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Altogether now . . . understanding the role of international organizations in iCCM policy transfer

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Abstract

Introduction Policy transfer theories explain how policy ideas move across time and geography and offer an approach to understanding waves of policy change, a common phenomenon in global health. Four primary mechanisms for the transfer of policies from global to national levels are posited: learning, coercion, socialization and competition.

Methods We used six concurrent country case studies of policy change for child survival followed by a global study to analyse (1) mechanisms for policy transfer and (2) the roles of international organizations in promoting policy transfer. Our six country cases drew upon early adopters of integrated Community Case Management of Childhood Illness policy (Malawi, Niger), as well as countries that were slower to adopt due either to practical implementation challenges (Mozambique, Mali) and/or policy resistance (Burkina Faso, Kenya). In total, 145 semi-structured interviews and 283 document reviews were conducted across the six country cases, and 25 semi-structured interviews and 72 document reviews for the global study.

Results Three of the four diffusion mechanisms (learning, coercion and socialization) were important in these cases, but not competition. Multiple strategies were employed by multilateral organizations to support policy transfer, such as regional meetings or academic publications, frequently serving multiple diffusion mechanisms simultaneously (e.g. both learning and socialization). In just one country case, funding conditionalities were used to press for policy change. The emphasis of policy transfer mechanisms varied between early and later adopters. Early adopters, for example, were more likely to engage in learning. International multilateral organizations were active policy transfer agents, and national policy-makers perception of them as "trusted partners" made them well suited for this role. However, on occasion their role became more that of advocates than neutral facilitators.

Conclusions International actors use multiple synergistic channels to promote uptake of global health policies in low- and middle-income countries, and tailor strategies employed to country contexts.

Key words: iCCM, international organizations, policy transfer

Key Messages

- iCCM policy was transferred from the global level to Sub-Saharan African countries through a variety of mechanisms that combined learning (e.g. through international conferences and academic publications), coercion (e.g. funding conditionalities) and socialization (e.g. setting international norms and monitoring their implementation).
- Different transfer strategies are likely to be effective in different contexts: learning may be important for early adopters, socialization for later adopters; more coercive mechanisms appear to be a strategy of last resort.
- Multilateral organizations act as "transfer agents" regarding new policies in global health, actively facilitating exchange among countries and between countries and the international level.
- Multilateral organizations may face two types of role conflict as they support policy transfer (1) between a neutral facilitator role and an advocate and (2) between a neutral facilitator role, and being an in-country representative of a funding agent.

Introduction

Health policies in low- and middle-income countries (LMICs) commonly appear to be influenced by policy change occurring outside their national boundaries. Historically, LMICs, sometimes with quite different political, health system and epidemiological contexts, have adopted similar policies around the same time. For example, in the late 1980s and early 1990s user fees were introduced across many low-income country health systems (Leighton 1995; Gilson 1997) this was followed by a wave of user fee repeals during the 2000s (Gilson and McIntyre 2005). In the domain of child health, countries adopted programs on diarrheal control and acute respiratory infections in the 1980s that were then replaced with a more integrated approach in the mid-1990s, referred to as Integrated Management of Childhood Illness (IMCI) (Claeson and Waldman 2000). During the 2000s, many LMICs sought to extend child health services beyond health facilities, the primary focus of IMCI, to the community level through an approach now known as integrated Community Case Management of Childhood Illness (iCCM).

So why does this clustering of policy change occur? Views range from the belief that a hegemonic power is being exercised, perhaps by powerful international donors, to rationalist perspectives that attribute waves of policy change to the accumulation of scientific knowledge leading to tipping points (Dobbin *et al.* 2007). International organizations may also play a role: conditionalities stipulating policy changes required to receive aid and/or loans have historically been a central element of World Bank and International Monetary Fund programs (Stuckler *et al.* 2011), whereas the United Nations agencies, such as the World Health Organization (WHO) and UNICEF, have developed and promoted global norms and standards to guide policy change and implementation (Ruger and Yach 2005; WHO 2006). However, the array of activities undertaken by international organizations to promote national policy change and the influence of such activities on policy content is poorly understood.

This article presents a study of iCCM policy transfer from the global level to countries in Sub-Saharan Africa. We focus specifically on vertical transfer, in particular the role played by international organizations (especially WHO and UNICEF) in promoting iCCM policy transfer. We address the following questions:

- Through which mechanisms was iCCM policy transferred from the global to national levels in Sub-Saharan Africa and how did this vary across countries?
- What role did international organizations play in promoting policy transfer and how did they and others perceive their role?

iCCM (Figure 1) is a policy designed by global level health policy actors, primarily working in major bilateral and international agencies (Dalglish, George *et al.* this volume), to address the fact that in Sub-Saharan Africa many children were dying at home before reaching health facilities. The WHO/UNICEF Joint Statement on iCCM (WHO/UNICEF 2012) was published only in 2012; however, the policy was strongly promoted and relatively widespread prior to that time. A 2010 survey (George *et al.* 2012) found that of a group of 40 target countries in Sub-Saharan Africa, 83% had adopted national policies supportive of treatment of diarrhoea by community health workers (CHWs), 74% had similar policies for malaria and 65% for pneumonia.

Theoretical background

Policy diffusion and policy transfer theories explain how policy ideas move across time and geography (Dolowitz and Marsh 2000), and may offer an approach to understanding policy clusters. The literature on policy diffusion initially emerged from the analysis of how ideas spread across states in America, however the field has grown rapidly, and is increasingly used to understand the international diffusion of policies both across countries (horizontal diffusion) and from higher to lower levels such as from the global level to

iCCM for childhood illnesses encompasses (i) treatment for childhood pneumonia with antibiotics, (ii) treatment for diarrhea with zinc and oral rehydration salts (ORS), (iii) treatment for malaria with artemisinin combination therapy (ACT) and other antimalarials, generally by community or lay health workers (CHWs) at household and/or community levels.

Figure 1. Definition of iCCM.

national levels (vertical diffusion) (Graham *et al.* 2012; Stone 2012). The policy transfer literature is embedded within the field of Public Policy and typically studies the transfer of policy from one country to another.

There are distinctions between how the terms policy diffusion and policy transfer are used. Policy diffusion literature is closely associated with the field of International Relations and focuses on the spread of policies across a large number of countries, often using quantitative analyses to investigate the spread of policy. Analyses in this tradition often focus on structural factors, such as government institutions, or international regulations to explain diffusion. In contrast, policy transfer studies tend to use qualitative, process tracing methods, as well as focus more on the role of agency in policy transfer (Marsh and Sharman 2009). Marsh and Sharman (2009) argue that these two approaches are complementary and that the schism between them is unproductive. While both literatures inform our analysis, we prefer the term "policy transfer" to reflect our interest in the role of international agents in policy change, as well as the methods used to study this.

In both literatures, policy diffusion and policy transfer, mechanisms for the spread of policies are frequently grouped into four categories (Weyland 2005; Dobbin *et al.* 2007; Marsh and Sharman 2009):

1. *Learning*—the rational process of considering policies adopted by other countries, appraising their advantages and disadvantages and choosing whether or not to adopt them. Learning may occur via international study tours, policy meetings and knowledge transfer when technical assistants travel between countries and convey knowledge about a policy or program from one setting to another.
2. *Coercion*—where policy transfer results from external pressure for policy change. Coercion may take softer or stronger forms, from gentle pressure to adopt new policies as part of a donor funding agreement, to hard conditionalities that make aid commitments conditional upon policy change.
3. *Socialization*—where policies adopted by other countries are seen to be "modern" or "advanced" because of the reputation of the country adopting them rather than the policy content. Accordingly, countries adopt policy change not through a rational appraisal of the advantages and disadvantages of policy effects, but rather to conform to international social norms.
4. *Competition*—where payoffs for different policies are altered due to actions by competitor states. Competition is common in trade policy where, for example, states may implement tax or tariff cuts to remain competitive with other countries, however this mechanism is likely less relevant to health. We retain it in our framework in case there is evidence of countries competing with each other to "stand out from the crowd" to secure donor attention. Being a "donor darling" might endow a number of benefits to a country, from increased donor funding (Frot and Santiso 2009) to a stronger negotiating position with donors (Whitfield and Fraser 2010).

These categories are not mutually exclusive and often have blurred boundaries. Dolowitz and Marsh (2000) suggest that there is a spectrum ranging from fully voluntary learning from other countries to the coercive transfer of policies, with more central positions on this spectrum reflected, for example, in the voluntary adoption of policies from elsewhere driven by a desire for international acceptance. These insights suggest that in order to understand policy transfer mechanisms, it is necessary to understand both the actors involved in transfer and their motivations. Dolowitz and Marsh (1996, 2000) suggest a set of questions that may be used to investigate policy transfer including: Why do actors engage in policy transfer? What is transferred? From where are lessons drawn? What are the different degrees of transfer? What restricts or facilitates policy transfer? And, how does policy transfer influence policy success or failure?

With globalization, pressures for policy change increasingly come from outside national boundaries (Dolowitz and Marsh 2000) and may be triggered by international organizations seeking to promote global norms (Stone 2004, 2012). While there have been many studies of international policy transfer much of the empirical work in this field relates to high-income countries (e.g. policy diffusion in the European Union) (Knill 2005). In terms of empirical studies in developing country contexts, diffusion research has often addressed competition in economic and trade policy conducive to external investments (Prakash and Potoski 2006; Dobbin *et al.* 2007). There has been little empirical investigation of policy transfer in other spheres, such as health (Sharman 2008). Nay (2012) analysed the role of UNAIDS in promulgating HIV/AIDS policies but focussed on the transfer of policy ideas among actors within the international system, rather than from global to national levels. A set of related articles investigated the transfer of policies for treating sexually transmitted infections (STI) and tuberculosis, drawing on the perspectives of international agency staff (Lush *et al.* 2003; Ogden *et al.* 2003; Walt *et al.* 2004) and country-level research in Mozambique and South Africa (Cliff *et al.* 2004). These studies found an iterative loop, whereby country-level research and clinical practice informed the policies of international organizations, which were then "marketed" back to countries (Walt *et al.* 2004).

Other studies have examined development partner behaviour in countries including donor influence on country priorities and policies (Okuonzi and Macrae 1995; Sridhar 2009; de Cruz and McPake 2010; Hanefeld 2010; Dodd and Olive 2011; Kapilashrami and McPake 2013) however, these have not employed an explicit policy diffusion or policy transfer framework.

Methods

This study draws upon data collected in a broader study of the process of iCCM policy development at the global level and in six country case studies. The countries (Burkina Faso, Kenya, Malawi, Mali, Mozambique and Niger) were purposively selected to reflect variation in the speed and ease with which iCCM policy was adopted. These country case studies were followed by a study of iCCM policy development at the global level.

Country level

Data collection in five of the country studies was conducted by local research teams, in collaboration with the international research team including doctoral students between May and September 2012. The Burkina Faso study was conducted by a doctoral student earlier in 2012. A total of 283 documents were reviewed and 145 semi-structured interviews (between 19 and 33 per country) were conducted with stakeholders (including representatives of government, NGOs and development partners).

Documents reviewed included those providing broader context (e.g. describing child health strategies, primary health care and CHW cadres) as well as documents specific to iCCM. Both published and unpublished documents were reviewed. A standardized spreadsheet was used to extract a summary of the document, as well

as details on the aspect of iCCM it addressed. The document review was used to generate a first draft of a timeline for policy development in each country, as well as a list of potential people to be interviewed. Researchers used a standardized interview guide including questions on the actors involved, interactions between actors, policy processes, the role of international events and the use of scientific evidence. Interviews were transcribed and a common coding framework was developed and applied by each country team using NVivo. Country teams developed a first draft of findings based upon these data that was presented at a workshop in October 2012. Teams discussed and reviewed findings, identifying commonalities and differences across countries. Subsequent to the workshop each team finalized its country case study and shared findings with national stakeholders.

Global level

Data collection for the global study was conducted between May and August 2013. The timing of this was dictated by the availability of funding for the study, rather than as a result of a planned decision by the research team. A total of 25 semi-structured interviews were conducted with individuals involved in policy development including representatives of international multilateral organizations, bilateral donors and academics. A similar coding structure including categories on policy transfer was applied to global-level interviews. Seventy-two documents were reviewed and, of relevance to this article, information was extracted on timelines for major changes in global policy recommendations, and activities and events to promote uptake of iCCM policy by countries.

For this article, each of the country studies, and the global study, were re-read with attention to content pertaining to policy diffusion, policy transfer and relationships between international and national actors. Where country reports hinted at additional insights regarding the transfer process, we returned to coded data and/or interview transcripts. We sought initially to simply document diffusion activities (such as regional meetings, international norms, etc.) and the actors involved, but on closer reading also sought to understand how international actors understood the relevance and role of these various mechanisms, as well as how they were experienced by national actors.

Results

In presenting results we first provide an overview of policy change processes across the six study countries. We then explore each of the four policy transfer mechanisms, describing the role and assessing the significance of each mechanism in the iCCM case. Finally, we analyse the perceived and actual role of international actors in supporting iCCM policy transfer.

Overview

Table 1 presents a timeline of key global, regional and country-level events that drove the adoption of iCCM in Sub-Saharan Africa. At the time of this study all six countries had some form of policy supporting iCCM for diarrhoea, malaria and pneumonia, with the exception of Kenya which did not support community-based treatment of pneumonia.

Malawi and Niger were relatively early adopters of iCCM policies, with Niger initiating training for CHWs in iCCM in 2007 and Malawi in 2008. Both had previously established cadres of CHWs that provided a strong platform for iCCM. All four other countries needed to establish an appropriate service delivery platform to implement iCCM. National policy makers in Mozambique and Mali were enthusiastic to do this. In Mali, a 2009 international workshop led to a clear commitment to proceed with iCCM, but it subsequently proved difficult to work out operational arrangements. In Mozambique as early as 2007, there was a clear policy commitment to iCCM but implementation only started in 2010, due again to difficulties in working out implementation details, including sustainable funding.

iCCM met with more resistance in Burkina Faso and Kenya where local stakeholders harboured strong reservations about iCCM. In Burkina Faso, while there was broad support for community case management of malaria and diarrhoea, there were substantial concerns about the use of antibiotics to treat pneumonia. The government somewhat reluctantly agreed to include pneumonia in iCCM, albeit only in two districts and as a pilot, as part of negotiations with the Partnership for Maternal, Neonatal and Child Health (PMNCH) over a proposed grant. Kenya also lacked an appropriate infrastructure for iCCM having only a weakly established cadre of CHWs. Further, policy makers harboured concerns about iCCM policies due in part to previous negative experiences with CHW use of antibiotics (Kelly *et al*. 2001; Rowe *et al*. 2007).

The status of implementation across the six countries closely reflected the speed with which the countries had adopted the policy. At the time of the study only Niger and Malawi had succeeded in scaling up iCCM nationwide (see Table 2). Burkina Faso, Mali and Mozambique had partially implemented programs, and Kenya had not started implementation.

Policy transfer mechanisms

Learning

Efforts by international actors, specifically WHO and UNICEF, to generate learning about the potential benefits of iCCM policy were widespread and constituted an important transfer mechanism. International organizations employed a range of strategies to promote learning including the provision of technical assistance; demonstrations of potential child mortality reductions using the Lives Saved Tool (LiST); hosting of regional meetings; organizing study tours for policy makers to other countries that had already implemented iCCM; packaging and disseminating of international research evidence; and providing support for local studies. With the exception of this last strategy, all strategies transferred evidence from other countries, or from the global level, to the country. Actors at international organizations recognized the importance of pursuing a portfolio of different strategies to promote learning.

> Now there is no single intervention, there are multiple strategies, multiple approaches; it depends on what a country situation is like. (Global 2013-07-18, international agency)

International meetings were commonly perceived by country-level actors to have been particularly influential. For example, a 2008 meeting in Madagascar on iCCM organized by USAID and UNICEF was mentioned as a tipping point by respondents in Burkina, Mali and Mozambique. However, for the lessons derived from regional meetings and other learning events to have effect, timing was critical. For Malawi and Niger, the Madagascar meeting came too late to be of policy significance; instead Nigerien actors viewed a 2005 USAID and UNICEF-organized meeting in Senegal to have been critically important. In Burkina Faso, an international mission organized by USAID in 2005 had no policy effect:

> In 2004 or 2005 there was a BASICS mission that came and which gave a presentation to the national level, and they tried to convince the government but the government was categorically

Table 1. Timeline for iCCM policy development: Key global, regional and national events

Year	Key global and regional events	Key events within case study countries
2003	*Lancet* series on child survival	
2004	WHO/UNICEF Joint Statements: "Management of Pneumonia in Community Settings" *and* "Clinical Management of Acute Diarrhea "	
2005	Roll Back Malaria Strategy for improving Access to Treatment through Home Management of Malaria (WHO/RBM)-USAID AWARE project sponsored meeting on CCM for pneumonia in Senegal	**Niger**—MOH officials undertake study tour to Senegal, supported by USAID to examine community management of pneumonia. MOH launches pilot in one district to test feasibility of CHW treatment of all three diseases
2006		**Niger**—CHW training guidelines include treatment for malaria, diarrhea and pneumonia; iCCM begins to be implemented
2007		**Malawi**—adopts the UNICEF Accelerated Child Survival and Development strategy that includes iCCM **Mozambique**—health sector strategic plan 2007–2012 calls for community level treatment of childhood illness & Minister of Health urges revitalization of the CHW program
2008	Madagascar meeting to share approaches to iCCM	**Burkina Faso**—proposal submitted to PMNCH for iCCM funding; grant received **Malawi**—global training guidelines for CHWs on iCCM adapted for use in Malawi with support from WHO **Niger**—evaluation of CHW program found to be successful and decision reached to scale up nationwide using Catalytic Initiative funding
2009		**Burkina Faso**—UNICEF supported workshop in Ougadougou using LiST tool supports CCM of Pneumonia. CHW training guidelines for pneumonia produced (prior training guidelines already cover malaria and diarrhoea) **Kenya**—UNICEF supports study tour of MOH staff to Ethiopia, Uganda and India to observe community strategies **Mali**—international workshop in Bamako where countries that had already started to implement iCCM share expertise
2010		**Burkina Faso**—IMCI strategic plan details CHW treatment of malaria, diarrhoea and pneumonia **Mali**—implementation guidelines for essential community services includes treatment by CHWs for malaria, diarrhoea and pneumonia **Mozambique**—CHW revitalization program details plans for CHW treatment of malaria, diarrhoea and pneumonia & CHW training program includes these diseases in its curriculum
2011	WHO sponsored meeting in Nairobi on Global Action Plan for Pneumonia, Nairobi	**Kenya**—government with support from WHO commissions operational research to inform policy **Malawi**—health sector strategic plan 2011–2016 explicitly mentions iCCM **Mali**—CHW training guidelines include treatment of malaria, diarrhoea and pneumonia **Mozambique**—training for CHWs in treatment of malaria, diarrhoea and pneumonia begins
2012	WHO/UNICEF Joint Statement on iCCM	**Kenya**—draft CHW training curriculum includes training for malaria, diarrhoea and pneumonia, but remains in draft and unimplemented
2013	American Society for Tropical Medicine supplement on iCCM	

> against it. That is to say, community case management was not the order of the day. (Burkina 791; international agency)

However, 3 years later the Madagascar meeting, which similarly shared experiences across countries, was much better received by government actors in Burkina Faso, and was viewed by some as a turning point. By the time of the August 2008 Madagascar meeting, other changes in the Burkinabe policy environment, (notably the grant for iCCM from PMNCH discussed in the section "Coercion"), likely made policy makers more receptive to iCCM. Similarly, Kenyan policy makers had participated in multiple international meetings on iCCM, including a WHO sponsored regional meeting in Nairobi in January 2011, but while this stimulated policy discussion of iCCM, it failed to spur policy change.

Academic publications were perceived to be important in promoting policy diffusion, both by international actors and country-level respondents. For example, respondents in all six study countries referred to the significance of the Lancet 2003 series on child survival, which was supported by multiple international actors (including WHO and USAID) and drew attention to high rates of child mortality and effective strategies to reduce them (see Rodriguez, Shearer *et al.* this volume). However, it is unclear whether academic publications were truly a means for country policy makers to learn about iCCM, or rather were an instrument to promote the policy, as implied by the following quotation:

> The supplement to the ASTMH was an important publication although I always saw its major purpose as… advocacy to get more countries to take up the strategy and perhaps to convince donors to invest in this. (Global_2013-07-11-4, bilateral agency)

Countries varied in the extent to which national policy makers were active vs passive consumers of evidence and learning brokered by

Table 2. Implementation status of iCCM in study countries as of end 2012

	Implementation status and coverage	Sources of funding
Burkina Faso	Implementation begun in August 2010 after delays; iCCM is being piloted in all 1525 villages in two regions (out of 13 total regions) with ~3050 CHWs; antibiotics for pneumonia included only in two districts	Funding for pilots coming from BMGF through PMNCH and UNICEF to the government Government to receive additional funds from CIDA to support on-going program and expansion for MCH activities
Mali	iCCM being implemented in five of eight regions in Mali (Northern Mali not covered) in hard-to-reach areas; 65% of projected sites covered, 1841 CHWs trained amounting to 69% of projected CHWs	Financing for equipment, supervision and salaries currently provided by partners MoH responsible for supporting staff conducting supervision
Niger	iCCM fully scaled up in all 42 districts, with over 3000 CHWs trained	Funding from UNICEF and CIDA for training CHWs (first wave only), buying drugs and making health posts fully operational Supply of essential drugs through UNICEF to health posts via health system Government pays CHWs through Highly indebted poor country (HIPC) debt relief funds; HIPC and Catalytic Initiative funds and subsidy for ACTs expire in the short to medium term
Kenya	None to date	Currently no clarity on financing and sustainability plans No funds allocated from government
Malawi	Implementation taking place in all 28 districts in hard-to-reach areas	Funding coming from UNICEF, WHO, USAID, CIDA (sometimes directly to NGOs) for training, supervision and equipment MoH provides drug and supplies and pays CHWs salaries from Sector-wide approach funds
Mozambique	Started in 2010 in two phases: pilot and national scale-up Pilot phase: one district in eight provinces with 179 CHWs trained Scale-up phase: 42 districts added (50/128 = 39%) and 540 additional CHWs trained but training targets not being met	Issues around CHW payment unresolved; Implementing partners not willing to fund CHW subsidies medium/long-term and cannot provide long-term contracts

international organizations. In Malawi, an early adopter of iCCM, policy makers had proactively shaped the nature of technical assistance they received from WHO, in order to better meet their needs.

> WHO did not force this down our throats, we understood this, we adapted these materials to fit our cloth. (Malawi_Int_2-12-8-23 government official)

However, such active engagement and shaping of technical assistance or evidence, appeared to be more the exception rather than the rule.

> Well, WHO, UNICEF and certainly WHO reassured us that there wouldn't be any problems. Fine, we accepted. (Burkina_888, government official)

Coercion

The role of external funding to support iCCM policy change was recognized by both global and country actors to be critical, as it was commonly perceived that iCCM policy implementation was expensive, particularly in countries that lacked a community health infrastructure.

> Money is key, because [iCCM] is very expensive (Global_2013-07-10, NGO)
>
> I think obstacle one is resources, resources both in funds and also human resources because we must use the people in the system . . . . . So what is not very clear is how resources would be available to take it to scale. (Kenya 02 government official)

Country policy makers' willingness to adopt iCCM policies was often contingent upon funding availability, but typically discussions between international organizations and country authorities were subtle and negotiation-based, reflecting bargaining power on both sides of the table. In Malawi and Niger, early adopter countries where there was an existing community health infrastructure and governments were keen to move forward, external funding was important to support implementation, but did not appear significant in contributing to policy change. In countries lacking an appropriate delivery infrastructure but keen to develop one, as in Mali and Mozambique, the availability of external funding appeared critical to the decision to change policy.

> The Ministry of Health made requests, [and] each partner responded according to its available budget and this availability of funding had a positive influence on elaboration of the strategy. (Mali_216, NGO)

In contrast, in Kenya, funding was part of ongoing negotiations between government and donors. Government officers expected that iCCM implementation activities would receive substantial support from development partners, but no agreement about the nature and extent of this support had been reached at the time of the study. Government appeared unwilling to change policies pertaining to community-level treatment of pneumonia unless there was a clear commitment of external funding, but donors were unwilling to promise funding unless government also committed itself to support iCCM implementation for all three childhood conditions.

Burkina Faso was the sole country where a form of coercion appeared to take place as quite specific funding conditionalities were applied. In early 2008, the Ministry of Health (MOH) in Burkina was invited to submit a proposal to PMNCH, an international partnership based at WHO Geneva which had received support from the Bill and Melinda Gates Foundation for scale-up of iCCM implementation. At the time, the country's strategic plan encompassed CCM for malaria, diarrhoea and malnutrition, but not pneumonia. This was reflected in the initial proposal drafted by the MOH, with support from partners, particularly UNICEF, the focal agency for the grant in Burkina. Upon submission of this first version of the proposal, the government was advised that to be eligible for funding, pneumonia should also be included; this was subsequently added to the grant proposal, albeit as a pilot in two districts rather than a nationwide policy. This change was accommodated for a relatively small grant: the total amount of funding received from PMNCH was only US$1.2 million over 3 years.

Global actors acknowledged the potential for funding to induce policy change, but also recognized limitations of such a strategy, namely the fact that external funding could not necessarily secure sustainable policy change, and may usurp country ownership.

> If donors start saying this … [that] countries would receive funding for programs only if they adopt officially the strategy, this could also be, let's say, a tool, a weapon in our hands to improve the adoption of this strategy. (Global_2013-07-30, international agency)

> It's hard even for donors. I mean you can bulldoze your way into a country with a lot of money, but even then you don't necessarily get ownership or sustainability. (Global_2013-07-11-2, bilateral agency)

Socialization

The development and spread of international norms and targets was very influential in driving country policies towards iCCM in two distinct ways. First, typically iCCM came on to countries' policy agendas due to high-level attention to achieving the Millennium Development Goals (MDGs). Second, international guidelines, such as the joint statements on pneumonia and diarrhoea (WHO/UNICEF 2004a, b) as well as the later statement on integrated iCCM (WHO/UNICEF 2012) helped drive policy content in countries.

First, the MDGs were important in focusing governments on child health challenges in all six countries, and this was largely because very senior policy makers (including presidents) were publicly called to account by the international community over achievement of the MDGs. The MDGs created pressure for child health policy change both in countries that were on track to achieve them (such as Mozambique), where they proved to be a spur to even greater action, as well as to countries such as Mali that were not on track.

> IMCI [including C-IMCI] was the spearhead for achieving the millennium targets … Within three years, the President will proudly announce in the New York summit that we have reached the goal [for reducing child mortality]. (Mozambique-Int-2012-07-23-2, government official)

> The country has seen that we cannot reach the MDGs for children unless we follow a clear and effective strategy in the community. It is this that has brought the authorities to reflect and to say to themselves that we have to go with essential community care [iCCM] to attain the MDGs. (Mali_212, NGO)

This high-level political attention provided a window of opportunity for policy change: ministries of health were pressured by senior politicians to deliver on the MDGs.

Second, both global and country-level actors viewed global norms and guidelines to be important mechanisms for articulating global standards and driving convergence towards these standards. Global-level actors articulated a process that included securing agreement between international actors, developing global guidelines, disseminating these guidelines and tracking policy adoption on the ground. Thus in the view of global respondents, achieving agreement between global actors, particularly UNICEF and WHO, on the central tenets of iCCM and the issuance of the joint statements (WHO/UNICEF 2004a, b, 2012; WHO 2007) were critical to the establishment and enforcement of policy norms.

> I think the thing is that all of the partners are aligned. And having all the partners aligned means that the countries get the same messages from each one. … It also puts extra pressure on them. (Global_2013-6-20, international agency)

Actors at the country level shared this perspective on the importance of global norms and guidelines, and the joint statements issued by WHO and UNICEF were of some importance in driving policy change. However, it was notable that the strongest articulation of the need to translate global statements into national policy came from country representatives of the international organizations themselves, as compared to government officials.

International meetings appeared to play a dual role, promoting learning about iCCM and its effects, but also creating social norms that encouraged countries to adopt iCCM policies. Respondents did not directly articulate that regional meetings were a source of pressure, but there were subtle signals that this was the case. For example, a Kenyan government official noted that regional meetings were a means to "*see how far countries are in iCCM*" (Kenya 01 government official), and a colleague in Burkina Faso saw their role as to "*orient policy, to conform with the Declaration of Ouagadougou*" (BUR_375 government official). Socialization mechanisms were less important in early adopters such as Malawi, where iCCM policy was adopted ahead of some of the global statements.

Efforts to make iCCM the policy norm for expanding access to child health services in Sub-Saharan Africa were further reinforced by monitoring of policy and implementation status under the Countdown Initiative. Countdown country profiles available online have, since 2008, tracked the extent to which country policies allow CHWs to use antibiotics to treat pneumonia, among other policy indicators. Peer-reviewed publications have also sought to track policy change (de Sousa *et al.* 2012). This monitoring process was perceived to be important by global-level respondents:

> And then we monitor. We follow up and we give reports. And I think giving report back through the Countdown, for example, who's got a policy and who hasn't got a policy. … [We] report back to the assembly. And countries read those reports. (Global_2013-06-20, international agency)

Competition

Global actors did not discuss competition as an incentive for policy change. Competitive advantage is most likely to be an incentive for early adopters such as Niger and Malawi, however in both countries solid domestic arguments supported iCCM policy change including a high level of political priority given to the lack of access to child health services, and while there were hints that the promise of global visibility may have added to the momentum for change in Niger, this was clearly not a dominant reason in either country.

The role and perceptions of international actors in policy transfer. Table 3 illustrates the different types of roles international actors

Table 3. Role international actors played in iCCM Policy Transfer

Policy transfer roles	Type of actor	Organizational examples
Transfer agents—took primary responsibility for promoting transfer of iCCM policies	International multilateral organizations	WHO UNICEF Related bodies e.g. PMNCH
Funding agents—typically working through the international multi-lateral organizations, with limited (if any) in-country engagement	Bilateral funding agencies and foundations	CIDA BMGF
Implementing agents—negligible role in policy transfer, though once policy was agreed, implementation experience may inform operating norms and procedures	International NGOs and international projects	Save the Children Fund Management Sciences for Health, through the BASICS project

played in policy transfer. International multilateral organizations played a critical role in facilitating exchange among countries and between countries and the international level that, following Stone (2004), we refer to as "transfer agents".

Respondents from multilateral organizations typically saw this role, entailing the packaging of global evidence, its dissemination to country partners and facilitating forums for exchange as part of their core function.

> I think that one of our duties is to get the information backwards disseminated in terms of how [it] is packaged and who [it] reaches. (Global 2013-07-01, international agency)

In all study countries, respondents typically identified the MOH as taking the lead role, with WHO and UNICEF noted as the two critical "supportive" partners.

WHO and UNICEF were perceived to be well positioned to advise on health policy as they were thought of as "trusted partners" and frequently local staff within these organizations were well embedded in local policy networks.

> WHO enjoys great trust. They have a lot of confidence in WHO directives. We present the directives and later they adapt [them] . . . ." (Niger-2012-6-6, International agency)

However, perspectives on the role of international organizations varied across country contexts. In contexts such as Malawi and Niger where there was a natural fit of iCCM with existing health systems and government interest in proceeding with community-level treatment programs, the transfer agents played more of a neutral, supportive role. But in countries where governments were less convinced of the need for iCCM, international organizations were sometimes viewed to be drivers of change, rather than simply facilitators.

> In terms of the involvement of stakeholders in the process, I would say that the engine driving the strategy was primarily partners. They had funding to support the strategy. Partners such as UNICEF, WHO agreed with the strategy and they had resources to support the Ministry. (Mali, 211 NGO official)

In Kenya, given resistance to iCCM it was most difficult for international organizations to play the role of neutral facilitating partners, and national actors clearly perceived that multilateral organizations were active advocates for policy change.

> These two agencies [WHO and UNICEF] have really been drivers of child survival both at global, regional and country level. And maybe they feel that as a ministry we are not moving fast enough to start adopting these policies for them, this should have happened yesterday. (Kenya, 01 government official)
>
> The government was not initially ready for it despite the overwhelming evidence that iCCM works. But through advocacy and push from international organizations the government is now supporting it. We see the big role of non-state actors in influencing the process, particularly WHO and UNICEF. Left to government alone it would have taken much longer. (Kenya, 019 NGO)

The international foundations and bilateral donors [such as the Bill and Melinda Gates Foundation and the Canadian International Development Agency (CIDA)] that were the primary funding agents for iCCM typically had very little, if any presence in-country. Instead they operated through the transfer agents. All five of the countries actively implementing iCCM were part of the Catalytic Initiative which received substantial funding from CIDA (~CAD 105 million, matched by UNICEF) and the Bill and Melinda Gates Foundation, channelled through UNICEF and PMNCH/WHO.

Sometimes the pressure that multilateral organizations exerted on country governments was not of their own volition, but rather reflected the nature of their agreements with funding agents. This was clearly the case with regard to the Burkina Faso grant which UNICEF was managing in-country, but this phenomenon was also recognize by national stakeholders in Mozambique who attributed the pressure they were under to accelerate iCCM policy implementation not to the international organizations themselves, but the funding agents.

While, international NGOs such as Save the Children and USAID projects such as the AWARE and BASICS project participated in national policy forums such as technical working groups, their role was primarily that of implementing agents. Overall they played a relatively minor role in iCCM policy transfer. One notable exception was the AWARE project that in 2005 hosted a meeting on community treatment of acute respiratory infections in Senegal, and conducted a trip to Niger that were influential in promoting iCCM policy in Niger.

USAID stands out as playing a hybrid role. In Niger and Mali it was seen as being as important a transfer agent as WHO and UNICEF, but elsewhere it was perceived primarily as a funding agent, and sometimes as an implementing agent.

Discussion

This article sought to understand the mechanisms through which iCCM policy was transferred from the global to the national level, and the role of international actors in supporting policy transfer. We start by addressing the strengths and limitations of the article, before considering key findings, and their implications for understanding policy transfer processes.

Strengths and limitations

This study combined country cases and a global-level study to analyse policy transfer mechanisms for iCCM. The study compared early adopters such as Malawi and Niger with later adopters such as Burkina Faso and countries such as Kenya that have still not fully adopted iCCM, providing insights into how policy diffusion mechanisms may vary in different country contexts. Although the WHO/UNICEF policy publication on iCCM was only published in 2012,

shortly before our study, we do not believe this to be a limitation given the number of prior policy documents addressing specific components of iCCM, and the extensive prior work done by multilateral organizations to promote iCCM.

Limitations include the challenge of eliciting honest responses from senior policy makers who may frequently relay what is politically correct or seek to shape how the story is told, rather than sharing their true opinions. We addressed this common problem in elite interviewing (Berry 2002) by preparing research teams prior to data collection, triangulating between different interviewees and data sources and verifying events via the document review. Due to the nature of research funding available we undertook the country-level studies prior to global data collection. Reversing this order may have allowed us to probe more at country level about how regional and global events affected country policy. Finally, there are limitations to the transferability of study findings: iCCM is a relatively technocratic policy and as such, one might expect a strong role for a technocratic and norm-setting agency such as the WHO. Policy transfer may look very different where local populations hold strong views about the policy. Further, all our country cases were low-income Sub-Saharan African countries where scientific, fiscal and bureaucratic capacity were relatively low, albeit with variation across the group.

Implications for understanding of policy transfer

Our research suggests that three out of four of the main mechanisms for policy transfer (learning, coercion and socialization), with the exception of competition, were relevant to the case of iCCM policy. A wide array of policy transfer strategies were employed, including international conferences, publications in peer review journals, the provision of technical assistance, external funding targeted at iCCM, study tours and global guidelines. Frequently, and as acknowledged elsewhere in the policy transfer literature (Shipan and Voldan 2008), the same activity promoted policy diffusion through multiple mechanisms. For example, regional meetings served to disseminate technical knowledge and simultaneously reinforce social norms.

For early adopters such as Malawi and Niger, international actors played an important role in facilitating learning through the provision of technical assistance, support to study tours, and evaluation of pilots. Socialization only became effective once there was widespread agreement about the nature of norms and a number of early adopter countries had proceeded with implementation: the Madagascar (2008) and Nairobi (2011) meetings perhaps fit this role. Coercion via funding conditionality was only used in Burkina Faso where prior more voluntary approaches had not proved effective. The extent to which this example really reflects coercion depends in part on the magnitude of the funding available, and the extent to which it represented an undue inducement. In reality it appears that the level of funding promised was relatively low, and the government, by only implementing CCM for pneumonia in two districts, did not modify its policies substantially.

International organizations clearly understood the challenge that financial inducements for policy change presented, and recognized that while such a strategy could lead to the formal adoption of a policy, there may be no inherent commitment to implementation. Furthermore, international multilateral organizations often relied on other funders to support implementation. This layering of funding relationships created further complexity as the multilateral organizations themselves were under pressure to deliver results. While others have recognized the conflict of interest that reliance on voluntary (as opposed to assessed) contributions presents to multilateral organizations (Clift 2013), this study underlines this problem.

In the transfer of policies on STI and tuberculosis, Walt *et al.* (2004) identified a policy loop whereby policies emerge from countries, are adopted at the global level and then filter back to national contexts. For iCCM in Sub-Saharan Africa this was not apparent. As discussed in Dalglish, George *et al.* (this volume) global policy on iCCM was informed mainly by studies from Asia with very limited involvement of policy makers from Sub-Saharan Africa, or evidence from the region.

It is difficult to discern how policy transfer mechanisms ultimately influenced implementation success. As already described, policy transfer mechanisms varied according to whether the country was an early or later adopter of iCCM. At the time of the study, it was apparent that early adopters had been more successful in implementation than later ones. However, this distinction probably relates more to the fact that early adopters had an appropriate implementation infrastructure (that encouraged them to adopt early), as well as the fact that they had had more time to roll out the policy, rather than the nature of policy transfer mechanisms.

Conclusions

International organizations have an important role to play in facilitating the transfer of policy innovation from the global to national levels. Yet they may encounter role conflict between the technocratic and normative work of synthesizing evidence and producing norms or guidelines, and the advocacy work entailed in promoting policy change within member states (de Cruz and Walt 2013). This study suggests that international organizations play both roles—neutral technocrats and active advocates—but the nature of these roles vary across country contexts, and probably across policies. UN agencies enjoy a privileged position among the ranks of development partners, given their perceived neutrality and indeed their formal mandates to support member states (Dodgson *et al.* 2002). Thus, there is a need to further understanding regarding how different roles that international organizations play in policy transfer affect relationships with countries and what measures may be taken to continue to protect their neutrality.

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Ethical Review

Ethical review was sought at JHSPH as well as in each country by local institutions. The study was exempted by the JHSPH Institutional Review Board and approved by all in-country review boards.

Conflict of interest statement. None declared.

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