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# The development of hospital accreditation in low- and middle-income countries: a literature review

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## Abstract

Hospital accreditation has been transferred from high-income countries (HICs) to many low- and middle-income countries (LMICs), supported by a variety of advocates and donor agencies. This review uses a policy transfer theoretical framework to present a structured analysis of the development of hospital accreditation in LMICs. The framework is used to identify how governments in LMICs adopted accreditation from other settings and what mechanisms facilitated and hindered the transfer of accreditation. The review examines the interaction between national and international actors, and how international organizations influenced accreditation policy transfer. Relevant literature was found by searching databases and selected websites; 78 articles were included in the analysis process. The review concludes that accreditation is increasingly used as a tool to improve the quality of healthcare in LMICs. Many countries have established national hospital accreditation programmes and adapted them to fit their national contexts. However, the implementation and sustainability of these programmes are major challenges if resources are scarce. International actors have a substantial influence on the development of accreditation in LMICs, as sources of expertise and pump-priming funding. There is a need to provide a roadmap for the successful development and implementation of accreditation programmes in low-resource settings. Analysing accreditation policy processes could provide contextually sensitive lessons for LMICs seeking to develop and sustain their national accreditation programmes and for international organizations to exploit their role in supporting the development of accreditation in LMICs.

**Keywords:** Hospital accreditation, low- and middle-income countries (LMICs), policy transfer, lesson drawing, policy learning

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## Introduction

Accreditation can be defined as ‘a public recognition by a healthcare accreditation body of the achievement of accreditation standards by a healthcare organisation, demonstrated through an independent external peer assessment of that organisation’s level of performance in relation to the standards’ (Shaw, 2004, p. 9). Accreditation first developed many decades ago in the USA and was adopted in some other Anglophone countries (such as Australia and Canada) before it spread worldwide in the 1990s (Shaw, 2000, 2003). While

accreditation originated largely in high-income countries (HICs) (Shaw, 2015), national accreditation programmes have more recently been developed in many low- and middle-income countries (LMICs) (Lane *et al.*, 2014).

This literature review provides a structured analysis of the development of hospital accreditation in LMICs. Key questions addressed by the review are to what extent are the structures and processes of hospital accreditation drawn from international models perceived as successful, and to what extent are they shaped by national policy

### Key Messages

- Hospital accreditation has been adopted and developed in many low- and middle-income countries (LMICs) and national accreditation programmes have developed in many of these countries.
- Policy transfer theory is a useful tool to analyse policy processes and the transfer of policies from one country or setting to another, including the transfer of accreditation policy to LMICs.
- Lack of resources has remained a major challenge to the development of accreditation policy and its sustainability in LMICs.
- Analysing accreditation policy processes can provide contextually sensitive lessons for LMICs and for international organizations which support accreditation development in LMICs.

contexts in LMICs? A policy transfer framework (Dolowitz and Marsh, 2000) is used to analyse accreditation policy development and to answer these questions. Policy transfer is defined by Dolowitz and Marsh (1996, p. 344) as ‘a process in which knowledge about policies, administrative arrangements, institutions, etc. in one time and/or place is used in the development of policies, administrative arrangements, and institutions in another time and/or place’.

This growth of accreditation programmes and their implementation in LMICs has been supported by many international organizations. These include, but are not limited to, the International Society for Quality in Healthcare (ISQua), the World Health Organization (WHO), the US-based Joint Commission on Accreditation in Healthcare Organisations (JCAHO), and its international organization: the Joint Commission International (JCI) and donor agencies such as the United States Agency for International Development (USAID) and the World Bank (Shaw *et al.*, 2010; Braithwaite *et al.*, 2012). However, the lack of resources in LMICs has remained a major challenge to the transfer of accreditation and its sustainability in these countries (Purvis *et al.*, 2010; Shaw *et al.*, 2010; Mate *et al.*, 2014).

The review also explores who is involved in the transfer of accreditation to LMICs. It examines the interaction between different networks and communication channels involved in the process of accreditation transfer, highlighting the role of international actors in the transfer process. It shows how a policy or practice that is successful in one setting can be transferred to another, and what mechanisms facilitate or hinder the transfer of accreditation policy to LMICs and affect its outcomes. Finally, the review provides contextually sensitive lessons for LMICs seeking to implement and sustain their national accreditation programmes, and for international actors to help them support these countries.

### Background

Accreditation programmes can be described in terms of four components: the accreditation body, standards, the survey process and surveyors, and finally incentives (WHO, 2003; Morena-Serra, 2012; Johnson *et al.*, 2016). According to Shaw (2003), the aim of accreditation in HICs is to standardize the processes in healthcare organizations in order to promote safety and quality of care which will result in patient satisfaction, public accountability and staff development. LMICs commonly have limited resources and poor hospital infrastructure, so their main focus is often to ensure better and equal access to healthcare services by establishing basic health facilities with adequate staffing and equipment (Shaw, 2003). However, LMICs can still vary widely with regard to their actual level of resources, along with other factors such as, political goals, the

existing healthcare infrastructure, involvement in conflicts and population demographics, all of which may influence the nature of their national accreditation programmes. For example, in 2018 the gross domestic product (GDP) per capita in Lebanon was almost 70% higher than that in nearby Egypt (World Bank Group, 2018). Lebanon’s accreditation system focused on improving quality in the predominantly private hospital sector (Ammar *et al.*, 2007). Egypt has an underfunded, low quality, public healthcare system, and it initially prioritized accreditation of primary healthcare (Rafeh, 2001).

There have been 13 previous literature reviews on accreditation that provide information about the origins of healthcare accreditation programmes and their development, along with many empirical findings related to their implementation (see Table 1). However, none of these reviews focused specifically on the mechanisms by which accreditation policies and practices spread from one country to another, and none made use of a theoretical framework to structure their analysis of the development of accreditation.

Previous reviews drew variously on research published from the 1960s to 2015, although the time periods covered, and the primary literature included by the reviews varied considerably. Four emphasized the introduction and growth of accreditation, described its processes, technical aspects and outcomes. They also looked at the governance of accreditation and how it can be institutionalized in health systems (El-Jardali, 2007; Greenfield and Braithwaite 2008; Fortes and Baptista, 2012; Hinchcliff *et al.*, 2012). Eight reviews explored the value and impact of accreditation, including the impact on the quality of care on overall hospital performance or on a single aspect of performance [Ciapponi and Garcia Marti, 2009; The Haute Autorité de santé (HAS), 2010; Alkhenizan and Shaw, 2011; Tabrizi *et al.*, 2011; Ng *et al.*, 2013; Brubakk *et al.*, 2015; Nicklin, 2015; Zarifrafter and Aryankhesal, 2016]. Two of the reviews from the first group also included some consideration of this. Greenfield and Braithwaite (2008) looked at both accreditation processes and the impact of accreditation on healthcare organizations. Similarly, El-Jardali (2007) described the development of accreditation programmes and the barriers to implementation, with a particular focus on countries in the Eastern Mediterranean Region (EMR). The remaining review explored the attitude of healthcare professionals towards accreditation (Alkhenizan and Shaw, 2012).

### Policy transfer framework

This review uses the Dolowitz and Marsh policy transfer framework to describe how policy ideas develop across time and space. It is the most commonly used framework by researchers to describe the process of policy transfer (James and Lodge, 2003; Benson, 2009; Minkman *et al.*, 2018). It employs a series of questions that may be

Table 1. Summary of the literature reviews

| Author (year)                            | Title   | Sector  | Date/period                      | # found    | Search terms   | Key findings  |
|--|---|---|----------------------------------|------------|--|---|
| El-Jardali (2007)                        | Hospital accreditation policy in Lebanon                                      | Hospital accreditation  | Not stated                       | Not stated | Not stated   | <ul style="list-style-type: none"> <li>This literature reviewed other countries' accreditation systems and identified some challenges to their implementations and some lessons learnt for policymakers in Lebanon and other EMR countries in order to improve their hospital accreditation policy or to develop a new system.</li> <li>It also claimed that the current accreditation programme in Lebanon is a crucial step for the health sector reform in the country and could possibly lead to quality improvement in healthcare organizations. However, this is not guaranteed until challenges are considered carefully.</li> </ul>   |
| Greenfield and Braithwaite (2008)        | Health sector accreditation research: a systematic review                     | Health service accreditation  | Prior to 2007                    | 66         | Accreditation, health care, systematic literature review, quality and safety | <ul style="list-style-type: none"> <li>This literature reviewed and analysed 66 studies that looked at accreditation and its related activities.</li> <li>It identified the impact of accreditation and classified it into 10 categories 'professions' attitudes to accreditation, promote change, organisational impact, financial impact, quality measures, programme assessment, consumer views or patient satisfaction, public disclosure, professional development and surveyor issues'.</li> <li>Its analysis identified consistent findings in two categories 'promote change and professional development' and inconsistent findings in another five categories 'professions' attitudes toward accreditation, organisational impact, financial impact, quality measures and programme assessment'.</li> <li>There were no sufficient studies available to draw conclusions on the remaining three categories.</li> <li>In conclusion, some national accreditation organizations are involved in accreditation research, and accreditation in healthcare is generally moving forward and this, in turn, will provide a deep understanding of accreditation and its related processes.</li> </ul> |
| Ciapponi and García Martí (2009)         | What are the impacts of health sector accreditation?                          | SUPPORT Summary of a systematic review: based on Greenfield systematic review in 2008 and relevance of the review for LMICs |                                  |            |  | <ul style="list-style-type: none"> <li>The summary supports the idea that decisions about accreditation must be guided by pragmatic factors such as 'institutional circumstances, feasibility, the costs of programmes, management competence and authority, professional self-regulation'.</li> <li>It also identified some challenges to the transfer of accreditation to LMICs such as technological advancement as well as the limited resources, especially among disadvantaged and rural populations.</li> </ul>  |
| The Haute Autorité de santé (HAS) (2010) | What is the impact of hospital accreditation? International literature review | Hospital accreditation  | 1 January 2000 to 31 August 2010 | 56         | Not stated   | <ul style="list-style-type: none"> <li>This literature reviewed the international literature on the assessment of the impact of accreditation of hospitals.</li> <li>It examined the methodological strengths and weaknesses of the included studies and confirmed the feasibility of assessing the impact of accreditation despite the methodological problems.</li> <li>It suggested some directions for future work in impact assessment: <ul style="list-style-type: none"> <li>Mixed qualitative and quantitative approaches appear to be suitable for studying this type of complex intervention;</li> <li>The inclusion of multiple factors into the analysis, perhaps other quality improvement programmes, would provide better explanations for the changes induced;</li> </ul> </li> </ul>   |

(continued)

Table 1. (continued)

| Author (year)                   | Title  | Sector                       | Date/period                   | # found | Search terms   | Key findings   |
|---------------------------------|--|------------------------------|-------------------------------|---------|--|--|
| Tabrizi <i>et al.</i> (2011)    | Advantages and disadvantages of healthcare accreditation models                                      | Health service accreditation | January 1985 to December 2010 | 23      | Quality, Accreditation, Hospital, Healthcare   | <ul style="list-style-type: none"> <li>Development of prospective studies would permit the inclusion of more reliable analysis;</li> <li>There is a need to have a more critical and rigorous approach to examine the quality of data used;</li> <li>Further studies are needed to explore the relationship between accreditation and the improvement of healthcare outcomes.</li> <li>This review identified some advantages and disadvantages of accreditation programmes from the perspective of LMICs such as Iran in an attempt to help in choosing the most appropriate approach.</li> <li>It identified six international accreditation models including the JCAHO from the USA, the Canadian programme of CCHSA, and the accreditation programmes of the UK, Australia, New Zealand and France.</li> <li>The main characteristic features among them were: 'quality improvement, patient and staff safety, improving health services integration, public's confidence, effectiveness and efficiency of health services, innovation, influence global standards, information management, breadth of activity, history, effective relationship with stakeholders, agreement with AGIL attributes and independence from government'.</li> <li>The JCAHO programme of USA and then CCHSA of Canada were identified as the most appropriate systems with the least disadvantages. Other programmes such as the ones from Australia, France, New Zealand and UK accreditation programmes were rationally comparable based on these criteria. However, the decision for policymakers to choose should be based on their specific objectives and needs' assessment.</li> <li>Based on the available literature, the JCAHO programme appears to be the most used as a reference model. However, there is possibly a bias in that assessment since the JCAHO is the most widely used programme for a long time and possibly the most written about.</li> </ul> |
| Alkhenizan and Shaw (2011)      | Impact of Accreditation on the Quality of Healthcare Services: a Systematic Review of the Literature | Health service accreditation | Prior to 2009                 | 26      | 'Accreditation', 'health services', 'quality', 'quality indicators', 'quality of healthcare' and 'impact'. | <ul style="list-style-type: none"> <li>This review analysed 26 studies that looked at the impact of accreditation on the quality of healthcare service.</li> <li>It identified '10 studies evaluated the impact of a general accreditation programme on the overall performance of hospitals. Nine studies evaluated the impact of a general accreditation programme on a single aspect of hospital performance. Seven studies evaluated the impact of subspecialty accreditation programmes'.</li> <li>It revealed that accreditation can possibly improve the quality of care provided by healthcare organizations and their medical outcomes.</li> <li>In conclusion, accreditation programmes should be supported as an improvement tool for healthcare quality.</li> </ul>  |
| Hinchcliff <i>et al.</i> (2012) | A narrative synthesis of health service accreditation literature                                     | Health service accreditation | Prior to 2012                 | 122     | Search 1: 'accreditation', 'Joint Commission on Accreditation of Healthcare                                | <ul style="list-style-type: none"> <li>The study reviewed the literature on health service accreditation and identified some findings with practical implications.</li> <li>It identified 122 studies, of which 67 studies were published since 2006, 60 studies in the USA and 79 studies focused on acute care.</li> </ul>   |

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Table 1. (continued)

| Author (year)              | Title  | Sector                       | Date/period           | # found | Search terms   | Key findings   |
|----------------------------|--|------------------------------|-----------------------|---------|--|--|
| Fortes and Baptista (2012) | Accreditation: tool or policy for health systems organizations?  | Health service accreditation | Year 1970–2000s       | 36      | Organisations' and 'Joint Commission' Search 2; Search 1 and 'research'.   | <ul style="list-style-type: none"> <li>It addressed two thematic categories that were examined &gt;60 times in literature including 'organizational impacts' and 'relationship to quality measures'.</li> <li>The literature examined 'financial impacts', 'consumer or patient satisfaction' and 'survey and surveyor issues' fewer than 15 times.</li> <li>It concluded that literature lacked the level of evidence and quality of studies but could outline some potential relationships among 'accreditation programmes, high-quality organisational processes and safe clinical care'.</li> <li>It also identified some common factors that might facilitate or hinder the development of accreditation programmes in seven studies.</li> <li>It revealed that costs required to administer accreditation programmes in LMICs could be the main risk to the sustainability of accreditation in these countries.</li> <li>This study examined the time of development and implementation of accreditation; with a particular focus on its technical aspects and the mechanisms for its transfer, identifying the possible connection between accreditation and health systems' organizations, in addition, how accreditation has been integrated with the guidelines of health systems.</li> <li>It claimed that accreditation could be considered as a policy issue that mobilises different state and non-state actors.</li> <li>The success of an accreditation programme might depend on the goals set by the policymakers, and what is believed to be the health system's objectives.</li> <li>It also claimed that accreditation could be used as a political tool, providing guidelines for regulating healthcare organizations and assessing the overall health systems' performance.</li> <li>This study examined the attitude of healthcare professionals towards accreditation in 17 articles.</li> <li>It found out that healthcare professionals had a sceptical attitude towards accreditation; they considered it a bureaucratic and demanding process.</li> <li>Hospitals' owners used accreditation as a potential marketing tool.</li> <li>In LMICs, the cost of accreditation programmes and their impact on the quality of healthcare services have been taken into account.</li> </ul> |
| Alkhenizan and Shaw (2012) | The attitude of healthcare professionals towards accreditation: a systematic review of the literature                              | Health service accreditation | Prior to 2011         | 17      | 'accreditation', 'Health Services', 'quality', 'quality indicators', 'quality of healthcare', 'attitude' and 'impact'. | <ul style="list-style-type: none"> <li>This review explored the implications for successful implementation and how accreditation can promote quality improvement, in an attempt to provide lessons for stakeholders including the government, public, patients and healthcare organizations about accreditation and its activities.</li> <li>The review used SWOT (strengths, weaknesses, opportunities, and threats) analysis to structure its findings.</li> <li><b>Strengths:</b> Increased staff involvement and communication, multidisciplinary team building, positive changes in organizational culture, and promoted leadership and raised staff awareness of continuous quality improvement.</li> </ul>  |
| Ng et al. (2013)           | Factors affecting implementation of accreditation programmes and the impact of the accreditation process of quality improvement in | Hospital accreditation       | Prior to January 2011 | 26      | 'Public hospital', 'hospital accreditation' and 'quality improvement'  | <ul style="list-style-type: none"> <li>Increased staff involvement and communication, multidisciplinary team building, positive changes in organizational culture, and promoted leadership and raised staff awareness of continuous quality improvement.</li> </ul>  |

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Table 1. (continued)

| Author (year)                         | Title   | Sector                   | Date/period  | # found    | Search terms  | Key findings   |
|---------------------------------------|---|--------------------------|--|------------|---|--|
|                                       | hospitals: a SWOT analysis  |                          |  |            |   | <ul style="list-style-type: none"> <li>• <b>Opportunities:</b><br/>Identification of opportunities for improvement promoted patient safety created an opportunity for healthcare organizations to receive additional funding, enhanced public recognition, and provided a market competitive advantage.</li> <li>• <b>Weaknesses:</b><br/>Staff resistance to change, increased staff workload, lack of awareness about quality improvement, insufficient staff training and support for quality improvement, lack of appropriate accreditation standards for local use, and lack of performance outcome measures.</li> <li>• <b>Threats:</b><br/>Opportunistic behaviours, funding cuts, lack of incentives for participation, and a regulatory approach to mandatory participation.</li> <li>• This study provided an overview of the impact of hospital accreditation on quality and patient safety outcomes; however, it could not draw any conclusions due to lack of evidence that supports its effectiveness.</li> <li>• It found out that accreditation is a growing industry with many stakeholders involved who may profit on promoting accreditation and its related activities.</li> <li>• It suggested that future research needs to focus on 'what aspects of accreditation serve a useful purpose, rather than focusing on does it work?'</li> </ul>                        |
| Brubakk <i>et al.</i> (2015)          | A systematic review of hospital accreditation: the challenges of measuring complex intervention effects | Hospital accreditation   | Prior to July 2014 (all studies on accreditation/certification in 2006 and this was repeated in 2009, 2013 and 2014) | 4          | Accreditation, Hospital, Patient Safety, Evaluation |  |
| Nicklin (2015) (Accreditation Canada) | The Value and impact of healthcare accreditation: a literature review                                   | Healthcare accreditation | Not stated   | Not stated | Not stated  | <ul style="list-style-type: none"> <li>• This study explored the impact and value of accreditation.</li> <li>• It found out that accreditation can be considered a risk mitigation tool. It can also be used to measure the performance; provide key stakeholders with 'an unbiased, objective, and third-party review'.</li> <li>• It can also be considered as a management tool for identifying strengths and opportunities for improvement, as well as for facilitating the collaboration of healthcare organizations by developing common quality culture and practices.</li> <li>• It claimed that comparing accreditation programmes is difficult since they are varied in approach and content, especially there is no certain evidence about the direct impact of accreditation on medical outcomes.</li> <li>• Some studies could explore the impact of accreditation on strengthening multidisciplinary team building and communication and how the use of indicators could lead to informed decision-making and improve health outcomes.</li> <li>• However, further research is needed to study the direct impact of accreditation on health outcomes.</li> <li>• Accreditation organizations need to provide a broad idea about the challenges and successes of healthcare organizations and to recognize patterns and trends in the delivery of health services.</li> </ul> |

(continued)

Table 1. (continued)

| Author (year)                     | Title   | Sector                       | Date/period                     | # found | Search terms  | Key findings   |
|-----------------------------------|---|------------------------------|---------------------------------|---------|---|--|
| Zarifrafar and Aryankhesal (2016) | Challenges of implementation of accreditation standards for healthcare systems and organizations: a systematic review | Health service accreditation | From January 1960 to March 2014 | 24      | Challenge, Barrier, Hospital, Healthcare Systems, Healthcare Organisations, Implementation of Accreditation standards | <ul style="list-style-type: none"> <li>• There is a need to promote the data collected through accreditation since it can be a crucial resource for governments and other healthcare organizations that can promote the informed decision-making process, ensure the continuous quality improvement processes and reduce costs through risk mitigation.</li> <li>• This study identified the challenges of implementation of accreditation systems and their target and audited standards in healthcare systems and organizations, respectively.</li> <li>• Challenges were divided into two main categories: 'programme (external) and organisation (internal) factors'.</li> <li>• Programme challenges were classified into             <ol style="list-style-type: none"> <li>i. the support of regulatory initiatives including 'legal support; independent or dependent accreditation entity; sustainable resourcing; and voluntary or mandatory accreditation programme';</li> <li>ii. encouraging drivers including 'financial incentives; and accreditation marketing';</li> <li>iii. Professional requirements including 'perception of accreditation standards; standards development; and reliable surveying practices'.</li> </ol> </li> <li>• Organization challenges were classified into: 'management and organization; human resource; financial and facilities resources; and quality improvement'.</li> <li>• Financial incentives and perception of accreditation standards were the most frequently stated challenges, other studies found out that independent or dependent accreditation entity; standards development; management and organization and human resources are among the main challenges.</li> <li>• In conclusion, policymakers should take into account programme and organization challenges before the development of accreditation programmes.</li> </ul> |

**Table 2** Dolowitz and Marsh policy transfer framework (Dolowitz and Marsh, 2000)

| Why transfer? Want to.....Have to    | Who is involved in the transfer?     |                            | From where?       |                   | Degree of transfer | Constraints on transfer               | How to demonstrate policy transfer? | How transfer leads to policy failure? |
|--------------------------------------|--------------------------------------|----------------------------|-------------------|-------------------|--------------------|---------------------------------------|-------------------------------------|---------------------------------------|
|                                      | Mixtures                             | Coercive                   | Past              | Cross-national    |                    |                                       |                                     |                                       |
| Lesson drawing (perfect rationality) | Lesson drawing (bounded rationality) | Direct imposition          | Elected officials | Internal          | Copying            | Policy complexity                     | Media Reports                       | Uninformed transfer                   |
| International pressures              | Conditional                          | Bureaucrats                | Bureaucrats       | Global            | Emulation          | Past policies                         | • Commissioned                      | Incomplete transfer                   |
| Image                                | Loans                                | Civil servants             | • Goals           | Regional          | Mixtures           | Structural, institutional feasibility | • Un-commissioned                   | Inappropriate transfer                |
| Consensus                            | Business activities                  | Pressure groups            | • Content         | State             | Inspiration        | • Ideology                            | Conferences                         |                                       |
| Perceptions                          | Political parties                    | Policy entrepreneurs       | • Instruments     | Local Governments |                    | • Cultural                            | Meetings Visits                     |                                       |
| Externalities                        | Obligations                          | Experts                    | Institutions      | Past Relations    |                    | proximity                             | Statements                          |                                       |
|                                      |                                      | Consultants                | Ideologies        |                   |                    | Technology                            | Written                             |                                       |
|                                      |                                      | Think Tanks                | Attitudes         |                   |                    | Economic                              | Verbal                              |                                       |
|                                      |                                      | Transnational corporations | Cultural values   |                   |                    | Bureaucratic                          |                                     |                                       |
|                                      |                                      | Supranational institutions | Negative lessons  |                   |                    | Language                              |                                     |                                       |

used to explore the transfer of policies, including: Why does policy transfer? Who is involved in the transfer process? What is transferred? From where is policy transferred? What is the degree of transfer? What are the constraints on policy transfer? How does policy transfer lead to policy failure? (see Table 2). This section highlights some important issues raised by these questions (Dolowitz and Marsh, 2000).

The transfer can range from being ‘voluntary’ learning or ‘lesson drawing’, to ‘coercive’ transfer of policies or practices (Dolowitz and Marsh, 2000). Policymakers may voluntarily choose to adopt a certain policy or practice that is successful elsewhere and adapt it to their context (Rose, 1991; Dolowitz and Marsh, 1996). Alternatively, governments may be coerced directly by another government or organization to apply a policy change or adopt certain practices against its will, or indirectly to secure grants or loans from a government or other donor agencies (Evans, 2009; Stuckler et al., 2011).

Ugyel and Daugbjerg (2015) classify the transfer agents in developing countries into three categories: (1) domestic civil servants, politicians and bureaucrats, who may look for solutions to their domestic policy issues (Dunlop, 2009); (2) officials affiliated to international organizations established by groups of countries, such as the World Bank, Organisation for Economic Co-operation and Development (OECD) and International Monetary Fund (IMF), that support public sector reform across developing countries (Stone, 2004; Jones and Kettl, 2003); and (3) non-state actors, including transnational advocacy networks, non-governmental organizations (NGOs), think tanks and ‘epistemic communities’, which are defined by Haas (1992, p. 3) as ‘networks of professionals with recognised expertise and competence in a particular domain and an authoritative claim to policy-relevant knowledge within that domain or issue-area’. The review uses this classification to examine transfer agents in LMICs.

Stone (2004) categorizes the elements to be transferred during the transfer process into two main groups: hard and soft elements. Hard elements are tangible and include legislation, regulations, institutions, policy instruments and programmes; whereas soft elements comprise the ideas, principles, lessons and interpretations obtained from policies. These lessons may be about what to do, or what not to do (Dolowitz and Marsh, 1996). A policy can be transferred endogenously within a country (e.g. between sectors or from one geographical district to others), or exogenously from another country. Bennett (1991, p. 220) suggests that there is ‘a natural tendency to look abroad, to see how other states have responded to similar pressures, to share ideas, to draw lessons and to bring foreign evidence to bear within domestic policy-making processes’.

There are four different degrees of transfer: (1) copying: which is direct and complete transfer; (2) emulation: which involves adapting policies or ideas to fit the local context; (3) inspiration: where a policy in one jurisdiction inspires a policy change in another one, but the final policy does not follow the original; and (iv) combinations: which comprise mixtures of different policies from two countries or more (Dolowitz and Marsh, 2000; Stone, 2000).

Benson (2009) groups constraining factors into four groups directly related to the transfer process: (1) demand side: when policymakers in the recipient country resist the policy change; (2) programmatic: when the complexity of the policy constraints its transferability; (3) contextual: cultural differences between the two political systems (the exporter and the importer); and (4) application: organizational arrangements and institutionalization of the new policy.



Finally, it is not necessarily the case that policies which have been successfully implemented in one country will be similarly successful in another. Dolowitz and Marsh (2000) identify three main ways in which transfer can lead to policy failure: uninformed, incomplete, and inappropriate transfer. Uninformed transfer occurs when the recipient country has insufficient information about the policy or practice being transferred. Incomplete transfer happens when crucial elements of the policy have not been transferred to the recipient country. Inappropriate transfer occurs when the recipient country does not sufficiently consider the cultural differences between it and the exporter country (Dolowitz and Marsh, 2000). Geographic proximity and similarities in cultures, ideologies and resources may raise the chances of policy success and facilitate adaptation between the borrowed policy and the local settings in the recipient country or organization (Walker, 1969; Dolowitz and Marsh, 1996).

Policy transfer thus provides a rich set of concepts which can be used as an analytical tool to analyse the development of a new policy and its processes and outcomes. It is used in this review to explore the mechanisms of the growth of hospital accreditation policy and its adoption by LMICs.

## Methods

### Search strategy

The literature on hospital accreditation and its development in LMICs was identified from three databases: Medline (OVID), the Cochrane Library and the Health Management Information Consortium (HMIC). The keywords for the search were hospital accreditation and terms for LMICs. Specific countries were identified from the World Bank classification of countries into low-, middle- and higher-income groups based on their levels of income per capita (World Bank Group, 2016). The search was conducted between October 2016 and February 2017.

The search sought to increase sensitivity by using wildcards to include different forms of root words, e.g. accredited, accrediting and accreditation. Wildcards were also used in conjunction with country names to include nationalities, e.g. Albania and Albanian.

The search covered abstracts, keywords and titles. The initial search in the three databases produced 510 articles. The keyword search was supplemented with a snowballing approach until saturation was reached (Greenhalgh and Peacock, 2005). After the original search, a further search was then conducted on Google Scholar using hospital accreditation, low-middle-income countries, developing countries as keywords, plus citation searches for each document found. Online resources of relevant organizations that were known to participate in or fund regional and national accreditation activities (e.g. WHO, USAID and ISQua) were also reviewed. Reference lists of included articles were further screened for any potentially relevant articles not identified in the primary search, in addition to contacting other researchers in the field, who identified additional publications for consideration. All these broadened the literature search and produced another 63 articles; many of which were not published in the journals covered by the three examined databases.

The search was not limited by a specific study design or a certain period. It included both qualitative and quantitative studies that looked at hospital accreditation and its development in any individual LMIC or group of LMICs. Any article that generally discussed accreditation and its processes, its main components, requirements, impacts and common barriers to its implementation and sustainability were also included. The search excluded any article that focused

exclusively on accreditation in any setting other than hospitals, such as primary healthcare, specialized hospital departments, disease/medication-specific regulation, and public health and health research. It also excluded any article that discussed the development of accreditation in HICs only, plus non-English language articles. All 573 articles were imported to Endnote and duplicates excluded. The resulting 555 articles were screened by reviewing titles and abstracts. A total number of 95 full texts were obtained, 17 were not relevant, leaving a final number of 78 articles to be included in the analysis, as shown in Figure 1.

### Data analysis

A deductive thematic analysis based on policy transfer theory and the questions in the Dolowitz and Marsh framework (see above) was used to analyse the documents found. Text relevant to any of these questions was highlighted and coded. Patterns were identified through an iterative process of bringing relevant information together (Miles and Huberman, 1994). Through this process, contextually sensitive lessons were drawn about how LMICs can develop sustainable hospital accreditation programmes and how international organizations can exploit their role in the field of international policy transfer to be able to support accreditation activities in LMICs.

## Results

The findings of the review are structured according to the questions in the policy transfer framework. They are described in more detail in the rest of this section.

### Why is accreditation transferred to LMICs?

Accreditation was largely pursued voluntarily as an approach to improve hospital performance (Bukonda *et al.*, 2002; WHO, 2003; Ruelas *et al.*, 2012). There were, however, also a few instances of indirect coercive transfer of accreditation to LMICs (Rafeh, 2001; Bukonda *et al.*, 2002; Legros *et al.*, 2002; Bateganya *et al.*, 2009). Policymakers looked outside their countries, searching for suitable accreditation models to transfer to their home countries to enhance public accountability of healthcare organizations. Some policymakers seeking a 'quick fix' for poor hospital performance, decided to transfer accreditation to their home countries, which was limited by time, resources and information.

The literature reports some examples from LMICs in which accreditation programmes were used as an improvement tool for poor hospital performance, a reform instrument for weak health systems, or a regulatory tool for both public and private health sectors (Ammar *et al.*, 2007). Accreditation was also used as part of the implementation of internationally agreed practices such as universal health coverage (UHC), or national policies such as medical tourism (Mate *et al.* 2014).

### Transfer of accreditation as an improvement tool

To face health system challenges in sub-Saharan Africa, a number of Ministries of Health (MOHs) there introduced comprehensive health facility quality standards to their healthcare organizations that set minimum basic requirements for the availability of equipment and use of clinical guidelines. Some organizations in these countries could not comply with these standards due to lack of resources, poor administrative systems and poor organizational inspection (Rowe *et al.*, 2005; Lane *et al.*, 2014). However, governments in these countries persisted in trying to bring quality standards into operation through national health facility accreditation programmes (Bukonda *et al.*, 2002; Lane *et al.*, 2014). For

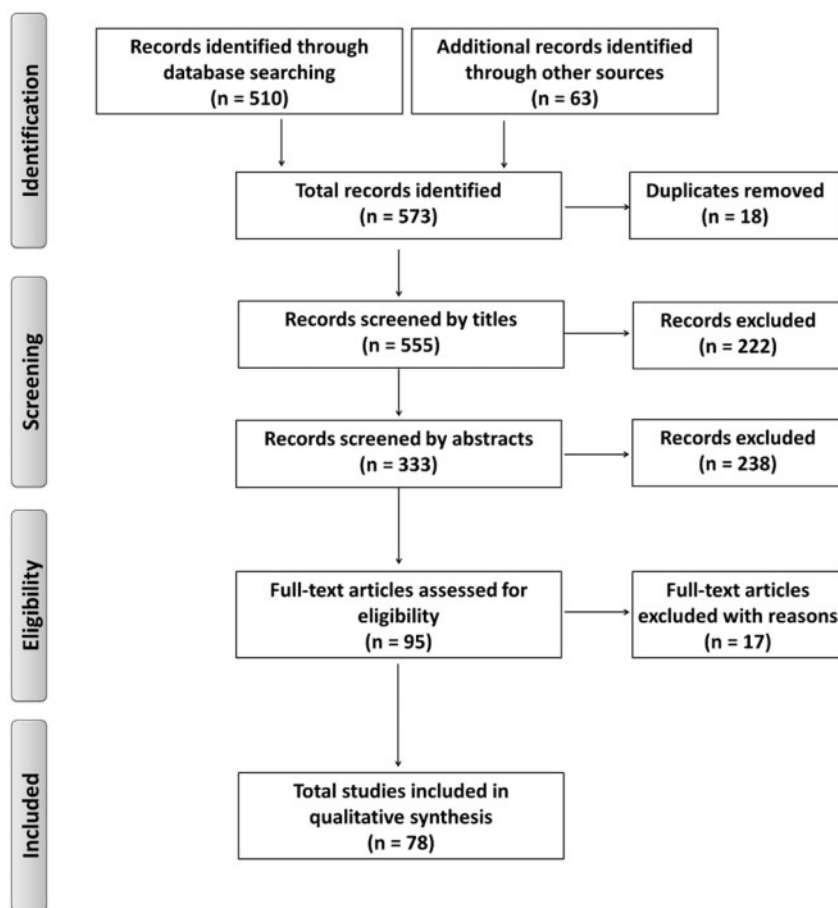


Figure 1 PRISMA Flowchart of the study selection process (Moher *et al.*, 2009).

example, Zambia, Uganda and South Africa were reported to have begun extensive reform plans for their health systems and accreditation was essentially included in these plans. Hospitals within these health systems tried to comply with accreditation standards in order to improve the quality of care and promote their public image (Whittaker *et al.*, 2000; Bukonda *et al.*, 2002; Galukande *et al.*, 2016).

The recession of the 1980s in Latin America led to the deterioration of their public sector and its hospitals. In the 1990s, in collaboration with the Pan American Health Organisation (PAHO), several countries in Latin America such as Brazil, Chile and Argentina launched their hospital accreditation programmes, in an attempt to strengthen their weak health systems and improve the quality of health services (Arce, 1999; Novaes and Neuhauser, 2000; Legros *et al.*, 2002).

#### Transfer of accreditation as a regulatory tool

Lebanon and Iran voluntarily chose to use accreditation as a regulatory tool to ensure the quality of healthcare services. Unlike in improvement, accreditation is mandated on all hospitals by law and linked to payments when it is used for regulation (El-Jardali 2007; Kiadaliri *et al.*, 2013; Agrizzi *et al.*, 2016). Countries such as Kenya and Tanzania established a system of National Health/hospital Insurance Funds (NHIF) (Lane *et al.*, 2014). As a result, a number of new accreditation programmes emerged, managed by the NHIFs, where only accredited hospitals could be 'reimbursed' for services (Purvis *et al.*, 2010, p. 11).

Accreditation was also used as a mechanism for regulating the private health sector in some LMICs. With lack of inspection by legislative authorities and outdated and poor regulations, the government in India decided to use accreditation to monitor the performance of the private sector (Bhat, 1999; Nandraj *et al.*, 2001). Similarly, in Lebanon, the Ministry of Public Health (MOPH) contracted with private hospitals to manage uninsured patients. With poor quality of care and the high cost of health services as a result of the unregulated private sector and poor governmental control, the MOPH used hospital accreditation as a mechanism to regulate the private sector and improve its service delivery (Ammar *et al.*, 2007).

#### Transfer of accreditation as part of UHC and medical tourism

Another motive for accreditation in LMICs was medical tourism, e.g. in India (Dastur, 2012) and Jordan (HCAC, 2013). Since patients might limit their search for high-quality health services to accredited hospitals, hospitals were encouraged to participate in accreditation programmes to improve performance and medical outcomes and become medical tourism destinations (Dastur, 2012). This would provide additional income both to the hospital and to the local economy.

The basic principle of UHC is that 'all people should have access to quality health services they need without facing financial hardship' (WHO, 2015, p. 2). Public pressure and high social expectations have created a call for equal access to quality healthcare and financial protection from the high costs of health services (WHO,

2015). To achieve this quality of care and ensure value for money, the demand for accreditation has increased and the international move towards UHC raised interest among some LMICs to develop their national accreditation programmes (Shaw, 2015). The payers for UHC—either the governments or insurance funds—support accreditation by providing financial incentives for hospitals to join the programme, and hospitals, in turn, compete to be accredited. Accreditation helps the payers to make informed decisions about which hospitals to include in their payment schemes (Mate *et al.*, 2014).

#### Indirect coercive transfer of accreditation

The literature shows that the international community can create an indirect coercive transfer by compelling countries, particularly LMICs, to adopt certain policies as a condition of securing funds or loans (Dolowitz and Marsh, 1996; Evans, 2009). This occurred when USAID funded health reform programmes, which specified the inclusion of accreditation in Zambia (Bukonda *et al.*, 2002), Chile (Legros *et al.*, 2002), Indonesia (Broughton *et al.*, 2015), Uganda (Bateganya *et al.*, 2009) and Egypt (Rafeh, 2001).

#### Who is involved in the transfer of accreditation to LMICs?

This review looked at the agents who were involved in the transfer of hospital accreditation policy to LMICs.

#### National (state) actors

Officials and national policymakers in LMICs wanted to import the best accreditation model that could fit their national context (Nandraj *et al.*, 2001). Many accreditation programmes started and were managed within the MOHs. This MOH ownership of

accreditation programmes, especially in their early stages of development, helped in maintaining the financial and political support needed to sustain the programmes, and in avoiding the financial burden of establishing an independent accreditation body (Mate *et al.*, 2014). The national stakeholders such as civil society organizations, independent hospitals, patient organizations and individual donors also played an important role in supporting their governments' move towards implementing national accreditation programmes. This, in turn, helped to direct all available national resources towards one common strategic objective that was improving the quality of care (McNatt *et al.*, 2015).

#### International (non-state) actors

International non-state actors gained the trust of national policy-makers through their continuous support to LMICs (Bennett *et al.*, 2015). They used multiple synergistic strategies in the transfer of accreditation policy to LMICs. This occurred through regular regional meetings, annual conferences and academic publications, offering technical support to governments and healthcare organizations and in some cases funding accreditation and its related activities (see Table 3).

International accreditation experts and individual consultants played a crucial role in the transfer of accreditation to LMICs. For example, consultants and experts from the JCI worked with the Chinese Ministry of Health in 2007 and with the South Korean Hospital Association in 2009 (The Joint Commission, 2017). They helped them through their regular visits, their assistance in developing and revising the standards, and provision of training, which in turn, led to the transfer of knowledge about accreditation and its policy learning, and, in addition, the transfer of new technical skills (Ikbal, 2015).

**Table 3** The role of international organizations in supporting accreditation in LMICs

| Organization  | Activities   |
|---------------|--|
| WHO           | <ul style="list-style-type: none"> <li>In 2005, WHO established a partnership with JCAHO and JCI to reduce medical errors (Tabrizi <i>et al.</i>, 2011) and to establish guidelines about patients at risk in healthcare organizations worldwide (Fortes and Baptista, 2012)</li> <li>PAHO/WHO plays an important role in using accreditation for articulating the goal of 'Health for All in 2000' (Fortes and Baptista, 2012)</li> <li>Hospital accreditation model for Latin America took place with two conferences held by PAHO on Hospital Accreditation in 1989 and 1992 (Novaes and Neuhauser, 2000).</li> <li>PAHO staff members prepared a 'Manual of Hospital Accreditation' that has been used by many countries in Latin America for setting up their national hospital accreditation programmes (Novaes and Neuhauser, 2000).</li> <li>The 'Patient Safety Friendly Hospital Initiative', launched by the WHO EMRO in 2007 (Siddiqi <i>et al.</i>, 2012).</li> </ul>   |
| ISQua         | <ul style="list-style-type: none"> <li>ISQua is the highest international body on healthcare quality activity that accredits the accreditors (Tabrizi <i>et al.</i>, 2011; Greenfield <i>et al.</i>, 2012).</li> <li>The ISQua International Accreditation Programme (IAP) has been established in 1999 to provide credibility and comparability for national accreditation organizations and consistency of the standards and procedures based on common international guidelines (Shaw <i>et al.</i>, 2010).</li> <li>ISQua reports that the IAP has accredited 19 organizations and 35 sets of standards (from 21 organizations), and eight survey- or training programmes (Braithwaite <i>et al.</i>, 2012).</li> <li>The accreditation workshop at the ISQua international annual conference brings together practitioners and researchers to consider current updates and challenges associated with healthcare accreditation programmes and its development, implementation and sustainability (Greenfield <i>et al.</i>, 2012).</li> </ul> |
| USAID         | <ul style="list-style-type: none"> <li>USAID supports the development of national accreditation systems in LMICs by offering funds and technical support e.g. Indonesia (Broughton <i>et al.</i>, 2015), Egypt (Rafeh, 2001), Jordan (HCAC 2013), Uganda (Bateganya <i>et al.</i>, 2009), Chile (Legros <i>et al.</i>, 2002) and Zambia (Bukonda <i>et al.</i>, 2002).</li> </ul>  |
| JCAHO and JCI | <ul style="list-style-type: none"> <li>JACHO programme has the most active focus on quality, the design of standards to identify and prevention of injury in healthcare, use of comprehensive and suitable quality indicators and emphasis on 'best practice' (Tabrizi <i>et al.</i>, 2011).</li> <li>JCAHO has expanded its activity in other healthcare environments and established a specific international branch, the JCI, to offer accreditation services at an international level (Fortes <i>et al.</i>, 2011).</li> <li>JCAHO is actively collaborating with the WHO as a consultant body to reduce medical errors and with the USAID and other international organizations (Tabrizi <i>et al.</i>, 2011).</li> </ul>  |

Donor agencies also played an active role in the introduction of accreditation programmes in LMICs (Mate *et al.*, 2014; Galukande *et al.*, 2016). USAID funded accreditation programmes and provided technical support to governments in many LMICs (see above). USAID also maintained active communication with other actors supportive of accreditation, such as the JCI and ISQua, who further helped in building capacities in LMICs such as in Jordan (USAID, 2013).

The World Bank, WHO and ISQua have worked together for many years to provide support for accreditation programmes in LMICs (Shaw, 2015). They offered technical support to governments and healthcare organizations through regional meetings, conferences, country visits, and publishing of numerous reports, empirical studies and technical working papers explaining accreditation and its processes. ISQua, in particular, produced guidelines for developing accreditation programme and its relevant components.

In conclusion, a number of transfer agents were actively involved in the transfer of accreditation to LMICs including national and international actors. Those actors maintained mutual communications and partnerships to facilitate the uptake of the accreditation policy in limited resources settings.

### What is transferred and from where?

There were examples of both soft and hard transfer of accreditation policy. Soft transfer occurred with the growth of the general idea of continuous quality improvement in healthcare in many LMICs (Ammar *et al.*, 2007). The need to tackle challenges in health systems encouraged policymakers to introduce initiatives based on quality improvement concept to their hospitals (Mate *et al.*, 2014). However, they did not necessarily do this through an accreditation system, but sometimes utilized smaller peer review systems as a more appropriate approach to quality improvement with scarce resources (Siddiqi *et al.*, 2012).

The hard transfer of the main components of accreditation programmes (standards development, surveyors, incentives, accreditation body) also occurred. National accreditation programmes that developed in many LMICs were influenced by the success of international programmes in developed countries (Fortes and Baptista, 2012; Aryankhesal, 2016). For example, the accreditation programme in Indonesia was influenced by the Australian programme (Broughton *et al.*, 2015). Similarly, in the EMR, accreditation programmes were commonly influenced by the JCI programme, which established a base in Dubai in 1994 (The Joint Commission, 2017). Governments looked abroad, mainly to these developed countries, to see how they resolved the problem of poor quality of care in their healthcare organizations. They looked at international standards from accreditation bodies in these countries to find the best framework that would be cost-effective, could be adjusted to their national settings and could ensure their quality of care (Whittaker *et al.*, 2000; El-Jardali, 2007; Saleh *et al.*, 2013). Thus, the transfer of hospital accreditation to LMICs was mainly through exogenous sources from developed countries rather than from other LMICs, or endogenously from within the same country.

### What is the degree of transfer?

The success of international accreditation models in the developed world inspired many LMICs to change their health policies and make accreditation an integral part of their health systems. JCAHO and its international arm, the JCI programme, were the inspiration for a wide number of accreditation programmes in the developing world, but the final policy did not follow the original framework.

Scrivens (1997) claimed that different models of accreditation had successfully developed in LMICs.

Some LMICs emulated international accreditation frameworks. They followed the basic structure, components and processes (Smits *et al.*, 2014); but adapted these frameworks to fit their national contexts and their hospitals. For example, Iran changed its original hospital accreditation programme that was criticized for being structure-based standards. The government developed its updated 'Accreditation Standards for Hospitals', which was derived from the JCI standards but included some religious standards that reflected the Iranian national context (Bahadori *et al.*, 2015; Agrizzi *et al.*, 2016).

Also, the Joint Learning Network (JLN) for UHC in their meeting in Bangkok, Thailand, in April 2013 (Mate *et al.*, 2014) reported that members in Ghana, Malaysia, Indonesia, Mali, India and the Philippines discussed approaches to adapting accreditation processes to their local circumstances. This included starting with one basic structural standard such as standards for hand washing and gradually introducing more sophisticated and outcome-oriented standards. Also, using a set of basic standards for all hospitals and gradually adding complex and specialized standards for specialized hospitals such as paediatric hospitals. A third approach was an incremental multi-level accreditation programme where a hospital is granted an entry-level score when it complies with a basic structure such as a policy or procedure, and a full accreditation when the programme is fully implemented and effective (Mate *et al.*, 2014).

Finally, some LMICs looked at a number of available international accreditation models. Although the JCI programme was the main reference for them, they drew on a combination of models from other developed countries such as Australia, Canada and the UK in devising national programmes that fitted their local contexts (Fortes and Baptista, 2012; Aryankhesal, 2016). For example, the accreditation standards in Lebanon have been derived from a combination of seven accreditation programmes used in the USA, Canada, Australia, France, New Zealand, Ireland and the UK (Ammar *et al.*, 2007).

### What are the constraints on accreditation transfer to LMICs?

The review identified many barriers to the transfer of hospital accreditation to LMICs. The decision to adopt accreditation was limited by time and scarcity of resources in many LMICs. These limitations represented major challenges, not only to implement accreditation programmes but also to sustain them. The commonly reported constraints in LMICs, according to the categorization in Benson (2009), were contextual and application factors, but not programmatic nor demand factors.

#### Contextual factors

Policymakers in some LMICs, such as in India and Thailand (Smits *et al.*, 2014), avoided the incompatibilities that could have resulted from cultural differences by adapting international accreditation frameworks to their local contexts. Government policies in LMICs could also be inconsistent, especially if there were frequent changes in governments and ministries, as has happened in Zambia, Liberia and India (Shaw, 2004; Braithwaite *et al.*, 2012), and this hindered the transfer of accreditation. Politicized bureaucracy, corruption and policymakers' interest in showing their existing policies to be successful were also identified as potentially hindering the transfer of accreditation (Mate *et al.*, 2014; Sax and Marx, 2014). Additionally, a lack of financial resources and premature end to

core funding by international donors were considered a major threat to accreditation programmes in LMICs. For example, the ‘Yellow Star’ programme in Uganda was suspended by the government in 2009 after the end of USAID funding in 2005 and the inability of the government to sustain the programme (Bateganya *et al.*, 2009). In Zambia, the programme stopped for the same reason (Lane *et al.*, 2014).

#### Application factors

The implementation of accreditation remained difficult in many LMICs due to a variety of factors. Poor hospital infrastructure and lack of technology in many LMICs were among the major challenges (Braithwaite *et al.*, 2012; Mate *et al.*, 2014; Bahadori *et al.*, 2015). In addition, many hospitals suffered from inadequately skilled and trained hospital staff and surveyors. Some hospital managers were neither committed to nor enthusiastic about the programme. Running an accreditation programme also required significant administrative resources which hospitals lacked. Such constraining factors were reported in Zambia, Lebanon, Iran and Uganda (Bukonda *et al.*, 2002; Braithwaite *et al.*, 2012; Saleh *et al.*, 2013; Mate *et al.*, 2014; Bahadori *et al.*, 2015; Galukande *et al.*, 2016; Zarifraftar and Aryankhesal, 2016).

#### What is the outcome of accreditation transfer to LMICs?

Not all transfer cases are successful. Although transfer can promote the development of policies, there is still a risk of implementation failure or lack of sustainability (Dolowitz and Marsh, 2000). Disappointingly, this was a relatively frequent occurrence in the transfer of accreditation to LMICs such as in the cases of Uganda (Bateganya *et al.*, 2009) and Zambia (Lane *et al.*, 2014). As reported by Purvis *et al.* (2010), many accreditation programmes could not sustain their viability in countries with limited resources. The reasons for such accreditation policy failure are examined using the classification of policy failure as described by Dolowitz and Marsh (2000).

#### Uninformed transfer

This occurred when LMICs lacked the information needed to guide their accreditation processes and practices, e.g. standards and guidelines (Hort *et al.*, 2013). To develop a new accreditation programme, governments in LMICs were said to be ‘left to reinvent the wheel’ in basic areas such as standards development, surveyor training programmes and structuring of incentives (Smits *et al.*, 2014). Subsequently, this led to poor policy learning and confusion on handling accreditation and its outcomes at the organizational level as reported in the Zambian experience (Bukonda *et al.*, 2002). In addition, in Thailand, lack of surveyors’ training led to criticisms of ‘subjective’ evaluation by surveyors which influenced the survey process and its reported outcomes (Sriratanaban and Ungsuroat, 2000; Pongpirul *et al.*, 2006).

#### Incomplete transfer

Sometimes key elements of accreditation were omitted when the policy was transferred. Some LMICs developed standards that mainly considered input indicators while ignoring other indicators such as those related to patient safety, process or quality performance (Broughton *et al.*, 2015). It was also a challenge to establish and administer an accreditation body independent from the MOH (Mate *et al.*, 2014; Shaw, 2015). One study that looked at the development of accreditation in Pakistan identified as a major challenge the

establishment of an accreditation body that could transparently manage all accreditation processes (Sax and Marx, 2014).

Furthermore, in the cases where payments were linked to the NHIF, conflict of interest arose with the automatic accreditation of all public hospitals such as in Kenya in 2009, when private hospitals needed to conduct an initial assessment to be accredited, while, public hospitals automatically obtained accreditation (Lane *et al.*, 2014). Mandating accreditation on all hospitals in some LMICs led to a distortion of the philosophy of accreditation as a voluntary tool promoting the concept of continuous quality improvement (Pongpirul *et al.*, 2006).

#### Policy success

The literature highlighted some factors that supported the successful transfer of accreditation policy to LMICs. Political support and commitment of the national healthcare leaders was an essential element in developing hospital accreditation programmes in many LMICs (Novaes and Neuhauser, 2000), this was evident in Jordan (HCAC, 2013). MOH ownership helped in maintaining the financial and political support needed to develop and sustain the programmes (Cleveland *et al.*, 2011). Also, approaches like linking accreditation to reimbursement or insurance schemes, the availability of incentives such as recognition of a hospital or one of its staff and designating hospitals as medical tourism destinations, also helped with the success of accreditation programmes and their sustainability in some LMICs (Mate *et al.*, 2014).

Collaboration between LMICs and some international organizations and accreditation agencies (see Table 3), and stakeholders engagement also supported the development of accreditation programmes and facilitated the implementation process (Cleveland *et al.*, 2011; Ng *et al.*, 2013). For example, in Thailand, stakeholders such as patient organizations and national insurance companies were involved in the development of national accreditation standards and strengthening the capacity of the national accreditation programme (Pongpirul *et al.*, 2006).

## Discussion

The primary goal of this review was to provide deeper understanding and interpretations of the development of hospital accreditation in LMICs through an extensive analysis of policy transfer, its processes and outcomes. The review has taken into account the different local contexts of LMICs and the implications for policy transfer. Policy transfer provided a useful analytical framework to examine the research questions and to explore the transfer process in LMICs, and how governments and policymakers reacted to and interacted with accreditation as a new policy.

Interestingly, despite limited resources in many LMICs, governments voluntarily chose to adopt hospital accreditation as an improvement tool for their hospitals. The decision to use accreditation was based on ‘bounded rationality’ since it was limited by insufficient financial resources and lack of experience, technology and information about accreditation. This review concluded that the lack of financial resources remains a major challenge to many LMICs that seek to develop their national accreditation systems. This concurs with the findings of Purvis *et al.* (2010), Shaw *et al.* (2010) and Mate *et al.* (2014) that implementation and sustainability of accreditation programmes in LMICs are very challenging with the unavailability of resources and poor hospital infrastructure. However, in addition, this review examined how countries were able to develop and implement their accreditation programmes within these

limited resources and drew lessons for other countries with similar settings, which may help them to establish and sustain their accreditation programmes.

The literature on policy transfer identifies geographic neighbours as the main source of policy transfer and lesson drawing (Dolowitz and Marsh, 1996). However, this geographic proximity has not been reported in the literature to play a significant role in the transfer of accreditation policy to LMICs. The transfer of accreditation was mainly exogenous from the developed world. International accreditation frameworks from the USA, Canada, Australia and the UK have transferred to many LMICs, particularly the JCI programme from the USA. Meanwhile, countries within the same region were motivated by the support of international actors such as the WHO to develop their accreditation programmes. Regular regional meetings by the WHO offices such as EMRO and PAHO supported the growth of accreditation among countries in their regions and helped with accreditation policy learning. The voluntary transfer of accreditation to LMICs also helped in learning accreditation policy, which was also supported by a number of international actors such as the JCI, ISQua and USAID. This, in turn, helped to avoid the uninformed transfer.

The review found that national accreditation programmes were typically inspired by international frameworks. In many cases, governments emulated the accreditation policy but avoided the 'lift and shift' of these international standards that could lead to inappropriate transfer and policy failure. They successfully paid attention to the economic, social, political and cultural settings in their countries and tailored the international accreditation models to fit their hospitals, pursuing approaches such as those advocated by the JLN (Mate *et al.*, 2014).

These approaches could be considered as a particular form of emulation of the accreditation policy where there is some moderation of the standards and a sense of progression over time in order to fit with the realities of lack of resources in some hospitals. It might be helpful if international actors could encourage such approaches when funding accreditation programmes in LMICs since many LMICs failed to sustain their accreditation programmes after donor funding ends. Encouraging such approaches might be considered as an appropriate involvement of international actors to support both the transferability and sustainability of accreditation in LMICs.

Government officials in LMICs also supported the voluntary transfer of accreditation to their countries, and accreditation programmes were managed within the MOHs in most LMICs, especially during the early stages. A study conducted by Braithwaite *et al.* (2012) to compare accreditation programmes in LMICs with those in HICs found that in 60% of the respondents from 20 LMICs, accreditation was managed within the MOH in comparison to only 8% in respondents from HICs, and justified this as being a governmental response to the lack of resources in LMICs and an approach to ensure the viability of their accreditation programmes. This MOH ownership supported the sustainability of many accreditation programmes in LMICs (Smits *et al.*, 2014).

WHO has recommended that LMIC governments participate in standards development, as the public sector is the predominant healthcare provider in many of these countries (Al-Assaf, 2007; Maamari, 2007). Similarly, Nandraj and colleagues (2001) argue that the MOH ownership of the accreditation programme does not contradict its main role as a healthcare regulator. Instead, it can reinforce both a culture of change and quality improvement within the national health system. In contrast, Shaw (2004) argues that many successful accreditation programmes are independent of the MOHs

and have their own legal responsibilities and their governance system. Consequently, Maamari (2007) raises the need to keep a balance between the independence of the accreditation body and the accountability for its recommendations for healthcare organizations in order to maintain its credibility and authority. One of the recommendations of this review is to start the national accreditation programme with the MOH as the main governing body of the programme to ensure reliability and maintenance. An independent accrediting body can then be set up once the programme is well-established and functioning, in order to avoid conflict of interest, especially if the public health sector is the predominant healthcare provider.

Strong government commitment and political support, the MOH ownership, linking accreditation to payments and partnering with international actors appear to be the most common factors that facilitated the transfer of hospital accreditation to LMICs. Partnering supported the synchronization with and adaptation from international standards, and the training of local surveyors. In turn, these helped with the sustainability of the programme (Ng *et al.*, 2013). Contextual and application factors were the most common barriers to the transfer of accreditation, mainly due to the lack of financial resources. This, in turn, led to an incomplete transfer of some crucial elements of the accreditation programme such as the unavailability of financial incentives and the inability to develop and manage a national accreditation body, with an ongoing debate about whether it should be independent of the MOH or not.

This study contributes to the literature by developing a thorough and updated review of the literature on hospital accreditation and its processes, identifying key requirements and common barriers to the implementation and sustainability of accreditation in LMICs. The review contributes to the body of knowledge regarding both accreditation and international policy transfer.

The literature on accreditation lacks the theory development that can explain the growth of accreditation and its processes and outcomes (Greenfield and Braithwaite, 2008). The review addresses this by using the Dolowitz and Marsh policy transfer framework as an analytical tool. Few studies have explored the development of accreditation and its components in LMICs. The review addresses this gap by using a structured analytic framework to consider examples from LMICs in detail.

Most cases of international policy transfer in the literature have described what was transferred rather than how the transfer process proceeded (Mossberger and Wolman, 2003). This review analysed the process of accreditation policy transfer to LMICs and its outcomes. The Policy transfer framework provided a useful tool for examining how accreditation has transferred from one setting to another and how policymakers in LMICs could adopt the policy in their home countries and how they adapted it to their local contexts. Furthermore, the review looked at accreditation policy outcomes from both the success and failure angles, going beyond the Dolowitz and Marsh framework, which focuses only on the reasons for policy failure.

### Limitations of the study

There are some limitations to this literature review that need to be considered. Limiting the search to only English language articles might have led to missing articles from LMICs in Latin America, Africa and South Asia. There were also some aspects which the review did not consider due to time constraints, such as how governments in LMICs could relate accreditation policy to their national health policies. This might benefit from further research.

## Recommendations for research and practice

Future empirical research on accreditation underpinned by explicit theory would be valuable so that it is easier to assess the relevance of research to different countries and for studies to build on each other's findings. Further research is also needed to study the background of some emerging policies in LMICs, e.g. UHC and medical tourism and their linkage to accreditation in these countries, as the literature on these areas was sparse. Such research would also be an opportunity to further develop this review's analysis of the role of international actors in policy transfer of accreditation to LMICs.

Since the lack of financial resources is a major challenge to accreditation in LMICs, further research is needed to analyse the cost-benefit of accreditation programmes in countries with limited resources. There is a need to explore how to reduce the administrative costs of accreditation programmes, or perhaps how to share these costs with NGOs and other international actors. Research on how to enhance the role of these organizations to better support accreditation and quality initiatives in LMICs is also indicated. It may be useful to explore the existing international networks that are involved in accreditation transfer, how they operate and to what extent accreditation as a policy can be shaped by national and international structures.

## Conclusion

Many LMICs have developed national accreditation programmes, but lack of financial resources remains a key constraint to the success of accreditation and its sustainability in LMICs. The review concludes that political support and government commitment are critical to developing and sustaining national accreditation programmes in countries with limited resources. MOH ownership can be effective in supporting the programme during its early stages giving it prestige, accountability and authority.

Governments in LMICs might use alternative accreditation models such as incremental multi-level accreditation programmes to encourage hospitals to comply with accreditation standards; they can gradually proceed to full accreditation based on the infrastructure of the hospitals and the availability of funds. International actors, particularly donor agencies, should give greater emphasis to providing ongoing support to LMICs to develop and sustain accreditation. Research also needs to focus not only on the introduction of accreditation programmes and their implementation processes but equally importantly on how to sustain them.

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