Oxford Policy Management

Landscaping review part 3: Review of international health policy transfer literature

Learning for Action Across Health Systems

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May 2017

Acknowledgements

This report was produced as part of a larger project to develop recommendations on future investment in *Learning for Action Across Health Systems*, which is being implemented by Oxford Policy Management with funding from the Bill & Melinda Gates Foundation.

We would like to thank David Sanders and George Schieber for their written feedback. We would also like to thank the attendees of the project's first expert convention, who read the report in advance of the event and gave verbal feedback. As the meeting was held under the Chatham House Rule, we will not give names.

We would finally like to thank our Bill & Melinda Gates Foundation counterparts, in particular Mariam Zameer and Jack Langenbrunner, who offered regular assistance and feedback throughout.

All opinions expressed, and any mistakes, remain the responsibility of the authors.

This assessment is being carried out by Oxford Policy Management with funding from the Bill & Melinda Gates Foundation. The project manager is Alex Jones. The remaining OPM staff team members are Nouria Brikci and Matthew Roxborough. For further information contact alex.jones@opml.co.uk.

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Abstract

Low- and middle-income countries cannot afford to waste scarce financial and human resources, and political capital, on programmes that are not effective, efficient, equitable or sustainable. There are many lessons from individual country experiences about 'what works' – and what does not work – in terms of strengthening health systems in low- and middle-income countries. But what are the processes through which lessons are learnt and shared between health systems? This paper reviews the literature on the processes of international policy transfer in health, in a bid to identify the key players involved and the dynamics at play between them.

This report is the third of three landscaping papers that lay the foundation for a larger project. The larger project will develop recommendations for the Bill & Melinda Gates Foundation (as well as the wider community) on fruitful future investment into the state-of-the-art of learning from the successes and failures of other health systems by low-income countries, and using those lessons to achieve improved health outcomes. We have termed this *Learning for Action Across Health Systems*. All three landscaping papers are available online.

Landscaping review part 1 is a review of comparative health systems literature: www.opml.co.uk/publications/learning-action-across-health-systems-landscaping-review-part-1

Landscaping review part 2 is a review of institutions and platforms that currently exist and aim to facilitate learning across health systems: www.opml.co.uk/publications/learning-action-across-health-systems-landscaping-review-part-2

Landscaping review part 3 is this review of published analyses of international policy transfer in health: www.opml.co.uk/publications/learning-action-across-health-systems-landscaping-review-part-3

Executive summary

The transfer of health policies between countries has been identified as a significant trend in the development of effective health services in low- and middle-income countries. As such, it is important to understand how and why health policy transfer takes place and the processes that facilitate and hinder transfer.

To undertake this review, 21 studies exploring the processes of international health policy transfer published between 1994 and 2007 were identified from research by Gilson and Raphaely (2008). Then, a modified version of Gilson and Raphaely's search protocol was repeated to gather literature published since 2008. After title and abstract screening, 60 articles were deemed relevant for analysis.

For each instance of international policy transfer analysed, information was categorised according to the origin country, recipient country, types and programmes of health systems change and categories of policy-maker involved. The different theoretical constructs used for analysis were also explored.

The primary stakeholders identified within the literature were international agencies, political actors, private sector actors (including corporations, civil society and non-governmental organisations), and beneficiaries of policies. Significant attention in the literature has been placed on the role of international organisations. Questions around individual country-to-country transfers are not as well understood, and the roles of private sector stakeholders even less so. Programmes and health systems changes related to HIV/AIDS were the most commonly analysed, followed by sexual and reproductive health, perhaps reflecting the perspectives of those funding the research. African, Asian and Latin American countries were the most common recipients of policy transfer, whereas global policy networks and the United States were the most common originators.

Six phases of policy transfer were identified: 1) conceptualisation; 2) formation; 3) internalisation; 4) contextualisation; 5) operationalisation; and 6) evaluation. The literature discusses the processes through which policy is transferred at each stage, but with differing degrees of strength of assessment. Mechanisms and facilitators of policy transfer were then categorised as learning, coercion, socialisation and competition. All four appear to happen at the conceptualisation, formation, internalisation and contextualisation stages. Learning and coercion appear to happen at the operationalisation stage, and learning at the evaluation stage.

The literature on health policy transfer is still a growing field, and it addresses crucial strengths and weaknesses among current transfer processes while incorporating existing theory and attempting to develop its own frameworks. However, broad theories of interaction between the phases of transfer, however they may be defined, have yet to be developed, and significant additional research is required to address gaps in the current literature.

A growing branch of the literature explores how finance has led to changes in in-country policy, in most cases the adaptation of policy specifically to receive aid.

There are two major factors in health policy transfer that are not adequately explored by the current literature. First, the research has not sufficiently incorporated broader theories of the feedback loops through which policy is continually formed and standardised. Second, the literature does not sufficiently address the processes by which policy is exported from origin countries, and instead focuses almost entirely on the mechanisms and experiences of recipient countries.

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1 Introduction

Learning across health systems is an emerging field of research in policy and international relations. The transfer of health policies between countries has been identified as a significant trend in the development of effective health services in low- and middle-income countries. As such, it is important to understand how and why health policy transfer takes place and the processes which facilitate and hinder transfer. Policy transfer is encouraged by collaboration between stakeholders on a global level, contextualisation of policies to fit changing socio-political environments, and effective mobilisation of policy networks and resources. There is a growing base of literature addressing processes for international health policy transfer, which this review aims to summarise. The following report will proceed with an overview of the methodology used for the literature search, the theoretical frameworks used by current research, the stakeholders of policy transfers (international agencies, national elites, political systems, non-governmental organisations (NGOs), civil society, policy beneficiaries, and the private sector), and the phases of policy transfer (conceptualisation, formation, internalisation, contextualisation, operationalisation, and evaluation). The review will end with a discussion and summary of areas for future research.

2 Methodology

A rapid review of literature on processes of international health policy transfer was conducted. Studies conducted from 1994 to 2007 were obtained through a review of health policy systems conducted by Gilson and Raphaely in 2008. 21 studies on international-national policy transfer were covered by this review. Studies were included after seminal research on health policy in low- and middle-income countries was published by Walt and Gilson (1994). Gilson and Raphaely's (2008) inclusion criteria were used for the systematic search for studies published between 2008 and the present date. Criteria for inclusion thus were as follows: article is published in English; fully accessible; focuses on health policy; considers the processes of policy change, experience of policy change within and across countries, and factors which influence these processes; focus on low- and middle-income countries; acceptable methodology; and empirically based. Additional inclusion criteria added by the new systematic search were: article describes and/or analyses processes of international health system transfer; and article has sufficient internal and external validity.

A systematic search was then conducted using specified inclusion criteria for studies produced since 2008 on literature assessing health policy transfer processes in low- and middle-income countries. Seven databases were searched on 21 March 2017: Applied Social Sciences Index & Abstracts; International Bibliography of the Social Sciences (IBSS); PAIS Index; Policy File Index; Social Services Abstracts; Sociological Abstracts; and Worldwide Political Science Abstracts. The following search terms were used: 'health AND (policy OR system* OR process* OR procedure*) AND ab(transfer* OR international policy OR international organi* OR global policy) AND (develop* countr* OR transition* countr* OR low income countr* OR third world countr* OR underdeveloped countr*)'. This search resulted in 2,295 results, out of which 114 articles were found to be relevant after title and abstract screening. Articles were categorised into most relevant (60) and less relevant (53), with a deeper analysis conducted for the most relevant articles.

3 Results

Sufficient data saturation has been achieved by the search, with articles representing a range of both recurring and varying theoretical, methodological, and geographical characteristics. A limitation of this review is that it only considers studies published in the English language, and those available via online channels. Furthermore, due to the variety of theory cited by the literature, there is a restricted ability to apply construct validity as an inclusion criterion. The review is also limited by its exclusion of studies which address the transfer of policies not relating to health, thereby potentially lacking consideration of policy transfer theory and mechanisms, which may be useful to health policy inasmuch as policies function similarly for varying types of social problems in their formation and implementation. The section on 'Mechanisms of transfer' does briefly discuss mechanisms as they appear in the broader theoretical literature; however, it does so more to highlight their weaknesses rather than strengths. In this way, it is not anticipated that inclusion of non-health policy evidence would provide more information on the specific mechanisms through which policy is transferred.

The following table summarises key countries, types and programmes of health system change, and categories of 'policy-makers' in the 60 most relevant articles identified. Under 'Origin countries' and 'Recipient countries', 'Global policy networks' refers to associations between countries and international agencies which facilitate collaboration and knowledge transfer. 'International agencies' refers primarily to intergovernmental organisations, such as the United Nations (UN) and World Health Organisation (WHO), among others.

Origin countries		Recipient countries		Types and programmes of health system change		Categories of 'policy-maker'	
Global policy networks	51	Other African countries	30	HIV/AIDS	16	International agencies	53
United States	12	Other Latin American countries	16	Sexual and reproductive health	13	National elites	41
Other African countries	7	Other Asian countries	21	Efficiency and equity in health systems	10	Civic organisations	23
Other European countries	4	Other European countries	11	Access to medical care	9	NGOs	18
Other Asian countries	3	South Africa	9	Vaccination and immunisation	6	Health professionals	13
South Africa	3	India	6	Population	5	Government ministries	11
United Kingdom	2	Zambia	6	Drug enforcement	4	Private sector	10
Brazil	1	Malawi	5	Health insurance	3	Academics	8
		Kenya	4	Case management of childhood illness	2	Local communities	6
		Bangladesh	3	Disease preparedness	2	Civic leaders	5
		Brazil	3	Malaria	2	Political parties	4
		Burkina Faso	3	Mental health	2	Media	1
		Mozambique	3	Use of aid in health services	2		
		Pakistan	3	Nutrition	1		
		Thailand	3	Tuberculosis	1		
		Zimbabwe	3	Urban–rural health worker relocation	1		
		Global policy networks	1				

4 Theoretical overview

The literature base utilises various theoretical frameworks for understanding how health policy is transferred. Kingdon's model for policy formation is the most commonly cited in the literature, perhaps because of its strong position within the policy research community and its versatility with regards to conceptualisation of stakeholder involvement. This is especially opportune for the literature given the diverse types and roles of stakeholders in policy transfer between countries. Kingdon proposes the existence of three streams through which policy formation takes place: the problems, policies, and politics streams (Kingdon, 1995). The literature uses Kingdon's model in several ways: for example, by understanding NGOs to be policy entrepreneurs and activists in the promotion of equity (Klugman, 2000). Kingdon's policy streams are also used to explain that certain issues emerge at the forefront of the policy agenda because of opportunities for change and the key role of policy-makers (Atkins *et al*., 2012; Lush *et al*., 2003). Ogden *et al*. (2003) show that the interaction between researchers and policy-makers in the creation of evidence around the emerging problem of tuberculosis mirrors Kingdon's theory of relationships between stakeholders. The use of Kingdon's model in the policy transfer literature, compared to the literature around policy formation in general, which does not utilise Kingdon as much, indicates the need to theorise communication and action between stakeholders in international policy.

Punctuated equilibrium theory, which explains why certain issues are placed on the agenda after long periods of stability, is also used somewhat by the literature. Shiffman *et al*. (2002) use punctuated equilibrium to explain why polio suddenly emerged as a policy issue in the 1970s and 1980s. Because punctuated equilibrium theory is well cited throughout the policy research community, it can be applicable to policy transfer inasmuch that agenda setting processes are similar for policies which are primarily domestically as they are internationally induced. Punctuated equilibrium has not been sufficiently applied to international policy issues, however, to the extent it has been applied to policy formation within countries. The internationalisation of punctuated equilibrium could offer useful directions for understanding how, for instance, public opinion and agenda setting interact on a global instead of just a national level.

Social network theory is used in the policy transfer process literature to explain how and why actors interact. Wonodi *et al*. (2012) use social network analysis to show how information is exchanged between different levels of government in Nigeria, as well as health care providers and the media, around the introduction of vaccines into immunisation programmes. Given the increasing need to understand the complex relationships between stakeholders in the global policy environment, social network theory could be used more often by the literature. Research has the potential to utilize current insights into specific transfers of knowledge which occur between actors at the local, national, and global levels observed by proponents of social network theory.

Aside from the uptake of issues in the global policy agenda setting, Jafflin (2013) uses a combination of theories to explain the often-observed dominance of international organisations in policy formation within countries. She argues that the exertion of power by international organisations over national policy-making can be understood through constructivism, and that Weber's theory of legitimate domination explains that such exertion occurs through the legitimacy organisations gain through the expertise of personnel and agreement among stakeholders on the values and goals of policy transfer. Jafflin (2013) adds that an organisation's position and capacity for influence, including power to control and availability of funding, also affects its involvement in national policy-making processes. Additional use of theory to understand how policy is implemented rather than just conceptualised should be pursued by future research.

Recent literature uses current theory and empirical findings to create new frameworks for international health policy transfer. Ogden *et al*. (2013) propose that one method for categorising

health policy is by determining whether a transfer is coerced or voluntary. The idea of coercion is also used by Bennett *et al*. (2015), who summarise the mechanisms for transfer discussed in the broader policy transfer literature as learning, coercion, socialisation, and competition. Another dichotomous categorisation proposed to describe health policy is that between internal and external factors which facilitate international transfer (Clark, 2009). Emerging classifications for determinants of policy transfer are a first step towards the development of increasingly broadly applicable theories to international health transfer processes.

5 Stakeholders of policy transfers

The roles of various stakeholders are acknowledged and explored throughout the literature as primary factors in the successful transfer of health policy across low- and middle-income countries. Primary stakeholders are international agencies; political actors; private sector actors including corporations, civil society, and NGOs; and beneficiaries of policies. This section will explore the roles of stakeholders as discussed in the literature.

5.1 International agencies

International agencies are prominently observed stakeholders in the literature and are recognised as significant facilitators of policy transfer between countries. Whether positive or negative, almost all research emphasises the crucial role of international agencies in the facilitation of relationships and dialogue between governments, as well as the formation and implementation of health policy (Clark, 2009). Agencies are shown to formulate policy at a global level and issue country-specific directives, such as the WHO's recommendations for urban to rural health worker relocation (Buchan *et al*., 2013), as well as act in response to financial incentives from funding governments.

Current research conceptualises the role of international agencies as being a positive and effective force in the transfer of health policy. Agencies are seen to be effective when controlled by staff members who have previously worked as physicians and researchers close to the implementation of policy (Lush *et al*., 2003). This is especially useful for policy transfer in both development and implementation of policy, given the need to enhance the feasibility of policies in new and evolving environments. The literature emphasises the effectiveness of international agencies when there is consensus on the goals and objectives of policy transfer (Hussein and Clapham, 2005). This is especially the case when there is political uncertainty within the recipient country, for instance in the case of Vietnam's sexual rights movement, which relied upon multiple global stakeholders in the midst of internal state disagreement (Gomez and Ruger, 2015). The large space occupied by international agencies in the literature merits greater research into specific mechanisms through which dialogue, formation of context-appropriate policies at the global level, and interaction between agencies and other stakeholders occurs.

Bennett *et al*. (2015) describe the role of agencies as being between advocates and neutral facilitators in the transfer of policy. This is a theme which emerges throughout the literature as agencies either impose policy or neutrally act as the medium through which policy is transferred. Although coercion may take place in various degrees and in different forms, such as through conditionalities or pressure to accept policy guidelines, literature on health policy transfer processes primarily refers to coercion as the general imposition of policy by an origin country or international agency upon a recipient country. Most criticism of international agencies in the policy transfer literature centres around this issue of coercion, some of which argues that agencies have been used as a means for wealthy countries to shape policy formation for their own agendas (Banerji, 1999; Clark, 2009). There is little known about the role of elites in international organizations in the promotion and coercion of policy, for instance in the case of universal health care which was largely popularized by the World Bank and WHO (Kieny & Evans, 2013; Reich *et al*., 2016). The under-representation of transfer recipient countries in policy formation processes, such as the exclusion of African partners from creating policy to improve access to medication, is one illustration of how policy coercion may occur (Ngoasong, 2009). International agencies are also shown to recommend similar policy transfers to countries with different internal socio-political environments, essentially grouping the policy needs of low- and middle-income countries together. For example, the WHO came under criticism for recommending similar immunisation coverage strategies to both Cameroon and Malawi in the 1980s, both of which lacked effectiveness and adaptability to in-country climates (Jafflin, 2013). Policy coercion, exclusivity of dialogue, and

broad-based policy recommendations are the most common criticisms of international agencies in the policy transfer literature.

5.2 Political actors

National elites are identified as key decision-makers in the process of receiving, translating, and implementing health policy. 'National elites' refers to elected politicians as well as what Kingdon (1984) defines as 'policy entrepreneur', leaders of interest groups and civil society or private sector organizations, who influence policy at a national level, are generally the most publicly visible actors in policy formation, and have the most ability to bring certain issues to the national agenda (Ogden *et al*., 2003). Elites may consist of politicians, leaders of government agencies and organisations (Juma *et al*., 2015), individuals with a large stake in private corporations and advocacy groups who influence policy on behalf of group interests (Powers, 2012; Prince, 2012), and on occasion individuals who are employed by or participate in their home government but interact with international policy communities (Robinson, 2015). The commitment of national elites to policy transfer is commonly cited throughout the literature as crucial for the success of policy implementation, in some cases more important than economic capacity (Lee and Walt, 1995; Robinson, 2012). The ability of national leaders to mobilise resources for policy transfer and secure necessary administrative support is important for the involvement of other stakeholders, perception of the transfer's success, and developing systems of accountability (Brundage *et al*., 2011). National elites are also identified as crucial for the adoption of policy into country-specific social, economic, and political environments, making their involvement in global policy formation processes necessary. For example, the adoption of new population policies after the 1994 Cairo conference was highly dependent on the willingness and ability of national elites to internalise and contextualise policies (Luke and Watkins, 2002). While there have been ample observations of the value-added of national elites in relation to policy transfer processes, the literature has not adequately researched how and why national policy-makers are incentivised to participate in the transfer of policy as opposed to the creation of original policy. This may be facilitated by relationship-building; the reputational value-added of attending well-known conferences and meeting with influential policymakers at the international level; or the provision of funding or resources, however there is little evidence to show which factors most effectively engage national elites.

The mobilisation of political parties and associations is a vital component of policy internalisation, contextualisation, and operationalisation. Political power often supersedes the influence of international agencies and national elites, having earned support from the wider public and established social groups (Hunter and Brown, 2000). Unlike other policy transfer stakeholders, political parties have the ability to manoeuvre both public and private (e.g. corporate) interests (Gomez and Ruger, 2015). In addition, other stakeholders often rely on political support to influence policy decisions, including those who provide financial, programmatic, and technical services (Wonodi *et al*., 2012; Perez-Ferrer *et al*., 2010; Minoletti *et al*., 2012). For example, the World Bank was unable to widely adopt increased investment in primary education in Latin America due to lack of in-country political support (Hunter and Brown, 2000). The Treatment Action Campaign in South Africa, headed by the African National Congress party at the time, effectively challenged antiretroviral drug prices set by international pharmaceutical companies by building alliances with international agencies and institutions influencing global policy (Powers, 2012). Political systems are thus important stakeholders in policy transfer processes and are often discussed by broader literature on policy development (Heywood, 2007). This body of literature provides information on how civil society and policy beneficiaries, for instance, interact with national elites through political actors to shape policy contextualisation and implementation.

5.3 Policy beneficiaries

Success of policy transfer is often determined by policy beneficiaries, or sections of the general public which are affected by policy implementation. Beneficiaries largely determine whether a policy is applicable to a certain context, a factor of policy evaluation which is especially necessary in international policy transfer due to the differing contexts within which policies originate. The simplest value added by beneficiaries is an improved understanding of societal norms to which a policy should be adapted by national decision-makers (Gomez and Ruger, 2015). In addition, beneficiary awareness of health issues and transferred policies affects the success of implementation, and is often determined by civil society, political advocacy, and the media (Perez-Ferrer *et al*., 2010; Clark, 2009). Public awareness in countries from which transferred policies originate also affects implementation, especially when 'origin' countries are unable to export or advocate for specific policies because of the differing views of their constituencies (Bergen-Cico, 2013). Dionne (2012) uses the example of weak local demand for policies providing HIV/AIDS services in Malawi to argue that health policy, as well as development interventions, is dependent upon local reception. She concludes that there should be increased consideration of citizen opinions in policy. Because improved incorporation of beneficiary opinions into policy formation is perhaps the most direct method for ensuring contextualisation of transferred policies, additional research should seek to understand how these processes can be most effectively achieved given the distance between beneficiaries and global policy-makers.

5.4 Private sector

The private sector may be an important stakeholder in health policy transfer, however it is not widely theorised or observed by the empirical literature. Through various examples, research illustrates how the private sector prevents or encourages the uptake of policy issues. For example, corporations financing medical social security face large incentives to influence insurance-related health policy (Iriart *et al*., 2001). It is generally agreed throughout the literature that private corporations maintain significant influence over the political process and development of health policy, for instance by encouraging support for private rather than public insurance. The private sector also acts as a powerful creator of norms within society, for instance through social marketing, which affects public opinion, agenda setting, and policy effectiveness. Industry is conceptualised as being an opponent of the policy sphere, specifically when reacting to policy change for the purposes of private benefit rather than societal well-being (Gneiting and Schmitz, 2016). Aside from profit-seeking, there is much to be learned about private sector incentives and how they affect and are subsequently shaped by policy transfer.

Civil society is another important stakeholder in the health policy transfer literature, most widely conceptualised as advocating on behalf of policy beneficiaries and playing a role in the contextualisation of global policies within national environments. Unlike other stakeholders, civil society is less theorised by the literature, and is more often mentioned as an important actor in the creation of dialogue and agenda setting. Civil associations and social movements have been shown to advocate for better health care provisions (Birn *et al*., 2016), establish health issues into national policy agendas (Dodd *et al*., 2009; Minoletti *et al*., 2012; Powers, 2012), increase awareness of health issues and policy change at a local level (Gomez and Ruger, 2015; Oronje, 2013), collaborate with government and foreign donor communities (Hirsch *et al*., 2015), and encourage the spread of global norms (Jafflin, 2013). Having established the importance of civil society, researchers have the opportunity to link theories of civil society and participation in political mechanisms to processes which are specific to international health policy transfer.

Although not as widely conceptualised in the literature as an important stakeholder in policy transfer, NGOs working within and among countries at both national and local levels play a

significant role in the implementation and adaptation of transferred policies. NGOs have at times influenced the uptake of national policy, such as global population policy (Luke and Watkins, 2002). Interestingly, NGOs are discussed more in theoretical frameworks for policy transfer than in process evaluations of actual transfers. This may be a result of the less visible nature of NGOs' contributions to national policy. Klugman (2000) argues that NGOs are often used by other stakeholders to gain legitimacy in dialogue and action around particular health issues. Furthermore, NGOs often advocate for the inclusion of equity in policy goals, facilitate expression of views on behalf of marginalised populations, and adapt their work to fill gaps that may exist in policy transfer processes (Klugman, 2000). Similarly to the role of political systems, NGOs are an important facet of international health policy transfer; however, they have not been adequately understood for their value-added in bridging the gaps between beneficiaries and makers of policy.

The private sector is perhaps the most difficult stakeholder to understand due to the limited access researchers may have; however, it is the least well understood by the current literature and therefore the most in need of supplemental inquiry. The private sector is widely understood to advocate for policies and programmes (Scintee and Galan, 2005) whether in order to improve personal or public health objectives. While the reviewed literature may not prominently utilize terms such as 'advocacy group' or 'lobbyist group', such differentiations are useful for analysis of private sector roles in policy formation and implementation and are generally provided by the wider literature which is not confined to either health policy or transfer processes.

6 Phases of policy transfer

The current body of literature discusses the processes through which health policy is transferred internationally; however, it does so at various stages of the transfer and with differing degrees of strength of assessment. Six phases of policy transfer have been identified from existing research: 1) conceptualisation, 2) formation, 3) internalisation, 4) contextualisation, 5) operationalisation, and 6) evaluation. This section summarises these processes which are identified by the literature.

6.1 Conceptualisation

Conceptualisation is the beginning of the policy transfer process and refers to developing the concept of the policy itself. International agencies are often cited as important in this phase since they mobilise interest and resources around a particular issue which affects how and when a policy is conceptualised (Ogden *et al*., 2003). Conceptualisation of policy occurs within the context of numerous ideological, normative, and operational motives held by stakeholders at both the national and interventional levels, as well as global socio-economic and political trends such as neoliberalism after the 1980s (Iriart *et al*., 2001; Hunter and Brown, 2000; Sundby, 2014). The concept of a policy often arises from the identification of problems with current policy and/or practice: for instance ineffective tuberculosis treatment (Atkins *et al*., 2012) and unequal distribution of health workers in urban and rural settings (Buchan *et al*., 2013).

The concept of a policy is often cited by the literature as arising from sudden events, such as the outbreak of a health issue or political instability, which provides the need and/or opportunity for policy transfer (Bewley-Taylor, 2014). The understanding of events which trigger policy transfer are often supported in the literature by both Kingdon's model for policy windows and punctuated equilibrium theory (Ogden *et al*., 2003). The global economic crisis (Kalo *et al*., 2013), outbreak of health problems such as HIV/AIDS (Gneiting and Schmitz, 2016; Clark, 2009; Banerji, 1999; Ogden *et al*., 2003; Lush *et al*., 2003), and political instability such as the Arab spring (Saleh *et al*., 2014), are examples of events which have prompted the conceptualisation of policy transfers. Political instability can also encourage the transfer of a policy: for instance in tandem with peace-building efforts or the need for a new policy as a result of a crisis (Bewley-Taylor, 2014). The literature often cites events as reasons for why policy transfer is conceptualised; however, it has not adequately explored the direct linkages between types and frequency of events and how a policy is conceptualised globally.

Policy networks take up a significant portion of the literature on policy conceptualisation, specifically with regards to relations between stakeholders and subsequent forms of dialogue and interaction. Policy networks consist of formal or informal relationships between governments and other policy stakeholders (Rhodes, 2008) and are instrumental in the conceptualisation of policies to address important health issues such as mental health and abortion policy (Minoletti *et al*., 2012; Storeng and Ouattara, 2014). A key role of policy networks is simply to facilitate relationships between stakeholders such as international organisations, national elites, and at times political systems and civil society. Facilitation of relationships is encouraged by trade, diplomacy, and the increasing recognition of the need for more effective health systems (Gomez and Ruger, 2015; Powers, 2012). Improved collaboration between stakeholders through political and social connections also improves the effectiveness of policy transfer (Clark, 2009; Lee and Walt, 1995). Policy networks are also understood to be useful for promoting dialogue and learning between stakeholders (Bennett *et al*., 2015; Buchan *et al*., 2013; Pallas *et al*., 2015), for instance through international conferences (Oronje, 2013; Lee and Walt, 1995; Shiffman *et al*., 2002). As one of the most common factors of policy conceptualisation cited throughout current research, the influence of policy networks will likely continue to characterise policy transfer literature, especially that which explores the distinct relationships and outcomes of interaction between stakeholders.

Alignment of goals between stakeholders at the local, national, and international level is recognised as crucial to the success of policy conceptualisation. A large portion of the literature cites the necessity for shared values and objectives between stakeholders during conceptualisation (Bewley-Taylor, 2014; Dodd *et al*., 2009). Alignment during conception is necessary for the effective implementation of policy in local settings (Pedregal *et al*., 2015), along with consistency of the messages conveyed by global stakeholders to local (Robinson, 2012), and donor coordination of overall policy transfer objectives (Leiderer, 2013). Goals for health policy transfer are often conflated with other 'development' objectives which may also appear on the agendas of conceptualising actors, for example combining anti-poverty policy with public health policy (Dodd *et al*., 2009; Kwon, 2008; Wachira and Ruger, 2011; Watt *et al*., 2013). Despite consistent emphasis on the importance of goal alignment in policy conceptualisation, there is an opportunity for the literature to explore the specific processes by which alignment (or misalignment) occurs.

6.2 Formation

Formation is the process by which the key conceptual and operational tenets of policy are concretised, and is often conceptualised throughout the literature as the bridge between the ideas and practice of a policy transfer. Cliff *et al*. (2004) describe formation as a combination of exchanging ideas and creating guidelines to be used in implementation. While formation itself is a significant factor of international health policy transfer processes, the literature lacks a comprehensive description of specific elements which constitute formation. It is often portrayed as the release of standards or codes of practice, for instance, without acknowledging the mechanisms through which elements of policy are formed after conceptualisation.

The literature also explores the use of evidence in policy formation. Discussions of evidence use in policy transfer are usually normative in nature and recognized as necessary by stakeholders but not fully understood as a mechanism of learning. The literature agrees that the availability of evidence alone may not be enough to change policies, suggesting that it is the responsibility of policy-makers to use evidence for policy formation, for instance by seeking political support for evidence-supported health issues (Atkins *et al*., 2012; Gneiting and Schmitz, 2016). The collection of evidence can make policy formation more effective over time and create policy environments that are conducive to transfer and learning across systems (Brundage *et al*., 2011). Evidence can also provide an opportunity for action on important health issues when public systems are unable to immediately respond: for instance, in the case of South African researchers who began academic inquiry into treatment programmes funded by the US President's Emergency Fund for AIDS Relief after delays in government action (Hanefeld, 2008).

A detailed example of formation is provided by Gilbert and Gilbert (2003), in their description of how Health for All principles were formed and endorsed in the 1970s by the WHO and Alma Ata Declaration. They show that international dialogue influenced how governments understood public responsibility in health, which was largely a result of the definition of health itself, as well as its determinants. This was followed by the involvement of international agencies in funding health services, and resulted in greater involvement of the private sector in health care provision (Gilbert and Gilbert, 2003). Current research also emphasises the role of knowledge procured from local communities and policy beneficiaries in contextualising policy; however, it does not specify methods for obtaining such evidence (Ir *et al*., 2010). Overall, the literature lacks insight into how specific concepts are formed into a policy which is transferred—specifically regarding the role of stakeholders and how formation can sometimes occur as a reaction to global or national events.

6.3 Internalisation

Internalisation is the process by which a formed policy is accepted and transformed by in-country policy systems. Although the literature does not specifically identify such processes as internalisation of policy, current research does explore how the creation of policy and laws interacts with the formation of societal norms, which then influence internal policy formation. Similar to formation, internalisation is often conceptualised as a link between the idea and the concrete elements of a policy; however, it more closely concerns the national adoption and transformation of a transferred policy than it does the original formation. Furthermore, while the process of formation may occur primarily outside of the recipient country, internalisation is necessarily undertaken by policy-makers within the recipient country and often differs according to the health issue addressed (Hunter and Brown, 2000).

Cliff *et al*. (2004) describe internalisation as occurring in recurring knowledge generation and policy standardisation processes at local, national, and global levels. Internalisation is also understood to be a joint process of cultural change and power differentials between stakeholders wherein a change in societal norms and 'culture', which may be induced by coercion, influences policy voluntarily. In other words, there is simultaneously a coerced and voluntary adoption of a transferred policy (Luke and Watkins, 2002). Internalisation is aided by NGO involvement in the spread of norms at a local level and in advocating reform at the national level (ibid.; Jafflin, 2013); branding and marketing of transferred policy (Ogden *et al*., 2003); domestic support of policy from beneficiaries and national elites (Gilbert and Gilbert, 2003); relationships between, commitment of, and transfer of resources among in-country and global policy-makers (Kahler, 1992; Pallas *et al*., 2015; Sgaier *et al*., 2013); geographic proximity of origin and recipient countries (Clark, 2009); and shifts in societal norms (Iriart *et al*., 2001). Effective internalisation determines the extent to which policies can be contextualised and subsequently operationalised.

Internalisation is often dependent on the social, economic, and political environment to which a policy is transferred. Past adoption of policies, public perception in similar health issue areas (Gneiting and Schmitz, 2016), and histories of international collaboration on health and other development policy implementation, diplomatic tension, and colonialism (Jafflin, 2013; Barnes *et al*., 2016; Ngoasong, 2009) all affect how policies are internalised by recipient country policy systems. For example, post-apartheid social instability and disagreement on health issues among prominent political ideologies in South Africa inhibited dialogue around HIV/AIDS and effective implementation of health policy (Powers, 2012). The literature on health policy transfer processes commonly mentions type of government as an important factor in policy internalisation. It is observed that although democratic governments positively encourage discourse and civic participation, they also foster debate and information sharing, which generally slows the internalisation process (Bergen-Cico, 2013; Clark, 2009). Authoritarian governments, on the other hand, tend to make faster decisions that are less aligned with beneficiary views (Iriart *et al*., 2001). Further research is needed to explore how shifting societal norms, both on a local and national level, interact with forms of governance and the internalisation of health policy.

6.4 Contextualisation

Contextualisation is the process by which policy is considered for adoption and modified to the social, economic, political, and cultural norms of the recipient country. The functions of contextualisation are varied and depend on the environment from and to which a policy is transferred, with some policy contexts requiring greater local input than others (Bewley-Taylor, 2014) or more integrated financial system changes (Kalo *et al*., 2013). Local knowledge is thus key to effective contextualisation of policy transfer, once again forming a common theme in the literature, which emphasises the role of policy beneficiaries (Juma *et al*., 2015). Reproductive

health issues are often undervalued because of religious and cultural aversion, for instance (Oronje, 2013). The literature also stresses the role of community and religious leaders in the contextualisation of policy, specifically in understanding cultural practices and in disseminating information (Wonodi *et al*., 2012). Similarly to policy formation and internalisation, linkages between policy beneficiaries and stakeholders with decision-making power should be explored to improve understanding of how to most effectively engage local communities and civil society in policy transfer.

Health is an especially culturally oriented issue, which requires contextualisation at all levels of implementation, especially when a policy is transferred from former colonial powers and when there is cultural meaning attached to different health practices (Banerji, 1999). Marketing and branding of policy, which also relates to internalisation and operationalisation, is a key factor of contextualisation, particularly with regards to the shaping of public norms and opinions. This can be seen in the Directly Observed Treatment Short (DOTS) course treatment of tuberculosis, which relied heavily on the marketing of ideas to mobilise resources (Ogden *et al*., 2003). Population policy had to be rewritten to fit policy beneficiaries in Jordan and Senegal, for instance, in order to be effective (Luke and Watkins, 2002). The role of social marketing in public health is a widely theorised concept in regard to the shaping of societal norms and health practices; however, more research could be undertaken to understand how marketing actually shapes policy itself, especially policy which is transferred from external contexts.

Policy images are one recurring factor of contextualisation which appears throughout the literature. Images may refer to messages or ideologies which are produced by stakeholders in the transfer process, and which affect contextualisation insofar as they define various components of the policy and how it is perceived. Images and ideas are often contrasted with policy mechanisms themselves and are described as complex but important factors of contextualisation which result from changing ideologies at multiple levels of policy implementation (Bewley-Taylor, 2014; Hussein and Clapham, 2005). Cultural factors also affect how a policy is operationalised: for instance, social norms regarding accountability and the role of policy-makers (Hirsch *et al*., 2015), or even how messages produced by policy-makers which affect perceptions among implementers and beneficiaries are received (Brundage *et al*., 2011). Policy images may also be intentionally constructed rather than produced by cultural and ideological changes: for instance after the 2006 G8 summit, when health ministers portrayed a strong, developed, and modern image of their countries instead of calling attention to pressing HIV/AIDS issues (Watt *et al*., 2013).

6.5 Operationalisation

In-country operationalisation is argued to be a separate process from global-level policy formation and conceptualisation, with domestic governments retaining the most influence over implementation (Gomez and Ruger, 2015). Policy transfer in the operational phase is commonly understood by the literature as being a product of effective mobilisation of stakeholders, such as use of policy networks, alignment of objectives, and validity of policy frameworks themselves. The quality of policy formation is also argued to be a primary determinant of operationalisation. Policies that are ineffective in transfer origin countries are less likely to be received well in recipient countries (Bergen-Cico, 2013). Unlike other aspects of operationalisation, learning and skills dissemination among local implementers is mentioned within the literature as an important factor of operationalisation but is not sufficiently explored (Brundage *et al*., 2011; Hanefeld, 2008).

A major theme within current research is the necessity of stakeholder alignment within the implementation of policy transfer – a factor which is also vital in conceptualisation. Because of the variety of and differences between stakeholders, operationalisation is not uniform, as observed by Jafflin (2013) who showed how differing goals among global, national, and local levels of policy

transfer resulted in miscommunication and inefficiency in Malawi and Cameroon's immunisation policy. Synergy among stakeholders encourages collaboration, utilisation of complementary skills and knowledge, participation in political processes, dialogue with civil society, and successful use of finance (Barnes *et al*., 2016; Gomez and Ruger, 2015; Hanefeld, 2008; Jashi *et al*., 2013; Leiderer, 2013). Conflict between stakeholders can harm policy operationalisation, reduce partnership between actors at different levels of implementation, and create gaps in health service (Hussein and Clapham, 2005; Palmer *et al*., 1999; Clark, 2009; Juma *et al*., 2015).

Finance is one of the most prominent features of policy transfer mentioned by the literature on health policy transfer processes. There are some examples of finance enabling policy transfer and improving the effectiveness of operationalisation. Aid can reduce the time it takes for recipient countries to internalise (Clark, 2009; Grace, 2006), contextualise and operationalise policy (Hanefeld, 2008), and move policy from a global to a national level (Luke and Watkins, 2002). Funding for policy implementation may also empower governments to contextualise and operationalise policy on their own terms and increase the effectiveness of policy transfer (Leiderer, 2013). In addition, the literature's portrayal of positive outcomes often conflates the role of funding with support from origin countries and policy networks, presenting a gap in the research, which shows positive policy outcomes from finance.

The majority of the literature on finance in health policy transfer, however, is critical of the inefficiency and policy coercion which often occurs as a result of aid. This is commonly portrayed in the context of power differentials and policy coercion between origin and recipient countries (Luke and Watkins, 2002). Attachment of funding to specific policy transfers can result in a polarised domestic dialogue for the purpose of attracting aid (Lush *et al*., 2003), failure of feedback loops when donors are appeased instead of criticised (Barnes *et al*., 2016), dependence on finance for the success of policy transfer (Brundage *et al*., 2011; Pallas *et al*., 2015), competition between recipient countries (Dodd *et al*., 2009), implementation of policies favoured by donors but not recipient countries (Leiderer, 2013), and lack of recipient country ownership of policy transfer (Sgaier *et al*., 2013; Sundby, 2014).

6.6 Evaluation

Evaluation takes up a surprisingly small amount of the literature around health policy transfer. Since research on health policy transfer is still growing, it currently relies on the general policy and health systems literature for theoretical and observational input in regard to evaluation. The literature often calls for improved monitoring and evaluation in policy transfer; however, it has failed to produce widely agreed standards for these processes. The literature argues for improved evaluation in order to improve dissemination of progress in policy transfer (Brundage *et al*., 2011), follow-up, management, and community-based collaboration (Jashi *et al*., 2013), alignment of policy goals and messages across stakeholders (Ngoasong, 2009), and the quality of health services provided through transfer (Sundby, 2014). The creation of standards for health policy transfer evaluation is important given the variety of interconnections found in the literature between stages of implementation (conceptualisation to operationalisation). Evaluation may also expose gaps in health policy transfer and encourage accountability and transparency between stakeholders.

7 Mechanisms and facilitators of transfer

The literature examining health policy transfer in low- and middle-income countries focuses primarily on broader processes of transfer rather than specific mechanisms which enable transfer to take place. A review of policy diffusion from 1960 to 2000 refers to 'mechanisms' as learning, competition, and coercion between countries (Schmitt and Obinger, 2012), for instance, which this review has identified as processes rather than functions of transfer implementation. The literature commonly identifies specific mechanisms in case studies, instead of listing or theorising such mechanisms. The following is a list of specific mechanisms which are mentioned.

Mechanisms

- Collection and dissemination of evidence around emerging health issues
- Conflation of health issues with other development issues, which facilitates agenda setting and coercion
- International conferences are used to reach consensus and disseminate information on goals and policy content among origin and recipient countries, as well as international agencies
- Country- and/or issue-specific directives, standards, and/or conditions are issued to origin countries
- International agencies controlled by former health practitioners and/or field workers promote more adaptable policies
- Mobilisation of resources and administrative capacity is used to operationalise policy
- Social marketing is used by implementing agencies as well as the private sector to affect public opinion and influence the success of a policy
- Consistent messaging of the needs, intended outcomes, and financial incentives of health policy from international agencies and government institutions, both internationally and domestically

The literature included in this review identifies actions and circumstances which are facilitators of health policy transfer, and that may be used by stakeholders and processes identified above to facilitate transfer. The following table displays facilitators of health policy transfer identified in the literature using a system of dual categorisation proposed by Clark (2009). First, categories of external and internal factors are used to differentiate facilitators which exist internationally among countries and agencies (external) and domestically in recipient countries (internal). Second, processes of learning, coercion, socialisation, and competition, which are widely theorised in the general policy transfer literature (Bennett *et al.,* 2015), are used. Sub-headings of transfer processes identified by this review further situate facilitators within the context of external and internal factors. Operationalisation and evaluation are included in external and internal factors since they may be implemented by both international or domestic actors. One way to understand the table is to select a bullet point and read it as a facilitator of the process of transfer in the external or internal context. For example, policy networks promoting dialogue and relationships between countries are facilitators of learning in policy conceptualisation.

Processes	External	Internal
	Conceptualisation	**Internalisation**
Learning	• Policy networks promote dialogue and relationships between countries • International agencies mobilise interest around particular issues • Global socio-economic and political trends place health issues at the top of the agenda • Problems with the current system are identified • Researchers use evidence to place health issue on the policy agenda	• Exchange of information between different levels of government and other stakeholders, such as health care providers and the media • Problems with the current system are identified • Researchers use evidence to place health issue on the policy agenda • Political ideologies affect which policies are promoted
Coercion	• Legitimacy of origin countries and international agencies in exertion of power in promotion of policies • (Under-)representation of countries in dialogue • Ability of origin countries to support policies • Sudden events provide opportunity for policy action	• Advocacy groups promote policies for their interests • Legitimacy of political parties is used by in-country interest groups to promote policy • Sudden events provide opportunity for policy action • Political instability provides opportunities for external involvement • Democratic governments experience slower but more efficient internalisation than authoritarian governments, from civic participation and encouraged discourse
Socialisation	• Collaboration between stakeholders • Agreement between stakeholders on values of, and goals for, policy transfer • Stakeholders are mobilised around goals of equity and efficiency • Increasing synergy in ideological, normative, and operational motives across actors	• Collaboration between stakeholders • Agreement between stakeholders on values of, and goals for, policy transfer • Stakeholders are mobilised around goals of equity and efficiency • Increasing synergy in ideological, normative, and operational motives across actors
Competition	• Relationships between countries (sometimes exhibited through diplomatic relations, trade, etc.) • Promotion of policies which are favoured by donors	• History of diplomatic relations between countries
	Formation	**Contextualisation**

Processes	External	Internal
Learning	• Policy networks promote dialogue and relationships between countries • Policy-makers use evidence to inform policy	• Commitment of national elites to policy transfer • Civil society advocates for the needs of policy beneficiaries • Policy beneficiaries provide information on the likely success of a policy in a specific context • NGOs promote views of marginalised populations • Policy-makers use evidence to inform policy
Coercion	• Grouping health needs of similar countries	• Policy beneficiaries accept a policy if it is appropriate to their needs • Advocacy groups and the media affect public opinion and social norms • NGOs advocate for equity
Socialisation	• Communication of outcomes to other origin/recipient countries and international agencies	• Civil society encourages the spread of norms
Competition	• Formation of policies in a way that is favoured by donors	• Formation of policies in a way that is favoured by donors
	Operationalisation	
Learning	• Political instability produces the opportunity for in-country stakeholders to learn from international agencies that intervene	• Civil society increases local awareness of health issues • NGOs adapt work to fill gaps in policy provision
Coercion	• Funding from external sources influences the type of health policy which is implemented	• Funding from external sources influences the type of health policy which is implemented • Financial systems undergo change to adapt
	Evaluation	
Learning	• Communication of outcomes on an international level	• Developing systems of accountability • Continuous knowledge generation informs subsequent standardisation of policy • Community and religious leaders provide feedback and represent local views

It is interesting to note trends in these observations, such as facilitators which appear in both external and internal contexts. Within the literature included in this review, there are gaps in

knowledge around facilitators for certain processes, such as a lack of information on how evaluation is affected by coercion, socialisation, and competition. Facilitators of socialisation are identical in conceptualisation and internalisation, suggesting that mechanisms supporting collaboration, agreement, and mobilisation of stakeholders are similar in both international and national environments. Additionally, processes for operationalisation and evaluation are significantly under-researched in the international health policy transfer literature.

8 Discussion

Although the literature on health policy transfer is still a growing field, it addresses crucial strengths and weaknesses among current transfer processes while incorporating existing theory and attempting to develop its own frameworks. The literature clearly references specific stakeholders, and provides evidence regarding the value added by interaction and dialogue. It is agreed that the changing roles of stakeholders is an important area for further research, especially in regard to the alignment of goals and the effects of power differentials between key actors. The literature also references policy processes which fall into various phases of a transfer, defined above as conceptualisation, formation, internalisation, contextualisation, operationalisation, and evaluation. Although most of these phases are not explicitly defined by the literature, current research attempts to explain processes of transfer through mechanisms which align with one or more of these categories.

Broad theories of interaction between phases of transfer, however they may be defined, have yet to be developed, and significant additional research is required to address gaps in the current literature. These gaps include: the mechanisms of interaction and dialogue between global-level stakeholders, such as international agencies; effective engagement of national elites and domestic bureaucrats; the role of political systems and NGOs in the facilitation of dialogue between policy beneficiaries, civil society, and national elites; the role of the private sector in health policy transfer; processes through which the alignment of goals across stakeholders takes place; use of evidence in the formation of policy; the effect of societal norms and type of government on internalisation of policy transfer; the role of social marketing and policy images in contextualisation; the value added by learning among field-level implementers; and processes for monitoring and evaluation of policy transfers.

A growing section of the literature explores how finance has led to changing in-country policy, in most cases the adaptation of policy specifically to receive aid. Policy change may be undertaken to attract funds or fulfil conditionalities (Cliff *et al*., 2004; Bennett *et al*., 2015), adapt agenda setting priorities to those of donors rather than national elites (Luke and Watkins, 2002), and compromise the sustainability of policy operationalisation (Banerji, 1999). The role of finance, while overwhelmingly observed to reduce the legitimacy, sustainability, and successful operationalisation of policy transfer, is nevertheless a significant factor of learning from health systems across countries. This is especially the case in low- and middle-income countries where finance is sometimes valued over the efficacy of policy transfer implementation, and therefore is used to control or coerce policy change.

There are two major factors in health policy transfer which are not adequately explored by the current literature. Firstly, the research has not sufficiently incorporated broader theories of the feedback loops through which policy is continually formed and standardised. This is important for developing linkages between phases of transfer (for instance, formation and internalisation), as well as for understanding how policy beneficiaries are included in larger policy transfer processes (Cliff *et al*., 2004). While theories of feedback exist within the policy literature, future research should aim to incorporate these frameworks into specific policy transfer environments, which may be unique in terms of the need for adaptability and incorporation of multiple stakeholders.

Secondly, the literature does not sufficiently address the processes by which policy is exported from origin countries, and instead focuses almost entirely on the mechanisms and experiences of recipient countries. Brazil is one country which has received attention for intentionally advocating policy, specifically the provision of free treatment to AIDS patients. After diverging from global recommendations at the time, Brazil challenged infeasible private sector drug prices and the global status quo in AIDS treatment. Brazil's policies to improve access to medication were adopted by

international agencies, and subsequently by other low- and middle-income countries (Nunn *et al.*, 2009). A commitment to social justice and health as a human right, as well as a desire to assert international influence, are cited as reasons why Brazil's policies were internationalised (Watt *et al*., 2013). While there may be numerous cases of low- and middle- income countries actively promoting health policy within international policy communities and amongst other governments, such as Turkey's engagement in learning for universal health coverage (Akdag, R., 2015; Atun *et al*., 2013), knowledge of the processes by which countries promote and export health policy remains lacking and presents a large gap in the research.

9 Conclusion

The literature on health policy transfer processes cites global policy networks, or, more specifically, coalitions of stakeholders that identify, formulate, and communicate policy in response to agenda setting processes, such as current events and research highlighting public health needs, as the most prominent originators of international health policy transfers. While there may be circumstances in which low- and middle-income countries learn from neighbouring countries' health policy strategies, these are less researched compared to policy transfers which are organised by networks of highly influential donor countries and international agencies with more capacity to both attract and initiate research. The United States and European countries are listed as common places of policy origin, whereas low- and middle-income countries are less active in promoting their own policies. The opposite is the case for recipient countries, which are most commonly listed as low- and middle-income countries and less commonly as higher income countries. HIV/AIDS is the most prominent health issue addressed by the literature, a possible result of the widespread media and academic research concerning the issue. The most common categories of 'policy-maker' are international agencies and national elites, perhaps because they are easily distinguishable by researchers examining foreign contexts. Civic organisations and NGOs are also listed as prominent 'policy-makers', largely due to their significant influence in advocacy and importance in the contextualisation process.

The literature is still a developing field of research, with much room for growth. Weaknesses of the literature include its failure to sufficiently explain connections between phases of transfer, processes of policy internationalisation and export from domestic contexts, and recurring mechanisms of policy formation and standardisation. Despite the gaps in current research, the evidence base indicates that encouraging effective health policy transfer involves the mobilisation of policy networks, the alignment of goals among stakeholders, the use of images and ideology in contextualisation, and effective utilisation of finance. In the context of low- and middle-income countries, it is important to consider the role that finance and histories of economic marginalisation and colonialism have in regard to the potential for policy coercion and the incapacity of implementation systems to effectively contextualise policy. This is especially crucial in light of the unique social, economic, and political forces which determine health system issues and outcomes.

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