find out in detail what the implementation of mobile hospitals entails, particularly in the Zambian context. The review of the mobile health unit initiatives in various contexts is neither exhaustive nor all-inclusive because some of these efforts are locally focused and may not be reported in the published literature. Reviewing the initiatives is however a way to cite examples of the contexts in which mobile health units are being used across the globe, and their preference over static facilities. The focus is on mobile health units transported by means of vehicles which is the most common way of doing so.

The chapter thus begins by describing explaining mobile health units, and citing their advantages and disadvantages over static health facilities. It then proceeds to discuss their use in various contexts including developed countries, developing countries and in crisis situations. The chapter further looks at mobile health units in Zambia, as provided mainly by partner organisations working in the health sector and by the Ministry of Health through the mobile hospitals. It discusses the agenda setting and policy formulation of the mobile hospitals. It concludes by highlighting some of the challenges faced in implementing these mobile hospitals. It is important to note that the chapter uses the terms mobile health units and mobile hospitals in such a way as to distinguish that the former is a more general term used in the literature while the latter refers specifically to the type of mobile health unit provided by the Zambian Ministry

of Health - which are mini hospitals. They are referred to as hospitals because of the wide variety of health services they offer, similar to a mini hospital or provincial hospital. Overall, the chapter shows how mobile hospitals are implemented in Zambia and concludes that despite being useful, they are expensive to run.

5.2 Discussing mobile health units

The development of mobile technologies and the increasing importance of health service delivery have led to the emergence of mobile health services around the world. Mobile health services use technologies such as mobile phones or mobile vessels to deliver services across populations. While mobile and wireless communication technologies for accessing health and health care have increased, there has not been such an increase in the use of mobile health units to deliver health services across populations from one area to the other. Rather, what is common is they can be used as and when needed. This section on mobile health units shows that these facilities are better placed to deliver health services in many circumstances than static health facilities.

Mobile health units can be in the form of air, water or road transport. Providing emergency and primary health care services to hard-to-reach communities by air for instance is a common feature of most health systems around the world, known as flying doctor services. Established in 1928, the Royal Flying Doctor Service (RFDS) of Australia is listed as the longest running tele-health provider and aeromedical retrieval service in the world (Margolis and Ypinazar, 2008). Besides primary health care, other services normally offered by flying doctor services include emergency responses to diseases, emergency evacuations, training opportunities, and delivering tele-medicine.

Health services are also delivered using water transport by means of boats. Boat clinics are common where communities are geographically isolated such as islands or isolated areas due to floods or similar conditions. Lower income countries mainly in Africa, Asia and South America make use of boat clinics to serve isolated areas. India and Bangladesh are among the countries leading in the use of boat clinics to deliver health services (Arora, 2011:8; Sangstha, 2007:3). There are also mobile health units which take the form of trains, bicycles, and motorbikes to reach target populations. In India and China for instance, a hospital train goes to remote locations to help people with disabilities and provide eye surgeries to the poorest (Chatterjee, 2010:1860). Bicycles and motorbikes are usually used in rural areas that are hard to reach by regular vehicles due to bad terrains. For instance, in Kenya, a mobile clinic that uses

motorbikes is furnished with cooler bags of basic medications and vaccines, and travels to villages far from health centres three days a week (Centre for Health Market Innovations, 2010). The literature shows that mobile health units in the form of vehicles or cars are the most commonly used. A key feature of all these units is that they are not stationed in a particular place but move from one location to the other according to their schedules.

Over the last four decades, mobile health units have been used globally to address many public health issues such as controlling disease, infections, health education, and vaccinations (Hawkins, 2007:2). They now have expanded access to include caring for many underserved segments of the population that are hard to reach by traditional systems. Since providing suitable and timely services is one of the main challenges in the health care system of almost every country, mobile health services have been increasingly considered in health care policies in many countries in recent years (Abbasi et al., 2016:1). The advancement in technology and health has contributed to the use of these services, especially to conduct outreach programmes to disadvantaged areas. Outreach programmes are a key strategy for providing services to underserved or hard-to-reach populations.

Mobile health units also form part of strategies involving the provision of occasional ambulatory health services (Mortier and Coninx, 2007:1). Mobile health units are customised vehicles that travel to communities, both urban and rural to meet the demands of combat situations by providing health services in comparison to a fixed hospital (Bolster, 2006:115). The units operate on some kind of a fixed schedule reaching villages at specific intervals such as weekly or monthly (Buch, 1984:1). Transport support systems must be present and the service must aim at true community participation (Bolster, 2006:116). The units usually have the required equipment for temporary admission and treating patients in critical situations, and sometimes have the necessary equipment for specialised medical services (Abbasi et al., 2016:1). In order for the units to operate well, they must have regular visiting schedules, enough trained staff, equipment, adequate drugs, proper record systems, and other necessary facilities.

The staff of the mobile health units vary based on the services offered. In most cases where primary health care services are offered, nurses are usually the most senior care givers, while in other cases doctors and specialised staff are part of the team. Volunteer staff are common in mobile health units, especially in developing countries where they are heavily relied upon (Hanson, 2012:6). In terms of funding, few are fully sponsored by the governments. Most of them are run by charity organisations or faith- based organisations from donor funds, and some

are supported by private organisations (Hanson, 2012:7). Mobile health units usually overcome barriers of time, money, and trust, and provide community-tailored care to vulnerable populations (Hill Powers, Jain, Bennett, Vavasis and Oriol, 2014:261). They are most commonly used on a temporary basis, such as in emergency relief, in situations where health services are inadequate or absent, or before the opening of more permanent health facilities.

5.2.1 Advantages of using mobile health units

The International Committee of the Red Cross (ICRC) recommends the use of mobile health units in emergency relief settings (Mortier and Coninx, 2007:2). In many instances, mobile units prove efficient in providing care and treatment in natural disasters or emergency cases such as tsunamis, hurricanes or earthquakes. However, their use extends well beyond emergency relief as a variety of services are provided, and include promotive, preventative and curative depending on the population's needs (Hanson, 2012:4). The units offer flexible and viable options for treating isolated and vulnerable groups that stationary health facilities do not. They often operate in ways that address temporal, geographic and cultural barriers to health care utilisation (Hawkins, 2007:2), and are also used for services such as screening for diseases or for voluntary counselling and testing in many communities, including urban areas (Oriol et al., 2009; WHO, 2014).

Studies suggest that mobile health units are able to provide necessary health care services with acceptable efficacy in places which do not have adequate that infrastructure required for static health centres. They are usually reported to as successful in ensuring delivery of services such as prenatal and antenatal care, medications, vaccines, clinical rounds and educational initiatives to rural areas (Peters, Doctor, Afenyadu and Findley, 2014:643). By providing services for various groups of people in both urban and rural areas, such as women, children, the elderly and the poor, mobile health units answer the health needs of these populations that may otherwise prove impossible. Moulavi, Bushy, Petersen and Stullenbarger (1999) argue that mobile health units are successful especially if they aim to provide primary health care services to far-flung areas of the country where people find it difficult to access treatment. Even though most mobile health units focus on offering vertical primary health care services such as screenings, prevention or reproductive health, as opposed to comprehensive primary health care services, they do help to improve the health situation of individuals (Abbasi, et al., 2016:2).

Research has shown that mobile health units impact positively on access, cost and quality by expanding access for vulnerable populations, improving chronic disease management and

reducing costs for clients (Hill et al., 2014:262). Research has also found that people appreciate the informal, familiar environment in a convenient location associated with mobile health units, thereby building trusting relationships (Hill, Zurakowski, Bennet, Walker, Osman and Quarles 2012:409).

5.2.2 Disadvantages of using mobile health units

Despite their advantages and successes where they are used, mobile health units remain a controversial way of providing health care due to irregular service provision, cost, and cumbersome logistics involved (Mortier and Coninx, 2007:1). In addition, they rarely have lasting effects particularly in situations where follow-ups are needed. Their main objective is to improve access to health services by groups that do not have access to them and are often used as a last resort (Mortier and Coninx, 2007:1).

In a comprehensive study of the mobile clinic sector in the United States, Hill et al. (2014:241) found that the implementation of mobile health units was certainly demanding and there was insufficient evidence about their feasibility due to limited research. Abbasi et al. (2016) reviewed the challenges presented by mobile units in the literature and found that in most cases, their place in the health care system is uncertain According to Hill et al (2016:241), the lack of resources to evaluate, advocate and share best practices for their use has reduced their visibility in the healthcare sector. The main disadvantages of using mobile health units are financial, structural and procedural problems, lacking certain tools and specialisations and the unwillingness of people to use the facilities (Abbasi et al., 2016:2).

Inadequate financial resources is one of the greatest limitations of mobile health units to function effectively. It is not surprising that they are expensive, and therefore often do not have receive government commitment and dedication in the form of funding. The most commonly reported sources of financial problems are lack of infrastructure, initial investment in purchasing, adapting and maintaining vehicles, as well as the high cost of equipment and medicines (Hanson, 2012:7).

In view of this, feasibility and cost issues must be assessed before considering mobile health units, especially in situations that are not emergencies. Moulavi et al. (1999:36) discuss various factors that must be considered when planning for a mobile health unit. These are:

- whether the mobile health units are appropriate for the population to be served
- whether to combine multiple services in one vehicle or to have only a single service unit

- whether mobile health units are the most cost-effective option of delivering health services
- whether funding and maintenance of the units are feasible in the short to medium term
- how to integrate volunteer services
- how to secure appropriate staffing to operate the unit
- what type of vehicle is best suited to deliver the services

While mobile units usually provide services that would otherwise be difficult to access, the location and schedule of the clinics can hinder successful operation (Aljasir and Alghamdi, 2010:1085). The services offered through mobile health units must be able to live up to community expectations to build trust and confidence from the community. In order to gain trust and confidence a community-oriented programme, detailed schedules and a commitment to follow-up on the schedule are vital (Dash, Muraleedharan, Prasad, Acharya, Dash and Lakshminarasimhan 2008:21; Hamel, Kutzner and Vorderwülbecke et al., 2015:6). Dash et al. (2008:5) recommend for governments to conduct operational research through studies on vehicle schedules and visits to various sites to maximise their coverage.

In addition, governments must decide on a fixed package of essential services to be delivered through the mobile health units. Awareness promotions and acceptance of mobile health units by the local population is therefore very important. Community members need to be aware of the services available through the mobile units to ensure maximum utilisation of the services and to adequately meet the expectations by matching the needs of the serviced area (Dash et al., 2008:5; Aljasir and Alghamdi, 2010:1090).

Mobile health units cannot match static health facilities in terms of delivering a broad range of health services consistently (Peters et al., 2014:643). Monitoring patients may not be easy. The units can only operate at a certain central point and when the time comes, they leave and the service is no longer available until the next time it is scheduled to visit the area. Because of this, effective follow-up is difficult (Moulavi et al., 1999:35). These units can therefore not be viewed as substitutes for primary health care centres; rather they should exist alongside static facilities and complement them. A study conducted in rural Saudi Arabia to determine user satisfaction of mobile clinics revealed that more than 90 percent of users felt they could not depend on the mobile clinics to meet all their routine or emergency care (Aljasir and Alghamdi, 2010:1086).

5.2.3 Use of mobile health units in developed countries

Mobile health units are generally used to provide direct medical and health care services, social support, case management services, health promotion and disease prevention activities, and referral to medical and social resources in the community (WHO, 2016:2). They are commonly used in emergency situations, to reach underserved communities, or to complement static health facilities by offering certain services strategically. The choice of services offered differs, but usually encompasses a range of preventive measures such as immunisation, health promotion and disease screening, as well as curative services such as surgical or dental care (Mortier and Coninx, 2007:1). Typically however, in most developed countries mobile health units provide mainly routine emergency health services, preventive services such as immunisations, maternal health services like emergency contraception, blood pressure and blood sugar screenings, voluntary and counseling testing services and general advice on health care (Peters et al., 2014:643).

As has been established, mobile health units operate in specific contexts to provide certain services to particular populations. In most developed countries, mobile health units are regarded as very useful for screening campaigns such as breast cancer, uterine cancer, tuberculosis, and, more broadly, for health promotion and preventive activities (Mortier and Coninx, 2007:2), than for curative activities, and are typically used in urban settings to improve citizen satisfaction. For example, in the former Yugoslav Republic of Macedonia, mobile clinics mainly supported by the United Nations Population Fund Agency (UNFPA) provide sexual and reproductive health services to women, mostly those caught up fleeing conflict (UNFPA, 2016:1). In London, a mobile clinic provides health education and risk awareness to young people aged 12-25 years (Edgecombe and Rourke, 2002) while in Australia, a mobile clinic provides screening and health promotion services to the local Aboriginal people (HSCC, 2014). Mobile clinics are also a popular way of delivering health care services to people across Canada, especially the homeless (Whelan, Chambers, Chan, Thomas, Ramos & Hwang, 2010). Funded mainly by corporate and charity organisations, these mobile clinics provide services such as dental, normal medical services, counseling rooms and overall preventative or diagnostic testing services (Whelan et al., 2010)

Since mobile health units are usually used for health promotion, Hamel et al., (2015) for instance suggest that they could be looked into as a model for the provision of health care in rural regions in Germany. In a few cases, mobile health units also provide surgical services, such as the mobile surgical service bus in New Zealand which provides specialist services and

surgical care to rural communities (Bax, Shedda and Frizelle 2006). In Colorado in the United States, curative services such as internal medicine clinics for service veterans are provided by mobile clinics (Mortier and Coninx, 2007:1).

It is estimated that about 1500 to 2000 of the clinics on wheels in the United States visit about 5 million to 6 million patients every year (Hill et al., 2014:261; Srinivasan, 2015:6). The mobile clinics are widely used to service communities that have limited access to decent health care due to lacking or inadequate health insurances, or they live far from health care centers. These usually include racial and ethnic minorities, the homeless, displaced populations, recent immigrants, migrant workers, children and nomadic reindeer herders in Alaska who would otherwise be deprived of health services (Hill et al., 2014:262; Mortier and Coninx, 2007:2; Srinivasan, 2015:4). The clinics offer primary and preventive care through such services as screenings for various health issues and treatment for minor injuries. The majority of these mobile units exist as independent entities and some are run by health facilities or academic medical centres. Funding is largely dependent on philanthropic gestures more than state funding (Hill et al., 2014:262).

5.2.4 Mobile health units in crisis/war situations

The demand for mobile health units has been rising, especially in crisis situations as they are recommended for providing quick, suitable, and quality health services (Martier and Coninx, 2007:2; Abbasi et al., 2016:5). The World Health Organisation (WHO) supports the use of mobile health units by either supplying them, or paying for partners to buy or supply them (WHO, 2016a). In 2015 for instance, it provided 34 mobile clinics to Syrian health non-governmental organisations to serve populations in hard-to-reach areas. It further supported the operation of mobile clinics in countries affected by war and conflict in the Middle East such as Iraq, Jordan (to assist Syrian refugees), the Syrian Arab Republic, the Ukraine and Yemen, among other countries (WHO, 2016).

In many of these countries, mobile clinics assist in tackling the health needs of displaced populations including migrants and refugees who live in places such as camps, informal settlements, and in urban and remote areas across the country that have limited access to health care services. In the Ukraine for instance, mobile health units provide primary health care to internally displaced people (IDPs) and communities in conflict areas, giving over 1600 consultations per week (WHO, 2015:1).

In Afghanistan and many other post-conflict environments such as Rwanda, Bosnia, Serbia, Kosovo, Cote d'Ivoire and Nepal, among others, mobile clinics are considered a vital element of peace building through providing primary health care in remote and deprived areas (Morikawa, 2011:55). In most of these countries, support and funding for the mobile clinics comes from various international organisations and governments, rather than from the national governments.

5.2.5 Use of mobile health units in developing countries

Mobile health units can be an effective a way of improving access to health care in developing countries where the majority of the population has to walk long distances to access nearest health centres. In most developing countries, 40 to 60 percent of people are estimated to live more than 8 km from a health care facility (Karra et al., 2017:821). In many of these countries, mobile health units are usually mainly funded from state funds, with assistance from donor agencies. The units are also often used to bring vertical or specific programmes to remote areas (Mortier and Coninx, 2007:1).

In most cases they deliver health services to neglected or underserved communities. In India they have been an important tool for delivering health care to neglected tribal areas since the early 1950s, supported by the state and other partners (Dash et al, 2008:7). In Kenya too, mobile clinics are used to deliver health care services to the Masai who usually live in secluded areas (Hanson, 2012:3) while in Zimbabwe they are commonly used by rural farming communities (Vos, Borgdorff and Kachidza, 1990).

In certain cases, children and pregnant women are especially targeted for nutrition services as they are most vulnerable in this area. In central Chad for instance, mobile clinics are useful to the nomadic population, mainly women and children who struggle to access the necessary healthcare and nutrition services they require (Wanless, 2016). In Somali and Ethiopia, mobile health units supported in part by donor agencies provide health and nutrition services such as maternal health and child malnutrition to women and children (Jensen, 2012). Mobile clinics are also useful for providing sexual and reproductive health services. In Egypt for instance, mobile clinics provide services such as family planning, medical care during pregnancy and after childbirth, and other similar services to rural areas that are at least 3 km away from the nearest health centre (Ghada and Al-Attar, 2009).

Studies also show that providing primary health care services, including voluntary counseling and testing for HIV using mobile units has been successful and is a common feature in many

countries. Mobile units are reported to reach individuals in the early stages of HIV infection or those who may be at higher risk but do not have access to health services (Hanson, 2012). For instance, in Malawi, some remote villages have been accessing HIV counseling and testing through mobile clinics supported by the government and international donor agencies since 2008 (Lindgren, Deutsch, Schell, Hart and Rankin, 2011). In northern Nigeria, primary healthcare services are offered at no cost to rural populations in hard to reach areas which are more than 10km from a health facility (Peters et al., 2014). In Mozambique too, antiretroviral therapy is offered on top of primary health care in order to address transport challenges to accessing HIV services (Schwittersa, Lederera, Zilversmitc, Gudo and Ramiro, 2015).

Mobile clinics have proved to be effective for screening diseases such as cancer or infectious diseases in rural areas in several lower income countries, where existing screening activities do not effectively reach the populations at risk. This is the case in Thailand (Swaddiwudhipong, Nguntra, Mahasakpan, Tatip and Boonmak, 1999) as well in South Africa where mobile clinics supported by various organisations travel to various rural areas to reach both women and men who would otherwise not have access to screening and other services (Kennedy, 1997).

5.3 Providing health services using mobile health units in Zambia

A number of mobile health clinics offering various services have been piloted in different parts of Zambia targeting rural populations for campaigns such as immunisation, antenatal and other primary health services (Mupela, Mustarde and Jones, 2011). These clinics are either run or supported by charity organisations. In the Eastern province for example, a pilot project called ‘The Virtual Doctor Project’ uses mobile clinics to facilitate free doctor-supported primary healthcare to remote under-served areas to mitigate a shortage of skilled staff in the country (Mupela et al., 2011). The project is modeled around telemedicine whereby doctors offer their time and expertise from the comfort of their own consulting rooms using modern communication technologies, rather than going to remote locations to render their services. The mobile clinic therefore travels to village sites equipped with relevant technology to set up temporary clinics.

At rural health centres in Mumbwa district, one of the districts in the Western Province of Zambia, a mobile anti-retroviral therapy (ART) service was introduced as a pilot project by the Ministry of Health in 2007 to improve accessibility to ART services (Dube, Nozaki, Hayakawa, Kakimoto and Simpungwe, 2010:78). It was reported that due to the mobile service, the number

of ART clients in the district increased as they did not have to travel very long distances to reach the nearest health centre (Dube et al., 2010:80). Because of this, people may have been persuaded to go for voluntary counseling early enough and commence on ART in the early stages of contracting the virus.

Mission Medic Air (MMA), a charity-based mobile medical service that uses light aircraft to reach remote rural areas of the country has been operating a mobile medical clinic known as Longezia since 2006 in a rural district of Sinazongwe in the Western province (Mupela et al., 2011:3). The MMA operates on a purely volunteer basis, where medical specialists donate their time and expertise to help people in remote areas. The specialists hold clinics and attend to various ailments ranging from malnutrition, anemia, and eye problems to surgeries such as intestinal blockages, cesarean sections and amputations. Seriously ill patients are transported to urban hospitals and MMA brings vaccines and medications to the remote locations they serve.

Beit CURE Hospital, a charity hospital that provides free treatment to children, uses mobile clinics for most of its outreach programmes. The hospital provides paediatric teaching and specialises in the treatment and care of children living with physical disabilities. In 2010, it launched a mobile Ear Nose and Throat (ENT) mobile clinic, aimed at providing services to the rural poor who cannot afford to travel to Lusaka for specialised medical services. The mobile clinic is equipped with modern specialised equipment to attend to patients with ENT complications

Mupela et al. (2011:8) caution that while many mobile health clinics around the country continue to fill the gap left by the main health care system of the country, they should not continue being dependent on charity funding because it is not guaranteed. They point out that sustainability depends on their transition into the main health delivery system of the country at some point. This transition has occurred as the government introduced mobile hospitals in 2011 to operate alongside static health facilities as a means of ensuring access to health services for all.

While the literature shows evidence in support of the use of mobile health units in varying situations, most of the available literature focuses on the operation of mobile health units in specific contexts, the types of services offered (particularly for primary health care delivery), and the number of people accessing them. However, there seems to be a lack of sufficient evidence which focuses on their use in providing secondary care, particularly in developing countries. There is also very little documented on their implementation in low resource

countries, particularly those with full support from their governments. Zambia is such a country where mobile health units have been incorporated in the main health care system with funding from the government. The following sections discuss the agenda setting, policy formulation, and implementation of these mobile hospitals. This discussion is important to tell the 'implementation story' which serves as background to the analytical chapter on coupling and streams.

5.3.1 Agenda setting for mobile hospitals

President Rupiah Banda announced the government's intention to purchase and implement mobile hospitals for rural areas in his first speech as Republican President to the 9th session of the National Assembly in January 2009 (Banda, 2009). He was elected as President in November 2008 after the death of President Mwanawasa on August 19, 2008. Mwanawasa suffered a stroke in June 2008 while attending an African Union meeting in Egypt and was admitted in a Paris hospital where he passed away.[13] The law stipulated that elections had to be called within 90 days and the presidential by-elections were held on October 30, 2008**.** Based on a single round of the first-past-the-post system, Vice President Banda, the presidential candidate for the MMD, won the competitive election with 40.09% of the vote against his closest rival Mr Sata of the Patriotic Front who won 38.13% of the vote (Electoral Commission of Zambia, 2008). President Banda was to serve the remainder of the late Mwanawasa's term, ending in September 2011.

During the campaigns leading up to the 2008 election, there was no indication from Mr. Banda's camp that they intended to provide mobile units as a way to help alleviate problems of access to health care in rural areas. Rather, Mr. Banda often stated that he was there to finish off Mwanawasa's legacy, and would continue with the programmes that were already in place (Kyambalesa, 2009; Nkonde, 2011). Some people argued that mobile hospitals were not part of that legacy (Zambian Economist, 2009). Further, it was believed that the idea to have mobile hospitals came mainly from outside the health sector. President Banda mentioned in his own words that the concept to procure mobile hospitals came from the Chinese but that it was a good idea.[14] The Chinese state owned firm that supplied the mobile hospitals, Aviation Industrial

[13] Read more at https://www.reuters.com/article/us-zambia-president/zambia-president-mwanawasa-died-in-france-idUSLJ48660020080819 (Accessed March 3, 2017)
[14] President Banda speaking on mobile hospitals. Available at http://maravi.blogspot.com/2009/05/hakainde-is-right-about-rupiahs-deals.html (Accessed June 12, 2017)

Corporation of China (AVIC) International thus proposed the idea to government, and coupled it with issues in the health sector related to accessing health services in the rural areas. While it is not clear how much it pushed the president and his government into having mobile hospitals, it was clear that it had a significant influence on the president as he went against all criticism and advice in order to have mobile hospitals. In the words of one senior doctor from the medical association, the idea "*was proposed by China and imposed on us by the president and his government."* (Interviewee M, 2016). Secondary sources also confirmed that the idea to have the units came from outside the health sector and indeed from AVIC International (Morangi, 2016).[15] According to its website, AVIC International commits itself to commercial transportation industry, cooperating with the global partners and actively participating in the development of international programs.[16] AVIC International is also one of government's largest contractors, contributing to infrastructure development through construction of roads, bridges, houses, and airports among others.[17]

China's growing role in Africa has been a subject of debate in the literature. According to Johnston and Yuan (2014:8) aid, investment and trade are the major arterials that define China-Africa economic ties. While businesses around the world are connected to states through purchasing, taxes and incentives, Kaplinsky, McCormick and Morris (2010:396) note that Chinese business engagement is Africa is different because much of its foreign direct investment into Sub-Saharan is from wholly or partially state-owned firms with access to very low-cost capital, and operating with much longer time-horizons. Despite criticism from various sectors in the country over Chinese engagement in Zambia, China's role as a non-traditional donor in Zambia is increasing (Kragelund, 2014). Zambia is the third largest recipient of Chinese foreign direct investment in Africa, and the nineteenth largest in the world (UNCTAD, 2007 cited in Carmody, Hampwaye and Sakala, 2012:217). China and Zambia have in fact had long established ties, dating from independence. After independence in 1964, Zambia was the first country on the continent to enter into diplomatic relations with China (Engstrand, 2013:14).

In his inaugural speech at his swearing-in ceremony as President of Zambia on November 3, 2008, President Banda declared that his government would continue investing in health care citing "new and refurbished hospitals, better training for doctors and nurses and a strengthened

[15] More at http://www.chinadaily.com.cn/a/201608/05/WS5a2b86cea310eefe3e9a0e5a.html (Accessed 1 October, 2019)
[16] AVIC website http://enm.avic.com/aboutus/overview/index.shtml (Accessed 10 September, 2019)
[17] Zambia Daily Mail. May 27, 2019. Available at http://www.daily-mail.co.zm/avic-true-ally-in-national-development/ (Accessed November 03, 2019)

staff retention scheme." (Banda, 2008:6). Being a new president and starting his own administration, it can thus be argued that this was part of a strategy. According to parliamentary debates, it was first time that the public, including Members of Parliament heard of this initiative.[18] It took most people by surprise, and they did not support it. This led to accusations from some sections of society that officials like the president himself were benefiting from the deal.[19] The units were purchased at a cost of a US$53 million concessional loan from AVIC International to be paid in 40yrs at 2% interest rate (Kyambalesa, 2011). Many questioned the need for a mobile unit that gobbles up thousands of dollars for every outreach instead of building infrastructures and investing in long-term measures to improve the health system. Some critics cited that bad terrains in most rural areas would become either impassable or non-existent in the rainy season, that there was a shortage of health staff countrywide, and that the project entailed huge administrative and maintenance costs, and others saw it as a political move to appease the rural population since general elections were approaching (Zambian Economist, 2009). It is against this background that many argued there were other alternatives which could have been considered, and which would have been more beneficial in the long run.

However, the government argued that the concept of mobile health clinics was not very different from the Zambia Flying Doctor Services, only that the latter moves in the air and the former on land but they both target rural and disadvantaged areas (Simbao, 2011:4). Further, it was envisaged that mobile hospitals were in line with the Ministry of Health's vision to ensure equity of access to affordable, cost-effective and quality health services that are as close to families as possible (Ministry of Health, 2010:3). It is estimated that about 70 percent of Zambians live within nine kilometers of a public health facility (Simbao, 2011:4).

Because of the backlash from stakeholders, a government spokesperson at the time noted that it had put together a technical committee team to study the feasibility of having mobile units and would be advised by this team on the way forward.[20] A presentation on mobile hospitals had already been made by AVIC to senior management in the Ministry of Health, after which a committee was set up to scrutinise the proposal and make recommendations (Chilemba, 2009). The government stated that it was going to listen to the views of the people and experts

[18] Parliamentary debates October 7, 2009. Available at http://www.parliament.gov.zm/node/1664 (Accessed June 10, 2016).
[19] Lusaka Times Online. July 29, 2010. Available at https://www.lusakatimes.com/2010/07/29/saga-mobile-hospitals/ (Accessed May 5, 2017).
[20] Lusaka Times Online, April 29 2009. Available at https://www.lusakatimes.com/2009/04/29/mobile-hospitals-initiative-to-be-determined-by-technocrats-shikapwasha/ (Accessed 20 August, 2017).

before making a final decision. Informants interviewed however, pointed out that even though experts and consultants in health, particularly people already working in the Ministry of Health, were invited to the meetings some donors refused to be part of the meetings stating that government was not being honest (Interviewees K, L and N, 2016). Other stakeholders such as the worker unions also disagreed with the government, noting that it had already made a decision and had ordered the units (Chilemba, 2009).

An interview with a senior official from the medical association also revealed that while there was a different mix of specialists who studied the proposal for mobile hospitals, they were all mainly from the Ministry of Health, therefore the intention was somewhat biased (Interviewee M, 2016). The government later stated that the committee put in place to study the proposal decided that the concept of the mobile hospitals should be supported in *principle* (my emphasis), while continuing to seek guidance from the Ministry of Finance and National Planning and the Zambia Public Procurement Authority (Mtonga, 2009). This further suggests that the deals had already been signed and going against a presidential decision was not possible. This case of single sourcing of the mobile hospitals by the Zambia Public Procurement Authority is just one example of an institution being led to rubber stamp a decision that had already been made by the executive.

There are similar examples of investigations which have either been compromised or not taken up because they implicated the top executive. For instance, in June 2018, the Financial Intelligence Centre (FIC) released a report that found some cabinet members and presidential aides had siphoned billions of Zambian kwacha from government coffers through money laundering. Instead of acting against those named in the findings, the state chose to go after the chairperson arguing that the report was released in an irregular manner[21]. Similarly, alleged corruption in the procurement of 42 fire tenders for US $42 in 2017 involved senior officials with close ties to the state house. The Anti-Corruption Commission however controversially found that all the correct procedures were followed.[22] This shows the dangerous levels of presidential powers; as long as something is believed to have originated from the top, no other authority has the power to overturn it.

[21] Aljazeera, June 23, 2018 Available at https://www.aljazeera.com/indepth/opinion/corruption-zambia-42-fire-trucks-42m-180620084648448.html (Accessed March 2, 2019)
[22] Lusaka Times Online, September 29. 2017. Available at https://www.lusakatimes.com/2017/09/29/no-evidence-corruption-found-fire-trucks-investigations-acc/ (Accessed March 2, 2019).

Indeed, the government had already identified and single-sourced the provision of the health units by the time the idea was being presented to parliament, without having followed any procurement standards (Kyambalesa, 2010). Ideally, what the government was supposed to have done was to state its intention to have mobile health units, and then a tender process should have determined where to order or who was offering the best deal. Partners such as the aid agencies also raised concerns about this single-sourcing (Interviewee L, 2016). Tender procedures stipulate that for high-value procurements ($53 million), such as the case was for mobile hospitals, open bidding and selection must be conducted. Invitations to bid must be gazetted and advertised in newspapers and authorisation for award of the contract should either be granted by the Procurement Committee or the Central Tender Committee (ZPPA, 2011). This process was not followed; the Zambia Public Procurement Authority was given authority by the president to single-source (Chilembe, 2009). Because the president has a lot of executive power including appointing the Head of the Procurement Authority, it illustrates that institutions which should operate independently are not, and therefore cannot influence policy effectively.

According to ZPPA (2011) single-sourcing is permitted in cases of emergency or in situations where there are only one or two sources specialised in an area able to supply the kind of good or service sought. There was however nothing urgent that warranted single-sourcing of the mobile hospitals. Furthermore, a senior informant from the Ministry of Health revealed in an interview that there were three other sources which could have supplied the mobile units but because there was no tender process, they were not considered (Interviewee B, 2016). A number of reports and studies have noted that political interference in the Ministry of Health is a major problem in procurement processes (OECD-DAC, 2007; CYMA, 2011; CSPR, 2012). This contributes to corruption as it disregards the need for transparency and accountability.

5.3.2 Policy formulation for mobile hospitals

Similar to the stage model (Howlett and Ramesh, 2003), the Zambian health policy formulation has four (4) stages summarised as follows (Ministry of Health, 2018: 46).

i. Formulation Stage - The lead ministry identifies and defines issues to be addressed. It consults with the Policy Analysis and Coordination Unit (PAC) at Cabinet Office before and during policy formulation, after which the lead ministry prepares Cabinet Memo and circulates Cabinet Memo (14 days) for comments to all key stakeholders.

The lead ministry then submits the final Cabinet Memo with incorporated comments to PAC which is then submitted to Cabinet for approval.

ii. Adoption Stage- This stage involves inclusion of the policy proposal on Cabinet Agenda and the initiating minister presents the recommendation to Cabinet which then makes a decision on the recommendation.

iii. Implementation Stage- Following the decision made, Cabinet Secretariat conveys the decision to the initiating ministry on the outcome. The ministry ensures that the Cabinet decision is implemented as per implementation plan.

iv. Monitoring and Evaluation Stage- The lead ministry submits to PAC the monitoring and evaluation framework for the policy, through Agenda or Information Cabinet Memo where progress reports are presented. The minister responsible presents progress reports on the implementation of the policy in Cabinet.

Following his announcement to the National Assembly on government's intention to purchase mobile hospitals, President Banda directed for the formation of a unit to be responsible for these outreach operations at the Ministry of Health (Ministry of Health, 2010). The Cabinet office and the Ministry of Finance thus allocated funds to the new unit and President Banda appointed senior directors to oversee it. As noted earlier, this initiative differed from previous concepts of mobile health units which are mainly supported by charity or run as projects, in that these mobile health units announced by the President were to be a government project with a commitment of funding from the government.

After it was discovered that the units were already purchased without considering the views of stakeholders and partners, donors were incensed and threatened to cut funding to the Ministry of Health (Pereira, 2009:9). However, despite the influential position that donor partners hold regarding health policy in the country, their pressure on government to not adopt and implement mobile hospitals, did not prove enough to stop it. Even the committee that they pressured government into setting up to scrutinise the purchase had no effect. Further while most of the bureaucrats in the committee may be neutral with no affiliation to the ruling party, they serve the government of the day and could not recommend otherwise. Interviews held with two officials, one of them representing the medical association, further indicated that the experts and bureaucrats were only asked to come in after donors raised concerns over the purchase. They argued that the government had already made a decision and that the meeting was merely a formality (Interviewees G and M, 2016). These interviewees further stated that there was very

little consultation on the part of government. The other alternatives were not taken up and the proposal for mobile hospitals put on the table by the president was taken forward.

Therefore, the announcement of his government's intention to have mobile hospitals automatically meant that the relevant authorities such as Cabinet Office and the Ministry of Health in this case were directed to come up with a health policy to that effect. The Ministry of Health led the discussions, and also expanded their outreach office which was now called the Mobile Health and Emergency Services Directorate. The directorate was established in 2010 to strengthen the provision of health care through mobile hospitals and to ensure that the right staff was employed to oversee the units at this new level of service provision. It was envisaged that about 9 million people would benefit from affordable, cost-effective and quality health services through this mode of delivery (Ministry of Health, 2010:4). The Ministry of Health ensured that medical staff would be adequately to operate the units and the training would be sponsored by the supplier, AVIC as part of the sale contract. The main policy document for the units which guides their operation was also formulated by the Ministry of Health in 2011. The guidelines state how and under what circumstances the mobile hospitals can be used. They also state the departments involved and the roles of each in ensuring the smooth operation of the units (Ministry of Health, 2011).

The Minister of Health told Members of Parliament during debates on the mobile hospitals that the $53 million concessional loan from China included various other benefits such as training local staff and servicing the units which made a great deal for the government.[23] All these gestures it seems contributed to the government justifying the need for adopting mobile hospitals as a means to helping address the issue of inadequate access to health services, as opposed to considering other options, which were more expensive.

5.3.3 Implementation of mobile hospitals

Despite the idea of mobile hospitals being introduced in January 2009, it took until the 2011 for implementation to take place - almost two years later. Implementation of the mobile hospitals countrywide was finally officially launched in Chongwe district in Lusaka Province in April 2011 by President Banda. Besides the fact that the government had to wait for the units to be fitted by the supplier and shipped to the country, the delay could also be attributed to the controversy that surrounded the whole ordeal. It is reported that once donors questioned the

[23] Parliamentary debates October 21, 2010 Available at http://www.parliament.gov.zm/node/1416 (Accessed April 4, 2017).

government about it, the government decided to shelve the idea for a while, or to unfold it slowly (Chilemba, 2011). But President Banda was on record saying that those who were criticising the mobile hospitals had no business doing so and that the government had the authority to get into any transactions they deemed best for the citizenry.[24] He stated during the launch of the units that the mobile hospitals would bring health services closer to the people even in areas not easily accessible.[25] In June 2011, two months after the president launched the implementation of the units, the Minister of Health issued a statement to parliament on their operational guidelines (Simbao, 2011). The president and his top appointees were very influential in ensuring that implementation proceeded despite fierce opposition.

President Banda launched the implementation of the mobile hospitals in April 2011, a few months shy of the general elections. In the next chapter, I further explore how these elections provided a window of opportunity for the implementation of the mobile hospitals as they were seen by many as a means to campaign for the rural vote. The general elections were held in September 2011 and President Banda lost to the main opposition party leader, Michael Sata of the Patriotic Front, a strong critic of the mobile hospitals. However, when Sata became president, his government did not do away with the mobile hospitals. President Sata was criticised by the opposition too for appearing to have gone back on his word, when he himself was such a strong critic (Mwenya, 2013).

The promise of better health is capable of attracting voters. It is used to campaign in almost all elections which means that health and politics cannot be separated. In fact, almost all presidents have placed health at the top of their developmental agendas, and rightly so. As a senior informant from the medical association explained:

> *Health and politics cannot be separated, especially in a resource deprived country like ours. So in a political campaign, you tell people something that will have an impact on them, and health is exactly that. To reap the benefits from school can take even up to 12 years until you finish your high school. But for health, today you have a headache tomorrow you don't. It's not a future investment, it's a now investment. And health has*

[24] Post Newspapers 29 May, 2011 Available at http://postzambia.com/post-read_article.php?articleId=12082&highlight=mobile hospitals (Accessed May 10, 2016)
[25] Lusaka Times Online, 2 April, 2011. Available at https://www.lusakatimes.com/2011/04/02/president-banda-commissions-mobile-hospitals/ (Accessed July 8, 20170

> *been used by all governments to campaign, past and present, and even future ones will do so. Health is one of the most politicised sectors in the country* (Interviewee M, 2016).

There was evidence to support that lack of access to health services was indeed perceived as a problem even though there were no major focusing events or indicators at the time in the Ministry of Health which could be said to be responsible for highlighting access to health services. However, it was a well-known fact that people in rural areas faced many challenges in accessing health services where there were fewer health facilities compared to urban areas, and people walked long distances to nearest health centres which in most cases were under-equipped and under-staffed. These issues were used by government as justifications for the mobile hospitals.

On 28 October 2014, President Sata died in a London hospital where he had been admitted for an undisclosed illness. Presidential by-elections were held three months later and President Edgar Lungu was elected in January 2015 from the same party to finish off Sata's term up to August 2016 according to the constitution. President Lungu continued with the implementation of the mobile hospitals as per the previous government. Indeed, in his first term, he made little changes to top personnel in the health ministry but continued with the ones appointed by the late President.

In August 2016, general elections were held and President Lungu emerged victorious to govern for a full 5-year term. In this second term which can be considered his own term, he was arguably freer to introduce or do away with certain policies, programmes or appointments compared to the previous term in which he repeatedly stated that he was continuing on the path of the late President Sata (Lungu, 2014). And indeed, shortly after emerging victorious in this second election, President Lungu appointed a new Minister of Health and new Permanent Secretaries in the Ministry.

It was reported that the new Minister of Health (Dr Chitalu Chilufya) made a number of changes in the administration and management of affairs in the ministry. Some departments such as the one responsible for the mobile hospitals were abolished and others merged into already existing ones. The minister reaffirmed his commitment to primary health care, emphasising health promotion, disease prevention, and curative and rehabilitative services in close-to-client settings (Ministry of Health, 2017:4). A new directorate known as Directorate of Health

Promotion, Prevention and Control was thus formed.[26] As stated earlier, it was observed that primary health care was neglected in the operation of the mobile hospitals because of their heavy focus on surgical cases. The change in policy thus resulted in the abolishment of the Directorate of Mobile and Emergency Unit at the Ministry of Health, and the management of the mobile hospitals was placed under another directorate. This meant that the operation of the units would no longer be considered a separate activity with its own budget, but considered as a complementary service delivery mode to people in hard-to-reach and remote parts of Zambia in all provinces with the exception of Lusaka, Central, and the Copperbelt Provinces (MOH, 2017:50).

Unlike the various mobile health clinics operating around the country as discussed above in section 5.3, the introduction of mobile hospitals to operate in disadvantaged areas goes beyond the global health policy expectations expressed in the Alma Ata Declaration of 1978. The services offered are mostly secondary care because of the nature of the mobile hospitals. Secondary care services refer to more curative services, usually provided by a specialist. They represent the second tier of the health system (Jones, 2013:380). However, primary healthcare had been reported as neglected since there seemed to be a focus on secondary cases. Since their inception, a total of 642,056 clients were attended to and 31,196 operations were conducted as at December 2016 countrywide (Ministry of Health, 2017:50).

The mobile hospitals deliver all kinds of services to the communities they visit, ranging from promotive to curative health services, all free of charge. They provide all the services found at second level hospitals, including dental services and surgical operations such as caesarean sections. Hjorstberg and Mwikisa (2002:77) however recommend that such outreach services concentrate on providing basic health care and focus on major diseases that affect the community such as malaria and TB. By traveling to communities and offering free services, the mobile hospitals help to remove logistical barriers associated with accessing health care such as transportation, finances, making appointments, long waiting times before appointments are due, and complex administrative processes.

In sub-Saharan Africa, Zambia is one of the few countries implementing mobile health units which operate as second level hospitals and offer more advanced services than just primary health care. This is probably why they are referred to as mobile ‘hospitals’, as opposed to mobile

[26] See more at https://www.lusakatimes.com/2017/02/18/dont-want-ministry-treatment-want-ministry-health-dr-chilufya/ (Accessed February 24, 2019)

clinics. The hospitals are integrated into the national health system and are implemented by the Ministry of Health. In most cases, mobile health units are set up by charities in parallel to the public health system (Mortier and Coninx, 2007:6). This is not the case in Zambia as interviews conducted with officials from the Ministry of Health revealed that government provides all the funding and support, including medicines and staff payment. Explaining the rationale behind mobile hospitals, a high-level official at the Ministry of Health reiterated that most health workers were concentrated in urban areas, and therefore the few facilities in the rural areas lacked adequate and specialised staff to attend to them. He stated, "*There is a gap in the provision of health services. People in urban areas have access to all these higher levels of healthcare while the ones in rural areas access the lower levels of care, so the mobile hospital takes second level health care to these places." (*Interviewee B, 2016)

The interviewees from the Ministry of Health and health workers all confirmed that the majority of cases attended to at mobile hospitals deal with surgical operations, and not primary health care interventions. The focus of the mobile hospitals has been on surgeries, hence primary health care which is the government's main approach in the delivery of health services, is not being followed.Table 7 below gives an example of the number of surgical operations done in 2015, which is the latest data available. There was a total number of 432 surgical operations which included 235 minor operations and 197 major ones such as caesarean sections. Table 8 shows the total number of patients attended to in the province in the year 2015.

Table 7: Number of surgical operations in Lusaka Province-2015

No	Outreach Site	No. of Surgical Operations		Total Surgical Operations
		Minor	Major	
1	Matero (Lusaka district)	58	8	66
2	Shibuyunji- Chilanga districts	71	9	80
3	Luangwa district	14	4	18
4	Ngwerere (Chongwe district)	36	20	56
5	Chiawa- Chipepo (Kafue district)	40	13	53

6	Kazimva (Chilanga district)	6	24	30
7	Chawama (Lusaka district)	10	119	129
Total		**235**	**197**	**432**

Source: Ministry of Health, 2015:13

A high-level officer at the Ministry of Health (Interviewee B, 2016) admitted that there was a gap in the implementation of mobile hospitals because the government was losing out on primary health care. He added that they were looking to add primary health care as one of the services offered by the mobile hospitals. The NHSP (2017-2021) also acknowledges that there is demand for increased primary health care and strengthening existing services such as cervical, breast, and prostate cancer screening as well as health promotion activities (Ministry of Health, 2017:50). The plan places primary health care as the main vehicle of health service delivery during the five-year implementation period (Ministry of Health, 2017:13). This re-focus on primary health care has been fostered by the new Minister of Health appointed in 2017 after President Lungu won the election.

There have been additional changes in the Ministry of Health brought about by the new minister. Another senior informant at the ministry stated that there were many changes with regards to mobile hospital implementation beginning at policy level with the dissolution of the directorate (Interviewee O, 2017). The interviewee further revealed that this posed a challenge in terms of fund allocation as it was dependant on how the specific directorate allocated funds. Due to insufficient funds, the mobile units were not going into the field as often as they were supposed to. For the first half of 2017 for instance, the mobile hospital had been out in the field less than three times. The informant added, "*In the near future when the units wear out, there will be no need for their replacement as they would be done away with due to the huge costs involved, both financial and human resources. Things have already started changing going by the policy decisions that had been made so far*." (Interviewee O, 2017).

Table 8: Total number of patients attended to in Lusaka Province in 2015

No.	Outreach site	District	No. of patients seen
1	President's inauguration	Lusaka	16
2	Matero	Lusaka	3603
3	Cancer conference	Lusaka	34
4	Shibuyunji-chilanga	Shibuyunji and Chilanga	4323
5	Public service day	Lusaka	310
6	Feira and Luangwa	Luangwa	1689
7	Ngwerere	Chongwe	3659
8	Agricultural show	Lusaka	256
9	Chiawa - Chipepo	Kafue and Chirundu respectively	1901
10	Kasisi	Chongwe	645
11	Kazimva	Chilanga	3526
12	Chawama	Lusaka	7883
Total			**27,845**

Source: Ministry of Health (2016:12)

Components of the mobile hospital and operating schedule

From my observation of the mobile hospital in the field, it is a combination of seven vehicles or units making up seven units/departments. These are: an X-ray motor vehicle, a laboratory motor vehicle, a dispensary and audio visual motor vehicle, a mini theatre motor vehicle, an out-patient motor vehicle, a power and water supply motor vehicle and a living motor vehicle which carries equipment plus a mini kitchen and other amenities for staff while they are on site. The power and water supply motor vehicle which contains a water tank, water purifier, water pump, generator set, and diesel tank is particularly useful in areas where power or water

supplies are erratic. In addition to the above units, a tent transportation trolley for personal effects, food, tents, and other items is also part of the mobile health unit. A waste collection and transportation trolley collects and transports medical and human waste generated whilst on deployment.

The mobile hospital when not in the field is stationed at the Levy Mwanawasa General Hospital. This provincial hospital is also in charge of making yearly visits for the mobile hospital to all eight districts in the province. At the beginning of the year, the responsible team meets to decide when and which areas the mobile hospital will visit for that year. The composition of the team for the mobile hospital is determined by the purpose of the outreach and the types of services that are likely to be offered. The provincial hospital has a mobile health services team which is responsible for mobilising specific staff with the required skills from wherever they may be within and outside the province and from public and private sectors for the purpose of the outreach programme (Ministry of Health, 2010:9).

Health workers based at the local health facility in the respective districts are important in the mobile hospital outreach as they lay the groundwork and participate in offering the services. Before an outreach, the provincial hospital coordinates with the local health facility in the respective district to determine what kinds of cases or health issues are to be anticipated. The local health facility also sends word around in the community so that everyone with a health issue is aware of the date when the mobile hospital will be in the area.

The mobile hospital is supposed to go out in the field at least once a month, for a period of between seven and fourteen days on average in a particular district. Districts that are close together are often visited in one outreach if the mobile hospital finishes earlier than expected. The service point for the mobile hospital must be one that has access points to a leveled ground, water, electricity and sanitary facilities amongst other fixtures (Ministry of Health, 2010:19). Schools or churches usually meet these requirements. Because accommodation is not easy to find in most rural areas, the health workers often end up lodging in schools or churches.

Even though the idea is to be stationed at a central place closer to the people, this location may sometimes still be far for some people and buses are usually sent in the villages to pick people up at a central point, and drop them off later after being attended to. The mobile hospital usually opens as early as 8 am and staff sometimes work as late as 10 pm. People queue and the team begins the programme by first conducting a registration exercise of all the patients in the queue. The exercise includes logging of demographic information and vitals (blood pressure, pulse,

temperature, respiratory rate, and weight) by the nurses. Patients are then sent to the relevant departments such as the laboratory or radiology for further management.

Besides the laboratory and radiology, the mobile hospital provides a wide range of other services which are contained in the Basic Health Care Package and offered on a daily basis at any first or second level health facility. Since the mobile hospitals offer services provided at a second level facility, as already mentioned, they offer preventative, promotive, curative and rehabilitation services (Ministry of Health, 2010:11). These include various medical and paediatric, surgical, laboratory, radiological, pharmaceutical, physiotherapy, oral and eye health, rehabilitation and maternal and child health services, and cancer screenings, either on an out-patient or in-patient basis, among many other services – free of charge. According to the Ministry of Health (2010:11), health service targets for the mobile hospitals are complementary to those offered by static health facilities, as set in the National Health Strategic Plan (NHSP 2011-2015). The mobile hospital therefore has all the professional health workers such as specialised doctors, nurses and many other essential health workers.

If someone has a serious ailment that cannot be adequately handled by the mobile hospital, they are referred to a higher hospital, usually the district or provincial hospital. If a patient also requires further monitoring or continuing medical attention, they are also referred. The District Medical Office is responsible for all referrals and must ensure effective and efficient deployment of the mobile hospitals. The subsequent reviews and follow-ups of all patients seen during the outreach is also the responsibility of the District Medical Officer.

Being the most populated and most urban district in the province, the problem in Lusaka district is not necessarily access to health care services; it rather concerns the quality of the services (CSO, 2012). Because health facilities are usually overwhelmed by large numbers against few staff, the use of the mobile hospital in the district helps to decongest and minimise pressure on these facilities. As seen in Table 8 above, Chawama in Lusaka District had the highest number of patients: 7,883 attended to in 2015. When the mobile hospital is in the district, it usually camps in one of the densely populated areas so that people who would have gone to the static facility can use the free services of the mobile hospital.

However, the problem with implementing the mobile units in urban areas where people have fairly good access to health services is that at the end of the day, the rural areas still remain

deprived. It was stated during the interviews with health workers[27] that whenever the unit went for outreach in rural areas, they were overwhelmed with cases. Despite this, there was a general sense of gratitude and fulfillment for the work that the mobile hospital was able to give patients. Therefore, it appears that it would make more sense to have the unit operate there more often. The need to build more health facilities across the country and to staff them with the trained health workers therefore cannot be over-emphasised.

Besides scheduled visits to the districts, the mobile hospital is also employed at various national functions and events that happen during the year. For instance events such as Independence Day celebrations, Womens' Day, Youth Day among others that attract large numbers of people are used as an opportunity to provide free health services. In most cases however not all the components or units of the mobile hospital are carried along, and only one truck is used, mainly for screening purposes.

Figures 8 and 9 below show part of the units/trucks that make part up the complete mobile hospital with clients queuing up waiting to be seen by a health professional at one of the outreaches in Lusaka district respectively.

Figure 8: Two of the seven units that complete a mobile hospital

Source: My own photograph from the field

[27] Interviews with health workers in October and November 2016 (Interviewees G, H, I and J)

Figure 9: People waiting to be attended to at the mobile hospital in Lusaka district

Source: My own photograph from the field

Limitations and Challenges faced in implementing mobile hospitals

A primary health care approach is the underlying strategy that the Ministry of Health follows for delivering health services to the people of Zambia. However, the way that mobile hospitals were implemented moved away from this mandate since they focused on serious and complicated cases. This meant that the goals of health promotion and disease prevention were not being achieved and had implications for not only receiving donor funding (which the Ministry is highly dependent on), but also for the ministry losing focus on the international Alma Ata agreement which it has re-committed itself to. Primary health care has been identified as key to the attainment of the goal of Health for All (Alma Ata), which the Zambian government is ultimately trying to achieve.

Health for All is a holistic concept which relies on extended advancement in medical care and public health. Health services need to be accessible to all through primary health care, with basic medical help available in every village, supported by referral services to more specialised care (Brown et al., 2016:36). This commitment to enhancing health globally, particularly for the most disadvantaged populations, was reaffirmed and updated by the World Health Assembly in 1998 through the Health-for-All for the twenty-first Century document (WHO, 1998). It is also worth noting that the WHO Director General Dr Tedros Adhanom Ghebreyesus from Ethiopia who was elected in 2017, reaffirmed his commitment to a strong primary health care platform with integrated community engagement within the health system as the backbone

of achieving universal health coverage[28]. The Ministry of Health has also placed primary health care as its focus in the implementation of the current NHSP 2017-2021.

Another limitation of the mobile hospitals has been budget constraints which affected the deployment of units in the field. Operational costs were especially listed as the main challenge that hinders proper implementation. An official at the Ministry of Health working in the department noted that it was very expensive to run the units and that a minimum of about US $12,000 was required for a field trip of about seven days (Interviewee C, 2016). Ideally, the mobile hospital must be in the field every month for at least seven days. However, due to limited funds, this is not always the case. An informant at the provincial hospital disclosed that in the first half of 2016, the unit only did outreach less than 4 times due to limited resources (Interviewee E, 2016). The health workers interviewed also mentioned that due to funding constraints the units were in the field for less than ten days, when the ideal was supposed to be about fourteen days. It appears that the units are slowly but surely being phased out.

It cannot be overemphasised that the mobile units cannot be used as a substitute for static facilities. Besides logistical issues, the equipment is also expensive to maintain. Indeed, at the time I was in the field in 2016, I was informed by one of the interviewees at Levy Mwanawasa Hospital that the Xray machine had been down for a couple of weeks. The informant disclosed that as a result, whenever the mobile hospital was going into the field, staff carried the X-ray unit from the provincial hospital to the mobile unit (Interviewee F, 2016). This obviously means that the hospital remained deprived until the mobile hospital returned. The NHSP (2017-2021) also states that the constant breakdown of equipment in the mobile health units, particularly laboratory and X-ray equipment was a key constraint (Ministry of Health, 2017:51).

The lack of human resources was another major drawback in implementing mobile hospitals according to the health workers (Interviewees H, I, and J, 2016). Zambia faces a human resources for health crisis, and faces challenges in ensuring adequate staff to deliver health services. The fact that outreach programmes depend on skilled staff such as surgeons and theatre nurses who are mainly employed at tertiary hospitals means that these facilities are deprived of key staff members when the mobile hospital is out in the field. This is tantamount to creating an artificial shortage of staff. In addition, the health workers interviewed stated that despite the mobile

[28] Dr Ghebreyesus commentary on achieving universal health coverage. Available at http://www.who.int/mediacentre/commentaries/2017/universal-health-coverage/en/ (Accessed 12 September, 2017)

hospitals being helpful to the people, the health workers faced challenges in having patients back for review when they were referred to a health facility for further check-up**.**

Despite these challenges faced, health workers and staff from the ministry noted that they were generally happy with the implementation. They viewed the units as a good initiative doing a commendable job. Apart from the fact that they have witnessed first-hand how people benefit especially in rural areas, this optimism can also be explained by the fact that being public servants, they could not afford to be critical of the programme, probably for fear of risking their jobs. This is despite total confidentiality having been assured. Most of the senior health experts and civil servants responsible for implementing mobile hospitals in the province that were interviewed during the fieldwork appreciated the services of the mobile hospitals. This is despite some of whom admitting to having been totally against them initially. They may be seen as having changed their minds but the very nature of their jobs makes it difficult for them to be against initiatives meant to save lives.

5.4 Conclusion

This chapter described and contextualised mobile health service provision in Zambia and how this has been integrated in the health system to provide free of charge medical care beyond primary health care to both rural and urban populations. It described the agenda setting and policy formulation of mobile hospitals. It contextualised the adoption of mobile hospitals to complement static health facilities as a way of achieving the goal of bringing health services closer to people. It showed how mobile hospitals are implemented in Lusaka Province and discussed the challenges such as financial burdens, and primary health care being left out. This discussion on the implementation of mobile hospitals is important as it provides context for understanding the next discussion of the problem, policy and political streams in mobile hospital implementation.

The main purpose of the chapter was to answer the research question on what implementation of mobile hospitals involves. The chapter showed that mobile health units are becoming increasingly popular in many countries to serve underserved populations for a number of reasons, and some provide care beyond primary services. There are many instances where mobile units are preferred over static health facilities. While this is the case, they are however expensive to run in terms of both human and financial resources and should be carefully analysed before implementation, especially in non-crisis situations. The chapter described and

contextualised mobile health service provision in Zambia, showing that mobile hospitals complement static health facilities as a way of achieving the goal of bringing health services closer to people. It showed that this has been integrated in the health system to provide care to both rural and urban populations. It noted that while this has been appreciated, the primary health care aspect has actually been neglected.

In Lusaka Province, various services are offered free of charge, including surgical operations. The chapter also presented Zambia's health system, which is underpinned by a primary health care approach in which health reforms and decentralisation have been a key feature. This background helps to understand the following two chapters which discuss the three streams in relation to the implementation of mobile hospitals. The next chapter focuses on the role of each of the three streams in relation to mobile hospital implementation.

CHAPTER SIX: APPLYING KINGDON'S STREAMS IN MOBILE HOSPITAL IMPLEMENTATION IN ZAMBIA

6.1 Introduction

The purpose of this chapter is to discuss the findings from the field in relation to Kingdon's streams, policy entrepreneurs, and coupling. It offers both a descriptive and analytical accounts of the issues that were identified as present in each of the streams. The aim of doing so is to answer the second and third research questions about which issues were present in each of the streams that facilitated implementation, and who the policy entrepreneurs were that helped to couple the streams in order for mobile hospitals to be implemented. The chapter builds onto the discussions in the previous two chapters that contextualised governance and mobile hospital implementation respectively. This chapter shows that the policy process in Zambia is highly influenced by political institutions such as the executive and that coupling is mainly a function of this. Other institutions and non-state actors therefore had little influence on the decision by the government to implement mobile hospitals.

An important finding noted in this chapter is that the three streams were not running as independently as Kingdon (1984) asserts for agenda setting because of the unique type of policy entrepreneur who participated in all three streams by virtue of his position. This policy entrepreneur is identified as the president of Zambia, who collaborated with AVIC International. The chapter thus argues that the multiple streams framework is useful for understanding implementation because it brings into focus agenda setting and policy formulation processes which may help to understand implementation better. It further argues that to enable a better contextualised understanding of implementation, the multiple streams framework needs to be adapted to incorporate institutional factors in the political stream. Despite this, it concludes that the framework does not comprehensively help us to understand policy implementation in this case because it does not clearly show for instance where the idea of mobile hospitals emerged and also because of the lack of an active policy stream dominated by experts discussing solutions as articulated by Kingdon (1995).

The chapter is divided into two parts. The first part starts by discussing the streams to understand the issues in each stream. In the problem stream, it is shown that contrary to the views of government and the party in power stating that inadequate access to health services was a major issue that needed to be addressed, there were numerous problems in the health

sector according to various actors. The chapter then discusses the policy stream showing the solutions preferred by actors to address health issues instead of implementing mobile hospitals. The problem and policy streams in this chapter therefore give the understandings of health policy related problems and solutions as articulated by various actors, while the political stream indicates the 'political activities' and their impact on the implementation of mobile hospitals. The political stream also shows how the framework was adapted for the study.

The second part of the chapter ties all this together by identifying the policy entrepreneur and showing in detail how coupling took place, that is, the opening of policy windows that necessitated the joining of streams not only for implementation, but during agenda setting and policy formulation too. This is because these prior processes help to provide a background for understanding implementation. Further, it helps to understand how issues become problems in the first place and how solutions are arrived at. This information is vital knowledge for implementation. As most implementation research has not focused on agenda setting or policy formulation when studying implementation, the multiple streams framework brings these aspects of the policy process into focus.

6.2 The Problem Stream

This section presents the health issues which were prevalent before and during the mobile hospital implementation, and who was presenting these issues. The purpose of doing this is to understand why inadequate access to health services was considered a major public problem that deserved attention. The problem stream looks at why some problems seem to occupy the attention of officials more than others. It refers to conditions that policymakers, interest groups, and other policy actors believe warrant attention (Ackrill, Kay and Zaharadis, 2013:873). Policy makers find out about these problems through indicators, focusing events, and feedback (Kingdon, 2003:90). Indicators which include birth and mortality rates, are used to assess the magnitude of a condition. Officials in and around government therefore usually monitor various activities to look out for changes in indicators. Focusing events refer to sudden disasters or crises that direct attention to a problem, such as a major road accident or plane crush for instance (Birkland, 1998). Lastly, feedback is often provided in the form of monitoring and evaluation studies of existing programmes, or informally through complaints from communities. While there was no focusing event that could be held responsible for informing issues in the health sector leading to policy formulation and the implementation of mobile hospitals, a combination

of indicators and feedback were identified as present which influenced the policy decision regarding mobile hospitals.

The distinction between a 'condition' and a 'problem' is critical according to Kingdon (2003:91) since it determines whether or not a particular issue will receive the needed attention. Whilst a condition is just any situation present in society, a problem is one that seeks attention and action from government. He also notes that those who are able to define an issue and make it a public problem usually have their way in finding a solution (Kingdon, 2003:92; Zahariadis, 1999:67). This is an important point for the discussion as it will be shown that those who labelled the problem (as inadequate access to health services in rural areas) also tabled what the solution to the problem would be (mobile hospitals).

6.2.1 Issues presented as problems by different actors before mobile hospital adoption

Interviews conducted with the various categories of informants and a review of different documents revealed that there were many definitions of what the problems in the health sector were at the time when the mobile hospital agenda was proposed. Different actors understood the problems in the health sector differently, and therefore had different views of what the priority issues were. I have grouped these actors and informants in three categories namely government, health workers/staff at Ministry of Health, and donor partners. Kingdon (2003:92) argues that for a condition to be a problem, people must be convinced that something should be done to change it. Critics were adamant that lack of adequately trained staff, the poor infrastructure of health facilities and equipment, and the non-availability of essential drugs were far more pressing policy issues that needed to be invested in (Forster, 2011; Kavindele, 2010). This section presents the varying perspectives, as summarised in Table 9 below.

Policymakers

This reference to government entails the Office of the President/executive and the party in power as distinct from the Ministry of Health for instance which is a government department. It was evident that for government the issue of inadequate access to health services in rural communities was perceived as a public problem which deserved attention. This is so because when President Banda announced the government's intention to introduce mobile hospitals, he stated that they would operate in rural areas to ease the burden of inadequate access to health

services (Banda, 2009). Indeed, access to health services in the country was skewed in favour of urban areas, as was the distribution of staff (Ministry of Health, 2006:13).

Table 9: Health sector problems as presented by various actors

Government	**Health workers and Staff at the Ministry of Health**	**Donor Partners**
Inadequate access to health services in the rural areas due to few health facilities and lack of adequate and skilled staff	Shortage of staff	Primary health care issues (fighting malaria, HIV/AIDS, maternal and child health, sexual and reproductive health)
	Poor infrastructure of health facilities	
	Shortage of drugs and medical supplies	

Source: Own summary

Even at the lower levels of health care provision, there were shortages in the number of health facilities. For instance, there were only 1,029 rural health centres against a target of 1,385 in 2008 (Ferrinho, Siziya, Goma and Dussault, 2011:2). The government, through its spokesperson argued that people in rural areas walked long distances to access nearest health centres, and walked even farther to secondary facilities as these were limited hence the need to bring the health services closer to the people (Shikapwasha, 2009).

The World Health Organisation recommends that people must be within 5km walking distance from a health facility (WHO and UNICEF, 1978). However, in some areas people walk up to 30kms to the nearest health centre (Chatt and Roberts, 2014:15). In addition, most health workers were concentrated in urban areas, and the few facilities in rural areas lacked adequate and specialised staff. The government further argued that this was its mandate in health care provision as stated in the Ministry of Health's mission statement (Shikapwasha, 2009). The mission statement reads that it is the governments stated aim: "to provide equitable access to cost effective, quality health services as close to the family as possible in order to ensure equity of access in health service delivery and [to] contribute to the human and socio-economic

development of the nation" (Ministry of Health, 2011:2). This statement is also found in all the National Health Strategic Plans (from 2006 up to 2021).

Ministry of Health staff and health workers

According to interviews[29] conducted with health workers and staff from the Ministry of Health, as well as records from secondary sources, there were more pressing issues in the health sector that needed to be addressed than access to health services. The main issues presented were shortage of staff, poor infrastructures, few health facilities around the country, and a shortage of drugs. It was felt that these issues were a priority which if resolved could further assist in ensuring access to health services. The issues are discussed below.

Human resources for health in terms of numbers, utilisation of staff, and morale had been issues for many years as the ministry had been operating under a critical staff shortage. The rural areas had been the worst off, with staff population ratios almost 1:14,500 and 1:1,800 for doctors and nurses respectively (Ministry of Health, 2011:28). This is way below the staff population ratios recommended by the World Health Organisation of one health worker per four hundred people (1:400). A health worker is defined as a trained doctor, nurse, clinical officer, pharmacist, or laboratory, radiology and environmental technician (Tjoa et al., 2010:8). A senior medical doctor interviewed noted that adequate human resources was a major challenge that needed to be addressed as it negatively affected the delivery of health services (Interviewee G, 2016). By 2009, the year that the president announced the need for mobile hospitals, there were just over 600 doctors and about 6000 nurses working in the public sector and severe shortages of other key staff (Ministry of Health, 2011:30).

The number of health facilities in the country also fell short of what was needed to cater for the population. For instance, the National Health Strategic Plan (NHSP) for the period 2006-2010, which is the document that guided the Ministry of Health's operations for that five-year period, indicated that the target was to have 3,000 more health posts but that only 20 had been commissioned by 2006 (Ministry of Health, 2006:9). This meant there was a huge gap which needed to be filled in building health posts. Critics also argued that the lack of adequate facilities was a serious issue that needed to be addressed. A high-level officer interviewed at the Ministry of Health headquarters admitted that 10 years later there were still few health facilities in the country, contributing to congestion and compromising quality health care (Interviewee B, 2016). In terms of the expansion of health facilities, interviewees mainly from the ministry

[29] Interviews conducted between September and November, 2016 (See list in appendix)

headquarters and the provincial hospital noted that a number of health facilities had been built and many other upgraded countrywide between 2009 and 2011, but lacked sufficient amenities. [30]

Lack of drugs in hospitals and disease burden largely influenced by the high prevalence and impact of communicable diseases, particularly malaria, HIV/AIDS, TB and STIs, were also cited as issue in the health sector (Ministry of Health, 2006:1). The Ministry of Health's document on progress towards meeting the health-related Millennium Development Goals noted that disease burden, coupled with inadequate human resources, presented a critical impediment as the numbers were high (Ministry of Health, 2006). Furthermore, a mid-term evaluation of the Fifth National Development Plan (FNDP 2006-2010) showed that despite improved access to health care services for vulnerable communities, most health facilities had inadequate drugs and other medical supplies (Ministry of Finance and National Planning, 2010: 89). Access to drugs is important to ensure access to health services for all. Most health facilities, particularly those in the rural areas, lacked drugs for patients. Medical Stores, a government department responsible for stocking and distributing drugs to health facilities across the nation, had been facing a number of challenges, and health facilities in the country had to send staff to the Medical Store centre in Lusaka to collect drugs. This posed many challenges and essential drugs were often scarce.

Donor Partners

Donors form a significant partner group of the Ministry of Health in Zambia. Most of them contribute to a basket fund referred to as the sector wide advisory approach (SWAp), which is an important source of funding for the Ministry of Health. For the partners interviewed (Interviewees K, L and N, 2016), the issues in the health sector that needed to be addressed were linked to primary health care: fighting malaria and HIV/AIDS, and providing maternal and child, and sexual and reproductive health. These issues represent some of the core health problems that are supported by the various donor partners in the country.

6.3 The Policy Stream

This section looks at the policy alternatives which were proposed by various actors to address the issues that were prevalent in the health sector around the time of the mobile hospital adoption. The policy stream involves various policy proposals and alternative solutions that are

[30] Interviews with staff at HQ and Levy Hospital between September and November 2016

generated for problems. According to Kingdon (2003:116), many ideas, suggestions and proposals are presented but then float around. However, only a few are ultimately selected for serious consideration depending on factors such as technical feasibility, congruence with the political and social values of community members, budget constraints, public acceptability, and politicians' receptivity (Zahariadis, 2007:177). Proposals that appear difficult to implement have a lower chance of being selected. This point is explored further in the second part of this chapter, and shows how the streams were coupled and why it was easier for the government to justify the adoption of mobile hospitals. Table 10 below summarises the policy alternatives which were suggested by different actors. Reviewing these alternatives helps to understand the rationale for the mobile hospital implementation.

Table 10: Health sector policy solutions as presented by various actors

Policy Makers	**Health workers and Staff at the Ministry of Health**	**Donor Partners**
Introduce mobile hospitals to operate in rural and peri-urban areas	Improve the distribution of drugs and medical supplies in all districts	Continue to implement efforts to improve primary health care such as community health worker interventions and building more health posts at health centres in rural areas.
	Renovate and upgrade health infrastructures	
	Address human resources crisis	
	Look into telemedicine	

6.3.1 Solutions proposed by different actors to address issues in the health sector

The majority of informants, particularly those working in the public health sector, also did not associate access to health services in rural areas as being so important to be addressed in what appeared to be a hasty decision to implement mobile hospitals. This could be because they

understood the problems in the health sector differently from the government. They suggested other alternatives presented below.

Policy Makers

According to the government, mobile hospitals were an appropriate solution to the problem of inadequate access to health care services in rural areas. The proposal for mobile hospitals was made by President Banda in his first address to the National Assembly in January 2009, amid criticism. Many actors and commentators felt other solutions could be considered. Some of these are given below as obtained from interviews and document analyses. In response to the criticisms against mobile hospitals, the government stated that it had a duty to provide health services to everyone and bring the services closer to people. It argued that mobile hospitals was part of its plan to extend the outreach services already being implemented through the Zambia Flying Doctor service. Furthermore, those who were against the initiative were accused of doing so from a comfortable position with little knowledge about the difficulties that people in rural areas experienced to access health centres (Shikapwasha, 2009).

Ministry of Health bureaucrats and health workers

Health workers and staff in the ministry stated that they preferred other solutions to be implemented to address the numerous problems in the health sector. Further, they stated that they resisted the idea of mobile hospitals because they felt that the resources could have been invested in addressing other challenges in the health sector as presented above in the problem stream. The idea was resisted also because it was seen to have been imposed by the authorities without proper consultation and without considering other options. Different interviewees expressed the following sentiments: *"If you want buy-in in a project, you do not do top-down." "It was not a priority". "There was need to engage stakeholders from the ground." "There was so much secrecy and lack of information."* (Interviewees H, I and M, 2016).

Commenting on mobile hospitals in the country, the Health Workers Union of Zambia stated that the government rushed to procure mobile hospitals without addressing critical challenges the country was facing in the health system.[31] Improving the distribution of drugs and medical supplies was seen as more important than mobile hospitals. It was only in 2015 that the government introduced medical hubs in all provinces to help eliminate drug shortages (Chibuye, 2015). In addition, vehicles have only recently been allocated in each province to

[31] Read more at Post Newspapers. 03 Feb. 2011 (http://postzambia.com/post-read_article.php?articleId=18627&highlight=mobile%20hospitals) Accessed 5 June 2015

take drugs to the remote facilities. Prior to this, districts had to send staff to the medical stores in Lusaka to collect medical supplies which was costly and not an efficient way of ensuring drug availability in health facilities.

Another solution proposed and implemented was to continue improving health infrastructures around the country. For instance, facilities and specialised services at the University Teaching Hospital (UTH) were improved, and the standards of all provincial hospitals in the country raised to central or third level hospitals. District hospitals were also upgraded to first level hospitals. In Lusaka province, five clinics were upgraded to first level hospitals in 2011. Other initiatives implemented in the province were the completion of the provincial hospital, the Levy Mwanawasa General Hospital, plus a specialist hospital for cancer. The provincial hospital, built with financial assistance from China also became operational in 2011. However, some health workers interviewed noted that while these initiatives were good, more could be done to ensure that the facilities were up to standard. For instance, it was reported that the upgrading of clinics to first level hospitals was done in a rush. A senior doctor stated, "*The facilities had no equipment and staff befitting the status. It was just on paper. If someone came for a serious issue, we would still refer them to UTH even when we did not have to."* (Interviewee H, 2016). Because of such cases, it is no wonder people argued that upgrading the facilities alone was not enough and that proper resources were not allocated.

Another solution proposed to address the inequities in access to health services was to improve the human resources situation. The Resident Doctors Association reiterated that mobile hospitals were not the best solution to the health problems in the country, noting that most provincial and district hospitals did not even have adequate specialists.[32] Since the Ministry of Health was operating under a staff shortage, workers proposed that increasing the numbers, improving staff morale through incentives such as hardship allowance, and training more specialised staff could be helpful to improve the situation. This would also help to staff rural facilities and improve access to health services.

Some health workers as well as the Ministry of Health staff were of the view that the government could consider initiatives such as tele-medicine as opposed to mobile hospitals to bring health services closer to the people. Two senior health workers interviewed stated that since tele-medicine provides a proper triage system; people can be seen from wherever they are

[32] Post Newspapers. 3 August, 2010. http://postzambia.com/post-read_article.php?articleId=12278&highlight=mobile%20hospitals) Accessed 20 October, 2015.

without needing a specialist to travel there (Interviewees G and H, 2016). A specialist would remotely advise on the patient while a local staff member did the work. It was argued that in the long run, if funds being spent on mobile health were to be invested in tele-medicine, a proper fibre network and other infrastructures could be built.

While the Ministry of Health has an eHealth policy and an mHealth technical working group, tele-medicine has not been fully explored as a way to deliver health services to rural and underserved populations. Examples of a few initiatives in this regard are the Zambia Defense Forces who have partnered with United States of America donors to link clinical experts at the main Defense Force hospital in the capital Lusaka with their pilot health sites in other parts of the country. The Virtual Doctor project is a similar project supported by funds from an organisation in the United Kingdom. Telemedicine has also been identified as a significant enabler of affordable and accessible quality healthcare in the country (Freedom to Create, 2016).

Donor Partners

Donor partners were of the general view that mobile hospitals should not have been considered to begin with as they were not a priority at the time. They argued that what the government needed was to continue with efforts to improve primary health care. Focusing on primary health care in the rural areas was suggested as an alternative to mobile hospitals because it was a cheaper long-term way to prevent diseases. One of the donor partners interviewed argued that what was needed was to find a way to manage diseases from the onset by investing in nutrition and health which would ultimately prevent some of the conditions addressed by mobile hospitals (Interviewee L, 2016). Another donor partner (Interviewee K, 2016) stated that they had advised the government to expand and improve its use of community health assistants in rural areas to help solve the problem of inadequate staff and to build capacity. The donors interviewed stressed that mobile hospital implementation as they understood it, was not part of their focus areas since it did not address primary health care. Most of them disclosed that they directly supported through funding, the implementation programmes related to primary health care: malaria, HIV/AIDS, maternal and child health, sexual and reproductive health, and cervical cancer.

In view of the impact of international health organisations and donors in health policy in a context like Zambia which relies on donor funding for most of its activities, the applicability of MSF in a public health context in terms of setting the agendas one can be said to be minimal

because the agenda for health is usually set by these organisations. Therefore, Kingdon's policy stream activity where experts debate and study solutions is not a prominent feature in this context as this is already decided. Rather, it is part of the official procedure which can help to endorse an emerging policy, as such, the 'debates' are formality. In this case, the agenda was already set by the president and the 'donor' which is AVIC and the meetings and consultations had were all formality. However, the MSF as a tool for studying certain aspects of public health is still valuable as it helps to understand how policies enter the public domain and how they compete among many other policies. It helps to show how the president for instance ensured policy implementation.

6.4 The Political Stream and the Modification of the Multiple Streams Framework for the Study

In this section the focus is on the last of Kingdon's three independent streams, the political stream, and how activities have impacted the implementation of mobile hospitals. Kingdon's (2011:145) political stream originally comprises "public mood, pressure group campaigns, election results, partisan or ideological distribution in Congress, and changes of administration." The perceptions of policy makers about factors such as these are seen as the most vital contributors to influencing the prominence of an issue on the state's agenda. They must therefore take note of the problem and be open to proposed solutions (Kingdon, 2003:198). For instance, a new administration might put forward new agenda items while at the same time shelving existing issues for a more opportune time.

While acknowledging that the multiple streams framework is rooted in universal concepts that can apply to many settings including this case, this study has modified and adapted the framework to suit the context in order to highlight the impact of institutions on policy implementation. As a lens, the framework was limited in its scope regarding institutional factors.

Modifying the framework

Taking the idea of coupling put forward by Kingdon (1984) forward to implementation, Ridde (2009) has argued that for implementation to occur, there must also be coupling of the policy and problem streams. I amend this argument to state that this coupling depends on the institutional position of the policy entrepreneur, and further that the coupling of streams is also needed for implementation to continue. I thus argue that institutions then continue to have an

impact not only in decision-making but also in implementation. This is because a supportive political stream is essential for the coupling of the other two streams (the problem and policy streams) and it is in the political stream where we find political institutions which should structure the policy decisions made during the decision-making stage. However, I find that Kingdon's framework is limited in its focus on institutions and how they impact policy, particularly as the framework places more agency on the policy entrepreneur's skills than the position of power they may hold.

In this study I, therefore, modify the political stream in the framework to pay attention to institutional factors. The adapted framework explored questions such as the underlying institutional factors shaping the implementation of mobile hospitals and the way that these factors can be incorporated in the framework, especially the political stream. This adaptation was needed to help facilitate a more contextualised understanding of policy implementation for this case. In order to do this, I partly draw on insights on the role of ideas in policy (Beland, 2005), and on insights from new institutionalism which asserts that the conditions of political opportunities are set institutionally (John, 2012).

New institutionalism examines both the way that institutions constrain as well as enable political action by the state and societal actors (Kern, 2011). The major argument of these approaches is that institutions are important and that there is something inherent in them which accounts for the way that governments make decisions (Peters, 2005:164). I particularly draw on insights from empirical institutionalism which is one of approaches within new institutionalism. Empirical institutionalism argues that the structure of government makes a difference in the way in which policies are processed and the choices made by governments (Peters, 2012:90). It recognises the country-level contrasts in styles according to the formal institutions that are present in a political system (Cairney, 2012:82). Table 11 below is an example of these differences that empirical institutionalism refers to.

The multiple streams framework was, as already mentioned, developed in the United States for agenda setting, a developed country with a different governance style compared to Zambia. Although both practice the presidential system, the USA is more decentralised and has several players involved in policy and decision making, unlike Zambia. Scholars such as Cairney & Heikkila (2014) and Zohlonhfer et al (2015) have called for an extensive academic debate on ways to theoretically modify and advance the multiple streams framework further, beyond its initial development.

Table 11: Majoritarian-consensus democracy dichotomy

Institutional divisions	Majoritarian democracy	Consensus democracy
Executive power	Concentrated in single party majority cabinet	Shared in broad multiparty coalition
Executive-legislative relationship	Executive is dominant	Balance of power between executive and legislature
Party system	Two-party system	Multiparty system
Electoral system	Majoritarian & disproportional (based on a plurality of votes)	Proportional
Interest group system	Pluralist free-for-all and competition among groups	Coordinated and corporatist, exhibiting compromise and concertation
Federal–unitary	Unitary and centralized	Federal and Decentralized
Legislative power	Concentrated in unicameral legislature	Divided between two strong houses
Constitutions	Flexible constitutions that can be amended by simple majorities	Rigid constitutions that can be changed only by large majorities
Constitutionality of laws	Decided by legislatures	Subject to judicial Review
Central banks	Dependent on the executive	Independent

Source: Adapted from Lijphart (1999 cited in Cairney, 2019 forthcoming)

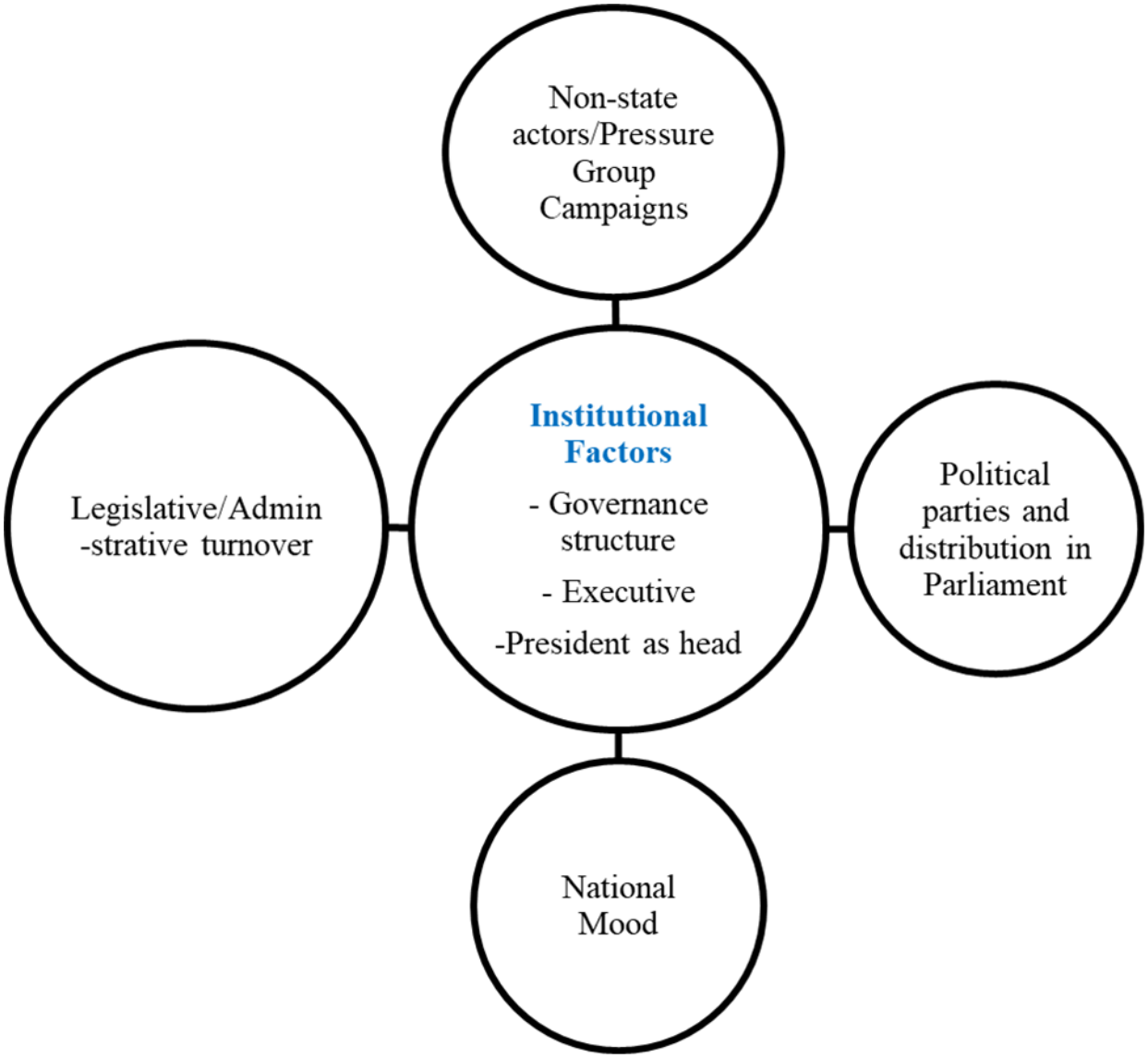
I modified the framework, particularly the political stream, to place emphasis on institutional factors, and to put them at the centre of the political stream since all the other elements in the stream tend to be influenced by institutional factors. This is not something that Kingdon (2003) paid attention to in his framework. This study observed that the multiple streams framework did not provide an adequate lens through which to study policy implementation in this context

due to its limited focus on institutional factors which impact on policy. To facilitate a better and contextualised understanding of policy implementation, the framework was thus modified and adapted to suit the context by placing institutional factors at the core of the political stream.

Suggestions on how to integrate institutions in the multiple streams framework have mostly been put forward at decision making stage (Saetren, 2016; Zohlnlofer, 2015). This dissertation extends the research to also include the implementation stage. As Zohlnhöfer and Rüb (2016:8) point out, there is nothing in the framework that prevents the possibility of introducing institutions into the framework. I thus focus on the overall governance structure within which policy actors operate, thereby arguing that to study implementation, especially in this context, it is important to first examine this structure. Further, I argue that there is need to understand the streams, especially the political stream, differently. Applying the multiple streams framework in Zambia showed that the political stream in particular was not exactly the same as in the United States in terms of the roles and powers of political institutions, including non-state actors, in policy implementation. For instance some institutions and non-state actors had limited authority to act independently without interference from the executive. The study therefore argues that other political institutions in Zambia tend to be 'abused' or manipulated by actors in the executive central government to pursue their own ideas and interests.

These factors in the political stream are analysed in relation to the implementation of mobile hospitals. While many policy analysts agree that developments in the political sphere alone can be powerful agenda setters (Birkland, 2005; Huang, 2006; Kingdon, 2003; Sabatier, 1999), this section shows that elements in this stream are just as powerful for implementation, as they are for agenda setting. While invisible participants in and around the administration also shape the agenda, it is mostly visible participants like the president and his appointees who contributed to ensuring implementation. Members of Parliament on the other hand despite being among the visible participants did not influence agenda setting or implementation. The components in the political stream presented below are analysed in relation to their impact on implementation of the mobile hospitals. An illustration of how the political stream in the framework was adapted for the study is provided below (Figure 10). Institutional factors are placed at the centre of the stream because the context is one in which most power is retained at the centre thus impacting the entire policy process as well as the other elements in the stream. I therefore argue that understanding the political and governance structure first is important in order to examine policy implementation in this context.

Figure 10: Adaptation of the political stream for the study



Source: Own modification after applying the MSF in the study

6.4.1 Media and National Mood

The national mood according to Kingdon (2003:147) is the general climate in a country which reflects what a large number of people are thinking along common lines. As vague as it may be, the mood changes from time to time and the changes have significant impacts on policy agendas and policy outcomes. Zahariadis (2007:73) therefore argues that government participants sense the mood in a country and promote items on its agenda that seem to be in favour of the mood, or shelve the items until a more favourable time. When the participants

detect that the mood has changed, they also change the agenda in line with the new mood. The point I am making here is that despite the national mood being strongly in favour or against a policy, it is not enough on its own to influence whether or not the policy is implemented where the executive is very strong and pressure group activity is weak. In this case, even though the national mood appeared to be strongly against mobile hospitals, it was not enough to determine whether or not government would adopt mobile hospitals.

Analysing the national mood around the time of the mobile hospital agenda and its implementation shows that this mood was strong against the proposal. The mood is analysed from the perspective of media reports which generally presented an apathetic view of the hospitals even though this did not affect its implementation. Kingdon (2003:57) notes that unlike other interest groups, the media is not as influential in agenda setting as is sometimes perceived. It does not affect the government's agenda because it reports on issues that government is already aware of in most cases; its role is more informative and does not necessarily cause government to act on particular issues. According to various media reports especially from private media[33] as well as various Parliamentary debates of 2009 and 2010[34], the general feeling among most people regarding the introduction of mobile hospitals was apathetic. Citizens expressed their views in the press and made it known that there were other ways in which the government could have invested in health services for underserved areas (Kyambalesa, 2009; Katulwende, 2009). Interviews conducted with various informants also acknowledged the negative feedback and criticism from other stakeholders.

The media in Zambia, a vehicle through which citizens remain informed, has often had clashes with the government especially when it involves negative reporting (Kaliba, 2014:12). It is neither fully independent nor free from state interference. The private media in particular played an important role in bringing to the public attention the government's intention to secure a loan for the purchase of the mobile hospitals. It presented critical views of this agreement from citizens and stakeholders while the public media was more passive and reported on the would-be benefits. The public media organisations which have wider coverage in the country are heavily influenced by the state and their reporting is usually biased in its favour. The Post

[33] Private media organisations such as The Post, Zambian Watchdog and Lusaka Times were in the forefront of informing the public on mobile hospitals eg see https://www.zambiawatchdog.com/china-gives-zambia-53-loan-for-mobile-hospitals/ (Accessed July 5, 2018)
[34]See Parliamentary debates of 21 October, 2010 available at http://www.parliament.gov.zm/node/1416 (Accessed May 10, 2017)

Newspapers, considered the most influential and critical independent media organisation at the time, revealed most of the information that was withheld by government, and generally presented a negative view of the hospitals. Information such as the estimated costs of operating the units, the alleged corruption involved, and the fact that government had already signed the contract to procure the mobile hospitals before consultations were concluded, were reported. The Post Newspapers has since been forced to shut down for arguable reasons related to failure to pay tax.[35]

Despite all these efforts, the media was not able to stop the government from implementing the mobile units. Even when the hospitals were implemented, the private media organisations argued that government were wasting resources, and that their main aim was to appease the rural areas ahead of the 2011 general elections (Zambian Watchdog, 2011). The media continues to play an important role in highlighting the challenges of rural populations in accessing health services by reporting on the implementation of mobile hospitals today. It has contributed to the positive image that is now associated with the mobile units as pictures of people waiting to be attended to are shown, and interviews are held with various beneficiaries of the services. Its role in the implementation has moved to a more supportive one as opposed to its critical and skeptical position in the beginning. The research nonetheless shows that as important as the media is perceived to be, it could neither influence agenda setting nor the implementation of the mobile hospitals. This can be attributed to the fact that a decision had already been made by the government and it was not willing to back down.

6.4.2 Political Parties and Members of Parliament

The commissioning of the mobile hospitals was heavily criticised by opponents of President Banda and his party. The opposition political parties were among the strongest critics of the mobile hospitals particularly the two biggest opposition parties, namely the Patriotic Front and the UPND. They argued that the government needed to construct hospitals in underserved areas rather than implement mobile hospitals. Sata, the leader of the Patriotic Front, the biggest opposition party at the time, also argued that corruption was the main reason for government's decision to procure the health units (Chilembe, 2009). Another opposition party leader, Hichilema of the United Party for National Development similarly charged that corruption was

[35] The Zambia Revenue Authority shut down the Post Newsapers in June 2016 for failure to pay various taxes equivalent to about USD $3.7m. See more at https://www.lusakatimes.com/2016/06/21/zra-shuts-down-post-newspapers/ (Accessed 10 October, 2019)

the motivating factor behind the acquisition and that the president was benefiting from a deal (Chilemba, 2011:3; Engstrand, 2013:13).

Despite the debates in Parliament about whether the mobile hospitals were suitable for the country, it was not possible to stop the government from going ahead, as already mentioned.[36] The ruling MMD commanded 50% of the House but had support from other opposition members who were serving as deputy ministers in Banda's cabinet. It was therefore able to convince Parliament and ensure that the policy to support the provision of health services through mobile hospitals was not only formulated but also implemented. Concerns from the opposition were also raised as to whether this was meant to boost the popularity of President Banda during the campaign so as to win votes in the rural areas since general elections were scheduled to be held in October 2011 (Kyambalesa, 2010). One of the opposition Members of Parliament described the move as a mere "campaign gimmick" that would be done away with after the elections (*Lusaka Times Online, April 29, 2009*).

This was however, not the case. Even though President Banda's party lost that year's general elections, Sata's new government continued with the implementation of the mobile hospitals stating that it was not easy to deliver health services, but that the use of mobile hospitals would ease matters (Mwenya, 2013). Sata further argued that since they were already purchased and all loan agreements had been finalised, they could as well be utilised. President Sata was criticised by the opposition for appearing to have gone back on his word when he himself had been a strong critic (Mwenya, 2013).

6.4.3 Donor Partners impact on policy implementation

A discussion about health policy in Zambia is incomplete without including donors because they are key partners mainly due to the technical and financial support offered to the Zambian health sector. And there is no doubt that they operate in the political space which makes their role relevant. In addition, this discussion highlights the somewhat sour relationship between donors and the Ministry of Health at the time when the mobile hospitals were being introduced to give some context and to help understand why they were unable to effectively influence the government's decision. As the health sector in Zambia is largely donor reliant, the donors usually have a say in various health policy formulation and implementation processes. For

[36] Parliamentary debates on June 8, 2011 on the operational guidelines of the mobile hospitals. Available at http://www.parliament.gov.zm/node/1322 (Accessed 14 October 2017).

instance, PEPFAR and the GFATM have had significant impact on national and sub-national level implementation processes of ART roll-out (Hanefeld, 2009). Similarly, they have also in the past mounted pressure on government to improve financial control systems and investigate cases of abuse of funds in the Ministry of Health (Pereira, 2009; Engstrand, 2013). In this case related to mobile hospitals however, donors were not able to significantly impact the policy process apart from mounting pressure on the government to set up a committee to determine the feasibility of having the mobile units. This is in part due to the fact that a decision had already been made to purchase the units, with government arguing that it was a caring government that wanted to look after its people who are disadvantaged in terms of access to medical facilities[37]

It was reported that various donor partners in the country felt that the pressure to have the mobile health units came from outside the health sector and definitely from outside the experts themselves (Chilemba, 2009). They questioned the purchase of the hospitals and argued that they should have been consulted because they were the ones to pay for the loan after all, and threatened to cut funding (Pereira, 2009). They believed they should have been consulted by the government before the purchase, and that the government was not being honest about the deal (Katulwende, 2009; Richey and Ponte, 2016:151).

When it was apparent that the government would go ahead with the purchase, most agencies withdrew part of their funding to the Ministry of Health, arguing that they were not made aware and would not pay for something they did not support (Katulwende, 2009). They further stated that mobile hospitals were not a priority since they did not appear on the list of priorities in the National Health Strategic Plan (NHSP 2006-2010). This discontent did also not affect the decision to implement the units. Neither did it affect their operations. The NHSP outlines health sector development over a five-year period. It is developed by the Ministry of Health and its co-operating partners including donors, NGOs and civil society.

Donor partners spoken to during fieldwork interviews stated that they did not consider mobile hospitals a priority for either themselves or the government. They felt that their direct support in the health sector was meant for priorities in reproductive, maternal, new born, child and adolescent health (RMNCAH), nutrition, community health assistants, HIV/AIDS, TB,

[37] Vice President and Minister of Justice George Kunda responding to a question in Parliament on why government had insisted on mobile hospitals, Parliamentary debates 26 August, 2010. Available at http://www.parliament.gov.zm/node/1501 (Accessed 20 November, 2019)

malaria, family planning and health systems (Interviewees K, L and M, 2016). However, the government claimed that it would have been premature for the Ministry to present the donors with the concept without first having arrived at a definite position (Shikapwasha, 2010). The donors argued that mobile hospitals were not the solution to the country's health problems and that the huge amount which had been spent was not justified.

One of interviewees from the donor community revealed that the disclosure by the government to introduce mobile hospitals came at a time when there was tension between donor partners and the Ministry of Health due to allegations of corruption and fraud (Interviewee K, 2016). This tension was caused by a two-million-dollar fraud which was unmasked in 2008 in which employees, among them a former human resource manager, used donor funds to acquire property and luxury vehicles (Engstrand, 2013). Following these reports of poor accountability, and unimpressed with the slow pace at which government was addressing the allegations, most of the donors were considering cutting funds to the ministry. So when the issue of mobile hospitals came up, it compounded the situation and made dialogue between the government and major donor partners like DfID and SIDA, even more difficult.

Donors called off the signing of a memorandum of understanding for support to the Ministry of Health pending a satisfactory explanation from the Ministry of Health. According to Engstrand (2013:70), the Swedish Embassy made a decision to stop the disbursement of the next tranche of Swedish direct budget support (US$11 million) to the Ministry of Health until the investigation into the allegations were completed by the Auditor General. Other partners such as the Dutch, and even those who were not directly contributing to the pool basket, also resolved to at least stop the flow of finances. As a result, practically all external funding in the ministry ceased within two weeks from the disclosure (Engstrand, 2013:70).

The officials representing the donor partners felt that the lack of an open tender process was a source of corruption and that the government was secretive about the whole process. Responding to a question to why the donor community in the country did not support mobile hospitals, one of the partners said, "*As joint investors in the health programme in Zambia, donors at the time felt that they should have been informed of the intentions of Ministry of Health to purchase mobile hospitals from a single source for US $53million which was one sixth of the entire health budget."* (Interviewee L, 2016). Another informant from the donor partners echoed similar sentiments, stating that one of the main reasons they pulled out of the SWAp was, "*because of corruption related mainly to procurement issues in the ministry, and*

related to single sourcing of the mobile hospitals." (Interviewee N, 2016). The number of donors contributing to the SWAp basket has since dropped and some of them have continued to provide off-budget funding which is not channelled through government systems (Chansa et al., 2013:247).

However, a high-level officer at the Ministry of Health pointed out that it was because these aid agencies do not consider anything that does not involve HIV/AIDS, TB, malaria, and maternal health as a priority that they did not support the implementation of the units. He added that the fact that the burden of disease which mobile hospitals were addressing was not related to their priority areas, they would not support the initiative no matter how many people were affected. He stated, *"Even if we had 20 diabetic patients in a rural area who needed attention and we asked them for vehicle to go there, they cannot give. But if we say there are 4 people with HIV, we will be assisted.*" (Interviewee B, 2016).

In June 2012, Sweden decided to renew its partnership with the Ministry of Health stating that it was satisfied with the governance action plan to improve accountability and transparency after the embezzlement of funds in 2009 (Engstrand, 2013:71). Two other partners also declared during the interviews that plans were under way to start giving aid directly to the ministry again (Interviewees L and N, 2016). A high-level informant at the Ministry also confirmed that some donors were warming up to the idea of mobile hospitals and were showing interest in supporting activities that were of interest to them, as opposed to covering the operation of the units in general. He gave the example of cervical cancer screenings as an area where donors were showing interest. He stated that the ministry had separated the unit from the services offered, that the vehicle was just a platform to deliver health services, and that donors could the add services they wanted to support to this platform. He added, *"The whole idea is that we need to be patient-centered and not be tied to the politics of how, where and when.*" (Interviewee B, 2016). However, support is yet to come from the donors. As they are expensive to maintain, the mobile units which are fully financed by the government presents a challenge because funds are limited and affects the programme.

6.5 Discussing Policy Entrepreneurs and Coupling of Streams

In this second part of the chapter, policy entrepreneurs and coupling are discussed as articulated by Kingdon (1995). The section starts by discussing the concept of policy entrepreneurs before proceeding to place the head of state and AVIC International as the policy entrepreneurs in the stages leading up to implementation. Coupling and policy windows are then discussed, what

they are, when and how they open. These are analysed in relation to the agenda setting, policy formulation and subsequent implementation of the mobile hospitals. This is done because it is almost impossible to discuss implementation of the mobile hospitals without first discussing the prior processes of agenda setting and formulation when using the multiple streams framework.

This ability to bring these stages of the policy process together when analysing policy implementation is one of the major elements that makes the multiple streams framework different from other approaches to implementation. As such, it helps to highlight the impact of political institutions on the policy process and how opportunities for policy implementation are created or lost through coupling or decoupling of streams as a result of institutional factors. The study thus found that the political structure was an important factor in determining the implementation of mobile hospitals. The chapter concludes with a summary of the discussion and the arguments presented here.

Policy entrepreneurs are defined as individuals or corporate actors, operating in and out of government and willing to invest time, energy, expertise, or money in pushing for the adoption of policies that they may have an interest in (Kingdon, 2003:179; Mintrom and Norman, 2009:650; Zahariadis, 1999:60). They can also be identified by their efforts to promote significant policy change (Mintrom and Norman, 2009:651). These entrepreneurs usually form part of the networks or a policy community involved in the generation and specification of policy solutions to problems. Policy entrepreneurs can be found in many places including in or out of government, in elected or appointed positions, in interest groups or research organisations. But their defining characteristic, much as in the case of a business entrepreneur, is their willingness to invest their resources – time, energy, reputation, and sometimes money – in the hope of a future return (Kingdon, 2011:122). Usually, those inside government can be quite influential (Saetren, 2016).

Networks include policy actors inside and outside of government who interact with each other, define problems, build teams, exchange ideas, and formulate and reformulate policy alternatives (Mintrom and Norman, 2009:651; Young et al., 2010:40). These networks are made up of academics, research think tanks, bureaucrats, staff and members of parliament, and funding organisations who share a common interest in a particular policy area. In promoting policy change, these advocates in and around government with solutions at hand wait for problems to float by to which they can attach their solutions, or wait for a development in the

political stream that they can use to their advantage (Kingdon, 2003:165). Policy entrepreneurs are able to ensure that a situation is labelled a problem so that policy makers can pay attention to it, working hard to direct resources towards the issue, classifying it as such, and ensuring that the policy is implemented.

Kingdon (2003) is however silent about the kind of strategies and actions successful policy entrepreneurs tend to engage in. Scholars like Zahariadis and Exadaktylos (2016) have looked into this and argued that an examination of entrepreneurial activity is typically divided in two parts: attributes and strategies. While Kingdon (2003) focuses on the major attributes of policy entrepreneurs such as access and persistence which increase the chances of entrepreneurial success, Zaharadis and Exadaktylos (2016:62) argue that explanations of policy outcomes must include the context (institutions, roles, and resources) that regulates social interaction, and that strategies by entrepreneurs must therefore also be studied. This study shows that institutions of power were used by the president as a policy entrepreneur to support his idea about mobile hospitals.

Aberbach & Christensen (2014:8) contend that coalitions or actors who favour a policy at the policy formation stage may not be the same as those who support it for implementation. This is because in the former stage politicians are usually the one making decisions while in the latter stage they are usually monitors because agencies and bureaucrats are involved in the implementation of the policy. In the context of mobile hospital implementation, there was not much of a difference in influential actors between the two stages; the study shows that the office of the president was actively involved in both. For instance, in terms of policy formation, President Banda pushed or rather persuaded his government as well as other institutions and actors into having mobile hospitals by ensuring a policy to that effect was formulated and later implemented despite resistance from various sectors. Implementation was not limited to bureaucrats, but actors in the political stream were also involved in ensuring that it was initiated and implemented as will be shown later in this chapter.

As Kingdon (2003:165) argues “advocates lie in wait in and around government with their solutions at hand, waiting for problems to float by to which they can attach their solutions, or waiting for a development in the political stream that they can use to their advantage.” I argue that AVIC International had a proposal on hand in the form of mobile hospitals which it sold to President Banda and his government. Kragelund (2014:151) notes that loans offered by China should be distinguished from aid as their aim is not first and foremost developmental but to

help Chinese companies access the African market. AVIC International and President Banda thus worked together to ensure that this policy was adopted. President Banda did not have to wait for a problem to float by to push this through because lack of access to health services was already a recognised policy concern which could be used as a reason. It was just a question of picking the 'right' problem to suit the solution. A development in the political stream made this possible for agenda setting when President Mwanawasa died and President Banda took office. In addition, being the president, he did not have to invest a lot of resources to advocate for the adoption of his idea like a usual policy entrepreneur would have to; he could use his position. As noted already, when President Sata took over in 2011, he continued with the implementation despite being a strong critic when he was in the opposition. I discuss this coupling and how the identified policy entrepreneurs ensured that their proposals and solutions were acted upon further in this section beginning from section 6.5.1.

Elections usually bring about a change in administrative or legislative offices. This is considered one of the most vital contributors to influencing the prominence of an issue on the state's agenda. For instance, a new administration might bring new agenda items while at the same time existing issues are shelved until an opportune time comes by (Kingdon, 2003). The change in administration from President Mwanawasa to President Banda in 2008 was a major factor contributing to setting the agenda and the subsequent implementation of mobile hospitals. This is because the first time that the idea was being heard was during President Banda's first speech as President to the National Assembly. Furthermore, the changes in administration from President Sata to President Lungu in 2015 affected implementation of the mobile hospitals. These changes and events are elaborated on in the paragraphs below and further in the chapter.

President Lungu also initiated changes that impacted on the implementation of the mobile hospitals. Therefore, the role of the head of state in implementation was very significant. President Banda is identified as the policy entrepreneur responsible for coupling for initial implementation, while President Lungu is identified as being responsible for the decoupling that has led to changes in implementation. This decoupling is explained further in the last section of this chapter. Studies have indicated that a favourable political stream is vital for implementation (Ridde, 2009; Zaharadis and Exadaktylos, 2016). This study shows that in a centralised economy like Zambia where the executive holds so much power, institutional factors are a determining factor for policy implementation. Further, the head of state in particular in the political stream must be supportive of the policy for implementation to proceed.

Blavoukos & Bourantonis (2012 cited in Gunn, 2017:267) argue that strategies used by policy entrepreneurs depend on the institutional context in which they are operating and that the most important structural institutional parameter that enables or hinders entrepreneurial activity is the level of entry barriers that policy entrepreneurs face in any given policy arena, which dictate the amount of resources that the policy entrepreneur has to invest in order to advocate policy change. This study thus argues that while AVIC International as a policy entrepreneur committed financial and human resources to ensure adoption of this policy, the President on the other hand did not have to invest much resources, rather it was about timing on his part. It is therefore essentially because of institutional factors that the streams were coupled. These factors include the privileged position of the president acting as a policy entrepreneur in collaboration with AVIC International. Instead of him engaging in entrepreneurial activities to push a proposal like the typical entrepreneur which Kingdon (1995) speaks of, because of the powers vested in his office he was already at an advantage and thus able to manoeuvre across all the streams to facilitate coupling. The study shows that the president as head of the executive, championed the cause for mobile hospitals. It reflects that mobile hospitals were an agenda supported by the president and that implementation was made possible mainly because of this.

For Kingdon (2003), coupling is relevant for policy change. The joining of the three streams of problems, policy, and politics which happens when a policy window opens, is important for policy entrepreneurs to push through their proposals. Coupling the streams is more likely when entrepreneurs frame issues appropriately. This is not just about ensuring that a particular proposal is adopted by policy makers, rather, it entails highlighting specific parts of the problem to put them in line with the language that is of interest to the the various policy makers (Zahariadis, 2007:70). Advocates in and around government keep their ideas about their pet proposals and problems at hand, waiting for a policy window to open as this is an opportunity to push these proposals through or bring attention to their problems (Kingdon, 2003:180).

Windows of opportunity are opened by events either in the problem stream or the political stream, such as a new problem which creates an opportunity to attach a solution to or significant political events that lead to the adoption of certain policies. According to Kingdon (2003:179), public policies are as a result of policy entrepreneurs seizing windows of opportunity to couple a problem stream with a political stream. While the policy stream is also present, it is loosely coupled with the other two streams. In the absence of this coupling, it is not possible for a policy to emerge. Taking Kingdon's (2003) point above forward, Ridde (2009:941) contends that an extension of the multiple-streams framework to implementation must therefore require a

coupling of the problem and policy streams with a supportive political stream. Furthermore, a coupling of streams must be shown to have occurred in the preceding stages when applying the framework to implementation (Ridde, 2009:941). These stages are agenda setting and policy formulation which were already discussed in the previous chapter. Coupling in these stages is thus discussed to help see the role that institutional factors played. I take Ridde's (2009) ideas on coupling forward by considering institutions as vital for this process. Further, while Zohlnhöfer et al (2015) discuss institutions and coupling at the decision-making stage, I go further and highlight the importance of institutions in coupling even at the implementation stage.

6.5.1 Coupling for agenda setting

In terms of agenda setting, the policy on mobile hospitals emerged when AVIC International and President Banda coupled the lack of adequate access to health services in rural areas with his new term in office when he delivered his first speech. The mobile hospital agenda which was set in 2009 was thus as a result of coupling the problem stream (the lack of adequate access to health services in rural areas) and the political stream (new President in office). One would ask whether policy windows are necessary when you have a powerful policy entrepreneur such as a president. I argue that a policy widow is indeed necessary as there needs to be a way in which the idea can be made easily acceptable. Timing is therefore important. In this case, a policy window was opened in the political stream when President Banda took over as the new Republican president in December 2008 after winning the presidential by-elections necessitated by the death of President Mwanawasa in August 2008. This was a window of opportunity because a change in government leadership usually brings about a change in policy (Kingdon, 1995). As Cairney (2018:207) points out, "outside of Kingdon's original study, there is often more scope for entrepreneurs to influence their environment or generate a wider range of strategies." Therefore, the strategy used by the president as a policy entrepreneur here is not about skill, rather timing and exploiting the window of opportunity enabled by the position of being in office.Even though both presidents belonged to the same party, the change brought about what was seen as a new policy in the form of mobile hospitals. The two presidents were indeed different people with arguably different policy agendas. Even though it is also not easy to determine exactly whether the idea to have mobile hospitals had always been an agenda item even before President Banda even took office, interviews with various key informants

suggested that it was an idea that just sprang up from nowhere.[38] As Kragelund (2014:151) reports, a representative of the donor community remarked "these mobile hospitals were not even on the horizon. I don't know who came up with the idea. Banda met with the Chinese ambassador to Zambia in January 2009 at Rupiah Banda's farm and a few days later it was announced." Based on this, it can be argued that Banda's new term availed him a chance to present this idea, which he did not do when he was acting president during the illness of President Mwananwasa, and which President Mwananwasa himself had not introduced. Furthermore, I argue that China (AVIC International) was an influential player in the agenda setting of the mobile hospitals because it is reported to have proposed the idea to the president (Banda, 2009; Morangi, 2016), who ran with it and ensured policy adoption and implementation against all criticism. Commenting on its' role in the initiative, AVIC project manager stated in ChinaDaily, a Chinese online news site that the "concept of mobile hospitals backs government's commitment to roll out nationwide healthcare that offers free quality services to 100 percent of the population." (Morangi 2016).

As narrated in the previous chapter, AVIC International committed resources, both financial and human resources to this project. It was supplying the mobile units at a concessional rate and was sending medical specialists as part of the deal to train local personnel. In addition, it was offering to service the vehicles for the first few years of implementation. On the local scene, the president had influence not only in the procurement process of the mobile hospitals by authorising single sourcing, but also in determining that the problem of access to health services was moved to the top of the agenda. According to Kingdon (1995), other actors such as bureaucrats or stakeholders working around the concerned policy area are usually or ideally policy entrepreneurs who identify the issues that need to be tabled for solutions. But this was not the case here. The president and AVIC International tabled this idea and acted as the policy entrepreneurs who ensured that addressing inadequate access to health to health services via mobile hospitals was top of the agenda. Gunn (2017) shows that policy entrepreneurs can be found at many levels, including working at the nation state level, but engaged with international organizations. For instance, Shroff et al. (2015 cited in Gunn, 2017:267) study of India's national health insurance reform scheme showed that domestic policy entrepreneurs such as party leaders, technocrats and senior government officials collaborated with international

[38] See list of interviewees in appendix

agencies for the adoption of the reform. Similarly here, the president working at state level engaged with an outside organisation to ensure policy adoption.

Despite several problems to be addressed in the health sector, and solutions proposed, what was ultimately passed was the suggestion of mobile hospitals. The president as a head of state in this case was at an advantage already and even though there was resistance to this idea from various sections of society, it did not stop the idea from rising to the top and eventually being adopted and implemented. The president was able direct the relevant authorities such as the ministries of health and finance, and the procurement authority on how to go about ensuring that mobile hospitals were implemented due to his institutional position. As alluded to earlier, many speculated that the president was persistent on having mobile hospitals because he could have been benefiting from the transaction with AVIC International (Chilemba, 2009). Even as the issue was taken to Parliament to be debated, it was too late because the ruling MMD commanded a majority in the House and the issue was passed. Furthermore, as a decision had already been made to purchase the units anyway, even the debates on their feasibility can be said to have simply been a matter of formality or to rubber stamp the government's decision. Non-state actors were also limited in how far they could affect the policy.

Similar to Boswell and Rodrigues (2016:511), I therefore argue that in order to understand implementation, it is important to understand the way policy problems are viewed by organisations in public administration as well as the pressures they encounter politically. The multiple streams framework in this case has helped us to see that institutions meant to provide oversight are weakened by the influence of central political figures such as a president, thereby affecting policy. It thus helps us to understand how institutions such as the executive impact on the policy process in a country like Zambia, by identifying the influential role of the president in the process. The president seems powerful because of the extent of authority he wields even over other institutions in the country. Issues can therefore get the needed recognition from officials even when there are no particular elements attached but simply because influential political actors are able to make a justification.

6.5.2 Coupling for policy formulation

Since policy formulation involves coupling policy and political streams (Kingdon, 2003), this study again argues that President Banda and AVIC International continued to be policy entrepreneurs responsible for coupling the political stream and thus the policy concerning mobile hospitals was formulated. Again, the policy window opened in the political stream

through his new administration. Once it was successfully identified that access to health services was a major issue in the health sector, the solution of mobile hospitals as suggested by the President Banda was formally adopted as suggested by the government. Despite there being a committee to look into the possibility of having mobile hospitals, it was viewed more like a formality as it could not go against the position of the president.

Further, Parliament was not effective or influential in ensuring that the policy was not adopted. This is because of the power dynamics that exist in the Zambian context whereby a decision had already been made and only taken to Parliament for approval since most members were aligned to the ruling party in some way. This finding shows the influence of the executive even in the legislature. While Zahariadis and Exadaktylos (2016) note that one of the strategies used by policy entrepreneurs is institutional rule manipulation, I contend that in this case, it is an authoritarian use of institutional rules, being able to decide and bend the rules because of the protection and the immunity of the office.

As has already been noted in Chapter Five, the idea for mobile hospitals was viewed as abruptly coming from outside the health sector, and did not even appear in the usual policy documents such as the National Health Strategic Plans prior to and after 2011. It can therefore be argued that an opportunity presented itself to purchase mobile hospitals and government attached a problem to it; this problem being that of addressing the challenges that rural communities face in accessing health care. It therefore follows that solutions implemented are not always in response to a problem, but can be attached to a problem by those advocating for the solution, and will be implemented nonetheless. In addition, since the government did not have to start looking for funds, it was easier to go ahead with the mobile units because they came funded. Resources such as a team of doctors to train local ones and the very fact that the units were fully equipped, contributed to making the selection easier. The policy and political streams can therefore be said to have been well coupled and implementation was made possible. Zahariadis (2007:177) notes that proposals are adopted based on factors such as technical feasibility, budget feasibility, and public acceptability. In this case, all these seemed favourable for the government to justify the need for mobile hospitals.

As one informant indicated, training health workers is expensive and could take up to 12 years for people to appreciate the benefits, but the mobile hospitals were a ‘now’ solution (Interviewee A, 2016). It was argued that the mobile hospitals seemed easier to implement and offered a faster solution to the problem of inadequate access to health services. At the time they

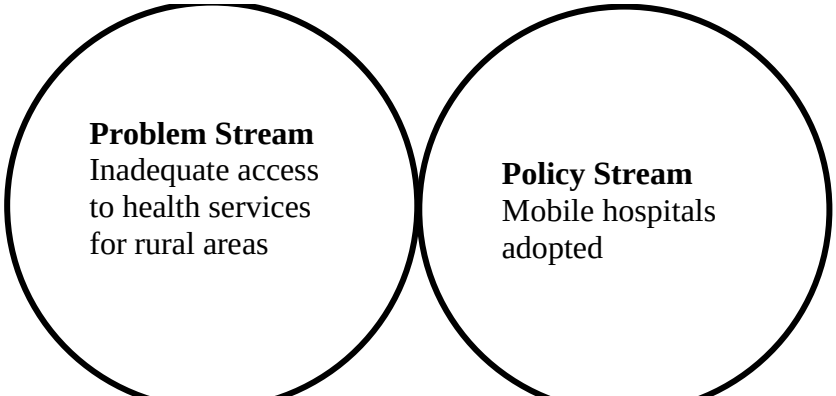
were seen at the time as convenient; an immediate solution to address an immediate need. The proposal appeared easy to implement and was selected even when it was not the preferred solution to inadequate access to health services. The Environmental Council of Zambia (ECZ) thus endorsed the project and the decision for it to be implemented was made and issued.

6.5.3 Coupling for Policy Implementation of Mobile Hospitals

Following the discussion above, agenda setting entails a coupling of the problem stream with the political stream, while policy formulation entails coupling the policy and political streams. As argued and demonstrated by Ridde (2009) as well as Zahariadias and Exadaktylos (2016) applying Kingdon's (2003) framework to implementation should thus entail a coupling of the policy stream with the problem stream, while the third stream (politics) in this case is loosely coupled. The politics is loosely attached because it is the bureaucrats who implement policies. However, the politics stream must be very supportive of the problem and policy for the implementation to occur.

As noted already by Ridde (2009), for this implementation to happen, it is essential that the situation be understood as a public problem warranting a solution. This suggests that implementation can only occur if the problem stream and policy streams are coupled. Since the mobile hospitals are being implemented, this coupling did occur. It can therefore be argued that implementation was made possible because inequities in the access to healthcare in rural areas was perceived as a public problem requiring a solution which mobile hospitals provided. A window of opportunity for implementation to begin that year in 2011 was opened by the fact that it was a general election year to elect the President, Members of Parliament and Councillors. President Banda therefore as a policy entrepreneur used this opportunity to bring about the coupling for implementation to begin, possibly as a campaign strategy to solicit votes particularly in the rural areas (Figure 10 below illustrates this coupling). As noted already, the rural votes were important to secure for the ruling party because it had lost popularity in the urban areas to the opposition Patriotic Front. Larmer (2007) shows that Sata's Patriotic Front party enjoyed strong support especially in the urban areas from around 2005.

Figure 104: Coupling of streams for implementation of mobile hospitals



Source: Own interpretation

As Kingdon (2011:122) notes, the defining characteristic of the policy entrepreneur is willingness to invest their resources – time, energy, reputation, and sometimes money – in the hope of a future return. That return might come to them in the form of policies of which they approve, satisfaction from participation, or even personal aggrandizement in the form of job security or career promotion. In view of this, I argue that for President Banda in this case, this return was in the form of hoping for re-election to office. As for AVIC International, there is no evidence to suggest that they could have been policy entrepreneurs for implementation to occur because as a business, their main interest was to sell the units and not so much about whether government actually used them.

This case study shows that the political stream supported a coupling of the two other streams, leading to implementation taking place. It confirms that the presence of a supportive political environment is necessary for a coupling of the problem and policy streams to ensure implementation. The argument that policies which are not favoured by actors such as implementers are likely to fail has been demonstrated here; as long as there is enough political buy-in, a policy is likely to succeed, more so if this comes from a top actor like a presidential figure. This finding contradicts Boswell and Rodrigues (2016) argument that implementation is mostly dependent on the decisions and behaviour of the actors responsible for overseeing and implementing policy than it is on political dynamics.

Policy windows exist during implementation (Zahariadias and Exadaktylos, 2016). These windows open and close due to changes brought about mainly by changes in administration. This opening and closing of windows can lead to coupling, or decoupling of streams.. If there is a decoupling of the streams in implementation, the implementation ceases. At some point,

the problem and policy streams were no longer coupled, hence the policy to implement the mobile units started showing signs of failure six years into the process. This was in 2017 under President Lungu, and mainly due to financial constraints brought about by the changes in administration and policy direction. These policy changes started from President Banda all the way through to President Lungu as noted in the previous chapter when a new Minister of Health was appointed by the latter. The problem and policy streams were coupled for implementation to occur, but were decoupled when implementation as per the guidelines was no longer possible. This shows that the opportunity for policy implementation of mobile hospitals that was created through the opening of a policy window during the general election was decoupled due to changes in administration.

Zahariadias and Exadaktylos (2016:64) note that while ideas and strategies may still be the same during implementation, the introduction of new actors may alter the outcome. The changes in political administration highlighted other issues as priorities for implementation, as opposed to implementation of the mobile hospitals such as ministerial turnover. The appointment of a new Minister of Health in particular in 2016 provided an opportunity to renew the objectives of the mobile hospitals, and to reaffirm the Ministry's commitment to primary health care instead. This change in administration created an implementation window, which needed to be seized.

This scenario also highlights that just as governments choose which issues to focus on as problems during the agenda setting stage, so do they during implementation by choosing which proposals to implement or continue implementing due to limited resources among other things, hence the need for a policy entrepreneur even during implementation. In this case, there was no policy entrepreneur to champion for continued implementation of the mobile hospitals, rather, the policy entrepreneur who I argue was President Lungu, championed for the implementation of primary health care instead. Mobile hospitals were no longer a priority for his government. The study therefore argues that for implementation to continue, coupling during implementation is just as important as it is at the beginning of implementation.

It is not enough to assume that once a policy has been created that it will be implemented, or that once implemented the policy will continue. There is also no guarantee that once a policy has been implemented it cannot be abruptly stopped. This is because even during implementation, new problems may emerge that require attention or new policies that need to be implemented. As a result, there have to be people to push for a particular policy to continue

being implemented because of competing demands. Policy entrepreneurs in implementation are therefore important. In this case, President Lungu chose to advance and direct resources towards primary health care over mobile hospitals. Once more, primary health care is on the top agenda even for the World Health Organisation as a means to attaining universal health coverage which the government of Zambia is also committed to do.[39] This highlights the important role of the political stream and actors such as policy makers in implementation. Policy makers, in particular the president was seen to be essential throughout the implementation process, and not just at the beginning of the policy. Further, the influence was not only at setting the agenda, but extended to implementation.

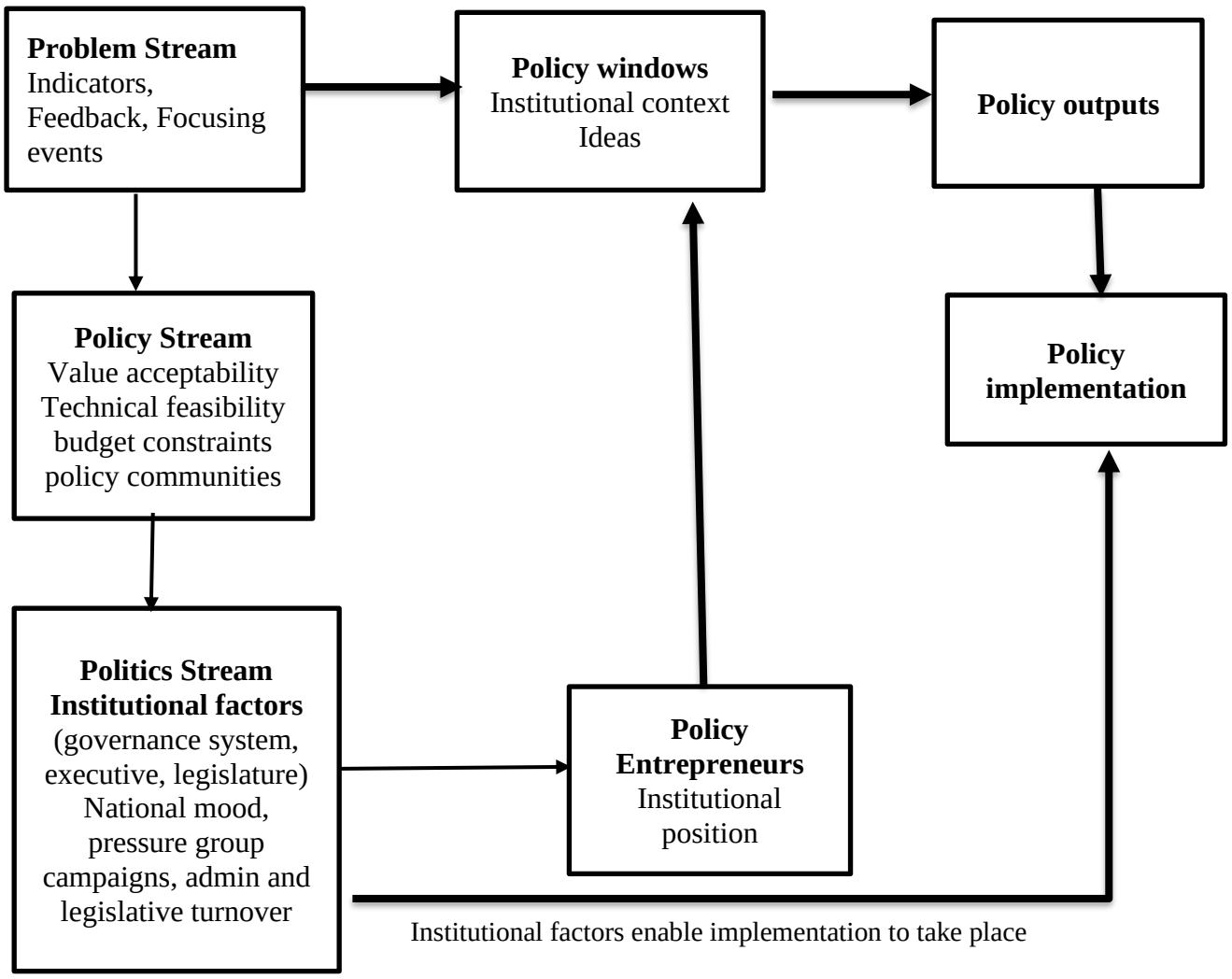
This study further highlights that even when a policy is heavily contested and extensively disapproved during its formulation, there is a still chance of it succeeding in most respects given political will. Undoubtedly, a favourable political stream is necessary for policy implementation. The study therefore suggests that implementation in a centralised context where there is strong central commitment to have a policy implemented, even when the proposed policy does not match what is perceived as a problem by implementers or the organisation, we can expect implementation to go ahead against all odds, and be effective to a large extent. The key here is having a strong commitment from the centre. However, where the policy doesn't appear to fit with the organisation's perception of policy problems and central government does not seem committed either, then we can expect weak implementation.

The adapted multiple streams framework thus explored questions such as the underlying institutional factors shaping the implementation of mobile hospitals. Issues such as centralisation of state power, cooperation with donor partners in health policy, and government department lack of discretion and independence, were explored. When analysing the influence of institutions on the implementation of mobile hospitals, an important institutional feature was the concentration of executive power in the president. This institutional context shows a governance system where the government can initiate new policies with or without stumbling blocks. The structure of the civil service and other government departments is another important institutional factor as they all get direction from the head of state. This leaves little room for autonomous decision making. In essence, the structure of the Zambian political system reinforces the political influence of the executive/president, who can oppose or propose

[39] The head of the WHO has reaffirmed his commitment to Primary Health Care and governments consented to renewed efforts to attain universal health coverage for all.

decisions for implementation. I found that while the concept of policy entrepreneur is important, Kingdon did not pay much attention to the institutional context/structure in which the entrepreneur was acting, which structure helps to determine the behaviour of the policy entrepreneur. Figure 11 below shows what the framework looks after it has been adapted. It highlights that institutional factors are an important element determining policy implementation

Figure 11: Kingdon's multiple streams framework after modification



Source: Own adaptation of the MSF for policy implementation

6.5.4 Challenging independence of streams

Understanding policies, problems and politics as separate streams, entails two things. Firstly, it entails that policies are formulated independently of the problem, but coupled to the politics stream by a policy entrepreneur when a window of opportunity opens (Kingdon, 2003:3). Secondly it entails that the type of actors found to be dominant in each stream is rather unique

(Kingdon, 1995:228). Based on these two points, the extent to which the streams can be said to be independent is questionable. As some have argued, the extent to which the streams are truly independent is debatable since actors operate in more than one stream at a time (Kendall, 2000; Muciaroni, 1992; Sabatier, 2007).

I argue that in this case, there was more of co-dependence rather than independence. On one hand, the streams could be said to be independent because the solution of mobile hospitals was developed independently of the problems in the health sector, but just coupled to them in order to justify their implementation since access to health services was an issue anyway. On the other hand, I also argue that the streams were not necessarily independent of each other because of the policy entrepreneur who was an actor in all three streams. As a powerful and privileged actor inside government with information on problems, policies and politics, all that was needed was to wait for the perfect time to couple all this together to ensure implementation. As shown already, the president was therefore involved in both problem and solution identification.

Problem identification in the problem stream is through mechanisms such as feedback, indicators, or focusing events while in the policy stream specialists dominate, designing and influencing policies which are usually selected based on set criteria such as feasibility. The political stream on the other hand develops based on several factors such as party ideology and legislative turnovers. However, as noted in the previous chapter, there was no evidence of policy specialists dominating or playing an influential role in the policy stream. While they participated in designing the policy related to mobile hospitals, they were not influential and only came in at a later stage after the decision to have mobile hospitals had already been made (Kragelund, 2014:151). Further, in the problem stream, instead of seeing bureaucrats influential in identifying issues as Kingdon (1995:228) claims, this was not the case either. This focus on the type of participant dominantly found in each stream is a vital part of Kingdon's framework, and one of the main reasons for thinking of streams as separate streams, flowing according to their own rules. As he argues in his book (1995:228)**:**

> As to the policy and political streams, I still find it useful to portray them as independent of one another, but then sometimes joined. First, they are independent in the sense that they tend to involve different people. Policy communities are made up of specialists in particular areas, with detailed knowledge and technical expertise; political communities include elected politicians and those around them. Second, these different sets of people have different preoccupations. The policy community concentrates on matters like

> technical detail, cost-benefit analyses, gathering data, conducting studies, and honing proposals. The political people, by contrast, paint with a broad brush, are involved in many more issue areas than the policy people are, and concentrate on winning elections, promoting parties, and mobilizing support in the larger polity.

Based on the above, I argue that the streams in this case can be seen as being interdependent as opposed to independent since one actor was found to be influential in all the streams. This lack of separation of streams can be explained by the type of governance system in this context; a type where the president as head of the executive holds significant power which enables him to be determine policy. Therefore, while Kingdon's framework is viable and can help us to understand implementation by showing how the agenda and policy is advanced for implementation to occur, this study finds that the framework when applied to implementation in this context, shows that the streams do not run as independently as portrayed by Kingdon (1995) for agenda setting.

Further, it argues that the framework in this context does not provide a comprehensive analysis for policy implementation because it does not quite show or illuminate where the idea for mobile hospitals came from exactly. While the literature on policy entrepreneurship often places the focus on specific individuals, how they collaborate with others is always fundamental to explaining the development and promotion of policy innovations (Mintrom, 2019). The problem here however is that it is not easy to determine for instance how or if the president worked with his cabinet or party members to encourage adoption of mobile hospitals. Rather, what is clear from the interviews and secondary sources is that the idea was communicated by the president against the advice of technocrats but supported nonetheless by his party. As noted throughout in the study, the idea seemed to emanate from outside the health sector and suggested by the Chinese company AVIC International. This was the view held by various stakeholders interviewed. However, there is not sufficient evidence to determine for sure where this idea came from, whether it was AVIC International looking for business or the president himself who found a company to buy in his idea. It is clear however that they worked together.

6.6 Conclusion

The chapter presented findings from the field related to Kingdon's three streams, showing how various actors analysed what they thought was the problem, and the solutions they proposed. The problem stream established that there were various understandings of health policy related problems in the health sector around the time that mobile hospitals were being offered as the

solution. The policy stream showed the various policy proposals or alternative solutions related to addressing inequities in the access to health services in rural areas. The chapter also showed how institutions were placed as the basis for analysis of elements in the politics stream because it was established that the institutional context was an important background for understanding implementation contextually. The adaptation of the framework in this manner makes it better suited to study policy implementation for the study. The chapter shows that the framework has not been used in this manner before as most studies that have incorporated institutions in the framework have not done so when analysing policy implementation. In addition, using the framework in this manner also shows that it can contribute to the field of implementation as it highlights aspects which have not been addressed by the other commonly used approaches. These are: the ways in which agenda setting and policy formulation stages affect policy implementation. The politics stream thus showed the executive's influence in all the policy stages and why other actors, including non-state actors such as the media, donor partners and organisations representing workers, were unable to effectively influence the policy concerning mobile hospitals.

The chapter showed that in essence, the three streams had one common actor, namely the office of the president. The president in collaboration with AVIC International was influential in defining the problem, proposing the solution and having it implemented all together. In this vein therefore, the streams were not as independent of each other as Kingdon asserts. This finding is important for policy implementation because while other approaches highlight the various factors that affect and impact implementation, they do not offer a comprehensive analysis of the agenda setting and policy formulation phases that led to policy implementation. This places the multiple streams framework as a valuable tool for implementation because it brings the processes into focus, enabling a better understanding policy implementation. In this case, it shows that institutional factors affect the way that policy is adopted, formulated and therefore implemented. Therefore, the case demonstrates that in order to understand policy implementation, it is important to study the overall structure within which a policy is made. To this effect, the political stream was adapted to cater for an examination of institutions in the multiple streams framework. This is a contribution to modifying the framework, and to expand it theoretically. The chapter thus showed that policy is highly influenced by the presidency who wields so much power that other political institutions and non-state actors were only influential to a limited extent.

The chapter also reiterated the essence of coupling problem and policy streams not only for implementation to happen, but for it to continue during periods of change in government. The lack of adequate access to health services was understood as a public problem, such that government used this reason to attach its desire to implement mobile hospitals. It thus demonstrated the usefulness of the political stream in supporting the coupling of the policy and problem streams for implementation. Despite the resistance and objections from various sections of society, the government ensured that implementation was achieved, even though it took almost two years to do so**.** This reaffirms that a strong political will is vital for implementation to be initiated, as well as for it to continue. The chapter has thus helped to demonstrate that policies which have a massive political buy-in are much more likely to be implemented, even when other stakeholders such as implementers and bureaucrats may not be in support. This goes against the commonly held view that policies which lack support from the people may fail to be implemented. The next chapter provides a summary of the dissertation and offers recommendations for future studies.

CHAPTER SEVEN: SUMMARY, CONTRIBUTION AND CONCLUSION

7.1 Introduction

This dissertation aimed to assess the utility of the multiple streams framework for studying policy implementation. Despite being developed for agenda setting, a few studies have demonstrated the applicability of the framework to understand implementation (Lemieux, 2002; Exworthy et al., 2002; Exworthy and Powell, 2004; Ridde, 2009; Boswell and Rodrigues, 2016; Zahariadis and Exadaktylos, 2016; Sager and Thomann, 2017). My approach to this research on policy implementation was similar to Ridde's (2009) in that we both apply the framework to health policy implementation in an African state. In general, studies applying Kingdon's framework in Africa are few compared to continents such as Europe, Asia and North America. They are even fewer when it relates to applying the framework beyond agenda setting. Ridde (2009), as already stated is the only researcher so far in the literature who has used the framework for policy implementation in Africa.

However, my approach was different in that while Ridde (2009) uses the multiple streams framework to explain an implementation gap, I aimed to see how the framework can generally be useful for understanding policy implementation, to see what lessons can be picked for policy implementation by using the multiple streams framework. I thus did not begin from the assumption of policy failure, as did Ridde (2009) and indeed most implementation research. While this study confirms Ridde (2009) findings on coupling being necessary for implementation, I go a step to add that in a context with a strong executive, institutional positions of actors is an important factor that aids coupling. Therefore, I examined overall the political structure to understand the context in which actors operate and showed how institutions can affect policy implementation. I found that Kingdon's framework, as a lens through which to study policy implementation in this context was limited in scope as it did not adequately account for the impact of institutional factors on policy. To account for this, I modified the framework, particularly the political stream by placing institutional factors at the centre as the context here is one in which these factors affect the entire policy process. Doing so helped to facilitate a better and contextualised understanding of policy implementation.

In this chapter, the main aspects of this study are revisited, beginning with a summary of the research questions and findings. After this, I provide a summary of the empirical contributions

of the study, as well as the contributions to theory and to the field of policy implementation. This will be followed by recommendations for future research for both implementation and for the multiple streams framework.

7.2 Summary of findings

The main research question for the research was to assess whether the framework is relevant for studying policy implementation. In answering this, there were three other research questions that sought to be answered. These research questions were related to what implementation of mobile hospitals entails; the issues that were present in each stream that facilitated implementation of the mobile hospitals; and whether there were policy entrepreneurs that influenced policy implementation.

The research established that implementation of the mobile hospitals was a complex administrative task with many challenges such as inadequate human resources, lack of finances and equipment breaking down - all which have contributed to reduced field visits. While the mobile hospitals were able to bring health services closer to the people, they were not consistent in doing so especially due to financial challenges. The mobile hospitals did also not adequately provide primary health care services. This was going against the primary health care approach which government had committed itself to in order to achieve universal health coverage. Despite these challenges, implementation of the mobile hospitals had however generally been rated as a success by government officials. The reasons advanced for this include the large numbers of people waiting to be seen by health personnel whenever the mobile hospital was in their area, the huge numbers of cases attended to especially surgical cases, and the positive reviews from community members. Overall, the research found that running mobile health units were an expensive venture that needed to be well thought out and planned before implementation. Financial and human resources must be adequate in order to provide quality health services.

In terms of understanding the issues in the streams and policy entrepreneurs, the study identified AVIC International, working in collaboration with the executive, in particular the president as the head to be an influential in all the streams, influencing agenda setting and policy formulation. The president also ensured implementation of the mobile hospitals. The very structure of the political system in which significant power is vested in the president as the head of the executive ensured policy implementation. In such a centralised context, other institutions

of power and non-state actors are weak and their role in affecting policy implementation is limited due to political dynamics.

The political stream was thus seen as powerful not only for setting the agenda, but also for determining implementation. Further, it was established that governments are usually faced with the tough decision of choosing what policies to continue implementing amid tight resources, hence the need for policy entrepreneurs even during implementation to push for particular policies to be implemented. There were however no policy entrepreneurs to sustain implementation of the mobile hospitals, and so the schedule for implementation changed. The president who pushed for implementation of the mobile hospitals was no longer there to push for their continued implementation, neither did new policy entrepreneurs emerge. Instead, the new president prioritised other issues such as implementing activities that focus on primary health care. There was thus a decoupling of the policy and problem streams during implementation as a result of events in the political stream which further contributed to disruptions in the operations of the mobile hospitals. These events were the changes in political administration which led to changes in policy at ministerial level.

To answer the main research question on what the utility of the multiple streams framework for policy implementation studies is, it can be summarised as follows. The multiple streams framework contributes to understanding policy implementation by bringing into focus the agenda setting and policy formulation stages of the policy process when studying policy implementation in such a way that other approaches to implementation not necessarily do. The framework highlights among other things, how issues become problems warranting attention and how policy solutions are generated. The study further argues that to enable a better understanding of policy implementation contextually, the framework as a lens needs to be adapted or modified to adequately account for the impact of institutional factors on policy because in its current form, it is not. Studying policy implementation in this way helps to provide a better understanding of how policy implementation is affected by political and institutional structures. In this case, the political stream was adapted for the study to take the structure into account. While this adaption helps to study implementation, the study argues that the multiple streams framework does not comprehensively help us to understand implementation in this case because the agenda and the policy has not been chosen from an independent policy stream but rather decided by the president. Therefore, the framework in this case does not fully detail where the idea of mobile hospitals came from, despite sources indicating that it was an abrupt decision that came from outside the health sector.

The adaption of the framework is important because while the framework has been applied in various settings, it was originally developed in the United States, a far more developed country with authority being vested in various institutions, and non-state actors having a significant impact on policy. Therefore, applying the framework in a different context where the opposite applies shows how implementation is impacted. Zambia is characterised by a strong executive while other institutions of authority and non-state actors are weak which means that their influence is limited. Three things observed in this research are likely to be a feature in a context like Zambia where significant power lies in the executive through the president: 1) Other institutions of power are weak and fail to act independently. They are usually not able to oppose the executive. 2) Non-state actors are there to provide oversight but their influence on policy is limited because of the environment in which they operate which is not very open to opposing views. 3) Policy change and implementation is therefore made possible by the support of the executive. If it is in favour, implementation is possible and therefore stream coupling is facilitated despite opposition.

7.3 Empirical contribution of the study

Empirically, this study contributes to knowledge on the implementation of mobile hospitals in general, and more specifically in the Zambian context in Lusaka Province. The study was also driven by the desire to contribute to filling the gap in the existing empirical literature regarding the use of mobile units which offer services of a second level tertiary hospital. It has been noted that there is not much documented about mobile hospitals like the ones used in Zambia which are well integrated into the healthcare system as a way of improving access to health care beyond crisis situations and by delivering more than primary health care. Even in Zambia, I am not aware of any empirical research regarding mobile hospitals to date. Besides criticism on why mobile hospitals were not appropriate for Zambia, there is very little documented about their use in published articles. What I found instead are news-related articles such as Lombe (2017) who notes that despite the controversies that surrounded the purchase of the units, there has been an appreciation of the services offered.

Furthermore, the research contributes to drawing useful lessons on what could work in terms of mobile hospital implementation for other developing countries with characteristics similar to Zambia. This is important because there is a need to improve access to healthcare and attain universal health coverage especially in low- and middle-income countries (WHO, 2016). In addition, the study is useful for health policy implementation as it shows how predictable

windows of opportunity such as elections can be useful for improving health outcomes if utilised.

7.4 Contribution of MSF to implementation studies

This research has provided new insight into understanding public policy implementation. The framework helps to provide an alternative framework or model that can be more widely used to study implementation. As some scholars (Saetren, 2005; Winter, 2006) have argued, it is much better to test different partial theories and hypotheses that address certain implementation aspects than focusing on developing one general theory of implementation. My approach shows conditions that enable as well as affect implementation that have either not received much attention in the literature, or have been thought of in a different manner in a context with a strong executive presence in the policy process.

I argue that the multiple streams framework is valuable for policy implementation because of the way it brings into focus an analysis of the agenda-setting and policy formulation stages of the policy process that the usual traditional approaches to studying policy implementation do not necessarily do. The framework highlights among other things, how issues become problems warranting attention and how policy solutions are generated. By studying policy implementation in this manner, it helps to provide a better understanding of how actors impact implementation by affecting the agenda-setting and the policy formulation processes too. It helps to highlight the importance of understanding the governing context and how this impacts the overall policy process, including policy implementation in a context where top policy makers or actors hold significant power over the policy process.

Using the multiple streams framework in this context has highlighted the impact of the head of state on not only policy formulation, but also on implementation, and perhaps the policy process as a whole. The framework has also highlighted that as governments choose which issues to focus on as problems during the agenda setting stage, so do they during implementation by choosing what proposals to start or continue implementing due to limited resources among other things. This was shown in the entire dissertation, but more especially in Chapters Five and Six. The research helps to provide a nuanced understanding of the ways in which a head of state interacts to shape and transform policy implementation in a country that has weak non-state actors and institutions to provide oversight. The study explained in Chapter Four why the president is able to use his authority to influence policy implementation in the Zambian context.

This is important because while other approaches to implementation such as the top-down approach and forward mapping highlight the significance of policy makers in policy decision making and their discretionary power in implementation, they fall short of examining how the political activities of these officials influence implementation. They do not examine in as much detail as the multiple streams framework how for instance officials influence agenda setting and policy formulation and how this further impacts implementation. The multiple streams framework when applied to mobile hospital implementation in this case has shown that it goes further than just highlighting that elected officials delegate implementation authority to public servants. Rather, it has shown how a specific elected official such as a president acting as a policy entrepreneur ensures policy implementation by affecting the agenda and the policy formulation processes as well. However, the way this is done is not adequately addressed by Kingdon in the framework, that is, the institutional setting. While Kingdon places agency on the policy entrepreneur's abilities to couple the streams, in this study it was found that the institutional context was more important than the skills of the policy entrepreneur. It was the institutional position of the policy entrepreneur that mattered more. In light of this, I modified the framework by adapting the political stream and placing institutional factors at the centre. This meant that elements in the stream were examined from the perspective of the influence of the institutional context.

When applied to the case of mobile hospital implementation, a different kind of 'stream' relationship to what Kingdon (1995) describes in his framework was found to be in existence in Zambia. It was found that the three streams of problem, policy, and politics were not running independently of each other but were connected. Besides solutions being developed independently of problems, Kingdon (1995:228) also states that streams are independent in the sense that they tend to involve different people who have influence in each stream. The problem stream generally has bureaucrats paying attention to indicators and feedback, policy communities operate in the policy stream to design and suggest policies, and political people in the political stream win elections and mobilise support (Kingdon, 1995:228). In this case the streams were connected through the head of state, who was an active and influential actor in all three streams including playing the role of policy entrepreneur. Analysing the streams, the research shows that in the problem stream, the problem was identified by the president, and that the solution of mobile hospitals was proposed by the president as shown in the policy stream. With his active involvement, implementation was either initiated or disturbed as we saw in the political stream. While policy entrepreneurs can be found within and outside government,

having a top actor like the president is not the norm. Mostly, policy entrepreneurs are found in networks made up of academics, research think tanks, bureaucrats, staff and members of Parliament, and funding organisations who share a common interest in a particular policy area.

In the Zambian case, the policy entrepreneurs were the president and AVIC International who were able to ensure that the agenda for this was set and policy was adopted. President Banda further ensured that implementation took place as he was hoping to get re-elected. President Banda initiated mobile hospitals shortly after becoming president, identifying the problem and solution and acting as the policy entrepreneur together with AVIC which I argue was keen to do so as a business. Subsequent presidents (Sata and Lungu) played significant roles in implementation as explained in Chapter Five. President Sata continued with implementation of the mobile units despite being a strong critic and vilifying their purchase when he was in the opposition. President Lungu also continued with implementation in his first term of office in which he was finishing off Sata's term. However, in his second term which can be classified as his own term as he started a new five-year mandate, President Lungu initiated policy changes that affected implementation and focused more on primary health care initiatives as opposed to the mobile hospitals. The appointments of a new Minister of Health and Permanent Secretary re-introduced other priorities in the health sector and abolished the department that was directly responsible for mobile hospitals. As a result, implementation was affected and outreach services through mobile hospitals became less frequent than before.

The president's involvement in administration/implementation in a country such as Zambia shows a highly centralised system. Although public opinion can be strong, it does not count; we saw that despite the strong criticism from various non-state actors against the mobile hospitals, they were implemented. Furthermore, as explained in Chapter Six when analysing the political stream, institutions such as Parliament and other government agencies, as well as non-state actors like the media, aid agencies, and medical associations, were not able to significantly impact the policy process and implementation. In this case, the president becomes the all in all. He impacted the policy process from policy formulation to implementation as explained in the chapters focusing on the streams. This is different from developed countries such as the United States where the opposite is more likely to be case in part due to the separation of powers and the decentralised nature of powers to other institutions and pressure groups. This also helps to highlight that the politics administration dichotomy in a context like Zambia barely exists because the top policy maker, in this case the president, is able to determine what gets implemented and how far implementation proceeds. The interests of the

president are seen as more important than what general policy actors may suggest. This was confirmed by the fact that the changes in leadership that occurred at presidential level from the inception of the mobile hospitals to their implementation brought about change in implementation.

As I argue in Chapters Six and Seven and reiterate here for the purpose of emphasis, the study offers an explanation for how policy implementation is largely dependent on political leaders such as the president in a country where much power is vested in the executive. It also shows that those who are able to identify and label a problem in the first place are also able to ensure that a policy is formulated and implemented. It therefore shows that policy implementation does not just occur because a policy has been made, rather, it takes deliberate action by policy entrepreneurs to identify a problem and link a solution to it. If this entrepreneur happens to be a president as the case was here, chances of implementation are high, regardless of how many critics may be against the policy.

In view of the above where the agenda has been set by the president and not the typical policy entrepreneur; and where the chosen policy of mobile hospitals has neither come from an independent policy stream nor addresses the 'real' problems suggested by various stakeholders, the research concludes that while the framework offers some valuable insight in terms of understanding how actors impact the agenda for policy implementation, it however does not offer much in terms of helping us to understand where the idea of mobile hospitals came from in this case. As such, the framework in this case is limiting

7.5 Theoretical contribution of the study

The research used the multiple streams framework to determine its value for studying policy implementation. The framework is ideally meant for studying agenda setting but some scholars have managed to examine implementation using the framework (Lemiuex, 2002; Exworthy and Powell, 2002; Ridde, 2009; Zahariadis, 2014; Zahariadis and Exadaktylos, 2016; Sager and Thomann, 2017). This is despite the fact that implementation as a field has been studied for over 30 years using various frameworks and approaches. This research not only adds to the pool of studies that have applied the framework beyond its original design of agenda setting, such as policy implementation in this case, but also contributes to its broadening in terms of regional focus, southern Africa in this case. Limited studies have applied the framework to policy implementation in Africa.

While Kingdon's ideas on the separation of streams can be taken as useful for analytical purposes (Zahariadis, 2014), the finding in this study on the connection of streams through a common participant present in all three streams, helps to show that when the framework is applied to policy implementation, streams may not be as independent as is the case in agenda setting. This finding may answer the question posed by Howlett et al. (2016) on whether the streams were present in the implementation process and if so, whether they were independent. Further, the research shows that as opposed to agenda setting, policy implementation does not always depend on a crisis or focusing event; rather the head of state in this case was influential enough to drive policy change and implementation without waiting for any significant indicator, despite opposition to his idea. This is because he was not the norm of what a policy entrepreneur usually is, but placed at an advantage due to his institutional position to couple streams easily without the aid of a crisis or focusing event. This finding is important as it opens up the framework for further research on the interaction of the streams in implementation, that is, their independence or interdependence and under what circumstances this may change.

The multiple streams framework was modified in order to factor in the overall governance structure which is an important factor in this study. This was done in the political stream. Before modification, the framework was as articulated by Kingdon (1984), whereby the political stream consisted of elements such as pressure group campaigns, legislative and administrative turnover, national mood and political parties. The modification however included factoring in the institutional context by studying the governance structure and distribution of power overall and specifically in the executive as an institution. By modifying the multiple streams framework to incorporate institutional factors in the political stream, this study contributes to building it further and to respond to some criticisms such as its lack of modification (Zohlnhofer et al., 2015:244). The research was able to highlight the role that institutions played in facilitating implementation through the president, a central political figure. The multiple streams framework has been criticised for placing too much focus on the situational, temporal and human agency elements at the expense of systemic institutional factors (Mucciaroni 1992; Schlager 2007). The role of institutions is not as prominent in the framework as it is in other lenses of the policy process (Schlager 2007). Zahariadis (2014:44) notes that the garbage can model on which the multiple streams framework was based pays significant attention to institutions by specifying access and decision structures but that this institutional focus was lost in Kingdon's framework and therefore needs to be rediscovered. This study has thus made a contribution in this direction.

Considering how central institutions were in this research, the theoretical implication of the research therefore is that an understanding of policy implementation using the multiple streams framework would benefit from adapting it so as to allow for an exploration of the institutional context under study. There is broad consensus in the literature that it suffices to adapt the political stream when applying the MSF to institutional settings other than the United States so that institutional differences are taken into account (Zahariadis 1996; Schlager 2007; John 2012). In this case, the focus on the institutional context highlighted the somewhat overbearing powers of the president, which make it difficult for the generation of policy ideas and solutions from a policy community as suggested by Kingdon (1995). Despite this, the framework helps us to understand how policy actors can ensure policy implementation through timing and exploitation of windows of opportunity during agenda setting and policy formulation process.

As argued by scholars such as Ritter and Lancaster (2018:237), while the multiple streams framework "suggests a robust heuristic, refinements to suit politico-institutional structures different from the United States have been required." This study has contributed to re-contextualising the framework, showing its applicability in a different context, and further contributing to modifying it to suit the context for which it was being used. It has shown how institutional factors can be factored in the framework so as to broaden the scope for which to analyse policies. In a context such as this one with strong executive, the study argues that the role of institutions is important to examine because this is the structure that determines the policy entrepreneurs' ability to couple streams and, not necessarily their skills. The study thus argues that placing institutional factors in the political stream is more suitable because they tend to influence not only the other elements in the stream, but the overall policy process in a context like this one.

7.6 Research gaps identified for future studies

While many authors have already tested and shown the relevance of the multiple streams framework for studying policy implementation, this research has reaffirmed this relevance. It highlighted the impact of top policy actors like the president in ensuring policy implementation. It is proposed that future studies of policy implementation using the multiple framework could also study how bottom 'non-elites' operationalise policy in centralised contexts; policy for which they have little input but have to implement nonetheless. It would be interesting to see how the findings would differ from using the bottom-up approaches to policy implementation.

Since this was a single case study of mobile hospital implementation in Lusaka Province in Zambia, a comparative research can be conducted on implementation in similar contexts to determine if the findings of this research will be confirmed or not and under what circumstances. Specifically, such a study could address the extent to which streams are independent when studying policy implementation in other contexts.

A major observation made in this research is the confirmation that Zambia is a highly centralised country whereby significant power lies with the executive and the influence of the head of state on policy is very clear. While the research has shown that this may be positive for implementation as long as the centre is strongly in support of implementation, it is also disadvantageous in that sometimes there is no continuity of policy because it is likely to change once a new president takes over. It is thus imperative to have institutions and ministries that can be held accountable for policy by putting them in charge to a greater degree. The study thus speaks to the need for decentralising the powers of the president to other institutions and for a clear separation of powers in reality not just in theory. Future research can perhaps seek to determine the effect of this centralisation on implementation in terms of outputs. This part was beyond the scope of the research as it did not seek to investigate the outputs or impacts of the implementation of mobile hospitals.

In addition, the study identified the head of state as being the policy entrepreneur throughout the policy process. Kingdon (2011) despite placing policy entrepreneurs at the centre of policy change says very little about the strategies they use. He only talked about their attributes. Since Zahariadis and Exadoxtylos (2016) have looked at entrepreneurial strategies, and this study locates institutional manipulation as a strategy used by presidents in Zambia, further research can go in much detail to analyse other entrepreneurial strategies used by policy makers to ensure policy adoption and implementation in centralised contexts.

The study also brought an interesting conversation, that of China emerging as a significant player in not only Zambia's infrastructural development, but its health sector too. It can be classified as part of what are known as non-traditional donors from which many developing countries are seeking aid in various forms. While there are many studies on China's involvement in trade and many other sectors in Zambia, a study on the nature of its relationship with the Ministry of Health and its cooperating partners would shed light on how it is perceived as well as the nature of its development assistance. This is also in line with the widely held view that China is about to 'take over' especially in Africa and low-income countries.

7.7 Conclusion

In 2011, Zambia began implementing mobile hospital outreach programmes as part of the Ministry of Health's strategy to improve access to health services in rural and remote areas even though they were operating in urban areas as well. The research has identified those who were involved in ensuring that mobile hospitals were placed on the agenda and subsequently implemented by government, and all the circumstances that surrounded this. Coupling of the policy and problem streams, with a favourable political stream is very critical in the implementation of a policy. Timing, strategic thinking, observing and paying attention to key events in the political stream especially, is essential and can even be applied to advance the health agenda for the benefit of the people particularly more vulnerable groups. This research reaffirms what many scholars have contended before, namely that the MSF can be applied to other policy processes beyond agenda setting. It has shown that the MSF in general is useful for studying policy implementation. It provided us with ways which it can contribute to understanding implementation better. This information could be vital for helping to improve health systems in many developing countries as it would be known how policy makers favour implementation of one policy over another.

By 2017, the operations of the units had been hindered due to financial constraints among other factors. In addition, some aspects of their operation were being revisited, such as being restricted only to remote and hard to reach areas in all provinces except Lusaka, the Copperbelt and Central provinces. While they seem to have been appreciated by people on the ground, the mobile hospitals did not adequately address and promote primary health care. This study points to the importance of addressing health inequalities in Zambia. While this study was being completed, there were discussions of restructuring the Ministry of Health once again. It is not clear how exactly this will further affect mobile hospital implementation, but it is hoped that the restructuring will help to reduce health inequities in access to health care and move the country towards attainment of the goal of providing quality health care as close to the family as possible. It is also hoped that the ministry and government as a whole continues to explore ways in which to make itself more self-reliant in order to successfully implement its health priorities that are not covered by vertical funds from donors.

BIBLIOGRAPHY

Aantjes, C., Quinlan, T. & Bunders, J. 2016. Towards universal health coverage in Zambia: impediments and opportunities. *Development in Practice*, 26 (3): 298-307.

Abbasi, S., Mohajer, H. & Samouei, R. 2016. Investigation of mobile clinics and their challenges. *International Journal of Health System and Disaster Management*, 4:1-5.

Ackrill, R., Kay, A. & Zahariadis, N. 2013. Ambiguity, Multiple Streams and EU Policy. *Journal of European Public Policy*, 20 (6):871-887.

African Development Bank, 2005. *Zambia: HIPC Approval Document - Completion Point Under The Enhanced Framework.* Abijan: ADB. Available from https://www.afdb.org/fileadmin/uploads/afdb/Documents/Financial-Information/Zambia%20-%20Completion%20Point%20Document%20HIPC%20Initiative.pdf (Accessed 1 April, 2018).

African Peer Review Mechanism. 2013. *APRM Country Review Report No. 16: Republic of Zambia January 2013*. APRM Secretariat. Available from http://aprm-au.org/admin/pdfFiles/Country -Review-Report-No-16.pdf (Accessed 5 April, 2016).

Akena, F. A. 2012. Critical analysis of the production of western knowledge and its implications for indigenous knowledge and decolonization. *Journal of Black Studies*, 43(6): 599–619.

Aljasir, B. & Alghamdi, M.S. 2010. Patient satisfaction with mobile clinic services in a remote rural area of Saudi Arabia. *East Mediterrean Health Journal*, 16:1085-90. http://apps.who.int/iris/bitstream/10665/118009/1/16_10_2010_1085_1090.pdf (Accessed 24th January, 2017).

Aranda-Jan, B. C., Mohutsiwa-Dibe, N & Loukanova, S. 2014. Systematic review on what works, what does not work and why of implementation of mobile health (mHealth) projects in Africa. *BMC Public Health, 14:188.* Available from http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-14-188. (Accessed 23rd January, 2017).

Ashford, L. S. 2006. Creating windows of opportunity for policy change: incorporating evidence into decentralized planning in Kenya. *Bulletin of the World Health Organisation.* 84(8):669-672.

Babbie, E. 2008. *The Basics of Social Research.* 4th ed. Belmont: Wardsworth.

Babinard, J. & Roberts, P. 2006. *Maternal and Child Mortality Development Goals: What Can the Transport Sector Do*? Washington: World Bank.

Banda, D. 2014. *Sport and the multi-sectoral approach to HIV/AIDS in Zambia*. Unpublished doctoral thesis. Leicestershire: Loughborough University. Available from https://repository.lboro.ac.uk/articles/Sport_and_the_multisectoral_approach_to_HIV_AIDS_in_Zambia/9607343 (Accessed November 23, 2019)

Banda, R. B. 2009. *Speech by H.E. Rupiah Bwezani Banda, President of the Republic of Zambia on the occasion of the official opening of the third session of the 10th National Assembly*. Lusaka: Government of Zambia.

Barrett, S. M. 2004. Implementation studies: time for a revival? Personal reflections on 20 years of implementation studies. *Journal of Public Administration*, 82 (2):249–262.

Bax, K., Shedda, S., Frizelle, F. 2006. The New Zealand mobile surgical bus service: what is it achieving? *The New Zealand Medical Journal*, 119 (1236): 2025.

Baxter, P. & Jack, S. 2008. Qualitative Case Study Methodology: Study Design and Implementation for Novice Researchers. *The Qualitative Report*, 13(4):544-559.

Becker, S. & Bryman, A. 2004. *Understanding research for social policy and practice: themes, methods and practices.* Bristol: Policy Press

Beland, D. 2016. Kingdon Reconsidered: Ideas, Interests and Institutions in Comparative Policy Analysis. *Journal of Comparative Policy Analysis: Research and Practice,* 18(3): 228-242.

Bird, P., Omar, M., Doku, V., Lund, C., Nsereko, J.R., Mwanza, J., & the MHaPP Research Programme Consortium. 2011. Increasing the Priority of Mental Health in Africa: Findings from Qualitative Research in Ghana, South Africa, Uganda and Zambia. *Health Policy and Planning*. 26(5): 357–65.

Birkland, T.A. 1998. Focusing Events, Mobilization, and Agenda Setting. *Journal of Public Policy,* 18(1): 53–74.

Blackmore, M. 2001. Mind the Gap: Exploring the Implementation Deficit in the Administration of the Stricter Benefits Regime. *Social Policy and Administration*, 35(2):145–62.

Bolster, C.J. 2006. Mobile hospital provides care when disaster strikes. *Health Care Financial Management*, 60 (2): 114-118.

Boswell, C. & Rodrigues, E. 2016. Policies, politics and organisational problems: multiple streams and the implementation of targets in UK government. *Policy & Politics*, 44(4): 507–24.

Brown, M.T., Fee, E., & Stepanova, V. 2016. The Meaning of ‘‘Health for All by the Year 2000’’. *AJPH History*, 106 (1) Available from http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2016.106136 (Accessed 22 March, 2018).

Bryman, A. 2004. *Social research methods. 2nd ed.* Oxford: Oxford University Press.

Brynard, P. 2005. Policy Implementation: Lessons for service delivery. *Journal of Public Administration,* 40 (4.1): 649-664.

Buch, E. 1984. Mobile clinics-what can they do and achieve? *Paper presented at 2nd Carnegie inquiry into poverty and development in Southern Africa*. Republic of South Africa 13-19 April, 1984. Cape Town: University of Cape Town.

Burnell, P. 2001. The Party System and Party Politics in Zambia: Continuities Past, Present and Future. *African Affairs*, 100 (399): 239-263.

Burnell, P. 2002. Parliamentary Committees in Zambia's Third Republic: Partial Reforms; Unfinished Agenda. *Journal of Southern African Studies*, 28 (2): 291-313.

Buse, K. Dickson C., Gilson, L. & Murray, S.F. 2009. How can the analysis of power and process in policy-making improve health outcomes? *World Hospitals and Health Services Journal*, 45 (1): 4-8.

Cairney, P. & Jones, M. 2016. Kingdon's Multiple Streams Approach: What Is the Empirical Impact of this Universal Theory? *The Policy Studies Journal*, 44 (1): 37-58.

Cairney, P. 2018. Three habits of successful policy entrepreneurs. *Policy & Politics Journal*, 46 (2): 199–215.

Cairney, P. 2019. *Understanding Public Policy: Theories and Issues 2nd ed*. New York: Palgrave Macmillan.

Carmody, P., Hampwaye, G. & Sakala, E. 2012. Globalisation and the Rise of the State? Chinese Geogovernance in Zambia. *New Political Economy*, 17 (2): 209-229.

Central Statistical Office. 2014. *Zambia Demographic and Health Survey Report 2013-14*. Lusaka: CSO.

Central Statistical Office. 2015. *2014 Labour Force Survey Report*. Lusaka: CSO.

Central Statistical Office. 2018. *Zambia in figures 2018.* Lusaka: CSO

Centre for Health Market Innovations (CHMI). 2017. *Mama-toto mobile clinic*. Available from http://healthmarketinnovations.org/program/mama-toto-mobile-clinic#inbox (Accessed 10th February, 2017).

Chatt, C. & Roberts, R. 2010. Access to, and the delivery of, free healthcare in Kanakantapa, rural Zambia. *African Journal of Health Sciences*, 17:15-25.

Chatterjee, P. 2010. Hospital train provides lifeline to rural India. *The Lancet*, 375 (9729): 1860-1861.

Cheelo, C., Chitah, B., & Mwamba, S. 2007. *Tracking the effects of Donor Funds and Operations on the Health System in Zambia*. UNZA, Lusaka.

Cheeseman, N. 2019. Lungu erodes Zambia's democracy. *Mail and Guardian*. 6 September, 2019. Available at https://mg.co.za/article/2019-09-06-00-lungu-erodes-zambias-democracy (Accessed 10 November, 2019)

Chilemba, P. 2009. Mobile hospitals in Rupiah's concept. Available at http://maravi.blogspot.co.za/2009/05/53m-mobile-hospitals-is-rupiahs-concept.html. (Accessed 5 May, 2017).

Chilufya, C. 2017. *Ministerial Statement on the Construction of 650 Health Posts Countrywide.* Lusaka: MOH.

Chipenzi, M., Kaela, L.C., Madimutsa, C., Momba, J. C., Mubanga, H., Muleya, N., & Musamba, C. 2011. *The state of democracy in Zambia.* Lusaka: FODEP & UNZA-PAS.

Cline, D. K. 2000. Defining the Implementation Problem: Organizational Management versus Cooperation. *Journal of Public Administration Research and Theory*, 10 (3): 551-571.

Cobb, R.W &Ross M, H (eds.) 1997. *Cultural Strategies of Agenda Denial*. Kansas: University Press.

Cochran, C.E., Mayer, C.L., Carr, R.T., Cayer, N.J., McKenzie, M. 2009. *American Public Policy: An Introduction,* 9th ed. Belmont, CA: Wadsworth Cengage Learning.

Cope, G.D. 2014. Computer-Assisted Qualitative Data Analysis Software. Methods & Meanings. *Oncology Nursing Forum,* 41(3):322-323.

Crotty, M. 1998. *The Foundations of Social Research: Meaning and Perspective in the Research Process.* London: Sage.

Crowe, S., Cresswell, K., Robertson, A., Huby, G., Avery, A. & Sheikh, A. 2011. The case study approach. *BMC Medical Research Methodology*. Available from http://bmcmedresmethodol.biomedcentral.com/articles/10.1186/1471-2288-11-100 (Accessed 18 March, 2016).

Dash, U., Muraleedharan, V. R., Prasad, B. M., Acharya, D., Dash, S., & Lakshminarasimhan, S. 2008. *Access to health services in under privileged areas; a case study of mobile health units in Tamil Nadu and Orissa.* London: Consortium for Research on Equitable Health Systems.

Dattani, N. D. 2010. Setting the Healthcare Agenda. *Political Science Publications, Paper 1.* Available from http://digitalcommons.mcmaster.ca/polsci_coll/1 (Accessed 15 November, 2016).

DeJaeghere, J., Chapman, D., & Mulkeen, A. 2006. Increasing the Supply of Secondary Teachers in Sub-Saharan Africa: A Stakeholder Assessment of Policy Options in Six Countries. *Journal of Education Policy,* 21 (5): 515–33.

Denzin, N.K. & Lincoln, Y.S. (eds). 2000. The Discipline and Practice of Qualitative Research. *Handbook of Qualitative Research.* 2: 1–28. London: SAGE.

Dube, C., Nozaki, I., Hayakawa, T., Kakimoto, K., Yamadad, N. & Simpungwee, N.J. Expansion of antiretroviral treatment to rural health centre level by a mobile service in Mumbwa district, Zambia. *Bulletin of the World Health Organisation,* 8:788–791.

Edgecombe, J. & O'Rourke B. 2002. Mobile outreach services for young people. *International Journal of Adolescence Medical Health*, 14(2):111-5.

Electoral Commission of Zambia. 2001. Parliamentary Elections 2001 Provisional Results. Available at https://results.elections.org.zm/media/parliamentaryresults_2001.pdf (Accessed 15 March, 2019)

Engstrand, G. 2013. *Report on the Healthcare Sector and Business Opportunities in Zambia*. Stockholm: Swecare Foundation.

Exworthy, M., Berney, L., & Powell, M. 2002. How Great Expectations in Westminster May Be Dashed Locally: The Local Implementation of National Policy on Health Inequalities. *Policy and Politics*. (30)1:79–96.

Exworthy, M. & Powell M. 2004. Big Windows and Little Windows: Implementation in the ‘‘Congested State’’. *Journal of Public Administration,* 82(2):263–81.

Faguet, J. P. 2011. Decentralisation and Governance. *Economic Organisation and Public Policy Discussion Papers, EOPP 027*. London School of Economics and Political Science. Available at http://eprints.lse.ac.uk/37346/1/Decentralization_and_governance%28lsero%29.pdf (Accessed 5 April, 2019).

Ferrinho, G., Siziya, S., Goma, F. & Dussault, G. 2011. The human resource for health situation in Zambia: deficit and maldistribution. *Human Resources for Health*, 9 (30):1-11.

Free, C., Phillips, G., Watson, L., Galli, L., Felix, L., Edwards, P., Patel, V., Haines, A. 2013. The Effectiveness of Mobile-Health Technologies to Improve Health Care Service Delivery Processes: A Systematic Review and Meta-Analysis. *PLOS Medicine*, 10(1): 1-26.

Freedom to Create. 2016. *Policy Report on the Healthcare Financing System in Zambia*. Singapore: Freedom to Create.

Flick, U. 2007. *Designing Qualitative Research*. London: SAGE.

Flick, U. 2014. *The SAGE Handbook of Qualitative Data Analysis*. London: Sage Publications.

Fourie, P., Perche, D. & Schoeman, R. 2010. Donor assistance for AIDS in South Africa: many actors, multiple agendas. *Strategic Review for Southern Africa*, 32(2): 93-120.

Gabrysch, S., Cousens, S., Cox, J. & Campbell, O. M. R. 2011. *The Influence of Distance and Level of Care on Delivery Place in Rural Zambia: A Study of Linked National Data in a Geographic Information System.* PLoS Med. Available from http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1000394 (Accessed 1 July, 2018).

Gerring, J. 2004. "What Is a Case Study and What Is It Good for?" *American Political Science Review* 98: 341-354

Gerring, J. 2009. *Case Study Research: Principles and Practices*. Cambridge: Cambridge University Press.

Ghada, S. E., Al-Attar,T. S. 2009. *10 Years after introducing Mobile Clinics in Assuit, Egypt.* Cairo: Population Reference Bureau.

Ghebreyesus, A.T. 2017. *All roads lead to universal health coverage*. Geneva: WHO. Available from http://www.who.int/mediacentre/commentaries/2017/universal-health-coverage/en/ (Accessed 12 September, 2017).

Gibbs, G.R. 2007. *Analyzing Qualitative Data*. London: Sage Publications.

Gilson, L. Doherty, J., Lake, S., McIntyre, D., Mwikisa, C. & Thomas, S. 2003. The SAZA study: implementing health financing reform in South Africa and Zambia. *Health Policy and Planning*, 18 (1): 31-36.

Gilson, L. ed. 2012. *Health Policy and Systems Research; A methodological reader*. Geneva: WHO.

Goggin, M., Bowman, A., Lester, J. and O'Toole Jr. L. 1990. *Implementation Theory and Practice: Toward a Third Generation*. Illinois: Scott Foresman & Co.

Gore, R. & Parker, R. 2019. Analysing power and politics in health policies and systems. *Global Public Health*, 14 (4): 481-488.

Gosden, R. & Beder, S. 2001. Pharmaceutical industry agenda setting in mental health policies. *Ethical Health Sciences and Services*, 3 (3): 147-159.

Government of the Republic of Zambia. 2016. *Constitution of Zambia (Amendment) Act No. 2 of 2016*. Lusaka: Government Printers.

Green-Pedersen, C. & Wilkerson, J. 2006. How agenda setting attributes shape politics: basic dilemmas, problem attention and health politics developments in Denmark and the US. *Journal of European Public Policy*, 13 (7): 1039-1062.

Guba, E.G. & Lincoln, Y.S. 1994. Competing paradigms in qualitative research. *Handbook of Qualitative Research*, (2): 163–194. Thousand Oaks: SAGE

Guba, E.G. & Lincoln, Y.S. 2001. Guidelines and checklist for constructivist (aka fourth generation) evaluation. Available from https://wmich.edu/sites/default/files/attachments/u350/2014/constructivisteval.pdf (Accessed 10 June, 2017).

Gunn. A. 2017. Policy entrepreneurs and policy formulation, in M. Howlett & I. Mukherjee (eds.). *Handbook of Policy Formulation.* Cheltenham: Edward Elgar. 265-282.

Grepin, A.K., Fan, Y.V., Shen, C.J., & Chen, L. 2014. China's role as a global health donor in Africa: What can we learn from studying under reported resource flows? *Globalization and Health*, 10 (84).

Halwindi, H., Siziya, S., Magnussen, P. & Olsen, A. 2013. Factors Perceived by Caretakers as Barriers to Health Care for Under-Five Children in Mazabuka District, Zambia. ISRN Tropical Medicine. Available at https://www.hindawi.com/journals/isrn/2013/905836/ (Accessed 28 June, 2018).

Hamel, K., Kutzner, J. & Vorderwülbecke, J. 2017. Mobile Health Units: An Analysis of Concepts and Implementation Requirements in Rural Regions. *Healthcare Journal*, 79 (12): 1012-1018.

Hanefeld, J. 2010. The impact of global health initiatives at national and sub-national level - a policy analysis of their role in implementation processes of antiretroviral treatment (art) roll-out in Zambia and South Africa. *AIDS Care*, 22 (1): 93-102.

Hanson, L. 2012. *Mobile Health Units in Resource Poor Settings: Review of the Literature*. Boston: Boston University School of Public Health.

Hawkins, A. 2007. *Mobile Health Units: Review of the Literature.* Baltimore: Baltimore Healthy Start, Inc.

Herweg, N., Huß, C. & Zohlnhöfer, R. 2015. Straightening the three streams: Theorising extensions of the multiple streams framework. *European Journal of Political Research*, 54 (3): 435-449.

Hill, C., Zurakowski, D., Bennet, J., Walker-White, R., Osman, J.L & Quarles, A. 2012. Knowledgeable Neighbors: A mobile clinic model for disease prevention and screening in underserved communities. *American Journal of Public Health,* 102:406-10.

Hill, C.F., Powers, B.W., Jain S.H., Bennet, J., Vavasis, A., Oriol, N.E. 2014. Mobile health clinics in the era of reform. *The American Journal of Managed Care*, 20(3):261-264.

Hill, M. & Hupe, P. 2007. *Implementing Public Policy*. London: Sage Publications.

Hix, S. 2002. Constitutional agenda setting through discretion in rule interpretation: why the European Parliament won at Amsterdam. *British Journal of Political Science*, 32 (2): 259-280.

Hjortsberg, C. & Mwikisa, C. N. 2002. Cost of access to health services in Zambia. *Health Policy and Planning,* 17 (1): 71-77.

Hjortsberg, C. 2003. Why do the sick not utilise health care? The case of Zambia. *Health Economics Journal.* (12): 755–770.

Hogwood, B. W. & Gunn, L. A. 1984. *Policy Analysis for the Real World*. New York: Oxford University Press.

Howlett, M., McConnell, A. & Perl, A. 2015. Streams and stages: Reconciling Kingdon and policy process theory. *European Journal of Political Research*, 54:419–434.

Howlett, M. McConnell, A. & Perl, A. 2016. Moving Policy Theory Forward: Connecting Multiple Stream and Advocacy Coalition Frameworks to Policy Cycle Models of Analysis. *Australian Journal of Public Administration*, 76 (1) 65–79.

Huang, Y. 2006. The politics of HIV/AIDS in China. *Asian Perspective*, 30 (1):95-125.

Hupe, P.L. 2011. The Thesis of Incongruent Implementation: Revisiting Pressman and Wildavsky. *Public Policy and Administration Journal*, 26(1):63-80.

Hupe, P.L. 2014. What happens on the ground: Persistent issues in implementation research. *Public Policy and Administration 2014*, 29(2):164–182.

India Together Online. October 30, 2014. *Where the boats ferry in good health.* Available from http://indiatogether.org/assam-boat-clinics-deliver-healthcare-to-char-residents-health (Accessed 9 February, 2017).

Inter Parliamentary Union. 2009. *Parliament's Role in the Development Agenda: Two Case Studies*. Geneva: IPU

Jensen, M.K. 2012. Mobile health units saving lives in drought-affected Ethiopia. Available from https://www.unicef.org/emergencies/ethiopia_59786.html (Accessed 7 February, 2017).

John, P. 1998. *Analysing Public Policy*. London: Continuum.

John, P. 2012. *Analysing Public Policy*. London: Cassell.

Johnston, A. L. & Yuan, C. 2014. China's Africa trade and investment policies: review of a "Noodle Bowl". *The China Monitor*, 4: 6-41.

Johnson, R.B. & Onwuegbuzie, A.J. 2004. Mixed methods research: A research paradigm whose time has come. *Educational Researcher*, 33 (7) 14–26.

Jones, R. 2013. The future of primary and secondary care. *British Journal of General Practice*, 63 (612): 379–382.

Jones, M.D., Peterson, L.H., Pierce, L.J., Herweg, N., Bernal, A., Raney, L.H. & Zahariadis, N. 2016. A River Runs Through It: A Multiple Streams Meta-Review. *The Policy Studies Journal*, 44 (1): 13-36.

Kaliba, M. 2014. Toward an autonomous civil society: Rethinking state-civil society relations in Zambia. *International Journal of Not-for-Profit Law*, 16 (2):5-15.

Kamwanga, J., Macwan'gi, M. & Geest, S.V.D. 2000. Health Reforms and the Quality of Health Care in Zambia. Amsterdam: IESR.

Kaplinsky, R., McCormick, D. & Morris, M. 2010. China and Sub Saharan Africa: impacts and challenges of a growing relationship. In: Padayachee, V. ed. *The Political Economy of Africa*. London: Routledge.

Karra, M., Fink, G. & Canning, D. 2017. Facility distance and child mortality: a multi-country study of health facility access, service utilization, and child health outcomes. *International Journal of Epidemiology*, 46 (3): 817-826.

Kasonde, J. & Martin, J.D. eds. 1994. *Experiences with primary health care in Zambia*. Geneva: WHO.

Kasonde, J. 2013. *Ministerial Statement on the Construction of 650 Health Posts*. Lusaka: MOH.

Kasonde, J. 2014. Mobile hospital ops up by 100 percent. *Times of Zambia*. May 1. Available from http://www.times.co.zm/?p=21145. (Accessed 3 January, 2016).

Kendall, J. 2000. The Mainstreaming of the Third Sector into Public Policy in England in the Late 1990s: Whys and Wherefores. *Policy & Politics*, 28(4):541-562.

Kennedy, L. 1997. South Africa project provides cervical cancer screening. *AVSC News. Spring*, 35(1):4-5.

Kern, F. 2011. Ideas, institutions, and interests: explaining policy divergence in fostering `system innovations' towards sustainability. *Government and Policy*, 29: 1116 -1134

Kitchin, R. & Tate, N.J. 2000. *Conducting research in human geography; theory, methodology and practice.* New Jersey: Prentice Hall.

King, B. 1992. Taking Health Care to the Maasai. *Africa Health*, 14(2):27-30.

Kingdon, J.W. 1984. *Agendas, Alternatives, and Public Policies*. Boston: Little, Brown.

Kingdon, J.W. 1995. *Agendas, Alternatives, and Public Policies*, 2nd ed. New York: Longman.

Kingdon, J.W. 2003. *Agenda's, Alternatives, and Public policies,* 3rd ed. New York: Longman Publishers.

Kragelund, P. 2014. Donors go home': non-traditional state actors and the creation of development space in Zambia. *Third World Quarterly*, 35(1):145-162.

Kusi-Ampofo, O., Church, J., Conteh, C., & Heinmiller, B.T. 2015. Resistance and Change: A Multiple Streams Approach to Understanding Health Policy Making in Ghana. *Journal of health politics, policy and law*. 40(1):195-220.

Kyambalesa, H. 2010. The saga of mobile hospitals. *Lusaka Times*, July 29, 2010. Available at https://www.lusakatimes.com/2010/07/29/saga-mobile-hospitals/ (Accessed 10 March, 2016).

Larmer, M. 2007. Of cabbages and King Cobra: Populist Politics and Zambia's 2006 election. *African Affairs,* 106 (425): 611-637.

Larmer, M. & Fraser, A. 2007. Of Cabbages and King Cobra: Populist Politics and Zambia's 2006 Election. *African Affairs,* 106: 611-637.

Leiderer, S. 2015. Donor coordination for effective government policies? Implementing the Paris/Accra Agenda in Zambia. *Journal of International Development,* 27: 1422–1445.

Leslie, A.N. 2016. Zambia and China: workers' protest, civil society and the role of opposition politics in elevating state engagement. *African Studies Quarterly*, 16 (3-4): 89-96.

Leung, L. 2015. Validity, reliability, and generalizability in qualitative research. *Journal of Family Medicine and Primary Care*, 4(3): 324–327.

Lewis-Beck S.M., Bryman, A. & Liao, F.T. 2004. Semi Structured Interview, in Lewis-Beck, M. S., Bryman, A., & Liao, T. F. (Eds.). *The SAGE Encyclopedia of Social Science Research Methods*. 1020-1021. London: SAGE.

Lexow, J., 2003. *SWAps and Civil Society: The Role of Civil Society Organizations in Zambia's Basic Education Sub-Sector Investment Programme (BESSIP).* Oslo: NORAD

Lindgren, T.G., Deutsch, K., Schell, E., Bvumbwe, A., Hart, K.B., Laviwa, J., Rankin, S.H. 2011. Using mobile clinics to deliver HIV testing and other basic health services in rural Malawi. *Rural and remote health*, 11(2): 1682.

Lisimba, M. 2018. Political violence and regional voting patterns that characterized the 2016 elections needs to be checked thoroughly. *Lusaka Times Online, February 10, 2018.* Available from https://www.lusakatimes.com/2018/02/10/political-violence-regional-voting-patterns-characterized-2016-elections-needs-checked-thoroughly-lisimba/ (Accessed 13 March, 2018).

Lovell, A. 2010. *School choice and the coming window: An application of John Kingdon's Policy Framework.* Available from http://mason.gmu.edu/~alovell/portfolio/images/Educ875_final%20paper.pdf. (Accessed 7 April, 2017).

Lundstrom, T. 2012. *The impact of Global Health Initiatives and HIV and AIDS programs on the Zambian Health System.* Sundsvall: Mid Sweden University

Lusaka Times Online. April 29, 2009. *Mobile hospitals initiative to be determined by technocrats – Shikapwasha.* Available from https://www.lusakatimes.com/2009/04/29/mobile-hospitals-initiative-to-be-determined-by-technocrats-shikapwasha/ (Accessed 20 August, 2017).

Lusaka Times Online. August 27, 2010. *Beit Cure flags off mobile clinic***.** Available from https://www.lusakatimes.com/2010/08/27/beit-cure-flags-mobile-clinic/ (Accessed 16th February, 2017).

Lusaka Times Online. August 13, 2010. *Mobile clinics debate politicised, says Nyirongo*. Available from https://www.lusakatimes.com/2010/08/13/mobile-clinics-debate-politicised-nyirongo/ (Accessed 16th February, 2017).

Lusaka Times Online. July 26, 2010. China gives Zambia over K2.4 bn concessional loan. Available from https://www.lusakatimes.com/2010/07/26/china-zambia-k24-bn-concessional-loan/ (Accessed 16th February, 2017).

Mainza, M. 2017. Challenges of achieving deeper integration in Southern African Development Community (SADC): Agenda setting and decision making. *International Journal of Social Science and Economic Research,* 02 (10): 4796-4818.

Margolis, S.A, Ypinazar, V.A. 2008. Tele-pharmacy in remote medical practice: the Royal Flying Doctor Service Medical Chest Program. *Rural and Remote Health,* 8:937.

Marshall, M.N. 1996. Sampling for qualitative research. *Family Practice*. 13(6): 522-526.

Martineau, T. & Buchan, J. 2000. Human Resources and the Success of Health Sector Reform. *Human Resources for Health Development Journal, 4 (3):*174-183.

Masiye, F., Chitah, M.B., Chanda, P. & Simeo, F. 2008. Removal of user fees at Primary Health Care facilities in Zambia: A study of the effects on utilisation and quality of care. *EQUINET Discussion Paper Series 57.* Harare: EQUINET, UCT HEU.

Masterson, G. 2017. Zambia's Constitutional Groundhog Day: Why national debate about constitutional reform is not going away anytime soon. *Policy Briefing 157*. SAIIA

Matland, R. 1995. Synthesizing the Implementation Literature: The Ambiguity-Conflict Model of Policy Implementation. *Journal of Public Administration Research and Theory*, 5 (2): 145-174

Mauthner, N.S. & Doucet, A. 2003. Reflexive accounts and accounts of reflexivity in qualitative data analysis. *Sociology*, 37 (3): 413–31.

May, T. & Perry, B. 2011. *Social Research and Reflexivity: Content, Consequences and Context*. London: Sage.

Mills, A. J., Gabrielle, D. & Eiden, W. (eds). 2010. *Encyclopedia of Case Study Research*. Thousand Oaks, CA: SAGE

Ministry of Health. 2006. *National Health Strategic Plan 2006-2010: Towards Attainment of the Millennium Goals and National Health Priorities*. Lusaka: MOH

Ministry of Health. 2007. *Revised Guidelines on Removal of User Fees May 2007*. Lusaka: MOH

Ministry of Health. 2011. *National Health Strategic Plan 2011-2015*. Lusaka: MOH

Ministry of Health. 2017. *Human Resources for Health Planning & Development Strategy Framework. Lusaka:* MOH

Ministry of Health. 2017. *National Health Strategic Plan 2017-2021*. Lusaka: MOH

Ministry of National Development Planning. 2017. *Seventh National Development Plan 2017-2021; Accelerating development efforts towards the Vision 2030 without leaving anyone behind.* Lusaka: MONDP.

Ministry of Health. 2018. *National Health in All Policies Strategic Framework 2017-2021*. Lusaka: MOH.

Mintrom, M. 2019. So you want to be a policy entrepreneur? *Policy Design and Practice*, 2 (4): 307-323.

Mintrom, M. & Norman, P. 2009. Policy entrepreneurship and policy change. *Policy Studies Journal*, 37 (4): 649–667.

Moulavi, D., Bushy, A., Petersen, J. & Stullenbarger, E. 1999. Factors to consider when buying a mobile unit. *Journal of Nursing Administration*, 29 (2): 34-41.

Morangi, L. 2016. Initiative boosts health in rural Zambia. *China Daily.* Available at http://www.chinadaily.com.cn/kindle/2016-08/07/content_26376408.htm (Accessed 23 May, 2017).

Morikawa, M.J., Schneider, S., Becker, S., Lipovac, S. 2011. Primary care in post-conflict rural northern Afghanistan. *Public Health.* 125 (1): 55–59.

Mortier, S.D. & Coninx, R. 2007. *Mobile Health Units in emergency operations: A methodological approach*. London: Humanitarian Practice Network.

Mucciaroni, G. 1992. The Garbage Can Model & the Study of Policy Making: A Critique. *Polity*, 24 (3): 459-482.

Mulonda, M., Kanyamuna, V. & Kanenga, H. 2018. State civil society relationship in Zambia. *International Journal of Humanities, Art and Social Studies*, 3(4):17-26.

Mukanu, M.M., Zulu, J.M., Mweemba, C. & Mutale, W. 2017. Responding to non-communicable diseases in Zambia: a policy analysis. *Health Research Policy and Systems* 15 (34). Available at https://health-policy-systems.biomedcentral.com/articles/10.1186/s12961-017-0195-7#citeas (Accessed 22 November, 2019)

Mupela, N.E., Mustarde, P., Jones, L.H. 2011. Telemedicine in Primary Health: The Virtual *Doctor Project Zambia. Philosophy, Ethics and Humanities in Medicine,* 6: (9).

Mwenya, G. 2013. *PF Reverses Position on Mobile Hospitals.* Available at (https://zambiareports.com/2013/02/11/pf-reverses-position-on-mobile-hospitals/) Accessed 10 June, 2018.

Nagel, T. 1989. *The view from nowhere.* Cambridge: Oxford University Press

Namaiko, C. Health posts project to create 6,000 jobs. *Times of Zambia Online, February,* 11 *2014.* Available at http://www.times.co.zm/?p=9200 (Accessed 30 September, 2017).

Ndulo, N. 2016. Zambia's unfulfilled struggle for a new constitution: comments on the 2016 constitution. *Southern African Institute for Policy and Research,* Discussion paper series No 1.

Neuman, W. L. 2000. *Social research methods-Qualitative and Quantitative approaches*. (4th ed). Boston: Allyn and Bacon.

Odugbemi, S. 2008. *Public Opinion and Policy Making in Less Settled Polities*. Available from http://blogs.worldbank.org/publicsphere/public-opinion-and-policy-making-less-settled-polities (Accessed 1 March, 2016).

Olson, M. 2010. Document Analysis, in Mills, A. Durepos, G. & Wiebe, E. (Eds). *Encyclopedia of case study research.* 319-320. Thousand Oaks, CA: SAGE.

O'toole, L. R. Jr., 2004. The theory and practice issue in policy implementation research. *Journal of Public Administration Research and Theory*. 10 (2): 263-288.

Oriol, N.E., Cote, P.J., Vavasis, A., Bennet, J., Blanc, P. & Kohane, I. 2009. Calculating the return on investment of mobile healthcare. *BMC Medicine.* Available at http://bmcmedicine.biomedcentral.com/articles/10.1186/1741-7015-7-27 (Accessed 3 January, 2015).

Patton, M. Q. 2002. *Qualitative research and evaluation methods.* Thousand Oaks: Sage Publications.

Parsons, W. 1995. *Public policy: an introduction to the theory and practice of policy analysis*. Hampshire: Elgar

Paudel, N. R. 2009. A Critical Account of Policy Implementation Theories: Status and Reconsideration. *Nepalese Journal of Public Policy and Governance.* 25(2):36-54.

Payne, G. & Payne J. 2004. *Key concepts in social research.* Thousand Oaks: SAGE.

Pearlman, W. & Cunningham, K.G. 2011. Nonstate Actors, Fragmentation, and Conflict Processes. *Journal of Conflict Resolution* 56 (1): 3–15.

Penfold, E. 2015. Universal health care is a tall order given southern Africa's poor finances. *The Conversation*, October 22, 2015. Available at https://theconversation.com/universal-health-care-is-a-tall-order-given-southern-africas-poor-finances-48949 (Accessed 20 June, 2018).

Pereira, J. 2009. *Zambia-aid effectiveness in the health sector: a case study report.* Brussels: Action for Global Health.

Pershing J. 2002. Using document analysis in analysing and evaluating performance. *Performance Improvement*, 4 (1): 36-42.

Peters, G.B. 2005. *Institutional Theory in Political Science: The 'new Institutionalism'* (2nd ed). New York: Continuum Publishing.

Peters, G.B. 2012. *Institutional Theory in Political Science: The 'new Institutionalism'* (3rd ed). New York: Bloomsbury Publishing.

Peters, G., Doctor, H., Afenyadu, G., Findley, S., & Ager, A. 2014. Mobile clinic services to serve rural populations in Katsina State, Nigeria: perceptions of services and patterns of utilization. *Health Policy and Planning,* 29:642–649.

Pollack, A.M. 2003. Delegation, agency and agenda setting in the European Community. *International Organisation,* 51 (1): 99-134.

Pulzl, H. & Treib, O. 2007. Implementing Public Policy in F. Fischer, G.J. Gerald, J. Miller and M.S. Sidney (eds), *Handbook of Public Policy Analysis: Theory, Politics, and Methods*. Boca Raton, FL: CRC Press. 89–107.

Rasch, B.E. 2000. Parliamentary floor voting procedures and agenda setting in Europe. *Legislative Studies Quarterly*, 25 (1): 3-23.

Richey, L.A. & Ponte, S. 2014. New actors and alliances in development. *Third World Quarterly,* 35(1): 1-21.

Ridde, V. 2009. Policy implementation in an African state: An extension of Kingdon's multiple-streams approach. *Public Administration Journal*, 87(4): 938-954.

Rist, R.C. 2000. Influencing the Policy Process with Qualitative Research, in N.K. Denzin and Y.S. Lincoln (eds), *Handbook of Qualitative Research,* 2nd ed. London: Sage. 1006-1015.

Ritter, A. & Lancaster, K. 2018. Multiple Streams, in H.K. Colebatch and R. Hoppe (eds), *Handbook on Policy, Process and Governing*. Northampton: Edward Elgar. 232-247.

Robinson, S.E. & Eller, W.S. 2010. Participation in Policy Streams: Testing the Separation of Problems and Solutions in Subnational Policy Systems. *Policy Studies Journal*, 38 (2): 199-215.

Rothstein, B. 1998. *Just Institutions Matter: The Moral and Political Logic of the Universal Welfare State*. Cambridge: Cambridge University Press.

Sabatier, P.A. 1999. Fostering the Development of Policy Theory, in P.A. Sabatier (ed.), *Theories of the Policy Process: Theoretical Lenses on Public Policy.* 2nd ed. Boulder, CO: Westview Press. 261–75.

Saetren, H. 2005. Facts and Myths about Research on Public Policy Implementation: Out-of-fashion, Allegedly Dead, But Still Very Much Alive and Relevant. *Policy Studies Journal*. 33 (4):559–82.

Saetren, H. 2014. Implementing the third generation research paradigm in policy implementation research: An empirical assessment. *Public Policy and Administration,* 29 (2): 84–105.

Saetren, H. 2016. From controversial policy idea to successful program implementation: the role of the policy entrepreneur, manipulation strategy, program design, institutions and open policy windows in relocating Norwegian central agencies. *Policy Sciences Journal,* 49:71–88.

Saetren, H. 2016. Lost in Translation: Re-conceptualising the Multiple-Streams Framework Back to its Source of Inspiration, in R. Zohlnhöfer & F.W. Rüb (eds), *Decision-Making under Ambiguity and Time Constraints Assessing the Multiple-Streams Framework.* Colchester: ECPR Press. 21-34.

Sager, F. & Thomann, E. 2017. Multiple streams in member state implementation: politics, problem construction and policy paths in Swiss asylum policy. *Journal of Public Policy*, 37 (3): 287–314

Saidou, P.B., Somanje, H., Kirigia, J.M., Nyoni, J., Bessaoud, K. & Kasilo, O. 2010. *The Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving better health for Africa in the new millennium*. Geneva: WHO.

Schlager, E. 2007. A comparison of frameworks, theories, and models of policy processes. In P. A. Sabatier (Ed.), *Theories of the policy process (2nd ed.).* Boulder, CO: Westview Press.

Schofield, J. 2001. Time for a revival? Public policy implementation: a review of the literature and an agenda for future research. *International Journal of Management Reviews*, 3 (3): 245-263.

Schwittersa, A., Lederera, P., Zilversmitc, L., Gudo, S.P., Ramiro, I., Cumbaf, L., Mahagaja, E. & Jobarteh, K. 2015. Barriers to Health Care in Rural Mozambique: A Rapid Ethnographic Assessment of Planned Mobile Health Clinics for ART. *Global Health Science Practice,* 3 (1): 109-11.

Shirin. A., Hamid, M. and Rahele, S. 2016. Investigation of mobile clinics and their challenges. *International Journal of Health System and Management*, 4:1-5.

Silverman, D. 2013. *Doing Qualitative research: A Practical Handbook* (4th ed). Thousand Oaks London: Sage.

Simbao, K. 2011. *Ministerial statement on the operational guidelines for mobile hospitals*. Lusaka: Ministry of Health.

Simutanyi, N. 2005. Parties in Parliament: The Relationship between Members of Parliament and their Parties in Zambia. EISA occasional paper number 36.

Skelton, T. 2001. Cross cultural research; issues of power, positionality and race. In Limb, M. and Dwyer, C. (Eds.). 2001. *Qualitative methodologies for geographers: Issues and debates*. London: Arnold.

Skok, J.E. 1995. Policy Issue Networks and the Public Policy Cycle: A Structural-Functional Framework for Public Administration. *Public Administration Review*, 55(4):325-332.

Spohr, F. 2016. Path-Departing Labour-Market Reforms in the United Kingdom and Sweden: An Analysis Combining the Multiple-Streams Framework and Historical Institutionalism, in R. Zohlnhöfer & F.W. Rüb (eds), *Decision-Making under Ambiguity and Time Constraints Assessing the Multiple-Streams Framework.* Colchester: ECPR Press. 251-69.

Srinivasan, V. May 14 2015. *Docs on Wheels: Mobile clinics are a great way to deliver health care.* (Online news article) Available from http://www.slate.com/articles/health_and_science/medical_examiner/2015/05/mobile_health_clinics_outcomes_community_relationships_privacy_concerns.html (Accessed 3rd February, 2017)

Stake, E. R. 1995. *The Art of Case Study Research*. Thousand Oaks, CA: SAGE.

Strand, M., Brown, C., Torgersen, T. & Giaever, O. 2009. *Setting the political agenda to tackle health inequity in Norway*. Geneva: WHO.

Sumit, K. 2016. The Health Policy Process in Vietnam: Going Beyond Kingdon's Multiple Streams Theory**.** Comment on "Shaping the Health Policy Agenda: The Case of Safe Motherhood Policy in Vietnam" *International Journal of Health Policy Management.* 5 (7): 435–437.

Sun, T. 2019. The problem with applying Western theories that don't fit. University Word News 15 March 2019. Available from https://www.universityworldnews.com/post.php?story=20190312130941220 (Accessed 7 November, 2019).

Sundewall, J. 2009. *Health Sector Aid Coordination in Zambia; From Global Policy to Local Practice*. Stokholm: Karoliska Institutet.

Swaddiwudhipong, W., Nguntra, .P, Mahasakpan, P., Tatip, Y., Boonmak, C. 1999. A mobile unit: an effective service for cervical cancer screening among rural Thai women. *International journal of epidemiology,* 28(1):35-9.

Swedlund, H. J. 2013. From donorship to ownership? budget support and donor influence in Rwanda and Tanzania. *Public Administration and Development*, 33: 357–70.

The Post Newspaper, 09 May, 2009. *Hakainde is right about Rupiah's deals*. Available at http://maravi.blogspot.com/2009/05/hakainde-is-right-about-rupiahs-deals.html (Accessed 10 April, 2016).

Times of Zambia Online, 30 July, 2010. *Mobile hospitals: Mpombo grilled.* https://zambia.co.zm/news/local-news/2010/07/30/mobile-hospitals-mpombo-grilled/ (Accessed 15 June, 2018).

Tjoa, A., Kapihya, M., Libetwa, M., Schroder, K., Scott, C., Lee, J. & McCathy, E. 2010. Meeting human resources for health staffing goals by 2018: a quantitative analysis of policy options in Zambia. *Human Resources for Health Journal*, 8 (15): 6-12.

Ugland, T. 2011. *Alcohol on the EU's Political Agenda*. Norwegian Institute for Alcohol and Drug Research. Available from http://www.sirus.no/filestore/Import_vedlegg/Vedlegg_publikasjon/sirusrap.1.11.pdf. (Accessed 5 March, 2016).

United Nations Development Programme. 2016. *Zambia Human Development Report - Industrialisation and Human Development Poverty Reduction Through Wealth and Employment Creation.* Lusaka: UNDP

United Nations Population Fund. 1st March 2016 (news on their website). *On the move: A new mobile clinic reaches refugee women in the Balkans*. Available from http://www.unfpa.org/news/move-new-mobile-clinic-reaches-refugee-women-balkans (Accessed 6th February, 2017).

United States Agency for International Development. 2017. *PEPFAR Zambia Country Operational Plan (COP) 2017 Strategic Direction Summary*. Lusaka: USAID. Available from https://www.pepfar.gov/documents/organization/272026.pdf (Accessed 4 April, 2018).

Vos, J. Borgdorff, M.W. & Kachidza, E.G. 1990. Cost and output of mobile clinics in a commercial farming area in Zimbabwe. *Social Science and Medicine*, 31 (11): 1207-11.

Walliman, N. *2006. Social Research Methods*. London: Sage.

Wanless, J. 2016. *Mobile healthcare for a mobile population in Chad***.** Available at https://www.rescue-uk.org/article/mobile-healthcare-mobile-population-chad. IRC, London. News article, June 10, 2016.

Walt, G., Shiffman J., Schneider H., Murray, S.F., Brugha, R. & Gilson, L. 2008. Doing health policy analysis: metholodological and conceptual reflections and challenges. *Health Policy and Planning.* 23 (7): 308-317.

Whelan, C., Chambers, C., Chan, M., Thomas, S., Ramos, G. & Hwang, S.W. 2010. Why do homeless people use a mobile health unit in a country with universal health care? *Journal of Primary Care and Community Health,* 1 (2): 78-82.

Wild, L. & Domingo, P. 2010. *Accountability and aid in the health sector*. London: Overseas Development Institute.

Winter, S. 2006. Implementation, in Peters B.G & J. Pierre (eds). *Handbook of Public Policy*. Thousand Oaks: Sage Publications. 151-166.

World Health Organisation & United Nations Childrens Fund. 1978. *Declaration of Alma-Ata*. Geneva: WHO.

World Health Organisation. 2008. *Report on the expert consultation on positive synergies between health systems and global health initiatives.* Geneva: WHO.

World Health Organisation. 2008. *The World Health Report; Primary Health Care- Now more than ever*. Geneva: WHO.

World Health Organization. 2013. *Global action plan for the prevention and control of noncommunicable diseases 2013-2020.* Geneva: WHO.

World Health Organisation. 2015. *Mobile health care for Ukraine*. Available from http://www.euro.who.int/en/countries/ukraine/news/news/2015/06/mobile-health-care-for-ukraine (Accessed 3rd February, 2017).

World Health Organisation. 2016. *Mobile clinics provide health care to people in some of the world's worst crises.* Available from http://www.who.int/hac/donorinfo/2016/mobile_clinics/en/ (Accessed 2nd February, 2017).

World Health Organisation. 2016. March 2016. *Mobile medical clinics connect patients to health care in camps in Iraq.* Available from http://www.emro.who.int/irq/iraq-news/mobile-medical-clinics-connect-patients-to-health-care-in-camps-in-iraq.html (Accessed 3rd February, 2017).

World Health Organisation. 2016. *World Health Statistics 2016: Monitoring health for the SDGs.* WHO: Geneva.

World Bank. 1 July 2011. *Changes in Country Classifications.* Available from https://blogs.worldbank.org/opendata/changes-country-classifications (Accessed 06 March 2018).

Yanow, D. 2007. Qualitative interpretative methods in policy research, in Fischer, F., G.J. Miller, & M.S. Sidney (eds). *Handbook of Public Policy Analysis; Theory, Politics and Methods*. Florida: Taylor and Francis. 405-415.

Yezi Consulting and Associates, 2013. *Political Governance Study in Zambia*. Lusaka: Diakonia.

Yin, K.R. 2009. *Case Study Research: Design and Methods*. Thousand Oaks: Sage.

Young, T.V., Shepley, T.V. & Song, M. 2010. Understanding agenda setting in state educational policy. *Education Policy Analysis Archives*, 18 (15). Available from http://epaa.asu.edu/ojs/article/view/771 (Accessed 16 April, 2017).

Zahariadis, N. 1999. Ambiguity, Times and Multiple Streams, in P.A. Sabatier (ed.), *Theories of the Policy Process: Theoretical Lenses on Public Policy*. Boulder, CO: Westview Press. 73–93.

Zahariadis, N. 2014. Ambiguity, Times and Multiple Streams, in P.A. Sabatier & C.M. Weible (eds.), *Theories of the Policy Process: Theoretical Lenses on Public Policy*. Boulder, CO: Westview Press. 25-58.

Zahariadis, N. 2014. The Shield of Heracles: Multiple streams and the emotional endowment effect. *European Journal of Political Research,* 54 (3): 466-481.

Zahariadis, N. & Exadaktylos, T. 2016. Policies that Succeed and Programs that Fail: Ambiguity, Conflict, and Crisis in Greek Higher Education. *Policy Studies Journal, 44 (1): 59-82.*

Zahariadis, N. 2016. Delphic oracles: ambiguity, institutions, and multiple streams. *Policy Sciences Journal*, 49:3–12.

Zambia Daily Mail. May 27, 2019. *AVIC true ally in national development*. Available from *http://www.daily-mail.co.zm/avic-true-ally-in-national-development/ (Accessed 03 November, 20190*

Zambian Economist Online. 2009. *Foreign aid for mobile clinics.* Available from http://www.zambian-economist.com/2009/07/foreign-aid-for-mobile-clinics.html. (Accessed 5 February 2016).

Zohlnhöfer, R., Herweg, N. & Rüb, F. 2015. Theoretically refining the multiple streams framework: An introduction. *European Journal of Political Research*, 54 (3): 412–418.

Zohlnhöfer, R. & Rüb, F. 2016. Introduction: Policy-Making under Ambiguity and Time Constraints, in R. Zohlnhöfer & F.W. Rüb (eds), *Decision-Making under Ambiguity and Time Constraints Assessing the Multiple-Streams Framework.* Colchester: ECPR Press. 1-18.

Zulu, J. M., Kinsman, J., Michelo, C. & Hurtig, A. 2013. Developing the national community health assistant strategy in Zambia: a policy analysis. *Health Research Policy and Systems*, 11 (24). Available from https://health-policy-systems.biomedcentral.com/articles/10.1186/1478-4505-11-24#citeas (Accessed 20 November, 2019).

APPENDIX A: Ethics Clearance Stellenbosch

UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
jou kennisvennoot • your knowledge partner

Approved with Stipulations
New Application

22-Jul-2016
Kabwe, Kabaso K

Proposal #: SU-HSD-002698
Title: The utility of Kingdon's multiple streams framework for assessing policy implementation: a case study of mobile hospitals in Lusaka Province, Zambia

Dear Ms Kabaso Kabwe,

Your **New Application** received on **10-Jun-2016**, was reviewed
Please note the following information about your approved research proposal:

Proposal Approval Period: **22-Jul-2016 -21-Jul-2019**

The following stipulations are relevant to the approval of your project and must be adhered to:
The researcher is reminded to send copies of proof of institutional permission to the REC once it is obtained.

Please provide a letter of response to all the points raised IN ADDITION to HIGHLIGHTING or using the TRACK CHANGES function to indicate ALL the corrections/amendments of ALL DOCUMENTS clearly in order to allow rapid scrutiny and appraisal.

Please take note of the general Investigator Responsibilities attached to this letter. You may commence with your research after complying fully with these guidelines.

Please remember to use your **proposal number** (**SU-HSD-002698**) on any documents or correspondence with the REC concerning your research proposal.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

Also note that a progress report should be submitted to the Committee before the approval period has expired if a continuation is required. The Committee will then consider the continuation of the project for a further year (if necessary).

This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki and the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health). Annually a number of projects may be selected randomly for an external audit.

APPENDIX B: Ethics Clearance Zambia

33 Joseph Mwilwa Road
Rhodes Park, Lusaka
Tel: +260 955 155 633
+260 955 155 634
Cell: +260 966 765 503
Email: eresconverge@yahoo.co.uk

I.R.B. No. 00005948
F.W.A. No. 00011697

20th September, 2016

Ref. No. 2016-Aug-009

Principal Investigator
Ms. Kabaso Kabwe
Plot 105/3a Kalanga Road, Emmasdale,
LUSAKA.

Dear Ms. Kabwe,

RE: THE UTILITY OF KINGDONS MULTI STREAM FRAMEWORK FOR ASSESSING POLICY IMPLEMENTATION: A CASE STUDY OF MOBILE HOSPITAL IN LUSAKA, ZAMBIA.

Reference is made to your resubmission. The IRB resolved to approve this study and your participation as Principal Investigator for a period of one year.

Review Type	**Ordinary**	Approval No. **2016-Aug-009**
Approval and Expiry Date	Approval Date: 20th September, 2016	Expiry Date: 19th September, 2017
Protocol Version and Date	Version-Nil	19th September, 2017
Information Sheet, Consent Forms and Dates	• English.	19th September, 2017
Consent form ID and Date	Version – Nil	19th September, 2017
Recruitment Materials	Nil	19th September, 2017
Other Study Documents	Interview Schedules.	19th September, 2017
Number of participants approved for study	-	19th September, 2017

Specific conditions will apply to this approval. As Principal Investigator it is your responsibility to ensure that the contents of this letter are adhered to. If these are not adhered to, the approval may be suspended. Should the study be suspended, study sponsors and other regulatory authorities will be informed.

Conditions of Approval

- No participant may be involved in any study procedure prior to the study approval or after the expiration date.
- All unanticipated or Serious Adverse Events (SAEs) must be reported to the IRB within 5 days.
- All protocol modifications must be IRB approved prior to implementation unless they are intended to reduce risk (but must still be reported for approval). Modifications will include any change of investigator/s or site address.
- All protocol deviations must be reported to the IRB within 5 working days.
- All recruitment materials must be approved by the IRB prior to being used.
- Principal investigators are responsible for initiating Continuing Review proceedings. Documents must be received by the IRB at least 30 days before the expiry date. This is for the purpose of facilitating the review process. Any documents received less than 30 days before expiry will be labelled "late submissions" and will incur a penalty.
- Every 6 (six) months a progress report form supplied by ERES IRB must be filled in and submitted to us.
- A reprint of this letter shall be done at a fee.

Should you have any questions regarding anything indicated in this letter, please do not hesitate to get in touch with us at the above indicated address.

On behalf of ERES Converge IRB, we would like to wish you all the success as you carry out your study.

Yours faithfully,
ERES CONVERGE IRB

Dr. E. Munalula-Nkandu
BSc (Hons), MSc, MA Bioethics, PgD R/Ethics, PhD
CHAIRPERSON

APPENDIX C: Authority from Ministry of Health

THE NATIONAL HEALTH RESEARCH AUTHORITY
C/O Ministry of Health
Haile Selaisse Avenue,
Ndeke House
P.O. Box 30205
LUSAKA

Mr Mundanga
Kindly assist as authorised by the NHRA.
05/10/16

MH/101/23/10/1

29th September, 2016

Kabaso Kabwe Shawa
LUSAKA

Re: Request for Authority to Conduct Research

The National Health Research Authority is in receipt of your request for authority to conduct research titled **"Utility of Kingdon's Multiple Streams Framework for Assessing Health Policy Implementation: A Case Study of Mobile Hospitals in Lusaka Province, Zambia "**.

I wish to inform you that following submission of your request to the Authority, our review of the same and in view of the ethical clearance, this study has been approved to carry out the above mentioned exercise on condition that:

1. The relevant Provincial and District Medical Officers where the study is being conducted are fully appraised;
2. Progress updates are provided to NHRA quarterly from the date of commencement of the study;
3. The final study report is cleared by the NHRA before any publication or dissemination within or outside the country;
4. After clearance for publication or dissemination by the NHRA, the final study report is shared with all relevant Provincial and District Directors of Health where the study was being conducted, and all key respondents.

Yours sincerely,

Dr. P. Chanda-Kapata
For/Director
National Health Research Authority

APPENDIX D: Interview Guides

Interview guide for staff at Ministry of Health Headquarters

1. Have mobile hospitals always been on the policy agenda of the ministry?
2. What other initiatives were there to tackle inequities in the access to health care for rural and disadvantaged communities?
3. Why do you think mobile hospitals were picked as a way to improve access to healthcare for these disadvantaged communities? (eg technical feasibility, value acceptability etc).
4. Who would you say was the most influential in ensuring that mobile hospitals were adopted and implemented?
5. What elements in the political environment would you say influenced the issue of access to health care for rural populations to be that prominent? (eg elections, general national mood, pressure group campaigns, administrative/legislative turnover etc?
6. Inadequate access to healthcare has been an issue for quite some time. What would you then say finally made this become a serious one requiring such policy formulation and implementation? What is it that captured the attention of the President and his government? (e.g. was it as a result of a problem or political stream?)
7. There was a lot of resistance to mobile hospitals from the general population. Why do you think this was the case?
8. What are the goals and objectives of mobile hospitals?
9. How would you say these are being met?
10. The vision of the Ministry is to provide quality affordable healthcare as close to the family as possible. How challenging is this?

Interview guide for staff at Lusaka Provincial Medical Office

1. How many mobile hospitals do you have in the province?
2. What is the schedule of the mobile hospitals? How often should a particular area be visited and for how long?
3. How do you determine the area in which to station the mobile hospital?
4. How many units or departments are in each mobile hospital?
5. Are they all operational?
6. What kind of health services can one expect to receive?
7. What kinds of diseases or cases are mostly dealt with?
8. Do you have a referral system in place? How does that work?
9. Which categories of staff mostly work in the mobile hospitals?
10. Would you say mobile hospitals are meeting their objective? How?
11. Is there another way you would propose that would increase access to healthcare services for the communities you serve?
12. What are the logistics involved in ensuring that a mobile hospital is running effectively?
13. Do you think mobile hospitals are a sustainable policy program?
14. What are the main challenges you face in implementing mobile hospitals?

Interview guide for health workers working in the mobile hospitals

1. How different is working in a mobile hospital from working in the usual health facility?
2. How busy is the mobile hospital?
3. What type of patients/diseases do you mostly attend to?
4. How often do you have to refer cases if at all?
5. Would you say the services offered are adequate for the communities you serve?
6. Is there another way you would propose that would increase access to healthcare services for the communities you serve?
7. What do you think about this initiative? Is it meeting its objective and how so?
8. Do you think the mobile hospitals are sustainable?
9. What challenges do you face as you work in the mobile hospital?
10. Do you have any recommendations regarding mobile hospital implementation?

Interview guide for the Ministry's cooperating partners

1. How do you contribute to health policy making in Zambia? (e.g. limited to funding or help to formulate the policies?)
2. When funding any programmes or activities in the health sector, what do you consider?
3. There was a lot of resistance to mobile hospitals from many sectors. Why was this so in your case?
4. How did this affect your relationship with the Ministry of Health?
5. What is your opinion on mobile hospitals now?
6. Who would you say was the most influential in adopting and implementing mobile hospitals?
7. Is there another way you would propose that would increase access to healthcare services for the rural and disadvantaged communities?
8. Do you think mobile hospitals are sustainable?
9. How are you affected by happenings in the political environment in your work with the Ministry of Health?

APPPENDIX E: Observation Schedule for Mobile Hospital Operations

CRITERIA	**NOTES**
Opening and closing time of the mobile hospital if at all	
Whether all medical units/departments are operational	
Number of health workers dealing with patients	
Category of health workers	
General behaviour/attitude of health workers towards patients	
Inflow of patients and time taken to be attended to	
Numbers of people waiting to be attended to	
Whether patients are treated for most ailments or referred	
General ambience of the mobile hospital	
General comments/impressions on everything observed	

APPENDIX F: List of Interviewees

ID Assigned	Organisation	Date of Interview
Interviewee A	Ministry of Health HQ	7 October, 2016
Interviewee B	Ministry of Health HQ	8 November, 2016
Interviewee C	Ministry of Health HQ	29 September, 2016
Interviewee D	Levy Mwanawasa Hospital	17 October, 2016
Interviewee E	Levy Mwanawasa Hospital	17 October, 2016
Interviewee F	Levy Mwanawasa Hospital	12 October, 2016
Interviewee G	Levy Mwanawasa Hospital	13 October, 2016
Interviewee H	Levy Mwanawasa Hospital	18 October, 2016
Interviewee I	Levy Mwanawasa Hospital	19 October, 2016
Interviewee J	Levy Mwanawasa Hospital	8 November, 2016
Interviewee K	DFID	20 October, 2016
Interviewee L	SIDA	9 November, 2016
Interviewee M	ZMA	13 October, 2016
Interviewee N	USAID	11 October, 2016
Interviewee O	Ministry of Health HQ	9 November, 2016