Experiences with the expansion of hospital accreditation into the developing world

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EXPERIENCES WITH THE EXPANSION OF HOSPITAL ACCREDITATION INTO THE DEVELOPING WORLD

by

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Submitted in partial fulfillment of the requirements for the degree of
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DEDICATION

This dissertation is dedicated to the two people who made this work possible: my loving husband, Buck, for his unlimited support, constant encouragement, and infinite patience and my mentor, Dr. William Bicknell (1936-2012), for inspiring this research direction and career path and for doing a great deal to make the pursuit of both possible.
ACKNOWLEDGMENTS

First and foremost, I would like to thank my program advisors, Dr. Rani Elwy and Dr. Vicky Parker, for their personal and professional mentorship and support. Their constant availability and helpful guidance during all stages of study design, fieldwork, analysis, and writing far exceeded the typical role of an advisor. I learned an enormous amount from them and this dissertation is stronger because of them.

I would also like to thank the rest of my committee members: Dr. Sue Eisen, Dr. Malcolm Bryant, and Dr. Pierre Barker. I feel incredibly fortunate to have such esteemed researchers and practitioners contributing to this work and cannot thank them enough for being so generous with their time.

There are a number of others in the Boston University community who were a tremendous support to me. There are no words to express my gratitude to Dr. Bill Bicknell and Dr. Brian Jack for their significant role in preparing me for this journey. They taught me to always look for smart, sustainable solutions (even when they might challenge popular opinion), and they taught me about the importance of building relationships and establishing trust in identifying those solutions and effectively implementing them. It was their faith in my abilities and belief that I can contribute significantly to international health that led me down this path. I am also indebted to the Boston University Department of Family Medicine and am grateful to be associated with a group so passionate about ensuring that quality health services are delivered to those most in need in Boston and abroad.

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I would also like to extend a special thank you to Sue Fish and Rita Cosgrove with the Boston University Medical Campus Institutional Review Board. Sue helped me to navigate the complexities of my proposal given the unique nature of my research, and Rita went above and beyond to provide rapid reviews of changes made during a very
condensed period of fieldwork. The commitment of these, and others with the IRB, is far too often underappreciated.

There were many who made the fieldwork for this research possible. Most important to completing the fieldwork was Elena Richardson, who agreed to the demanding work of research assistant without compensation and under very challenging circumstances. Elena worked long days creating surveys, coordinating meetings, driving long distances delivering letters and surveys, waiting in Ministry of Health offices, taking notes, transcribing interviews, entering survey data, and doing anything else that was required. She also contributed a great deal to identifying important points from the interviews and focus groups and key themes to explore further. It was a pleasure working with her.

There are a number of people who helped to facilitate fieldwork in Lesotho. Obviously, the support of the Lesotho Ministry of Health and Social Welfare was critically important and I would like to specifically thank Dr. Thin, Mr. Nkonyana, and Dr. Moteetee for their assistance with a timely ethical approval and continued oversight and Mrs. Makhakhe and Dr. Tetteh for their guidance and direction in conducting the research. I would also like to thank my friends and staff with the Lesotho-Boston Health Alliance based both in Boston and Lesotho. Senate, Lisebo, Liteboho, Elizabeth, Carrie, Libby, Laura, Josh, and Zinnia made my fieldwork in Lesotho much easier and more pleasant.

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I would like to name each and every individual and hospital that participated in this study, but the protection of their anonymity prohibits me from doing so. Those who participated in interviews and as experts are in positions that demand a great deal from them, and I cannot thank them enough for taking the time out of their busy schedules to assist me.

Finally, there were many family members and friends who provided ceaseless
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EXPERIENCES WITH THE EXPANSION OF HOSPITAL ACCREDITATION INTO THE DEVELOPING WORLD

(Order No. )

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Boston University School of Public Health, 2013

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ABSTRACT

More developing countries are adopting hospital accreditation to improve the quality of their health systems, but it is uncertain whether accreditation standards and processes, largely borrowed from Western countries, are being adapted to fit each country's context. Three qualitative studies explore issues in assimilating hospital accreditation into developing countries, drawing mainly from experiences of two Southern African countries, Lesotho and Swaziland. Data sources included: archival records, documentary information, interviews, focus groups, expert panel surveys, and direct observations.

Study 1, *Explaining the expansion of hospital accreditation in the developing world*, investigates the proposition that institutional theory largely explains the adoption of hospital accreditation in developing countries and how this external motivation influences the innovation process. Adoption of accreditation in developing countries is associated with the perceived contribution of accreditation to quality care in developed countries, endorsement of accreditation by key international players, and substantial donor support for implementing accreditation. This can result in less adaptation of
Western accreditation practices, and this lack of local adaptation can hinder true assimilation and sustainability.

Study 2, *Connecting hospital accreditation with other quality improvement efforts in the developing world*, explores the perceived connection between hospital accreditation and other quality improvement efforts and the effects of this connection on subsequent improvement efforts. This study found that hospital accreditation is laying important groundwork and establishing norms for future quality efforts, but is not being tied to more comprehensive national strategies for quality assurance and quality improvement.

Study 3, *Considerations in implementing hospital accreditation in the developing world*, examines perceived appropriateness of hospital accreditation standards and processes implemented in Lesotho and Swaziland according to stakeholders in those health systems. Standards were perceived to be of high importance, fairly strong relevance, and moderate feasibility due to limited financial and human resources. Perceptions of the appropriateness of accreditation processes were strongly influenced by how accreditation was introduced to hospital staff, its gradual implementation, inclusion of hospital staff in the process, clearly defined role responsibilities, leadership commitment to accreditation, and implementation support. Overall, lower perceived control over accreditation standards and processes was linked to lower perceptions of appropriateness among hospital staff.
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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>CHAL</td>
<td>Christian Health Association of Lesotho</td>
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<td>COHSASA</td>
<td>Council for Health Service Accreditation in Southern Africa</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GNI</td>
<td>Gross National Income</td>
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<tr>
<td>GOL</td>
<td>Government of Lesotho</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>ISQua</td>
<td>International Society for Quality in Health Care</td>
</tr>
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<td>JCI</td>
<td>Joint Commission International</td>
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<tr>
<td>MCDI</td>
<td>Medical Care Development International</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MOHSW</td>
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<td>MOU</td>
<td>Memorandum of Understanding</td>
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<td>NDSO</td>
<td>National Drug Supply Organization</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<tr>
<td>OECD</td>
<td>Organization for Economic Cooperation and Development</td>
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<tr>
<td>PAHO</td>
<td>Pan American Health Organization</td>
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<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<td>PFR</td>
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<td>QA</td>
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<td>Qi</td>
<td>Quality Improvement</td>
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<td>SADC</td>
<td>Southern African Development Community</td>
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<tr>
<td>SAHCD</td>
<td>Southern Africa Human Capacity Development</td>
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<td>SA-RHAP</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TPB</td>
<td>Theory of Planned Behavior</td>
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<tr>
<td>TRA</td>
<td>Theory of Reasoned Action</td>
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<tr>
<td>USAID</td>
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<td>WHO</td>
<td>World Health Organization</td>
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BACKGROUND

As members of the international development community have been shifting their focus to a broader emphasis on health systems strengthening, more developing countries are turning to hospital accreditation as an important tool for improving the quality of their health care systems. Yet little effort has been made to understand the impact of hospital accreditation in resource-poor countries (International Society for Quality in Health Care [ISQua] & World Health Organization [WHO], 2003). The recent influx of foreign assistance into developing countries for improving health care, largely due to efforts to contain the spread of HIV/AIDS, has resulted in the development of funded programs that encourage Ministries of Health and other health care organizations in these countries to adopt systems that conform to the same structures and norms that have been successful in the developed world. However, it is unclear whether standards and practices being borrowed from Western countries are being appropriately adapted to reflect each country’s unique circumstances, capacity, case-mix, and culture. Meanwhile, developing countries are struggling, and at times failing, to sustain accreditation programs long-term (Bateganya, Hagopian, Tavrow, Luboga & Barnhart, 2009; Bukonda, Tavrow, Abdallah, Hoffner & Tembo, 2002; Cleveland et al., 2010). Given its rapid expansion, it is important to explore the factors that are at work in implementing hospital accreditation in the developing world in order (1) to understand what its implementation has meant for these health care systems and (2) to build a foundation for future quality efforts in these
countries.

This introductory chapter will present a brief overview of hospital accreditation and a summary of the study objectives and setting. The three chapters that follow are separate studies aimed at providing a more thorough understanding of hospital accreditation in the developing world. The first study, *Explaining the expansion of hospital accreditation in the developing world*, investigates the proposition that the adoption of hospital accreditation by developing countries can be largely explained by external pressures and explores the implications of this. The second study, *Connecting hospital accreditation with other quality improvement efforts in the developing world*, considers the perceived connection between hospital accreditation and other quality improvement efforts and the effects of this connection. The third study, *Considerations in implementing hospital accreditation in the developing world*, examines the appropriateness of hospital accreditation standards and processes that have been implemented in Lesotho and Swaziland from the standpoint of stakeholders in those health care systems.

These three studies explain the expansion of hospital accreditation in the developing world, provide an understanding of how hospital accreditation can lay the groundwork for other quality improvement work in this setting, and explore perceptions of the appropriateness of hospital accreditation standards and processes being implemented in two Southern African countries. Comparing the experiences of two similar countries that have taken different approaches to implementing hospital accreditation has been particularly useful in providing insights about the key factors that
can facilitate or hinder the successful implementation and assimilation of hospital accreditation in low resource countries. Together, these studies provide an understanding of the meaning of hospital accreditation to stakeholders in these settings by drawing on their experiences, which sheds light on how to best operationalize hospital accreditation in order to maximize its sustainability and potential impact on quality of hospital care in the developing world.

OVERVIEW OF HOSPITAL ACCREDITATION

The World Health Organization (WHO) defines accreditation as “the systematic assessment of hospitals against explicit standards (ISQua & WHO, 2003, p. 58).” The first set of minimum standards for hospitals was developed by the American College of Surgeons in 1919. Then in the 1950’s, the American Joint Commission Accreditation of Hospitals (now renamed Joint Commission) developed a set of standards for hospitals to follow and began to regularly assess and certify hospitals (Myers, 2012).

When accreditation was first formalized in the United States in 1951, in Canada in 1958, and then in Australia in 1973 (Bohigas, 1996), the basic staffing and resources available at any given hospital were highly inconsistent. With the introduction of accreditation, the aim was to address this inconsistency in resources by standardizing the structure and process of care across facilities and establish an environment that enables providers to deliver quality services (Scrivens, 1997). Accreditation systems establish standards that provide a benchmark against which hospital workers can compare their work, which can help workers ascribe to generally accepted norms. Workers are thought
to be motivated to meet these standards by the accountability that is created by having an external source of review. Areas of potential organizational risk are also identified through this process, which helps organizations correct issues that pose a risk to patient safety (Scrivens, 1997).

By the 1970’s, most U.S. hospitals were meeting all the required standards, which caused the Joint Commission to shift from minimal essential standards to a set of standards that laid out optimal, achievable levels of quality (Myers, 2012). In addition, the period of 1960-1990 was flooded by more advanced thinking about measuring and improving quality of care by Dr. Joseph Juran (who is said by many to be the father of today’s Lean and Six Sigma), Dr. W. Edwards Deming (who founded the Plan, Do, Study, Act cycle), Dr. Peter Senge (who first introduced the concept of the learning organization), and others. As a result, the expectations for accreditation have now shifted to include measuring and improving the quality of health care systems (Myers, 2012). Despite the lack of evidence to support the role of accreditation in measuring and improving quality of care (discussed more in Chapter 3), the number of countries introducing accreditation programs to meet these needs has increased exponentially each year since the 1990’s (ISQua & WHO, 2003).

STUDY SETTING

There is very limited literature available on the process of the adoption and development of hospital accreditation in developing countries (Cleveland et al., 2011; ISQua & WHO, 2003). Countries within the Southern African region have varied
experiences with adopting hospital accreditation. Parts of South Africa have been implementing voluntary hospital accreditation since the mid-1990's (Whittaker, Green-Thompson, McCusker & Nyembezi, 2000). Other countries have just implemented it recently and still others have yet to implement hospital accreditation at all. Given this variety and the recent increase in the rate of adoption, made possible in large part by the growth of the Council for Health Service Accreditation in Southern Africa (COHSASA), this is a particularly interesting region in which to study this issue (Whittaker, 2012). I identified countries in the region that would allow me to evaluate different approaches to implementing accreditation. I excluded non-English speaking countries, countries that have not implemented accreditation, countries that are only implementing accreditation in private hospitals, and South Africa, as its status as a developing country is questionable and is very different economically from other countries in the region.

Lesotho and Swaziland were selected as they represented an interesting dichotomy, with Lesotho implementing a locally developed approach using minimal resources and Swaziland implementing COHSASA's regional, internationally recognized, and resource-intensive system for accreditation. Although certainly distinct, there are many similarities in the history, economies, and health systems between the two countries, which make observed differences more likely to be attributable to differences in their approach to accreditation. Interestingly, by the time data collection had commenced, Lesotho was considering supplementing their original accreditation program and began a pilot of the COHSASA program in four of its hospitals. Although this
change was unanticipated, it created even greater opportunity to contrast the two approaches.

STUDY OBJECTIVES AND OVERVIEW

Overall, this collection of studies is aimed at improving the understanding of hospital accreditation in resource-poor countries from global, national, and hospital perspectives. The broad research questions guiding this work are listed below:

- **Global Perspective**: Given the lack of clear evidence supporting the benefits of accreditation in the developing world and the high costs associated with its implementation, why is hospital accreditation expanding so rapidly, particularly in developing countries with so few resources to support it?

- **National Perspective**: What is the perceived connection between hospital accreditation and other quality improvement (QI) efforts and what are the effects of any perceived connection between accreditation and QI?

- **Hospital Perspective**: Are current practices in hospital accreditation in the developing world appropriate for the developing world context, and if not, what would make them more appropriate?

The first study (Chapter 2) is a comparative case study that thoroughly explores the various factors working together to explain the decision of developing countries to implement hospital accreditation and how these countries go about implementing it. This study first uses an explanation-building approach to test the proposition that institutional theory largely explains the basis for the adoption of hospital accreditation in much of the
developing world for the sake of increasing legitimacy on the basis that this practice conforms to the norms of other successful hospitals (Meyer & Rowan, 1977). This study used archival records and documentary sources together with interview and focus group data to show how DiMaggio and Powell’s isomorphic mechanisms (the various ways that institutional isomorphism occurs) contribute to the implementation of accreditation and how Suchman’s moral and cognitive legitimacy (reflecting different sets of circumstances that motivate an organization to conform) served as the rationale for implementation in Swaziland and Lesotho. Then on the basis that externally driven decisions about innovation adoption have the potential to uniquely affect the innovation process (Greenhalgh, Robert, MacFarlane, Bate & Kyriakidou, 2004), this study applies a directed content analysis of documentary sources as well as interview and focus group data from Lesotho and Swaziland to understand how the innovation process is affected by an external motivation for implementation. This analysis explores how the first four stages of the innovation process (agenda-setting, matching, redefining/restructuring, and clarifying), as described in Rogers’ theory of diffusion of innovations (2003), have been affected by isomorphism in Lesotho and Swaziland and the likely effects on the fifth, routinizing, stage.

The second study (Chapter 3) uses a grounded theory approach to explore the perceived connection between hospital accreditation and other quality improvement efforts and the effects of this connection. Despite Donabedian’s well-known tripartite model that indicates a close association between the three elements of quality: structure, process, and outcomes (Donabedian, 1980), hospital accreditation’s effects on structure
and process have not been shown to extend to patient outcomes. Although accreditation is still believed by many to be a means of improving quality of patient care, most would agree that accreditation on its own can only do so much. Instead, hospital accreditation is usually viewed as one tool in a toolbox of other quality assurance and quality improvement approaches. These approaches are often ordered into a hierarchy with more foundational methods at the bottom that must be satisfied before more sophisticated processes at the top can be implemented, although there is disagreement about where accreditation should be placed in this hierarchy. At the time of this study, hospital accreditation was the singular approach targeting health systems improvement in both Lesotho and Swaziland, which presented an interesting opportunity to explore how hospital accreditation was building a foundation for other quality efforts and how staff reactions to hospital accreditation might be important to future quality efforts. Data from interviews, focus groups, and direct observations offered a comprehensive understanding of these issues and raised further questions about these popular conceptual models for quality of care and quality improvement.

The third study (Chapter 4) again uses grounded theory approaches to examine perceptions of appropriateness of hospital accreditation standards and processes implemented in Lesotho and Swaziland with appropriateness defined by three criteria used by the Organization for Economic Cooperation and Development (OECD) Health Care Quality Indicators Project (Mattke, Epstein & Leatherman, 2006):

- **Importance**: the extent to which the standard represents an important aspect, result or outcome of services provided.
• **Feasibility:** the extent to which it is reasonable to implement and measure the standard given the resources available (manpower, money, data).

• **Relevance:** the extent to which the standard fits within normative cultural beliefs and practices of the country.

Perceptions of appropriateness of the standards in use for each country were assessed using a panel of experts and a modified RAND/UCLA Appropriateness Method (Fitch et al., 2001) where experts rated the appropriateness of each standard and had the option to provide written comments for each standard as well. Then interviews with national leaders and focus groups with frontline hospital staff were conducted to further explore the appropriateness of the standards and the process being used in each country based on their experiences in implementing accreditation. This third study identifies a number of key factors influencing staff perceptions of appropriateness with many of these factors relating to the extent to which staff felt that they had control over the situation, which points to the theory of planned behavior, despite its previously limited application at an organizational level.

Each of these studies (summarized in Table 1.1) is distinct from the others in its focus and in its contributions. This is due in large part to the use of grounded theory approaches, which led to the identification of themes that emerged as most prominent for the three levels of study: global, national, and hospital. But together, these three chapters contribute to a broad and deep understanding of the expansion of hospital accreditation from the experiences of those most closely affected by its expansion, which begins to
construct a picture of how accreditation programs can be most effective for and successfully assimilated into developing countries like Lesotho and Swaziland.
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• Explanation-building approach to test proposition that institutional theory explains adoption of hospital accreditation in developing countries using:  
  - Archival records  
  - Documentary sources  
  - Interviews and focus groups  
• Directed content analysis to understand how the innovation process is affected by an external motivation for implementation based on:  
  - Documentary sources  
  - Interviews and focus groups | • Institutional theory (Meyer & Rowan, 1977)  
• Isomorphic mechanisms (DiMaggio & Powell, 1983)  
• Types of legitimacy (Suchman, 1995)  
• Diffusion of innovations (Rogers, 2003) |
| 3       | National perspective: What is the perceived connection between hospital accreditation and other QI efforts, and what are the effects of this? | • Grounded theory approach to explore perceived connection between hospital accreditation and other QI efforts and effects of this connection using:  
  - Interviews and focus groups  
  - Direct observations | • Structure-process-outcome elements of quality (Donabedian, 1980)  
• Hierarchical ordering of QA/QI approaches (e.g. Durand, 2009; Øvretveit, 2002) |
| 4       | Hospital perspective: Are current practices in accreditation in the developing world appropriate for this context, and if not, what would make them more appropriate? | • Modified RAND/UCLA Appropriateness Method with expert panel ratings of and comments on the appropriateness of standards in Lesotho and Swaziland  
• Grounded theory approaches to examine perceptions of appropriateness of hospital accreditation standards and processes implemented in Lesotho and Swaziland using:  
  - Expert ratings and comments  
  - Interviews and focus groups | • OECD definition of appropriateness (Mattke, Epstein & Leatherman, 2006)  
• Theory of planned behavior (Ajzen, 1991) |
CHAPTER 2: THE GLOBAL PERSPECTIVE

Explaining the expansion of hospital accreditation in the developing world:
A case study of two Southern African countries

INTRODUCTION

Hospital accreditation is being adopted by more and more developing countries with at least 40\%\(^1\) of the world's poorest countries (GNI per capita less than US$600) having established some form of hospital accreditation program in the last few years (Afghanistan Ministry of Public Health, 2006; Bateganya et al., 2009; Cleveland et al., 2010; Government of Nepal Ministry of Health and Population, 2010; Kaitesi, 2012; Kutengule, 2012; Medical and Dental Council Sierra Leone, 2012; Newbrander, 1999; World Bank Group, 2012). Today, accreditation is widely considered to be an important tool for improving the quality of health care structures, but its impact in resource-poor countries is less understood (ISQua & WHO, 2003). Of the very few developing countries that have published on their experiences implementing hospital accreditation, two of these countries, Zambia and Uganda, report that they were unable to continue to invest the resources necessary to sustain their accreditation programs (Bateganya et al., 2009; Bukonda et al., 2002; Cleveland et al., 2010). Still, increasing numbers of

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\(^1\) This figure was derived by conducting an on-line search for “hospital accreditation” and “hospital standards” separately for each country with a GNI per capita less than or equal to $600. These countries include: DRC, Liberia, Burundi, Sierra Leone, Malawi, Niger, Ethiopia, Madagascar, Eritrea, Guinea, Central African Republic, Mozambique, Uganda, Nepal, Tanzania, Togo, Burkina Faso, Rwanda, and Guinea-Bissau. The absence of a hospital accreditation program was confirmed when possible and it is reasonable to think that this information is accurate, but the actual proportion of poorest countries that have recently adopted hospital accreditation programs could be greater than 40\%. 

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resource-poor countries are adopting hospital accreditation despite its high cost and unknown effects (ISQua & WHO, 2003).

This case study of two countries in Southern Africa explores two related propositions that (1) the decision of developing countries to introduce hospital accreditation is driven largely by external forces (institutional theory) and (2) this has important implications for the innovation process and the likelihood of accreditation being sustained (the theory of diffusion of innovations). Rogers’ theory of diffusion of innovations is commonly used to explain the spread of new practices, and the theory’s innovation process describes spread in organizations. But the spread of accreditation to hospitals in the developing world cannot be fully explained by the theory of diffusion of innovations. Meyer and Rowan’s institutional theory (1977) asserts that organizations adopt new practices that conform to the norms of its successful peer organizations for the sake of increasing legitimacy, regardless of the efficacy or fit of the practice. Greenhalgh et al. (2004) suggest that an externally driven decision to adopt an innovation has the potential to uniquely affect the innovation process, in both positive and negative ways.

The innovation process in an organization, as described by Rogers’ theory of diffusion of innovations (2003), specifies five progressive stages: agenda-setting (identify the problem to be solved), matching (fit the identified problem with an innovation), redefining/restructuring (make adaptations to the innovation to fit the organization and to the organization to fit the innovation), clarifying (understanding what the innovation means for the organization as it is gradually established), and routinizing (incorporating the innovation into routine operations). This study explores the possibility that
institutional theory largely explains the basis for the adoption of hospital accreditation in much of the developing world. Then, recognizing the still important role of the theory of diffusion of innovations, it describes the innovation process in Swaziland and Lesotho, highlighting how each stage was likely affected by an external motivation for implementation.

The case study research method was applied for several reasons. In his book on case study research, Yin (2009) describes the three conditions that warrant using the case study method: “(a) ‘how’ or ‘why’ questions are being posed, (b) the investigator has little control over events, and (c) the focus is on contemporary phenomenon within a real-life context” (p. 2). In this study, I am interested in the question of why hospital accreditation is expanding in the developing world and how this impacts the innovation process. The case study method permits a thorough exploration of all the factors working together to explain the decision of developing countries to implement hospital accreditation and how they go about implementing it. Furthermore, this phenomenon is occurring in the present time and the investigator has no influence over the phenomenon. Finally, understanding the reasons for adoption of hospital accreditation by developing countries requires an exploration of not only what is directly observed and reported within each country but also what is happening in the broader national, regional, and global context. Including important context in the analysis is a key defining characteristic of the case study approach (Yin, 2009).

As described in Chapter 1, countries within the Southern African region have varied experiences adopting hospital accreditation. This, together with the recent
increase in the rate of adoption, due in large part by the growth of the Council for Health Service Accreditation in Southern Africa (COHSASA), makes the Southern African region a particularly interesting region in which to study this issue (Whittaker, 2012). Lesotho and Swaziland represent two countries in the region that have taken steps toward rolling out a national hospital accreditation program, but with different approaches to implementation.

This paper starts by laying out the theoretical background for my two propositions, the context and key characteristics of the cases used, and a description of methods for data collection, coding, and case analysis. Then I present evidence supporting the importance of institutional theory in the expansion of hospital accreditation in the developing world followed by findings from an analysis of the innovation process in Swaziland and Lesotho. By appreciating the forces involved in influencing the adoption and innovation process of accreditation, it is possible to understand how to best operationalize accreditation and complementary efforts in order to maximize their sustainability and their impact on quality of care. More generally, this provides important information about spreading other health care innovations to the developing world.

THEORETICAL BACKGROUND

Diffusion of Innovation

Rogers' theory of diffusion of innovations describes how an innovation – an idea, practice, or object – spreads (Rogers, 2003). An S-shaped curve illustrates the process of
slower early adoptions as the innovation is first introduced, followed by more rapid uptake, and then a plateau as the innovation has saturated the potential market of consumers and nears the maximum number of users. The emphasis of Rogers’ theory is on the individual adopting the innovation, but the theory has been studied extensively in organizations, albeit often focusing on the ways diffusion of innovation differed at the organization level. One major difference with organizations was an emphasis on the importance of the process of implementing the innovation rather than only the decision to adopt. From this emerged the identification of a sequence of five critical stages of implementation, or the innovation process, in an organization (Rogers, 2003).

There are two stages in the initiation phase leading up to the decision to adopt an innovation in an organization: agenda-setting and matching. During the agenda-setting stage, a problem is identified as a priority and an innovation is sought after that will resolve that problem. This can be done by various individuals, both internal and external to the organization. However, the theory recognizes that it is often knowledge of an innovation that drives the recognition and prioritization of the need it is able to address. During the matching stage, the organization assesses the ability of the innovation to address the identified problem and the ability of the organization to successfully implement it. It is during this stage that the attributes of the innovation are assessed.

The remaining three stages in the implementation phase are redefining/restructuring, clarifying, and routinizing. The redefining/restructuring stage is the period during which the innovation is adapted to fit the needs and structure of the organization and during which the organization’s structure is altered to better accommodate the
innovation. This stage is particularly important for innovations that have come from external sources, with greater reinvention of the innovation resulting in better assimilation. As the innovation is rolled out in an organization, the clarifying stage occurs as members of the organization develop a gradual understanding of what the innovation means for the organization and for them. This is the time when challenges are most likely to be raised and errors are most likely to occur; how these are handled is very important to sustainability of the innovation. The routinizing stage happens at the point when the innovation becomes fully assimilated as part of the organization’s regular operations and the diffusion process is complete (Rogers, 2003).

A large multi-level study of the innovation process in hospitals conducted by Meyer and Goes (1988) found that the perceived attributes of the innovation were the single largest predictor of assimilation of the innovation, accounting for 37% of the variance. Other measured variables were found to account for far less of the variance in assimilation. For instance, environmental factors contributed 4%, organization factors contributed 6%, and leadership variables contributed 1%. This fits with Rogers’ (2003) finding that 49-87% of the variance in the rate of innovation adoption can be explained by how five key attributes are collectively perceived. These include: relative advantage, compatibility, complexity, trialability, and observability. Relative advantage is the extent to which the new innovation is believed to be better than the status quo. Compatibility is the fit of the innovation with already established values and beliefs, previous experiences with other innovations, and needs. Complexity is how difficult it is to understand and use the innovation. Trialability is the ease with which an innovation can be tested on a small
scale. And observability is how clearly the results of the innovation can be seen and described to others. These five attributes, summarized in Table 2.1, are considered during the matching stage of the innovation process (Rogers, 2003).

**Table 2.1 Five key perceived attributes affecting innovation adoption.**

<table>
<thead>
<tr>
<th>Key innovation attributes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Relative Advantage: how much better than status quo</td>
<td></td>
</tr>
<tr>
<td>Compatibility: fit with values, beliefs, needs, etc.</td>
<td></td>
</tr>
<tr>
<td>Complexity: how difficult to understand and use</td>
<td></td>
</tr>
<tr>
<td>Trialability: how easy to test on small scale</td>
<td></td>
</tr>
<tr>
<td>Observability: how clearly results can be seen and described</td>
<td></td>
</tr>
</tbody>
</table>

The study of these attributes and many other aspects of diffusion of innovations have been studied extensively and refined since the 1960's. A systematic review on diffusion of innovations by Greenhalgh et al. (2004) highlights key findings along with areas that could benefit from more research. Of note, this review uncovered mixed findings regarding the effects of externally driven innovations. On the one hand, this push can facilitate success in the early stages, often through the provision of resources. On the other hand, external motivation does not increase the organization's readiness or capacity to implement the innovation, and it can move organizations away from locally driven solutions (Greenhalgh et al., 2004). These mixed findings leave us uncertain about what to expect as a result of the external forces of institutional theory at work in the diffusion of hospital accreditation in the developing world.
Institutional Theory

Organizations copy practices of successful peer organizations. Regardless of whether those practices contribute to the success of the organizations being copied, customers and competitors associate the structures and processes of successful organizations with success and desire the same success for their own organization. These structures and processes then lend legitimacy to other organizations that adopt them and they become institutionalized as prevailing operational norms (Meyer & Rowan, 1977). According to institutional theory, survival requires that an organization be viewed as legitimate, or perceived as acting in a way that is “desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definitions,” (Suchman, 1995, p. 574) thus perpetuating those behaviors established as legitimate, even if they are in conflict with other efficacy criteria (Meyer & Rowan, 1977).

DiMaggio and Powell (1983) also make the point that, “organizations compete not just for resources and customers, but for political power and institutional legitimacy, for social as well as economic factors” (p. 150). Social and political capital is particularly
important to hospitals, which depend on support from its community members as well as local, state, and national governments.

In addition, the very nature of accreditation makes it a practice likely to be established as an authoritative guideline for organizational behavior. As stated before, WHO defines hospital accreditation as "the systematic assessment of hospitals against explicit standards (ISQua & WHO, 2003, p. 58)." Accreditation endorses a standardized set of structures and processes it deems critical to an organization’s success. Being labeled "accredited" is intended to establish the organization as legitimate and groups the organization with other similarly legitimate organizations. It serves as external validation that the organization can be trusted to behave in an acceptable manner. In the difficult to validate health care context then, it is not surprising that the stamp of approval offered by hospital accreditation has become highly sought after.

Suchman (1995) describes three types of legitimacy - pragmatic, moral, and cognitive - that reflect different sets of circumstances that motivate an organization to conform. Pragmatic legitimacy is that which comes from an organization behaving in the way that its constituents determine is most beneficial for themselves. Moral legitimacy results in behavior that is beneficial for society as a whole and takes action because it is "the right thing to do." Cognitive legitimacy produces behaviors that are thought to create a necessary order in an otherwise chaotic environment or are simply assumed to be essential because they are taken for granted. These three types of legitimacy are not mutually exclusive but are comprehensive, meaning that all isomorphic changes are thought to be driven by one or more of these dynamics.
DiMaggio and Powell (1983) describe three ways that institutional isomorphism occurs: coercive isomorphism, mimetic processes, and normative pressures. *Coercive isomorphism* is driven by the influence of the organization’s stakeholders, both those that have some authority or power over the organization and those that are served by the organization with expectations about the product or service they receive. *Mimetic processes* result from the self-imposed inclination of an organization to model its structures and processes after more successful peer organizations. This inclination is the consequence of being aware of the need to improve but uncertain about what changes will have the greatest impact on outcomes. Organizations copy those approaches that are widely claimed to have produced positive results, jumping on the bandwagon of the latest popular trend (e.g. banks increase in subprime and adjustable-rate mortgages) or looking to the most successful institutions of other countries with strong industries (e.g. United States adoption of Japanese manufacturing processes). The uncertainty of the health care environment leaves hospitals searching for answers. *Normative pressures* are those that arise from the norms of one’s profession and training. The healthcare professions are known to be heavily influenced by its professional groups (Freidson, 1990). Rigorous basic training by specialty, extensive requirements for continuous education, and highly organized professional associations facilitate the indoctrination of a core set of values, beliefs, and norms and the spread of new practices accepted by the majority of the affiliated professional group. The Suchman types of legitimacy and DiMaggio and Powell’s isomorphic mechanisms together explain why and how institutional theory operates in the real world.
In thinking about the spread of hospital accreditation to developing countries, it seemed that many aspects of Rogers’ diffusion of innovations, although applicable, were not completely consistent with the experience of spreading hospital accreditation. My “global” level research question first described in Chapter 1 challenged these inconsistencies: Given the lack of clear evidence supporting the benefits of accreditation in the developing world and the high costs associated with its implementation (ISQua & WHO, 2003), why is hospital accreditation expanding so rapidly, particularly in developing countries with so few resources to support it? I hypothesized the following:

1. The decision of developing countries to introduce hospital accreditation is driven largely by external forces (institutional theory) and
2. This has important implications for the innovation process, or the process of spreading an innovation to an organization, and the likelihood of accreditation being sustained (the theory of diffusion of innovations).

I explored these propositions through a comparative case study of two countries in Southern Africa.

METHODS

The comparative case study methodology facilitated the inclusion of important global, regional, and national context in exploring the research question. Data was drawn from archival records, documentary information, interviews, focus groups, and direct observations. Data was analyzed using an explanation-building approach (Yin, 2009)
and directed content analysis (Hsieh & Shannon, 2005) to investigate how both theories apply to the expansion of hospital accreditation into the developing world.

**Case Selection and Study Setting**

As described in detail in Chapter 1, the Southern Africa region is a particularly interesting area in which to explore the introduction of hospital accreditation as about half of the countries have implemented accreditation with the majority of implementation initiated since 2007. Lesotho and Swaziland represented two English-speaking countries in the region that would allow me to evaluate different approaches to implementing accreditation. Lesotho’s approach was locally developed and used minimal resources while Swaziland’s was internationally recognized, developed by COHSASA, and required far more resources. Similarities between the histories, economies, and health systems of the two countries made observed differences more likely to be attributable to the differences in their approach to accreditation. And Lesotho’s decision to transition to the COHSASA program and pilot it in four hospitals during the time data collection had commenced created even greater opportunity to contrast the two approaches.

**Lesotho Context**

Lesotho is a small, mountainous country in Southern Africa with a population of 2.2 million (World Bank Group, 2011b). It is one of the 50 poorest countries in the world (World Bank Group, 2011a). Lesotho is completely surrounded by South Africa and has historically relied heavily on South Africa for trade and employment. This reliance
peaked during the 1980’s and by 1990, 127,000 Basotho\(^2\) were working in South Africa’s mines (Steinberg, 2005). Massive retrenchments due to changes in South Africa’s immigration policy in the name of national social reconstruction after apartheid hit Lesotho’s economy hard. Since then, Lesotho has worked hard to reduce its dependence on South Africa and has increased the share of GDP as a proportion of total income from 30% to 64% (International Monetary Fund, 2012). Still, 25% of Lesotho’s exports are to South Africa and Lesotho has the second highest remittance rate in the world (Ratha & Silwal, 2012).

Economic growth has been difficult in Lesotho, in part, because it has the third highest HIV prevalence in the world at 23.2% (Mwase et al., 2010). The country’s health system is overwhelmed by this burden and struggles from a diminished and burnt out health workforce. Nearly all (99%) of Lesotho’s health care services are provided by the Government and various church groups under the auspices of the Christian Health Association of Lesotho (CHAL). Since 1995, the Government of Lesotho (GOL) has paid for all salary costs at CHAL institutions, comprising 60-75% of all operating costs (Schwabe, McGrath & Kaseje, 2000). The early agreement governing the partnership was inadequate, so US-based NGO, Medical Care Development International (MCDI), was commissioned in the late 1990’s to assist in strengthening the specifics of the partnership. MCDI’s recommendations from 2000 included the requirement for certification of CHAL facilities in order to hold CHAL facilities accountable for the large subvention it received from Government. In 2005-2006, MCDI, in consultation with a

\(^{2}\) The Basotho are citizens of Lesotho.
few selected central Lesotho Ministry of Health and Social Welfare (MOHSW) staff, developed a first draft of these certification standards (Chase, Schwabe, Moji, Mohlomi, & Mohapi, 2006).

In January 2007, the Memorandum of Understanding (MOU) was signed that mandated accreditation for all CHAL facilities:

[CHAL] Institutions will be given a pre-certification period of three years to achieve the requirements for certification, during which time the GOL financial support will be sustained at the current level. A further three years provisional certification will be provided for all CHAL institutions. If at the end of the provisional certification period subject,...certification is not achieved, then GOL support may be withdrawn altogether and the entire operating costs of the Institution will revert to the Proprietor or the Proprietor may agree that the GOL may manage the facility on its behalf for one certification round (GOL & CHAL, 2007, p.8).

This contract clause gives CHAL facilities three years to meet the required accreditation standards. Institutions that fail to meet the requirements will lose their Government funding, and if they are unable to continue operations independently under these circumstances, ownership will be transferred to the Government. Later, the Lesotho MOHSW decided that the certification process should also extend to all Government district health facilities, though without the same financial implications.

The accreditation indicators that were developed included 124 standards divided across 11 domains with each standard having a clearly defined measure for what constitutes “met,” “partially met,” and “unmet.” Surveys relied on training internal senior management teams of GOL and CHAL hospitals to conduct the reviews. All of Lesotho’s 16 district hospitals underwent an initial testing of the accreditation criteria in late 2006 into early 2007 and were surveyed again in late 2008 into early 2009. Later,
Lesotho decided to supplement their MCDI standards with COHSASA’s internationally recognized accreditation standards, which were piloted in a sample of four hospitals in 2010.

Swaziland Context

The Kingdom of Swaziland is also a small, landlocked country in Southern Africa with a population of 1.1 million (World Bank Group, 2011b). Despite a diverse economy with active manufacturing, agriculture, forestry, and mining sectors (Government of the Kingdom of Swaziland, 2007), Swaziland’s economic growth has been slower than that of other countries in the region and its GDP has been declining since the 1990s. Swaziland has fewer migrant workers than Lesotho in South Africa, but is heavily dependent on South Africa for imports and exports with 45% of its exports going to South Africa. But unlike Lesotho’s Poverty Reduction Strategy that emphasizes the importance of reducing these dependencies, Swaziland’s Poverty Reduction Strategy focuses on initiating new markets as a safety net (Government of the Kingdom of Swaziland, 2007). Swaziland does not seem as concerned about securing its financial independence from South Africa; in 2011, Swaziland requested and accepted a financial bailout from South Africa during a cash crisis (BBC News, 2011).

HIV/AIDS has also been a major contributor to the prevalence of poverty in Swaziland (Government of the Kingdom of Swaziland, 2007) as Swaziland has the highest adult HIV prevalence in the world at 25.9% (Kingdom of Swaziland, 2012). The Government provides the large majority of health care services in Swaziland but about
one-third of facilities are mission-run (Kingdom of Swaziland MOH, 2011). The Swaziland Ministry of Health (MOH) began working with COHSASA in 2006 to develop its accreditation system. These accreditation indicators include 29 domains, which consist of 402 standards measured by 2,819 criteria. Baseline surveys were conducted in mid-2007 in all of Swaziland’s hospitals, with the exception of the two specialty hospitals. Following the baseline assessment, COHSASA began implementation of its “facilitated quality improvement program,” which includes a reassessment by external surveyors and report with action plan every six to 10 weeks. With the exception of February to September 2008, the facilitated program continued through October 2010, at which point the Swaziland MOH assumed full responsibility for the accreditation system.

**Data Collection**

Data was collected between May 2010 and August 2012 with fieldwork in Lesotho, Swaziland, and South Africa over five weeks during the period May-June 2010. Institutional Review Board approval was received from Boston University Medical Center. Ethical approvals were also provided by the Lesotho MOHSW and the Kingdom of Swaziland MOH. Table 2.2 summarizes the sources of data used, which are described in greater detail below.
Table 2.2. Description of data sources used for each analysis.

<table>
<thead>
<tr>
<th>Proposition 1</th>
<th>Primary Data Sources</th>
<th>Triangulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Historical global analysis: identify critical events that explain expansion</td>
<td>Archival records; Published literature, grey literature</td>
<td>Search engine searches to confirm facts with organization websites, news articles, etc.</td>
</tr>
<tr>
<td>National perspectives analysis: why and how accreditation was introduced</td>
<td>Interviews and focus groups codes: meeting international standards, laying the groundwork, importing accreditation, and need for quality care</td>
<td>Documentary information collected in country</td>
</tr>
<tr>
<td>Proposition 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Historical national analysis: identify critical events in development of national accreditation</td>
<td>Documentary information collected in country</td>
<td>Interviews and focus groups; Direct observations</td>
</tr>
<tr>
<td>National perceptions analysis: identify perceptions of five key innovation attributes</td>
<td>Interviews and focus groups codes: suitability of standards, negative/positive perceptions of accreditation, and changing perceptions of accreditation</td>
<td>Documentary information collected in country</td>
</tr>
</tbody>
</table>

Archival Records

Global databases from the World Bank Group and United States Agency for International Development (USAID) were accessed to retrieve the latest data on national population and health statistics and USAID spending for countries in the Southern African region. I searched the World Development Indicators Database for GNI, GDP, population, and health expenditure, and I searched through the data in the President’s Emergency Plan for AIDS Relief (PEPFAR) fiscal year 2010 operational plan to find the table showing approved funding by country (US PEPFAR, 2011).
Documentary Information

Published books and articles were used when possible, particularly for outlining the key historical events in the global spread of hospital accreditation. I relied heavily on a published global review of quality and accreditation in health care services that was released by the WHO and ISQua in 2003. I also relied on search engines to find news articles and grey literature for information on countries in Southern Africa. However, published documentation of events in developing countries is rare. Key representatives from Lesotho and Swaziland were asked for any documentation in their possession that might offer a better understanding of the development of hospital accreditation in the country. I received a variety of national reports (12), planning documents (2), manuals (3), survey results (5), national meeting minutes (1), and presentation handouts (3). These documents were read, key points were highlighted, and a summary of each was written and entered into a spreadsheet for further analysis.

Interviews

Initial contact was made with the individuals within the Ministry of Health in each country responsible for oversight of hospital accreditation. Using chain sampling, I solicited initial key informants for names of additional relevant individuals to interview. I included three categories of key informants:

- Key informants at the national level for each country,
- Other key informants identified by key informants at the national level, which may include international or regional organizations or individuals, who have
played a key role in the introduction or development of hospital accreditation, and

- Key informants from COHSASA

A total of 13 interviews were conducted, with the breakdown by country and key informant type indicated in Table 2.3. Interviews were about 60 minutes each.

**Table 2.3. Number of key informant interviews by interview type for each country.** *Note: Three interviews had more than one participant in the interview.*

<table>
<thead>
<tr>
<th>Country</th>
<th>National Level</th>
<th>Other Key Informants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lesotho</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Swaziland</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>COHSASA</td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

Eleven interviews took place in person during the period May-July 2010 and two interviews were conducted over the phone during the period June-September 2010. Verbal informed consent was obtained from each participant. With permission from the interviewees, all interviews were audio-recorded. No compensation was given to interviewees. A semi-structured interview guide was used that was applied flexibly, which facilitated being responsive to each interview situation while remaining within the scope of the principal research questions. The interview guide (attached as Appendix A) included four broad topics: (1) hospital accreditation perceptions and meaning, (2) hospital accreditation history, (3) hospital accreditation purpose, and (4) the future of hospital accreditation. Each broad topic included 2-4 primary questions along with a series of probes. Following a grounded theory approach, interview questions evolved slightly with each progressive interview to explore themes as they emerged.

I led all 13 interviews. For 10 of these interviews, a second researcher was present. During interviews where two researchers were present, the second researcher
took notes in order to capture who was talking, in cases with multiple interview participants, and to capture noteworthy non-verbal gestures. Immediately following each interview, field notes were written or digitally recorded that included impressions of how the interview went and salient content points from the interview. All interviews were then transcribed verbatim to the extent possible with any indiscernible or inaudible sections indicated.

Focus Groups

A sample of district hospitals from each country was purposely selected to represent a mix of geography (urban and rural), size (large to small), and ownership (Government and mission). Focus groups of seven to 10 frontline staff were organized in each of the selected hospitals per country. Four hospitals were selected in Lesotho (one-quarter of the total number of hospitals) and three hospitals were selected in Swaziland (one-half of the total number of hospitals). Participating frontline staff represented a diverse mix of physicians, nurses, allied health professionals, and administrative staff. The description of focus groups and hospital attributes by country are presented in Tables 2.4 and 2.5, respectively.
Table 2.4. Number of focus groups and focus group participants for each country broken down by professional group.

<table>
<thead>
<tr>
<th>Country</th>
<th>Lesotho</th>
<th>Swaziland</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allied Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of participants</td>
<td>33</td>
<td>28</td>
<td>61</td>
</tr>
</tbody>
</table>

Table 2.5. Mix of key attributes by hospital for Government vs. Mission, urban vs. rural, and large vs. small. Codes for each hospital are used to indicate the source hospital for focus group data presented throughout the study.

<table>
<thead>
<tr>
<th>Lesotho Hospital A Code: LES-GUL</th>
<th>Govt</th>
<th>Mission</th>
<th>Urban</th>
<th>Rural</th>
<th>Large</th>
<th>Small</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lesotho Hospital B Code: LES-GUS</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lesotho Hospital C Code: LES-MRL</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lesotho Hospital D Code: LES-MRS</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swaziland Hospital E Code: SWAZI-GRS</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swaziland Hospital F Code: SWAZI-MUL</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swaziland Hospital G Code: SWAZI-MRL</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All focus groups were conducted in person during the period June-July 2010.

Verbal informed consent was obtained from each participant. Participants were served lunch or tea during or immediately following the focus groups. With permission from the participants, all focus groups were audio-recorded. The focus groups were intended to
focus largely on the experiences of hospitals in implementing standards and perceived appropriateness of specific standards, but each focus group opened with questions aimed at gaining a sense of how familiar hospital staff were with accreditation and closed with a discussion on general perceptions of accreditation.

I led all seven focus groups. A second researcher was present who took notes in order to capture who was talking and to record noteworthy non-verbal gestures and group reactions. Immediately following each focus group, field notes were written or digitally recorded that included impressions of how the focus group went and salient content points from the discussion. All focus groups were then transcribed verbatim to the extent possible with any indiscernible or inaudible sections indicated.

Direct Observations

Although direct observations were not part of the formal data collection plan, they do serve as a source for triangulation of data. In managing a health program in Lesotho, I spent about one-third of my time in Lesotho between 2004 and 2008, and some observations from this time helped to support findings from other sources. In addition, many of the informal, off-record conversations had during the 2010 data collection period influenced the direction of future interview questions or served to confirm or challenge the data I was collecting. Most of these were captured in emails or field notes taken immediately following data collection.
Data Analysis

Archival reports and documentary information, both published and unpublished, were analyzed to uncover the sequential story of the spread of accreditation. Data were placed on a timeline and timelines with data from different sources were compared and integrated.

This particular case study is situated within the broader dissertation study exploring hospital accreditation in the developing world. This broader study used a grounded theory approach in conducting and analyzing interviews and focus groups (Charmaz, 2006). The identification of key themes in early interviews and focus groups influenced the direction of later interviews. Thematic analysis of interviews and focus groups started with manual open coding and progressed to coding using HyperResearch through which I eventually arrived at a final list of 32 codes that reflected all key concepts emerging from the data. This coding will be described in more detail in Chapter 3.

For the purposes of analysis for this case study, I followed Yin’s (2009) explanation-building approach to analyze the data’s fit or lack of fit with each of the two theories being considered: institutional theory and diffusion of innovations. To do this, I identified those codes from the broad dissertation study’s full list of 32 codes that contained data related to the initiation and implementation of hospital accreditation and conducted directed content analyses on the various sub-set of codes for the corresponding parts of the two theories (Hsieh & Shannon, 2005). Analysis focused specifically on looking for both positive and negative evidence for each component of the theories and
paying attention to similarities and differences between the two countries.

The analysis for Proposition 1 included a historical global analysis and a national perspectives analysis. The historical global analysis primarily included a review of published and gray literature to establish the critical events that most accurately portray the expansion of hospital accreditation globally and drew from international databases to obtain important population and health statistics. Using the ISQua and WHO global review of quality and accreditation in health care services (2003) as the starting point, I conducted a literature review to help establish the timeline of key events that corresponded to the increase in number of countries implementing accreditation. General search engine searches were conducted to confirm facts using organization websites, news articles, or other documentary information. Together, these data sources that contributed to the historical global analysis provided the top-down view of the role of isomorphism in spreading accreditation.

The national perspectives analysis was aimed at providing the bottom-up view of why and how accreditation was introduced. It drew from interviews and focus groups in both Lesotho and Swaziland. Reports were generated to include all data for a few selected codes including: meeting international standards, laying the groundwork, importing accreditation, and need for quality care. These codes were then sorted to identify key themes relevant to how and why accreditation was introduced.

The analysis for Proposition 2 included a historical national analysis and a national perceptions analysis. The historical national analysis primarily focused on a review of documentary information obtained upon request from key informants that
established critical events that most accurately portrayed the development of hospital accreditation in each country. Interview and focus group data were used to corroborate data from documentary sources and provide interpretations of key events that help to explain the national innovation process. The same key codes from the national perspectives analysis were examined in addition to a few others: suitability of standards, negative perceptions of accreditation, positive perceptions of accreditation, and changing perceptions of accreditation.

The national perceptions analysis, aimed at identifying perceptions of the five key diffusion of innovation attributes, drew largely from interviews and focus groups. The same group of codes used to explain the national innovation process was selected and analyzed using pattern-matching against the five attributes.

FINDINGS

Proposition 1: Institutional Theory Drives Expansion of Hospital Accreditation

To fully understand the innovation process of hospital accreditation for Lesotho and Swaziland requires an understanding of the role of isomorphism in the expansion of accreditation in the developing world. This first proposition posits that the decision of developing countries to introduce hospital accreditation is driven largely by external forces (institutional theory). I present data from international, regional, then national levels showing the confluence of DiMaggio and Powell's isomorphic mechanisms that contributed to the implementation of accreditation, particularly coercive isomorphism and mimetic processes. Although there was some evidence of the influence of normative
pressures in specialized laboratory accreditation, I found no evidence that normative pressures are at work in the adoption of hospital accreditation. Then I show how Suchman’s moral and cognitive legitimacy served as the national rationale for implementation. I found no evidence that pragmatic legitimacy influenced implementation of hospital accreditation. Findings are organized according to the four analyses described earlier in Table 1: historical global, national perspectives, historical national, and national perceptions.

Global History: Findings for Coercive Isomorphism

Between 1951 and 1993, only five countries had begun implementation of hospital accreditation (ISQua & WHO, 2003). But in 1992, the Pan American Health Organization (PAHO) released their Manual of Hospital Accreditation in response to the desire expressed by many Latin American countries to implement accreditation as a way to improve the deterioration of hospitals that resulted from the recession of the 1980s (Novaes & Neuhauser, 2000). By the end of 1998, six Latin American countries were implementing hospital accreditation and another seven were taking steps toward adopting accreditation as well. Many European and a few wealthier Asian countries had also begun implementation of hospital accreditation programs (ISQua & WHO, 2003; Shaw, 2004).
Figure 2.1. Number of countries with hospital accreditation programs from 1951 to 2001 with the introduction of the first five country programs highlighted (ISQua & WHO, 2003).

At this point, global attention to hospital accreditation began to mount. The 1998 World Health Assembly, attended by representatives of all WHO member states, passed a resolution, which pushes member states to take action on patient safety and specifically promotes "an integrated system of active surveillance and monitoring for health," including a focus on "implementation of international norms, standards and regulations." (WHO, 1998, p.38). It was in 2000 that the WHO commissioned the International Society for Quality in Health Care (ISQua) to conduct their review of "examples from around the world of quality structures and processes that might inform local improvement of health services, especially in the developing countries" (ISQua & WHO, 2003, p. xiii). That study was released in 2003 and asserted WHO's support of accreditation, claiming:
The current WHO programme includes technical support for countries to implement quality assurance and quality improvement programmes and national accreditation efforts. WHO will respond to requests from countries wishing to benefit from the Organization's technical expertise to implement such programmes or the accreditation of services (ISQua & WHO, 2003, p. 14).

The WHO formed the World Alliance for Patient Safety in 2004, which committed the WHO to provide this technical expertise and spurred the development of resources for countries to focus on patient safety issues (Healy, 2011).

In addition to the development of policies that promote hospital accreditation, a number of new programs were introduced during this same time period, setting the stage for supporting the further global expansion of accreditation (see Figure 2.2). In 1999, ISQua launched its International Accreditation Program, which accredits health standards, surveyors, and surveyor training programs (ISQua, 2012). In 2000, the Joint Commission International published a set of international standards and issued its first accreditation (Joint Commission, 2012). In 2002, the Organization for Economic Cooperation and Development (OECD) launched its Health Care Quality Indicators Project, which developed a set of standards aimed at measuring quality of care at the system-level (OECD, 2012).
These policies and programs coincided with a sharp rise in the number of countries implementing accreditation globally as is shown earlier in Figure 2.1 (ISQua & WHO, 2003). The number of countries with accreditation programs doubled from 1998 to 2001. Although some of the larger, better-resourced developing countries (e.g. South Africa, Brazil, Thailand) started accreditation of hospitals by 1999, the majority of low-income countries reporting on activity were still in the planning stages or had started implementation of accreditation after 1999. Only two countries on the African continent implemented programs before 1999: South Africa (initiated in 1993) and Zambia (initiated in 1998).

The African continent seemed to lag behind other countries, even other developing countries, in implementing hospital accreditation. Instead of being swayed by rousing policies, the uptake of accreditation by these resource-poor countries largely followed substantial donor support for accreditation. As described in the 2003 report by ISQua and WHO, “Rapid uptake of voluntary programmes is associated with direct financial incentives and government encouragement...The policies of development banks...
and foreign aid agencies can greatly influence the way quality systems are structured and operated, especially in developing countries” (p. 127).

Indeed, data indicate that the spread of hospital accreditation on the continent, and especially the Southern African region followed the introduction of the President’s Emergency Plan for AIDS Relief (PEPFAR). PEPFAR was established under the USAID program in 2003 with the spending of US$18.8 billion over five years by the United States government to assist countries hardest hit by HIV/AIDS in tackling this crisis. In 2008, that commitment was renewed for US$48 billion over another five years and included a new emphasis on “Health Systems Strengthening,” which opened the door to funding programs like hospital accreditation (Dybul, 2009). Much of the assistance offered to countries came indirectly through funding to selected organizations that then could provide technical assistance; that aid was contingent on recipient countries partnering with those selected organizations.

The USAID Southern Africa Regional HIV/AIDS Program (SA-RHAP) was established to coordinate assistance provided to the region (USAID Southern Africa, 2012). After the first grants were awarded by USAID to implementing partners, the presence of African institutions was noticeably sparse. In response, SA-RHAP funded the Southern Africa Human Capacity Development (SAHCD) Coalition, which comprises two US-based organizations and three African organizations, including COHSASA (USAID Southern Africa, 2010). Formed in 2006, the SAHCD Coalition offered partnering countries a large menu of programs, all funded by USAID dollars if the Governments chose to implement them. Table 2.6 illustrates the relationship between
PEPFAR funding and implementation of hospital accreditation in the 11 Southern African countries.

**Table 2.6. PEPFAR funding and hospital accreditation information for Southern African countries (Botswana-USA [BOTUSA], 2011; Bukonda et al., 2002; Chase et al., 2006; COHSASA, 2012; COHSASA, 2008; Kutengule, 2012; SAHCD, 2012; US PEPFAR, 2011; Whittaker et al., 2000; World Bank Group, 2011)**

<table>
<thead>
<tr>
<th>Country</th>
<th>PEPFAR spending per person (US$)</th>
<th>Accreditation Program Currently</th>
<th>SAHCD Partner</th>
<th>Year Accreditation Initiated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Namibia</td>
<td>$19.54</td>
<td>Yes</td>
<td>Yes</td>
<td>2012 - Present</td>
</tr>
<tr>
<td>Swaziland</td>
<td>$19.39</td>
<td>Yes</td>
<td>Yes</td>
<td>2007 - Present</td>
</tr>
<tr>
<td>Zambia</td>
<td>$11.94</td>
<td>No</td>
<td>No</td>
<td>1998-2001</td>
</tr>
<tr>
<td>Botswana</td>
<td>$8.72</td>
<td>Yes</td>
<td>Yes</td>
<td>2009 - Present</td>
</tr>
<tr>
<td>Lesotho</td>
<td>$7.98</td>
<td>Yes</td>
<td>Yes</td>
<td>2006 - Present</td>
</tr>
<tr>
<td>South Africa</td>
<td>$6.22</td>
<td>Yes</td>
<td>No</td>
<td>1993 - Present</td>
</tr>
<tr>
<td>Mozambique</td>
<td>$6.08</td>
<td>No</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>$2.66</td>
<td>No</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>Malawi</td>
<td>$2.14</td>
<td>Yes</td>
<td>Yes</td>
<td>Not Known</td>
</tr>
<tr>
<td>Angola</td>
<td>$0.48</td>
<td>No</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>Madagascar</td>
<td>$0</td>
<td>No</td>
<td>No</td>
<td>N/A</td>
</tr>
</tbody>
</table>

With the exception of Malawi and Zambia, a clear trend can be seen where those countries receiving the greatest amount of per capita PEPFAR assistance are the countries implementing hospital accreditation programs. As mentioned before, Zambia ended its accreditation program after a three-year trial determined that the program was not sustainable. Notice, though, that Zambia is not a SAHCD partner. Every SAHCD partner is in the process of implementing an accreditation program. Except for Malawi, every country with an accreditation program in the region now uses the COHSASA accreditation system, though Lesotho continues to use its original MCDI standards as well. Certainly by providing financial support for COHSASA's role in SAHCD activities, USAID was endorsing hospital accreditation as an important intervention for
improving health care. As a major funder of health programs in Lesotho and Swaziland, this influence would have been a major factor in the decision to implement an accreditation program. These data illustrate the role of coercive isomorphism, or the influence of powerful stakeholders, in the spread of accreditation into these two countries.

**National Perspectives: Findings for Mimetic Processes**

Data from interviews and focus groups indicate that mimetic processes, or copying structures and processes of more successful peer organizations in hopes of also becoming successful, are also at work in both Lesotho and Swaziland. In Swaziland, the desire for "international recognition" was cited repeatedly in all focus groups and nearly all interviews. In Lesotho, the desire "to be on the world's standards" (LES-MRL) and to "meet the universal standards" (LES-GUS) was expressed in three of the focus groups and a few of the interviews. Meeting regional expectations for performance was heavily emphasized as well. All three of Swaziland's focus groups and two of Lesotho's four focus groups frequently made comparisons to South Africa and other Southern African Development Community (SADC) countries. Most respondents felt that they should be at a similar level to that of other SADC countries, though there were some that preferred to make an exception for South Africa recognizing that it may be difficult to reach such high standards.

I think coming to the standards, we are at the low level, really at the low level. Because even if you can say, we cannot, um, look at the ways of Africa countries, but coming to the COHSASA standards, we're now
talking about SADC countries. We’re now talking about African countries. We should be the same. (SWAZI-MUL)

Although interviews and focus groups show that these same mimetic processes are at work in Lesotho, the considerable thought and long process that went into developing their own program was a point of pride for some. During an interview, one MOHSW representative was careful to point out that Lesotho’s accreditation program was home-grown and preceded that of Swaziland:

Q: Did Lesotho look to any other countries for guidance or advice in implementing accreditation?
A: No, why would we?
Q: No.
A: You mean for lessons learned?
Q: Yeah, for, yeah, the model that you’ve implemented, did you start from scratch or look to other countries?
A: No, we started from scratch.
Q: You started from scratch.
A: Like I told you, we sat down with the consultant from U.S.... We started from scratch. When we had already started, that’s when we heard that Swaziland is doing it. And now Swaziland was doing it primarily through COHSASA. In, in, in Swaziland, it was introduced by COHSASA. COHSASA had come to us when we had already started. Yeah. So where they’re working now, for us, we started our own model. But these other places, it is COHSASA that introduced them to the accreditation. Like Swaziland, I’m very sure they did it when we had already started. Ea.³ (LES-MOHSW3)

National Perspectives: Findings for Cognitive Legitimacy

For both Swaziland and Lesotho, though, there is little question that the implementation of COHSASA’s accreditation system was strongly driven by PEPFAR funding and, by extension, PEPFAR endorsement of the program. This indicates that

³ “Ea” means “yes” in Sesotho (the local language of Lesotho).
cognitive legitimacy factored into implementing these accreditation programs.

Accreditation originated in the United States and it is largely taken for granted as an essential part of hospital operations, so it is not surprising that PEPFAR would endorse COHSASA’s internationally accredited program as a way of moving developing world health care toward a more orderly, standardized approach. One health care worker in Swaziland described how accreditation brings order, “...you need standards. We need tools. You need things that you can see, that this is what you are doing, this is right, this is internationally recognized. This is a standard thing, so it was just that” (SWAZI-MRL). Another interviewee nicely described how accreditation’s long history and frequent use contribute to the assumption that accreditation is appropriate:

This process of, uh, hospital accreditation, I mean, uh, I don’t know, it’s a very old process, and it’s been done in many institutions in many countries, both private and public. And, uh, um, the more you try and standardize it, the, I think, the better it is for, for everyone else. (SWAZI-NGO1)

National Perspectives: Findings for Moral Legitimacy

The notion that accreditation is essential and it’s “better...for everyone,” also supports the importance of the role of moral legitimacy in implementing hospital accreditation. In both countries, study participants reported that the quality of care was poor, citing “many things that are happening, unprofessional things and negligency” (SWAZI-MOH). Hospital staff explained that “the patients, uh, were not taken of, care of properly” (SWAZI-MUL) and “people were not committed towards, uh, the lives of people” (SWAZI-MUL). Study participants in both countries listed countless examples
of the poor quality that was being delivered. One top Swaziland MOH official noted her own views about accreditation being the right thing to do:

You find that the quality they are providing to the people out there, it’s not of good quality, so I thought that going the accreditation way is the best way because if we have the standards in place, then everybody will be expected to comply. (SWAZI-MOH)

Individuals in both countries report motivations driven by both cognitive and moral legitimacy. For many, and one Lesotho participant in particular, international regard for accreditation and its perceived ability to improve care were equally important drivers:

...if I were to answer that question why the Government wanted accreditation, I don’t know if they want to move with the world or they want to improve the services. That’s what I thought, they want to improve the services or they want to be in line with the world as the world moves. I’m not sure, but I would agree with, with them. They said they want to improve the services to be on the world’s standards. (LES-MRL)

**Proposition 2: Isomorphism Affects Innovation Process**

Now that the importance of institutional theory in the expansion of hospital accreditation is clear, I can now turn to describing the implications of this on the innovation process. Data from interviews and focus groups as well as local documentary information show how the first four stages of the innovation process – agenda-setting, matching, redefining/restructuring, and clarifying – have been affected so far by isomorphism in Lesotho and Swaziland and how this will likely impact the routinizing stage.
National Histories: Findings for Agenda-Setting

Swaziland is perhaps the most obvious case of opportunistic implementation. SAHCD was funded by USAID in 2006 (USAID Southern Africa, 2010) and in October of that same year, Swaziland had already signed onto COHSASA’s accreditation program (COHSASA, 2008). One Ministry of Health representative mentioned that she had raised the idea previously but it was never seriously considered. The lack of any other evidence of prior consideration, either in documentary information or interviews, supports the idea that accreditation was introduced as a direct result of the SAHCD partnership and associated funding. In this case, the agenda was set by the available solution.

Lesotho’s case is a bit more complicated. Both documentary information and interviews suggest that Lesotho had seriously considered an accreditation system well before it was implemented in the country and had invested considerable thought and resources into its development. A certification system was strongly recommended in MCDI’s March 2000 report of its study of the CHAL-GOL partnership (Schwabe et al., 2000). One MOHSW representative explained how development of the CHAL-GOL partnership resulted in the development of accreditation:

This accreditation thing began because of the MOU issue where the intention was to find ways to measure the quality of services that is provided by CHAL, that the Government is purchasing the services. So that’s how it came up. (LES-MOHSW2)

The same MOHSW representative and a former MOHSW employee who had been engaged in the development of the MOU both confirmed that this was all in support of the larger health sector reforms that began in the late 1990’s. In June 2003, the MOHSW published the country’s Essential Services Package, and indicated its chief
purpose to be its contribution to the health sector reforms, including “establishing standards, guidelines, and monitoring indicators” (Kingdom of Lesotho MOHSW, 2003, p. 6). The MOHSW also commissioned a consultant to develop a framework for an action plan to implement quality assurance and quality management in Lesotho’s health sector in 2004. Finally, MCDI was contracted to assist with the development of the standards in 2005, which were finalized in June 2006 (Kingdom of Lesotho MOHSW, 2009).

The rigor of the standards developed with MCDI was called into question when COHSASA approached the Ministry and offered a more comprehensive set of standards and accreditation system. One Ministry of Health representative described how COHSASA questioned the legitimacy and feasibility of the MCDI system:

It is the coalition. The South African something, it is USAID funded. It is the one now that, on realizing that we were doing that exercise – this, I have to be frank with you – on realizing we were doing the exercise, they looked at our tools and then they critiqued that, yes, we may have that tool, it may be okay, but us as a country do not have the capacity to accredit, we also do not have the capacity to facilitate change in the hospitals, or in the health facilities that require change. That’s how the COHSASA came on board. (LES-MOHSW3)

COHSASA ran a preliminary test of its standards in Lesotho in 2007, but given the complexity of the COHSASA system and CHAL’s contractual obligation to comply with the MCDI standards, the MOHSW decided to continue implementing the original standards. But COHSASA persisted as several MOHSW representatives reported: “They were trying to make us understand why they have to be on board” (LES-MOHSW3) and “We didn’t know about them. And they introduced themselves with this new, own standards. It took time for us to really understand, to appreciate that we could work
together” (LES-MOHSW2).

Eventually, Lesotho bought into the COHSASA model, but in stark contrast to Swaziland’s experience, Lesotho had to be convinced that its standards were not sufficient on their own. In the end, though, it became clear that the MOHSW did, indeed, lack the capacity to provide the necessary technical assistance to realize the necessary gains from its own certification system, and COHSASA’s funded program seemed to be the logical answer to their lack of resources. Interestingly, although COHSASA’s role includes training the few individuals currently responsible for overseeing the implementation of accreditation in Lesotho, the long-term plan for successfully sustaining the COHSASA model after funding for COHSASA goes away includes the addition of many more national staff to provide the necessary oversight and support.

The availability of the regional COHSASA program with the endorsement of USAID was a particularly strong combination, and as we saw from Lesotho’s experience, very difficult to resist. When the legitimacy of the MCDI model was called into question, Lesotho was left with little choice but to adopt the COHSASA model. It’s thoroughly planned agenda was abandoned for a better reputed and better resourced approach. Table 2.7 highlights the timeline, which serves as supporting evidence for the major forces driving the adoption of each of the accreditation programs.
Table 2.7. Timeline for adoption reflects the opportunistic vs. planned nature of agenda-setting in Swaziland and Lesotho, respectively.

<table>
<thead>
<tr>
<th>Accreditation Program</th>
<th>Discussions Began</th>
<th>Baseline</th>
<th>Impetus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swaziland COHSASA</td>
<td>2006</td>
<td>2007</td>
<td>SAHCD Partnership/ Funding</td>
</tr>
<tr>
<td>Lesotho MCDI</td>
<td>1999</td>
<td>2007</td>
<td>CHAL-GOL Partnership</td>
</tr>
<tr>
<td>Lesotho COHSASA</td>
<td>2007</td>
<td>2010</td>
<td>Need for extra resources/TA</td>
</tr>
</tbody>
</table>

National Perceptions: Findings for Matching

Although Swaziland had not sought out hospital accreditation as the solution to its problems with the quality of care, this is not to say that Swaziland had not identified problems with their health care system as were described earlier under findings supporting the role of moral legitimacy. In fact, many interviewees and focus group participants credited public unrest as the reason for introducing accreditation. One MOH representative indicated that accreditation was an active response to public complaints:

So we started in 2006 after the, the, the, the, after the Ministry realized that the quality of service that is provided in the facilities, it’s not up to standard. There were so many complaints from the public, so many bad reports on the media were being publicized. And then we thought we should do something about it. (SWAZI-MOH)

This perception was also shared by many at the hospital level.

Q: Why do you think hospital accreditation was first started in Swaziland?...
A1: I think it was a, a public cry for hospitals becoming slaughter places so I think the Ministry was trying to put itself safe.
A2: Maybe it was also statistics that they had, mortality or morbidity rising.

((Murmurs, nods, "yes," and "mm hmm" from many in group)) (SWAZI-GRS)

Although these quotes and several others confirm that Swaziland’s citizens were highly dissatisfied with the health care services being provided, there is no evidence to
suggest that there was public demand for accreditation specifically. Nonetheless, public discontent likely contributed to Swaziland’s rapid response to accreditation and commitment to COHSASA. Although the decision to adopt accreditation may have been opportunistic in nature, they had no problem matching the solution to very real, existing problems.

In contrast, Lesotho had long considered accreditation as a solution to its problem of holding CHAL facilities accountable for the quality of services they were providing. In January 2007, the MOU was signed that mandated accreditation for all CHAL facilities. Soon after, it was decided that Government facilities would also be included in the certification process because, as one Ministry of Health representative described, “It became clear that we cannot be measuring the quality provided by CHAL and not do anything for Government health services (LES-MOHSW2).” A CHAL representative supported the same view:

But they thought that if they do that only for CHAL, that’s going to be a disparity, that means CHAL would be doing better and for Government, they would be left as they are. Yes. So they thought, let’s do that thing together. (LES-CHAL)

The language of both the MOHSW and CHAL suggest a concern that if excluded, Government health services would suffer. Accreditation was matched to one problem (measurement for accountability) and only after it was adopted, it was matched to address another problem (disparities in quality of care). And then the COHSASA model was accepted only after Lesotho’s decision-makers were convinced that it would address a third problem: the lack of sufficient capacity to assist facilities in making the expected improvements. But many still had reservations about the COHSASA standards. A
CHAL representative described her regret about agreeing to adopt COHSASA's standards:

...if we knew, we could have said that, no, we are using the MCDI standards and you COHSASA people, you only come with the facilitation, you help us to meet those standards. So we did not think before we said they should come with their standards and merge them with this MCDI. We find that their document is very big and the standards are, the people from the hospitals do not understand them. (LES-CHAL)

Interestingly, when asked why accreditation was adopted, very little was mentioned in either country about the intrinsic characteristics of accreditation itself, hinting that perceptions of the attributes of accreditation are not overwhelming influences. This is particularly interesting considering how important perceptions of innovation attributes (relative advantage, compatibility, complexity, trialability, and observability) have been shown to be for the rate of adoption and assimilation, so I consider each attribute in turn.

**Relative Advantage**

As discussed earlier, the evidence base supporting the ability of hospital accreditation to improve the quality of care is lacking. Although the 2003 ISQua and WHO report mentions the “dearth of robust research evidence to support [the benefits of accreditation]” (p.127), there is no evidence that the WHO or any other organizations have communicated this to the countries they are encouraging to adopt accreditation, and those encouraging the adoption of accreditation are not offering any other alternatives. However, none of the documentary information, interviews, focus groups, or direct observations indicate any awareness of the lack of evidence in support of hospital
accreditation, so this weakness should not be factored into the perceived relative advantage of accreditation by adopters in Lesotho and Swaziland.

For both Lesotho and Swaziland, hospital accreditation was viewed as a way to measure and improve quality of care. None of the interview participants indicated that there was any question that hospital accreditation would help to do these things, but the strengths of accreditation were also not talked about as affecting the decision to adopt it. Accreditation was not replacing any existing system and no one was making a choice between accreditation and some other system to improve care, so there seemed to be nothing to lose by adopting it.

Compatibility

For both Lesotho and Swaziland, accreditation is really the first introduction to any formal quality assurance or quality improvement approach, the importance of which is discussed in greater detail in Chapter 3. However, despite the novelty of this approach, most people felt that there was nothing inherently about the concept of accreditation that was in conflict with their culture, even when asked directly. However, one interviewee described how accreditation may require a bit more adjustment in the “African culture” compared to the “Western culture”:

Cause with the Western, with the Western culture, you know, it’s all this machine time, everything is time-based, everything is target-oriented, there’s a deliverable and all that. Yeah. With the African culture, basically, I mean, time is slow, you know? It’s manageable, eh? To be there, you do your own things, there isn’t so much pressure and it’s not so much about the deliverable, you know? Maybe it’s more of the methodology, eh? Oh, we are doing this and all that. So basically, when you look at quality assurance, it sets out very clear deliverables and
targets, you know, like you’re target-oriented, so that target orientation brings an element of pressure... Quality assurance inherently is not part of our culture, you know, eh? Basically I think for us, uh, it’s more of maybe the process, we’re a bit process-oriented and whatever.... So like, basically you are setting a new, it’s a paradigm shift, eh? Like from the, uh, what you’ve done business as usual, you go towards business unusual. So basically that’s where we’re going to. (SWAZI-NGO2)

Although I did not hear these cultural differences described by others, this Swazi interviewee explained that he was in a unique position to understand these differences given his extensive experience working with several different U.S.-based non-governmental organizations. Others described this process orientation and emphasis on moving slowly more indirectly:

Because we are not like a South Africa. We are Swaziland. And we take things step by step slowly. (some laughter from others) It’s not like, uh, today we are two years, tomorrow we’ll be five. We grow, step by step.

But for the most part, these comments seemed to be more directed at the specific standards or specific ways that accreditation was implemented and not the general concept of accreditation. It is worth noting that concerns in Lesotho about compatibility of the standards and the way accreditation was implemented were largely targeting the COHSASA approach. The MCDI standards, which were “tapped from international standards...but were localized to suit the local situation” (LES-MOHSW2), were customized specifically to be compatible with Lesotho’s situation. In contrast, there were limitations in the extent to which the COHSASA standards could be adapted in order to maintain their internationally accredited status.

Generally, though, problems with compatibility were expressed in terms of specific requirements imposed by standards that add significantly to the work burden and
do not fit with the available human resources, infrastructure, or capacity. Every interview and focus group spent a considerable amount of time focusing on the challenges that meeting accreditation posed with the limitations imposed by the country’s available resources, which is discussed in more detail in Chapters 3 and 4.

Complexity

Although national leaders interviewed from Swaziland did not express any concerns with the complexity of accreditation, all of the hospital focus groups indicated that it was difficult to understand when first introduced. The person responsible for oversight of accreditation in one hospital remarked, “I didn’t quite understand [accreditation] and it took me some time, a long time, in fact, to actually really understand what accreditation is. It took me a long time to understand it” (SWAZI-MRL).

Lesotho’s participants expressed far greater concerns with complexity, particularly comparing how “simple” (LES-CHAL) and “clear” (LES-NGO1) the MCDI standards were compared to COHSASA’s standards, which were “very lengthy” (LES-MOHSW3), and “the people from the hospitals do not understand them” (LES-CHAL). In 142 pages, MCDI’s standards included each indicator along with its definition, weight of importance, data collection approach, and targets for met, partially met, and unmet. COHSASA’s 585 pages included only the definition of the standard and general criteria being considered in assessing performance on the indicator with no indication of how to measure the criteria. One key representative in Lesotho described their reliance on the
COHSASA consultants in order to assess performance:

A: So the way they were asking questions and the scoring part of it was very much difficult. Yes. Unlike with MCDI, you know that if the things not met, it's not met. If it's partially met, you know how you're going to score it, but with this one somehow, it was very much subjective. Yeah.

Q: So if it's subjective, did it require more expertise?

A: Yes. For those consultants, it was very much easy for them to know that with these, for things like this, we know that it's met, but for us, we are not able to know. (LES-CHAL)

Trialability

It is unclear the extent to which accreditation can be tested on a small scale. In Lesotho's case, there were several phases of pre-testing and extensive discussions involved in the development of the MCDI standards, but once finalized, accreditation was written as a requirement into the CHAL-GOL MOU and rolled out nationally. The COHSASA standards were tested in one hospital in Lesotho and then underwent significant deliberations over two years before they were piloted in 4 hospitals. In Swaziland, the standards were tested in one hospital and then were introduced to the country as a pilot phase, but all of Swaziland's six hospitals were included in the pilot, which is much more widespread than one would expect for a trial phase. In both cases, COHSASA was contracted before the standards were finalized with the expectation that they would develop and implement accreditation. There is no indication that decision-makers in either country had even considered the possibility of a trial, but in hindsight, some expressed a desire for a more gradual rollout. One Lesotho MOHSW representative proposed a more gradual approach to rolling out the standards:
I think there are too many standards. Ea. Especially for, for starters, you know, for me, I think if we could introduce these ones, I am not trying to say there are standards that are less important than others, but for me, there are critical ones that we could start and then introduce these other ones, you know, gradually, when we think people have passed the critical ones. (LES-MOHSW3)

This desire for gradual implementation was raised as an important theme discussed in Chapter 4.

Observability

Accreditation is certainly measurable. Each participating hospital receives a score indicating how well they performed on the standards, and those scores are tracked over time. However, I did not find evidence that the visibility of accreditation elsewhere contributed to the adoption of accreditation in either country. A few people mentioned that they had the opportunity to tour accredited hospitals in South Africa, but these visits all happened after the decision to adopt accreditation had already been made, and only a small number of individuals were actually given the opportunity to go. Every time these visits were mentioned, the main focus was on how many more resources were available in these other institutions, as one nurse described:

I'm saying that we've toured, we've been exposed to some hospitals outside the country that have been accredited, uh, by the COHSASA standards. When you tour the department, like, at that time I was in the children's ward, when I toured the children's department, it was far, far, uh, how can I say it? It surpasses the standard of the SWAZI-MUL hospital children's ward. Eh, take for instance, when you go to, to that ward, children's ward, it has got a lot of nurses. I'm saying, the standards are okay provided we meet one, two, three. The one is that, um, in South Africa, they have got more resources, human resource.... So what I'm

4 "Ea" means "yes" in Sesotho (the local language of Lesotho).
saying is that these standards of COHSASA are okay with us except if you meet some of those points that are lacking. It’s a very good exercise, but then we have got to, to, to meet some of those barriers that will enable us to run COHSASA. (SWAZI-FG1)

National Histories and Perceptions: Findings for Redefining/Restructuring

Lesotho placed great emphasis on redefining accreditation to fit its needs and existing structure, both in terms of standards and process. The MCDI standards were sourced from Joint Commission International standards but went through an extensive technical review process to develop the final list. One MOHSW representative described the process:

So we had all these different committees, bringing in, drawing technical expertise from all these...looking at those standard by standard. Each standard, saying is this one relevant for Lesotho?...So it was a very detailed exercise sitting hours and hours through each and every standard, understanding: What does this mean? How can we define this? How do we define this in context of all the documentation that we already have? How are we going to be able to measure this? You know. It was a very detailed, detailed exercise. (LES-NG02)

The MCDI process, which involves external reviewers in most countries implementing accreditation programs, was also adapted to involve more of a peer review approach by neighboring hospital leaders to minimize costs and offer experiential learning that hospital leaders could apply to their own institutions. One Lesotho MOHSW representative described the benefits of this internal surveying process:

For one, it’s educational for the surveyors themselves as they go, I mean, that’s what we saw. As we go and assess somewhere and you find they are, they’re able to meet the standard you didn’t meet in your hospital, it’s an opportunity for you to see how they did that. And I think they did that. They were giving each other ideas as they were seeing better things in other hospitals. They were like, after the assessments, sitting down
informally to find out how did you manage to get this one. So I think it was useful. And secondly, cost-wise, it is, it wasn’t too costly compared to if we had to engage external surveyors, which would have to be paid more money than was given to the internal surveyors money. (LES-MOHSW2)

Lesotho attempted to similarly define COHSASA’s standards to better fit their needs. COHSASA described how implementation was delayed in Lesotho as a result of the desire to adapt the standards appropriately:

A1: What was interesting is it took longer to get started in Lesotho because they wanted, they said these are our standards, these are your standards. And we spent the first two years integrating those two sets of standards.
A2: They were very sort of specific in terms of how they wanted to do things.
A1: Mmm. I mean it was laborious to say the least, but -
A2: But...one of the things that we always try to achieve is ownership so we do, we do the best we can not to force anything on to people.
(COHSSASA)

Still, although a team from Lesotho got together with a team from COHSASA to review the standards and “literally sat and went through page by page” (COHSASA), COHSASA indicated, “the actual content of the standards has changed very little. It was more of the wording and the like.” In fact, COHSASA’s recognition as an international accrediting body by ISQua limits the amount of change they can make to their standards, as they described:

Q: How have you had to adapt the standards for this region?
A1: No, we haven’t adapted the standards.
Q: No.
A1: The standards, the standards meet ISQua principles. And that’s it. They have to, to meet the principles. Uh, we keep our standards, um, at a level that we believe is going to make hospitals safe and provide quality care and that’s through the ISQua principles. (COHSASA)
Swaziland’s changes to the COHSASA standards were much more minimal. Although MOH representatives discussed “customiz[ing] the COHSASA standards to the local situation,” (SWAZI-MOH) this focused on the decision to only incorporate the standards contained in 26 of the 38 broad service elements since the others (e.g. psychiatric care, nuclear medicine, social work) are not offered in Swaziland’s hospitals. Otherwise, the Ministry of Health understood that because the standards are international, “there’s nothing COHSASA can do” (SWAZI-MOH). But the MOH took a more relaxed approach in dealing with standards that it did not feel were appropriate by simply accepting that national policy and practice may not always agree with the accreditation standards. One MOH representative gave an example where national policy continues to deal with a national shortage of pharmacists by allowing trained nurses to prescribe even though COHSASA’s standards only permit pharmacists to prescribe:

A: ...like in our country, the nurses are in the clinics, the nurses are the ones who are consulting, prescribing, of which according to the international standards, nurses are not supposed to, so we tried to change that to suit our local situation. Yes.
Q: So according to the international standards, nurses aren’t supposed to prescribe?
A: Yes.
Q: ...So, the, um, they changed the, changed the standards to say that the nurses could prescribe?
A: ...It didn’t change much but we didn’t make it rigid because we know our local situation. We wanted it to have some flexibility in, you know, like if I’m a nurse, I’m, I have undergone a, even a short training on pharm, so that it can, it can allow those nurses to be able to, I mean, it can recognize that as a qualified somebody to work in pharmacy. (SWAZI-MOH)

Just as important as redefining the innovation to fit the structure of the implementing organization is restructuring the organization to better accommodate the
innovation. Lesotho and Swaziland each launched a Quality Assurance Unit (QAU) to support the implementation of accreditation. Unfortunately, in both cases, these units were very minimally resourced with three staff in Lesotho and one staff in Swaziland responsible for providing ongoing support to all health facilities in the country. The start-up operations of both QAUs were supported completely with donor funding.

National Perceptions: Findings for Clarifying

A few years into implementing accreditation at the time this study was conducted, both countries were in the midst of the clarifying stage of the innovation process and still in the process of developing their understanding of what hospital accreditation really means for their hospitals and for them. Not surprisingly then, responses were mixed. Although it is a bit premature to make any conclusions about the clarifying stage for either country at this time, there were some key themes that were clearly influencing the overall acceptance of accreditation by national leaders and hospital staff alike.

Both countries mentioned that they were going through the motions to satisfy external reviewers, but indicated a lack of real ownership, which is a major theme explored further in Chapters 3 and 4. One representative from an observing international organization described the experience assisting one hospital to meet the standards:

I think they were just, you know, like checking off the standards. Um, and making sure they had policies in place and they would write those policies, but did that mean they were implementing them? No, not really. Um, like we wrote a fire, fire policy and procedure manual with LES-MRL, but did they ever like practice it? If the fire actually happened, would they go to the policy? ((laughs)) Probably not. (LES-NGO1)
Even hospital staff, who were hopeful that hospital accreditation could help to improve the quality of care, admitted that it is not working that way now. One staff member talked about her hopes for accreditation in her institution:

A: In my opinion, I would, um, advocate that the administration, um, takes the accreditation survey as a tool for our day to day improvement. When we are accredited and some downfalls are found, they should try to make sure they do something about those. Yes.

Q: And right now, what do they do now?

A: Right now you have walls shiny and floors shiny only when the accreditation is going to be done. After the survey, the walls are dirty and the environment is just filthy to work in. (LES-GUS)

In Lesotho, under the MCDI model, lack of regular follow-up and support was frequently cited as a major reason for this apathy. One MOHSW representative lamented the slow progress resulting from the lack of resources directly related to meeting the standards and resources necessary to provide oversight and support of implementation efforts:

A: All [the QA Unit has] done is to go and then assess the facilities, introduce the assessment tools to them, you know, but we are unable to monitor and then empower them to improve. The accreditation survey brings out a lot of strengths and weaknesses, the weaknesses are highlighted. Some of them needs resource mobilization to improve, others need just internal arrangement of what they do, what is lacking, actually, is the follow up to empower them. You know, that is not happening here. And, uh, it’s sort of not giving, sending the right signals. We have not felt the impact significantly to say the truth. Because, uh, if you see the graphs of the first round of accreditation and the second round of accreditation, the improvement is rather slow in all their domains. It’s rather slow for maybe the various reasons that I enumerated: one, the concept is new, two we don’t have staff to embark on proper supervisory visits to do monitoring and evaluation all those things are not happening. Therefore, we wouldn’t expect the facilities to perform at their optimum as required. (LES-MOHSW4)
Although resources were certainly a major barrier to successful implementation in both countries, problems with acceptance of accreditation in Swaziland were often attributed to the fact that "outsiders" were responsible for introducing and implementing the program. One Swaziland NGO representative describes the "checkbox" mentality they see at hospitals:

All that happens is that "Oh, COHSASA's coming next week, please check if all of your controls are in place, your temperature charts, and..." I mean, I was working there, I had no idea who COHSASA was, they were just these people everyone would sort of pass in the corridor, "Please make sure you've got the red for the, the, the different wastes the, the different categories of wastes," and you know. And what they do, COHSASA doesn't educate. What they do is they come and they open your bin and they start going through your trash to see if it's the right waste in the right bin. That's what happened. (SWAZI-MOH4)

Another interviewee commented more directly on the resistance resulting from this externally driven innovation:

Well, um, I think part of the challenge is that this process itself is, is a challenge, obviously, was, was taken as an outside process they introduced into the country. And as such this (taking the?) approach of, uh, of dealing with, with issues, um, was not actually accepted very well in many of the facilities. Some of them accepted it, but some didn't. Okay? So, um, the impression given was that the, an outside process that is coming to bring a lot of work for us, you see?...So therefore, uh, there was some level, level of, of resistance, that one is true. (SWAZI-NGO2)

There were also plenty of positive perceptions of hospital accreditation making some specific improvements, setting expectations for care delivery, serving as a "reminder so that everybody can remember the type of work and the commitment that, yes, you have towards the patient care so to improve patient care" (SWAZI-MRL), and standardizing practices across hospitals. These are discussed in more depth in Chapter 3, but overall, the responses were very mixed with nearly every respondent reporting mixed
perceptions. Where they settle is likely to have a significant impact on whether or not the innovation becomes routinized.

DISCUSSION

Proposition 1: Institutional Theory Drives Expansion of Hospital Accreditation

Findings strongly support my first proposition that the decision of developing countries to introduce hospital accreditation is driven largely by external forces, though the extent to which external forces are a driver vary from country to country. Hospital accreditation is associated with providing good quality of care in the developed world and is strongly endorsed by key international players, particularly WHO and PEPFAR. However, data supports the claim in the 2003 ISQua and WHO report that development banks and foreign aid agencies are far more influential in the adoption of accreditation than policy or advocacy organizations alone. Although policy and program changes were enough to spur wealthy, middle-income, and better-resourced developing countries to adopt accreditation, adoption in resource-poor countries followed substantial donor support. Ultimately, it was this financial backing that swayed Swaziland to implement hospital accreditation and caused Lesotho to adopt a more internationally acceptable but more resource-intensive approach to hospital accreditation. Lesotho’s initial adoption of hospital accreditation appears to have been much more internally driven, but most of the required financial resources for start-up were still external donor resources.

There are three simple, compelling explanations for the special influence of these financial organizations in diffusing innovations to the developing world. First, it could
be assumed that these financial organizations do a better job of convincing countries of the importance of innovations, but this does not seem probable given the great sway of the WHO in many other situations. Second, developing countries are interested in and capable of implementing these innovations, but cannot afford the start-up costs and costs of risk if the program should fail. This is certainly a possibility and, if true, would be a good investment of donor resources. There was not strong evidence that this was the case in the adoption of hospital accreditation in Swaziland. In Lesotho, long-term interest in accreditation since it was first recommended by MCDI suggests that this may have been the case initially in Lesotho. However, their inability to invest additional resources to make their low-resource accreditation model successful long-term and their decision to adopt the COHSASA model for the additional resources associated with it suggests another explanation. Third, although low-income countries may see the value of an innovation, national resources are unlikely to be able to support implementation even if it is successful, but they may be able to benefit from implementation while external funding lasts. That this is even a possible explanation for the influence of external funding in the adoption of an innovation calls for greater scrutiny of funded innovations to make adaptations that are more likely to result in long-term sustainability of the innovations.

Both countries showed evidence that coercive and mimetic processes were at work in the diffusion of hospital accreditation, but data indicate that Lesotho was more resistant to these forces. Although the language used in both countries suggests that they hope to be more like successful peer organizations by implementing hospital accreditation, subtle differences indicated that Swaziland placed much greater emphasis
on wanting the approval of outsiders (focusing on international recognition) whereas Lesotho focused more on wanting to be as good as others (meeting universal standards). Lesotho invested considerable time and effort in the development of the localized MCDI accreditation program and took great pride in this fact. Even in transitioning to the COHSASA program, Lesotho was, at first, hesitant, and ultimately went to great lengths to integrate its own standards. Swaziland, on the other hand, was eager to adopt an internationally recognized program and took very little convincing to partner with COHSASA. This contrast between the two countries also reflects observed cultural differences. Lesotho, a country that was hit hard by massive retrenchments in South Africa, strives to operate independent of external support as much as possible. Swaziland, on the other hand, aims to make its markets more global and recognizes the value of and welcomes external aid to get through crises. These positions also agree with the study team's own observations of differences in reactions toward international partners, with greater receptivity and fewer barriers experienced in Swaziland. Although these differences likely influenced the rate of adoption and have important implications for the innovation process, this study shows that when the resources are provided, isomorphic change is difficult for low-income countries to resist.

**Proposition 2: Isomorphism Affects Innovation Process**

Data from this study also supported my second proposition that there are, in fact, important implications for the innovation process as a result of the fact that hospital accreditation in the developing world is being driven by external forces. Comparisons
between Swaziland and Lesotho and between Lesotho’s MCDI and COHSASA programs highlight how external push affects each stage of the innovation process.

**Agenda-Setting**

During the agenda-setting stage, the purpose of accreditation was clearer with less external push. National leaders and hospital staff alike understood that Lesotho’s MCDI accreditation program was intended to measure quality of care for purposes of accountability whereas only about half of the national leaders and no hospital staff felt that they understood the reasons for implementing the COHSASA program. National leaders and hospital staff throughout Swaziland, with one exception, made guesses about motivations for adopting accreditation but were uncertain about what ultimately triggered the decision to adopt accreditation.

It is impossible to ignore the irony in Lesotho’s decision to implement the COHSASA program: the national lack of resources to implement a very basic accreditation program prompted the adoption of a much more resource-intensive program. Concerns for long-term sustainability may have resulted in greater consideration of alternatives such as that suggested by one interviewee that it would have been preferable to use COHSASA’s facilitation expertise to buttress their existing accreditation program.
Matching

Diffusion of innovations theory gives a great deal of credit to the perceived attributes of an innovation for influencing the adoption of innovations. But in this case, it appears that the decision to adopt depended very little on any consideration of hospital accreditation’s attributes. Those encouraging accreditation’s adoption did not promote this type of evaluation of the merit of accreditation during the matching stage despite extensive research raising questions about the benefits of hospital accreditation in both developed and developing countries. This raises questions about the responsibility of international organizations to offer a process of informed decision-making to those targeted for spread of an innovation. And a process of truly informed decision-making should consider not only relative advantage as established from the experiences of others along with alternatives besides “doing nothing,” but it should uniquely consider the other key attributes (complexity, compatibility, trialability, and observability) as they are likely to be perceived in the specific context considering adoption. This process is as important to the decision to adopt an innovation as it is to helping to determine any necessary steps that should be taken in the redefining/restructuring stage of the innovation process.

Redefining/Restructuring

Less external push resulted in greater redefining of the innovation. Lesotho’s MCDI program was the most customized to fit Lesotho’s situation. Study participants described MCDI’s program as less complex and more compatible with Lesotho than the COHSASA program. Swaziland, on the other hand, largely accepted the COHSASA
program with little modification, but participants communicated challenges experienced with the complexity and compatibility of the program. This redefining/restructuring stage, with information collected during the matching stage, is critical to successful assimilation of the innovation and is most likely to be overlooked as a result of isomorphic influences where emphasis on legitimacy (e.g. the importance of ISQua approval) can place limits on the amount of redefinition that is possible.

Neither country did much restructuring, and the restructuring that did take place was driven and funded by external sources. The fact that these new structures were funded by outsiders raises questions about the likely permanence of these structures after funding goes away, even if these structures are relatively modest ones.

Clarifying

Although both countries were still in the midst of the clarifying stage of the innovation process, findings suggest that an external push created challenges to user acceptance of hospital accreditation by compromising their sense of ownership. On the other hand, external support resulted in more regular exposure and continuous review and oversight in Swaziland that was lacking in Lesotho. These findings mirror Greenhalgh’s description of the mixed effects of external motivation on the diffusion of innovations: that an external push can facilitate success in the early stages, often through the provision of resources, but it does not increase the organization’s readiness or capacity to implement the innovation, and it can move organizations away from locally driven solutions.
Routinizing

The likelihood that the innovation will be routinized will depend on the extent to which there is a clear purpose for an innovation, there has been careful consideration of the qualities of the innovation, there have been adaptations made to maximize the fit of the innovation, and there are largely positive perceptions around what the innovation means for the user. Even if the innovation does not go away, users who continue to implement the innovation only because it helps to establish legitimacy, will not gain the maximum value intended from implementation.

CONCLUSION

There is considerable evidence that institutional theory helps to explain the diffusion of hospital accreditation into the developing world, and it is likely that institutional theory can help to explain the diffusion of many other innovations into the developing world that originate in developed countries. The extent to which institutional theory is a factor varies from country to country, and the innovation process is more likely to be compromised where institutional theory is a stronger driver for adoption. But the innovation process is still important to true assimilation of the innovation, and great attention should be paid to this process to maximize the likelihood of sustainability – even more so when isomorphic mechanisms are at work. These isomorphic innovations may be presented as opportunities, rather than sought after as solutions to clearly defined problems. But these innovations should still be (1) evaluated for how well they match the specific circumstances and context, then, if adopted, (2) redefined to appropriately suit
the circumstances and context and enhance their perceived attributes, and finally, (3) adjusted to be strengthened as needed to address any concerns raised into implementation. There are considerable cultural and resource differences that should not be overlooked in transferring an innovation from the developed to the developing world.

I would like to believe that it is useful for national leaders to understand this so that they may more readily identify isomorphic innovations and pay particular attention to the innovation process in these instances to minimize the risks inherent in adopting such innovations. However, the experiences of introducing hospital accreditation into Lesotho and Swaziland have established that these low-income countries may not have sufficient influence to determine the direction of innovations being promoted by external organizations. The onus, then, is on the international community of policy-makers, funders, and partners to ensure appropriate translation of innovations as they diffuse from the developed to developing world. Only time will tell if the accreditation programs in Lesotho and Swaziland are sustained long-term. But this study, together with the studies presented in the next two chapters, offer a comprehensive look at how accreditation programs can be most effective for and successfully assimilated into developing countries like Lesotho and Swaziland.
CHAPTER 3: THE NATIONAL PERSPECTIVE

Connecting hospital accreditation with other quality improvement efforts in the developing world: Lessons from two Southern African countries

INTRODUCTION

The attention of the WHO and other international development partners has been expanding from their traditional focus on particular health conditions (e.g. HIV/AIDS, TB, malaria, mental health) and more isolated aspects of health system operations (e.g. supply chain logistics, information technology) to a broader, more holistic emphasis on “health systems strengthening” (WHO, 2007). A variety of quality improvement methods have been continuously developed, applied and refined as part of standard health care practice in the developed world, but efforts to apply these same methods in the developing world have been piece-meal and sporadic (Leatherman, Ferris, Berwick, Omaswa & Crisp, 2010). Hospital accreditation is becoming increasingly popular as an approach to strengthen health systems in developing countries (Durand, 2009).

Hospital accreditation is “the systematic assessment of hospitals against explicit standards” (ISQua & WHO, 2003, p. 58). There is little doubt that accreditation historically has played an important role in standardizing the structure and process of care, which at the very least, serves to identify and correct areas of potential organizational risk (Scrivens, 1997). Accreditation scores are also commonly perceived to indicate the quality and safety of the care being delivered, and there is certainly a strong theoretical and logical argument to support the likelihood of affecting outcomes by
manipulating structure and process. The most well-known is Donabedian’s tripartite model that includes structure, process, and outcomes as integral and interrelated elements of quality (Donabedian, 1980). This model is often used as the rationale behind the importance of accreditation: by strengthening health care structures and processes, clinical outcomes will improve. However, the association between accreditation and the quality of clinical care has repeatedly failed to be demonstrated (Griffith, Knutzen, & Alexander, 2002; Hadley & McGurrrin 1988; Hopkins, 1995; Joshi, 2003; McGurrrin & Hadley, 1991; Miller et al, 2005; Tokarski, 1990a; Tokarski, 1990b). Despite the logical connection between structures, processes, and outcomes, the interactions between these three facets of health care are much more complex in practice. In Donabedian’s own words on the lack of clear evidence of the association, “Clearly, the relationships between process and outcome, and between structure and both process and outcome, are not fully understood” (Donabedian, 2005, p. 713).

Accreditation is believed by many to be a means of improving quality of patient care in the developing world. However, there are no known studies to date that show that accreditation actually improves patient outcomes, though attempts have been rare and inadequate. For instance, the Quality Assurance Project conducted the only randomized controlled trial of accreditation when it randomly assigned hospitals in South Africa’s KwaZulu-Natal province to intervention and control groups to measure the impact of accreditation on performance. Two years later, they showed that the intervention group far exceeded the control group in compliance with the accreditation standards, but they failed to demonstrate any association between accreditation and patient health outcomes.
although not necessarily from a lack of association but because of a poor study design (Salmon et al., 2003).

Certainly, one could make the argument that hospital accreditation, which focuses on changing whole hospital and, in some cases, health systems, is more aligned with the shift towards whole health systems strengthening and has the potential to have more widespread impact than many other quality improvement approaches that have been used (Durand, 2009). Overall, though, the evidence base supporting hospital accreditation is lacking. A 2008 literature review by Greenfield and Braithwaite on accreditation revealed only 66 research studies and these reported inconsistent findings on the effectiveness of accreditation (Greenfield & Braithwaite, 2008). Case studies and attitudinal data collected at the individual setting in developed countries have reported many benefits of accreditation, which include enhancing patient safety, ensuring provider competency, stimulating quality improvement, increasing reputation among users, promoting capacity and organizational development, and providing a framework that leads to improving operational effectiveness and patient outcomes (Nicklin & Dickson, 2008). However, very few studies have explored the extent to which hospital accreditation is improving quality of care in low-resource countries.

Few would argue that hospital accreditation is the magic bullet that will solve all the problems of developing world health systems. Even the Joint Commission, responsible for the majority of hospital accreditation in the United States, recognizes the need for quality improvement approaches beyond hospital accreditation (Colton, 2000). Indeed, in the developed world, hospital accreditation, other quality assurance
approaches, and quality improvement methods have historically gone hand-in-hand. It seems a popular model to order these approaches into a hierarchy with more foundational methods at the bottom that must be satisfied before more sophisticated processes can be implemented. Interestingly, some place accreditation at the foundation of the hierarchy, noting its role in assuring basic operations (Durand, 2009), while others place accreditation at the top of the hierarchy, pointing to the expense and effort necessary to support and sustain such a program that could be invested differently to realize more lives saved (Øvretveit, 2002).

In any case, most would agree that there is need for the implementation of other quality assurance and quality improvement methods in developing countries beyond hospital accreditation (Øvretveit, 2002; WHO, 2007). But little is known about how hospital accreditation is connected to other quality improvement efforts in the developing world. This qualitative study conducted in two Southern African countries explores the “national” level questions first described in Chapter 1: (1) What is the perceived connection between hospital accreditation and other quality improvement efforts and (2) What are the effects of any perceived connection between accreditation and QI?

METHODS

Qualitative methods were used to facilitate a broad and deep exploration of the proposed research questions. Data was drawn from interviews, focus groups, and direct observations. Data was collected and analyzed using grounded theory approaches (Charmaz, 2006) with the aim of answering the broad research questions of interest.
without being constrained by any specific hypotheses given the lack of prior research in this area. This approach facilitates adherence to an inductive, objectivist study of this issue that avoids imposing non-validated assumptions on an understudied subject in order to identify important concepts that are grounded in reality (Patton, 2002).

Case Selection and Study Setting

Chapter 1 describes in detail the rationale for selecting the Southern Africa region and Lesotho and Swaziland specifically. Lesotho and Swaziland represent an interesting dichotomy with Lesotho’s locally developed, less resource-intensive approach and Swaziland’s internationally recognized, resource-intensive, COHSASA-led system for accreditation. The fact that Lesotho was beginning to pilot the COHSASA program in a few of its hospitals at the time of data collection afforded the unique opportunity to contrast the two approaches within as well as between countries.

The study described in Chapter 1 found that neither Lesotho nor Swaziland were engaged at a national level in other quality assurance and quality improvement activities beyond hospital accreditation. Because of the dearth of published literature on the quality assurance and quality improvement activities in developing countries, the extent to which Swaziland and Lesotho are representative of the other countries in the South Africa region is unclear. However, with the exception of South Africa, it is unlikely that other countries have robust quality programs that are very different from what is present in Swaziland and Lesotho.
Data Collection

Data was collected between May 2010 and October 2010 with fieldwork in Lesotho, Swaziland, and South Africa over five weeks during the period May-June 2010. Institutional Review Board approval was received from Boston University Medical Center. Ethical approvals were also provided by the Lesotho MOHSW and the Kingdom of Swaziland MOH. Data sources include interviews with key informants, focus groups with hospital staff, and direct observations taken from field notes.

Interviews

As described in detail in Chapter 2, a total of 13 interviews were conducted with the breakdown by country and key informant type indicated in Table 3.1.

<table>
<thead>
<tr>
<th>National Level</th>
<th>Other Key Informants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lesotho</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Swaziland</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>COHSASA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I led all 13 interviews and a second researcher was present for 10 of the interviews. Verbal informed consent was obtained from each participant, and all interviews were audio-recorded with permission from the interviewee. Details on the interview guide (see Appendix A) and interview and transcription process are presented in Chapter 2. It is important to note here, though, that a grounded theory approach was used, which resulted in the slight evolution of interview questions with each progressive interview to explore key themes as they emerged.
Table 3.3. Mix of key attributes by hospital for Government vs. Mission, urban vs. rural, and large vs. small. Codes for each hospital are used to indicate the source hospital for focus group data presented throughout the study.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Code</th>
<th>Govt</th>
<th>Mission</th>
<th>Urban</th>
<th>Rural</th>
<th>Large</th>
<th>Small</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lesotho Hospital A</td>
<td>LES-GUL</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Lesotho Hospital B</td>
<td>LES-GUS</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lesotho Hospital C</td>
<td>LES-MRL</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Lesotho Hospital D</td>
<td>LES-MRS</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Swaziland Hospital E</td>
<td>SWAZI-GRS</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Swaziland Hospital F</td>
<td>SWAZI-MUL</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Swaziland Hospital G</td>
<td>SWAZI-MRL</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Direct Observations

Although direct observations were not part of the formal data collection plan, they did serve as an important source for triangulation of data and identifying themes that were explored further in formal interviews and focus groups. Many of the informal, off-record conversations had during the 2010 data collection period influenced the direction of future interview questions or served to confirm or challenge collected data. These conversations were captured in detailed field notes, which were recorded no less than four times per week throughout the course of the 2010 data collection period.
Data analysis

This study used a grounded theory approach in conducting and analyzing interviews and focus groups (Charmaz, 2006). The identification of key themes in early interviews and focus groups influenced the direction of later interviews. Both interviewers discussed their thoughts after every interview and focus group as well as following key informal discussions, and these conversations were recorded and later transcribed. As key themes were identified in these conversations, a field note was written to document the rationale behind the importance of exploring this theme further. Earlier interviews and focus groups (largely those from Lesotho) also had the benefit of being transcribed during the course of the data collection, so key themes that were identified to explore further during transcription were also recorded and contributed to future interviews and focus groups.

Analysis of transcripts from interviews and focus groups started with manual open coding on one interview and one focus group, which both interviewers agreed contained rich data. I did line-by-line coding that identified key words and phrases from the text. From these, I identified a list of 24 “codes” or headings under which to group the key words and phrases. The marked transcripts and 24 codes were then discussed with two senior researchers, which resulted in further dividing, combining, and renaming of codes to produce a list of 20 codes. These formed my starting code list in HyperResearch, which was used to facilitate coding and management of the data. The first two transcripts were re-coded in HyperResearch using the revised code list and two additional interviews were coded. Data that did not fit into the original code list were
highlighted and discussed with senior researchers and additional codes were developed or existing codes and code definitions were revised as necessary. As new codes were added, already coded interviews were reviewed and re-coded for any data that would fall under new or revised codes. The use of this constant comparative method continued for several more iterations until about two-thirds of the interviews and focus groups had been coded and a final list of 32 codes had been generated that reflected all key concepts emerging from the data (see Appendix B for full codebook, including code definitions). Multiple codes may apply to a single piece of data.

Analysis of relationships between codes started by exploring the appropriateness of specific processes and structures of accreditation being implemented in Lesotho and Swaziland (the focus of Chapter 4), but the importance of the role of accreditation in connection with the broader picture of quality assurance and quality improvement emerged. Codes were analyzed by sorting and arranging data under similar themes to identify the key ways that accreditation is setting the tone for other quality efforts, and 19 of the 32 codes contained data that contributed to the identification of six prominent themes. Due to both the heterogeneity and the amount of data coded into two of these codes (changing delivery practices and inadequate resources), sets of sub-codes were developed for each to facilitate more detailed analysis and comparisons between the two countries. After key themes were identified, the analysis focused specifically on looking for variation within each theme and similarities and differences between countries.
Yeah, presently, um, we are more engaged with only accreditation of the health facilities, but quality assurance, it goes beyond that....Probably if we are about to have a national quality assurance policy we don't even have one. Okay, so we assume after the development of the national quality assurance policy and strategic plan, the appropriate HR for [the Quality Assurance] office, the terms of reference for this office, the resource allocation in terms of finance, all those things will be defined and then the scope of work of the quality assurance office will also be defined in the national policy. Then it will give us essential direction and vision. But as of now we are strictly limited to, uh, enforcing the use of the standards to strengthen the service delivery. (LES-MOHSW4)

At the time data was collected, the focus of Swaziland's national QAU was similarly limited to overseeing implementation of hospital accreditation standards, but was working on a national QA strategic plan that would include a broader scope.

Quality programs rarely go beyond accreditation

Other national leaders and hospital staff confirmed that there is very little activity related to quality assurance or quality improvement that is not directly related to the accreditation program. National leaders were asked directly about any other quality improvement or quality assurance activities nationally or at the hospital level. Responses included: "I don't think so," "I'm not sure," and "like what?" A couple respondents mentioned specific activities that one could certainly argue are geared towards improving the quality of health care services, but are not traditionally thought of as QA/QI activities, such as the introduction of a new national referral hospital under a private-public partnership in Lesotho. There was some mention at the national level and the hospital level about the expectation set in the standards for hospital development of QI projects, but all of the projects mentioned have been aimed at working towards correcting
deficiencies in the accreditation standards. A representative from one Lesotho-based NGO talked about the receptivity of hospital staff towards quality improvement and the challenges faced in trying to assist the hospitals in meeting the accreditation standards:

There's more buy-in for the quality improvement efforts instead of the accreditation, trying to meet the accreditation standards. We're trying to work with them on accreditation, they just, we would not take a part in it because they didn't find it really important. But we learned all the, you know, going through and telling them, okay, what are, what do we actually want to improve. Um, and how do we work through that process ourselves. It was, there was more buy-in for that. (LES-NGOI)

But other than the work of this particular NGO implementing a management strengthening program in four Lesotho hospitals and one NGO in Swaziland implementing their Leadership Development Program, no other programs were focused on improvement of operations hospital-wide at the time data was collected.

Quality concepts introduced through accreditation

The accreditation programs in both countries are emphasizing several concepts that are fundamental components of any quality assurance or quality improvement effort. For instance, some staff recognize the benefits of standardization. One laboratory technician in Lesotho pointed this out:

And one of the good things that is, like, uh, each other alike in this way. For instance, if I can go from HOSPITAL A to work in HOSPITAL B, I'll not have difficulty because the standards are uniform, like uniformity; all the labs are all uniform. (LES-MUL)

Concepts of patient safety and efficiency were also highlighted by hospital staff:

Q: What are some specific examples of ways that it's helped to improve your work here?
A1: It's safety.
A2: Yeah, one, okay. I was just about to say that. She said it before me. yeah, it's going to help us a lot, especially in safety, I think we have been somehow negligent in some of the things and it's helping us. Safety's number one...

A1: As far as that, I'll say I think our big, accreditation helps in efficiency, some of the things that, like he mentioned recording. The, it's good to know that when you're looking for something, you'll find it and where.

(LES-MRL)

Aside from accreditation, any efforts that discussed the importance of patient safety were in relation to specific HIV/AIDS policies and practices that were believed to help promote patient safety, but several staff discussed the effects or potential effects of accreditation on patient safety. COHSASA actually takes a very deliberate approach to coupling quality assurance with patient safety, “attempting to integrate patient safety monitoring, adverse event monitoring, as part of our accreditation program” (COHSASA). And improving “efficiency” was understood by most participants to relate to the need to work harder in order to accommodate the shortage of human resources. The earlier excerpt is the only mention of efficiency in relation to care processes with most talking about it as a “staff efficiency problem.”

Overall, in both Lesotho and Swaziland, national leaders and hospitals staff viewed the concepts of quality assurance and quality improvement as very closely associated with the national accreditation programs in both countries. This is made quite evident by the way that national leaders and hospital staff alike use the terms “accreditation” and “quality” interchangeably. Accreditation was often referred to in both countries as “the quality thing” or “the quality introduction,” and respondents would talk about “meeting quality” when talking about meeting the accreditation standards. The introduction of accreditation has changed the language such that “accreditation” and
“quality” are synonymous. In Swaziland, “the COHSASA thing” is also used as a substitute term. In an informal conversation, one Swaziland hospital administrator raised her concerns that this interchangeable language was resulting in hospital staff projecting negative feelings they might associate with accreditation or COHSASA towards “quality” more generally. One Swaziland MOH representative described this phenomenon as a challenge, “There’s also issues of acceptability. Most people, they don’t like quality because they think it’s policing, so it’s, it, was not well received in the facilities, especially when we were starting” (SWAZI-MOH). This highlights that there are important effects of this close, synonymous connection between quality and accreditation.

**Effects of perceived connection between hospital accreditation and QI efforts**

The presentation of findings in the previous section establishes that hospital accreditation is the first encounter of health professionals in Lesotho and Swaziland with systematic quality assurance or quality improvement. This next section builds off of those findings in exploring how the implementation of hospital accreditation is shaping the way that the national health systems and health professionals in two Southern African countries view quality improvement. Analysis of data uncovered six key themes that highlight both the benefits and the risks of conflating hospital accreditation with broader quality improvement, which will likely impact the implementation of other quality improvement approaches going forward. These six key themes include: (1) bringing attention to quality practices, (2) giving direction on how to maximize quality of care, (3)
providing oversight, (4) changing structures and processes of care, (5) affecting sense of ownership over quality efforts, and (6) influencing the perceived feasibility of achieving quality care. The first four themes describe staff perceptions about how hospital accreditation, and other quality efforts by extension, are able to impact the quality of care. The last two themes describe how staff experiences in implementing hospital accreditation are shaping staff perceptions toward their role in improving the quality of care. Table 3.4 below shows the codes that contributed to each of the six themes. The shaded column describes findings from the previous section.

**Table 3.4. List of 19 major codes reflecting key concepts that emerged from interview and focus group data.**

<table>
<thead>
<tr>
<th>Accountability</th>
<th>Accreditation synonymous with quality</th>
<th>Bringing attention to quality practices</th>
<th>Giving direction how to maximize quality of care</th>
<th>Providing oversight</th>
<th>Changing structures and processes of care</th>
<th>Affecting sense of ownership over quality efforts</th>
<th>Influencing perceived feasibility of achieving quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountability</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accreditation synonymous with quality</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changing delivery practices</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changing perceptions of accreditation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty changing established practice</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Futility of the effort</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Importance of measurement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Inadequate resources</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Locus of responsibility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need for quality care</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative views on accreditation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Other quality improvement</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ours vs. theirs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Performance towards meeting standards</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Policing and criticizing-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Bringing attention to quality practices

At the most basic level, everyone agrees that the introduction of an accreditation program has helped to bring attention to health care professionals about their responsibilities as providers of patient care, and staff and national leaders alike view this as an effective start to improving the quality of care. For a few hospital staff, they are learning new information about the proper way to provide care. This was the case for one staff member in a Swaziland hospital: "...I would say it's a very good exercise because it has, um, it has put us in, in a better position in terms of health, in terms of understanding actually what are we supposed to do and the right thing" (SWAZI-GRS).

For most hospital staff and national leaders in both countries, though, accreditation did not offer any new knowledge. However, it still served as a "reminder" to "what they're supposed to do," and there is wide agreement that this refresher on information originally learned in school was helpful in producing real change, at least for those who were interested in making improvements as participants in both Lesotho and
Swaziland described:

I don’t know, but I think it has made people, I think, to some extent it has reshaped people’s thinking. Because the standards, it’s not like they’re introducing anything new. I mean, physicians have been taught how to do things but due to circumstances like a lot of patients and whatever, you find probably they ignore some of the things, but introduction of the accreditation, it’s like a reminder that you still have to do things the right way….It did somehow really affect their way of thinking and their way of doing things for those that really wanted to, to get there. (LES-MOHSW2)

We all sign the code of conduct, which you actually put in their cupboard (group laughs)), but it all brings you back to a way we are supposed to conduct ourselves when we are managing the patients. We’re supposed to be nice, empathetic, you know, you know, everything. So code of conduct is good and COHSASA is bringing you back to say you have signed for this, do it diligently. (SWAZI-MRL)

These two descriptions show that accreditation is reminding staff of both the technical and relational aspects of care. Providers are reminded of steps in the process of providing care to patients and also of the commitment they made to act appropriately upon first becoming a health care professional.

This second quote also suggests that there is a sense of renewal that is associated with “bringing you back” to that initial commitment to the patient. Some indicated that “maybe it’s psychological.” The introduction of accreditation was motivation for some to work harder towards providing “better care.” As one hospital staff member in Swaziland put it, “…much of it is beneficial because it sort of rejuvenates us from what we already know, so we get the pep up” (SWAZI-GRS).

Giving direction on how to maximize quality of care

Part of this rejuvenation may come from the way that accreditation has provided
staff with feedback about performance, specific goals, and resources that have helped to provide guidance about how best to work in order to maximize the quality of patient care. COHSASA called it “a blueprint for excellent practice” and described how accreditation provided staff with a sense of direction:

I think what they saw is there was a lot of activity happening at Ministry level but it wasn’t getting into the actual health services, so I think the motivation was to give people something to aim at to help. So there’s, accreditation is your goal and here’s a method that’s worked. And the, all the work that had been done before, sort of piecemeal, whereas this was a coordinated program with an overall target of something to achieve, um, of going for accreditation. And that’s very motivating. (COHSASA)

National leaders and hospital staff in both countries discussed how the accreditation programs offered an approach that is helpful for directing their work. As one staff member described:

Actually, actually, um, the standards themselves, they’re quite excellent because it’s like, also, all our lives we’ve been pursuing patient care. And, uh, we have been using, maybe say, different models, but now with these new models, it’s like kind of like, they are bringing this quality in a different shape, maybe a much easier way of doing things. (SWAZI-MUL)

By providing a prescriptive process with a clear goal that is endorsed nationally, hospital staff feel that they have something definitive to works towards. One hospital staff member in Swaziland described specific ways that efforts to meet accreditation standards have provided better direction in their day-to-day work in everything from learning new clinical practices to knowing what to do in the case of a disaster or fire:

…before we didn’t have any direction but now we know where we are going. We’re having the strategic plan, we’re having clear laid objectives for in-services where we are taught so many different things and also do some up-keeping of some other things which we even learned from school, but now we’re clear like, uh, disaster management, we’re having the strategic plan, we’re having fire, fire plan, we’re having management
and we are, we are just clear, and we know by the year 2013 what we are expecting SWAZI-MUL to do. (SWAZI-MUL)

But even without strategic and operational plans, continuous measurement of key areas along with regular reports of progress in those areas has helped to provide direction and motivation to hospital staff. Two hospital staff in Lesotho described the value of these regular reports in understanding what needs to be done to close any performance gaps and in offering tangible results that can motivate the desire to make improvements in other areas:

...it's always a way of making us improve. Because it's like a mirror having you reflect where you are and keeps you where you, you want to go. So a lot is still yet to be done, but, but at least we know where we are and we know where we are going to be. (LES-MRS)

And also I feel as they boost the morale of, of, of the staff. Like we have had some [standards] unmet. When I told [the staff] now they are met, they, you know they want to find something and improve, improve, improvement. (LES-MRL)

National leaders and hospital staff in both countries describe how continuous monitoring and feedback also helps hospital management direct their resources more appropriately. Funds are being prioritized for the equipment and staffing shortages that have been noted in accreditation reviews in hopes of meeting the standards. In some instances, these are needs that have been communicated by staff to hospital management, but were disregarded until accreditation helped to validate the importance of the need. One laboratory technician in Lesotho gave an example of this where previous requests for an air conditioner were viewed as a luxury for staff rather than a necessity for proper operation of laboratory equipment:
...sometimes, the past, we would, uh, request, like let me make an example of an air conditioner...somebody who will do, who is requested to buy those things for us would think we just, it's for our comfort and yet not. We discovered that, uh, for accreditation, we must have an air conditioner because the machines run at an optimum temperature. If it's too cold, the machines don't work properly. If it's too hot, they don't work properly. In other words, they won't, there used to be a lot of breakdowns. Now because of accreditation when they talk, we won't be accredited because our results might be wrong in the laboratory, so should I say, the business office woke up now and they bought, uh, uh, an air con....In other words, if I said it myself, it wasn't very serious, but when accreditation requires it, then they saw the seriousness of it ("Mm hmmm from others in the group"). then they bought it. (LES-MRL)

The accreditation programs also helped to direct national priorities, particularly in terms of requests for assistance from international partners. In the case of CHAL, "they tried as much as possible to ensure that whatever request they sent to the IrishAID is aligned to the gaps identified by the accreditation assessment" (LES-MOHSHW2). In Swaziland, early results from the accreditation assessment prompted the Ministry of Health to seek out assistance from a WHO consultant to advise them on strengthening their radiation services, and they formed a directorate, which "will then have total control in ensuring that the standards, the safety standards for radiation are actually adhered to" (SWAZI-NGO1). By setting clearly defined priorities and measurable objectives, accreditation has helped to make quality something that can be defined and achieved.

Providing oversight

The accreditation programs also provided a system for oversight in order to promote actions and behaviors necessary to meet standards. In some cases, this was viewed as much needed accountability to help motivate the pursuit of improving the
quality areas identified as priorities by accreditation and was thought to be effective at keeping staff on task. In other cases, the additional oversight was viewed as “policing” and ineffective at promoting sustained change.

One hospital staff member described the importance of accountability for promoting positive behaviors:

And also sometimes not know-, not knowing that someone would like to check you, makes you to relax and feel comfortable in your zone, but knowing that somebody might require something makes you to be on your feet, to feel challenged, and be motivated to do the level best. (LES-MRL)

As one participant put it, “...people do what you inspect, not what you expect” (SWAZI-NGO2). Particularly in Lesotho, where follow up visits for accreditation were scheduled to occur yearly, people complained that there was not enough oversight. One representative from the Lesotho MOHSW admitted that the amount of oversight and support was inadequate to bring about real change:

You don’t only assess and sit back and expect them to improve. You assess and you do monitoring and evaluation, give them proper supervisory support for them to improve on their deficiencies. Presently, that is not happening adequately so you can’t expect them to improve, you can’t expect only two officers to run quality accreditation, quality assurance for the whole country. So these are the challenges. You know, so facilities will fail some through no fault of theirs. It’s the system itself that we need to look at to improve where we have to improve in order to be able to assess them. (LES-MOHSW4)

Other hospital staff offered many descriptions of the temporary nature of any improvements resulting from accreditation assessments indicating that oversight is ineffective at promoting sustained behavior change. One staff member complained, “Right now you have walls shiny and floors shiny only when the accreditation is going to be done. After the survey, the walls are dirty and the environment is just filthy to work
in” (LES-GUS). But this same staff member and many others recognize that the accreditation survey should be “a tool for our day to day improvement” (LES-GUS).

Although this relapse phenomenon was not mentioned as frequently in Swaziland where follow-up visits were scheduled every six to ten weeks, at least one hospital indicated that it was a problem, particularly in thinking about long-term sustainability:

Because what I have observed in the past is that after COHSASA has come, it's like everything goes back to normal, but when we hear that they are coming - ((shakes head; laughter and murmuring from all)) so that when they come, they find that everything is, is better. So I’m honestly concerned in that aspect because I know there will come a time where they will go and never come back again. (SWAZI-GRS)

Receiving too much oversight was a much more common concern among Swaziland leaders and staff, who indicated that the assessments were “too investigative.” COHSASA staff were described as “more like inspectors...to check what are you doing wrong” (SWAZI-MOH4) and “external police coming to police the normal work of the people” (SWAZI-NGO1). One Swaziland MOH representative described her experiences accompanying COHSASA on follow-up visits:

Even now, it's two years down the line, it's not even two years now, it's four years, but still, the facilities to them, when you come, it's like you are here to police them.... They don't look at it as like you are coming to help them to improve on the service. They are, they think you are here to corr-, I mean, to criticize them, yet we are saying, no, we are not criticizing you. We are helping you to do better. Mmm. (SWAZI-MOH)

This representative from the Swaziland MOH highlights the tension created by having to balance the need for accountability and support with sensitivities around receiving criticism that are all too common in the implementation of quality improvement programs.
Changing structures and processes of care

This research was not intended to study the effects of accreditation on the structures, processes, or patient outcomes of health care, yet these aspects of health care were discussed in every interview and focus group discussion. Findings showed that perceptions about the extent to which these “quality efforts” have had a direct impact on the quality of care were especially important. In terms of making direct improvements to health care delivery structures and processes, the perceived impact of accreditation was similar in both countries with only a few notable differences. Due to the importance of these, details of all direct improvements mentioned are noted here.

Both countries emphasized improvements in documenting information in patient medical records and medical record filing systems more than any other changes. Many staff indicated that proper patient care and education was being delivered despite poor documentation of the work, but some described ways that patient care has improved as a result of better documentation. One nurse described how proper documentation of the progression of labor has improved care:

Again, in this, this labor, Lesotho Obstetric Record, in labor ward, we have greatly tried to be filling the partograph, and we have observed that with the proper filling of the partogram, we really are able to see the progress of labor in this patient rather than just observing and just checking on ourselves. But with your – great – we are, we are, we are really documenting correctly, we are now able to see this lady has been in labor for quite some time because during admission, there was a time that was written that she came in labor ward at a certain time. Rather, when there was no time there, you find the lady in labor and you were thinking, maybe she just got in when actually she has been there for quite some time. So it has really improved in our, in our care, these people who are being helped. Yes. (LES-MRS)
Increases in availability of necessary equipment and supplies were mentioned frequently by Lesotho hospital staff (e.g. protective clothing for patients and staff in x-ray, emergency trolleys, BP machines, linens, appropriately colored plastic waste bags and bins), but it is worth noting that lack of equipment and supplies were noted more than any other factor as a barrier to achieving accreditation. In fact, the lack of necessary equipment and supplies was mentioned nearly three times more frequently than improvements in availability of equipment and supplies. Hospital staff in Swaziland also mentioned some improvements in equipment and supplies (resuscitation trolleys, chairs in patient waiting areas, and fire blanket in the kitchen), but not as often as staff in Lesotho. Similar to staff in Lesotho, limitations in equipment and supplies were mentioned four times more frequently than improvements.

There were not many instances of direct improvements to patient care processes mentioned in either country, but the few improvements discussed were often noted repeatedly. In Lesotho, improvements in the pharmacy were mentioned more than any other, which included reductions in drug stock-outs, expired drugs, and patient waiting time, and more supervisory visits from hospitals to health centers. Reductions in laboratory turnaround times, enhanced triaging in the outpatient department, and availability of the necessary bins for proper waste disposal throughout the hospital were also discussed. In Swaziland, the greatest emphasis was on overall reductions in the length of time patients spend at the hospital, particularly emphasizing patients receiving outpatient services. As in Lesotho, Swaziland hospital staff also mentioned enhanced triaging in the outpatient department and availability of the necessary bins for proper
waste disposal. Although only mentioned one time, other noteworthy improvements were: the availability of chairs for patients in the pharmacy waiting area, improved decontamination of instruments in the operating theatre, and increased follow-up with TB patients to reduce patient loss to follow-up.

Another improvement frequently mentioned in Swaziland was the recognition and communication of “patient and family rights” through the posting and discussion of the patient and family rights charter, the proper introduction of care providers to patients, and the production of informational pamphlets for patients. Swaziland participants also mentioned the creation of opportunities to solicit and respond to patient input through suggestion boxes and the identification of a customer care officer at each hospital. There were also several hospital staff and national leaders who indicated that there have been improvements to patient satisfaction. In Lesotho, there were a few mentions of the patient bill of rights, but overall, improvements to patient rights, patient input, or patient satisfaction were not important themes.

Both Lesotho and Swaziland also mentioned improvements in the writing of policies and the proper maintenance of administrative paperwork (staff training certificates, meeting minutes, etc.). In two instances, participants made general reference to the writing of policies having “helped us,” but most statements about the policies were neutral reports that the policies “are ready” or are “in place.”

Other improvements that were mentioned, but not as frequently were increased cleanliness, improved signage directing patients where to go, small increases in staffing, and intensified staff education programs. The fact that these were mentioned so
infrequently (one or two times in each country) indicates that they may not have occurred widely throughout the hospitals or that the effects experienced as a result of these improvements were minimal.

Affecting sense of ownership over quality efforts

Chapter 2 highlighted the desire felt by participants in both countries for “international recognition” and “to be on the world’s standards.” Certainly, recognition of accreditation as an international initiative lends credibility to accreditation as an effective tool for strengthening hospitals. However, the identification of accreditation as an international initiative and introduction by international organizations has placed accreditation, and by extension, quality, under the ownership of others. COHSASA emphasizes the importance of local ownership and describes considerable efforts they take during the development of the standards and during implementation to promote buy-in and ownership.

But achieving true local ownership has been a slow process for Swaziland and Lesotho. One Swaziland MOH representative describes the difficulty experienced in convincing hospital staff that accreditation is a program of the Ministry of Health:

When they, the, the, the program was introduced, everybody was saying it’s COHSASA, COHSASA, COHSASA. And it took time for them to understand that, no, it is the Ministry program, not COHSASA. COHSASA is coming to help the Ministry. So even now, when you go to the facility, you hear them talking about COHSASA, COHSASA, COHSASA. So I think that’s another problem because even though we’re trying to tell them, no this is not COHSASA, but it’s the Ministry program, for them, it was like, no. (SWAZI-MOH)
This association of accreditation with COHSASA was a “problem” for acceptance of the accreditation program in Swaziland because COHSASA was thought by many staff, at least in the beginning, to be “those monsters” or “that animal.” Staff from one hospital described their initial fear during a focus group discussion:

A1: Uh, according to my understanding, there was a bit of confusion, exactly what is happening when [COHSASA] first arrived. And we didn’t know what is exactly needed to, by us. We were lost because at first it was as if it was a monster. ((group laughs)) Because COHSASA is coming, it’s everyone is panicking.
A2: Mm hmm.
A1: It’s as if someone is going to take us to another place and won’t leave us alive. It was just that much fear and we, we don’t know what to do exactly until when we understood what is needed from us. (SWAZI-MRL)

But at least one participant in every focus group in Swaziland talked about how these perceptions were evolving and some even described how they eventually came to assume the duties of COHSASA:

Those monsters. ((laugh from all)) They are becoming beautiful with time. Otherwise, when they first came, ((some others murmuring)) we just didn’t want anything to do with that. Yeah. (SWAZI-GRS)

Initially we were panicking. Everything was COHSASA. Either they are there or they are coming. ((laughter from group; “yes” and “mm hmm” from others)) But, you, you realize it is actually our role. Uh, them to ask is to say do what you’re supposed to do in the right way. So whatever was COHSASA became our role and this is a positive bit of it, saying we continue keeping standards. (SWAZI-MRL)

Some experienced a greater sense of ownership than others. Staff in one of the Swaziland hospitals that was not far from meeting accreditation at the time of the interviews attributed its success to ownership and related their experiences with accreditation to experiences with community involvement in public health initiatives:
A1: I wonder if owning, owning the COHSASA... I think owning the thing like it is yours. If it falls, it, you are the, the one who is going to suffer...
A2: That is the truth what she is saying, I’ll give an example, something that happened, like I was here yesterday, we went to [a village], it’s a community, so we used to build the people latrines for their communities, um, I think it was, involvement was lacking. We’d build for one with one lady and she would lock the, the pit latrine, only open it when we come, come to visit her: “Eh, but madam here is your house, it’s still clean.” But she was still using the bush. So if we say, this is, we are doing this for COHSASA, we tend to even let things lie unattended to until the time when we know that COHSASA is up, it’s just around the corner. Now we start washing our- and asking any- we are just doing things just to get them done. There has to be this involvement, like she said, own it, it’s our thing, not COHSASA, our thing. ((lots of nods from group)) (SWAZI-MUL)

Staff from another Swaziland hospital recognized that ownership is key, but had yet to achieve this sense of ownership:

I think it all goes back to the issue that it wasn’t formally introduced to everyone, so some of the people are still resistant to be part of it. They don’t feel ownership of the program. I don’t know how it can be done so that everybody can feel part of it and actively involved. Otherwise, it’s their [COHSASA’s] thing now. (SWAZI-GRS)

Having played a more direct role in the development of the MCDI standards as well as the assessment process than they did with the COHSASA program, Lesotho national leaders contrasted the differences in ownership between the MCDI program and the COHSASA program. Every national leader in Lesotho referred to the MCDI program as “our own standards” or “my model” and the COHSASA program as “theirs,” or belonging to COHSASA. One of the national leaders talked about the complexity of the COHSASA program making it difficult for even those working alongside COHSASA to independently assess the facilities.

That confusion, I just remembered that, first with MCDI we are the ones doing the assessment, and we are comfortable doing that. And with the
COHSASA, we find that we can’t do that by ourselves, but we need those consultants to come and help us. Yes, so they are very difficult to understand, even for the facilitators. So, see, if it is difficult for the facilitators, what happens to these people that are supposed to implement them. (LES-CHAL)

As the COHSASA model had yet to be rolled out to the Lesotho hospitals we spoke with at the time of the interviews, staff had no direct experience with the COHSASA program of which to speak, but at least some staff at every Lesotho hospital had heard about COHSASA. With the exception of one staff member in one hospital who said “it is good,” several staff at every hospital expressed concerns about the COHSASA standards being South African and “too high,” even though no one had actually seen the standards:

Q: What have you heard about [COHSASA]?
A1: That their standards are higher than the accreditation that we know....
A2: It’s not fair to LES-MRS. (LES-MRS)

Q: Have you heard about COHSASA?
A1: Yeah, that is the monster that we are threatened with. If we don’t pass this one, we are definitely not going to pass COHSASA....
A2: The standards, they are so, no.
A3: No, they are too high.
A2: They are just too high. They are just too high.
A1: That’s what I said. If we can’t pass this one, we are definitely going to fail COHSASA. (LES-GUS)

Q: What have you heard about COHSASA?
A: That, really, it’s one of the, it’s a South African organization that, uh, maybe Lesotho is getting the standards from.
Q: Okay. And how do you feel about that?
A: About COHSASA, I think that the standards are too high for us. Because COHSASA will be, um, maybe likening us with South African institutions, which, which we are far from. (LES-MRL)

A1: It was in, I think it was around 2007, there’s a team of people from South Africa together with the ones from Lesotho Health Planning (indiscernible?).
A2: Mm hmm. And that was COHSASA.
A1: And that was, South Africans were so high. Their standards are so high because the expectations, we were copying South Africa to Lesotho. (LES-GUL)

But as mentioned, hospital staff only had firsthand experience with implementation of the MCDI standards. In contrast to the focus groups with Swaziland, “MCDI” was never mentioned in any of the Lesotho focus groups and the accreditation program being implemented was obviously known by hospital staff to be a program of the MOHSW. And although Lesotho hospital staff expressed problems with buy-in of accreditation, no staff raised concerns about ownership. One national leader, though, talks about lack of ownership at the local facility level as being a barrier to buy-in and preventing staff from feeling that they are directly responsible for the quality of care provided:

Q: So to what extent do you think the hospitals have bought into accreditation?
A: You know for hospitals, it’s a tricky one. Because they may have bought into it. The biggest problem is that it has to be owned...But to be honest, I think it is not yet good to the level that we think you can do things without being pushed or without being followed by central level to say, ah, what are you doing in this area, ae⁵. I don’t think they have taken it to, they have taken it to that level where they would function.
Q: What do you think it will take to get them to that level, to own it?
A: I think capacity building....We [the central MOHSW] should just let go. It is one of those things that we are holding on to. If we give it over to them, I think they will own it. One of the biggest challenges I see as to me, we are treating it as if it’s not part of us all. Because, you know, this fragmentation, whilst we are saying [national] quality assurance unit, yes, it has to be there to monitor, but every one of us should be looking at quality care. Because now if we just segregate it like that, it will, it looks like people think you are not supposed to be looking at quality when you get to the hospital because it’s not your business, it is the [national] quality assurance unit that is owning it. (LES-MOHSW2)

⁵ “Ae” is “no” in the local Sesotho language.
But the biggest struggle that Lesotho’s hospital staff expressed with feeling ownership was with the difficulty they had in achieving standards that were considered to be out of their control. In some instances, limitations in human and financial resources were a major barrier, particularly with regard to equipment and supplies. As one hospital staff member said of their biggest challenge: “Ours is about equipment, but equipment, there’s nothing you can do because it’s beyond our control” (LES-GUL). Staff expressed frustration at receiving poor accreditation scores when they felt there was nothing that could be done about the limitations in resources: “Everything that had to be done by her, she did perfectly, but as for the equipment, it was beyond her, her scope” (LES-MRS). Many staff felt that this was “unfair.”

In other cases, staff were limited by deficiencies or delays in the systems of those on which they depended for supplies or support. At times, this was an external entity such as a donor who had promised to supply smoke detectors or a drug supplier as one staff member described:

F2: [National Drug Supply Organization (NDSO)] is having so many out of stocks. Ea. But anyway, we have our smaller supply, which is TriPharm. Once we have the out of stocks from NDSO, we try TriPharm, but if both of them doesn’t have, we are hopeless. (LES-MRS)

At other times, it was central Government, who was supposed to commission the work for ceiling repairs, hire staff to fill vacancies, or form a hospital board to oversee hospital operations. One national leader described the demotivation that results from standards that are beyond the control of the hospital, particularly when support is not received from the central Government to reach these:

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“Ea” means “yes” in the local Sesotho language.
Accreditation, I mean, this certification process can be very frustrating if you keep doing it and for things that health center manager or health facility manager can't address themselves, if the central level is not seen to be supportive in providing an environment for them to be able to deal with that, then they will be demotivated. They will not be interested and it won't serve the purpose. So to the extent that the Ministry will actively ensure that they continually try to support the facilities to be able to realize those improvements, to own, the only thing that will encourage them to want to do better. (LES-NGO2)

Although limited resources were frustrating to all of Swaziland’s hospitals, this did not seem to have as much of an effect on ownership in Swaziland, particularly for the mission hospitals, which are managed as independent organizations, quite separate from Government. One Swaziland MOH representative described this key difference:

Q: What is it about those facilities [doing well] that makes them really good?
A: Uh, I think, eh, like SWAZI-MUL, it’s, um, the management, it’s about decision making because the, the, the management in the facility, they make decisions there and they, unlike the Government facilities where the management, they can take a decision, but they still have to take that decision to somebody else and that somebody else has to, you know, the bureaucracy of Government, it’s also another challenge. Mmm, like maybe they need the, um, certain equipment. They can’t, according to them, they would prioritize that this is the equipment that we need for the facility. Then they still have to write proposals to the Government, to us, for them to, to change whatever they need. Unlike the SWAZI-MUL and OTHER MISSION HOSPITAL because if they need something, they decide to buy this, they just go ahead and do it. (SWAZI-MOH)

But Swaziland’s Government hospital staff expressed the same frustrations as staff in Lesotho’s hospitals, saying, “It’s so hectic when you have to do something that you can’t really do” (SWAZI-GRS). Although Swaziland Government hospital staff were able to give examples of ways that the Ministry of Health had provided both technical support and resource support, they were still frustrated at what had yet to be done:
But the process has been very slow. I think it started in 2007 and we are still not reaching 65 percent. The process is too slow. There are some things that we can at our level, we cannot do, that needs to be done by, by, by, by top management at the Ministry level. (SWAZI-GRS)

One of the international NGOs in Swaziland also recognizes that this is a problem for hospitals in Swaziland:

So it's one thing to go to a facility, identify this broken down system or something like that, then whatever subsequent visit you make, it's almost predictable what you're going to find. So infrastructural challenges will rank as number one. So as long as there's no one intending to fix them, you see, then that hinders accreditation basically....But I think for as long as there's no advocacy, you can continue doing the routine visits, find the same problems, and then no one attends to them, you know, then accreditation will be a myth rather than a reality. (SWAZI-NGO2)

Recognizing this challenge, one COHSASA representative described how they try to abate this frustration by clearly delineating those standards that can reasonably be done at the facility level and facilitating the process of presenting other needs to higher levels:

[Some criteria] would be at the, at the level of the individual who's running the department. Others will be at the level of the management of the institution. And others at the higher, higher, resource-providing element like your high level authority. Now what we try to advise them is that what they need to do is we're trying to make sure that any elsewhere they can make a big difference on for themselves, not a resource limited or not resource, uh, uh, not resource extensive, then they can handle those. Then they actually put together those that need, uh, further injection of finance or, or whatever else that needs to be injected. Those then they need to take up to the higher authority because this program has been adopted by the country, meaning that there is commitment from senior level authorities to actually deal with the challenges as identified. (COHSASA)

But no hospital staff or national leaders in Swaziland reported that this clear delineation of responsibility for different types of standards was happening there.
Influencing the perceived feasibility of achieving “quality”

This feeling that the necessary resources and authority are not available to achieve accreditation, leaves some feeling like the whole exercise is futile. Hospital staff, national leaders, and international organizations all expressed serious doubts about whether accreditation was possible for them. These participants described how the standards, which are focused on in greater detail in Chapter 4, are not at a level that is feasible for hospitals to attain:

The, the, the document they, they are using, it’s mostly developed in South Africa. I have a feeling that they, they should have done what we called, assessment of- before they used the document, their document, because some of the standards, really, I’d say that what it wants is not there or it is impossible to be there at all. Because we are not like a South Africa. We are Swaziland. (SWAZI-GRS)

Even if COHSASA’s taking their standards from South Africa or, I don’t know if they had adapted them much, but I mean, just looking at some of the standards, you can tell that like, I feel like people haven’t read through them because some of them will be impossible for some of these places to meet. (LES-NGO1)

Hospital staff in Swaziland were also discouraged by how much effort was required to have any effect on the actual score that was received. One nurse commented:

Um, I, um, my comment that I’m having on the accreditation as well is that they will come and assess you and then finding that you have changed, probably what they’ll ask you to do, you have done it. And to your surprise that when they bring the results, you find that they have still scored you the same. They haven’t improved that score. So that, it makes you feel like, wow, what is it that I’ve done because I haven’t done so. (SWAZI-GRS)

But COHSASA emphasizes the importance of continuous progress. One COHSASA leader described how they draw a hard line when it comes to the standards that are used to certify a hospital as accredited, but they are more focused on quality
improvement overall:

Q: Obviously in these countries, you know, limited resources, both human and financial, and otherwise. How do you deal with it when there's just that barrier?
A: Well, basically, there is the accreditation component. As far as an accrediting agent, tough cookie, you can’t get accredited. Okay? Then there is the quality improvement component that, that we focus on as strongly as we can. Because we don’t believe that, uh, accreditation is the goal ultimately, but we believe that the most important ride is the quality improvement ride. Because that’s where you can make big differences. (COHSASA)

One COHSASA representative describes in detail their graded system of accreditation that was introduced to more effectively recognize interim achievements:

...we found that many of the facilities that we worked with in the public sector in South Africa were so far behind understanding standards, how to work with them, the concepts of accreditation, the concepts of quality improvement...you know, we can’t allow these hospitals that have worked so hard to just fall off the radar screen; we’ve got to do something to make sure that they are encouraged to stay in the mindset of quality improvement and work towards accreditation. And out of that was born what we call our graded accreditation system. And in a nutshell, what it is, is as health care facilities move towards achieving full accreditation status, we worked out algorithms of certain standards that have to be in place that do not compromise patient safety and the legality issues around a hospital operating. So they begin and they get what they call a progress certificate and all the departments in the hospital that have achieved a certain level of progress will get a certificate. Then we move to the next level, which is what you call an entry level. That’s what they call our red level. And then we moved to the next entry, which is an intermediate level and then if they start to improving at that level, they can move to an intermediate with a focus. And once you get to intermediate with a focus then you are very, very close to accreditation. And those are steps that just keep the momentum going and moving and moving so that – [our Director] has always said that it shouldn’t be seen as a goal that you work towards and once you get it, you relax and then everything falls apart anyway. It’s to instill and to institutionalize quality improvement as part of one’s everyday activities. It’s not an add-on, not something you do at the end of the day. You actually institute it. And so this idea of a graded accreditation program has been very, very good. (COHSASA)
None of the national leaders or hospital staff interviewed in either country were aware of COHSASA's graded system of accreditation when asked about it, but a representative from one international NGO in Lesotho describes the success of a similar approach used by another organization specifically for laboratory accreditation:

...this Clinton one that works through...giving them like stars and like, they reach like different levels, it's not just pass and not pass, but they go through different levels. Um, and that seems to be improving the laboratory quality. (LES-NGO1)

Despite the fact that no one was aware of the graded system of accreditation, a couple national leaders and a few hospital staff, particularly those in the higher performing hospitals, were still able to appreciate the value of making continuous forward progress even if it's impossible to achieve everything. As one staff member described:

They say this month you get 40, 40%, so when they come next month, we got 70, and they, they push us to, up until maybe we get 100, maybe it's impossible, something (laughter from group), but then, but then the thing that we are improving, you see, we're not going back as in like 40 to 30. It is encouraging us that, uh, we might do this thing. Yeah, it's possible. (SWAZI-MRS)

For some, any progress was encouraging and fostered hope while for others, the slowness of progress produced a very different reaction that placed achieving accreditation and quality of care out of reach.

DISCUSSION

Perceived connection between hospital accreditation and QI efforts

All quality-related infrastructure, programs, and concepts in both Lesotho and Swaziland are rooted in hospital accreditation. All resources in both countries dedicated
to quality efforts are directed towards supporting accreditation. One might argue that so much focus on accreditation may be detracting from other quality efforts, but it is just as likely that the infrastructure developed to support accreditation is helping to lay the groundwork for future quality assurance and quality improvement efforts as those national leaders working most closely with accreditation have that as their objective.

The major issue is that there is a profound lack of information about what quality assurance and quality improvement actually entails, even among those leaders at the national level that have been most actively involved in the development and implementation of accreditation. It is not surprising then, that this information gap continues at the facility level as well. And the expectation laid out in the accreditation standards to develop quality improvement projects comes without any capacity building on how exactly to create and conduct quality improvement projects. Instead, quality improvement projects implemented by hospital staff are focused on making changes necessary to meet accreditation standards, which often address issues that do not seem important to staff, so there is little enthusiasm around the quality improvement that is being done. And we know from published experiences (Massoud et al., 2001; VanDeusen Lukas et al., 2007), which was also reported by one NGO in Lesotho, that improvement work is more successful when staff are given the opportunity to address problems that they have identified as clinically important. Without these opportunities, staff may not recognize the value of quality improvement work. This knowledge gap is also apparent in discussions about other quality-related concepts. Accreditation is beginning to generate some awareness about concepts of standardization, patient safety,
and efficiency, but the fact that mention of these concepts was very infrequent and the meaning applied to them was inconsistent indicates that there is no explicit education happening around these ideas.

Perhaps most telling in making the case that everything related to quality in these countries is connected to accreditation is the fact that the terms accreditation and quality are used interchangeably. This serves as further evidence that no other quality efforts are being implemented, but this synonymous relationship also emphasizes that any perceptions of and experiences with accreditation are likely to be extended to “quality” more generally and therefore has important implications for other efforts to improve the quality of care.

**Effects of perceived connection between hospital accreditation and QI efforts**

In light of this synonymous relationship between accreditation and quality, staff experiences with and reactions to hospital accreditation become even more important. Staff perceptions about the impact that hospital accreditation is having on the quality of care provided (the first four themes relating to bringing attention, giving direction, providing oversight, and changing structures and processes) can influence the extent to which staff feel other quality efforts are worthwhile. Staff experiences in implementing hospital accreditation (the last two themes relating to ownership and feasibility) can shape staff perceptions toward their role in improving the quality of care.

The first two themes, bringing attention to quality practices and giving direction on how to maximize quality of care, highlight attributes of accreditation that have
produced very positive responses from national leaders and hospital staff alike. In these instances, accreditation is contributing added information, guidance, feedback, and targeted resources that were not available before. If extended to quality efforts more generally, these make quality something that can be defined, understood, and achieved.

The third theme, providing oversight, generated reactions that were much more mixed reflecting the recognition of the value of increased accountability and support but also the defensiveness that people can feel when their work is being inspected and criticized by outsiders. The oversight was perceived as particularly threatening for staff in Swaziland, but the reason for this difference is unclear. In Lesotho, reviews are conducted largely by peer health professionals from neighboring facilities, so it may be that this peer review is less threatening than having non-nationals doing the assessment. On the other hand, assessments have been conducted less than once per year in Lesotho and every six to ten weeks in Swaziland, so it may be the intensity of the oversight to which staff are reacting negatively. Either way, it is clear that the level and type of oversight and support can influence the receptivity and attitudes of hospital staff towards quality efforts.

Attitudes of hospital staff towards quality efforts are also likely to be shaped by the fourth theme, changing structures and processes. In the findings, I listed every change mentioned to any structure, process, or outcome in either country. Particularly in considering that learning about these changes was a major line of questioning pursued in every interview and focus group, reported changes were not overly impressive. No real changes in outcomes of care were mentioned with the exception of the sense by some that
patient satisfaction had improved, though this was not based on any actual measurement. Staff did report some changes to processes of care, but these were largely limited to some improvements in pharmacy, laboratory, outpatient triage, and documentation. And the reported changes to structure were often outweighed by those things left unmet, such as inadequate equipment and supplies and impossible-to-complete administrative paperwork. Overall, though, most national leaders and hospital staff reporting these changes felt that they had a positive impact on the quality of care. So although one might not expect overwhelming enthusiasm to be generated from these gains, changes are viewed as important progress and will likely have an overall positive effect on perceptions of the extent to which quality efforts can impact the provision of care.

The fifth theme, affecting sense of ownership over quality efforts, is where one can begin to see how staff experiences in implementing hospital accreditation can shape staff perceptions towards their role in improving the quality of care. The extent to which the program was perceived as being a nationally developed program versus an external program determined whether staff owned the programs as “ours” or thought of it as “theirs.” But even when whole programs are owned as “ours,” the extent to which individuals feel that they can make improvements themselves may be hindered when standards are beyond their control, whether it is due to resource limitations or deficient supporting systems. Recognizing this, COHSASA promotes an approach that clearly delineates responsibility among the different levels of implementers, but this was either not operational or not effective at the time data was collected. Swaziland’s mission hospitals, which operate the most autonomously, expressed the greatest sense of
ownership, but no staff in any of the facilities felt that they had taken full responsibility for ensuring the sustained implementation of accreditation. Perhaps more importantly, only a few staff recognized this as a goal, which indicates a strong perception that efforts to improve quality are not developed or fostered from within.

This is closely related to the sixth and last theme, influencing the perceived feasibility of achieving "quality." Although some noted that making measurable progress contributed to their feeling that accreditation is achievable, the more frequently expressed opinion was that meeting the standards is not feasible and accreditation is, therefore, a futile exercise. This is certainly cause for concern if this same sentiment is applied to quality efforts more generally.

**Accreditation in relation to other QI efforts**

Accreditation standards are generally focused on improving hospital structures and processes that are thought to be important for establishing an environment that promotes safe, quality patient care (Griffith et al., 2002). As noted in the introduction, despite Donabedian's popular tripartite model describing the logical relationship between structures, processes, and outcomes, studies of accreditation have failed to show the expected improvements in clinical outcomes that are desired from making improvements to structures and processes. Testing this association was not a focus of this study, but participants in every interview and focus group described their perceptions of the impact of hospital accreditation on the quality of patient care. With the exception of the perception of some staff in Swaziland that patient satisfaction has improved, this study is
consistent with other studies that have failed to demonstrate a connection between accreditation and patient outcomes. Staff did not—and even when asked directly, could not—report any perceived changes in clinical outcomes in either country.

This together with the experiences of others in trying to impact the quality of care described in the introduction confirms the need for implementing other quality approaches beyond accreditation. Study findings seem to suggest that accreditation is both a foundational approach, effective at addressing some of the gaps in basic operational needs and beginning to introduce some key quality concepts, as well as a more sophisticated method that would work better if it could build on other approaches that may better facilitate staff understanding of strategic quality improvement and staff ownership and engagement. So any given quality method may benefit from the simultaneous implementation of a complementary quality method. Thus, a model that places hospital accreditation along with other quality methods along a cyclical pathway or in a Venn diagram is likely a better approach than a model that proposes a hierarchical or sequential implementation.

CONCLUSION

At the time data was collected, in both Lesotho and Swaziland, hospital accreditation was the only national program of quality assurance and quality improvement. In this way, hospital accreditation is helping to lay important groundwork for future quality efforts. Yet it has also become the very definition of “quality” in these countries, which makes the experiences of national leaders and hospital staff with
accreditation all the more important in contributing to future quality efforts.

The lack of awareness about the fundamentals of quality assurance and quality improvement among top MOH/MOHSW officials emphasizes the need for education at the national level about what quality assurance and quality improvement entail and where hospital accreditation fits within this larger context. Hospitals could also benefit from some basic education about basic quality improvement methodology so that QI projects can begin to address clinical issues that are important to staff that accreditation may not touch. Even if the country is not ready to engage in other quality assurance or quality improvement methods, there are still some very basic steps that can be taken to improve staff experiences with hospital accreditation. For one, careful consideration should be given to the appropriate level and type of oversight that is provided. Ways to encourage ownership should also be emphasized so that the program becomes part of the national identity and tasks are assigned to persons with the ability to implement them. And the feasibility of standards should be improved, or at least recognition be given to the fact that progress is gradual and takes time and deserves to be celebrated along the way. These last two points will be covered in more detail in Chapter 4.

Overall, though, accreditation should be viewed as one tool in the quality assurance and quality improvement toolbox. With an awareness of the full range of tools available, national leaders should develop a more comprehensive quality assurance and quality improvement strategy that is maximally appropriate for strengthening their own national health systems. For those countries that are not yet implementing a hospital accreditation program, findings from Chapter 2 suggest that countries should weigh
carefully whether this strategy should include accreditation at all and should not make this decision based on pressures from external organizations.
CHAPTER 4: THE HOSPITAL PERSPECTIVE

Considerations in implementing hospital accreditation in the developing world:

Lessons from two Southern African countries

INTRODUCTION

Chapters 2 and 3 have established that hospital accreditation is rapidly expanding into developing countries and, where implemented, is helping to lay important groundwork for future quality efforts in these countries. It is important, then, to understand the factors that will facilitate the successful implementation of hospital accreditation in low-resource settings after a country has decided to adopt it.

Accreditation standards and processes being implemented in the developing world have largely been developed by international consulting groups and borrowed from programs established in Western countries. Although there is certainly value in making efforts to avoid “reinventing the wheel,” there is also a strong argument for making sure that borrowed practices are adapted appropriately to reflect each country’s unique circumstances, capacity, case-mix, and culture, referred to as the fidelity-adaptation debate in the implementation science literature (Berta & Baker, 2004; Castro, Barrera & Martinez, 2004; Durlak & DuPre, 2008; Hong & Kim, 2002). To date, no one has formally assessed the extent to which the various accreditation standards and processes that have been introduced in developing countries accurately reflect the context. Drawing from the experiences of hospital staff and national leaders in two Southern African countries (Lesotho and Swaziland) during the early stages of implementing
hospital accreditation, this study attempts to explore the “hospital” question first described in Chapter 1: Are current practices in hospital accreditation in the developing world appropriate for the developing world context, and if not, what would make them more appropriate?

Perceived appropriateness is defined by three criteria used by the OECD Health Care Quality Indicators Project (Mattke et al., 2006):

- **Importance**: the extent to which the standard represents an important aspect, result or outcome of services provided.
- **Feasibility**: the extent to which it is reasonable to implement and measure the standard given the resources available (manpower, money, data).
- **Relevance**: the extent to which the standard fits within normative cultural beliefs and practices of the country.

**METHODS**

In order to most thoroughly explore the proposed research question, a variety of qualitative methods were used. In order to address the research question, a modified panel of experts rated the appropriateness of each national standard on a scale from 1 to 9 and provided written comments modeled after the RAND Appropriateness Method (Fitch et al., 2001). Then interviews with national leaders and focus groups with frontline hospital staff were conducted to further explore the appropriateness of the standards and the process being used in each country based on their experiences in implementing

---

7 Note that scientific validity is excluded as this criterion is used for the development of measures of clinical quality while accreditation measures are usually broader in scope.
accreditation. Given the lack of prior research in this area, grounded theory approaches (Charmaz, 2006) were used in the collection and analysis of data with the aim of answering the research question of interest, which is described further in the methods section of Chapter 3. In keeping with grounded theory tenets, no specific hypotheses or models were used to structure the research.

Case Selection and Study Setting

The detailed rationale for selecting the Southern Africa region and Lesotho and Swaziland specifically is described in Chapter 1. Lesotho and Swaziland represent an interesting dichotomy with Lesotho's locally developed, less resource-intensive approach and Swaziland’s internationally recognized, resource-intensive, COHSASA-led system for accreditation. The similarities in the history, economies, and health systems between the two countries make observed differences more likely to be attributable to differences in their approach to accreditation. The fact that Lesotho was beginning to pilot the COHSASA program in a few of its hospitals at the time of data collection afforded the unique opportunity to contrast the two approaches within as well as between countries.

Lesotho Context

Chapter 2 provides an overview of Lesotho's economy, health care system, and approach to accreditation. However, it is important to understand the vast differences in availability of resources between the Western world and Lesotho. Although Lesotho's economic situation has improved dramatically over the past decade (International
Monetary Fund, 2012) with a GNI per capita of US$1220, it still remains one of the 50 poorest countries in the world (World Bank Group, 2011a). Unemployment is high (29.4%) and 56.6% of people live below the poverty line. In 2011, Lesotho ranked 160 out of 187 countries on the Human Development Index (United Nations Development Program, 2011), which indicates that it performs relatively poorly in looking at a combination of life expectancy, education, and income.

Lesotho’s health care system suffers due to a high burden of illness combined with limited financial and human resources. Lesotho has the third highest HIV prevalence in the world at 23.2% (Mwase et al., 2010). Care for this exceptional burden of illness in Lesotho is funded by about US$109 per capita based on the entire national health budget (World Bank, 2010). And nearly all of the care is provided by fewer than 150 physicians (one physician for ~12,600 people) and fewer than 1,200 nurses and nursing assistants (one nurse for ~1,575 people) (Schwabe, Lerotholi, & McGrath, 2004).

As described in Chapter 2, hospital accreditation began in 2006 as a way to improve the quality of health care services provided in this context. Both the standards and process that were used were developed with support from Medical Care Development International (MCDI) (Chase et al., 2006). These standards included 124 indicators divided across 11 domains and reviews were conducted by trained senior management teams of Government and CHAL hospitals. Representatives from all hospitals in the country were given the opportunity to critique the standards and draft standards were refined as a result of input received and an initial testing process that uncovered any problems with the standards. All of Lesotho’s 16 district hospitals were
surveyed in late 2006 into early 2007 and were surveyed again in late 2008 into early 2009. Later, Lesotho decided to supplement their MCDI standards with COHSASA’s internationally recognized accreditation standards, which were piloted in 2010 just as the data for this study was being collected. As described in detail in Chapter 2, this transition to the COHSASA program was in response to the lack of local capacity to effectively implement the MCDI accreditation program. National leaders interviewed in Lesotho were familiar with both models of accreditation, but none of the focus group hospitals were COHSASA pilot hospitals, so the experiences with implementation that they report are based on implementation of the MCDI program.

Swaziland Context

Swaziland has a relatively high GNI per capita of US$3300 (World Bank Group, 2011a) and a diverse economy with active manufacturing, agriculture, forestry, and mining sectors (Government of the Kingdom of Swaziland, 2007). However, Swaziland’s economic growth has been slower than that of other countries in the region and its GDP has been declining since the 1990s. The unemployment rate is as high as Lesotho’s (29%) and 69% of the population lives below the national poverty line, with 40% of households reporting that they never have enough to eat (Kingdom of Swaziland, 2007). Swaziland scored only slightly higher than Lesotho on the Human Development Index, ranking 140 out of 187 countries (United Nations Development Program, 2011).

Swaziland’s health care system also suffers due to a high burden of illness and limited financial and human resources. Swaziland has the highest adult HIV prevalence
in the world (25.9%), with 48% of cases occurring in men between the ages of 35-39 and 54% of the case occurring in women between the ages of 30-34 (Kingdom of Swaziland, 2012). Fortunately, HIV prevalence seems to be falling slightly for women under 30 and men under 35, but the combination of a continuing annual incidence rate over 2%, high prevalence rates, and effective treatment will only further increase the burden places on Swaziland’s health care system (IRIN PlusNews, 2011; Kingdom of Swaziland, 2012).

Swaziland funds its health care with about US$203 per capita (World Bank, 2010). And although there are more human resources than Lesotho, it still falls far short of meeting all the need with less than 175 doctors (one physician for ~6,100 people) and less than 1,650 nurses and nursing assistants (one nurse for ~650 people) (African Health Workforce Observatory, 2009).

As described in Chapter 2, the Council for Health Service Accreditation in Southern Africa (COHSASA) began to develop Swaziland’s hospital accreditation system in 2006 with 29 domains of 402 standards as measured by 2,819 criteria. As discussed under findings for redefining/restructuring in Chapter 2 and again under findings for relevance below, a few key people in the Swaziland Ministry of Health assisted in finalizing COHSASA’s internationally accredited standards for Swaziland, but modifications were minimal. COHSASA conducted baseline surveys in all of Swaziland’s district hospitals in mid-2007 and then implemented its “facilitated quality improvement program,” which included a reassessment and report with action plan every six to ten weeks. At the time data for this study were collected, one hospital was about to undergo the formal external review for accreditation.
**Data Collection**

Data were collected between May 2010 and October 2010 with fieldwork in Lesotho, Swaziland, and South Africa over five weeks during the period May-June 2010. IRB approval was received from Boston University Medical Center. Ethical approvals were also provided by the Lesotho Ministry of Health and Social Welfare and the Kingdom of Swaziland Ministry of Health. Data sources include surveys completed by local health experts, interviews with key informants, and focus groups with hospital staff.

**Expert Panel Surveys**

In order to thoroughly assess the appropriateness of the standards in use for each country, a panel of experts was recruited for each country that included individuals who were currently serving in hospital leadership positions. A survey was developed for each country that included a list of standards. For Lesotho, the complete list of 124 standards was included. For Swaziland, the standards for 4 domains (Obstetric/Maternity Care, Pediatric Care, Emergency Care, and Outpatient Care) were condensed to include only those standards, which were not already included under the domain “Medical Care,” in order to shorten the survey slightly to 308 standards instead of the full 402 standards while still capturing perceptions of appropriateness for the full set. Sample survey items are presented in Appendix C. Experts rated the appropriateness of each standard on a scale from 1 to 9 (with 1 being very inappropriate and 9 being very appropriate) and had the option to provide written comments for each standard as modeled after the first round of review in the RAND/UCLA Appropriateness Method (Fitch et al., 2001). According
to the RAND/UCLA Appropriateness Method, a panel of experts engages in a two-round modified Delphi process with ratings provided independently by experts, with no interaction between experts during the first round. The second round involves a moderated discussion of the ratings with the aim of identifying the reasons for discrepant ratings, which this study aimed to accomplish with the collection of additional information through written comments and focus groups (Fitch et al., 2001). Basic demographic information (position, years of experience, ethnicity, gender) was also collected on the survey.

For Lesotho, a full 42-page survey was distributed to individuals who were currently serving in hospital leadership positions in five district hospitals throughout the country that represented a mix of large and small, Government and mission, and urban and rural facilities. Each expert was provided with instructions for completing the survey in writing and was briefed in person on these same instructions. In Swaziland, due to the still large number of standards (308), despite our efforts to make the list more manageable, and the length of text for each standard (spanning 153 pages), no single individual expert could reasonably review the entire set of standards. To reduce the survey burden, two complete sets of standards were divided among 11-15 senior leaders and heads of departments at each of the six district hospitals. Each expert was provided with written instructions, but only 1-2 experts in each hospital were briefed in person on the instructions for completion.
Interviews

Interviews were conducted with national key informants in each country as described in detail in Chapter 2. The breakdown by country and key informant type of the 13 key informant interviews conducted are indicated in Table 4.1.

Table 4.1. Number of key informant interviews by interview type for each country. *Note: Three interviews had more than one participant in the interview.

<table>
<thead>
<tr>
<th>National Level</th>
<th>Other Key Informants</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lesotho</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Swaziland</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>COHSASA</td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

I led all interviews and a second researcher was present for ten of the interviews. Each participant provided verbal informed consent and permission to audio-record the interview. The interview guide is presented in Appendix A and details of the interview and transcription process are presented in Chapter 2. It is important to note that the use of a grounded theory approach resulted in the slight evolution of interview questions with each progressive interview to explore key themes as they emerged.

Focus Groups

Focus groups of seven to 10 frontline staff were also organized in several district hospitals per country (four in Lesotho and three in Swaziland) as is also described in detail in Chapter 2 (see Table 4.2). This sample of district hospitals was purposely selected to represent a mix of several key attributes, which are presented in Table 4.3.
Table 4.2. Number of focus groups and focus group participants for each country broken down by professional group.

<table>
<thead>
<tr>
<th>Number of focus groups</th>
<th>Lesotho</th>
<th>Swaziland</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Nurses (senior nurses, nurses, midwives, nurse anesthetists, operating room nurse, nurse assistants)</td>
<td>15</td>
<td>13</td>
<td>28</td>
</tr>
<tr>
<td>Allied Health (Laboratory, Pharmacy, X-ray Occupational Therapy, Infection Control)</td>
<td>11</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>Administration (General, Human Resources, Kitchen, Maintenance, Accounting, Quality Improvement)</td>
<td>7</td>
<td>10</td>
<td>17</td>
</tr>
<tr>
<td><strong>Total number of participants</strong></td>
<td><strong>33</strong></td>
<td><strong>28</strong></td>
<td><strong>61</strong></td>
</tr>
</tbody>
</table>

Table 4.3. Mix of key attributes by hospital for Government vs. Mission, urban vs. rural, and large vs. small. Codes for each hospital are used to indicate the source hospital for focus group data presented throughout the study.

<table>
<thead>
<tr>
<th>Lesotho Hospital A</th>
<th>Lesotho Hospital B</th>
<th>Lesotho Hospital C</th>
<th>Lesotho Hospital D</th>
<th>Swaziland Hospital E</th>
<th>Swaziland Hospital F</th>
<th>Swaziland Hospital G</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Govt</th>
<th>Mission</th>
<th>Urban</th>
<th>Rural</th>
<th>Large</th>
<th>Small</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lesotho Hospital A</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lesotho Hospital B</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lesotho Hospital C</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lesotho Hospital D</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swaziland Hospital E</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swaziland Hospital F</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swaziland Hospital G</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I facilitated all focus group discussions and a second researcher was also present to take notes. Again, each participant gave their verbal informed consent and permission to audio-record the discussion. Details of the interview and transcription process are presented in Chapter 2.
Data Analysis

As described in detail in Chapter 3, this study used a grounded theory approach in conducting and analyzing interviews and focus groups (Charmaz, 2006). Analysis of transcripts from interviews and focus groups started with manual open, line-by-line coding on one interview and one focus group, which produced a list of 24 “codes,” or topical headings under which key words and phrases from interviews and focus groups were grouped. Discussion with two senior researchers resulted in further dividing, combining, and renaming of codes to produce a list of 20 codes, which formed the starting code list in HyperResearch. The first transcripts were re-coded in HyperResearch using the revised code list and additional interviews were coded and reviewed, which resulted in developing additional codes or revising existing codes and code definitions. This constant comparative method continued for several iterations and a final list of 32 codes was generated that reflected all key concepts emerging from the data (see Appendix B for full codebook, including code definitions). Multiple codes may apply to a single piece of data.

The analysis of relationships between codes focused primarily on exploring the appropriateness of specific processes and standards of accreditation being implemented in Lesotho and Swaziland. The three defining criteria of appropriateness (importance, relevance, and feasibility) guided the analysis of data to explore the appropriateness of standards. All codes were analyzed by sorting and arranging data under similar themes and 6 of the 32 codes contained data that contributed to an understanding of the appropriateness of accreditation standards. Analysis of data to explore the
appropriateness of processes was more open-ended, using the same sorting and arranging of data under similar themes, drawing data from 13 of the 32 codes to identify six prominent themes. After key themes were identified, analysis focused specifically on looking for variation within each theme and similarities and differences between countries.

Numerical ratings from expert surveys were analyzed to describe trends in appropriateness with comments helping to understand the rationale for the ratings. The numerical ratings were used for descriptive purposes only and were not used to test statistically significant differences in appropriateness. Ratings were analyzed for descriptive statistics (median, range) for each country and assessed for consistency across facilities within each country. Based on this information, each standard was classified into one of four categories, which were adapted from the levels of appropriateness developed by the RAND/UCLA Appropriateness Method (Fitch et al., 2001). According to the RAND/UCLA Appropriateness Method, the categories of appropriate, uncertain, and inappropriate are used to represent the median panel rating and the dispersion, or level of agreement, of panel ratings. The simplest representation of agreement was used by categorizing as appropriate and inappropriate only those with ratings which indicate high agreement (≤25% of ratings outside of extreme tertiles) and categorizing as uncertain both those with intermediate median ratings and those with ratings for which the dispersion indicates disagreement (Table 4.4). Due to low response rates in Swaziland, standards with three or less expert ratings were classified as having insufficient data.
Table 4.4. Definitions of standard classifications based on the median rating and dispersion of ratings provided by experts.

<table>
<thead>
<tr>
<th>Appropriateness Rating</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate</td>
<td>Medians in the 7-9 region AND ≤25% of ratings are outside of the 7-9 region</td>
</tr>
<tr>
<td>Inappropriate</td>
<td>Medians in the 1-3 region AND ≤25% of ratings are outside of the 1-3 region</td>
</tr>
<tr>
<td>Uncertain</td>
<td>All other with ≥4 expert ratings</td>
</tr>
<tr>
<td>Insufficient Data</td>
<td>≤3 expert ratings</td>
</tr>
</tbody>
</table>

Written comments were then compiled along with the ratings and reviewed to help understand the rationale for the given ratings. Although all comments were reviewed, comments on those standards that were classified as inappropriate or uncertain and comments on a small set of standards that received the highest ratings were sorted based on which of the three OECD criteria for appropriateness (importance, relevance, and feasibility) they corresponded to best.

FINDINGS

Perceived appropriateness of hospital accreditation standards

The first part of this study focused on understanding hospital-level perceptions of the appropriateness of hospital accreditation standards. Data was drawn from expert surveys, interviews, focus groups, and direct observations that helped to explain the level of appropriateness of the standards and the rationale for categorizing it as such. Out of the 32 codes, six codes contained data that contributed to understanding the appropriateness of accreditation standards: suitability of standards, performance towards meeting standards, difficulty changing established practice, unintended consequences, facilitating
factors, and impeding factors. First, findings are presented from expert survey ratings together with data from survey comments, focus groups, interviews, and direct observations that help to explain survey ratings. This is followed by findings from survey comments, focus groups, and interviews that help to explain the survey ratings and other perceptions of appropriateness organized according to the three defining criteria of appropriateness (importance, relevance, and feasibility).

Expert ratings of appropriateness

For Lesotho, 11 experts completed the full 42-page survey. Nearly all experts were Mosotho\(^8\) (10/11) and female (10/11). Surveys were completed by two clinical supervisors, five nursing officers, two hospital administrators (the three senior leadership positions in Lesotho's district hospitals), one head of human resources, and one respondent, who left the position blank. Years of experience in health care ranged from "less than 1 year" to "more than 20 years" and years in current position ranged from "less than 1 year" to "more than 20 years." Each expert was thoroughly briefed in writing and in person on the instructions for completion. Based on comments provided on the surveys, nearly all experts demonstrated good comprehension of the assigned task. Comments from one of the 11 experts (9%) indicated that this one expert provided ratings based on his or her perceptions of how well the affiliated facility performed for each standard rather than the appropriateness of the standard. For example, comments included "this process is not fully adhered to" and "some patients' care areas do not have

\(^8\) A Mosotho is an individual of the main ethnic group in Lesotho.
rights posted on the walls” with scores appearing to correspond to these types of comments. Because these ratings still represented the feasibility aspect of the definition of appropriateness and did not change any of the classifications for the standards, these ratings and comments were still included in the analysis. Most of the standards (87.9%) were rated by all experts. The remaining 12.1% were rated by ten of the 11 experts (see Table 4.5). Comments from at least one expert were given for 58.9% of the standards.

In Swaziland, a total of 33 individual experts participated in rating some sub-set of standards. Only 23 experts (70%) submitted demographic information, but of those who did, seven (30%) were male and 16 (70%) were female. Most experts (82.6%) were of Swazi\(^9\) ethnicity. Of the 22 experts that provided their positions, eight (36.5%) were senior leaders, 13 (59%) were heads of department, and one (4.5%) was frontline administrative staff. Years of experience in health care ranged from “less than 1 year” to “more than 20 years” and years in current position ranged from “less than 1 year” to “more than 20 years.” Based on comments provided on the surveys, experts demonstrated poor comprehension of the assigned task with the majority providing ratings based on their perceptions of how well the affiliated facility performed for each standard rather than the appropriateness of the standard. That this was a much greater problem in Swaziland than in Lesotho could be due to several factors including the lack of opportunity for providing face-to-face instructions as was done in Lesotho, the much lengthier text for each standard, or the lower level positions (and therefore lower level experience and education) among many of the respondents. More is said below about

\(^9\) A Swazi is an individual of the main ethnic group in Swaziland.
how this data should be interpreted differently as a result. The number of ratings for each standard ranged from zero to seven (see Table 4.5). Comments from at least one expert were given for 63% of the standards.

Table 4.5. Number of expert ratings for the standards surveyed in Lesotho and Swaziland.

<table>
<thead>
<tr>
<th>Number of Expert Ratings</th>
<th>Number (%) of standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lesotho</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>109 (87.9)</td>
</tr>
<tr>
<td>10</td>
<td>15 (12.1)</td>
</tr>
<tr>
<td>Swaziland</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>10 (3.3)</td>
</tr>
<tr>
<td>6</td>
<td>25 (8.1)</td>
</tr>
<tr>
<td>5</td>
<td>60 (19.5)</td>
</tr>
<tr>
<td>4</td>
<td>74 (24.0)</td>
</tr>
<tr>
<td>3</td>
<td>57 (18.5)</td>
</tr>
<tr>
<td>2</td>
<td>38 (12.3)</td>
</tr>
<tr>
<td>1</td>
<td>10 (3.3)</td>
</tr>
<tr>
<td>0</td>
<td>34 (11.0)</td>
</tr>
</tbody>
</table>

Nearly all (91.1%) of Lesotho’s standards were categorized as appropriate with the remaining (8.9%) standards categorized as uncertain. No standards in Lesotho were categorized as inappropriate. Many of Swaziland’s standards (45.1%) had fewer than 3 ratings, so these were categorized as having insufficient data. After excluding those standards with insufficient data, 48.5% of standards were categorized as appropriate, 50.9% as uncertain, and 0.6% as inappropriate (see Table 4.6). It should be noted that ratings and classifications for Lesotho and Swaziland should be interpreted differently given the different understandings of the assigned task between the experts in the two countries. While Lesotho’s ratings are more representative of the full definition of appropriateness, Swaziland’s ratings, having been assigned by many experts based on
performance, largely represent the “feasibility” component of appropriateness, and should be interpreted as such.

Table 4.6. Classification of appropriateness for standards in Lesotho and Swaziland (after excluding 137 standards with insufficient data from Swaziland).

<table>
<thead>
<tr>
<th>Classification of Appropriateness</th>
<th>Lesotho (N=124)</th>
<th>Swaziland (N=169)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of standards (%)</td>
<td>Number of standards (%)</td>
</tr>
<tr>
<td>Appropriate</td>
<td>113 (91.1)</td>
<td>82 (48.5)</td>
</tr>
<tr>
<td>Inappropriate</td>
<td>0 (0)</td>
<td>1 (0.6)</td>
</tr>
<tr>
<td>Uncertain</td>
<td>11 (8.9)</td>
<td>86 (50.9)</td>
</tr>
</tbody>
</table>

In Lesotho, three standards were given a rating of nine (the highest level of appropriateness) by all reviewers, summarized below:

- AOP 2.1: Laboratory services available to meet patient and provider needs.
- AOP 2.2: Laboratory register is maintained appropriately.
- PFE 1.3: Information on HIV/AIDS is provided to patients and caregivers as appropriate.

Only eleven standards were classified as “uncertain” rather than appropriate in Lesotho. These are summarized below in no particular order:

- PCI 1.2: The organization designates an individual to oversee all infection control activities.
- EMS 1.15: An appropriately equipped and staffed estate management workshop exists.
- OM 4.5: A system and procedures for ensuring staff satisfaction are in place.
- OM 1.2: The responsibilities of the Hospital Board are defined.
- SQE 1.3: Nursing and other health professional assignments commensurate with qualifications.
- OM 1.1: There is a functioning Hospital Board.
- COP 4.1: Required hospital inpatient furniture and equipment is available and functioning appropriately.
- EMS 1.10: A bathroom maintenance program is in place.
- AOP 3.3: Qualified x-ray personnel are available as required.
- COP 3.11: Outpatient satisfaction is evaluated regularly.
- COP 4.3: Inpatient satisfaction is evaluated regularly.
In Swaziland, only one standard was classified as “inappropriate,” which was standard 5.6.1: Organisation informs patients and families about how to choose to donate organs and other tissues. No Swaziland standards received a rating of nine from all reviewers, but four standards had a minimum rating of eight with a median rating of nine, indicating strong perceptions of appropriateness. These standards, in no particular order, were:

- 26.5.1: Policies and procedures guide management of service (for the food service).
- 32.5.1: All patients treated by physiotherapists have needs identified through established assessment process.
- 38.4.5: VCT performed according to set methodologies defined in policy and following guidelines.
- 38.4.6: Only qualified/experienced staff (as per guidelines) perform VCT.

Possible explanations for these and other ratings can be better understood through the comments provided on surveys and information communicated during focus groups and interviews, which are explored in the sections that follow.

**Importance of standards**

Overall, experts, national leaders, and hospital staff in both countries indicated that they felt the accreditation standards were important. Some challenged the value of all items listed in Lesotho’s essential equipment list and the value of developing policies that were not being followed, but otherwise, most agreed that the standards were important. Concerns were largely not with whether the standards were important, but whether they were as important as meeting more immediate, direct patient care needs. This section reviews the data supporting these perceptions of importance and these few noteworthy exceptions.
Many of the standards with high ratings of appropriateness were accompanied by comments such as “represents an important aspect” or “there is need for this” or “the indicator is vastly important but not feasible with the budget allocated to all the hospitals.” There was a commonly held perception that, if implemented as they are fully intended, the standards “would ensure a conducive environment for quality and health service provision” (LES-NG02). Staff referred to their positive experiences with accreditation as evidence of this importance: “Yes, they [the standards] are very important. Yes, they are. As we have mentioned, that they’re helping us, we are seeing. We are happy, we’re very happy” (SWAZI-MUL). Staff also emphasized that the reason for not meeting the standards was unrelated to perceptions of importance: “Do we think accreditation is important? Yes, it is important. The areas where we are not meeting, it’s not because we feel it’s not necessary to. We, we should meet it” (LES-MRL). In one Lesotho focus group, many examples were given of standards that were unmet as staff described resource constraints and other factors that prevented their adherence to these indicators. Upon asking about the importance of these standards, one staff member emphasized that their work-arounds are not sufficient for the delivery of quality care:

Q: How important would you say are these standards?
A: I think they are. As much as I cannot say much from the clinical side, but I think they are all meant for the good care of patients. They are important. At one stage, others, since we are used to improvising, we might think that we can do away with them, or we can still continue to do the work, but they, they, they bring the good quality of the nursing care in, in, in all. (LES-MRL)

A representative from the Lesotho MOHSW, who was familiar with both the MCDI and COHSASA standards also commented on important gaps in the MCDI standards that are
covered by the COHSASA standards:

But, uh, what happens is that, they [the COHSASA standards] are having things that are important, something like they did not have the, um, let me check, there are so many things that were not included in the MCDI, like this one, resuscitation, was not there, the MCDI, so we found that they are very important. (LES-MOHSW4)

It should be noted, however, that despite many believing in the importance of the standards, there is not complete buy-in to accreditation or the standards in either country.

As one national leader in Swaziland describes:

One, the negative attitude is still there because the program has come to change the wrongs to be done correctly. Some people are so much used to doing the things they know, they feel they can continue with that, so even with those facilities actually, the challenges are still there in terms of actually having a hundred percent adoption of the program. (SWAZI-MOH3)

One key exception to the otherwise widely held opinion that the standards are of great importance were the many comments pertaining to the essential equipment list developed for Lesotho. Several of Lesotho’s accreditation standards require facilities to fulfill the supplies and equipment itemized in the essential equipment list, which was also developed with the assistance of MCDI. Experts, national leaders, and hospital staff in several hospitals communicated their concerns specifically with the quantity of the items listed. In response to the standard “required outpatient furniture and equipment is available and functioning appropriately,” one expert wrote, “The furniture items requested are too many and not very essential e.g. To have a filing cabinet per room is too much. One can do for a dept., as well as the x-ray viewing box.” One national leader questions the importance of the equipment list, “There’s a standard equipment list, which
is, has been developed by, based on the typology of facilities. You’ll find that there are some specs that really, you don’t really know whether they matter, they make any difference to quality” (LES-MOHSW2). Numerous examples were given in focus groups and interviews where the quantity of equipment required was perceived as unnecessary, including the number of chairs required in a department, the number of trolleys required in the laundry space, the number of step stools to go beside patient beds, and, in the following description, the number of drip stands required in the wards:

The equipment, the list, they are essential, but the number, sometimes, they sound not really right, because like they would say for, for, for, there should be a drip stand with every bed. Does that mean, there will be – I was thinking that there could never be a time that all patients that are admitted in hospital are all on IV lines, when they are saying every bed, that there should be a drip stand with every bed. But apart from the necessity, yes, there was, the list, they are all necessary equipment, but then the number sometimes they don’t really…(LES-MRS)

Another area that was challenged by some in both Lesotho and Swaziland was the value of the many written policies required by accreditation standards in both countries. Hospital staff admitted that writing policies does not always translate to changes in behavior to follow the policies. The observations of one supporting international organization in Lesotho reinforced the view that new policies associated with accreditation are not being implemented:

...some of the standards, I mean, are just not related to quality I don’t think...a lot of them were just writing policies and procedures and if those aren’t implemented or if they, if those aren’t implemented, then it’s not doing anything, it’s just something that’s written down...They would write those policies, but did that mean they were implementing them? No, not really. Um, like we wrote a fire, fire policy and procedure manual with LES-MRL, but did they ever like practice it? If the fire actually happened, would they go to the policy? ((laughs)) Probably not. (LES-NGO1)
COHSASA recognizes that ensuring implementation of written policies can be a problem. They note that in doing their assessment, they are “asking for evidence that they’re implemented,” referring to the policies. However, as one hospital staff member in Swaziland explained, implementing policies is “extremely difficult:”

We had, uh, plenty of policies in place, but I, we, we find it hard to implement the policies because you also need to also provide a clear guide, a program of action, a clear guidelines as well....Now it requires that, okay, it requires much time so that we can formulate, uh, programs and try to also, uh, tell the people implementing the program that this is the way things should be done, so it, it, it’s like, it’s a very big thing on its own....So that on its own is very hard, it’s extremely difficult. (SWAZI-MUL)

Across the board, though, the value of the policies was questioned only to the extent that they were not being implemented.

Finally, in an environment of limited human resources treating large numbers of very sick patients, some staff expressed their feeling, not that the standards were necessarily unimportant, but that it was more important to spend their limited time on direct patient care. One Lesotho nurse describes how documentation can easily get overlooked in the busy moments of responding to the patient’s needs:

And together in the package of being admitted, there should be a consent form that this patient agreed to be admitted. But you’ll find that, the patient comes, we’re rushing to do certain things, what does this patient need? Needs to be put an IV line. Needs to be put on the bed. Needs to be attended for medications. So we will do that and we fail or end up forgetting to let the patient sign the consent of being admitted. So that was another thing that made us, that was a challenge to us. (LES-MRS)

A nurse in Swaziland also complains that documenting the care she is providing takes time away from the patient, “I think we struggled to give the, make it evident that I did that. At the same time, maybe another patient would have been gotten some help,
positive help from me” (SWAZI-MUL). For another Lesotho nurse, the failure to
document is less inadvertent, and is actually related to nurse perceptions around the
importance of documentation:

For the inpatients, the people that are being admitted in the hospital, the
accreditation standards, they wanted the name, the sex, the diagnosis, the
date of admission, and the time, the address, and the next of kin to be
filled in their admission form. So another challenge is, with nurses, when
we are working with many people, you know, they tend to ignore certain
things because they are thinking, this is not important. It’s not important
to write the name here of the patient, rather to put up an IV line. So they
will prefer to be doing things that are, you know, into, more into doing
rather than just writing. (LES-MRS)

Comments from experts also reflected this opinion. For instance, Lesotho standard ACC
2.1, “There is a process for hospital discharge,” requires that “Clear instructions are given
to the patient and/or their family, including when to return for follow up. This
information should be included in the patient record.” In order to meet this standard, all
of a random selection of 25 patient records from the past year must include the date to
return for follow up consultation and the medication to be taken. Expert comments
included: “Dr.’s find too much duplication. Write in chart, pt’s bukana, and other hospital
records” and “This process is not fully adhered to as medical doctors always complain
about shortage of doctors and attend to emergencies.” In Lesotho, and most countries in
the region, physicians document the care they provide in the patient’s portable medical
record, called a “bukana” in Lesotho, that the patient keeps with them. While this system
ensures that the patient’s medical history is readily available regardless of where the
patient goes for care, physicians complain about having to document patient care notes
again for the hospital’s records, as one nurse explained:
With the documentation, we are trying, but we, ah, doctors will just say that this is too much duplication. And then we have a, uh, that's still a major problem. "Ea." But with nurses, we are trying, doctors will tell you that I have written this in there, why should I also write this in here.

All these staff are discussing challenges with documentation, but the real issue is not necessarily that documentation is not perceived as important but rather that documentation is perceived by some to be in direct competition with patient care tasks that are considered to be more important.

Relevance of standards

Perceptions of relevance were also fairly strong and consistent. This section begins with a discussion of the process followed in each country to maximize the relevance of standards and follows with a few areas where questions about relevance were raised. The biggest concern was with requirements pertaining to services that were not yet offered in the country. There were also a few instances where standards did not agree with current national policy and one instance, in the case of patient and family rights, where staff perceptions were mixed as to the relevance of changing current practices to conform to more international norms.

Overall, interviews with national leaders heavily emphasized the importance and tediousness of the process to make the standards relevant for the national context. Both countries described a series of meetings to refine standards and a pre-testing process to address any issues. The development of the MCDI standards in Lesotho was a particularly inclusive process offering opportunities for representatives from all

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10 "Ea" means "yes" in the local Sesotho language.
Government and CHAL hospitals to provide input:

Of course, we made inputs on areas that we felt were needed to be improved on. And then the technicians from all over, like all the hospitals were brought in, in a workshop where now the standards were presented like standard by standard to discuss whether the standard was practical, the measurement mode, whether it was practical and even to give the standards their weight of importance because that was going to affect the scoring at the end. (LES-MOHSW2)

The pre-testing process was similarly rigorous and an important step in refining the standards:

Apart from discussing the standards, we actually went out to pre-test the tool. Yeah. And that’s what helped to refine the standards even before the bigger meeting. Because when you have something on, on, on paper and then you go and ask for one, two, three that is listed on the standards, you find, we are looking for things that don’t exist or this won’t work. So I think that practical, the pre-test, it was very useful. Because that’s where a lot of arguments – I remember, it was in Motebang and they were like after we talked to them, they were like, they didn’t understand why we were making so many arguments (laughs). These guys come here and say they are going to assess us and the next thing they are arguing amongst themselves like the whole day, but I guess it was really useful because as we went out to assess all the other facilities, now it was with a tool that was practical. (LES-MOHSW2)

This period for open constructive criticism was possible in Lesotho because they were attempting to develop a completely customized set of national standards without attempting to adhere to specific criteria for international accreditation. This was believed to be necessary in order to develop a set of standards that was reasonable for CHAL to accept as criteria that would influence the receipt of future Government subsidies.

Both in Lesotho and in Swaziland, the refinement of the COHSASA standards was done by a smaller group based largely within the Ministries of Health. But the outcome of having a set of standards that were “suited to our local environment” was the
same in both cases. As one Swaziland MOH representative described:

And then we customized the COHSASA standards to the local situation. So we just took what we thought is suitable for Swaziland and we just left out what we thought was not suitable for the country. And some of the services, we are not providing in the country, so all those we didn’t. (SWAZI-MOH)

But although the Ministries of Health could decide that whole service domains were irrelevant (e.g. Nuclear Medicine Service, Social Work Service), the content of specific standards still had to adhere to international accreditation standards. COHSASA explained their process of working with the Lesotho MOHSW to adapt the standards for the country:

We literally sat and went through page by page through – the key thing’s actually the wording. If we now look and sit with the Lesotho standards and the original COHSASA standards, there isn’t a huge amount of difference. What it is it’s about local naming conventions, making sure it fits in with their regulations and their legislation, the qualifications of nurses, doctors, and others, make sure those were right... So not – the actual content of the standards has changed very little. It was more of the wording and the like. (COHSASA)

The standards review process in Lesotho was described as “laborious to say the least,” but COHSASA also described the process as “worth it,” noting their commitment to making sure that national leadership is a part of the process and satisfied with the final product: “One of the things that we always try to achieve is ownership so we do, we do the best we can not to force anything on to people” (COHSASA).

However, despite the claim that standards were “left out” for services that were not provided in the country, Swaziland’s “inappropriate” rating and several of its lowest “uncertain” ratings were in response to standards for services that most or all of Swaziland’s hospitals do not offer. For instance, standard 5.6.1, “The organisation
informs patients and families about how to choose to donate organs and other tissues,”
was classified as inappropriate. Comments included:

- The facility doesn’t do the organs donation.
- NA
- Not done in the hospital. If donor available refer to Mbabane Government.
- Not currently available in the country, but patients through the national referral hospital are referred to South Africa.
- Blood/tissue donation not culturally universally accepted.
- Patients referred to South Africa for donation/organs.

Other standards refer to the care of patients on life support or patients on dialysis, which comments indicated were not applicable. Also, although there were only two expert reviewers, so that ratings were not classified, all nine standards falling under the speech therapy service received ratings of one by both experts because the program did not yet exist. They did indicate, however, that there are plans to establish a program in the near future. Standards pertaining to nonexistent services or patient populations were not identified as much in Lesotho, but there was a comment, which indicated that the procurement and donation aspects were irrelevant for standard COP 2.1, “there are policies and procedures in place for blood and blood products,” noting: “Blood is donated only centrally. It is only handled, used and administered.” Then again, informal conversations with district hospital staff in Lesotho indicate that shortages of blood often force staff to resort to taking donations from a patient’s willing family members when that patient’s life is threatened.

A few standards in both countries were felt to be irrelevant because they were not in agreement with current national policy. For instance, Lesotho’s standard OM 1.1, “There is a functioning Hospital Board,” was classified as “uncertain” with the following
comments:

• This does not exist in the government establishments.
• Government hospitals are solely owned by the government, they don't have any boards.
• Currently, we don't have such Board, but think it is appropriate.
• Currently, we do not have but we think it is important to have a hospital board.

Another example was the concerns expressed by experts and hospital staff in both countries with standards requiring a “project manager” position as this seemed to have a very specific definition associated with it. One staff member talked about their frustration around continually receiving low marks for not having an HIV Project Manager:

Some of the categories were not really proper for this hospital. Yeah. Like if you look into, um, HIV management, they wanted a manager, or a project manager of which can’t work here. Project manager, you have your own resources, your own activities, but we don’t have that category and it kept us putting our marks low. Because we couldn’t do it to improve, neither can senior medical officer do anything to improve, neither could the Ministry do anything to improve. (SWAZI-MRL)

For the most part, though, conflicts with national policy were infrequent.

One area where opinions were more mixed related to the protection of patient and family rights (PFR). Some expressed concerns with negative consequences that might inadvertently result from efforts to protect patient privacy. For Lesotho standard PFR 1.2, “Patient information is confidential and protected,” one expert commented, “Some files are kept at the patient’s bedside. Absence of charts at the patient’s bedside creates problems of omissions in recording care and treatments offered.” Other experts and staff felt that involving patients and family members in the decision-making process was not highly relevant. For some, this had more to do with the limitations of health care in the
developing world. For instance, Lesotho standard COP 5.2, "A protocol for explaining anesthesia risk to patients and caregivers is in place;" included one expert's comment, "Informed consent necessary but options are not many in third world situation."

For others in both countries, though, it is clear that not everyone feels that informed consent is necessary or appropriate. For instance, one expert's comment for Lesotho standard COP 6.4, "A protocol for explaining surgical risk to patients and caregivers is in place," was: "This is not applicable to patients." And Swaziland standard 5.2.1, "Processes ensure that care is considerate and respectful of patient's personal values and beliefs," included a comment, "culturally not openly expressed." One Swaziland hospital staff member explained the resistance to changing practices related to patient decision-making:

Maybe the other issue is the, the patient charter. We have been keeping patient rights almost in all the departments. The patients are reading their rights and everything, but in our service, there are some rights where you say even if the patient can refuse to be done that, she wants to be done that, you will still feel that huh-uh, this is what we have to be done here. You cannot choose whatever that you want. So we still ourselves, the workers, don’t know the patient charter and the rights. Really, it's becoming difficult to implement such a thing, but it is already there. They are not being taught about it, we just take it from the Ministry. (SWAZI-GRS)

However, more staff in both countries commented on the positive contributions of introducing patient and family rights as a result of accreditation (see Chapter 3).

**Feasibility of standards**

Issues with the feasibility of implementing accreditation standards were noted much more frequently than concerns with other criteria for appropriateness. Limited
availability of financial and human resources for health were cited most frequently as the reasons for challenges with feasibility, but there were also some instances where general limitations of the national infrastructure were problematic. This section reviews these challenges and also highlights some unintended consequences resulting from implementation of standards without the necessary supporting resources.

Even those who spoke very highly of the quality of the standards, noted problems in meeting the standards as this hospital staff member in Swaziland described:

Frankly speaking, the standards of COHSASA are quite excellent, no doubt about that, but us meeting those standards, it’s too high, I don’t know. It’s a little bit higher than us. Okay, there are quick wins that we can change and implement and make sure that, okay, we can try those ones, but some certain things like they’ve already touched on, there are some big challenges whereby we really need more money to, to put everything in place. But, uh, in short, the standards of, of ours is quite excellent. But we do have that issue. (SWAZI-MRS)

Even national leaders involved in spearheading the implementation of accreditation questioned the appropriateness of the level of the standards:

The COHSASA standards, the standards are too high for our countries, the developing countries. So they need to bring them down to the level of our economy. Yes. Because you’ll find that, uh, some of the standards are very high and they’re not affordable, so it will take years for us to, to achieve those standards, so maybe for them, before they adopt the standards, they should bring them, I mean, they should bring them to their level, to the, to the level of their economy. (SWAZI-MOH)

Although staff recognized that they can work towards meeting standards that do not require resources, financial constraints eventually became an important limiting factor:

We learned that some of the things, they are not things which they need money. We must try and look at things, which we do have within our finances, we must try and utilize those things. Some of the things, they were just, few of the things are practical things. And now we are doing, the main problem is coming to financial constraints, that we are starting
now. Because some of the things that need improvement, need finance. (SWAZI-MRL)

One hospital staff member in Lesotho nicely summarized the major problem affecting feasibility:

Q: How feasible are these standards to implement?
A: I think the ones that only use our hands and brains can be met, but those ones that needs to be bought, is still a challenge. (LES-MRL)

Indeed, limited financial resources, which translate directly into insufficient equipment and poor infrastructure, was the major factor contributing to concerns about the feasibility of accreditation standards. Numerous experts in both Lesotho and Swaziland provided comments reflecting these challenges for many of the standards. Some emphasize the importance of the standard despite financial constraints, such as “The indicator is vastly important but not feasible with the budget allocated to all the hospitals” and “Very appropriate, just that equipment is not up to standards.” On the other hand, as was noted earlier under the findings related to “importance,” other comments reflected the opinion that the requirements, particularly for equipment, were excessive, such as “The required furniture items are too many and some are expensive.”

Many examples were given in written comments, focus groups, and interviews, of specific challenges encountered as a result of budget limitations. There were also some instances reported where following accreditation standards without consideration of limited resources had important consequences for patient care. One nurse in Swaziland described the difficult circumstances they face, which “force” hospital staff to ignore some standards:
You find like, huh, we are trying to, they are using like, uh, when I’m giving a patient oxygen, you can’t use, reuse the nasal prongs. But we are forced to reuse. That is a poor quality, to reuse those things. But we are forced to reuse because if you have got a patient in need of oxygen, how can you throw away those nasal prongs when you have not. So it’s really challenging. (SWAZI-GRS)

And hospital staff in both Lesotho and Swaziland described problems with changes in hand-washing policies introduced by accreditation. Infection control dictates that reusable cloth hand towels should be replaced with paper towels for drying hands, but maintaining a supply of paper towels has been a challenge for hospitals. As one Swaziland hospital staff member pointed out, “Who can buy us those paper towels?” So hospital staff are left with nothing with which to dry their hands. In another instance, one staff member from a rural Swaziland hospital described how lack of access to lamination services resulted in the loss of important information:

Let me put for an example, we had posters, educational posters, ICE material on our walls. We had to remove all those posters because they were not laminated because the infection control states that nothing has to be on the walls... So we had to remove all those posters and some of our information was lost that day. Because some of the posters had even protocols, how do you do your sliding scales, how do you do those things, so we had to, the doctors were writing their own, their hand-writings and post it on the walls, so they had to remove all those things and now we don’t even have those... (SWAZI-GRS)

So although there are many standards that are unmet due to financial constraints, there are also cases where meeting standards has important consequences as a result of financial constraints.

Human resource shortages were reported as equally problematic in attaining many of the standards. There were several types of professionals required by the standards that simply did not exist at all or in sufficient numbers in the country. Lesotho standard AOP
3.3, “Qualified x-ray personnel are available as required,” was classified as uncertain and received the following comments:

- Though this is so important a standard, it is very difficult to meet it as in the country there is no institution to train radiologists so it is very difficult to have a trained person. Most of the time we work with experienced but not formally trained only trained on the job so maybe it will be important to take note of experienced personnel rather than qualified.
- No radiologist.
- The country has not made the provision for training the qualified personnel. Very few institutions have qualified persons. Must use persons trained on the job.
- There are no qualified staff. They are all trained on the job.
- People working at x-ray are not professionals, but have been trained to do or perform the job (training on the job).
- Very inappropriate, where do they come from, is there any provision made to train radiographers, as it is, I don't even think there is a qualified one in district hospitals.
- There are personnel who are not qualified but they are provided with training skills in order to perform their duties.

Medical doctors interpret x-rays taken by x-ray technicians as there are no radiologists in district hospitals. Nurse anesthetists serve in place of “doctor anesthesiologists.” Nurses prescribe patient medications to cover shortages in the supply of pharmacists.

Psychologists are not available to visit hospitals in Swaziland as required by accreditation. The human resource challenges are very similar in both countries but Lesotho’s standards more accurately reflect these constraints as one interviewee described:

Due to the challenges, firstly of the human resource base in the country, but also of how many we are able to produce in country, how fast we are able to recruit them, how much we are able to retain because there was a lot of attrition. So due to all those factors and obviously, budget constraints, we could, as much as we knew what the ideal was, the ideal staffing for each of – we had to trim it down to what was realistic and affordable for the country. So that was modified. (LES-NGO2)
Whereas in Swaziland, "[the standards] didn’t change much..." in response to their inability to fill these professional posts, "but [the Ministry of Health] didn’t make it rigid because we know our local situation" (SWAZI-MOH). But there are many other standards that are indirectly affected by staff shortages due to limited staff time. One Lesotho nurse described how nursing shortages interfere with their ability to document patient assessments:

For assessment of patients, assessment documentation, patients are really assessed at appropriate intervals, unmet, sometimes due to the number of doctors we have and nurses. Like, uh, sometimes you will have three nurses in the ward. It will be a registered nurse, a nursing assistant, and a ward attendant, so if you want to reach the standards, you can’t reach the standards with one nursing sister because when she’s sick, maybe she has gone to the pharmacy or laboratory, then she will leave one ward attendant... (LES-GUL)

Human resource shortages also applied to concerns about the feasibility of the measurement requirements for certain standards, particularly for those related to staff and patient satisfaction. Commenting on Lesotho standard COP 4.3, “inpatient satisfaction is evaluated regularly,” one expert wrote, “Good [standard] but conducted by who? when we are already extremely short staffed, and managers overstretched.” For this same standard, another expert suggested administering patient satisfaction surveys to fewer patients to make it more feasible: “100 is a little steep. 50 is more attainable for smaller hospitals.”

The general economy of the country also affects feasibility by limitations imposed by national infrastructure. For instance, Lesotho standard AOP 3.1, “Radiology services are available to meet patient and provider needs,” included one comment from an expert, “Dependent on national electricity supply.” The pharmacy service also described
problems meeting standards because they have to rely on a single drug supplier for the country: “...for all the drugs, priority drugs needed in the hospital, we are somehow having the problems with the main supplies from NDSO, but we are trying” (LES-MRS).

An international partner in Lesotho noted:

Like the health centers, they have one standard that I think, an ambulance has to be there within two hours or something. Some of those health centers, you can’t get an ambulance there in two hours, you know? Um, some of them you can’t even get an ambulance to. (LES-NGO1)

These limitations in national infrastructure are obviously beyond the control of the hospital staff.

The large majority of experts, national leaders, and hospital staff expressed at least some concern with issues of feasibility and the failure of all the standards to appropriately consider the local economic situation. However, one Lesotho MOHSW representative felt very strongly that all the standards, for both MCDI and COHSASA, are “perfectly achievable:”

It doesn’t, uh, make sense to search very high standards that are not attainable, you know so all the standards that are here are the minimum international standards. What I can agree with is some of the things are not applicable in our context like, uh, nuclear medicine is not applicable, so those ones we removed them but the others they are all perfectly achievable with the correct staff compliment, the policies and guidelines, everything here is achievable. (LES-MOHSW4)

While no one else expressed quite as much unequivocal support for the standards, it is worth noting that many staff did express considerable optimism that many of the barriers they were experiencing in meeting the standards could be overcome as was referenced under the findings related to “influencing the perceived feasibility of achieving ‘quality’” in Chapter 3.
Key perceptions about accreditation processes

The second part of this study focused on understanding perceptions of the appropriateness of hospital accreditation processes. Data was drawn from expert surveys, interviews, focus groups, and direct observations that helped to identify practices that have played a key role in influencing perceptions of the appropriateness of hospital accreditation. Analysis of data uncovered six key themes that were particularly important to the implementation of hospital accreditation in both Lesotho and Swaziland. These six themes include: (1) introducing accreditation to hospital staff, (2) promoting a gradual implementation process, (3) including all hospital staff in the process, (4) defining who is responsible for what, (5) demonstrating leadership commitment, and (6) providing implementation support. Table 4.7 below shows the codes that contributed to each of the six themes as well as our findings from the previous section.

Table 4.7. List of 14 major codes reflecting key concepts that emerged from interview and focus group data.

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<tr>
<th></th>
<th>Introducing accreditation to hospital staff</th>
<th>Promoting a gradual implementation process</th>
<th>Including all hospital staff in the process</th>
<th>Defining who is responsible for what</th>
<th>Demonstrating leadership commitment</th>
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<td>Difficulty changing established practice</td>
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<td>Impersonal implementation support</td>
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<td>Incentives for compliance</td>
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<td>Including everyone</td>
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Introducing accreditation to hospital staff

A major point of discussion in every Swaziland focus group was the way that hospital accreditation had been introduced to the hospital staff so that they were “taken by surprise.” The sudden entry and lack of communication about the purpose of the exercise were cited by many staff as major problems for initial, and still lingering, resistance to the program among hospital staff:

Maybe the problem is what was with us here, maybe the way it came, that’s why they rejected it. The way it came, it came as a monster. Try and introduce it nicely, maybe bit by bit until those people understand exactly what is it. (SWAZI-MRL)

I think it all goes back to the issue that it wasn’t formally introduced to everyone, so some of the people are still resistant to be part of it. (SWAZI-GRS)

Even in offering advice to Lesotho in implementing COHSASA’s accreditation program, this was the major focus:

A1: They must be geared.
A2: I think it’s, it’s, it’s the initiation that is critical, how it is introduced because that is where the attitudes can be taken care of. If it is going to be introduced like it was done in Swaziland...
A3: It won’t work.
A2: It may not, may not yield the results that they want it to. (SWAZI-GRS)

Those leading implementation efforts at the Swaziland Ministry of Health were also aware that this was a very important issue in getting buy-in from hospital staff. One leader had heard complaints from the staff about the lack of communication about what to expect, which contributed to initial negative perceptions of the program:

In fact initially, it was very difficult for them, I think maybe the, the way it was introduced ... had a bearing on the negativity when the program was first initiated. Why am I saying that? Because we got the feedback. When they realized that the programs would, it's bringing the best out of it, they said, since when the consultants came, there was no pre-warning that such people would be coming to do A, B, and C, so expect that. The day they came, they were introduced and they started on the exercise. You can imagine....They felt embarrassed, so I think that's why, they, they, they, they did not take it positively. (SWAZI-MOH3)

This sudden entry was made more difficult by the fact that most staff were made aware of the accreditation program when "these outsiders" came to conduct a baseline assessment, which involved "exposing...weaknesses" as one staff member reported:

There were a lot of resistance from, from most of us because honestly the entry point they used, we don't feel it was the right one. It was like they have come to, to expose our weaknesses, yet they had come to make us strong and we are weak. (SWAZI-GRS)

And the feedback staff received was not positive, which created a sense of nervousness around accreditation among the staff as another staff member described:

They didn't come with basics. They came already on the accreditation. (lots of murmuring and "mm hms" in the background)...They came here, introduced the program, and went round, told you that, "oh, you, huh, horrible." So when you start from horrible, then you get so fidgety, you won't know where you are. (SWAZI-GRS)

COHSASA recognized the effect that a proper introduction can have on buy-in:
Q: So how long does it usually take, um, once you go into a hospital for the hospitals to buy in to accreditation? What does that look like, that process?
A: It depends on, uh, how much introduction a hospital has had before the program. And if we find that, uh, there's a hospital that knows about the program or been in it before, they're basically not too much of a problem. (COHSASA)

COHSASA agrees that "the way that the baseline is done is also important," and described their facilitative baseline where they conduct the assessment together with hospital staff, "So it's not somebody coming in and doing the evaluation. It's us working with them. And when we find something there and they can see that what we record is real, that's really important" (COHSASA). As a general rule, COHSASA presents general information about quality assurance, quality improvement, and accreditation and gives their accreditation tools to the senior leadership and heads of departments at each hospital several weeks before conducting the baseline assessment. But they also are aware that staff have negative reactions to the baseline assessment:

I don't think you'd go anywhere and find people that were so excited that we're doing a baseline with them. Because we will find, maybe it's one manager, but the rest of the staff, were completely, um, they're really scared of this, of this issue. Because actually, it's partly, it might actually leave an impression, an impression on their jobs. Because if, if, if, they'll know about these issues, so it might be even looking at the level of their function and therefore it might have an impact on, you know, consequences on their jobs. So, so it's, uh, it's always, uh, a tough, a tough environment for the baseline. (COHSASA)

In Swaziland, baseline assessments were conducted less than a year following initial discussions between the Swaziland Ministry of Health and COHSASA and about six weeks after presentations were made introducing the program to hospital managers.

In contrast, Lesotho took about seven years from the time the idea was first
proposed to conduct its initial assessment. Most staff reported hearing about accreditation as part of the Memorandum of Understanding between the Government of Lesotho and CHAL, which took years to be negotiated. One interviewee described how the MOHSW made continuous updates to staff:

As the partnership was evolving, obviously each step of what was happening during the partnership between Government and CHAL, during the quarterly review meetings, hospitals, all the, all the health center, hospital staff would come in for those, so there would be regular updates in terms of where we are in the process, what are we doing, who would be involved at what stage and so on. So there was continuous reporting and consultation on that. So they knew as the process evolved what was going to happen. (LES-NGO2)

Other staff reported hearing about it on the radio or in the newspaper and still others heard about it from their leadership, who had been trained as reviewers. One Lesotho hospital staff member did describe the same sense of surprise that staff in Swaziland reported:

Hmm, one of the first times I heard about it, we had, that's when I saw people coming around here. Okay, what's happening? Accreditation comes, they really need to know what's happening. They are, I will say, maybe for the first time, it was, it, it caught us by surprise. Maybe we were not even prepared for it. (LES-MRL)

But for the most part, staff in Lesotho were aware that accreditation would be implemented long before the first assessment was conducted. Still, even though most staff in Lesotho knew well in advance that their hospital would undergo a review for accreditation and leaders understood what this meant having been trained as reviewers, frontline staff may not have been entirely clear on the details of what the accreditation review entailed. When asked how they first learned about accreditation, one nurse responded:
We, we were just told that some people from the Government will come into our hospital for this, and we don’t know what they’re coming to look for. We just cleaned the wards. ((laughter from all)) And we don’t know what was, this was for. (LES-MRL)

But the baseline assessment was described as a “pilot” and the team from the Lesotho MOHSW “sat down with each of the facilities, [ensuring] that they understand where they have not performed well, how they are going to work” (LES-NG02). And the hospitals then had more than a year to address the problems before the second assessment was conducted. No staff in Lesotho complained about the way that accreditation was introduced.

One international partner in Swaziland noted that accreditation and quality assurance and quality improvement more generally could be strengthened by introducing these concepts during the training years to inculcate these principles even before staff arrive at the hospitals:

Cultural approaches, they are formed in the formative years, eh? So when we’re young, we’ve got certain ways of doing things. And one of the places where we, like, form all these cultural traits is school, you know, wherever we are trained. So now, if you have, let’s say a pre-service training institution, where you are training your future health workers, that person at training institution should have this quality assurance as part of their curricula, you know....We’re supposed to build that capacity way back, you know, eh. So that even when they are students, when they go for practicals, this is the reality of them, it’s who they are, not like you are trained on something else and then you come to implement something different. (SWAZI-NG02)

One hospital staff member also pointed out the value of training in college in equipping health professionals with the necessary skills to understand and implement the various components of accreditation:
If we can reinforce it [this accreditation thing] at the college level then it can work so by the time people like me are retired, those young kids there, they already know what is happening and they can implement it. Because we can be phased out and the other people coming in can implement it easily because for us, it's very difficult, very difficult. You know, we, we, we find it very difficult to write a policy. What is a statement, those things. So, so if those things can be taught at the college level, and more emphasized, unlike what we have done. (SWAZI-GRS)

Whether instilling a new set of professional norms, imparting skills that will aid in the implementation of accreditation and other quality improvement activities, or providing staff with information on plans for improvement, the overwhelming opinion was that the sooner this introduction can take place, the better.

**Promoting a gradual implementation process**

Closely connected with the idea that hospital accreditation should be properly introduced to all staff is the notion that the introduction of staff to accreditation should be more gradual. Staff in every Swaziland focus group felt that there should be a longer period for orientation and that “they should give the hospitals time to prepare themselves” prior to conducting an assessment. One Swaziland staff member described what they believed would have been a more appropriate sequence of events for the introduction of accreditation:

...the way it started, because these COHSASA people were informed, they came and do, and conducted a study. But we thought they would come and tell us what is accreditation, what is expected, for you to meet accreditation, what are the things that you should put in place. So by then, they should tell us the steps. Then they let us work on the steps and then they come maybe after a certain period and then assess, using a tool that maybe we’re aware of. (SWAZI-MRL)
The description suggests that accreditation should be introduced gradually in stages with the first stage to inform staff and define expectations, a second stage of hospitals working to address the standards and a third stage where hospitals are assessed. Staff in every Swaziland focus group presented this same sequence as the logical process for implementation of accreditation.

...possibly train the people, introduce the people into the program, do some bit of orientation so that everybody gets geared to the program. Thereafter, come. Because you cannot test something that you have never been trained on. You cannot test something that is not there. (SWAZIGRS)

Many staff and national leaders in both countries also proposed that the standards should be introduced more gradually. One Lesotho MOHSW representative recommended this gradual introduction to make the number of standards more manageable:

...I think there are too many standards. Ea\footnote{\textit{Ea} means "yes" in the local Sesotho language.}. Especially for, for starters, you know, for me, I think if we could introduce these ones, I am not trying to say there are standards that are less important than others, but for me, there are critical ones that we could start and then introduce these other ones, you know, gradually, when we think people have passed the critical ones. Like if we want to talk maternal mortality, you know, maternal and child health, we put them first and then we want people to understand them and then we sort of put them in gradually, because there are so many standards. (LES-MOHSW3)

A gradual introduction of the standards is also proposed as a way to help staff prioritize areas that are most important, so they know where to start. One Swaziland staff member described how introducing the program all at once was overwhelming to staff: "...they don’t know really where to start and how to implement the whole thing because it’s
coming at the same time within a short period of time” (SWAZI-MUL). COHSASA recognized that facilities are overwhelmed with the number of areas that need to be addressed, but did not agree that a fewer number of standards is the answer:

So we are aware of it, but one of the problems that we have is that hospitals are complex organizations. I mean, they’re big, uh, and as much as one would like to say, well, we want to have five standards, we can’t have five standards. I’m sorry, baby. You’re going to have to have about 300 standards and of those 300 standards, there’s a lot of criteria, three to four thousand of them. And if you’re going to make sure your hospital’s safe and working, you really should be meeting those. You know, I mean, the reality is that. And you know, I often get people say, but can’t you just give me one or two indicators. No, sorry, I can’t. Why not? Because out there is a huge institution, eh? (COHSASA)

Instead, to help facilities prioritize the many areas that are identified for improvement, they have developed a system of pulling critical areas, or “the scary things,” from their full reports into a quality improvement plan for each facility:

It’s a, about a five page document and we just pull information out of the, that big, uh, 2,100 page document the I showed you into a little summary form so we can show them and say we know this document looks a bit scary but in terms of starting, remember we talked about the triggers, the critical things, here’s where you need to start. These are the first steps that you need to do. (COHSASA)

But none of the staff or national leaders interviewed mentioned the quality improvement plan or any areas they were addressing that they knew to be more critical. And staff felt that the six- to ten-week timeframe for follow-up fails to recognize that even the implementation of a single standard is a gradual process. One Swaziland hospital staff member described his frustration at the frequency of follow-up that does not allow for the many steps that are needed in order to make meaningful progress:

...the time they give us to implement certain things when they come back to us, they say, well, how much ground have you covered. I feel it is very
short, you find that because, um, like myself, I was working in two levels: strategic level and operational level. You find that I have to create documents, new documents that were never in the hospital. You find that maybe I need to, um, to write that document, you need to consult, to get, uh, ideas from, from, from the ground, how people they view the whole, the whole thing that you’re trying to bring that, to bring about that reform. So you find that the timeframe, when they come they find that already you haven’t covered much ground because the nature of it, it requires more time. (SWAZI-MUL)

This leaves many staff feeling like they are constantly falling short of expectations and progress is never enough even though COHSASA supported the view that “accreditation is not an all or nothing process.”

As was described in Chapter 3, COHSASA introduced their graded accreditation system, which would recognize interim levels of accomplishments because, according to them:

We can’t allow these hospitals that have worked so hard to just fall off the radar screen; we’ve got to do something to make sure that they are encouraged to stay in the mindset of quality improvement and work towards accreditation. (COHSASA)

But this graded system is still based on overall scores. Staff continue to seek acknowledgement of the progress that is not necessarily reflected in the scoring and were frustrated that “…you find that you are not seeing any difference, yet, I have done something toward improvement” (SWAZI-MRL). One staff member talked about how discouraging it is when the reviewers fail to acknowledge this progress:

You try to make some few steps up… Then he won’t notice right exactly where you are. Then from there, he wanted you to put more but as, he doesn’t appreciate, because I think appreciation’s more important, it will give you strengths so that you can push forward. When always they say you have done nothing, you have done nothing, you have done nothing, it doesn’t give you more power to improve that thing. (SWAZI-MRL)
This emphasis on a gradual implementation process may also be related to cultural differences that were described in Chapter 2 with the Western culture being more “time-based” and “target-oriented” contrasted with the African culture where “time is slow,” “there isn’t so much pressure,” and “it’s not so much about the deliverable...maybe it’s more of the methodology.” One Swaziland hospital staff member described the importance of taking things “step by step”:

Some of the standards, really, I’d say that what it wants is not there or it is impossible to be there at all. Because we are not like a South Africa. We are Swaziland. And we take things step by step slowly. (some laughter from others) It’s not like, uh, today we are two years, tomorrow we’ll be five. We grow, step by step. (SWAZI-GRS)

Most staff, particularly in Swaziland but also in Lesotho, reported feeling pressure to meet the standards at a pace that they felt to be unrealistic. But some staff “have seen that it’s, it’s, it’s an ongoing process” (LES-GUL) and appreciated that there has at least been some movement in a positive direction despite falling short of their ultimate goal to achieve accreditation.

Including all hospital staff in the process

Staff in Swaziland indicated that only the heads of departments were included in the process initially. This process failed to recognize the role of frontline staff in implementation of accreditation, who noted, “it has been a supervisory thing, not for everybody, so some people, they felt isolated or disenfranchised, kind of, out of the whole project” (SWAZI-MUL). Staff felt strongly that the introduction of accreditation should be more inclusive of all frontline hospital staff and “should involve everybody
from the beginning and...have your clearly laid objectives so that everybody can know" (SWAZI-MUL). One hospital staff member noted that involving senior management alone is not enough to make accreditation work:

If they're to begin, I think all of us should be on board. Because it all requires teamwork. ((nods and murmurs of agreement)) So people, even though they are senior upstairs, or senior nursing officer, they will do, they will say something, but he's not the implementer on the ground level. So maybe staff need to, can be on board and then you see, they introduce us to, then they, they, they explain what they want to do and what they explain, they expect us to do and then it comes out like they are part and parcel to the program. (SWAZI-MRL)

One of the hospitals with higher accreditation scores in Swaziland reported that the senior management “discovered that they are supposed to include us [frontline staff]...[and] decided to include us as they carry forward” (SWAZI-MUL). Although this was credited as making a difference in terms of making progress towards accreditation, it was also regarded as “a bit late” with a clear preference for inclusion of staff in the process from the beginning. One representative from the Swaziland MOH recognized this as a key factor in determining whether or not the hospitals really accept accreditation, indicating, “Of course, uh, the, the involvement of all staff from low level up to high level. Because it makes everyone feel he or she’s important in her or his department” (SWAZI-QAU).

Defining who is responsible for what

Although hospital staff value being included in the accreditation process, they expressed frustration when they were inappropriately assigned responsibility for certain standards. In some instances, this was because staff lacked the necessary knowledge or
skills to successfully complete assigned tasks. This was particularly true for Swaziland hospital staff charged with writing policies. As one staff member described:

We felt like we are not the people, because the whole thing came about with writing policies and all those things, so we felt that, no, we are not the rightful people to write all those things...Like if I may make an example of the health care technology department. You see, the people who, in quotation marks, are in the health care technology department. The document, the standards that they use. It’s far, they don’t understand it. It’s too far ahead of them and their training, so it will lead to problem to make them do it. Yes. I mean, even to work in the hospital themselves, no, they don’t do writing things but when it comes to health care technology yet they are the people who are supposed to be answering all of these questions and writing the policies and everything, but it’s difficult for them to do. (SWAZI-GRS)

Some staff felt that some additional training would have assisted them in writing policies, while for other staff, literacy and general comfort with writing were the bigger issues.

Infection control was another area where existing hospital staff lacked the skills to identify and handle outbreaks. As one staff member described:

Infection control, it’s a scientific, it’s a scientific model thing. It’s not so easy just to wake up in the morning and say we can be able to implement it. To track down infection, to track down the incidences in, it’s so, it’s very intricate, so for me, if they can train, um, key people, uh, on the key service elements and they have the clear direction where are they, are they supposed, what are they supposed to do, how to take forward the program, it could be much faster. (SWAZI-MUL)

As it turns out, one Swaziland nurse was sent abroad to receive training in infection control.

More often, though, concerns about the inappropriate assignment of responsibility were related to staff feeling responsible for issues that are “not within our power.” One Lesotho nurse described her encounter with the reviewers that came to assess her ward:
On my side, I found it very unfair for the accreditation team to be asking about the ceiling....They will be watching the ceiling and the flooring, the tiling, and this stuff, so myself I was thinking that, but it's very unfair for you guys to be asking me about the ceiling. You know I'm in nursing, so let’s talk about the patient. And for a ceiling, you need other people who are (tending?) to the ceiling, but now that the labor ward, so in labor, you are responsible for everything, you are responsible for the ceiling, for the floor, for the bed, for everything else, including the patient, because on my side, I was thinking, ae, if they're going to ask me about my patient, and the sphignomenometers and stuff, not be asking me about the ceiling, but they did, and I had to accept that they would, but it was unfair. (LES-MRS)

Expecting staff to speak to areas that are not under their control contributed to feelings that the exercise was “impossible” and that their achievements were not being recognized. One Swaziland staff member summarized this feeling well: “it's so hectic when you have to do something that you can’t really do. (SWAZI-GRS)”

COHSASA has tried to address this by breaking down their standards and reports by service domain so that standards applicable to “Maintenance Service” are separated from those standards related to “Obstetric/Maternity Care,” for example, and each domain goes only to the head of that service area and/or the senior leadership. But national leaders and hospital staff reported that many of the standards are “beyond the management in the facility” (SWAZI-MOH) and “things that we can at our level, we cannot do, that needs to be done by, by, by, by top management at the Ministry level” (SWAZI-GRS). Particularly for standards requiring significant human or financial resources, staff indicated that “it’s at the Ministry level that these things should be sorted

12 “Ae” means “no” in the local Sesotho language.
so that we improve our standards” (SWAZI-GRS). And this is very demotivating for staff, as one interviewee described:

This certification process can be very frustrating if you keep doing it and for things that health center manager or health facility manager can’t address themselves, if the central level is not seen to be supportive in providing an environment for them to be able to deal with that, then they will be demotivated. They will not be interested and it won’t serve the purpose. So to the extent that the Ministry will actively ensure that they continually try to support the facilities to be able to realize those improvements, to own, the only thing that will encourage them to want to do better. (LES-NG02)

Staff and national leaders in both countries feel that their Ministry of Health is responsible for many of the deficiencies in accreditation.

This is even truer for Government hospitals. Overall, the mission hospitals in both Lesotho and Swaziland were performing much better with accreditation than Government hospitals. One reason noted for this was the “long chain of hierarchy (LES-MRL)” with the Government:

The Government, you know, it used to say in Sesotho, “Muso hao tate.” The Government doesn’t just do whatever wanted, you see, anything you want to do. It will take time and time and time till they do what you requested. (LES-GUL)

Although “muso hao tate” is a Sesotho phrase, this sentiment of there being no rush or urgency in government was heard by many participants in both countries. But much of the difference between Government and mission hospitals is related to the location of management with the authority to make the necessary decisions. One interviewee pointed to this as a key challenge with the implementation of accreditation:

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13 “Muso hao tate” is a popular Sesotho phrase used in Lesotho and means there is no rush or urgency in Government.
Well, there are a few challenges. One of them, which I think is very crucial in their system is the centralized nature of running the, the Ministry of Health facilities. So that, uh, that has a very serious impact in terms of, um, empowering the facility management to actually manage the, the institution. Examples: Issues of staff decision-making, whether staff planning, staff training, you know, uh, the further training of staff, all of those functions are quite centralized. So that, that limits, uh, the ability of, of the, the facilities themselves to have control of the various other elements that make a decentralized facility to do better.

(SWAZI-NGO1)

The senior leadership at mission hospitals are able to make more decisions than the leadership at Government hospitals, and mission hospitals have control of their own resources, at least to some extent, so that “if they need something, they decide to buy this, they just go ahead and do it” (SWAZI-MOH). In contrast, the senior leadership in Government hospitals “feel paralyzed” (SWAZI-NGO1) and find themselves “waiting for someone higher up to tell them what to do” (LES-NGO1). With these different management models, who is actually responsible for the various standards may differ from facility to facility, but neither MCDI nor COHSASA has a system in place for clearly defining the full range of levels of responsibility for each standard.

**Demonstrating leadership commitment**

Regardless of who has responsibility for addressing specific standards, international partners, national leaders, and staff described the importance of a clear commitment from the central “higher authorities” and from senior management at the hospitals. One international partner from Lesotho sees this commitment from the MOHSW as “the only thing” that will make accreditation effective:
So to the extent that the Ministry will actively ensure that they continually try to support the facilities to be able to realize those improvements, to own, the only thing that will encourage them to want to do better. And recognition that they are improving. (LES-NG02)

And when asked what will help with buy-in at the facilities, another international partner in Lesotho responds that the communication of a commitment from the central level is the key:

If a mandate comes down from the central level to say, you know: This is a priority for us. Please continue to review your standards. Please continue to look at your scores. Please continue to improve. (LES-NGO1)

One international partner in Swaziland saw the establishment of the national Quality Assurance Unit as a strong indication of the Government's commitment:

We have seen that wherever political will has been expressed, there has been success, you know. So in the area of quality assurance, we are happy that, uh, already, I mean, you can see steps in that direction. The very fact that government can acknowledge and create a directorship just in charge of quality assurance. (SWAZI-NGO2)

One interesting example that points to the power of real commitment at the central level is Swaziland's high performance in the Physiotherapy service domain. Several interviewees were unable to explain this phenomenon, but finally, one national leader offered an explanation:

Physiotherapy? ((pause)) Oh! I think recently, the, the, the Prime Minister gave, I don't know what, but a lot of equipment. He went there and he found they needed, taking somebody, physio, to the physio for himself and found there were no equipment and then ordered, it was a directive from the highest up there. That's the truth, and I don't know what made him to do it, just to buy physio- equipment. Lucky them. (SWAZI-MOH2)

In this case, commitment at the highest level was all it took to mobilize the necessary resources. Overall, staff in Swaziland did not have as many concerns about Government
commitment as we heard in Lesotho. Some Swaziland staff did view the lack of Government response to inadequate resources as a sign of low commitment from the Government, but overall, staff did not question the Swaziland Government’s commitment to accreditation.

In contrast, nearly every focus group and several interviews mentioned this as an issue in Lesotho. A staff member from a Government hospital in Lesotho reported:

Yes, there’s no incentive. Even the Ministry itself, I don’t think that they are very serious about the accreditation, but they only come, when it is time for the accreditation and then when they come to give the report and then they will come through for the next accreditation, so I think they should be doing more to see to it that we meet the standards. (LES-GUS)

One international partner in Lesotho also questioned the commitment from the Government, but noted that CHAL hospitals may have a different perspective:

I think they have to work through, I think they, I think the central level needs to think about is this a priority. I mean, I think they have so many initiatives going on at this point that it’s kind of, they just do a lot of superficial stuff but don’t take hold of any two or three things. So I don’t, I don’t, I don’t think the hospitals think about it much. CHAL probably does because they have this pressure, um, but the government, I just don’t think they think about it too much. (LES-NGO1)

According to the GOL-CHAL MOU, the continuation of the subvention provided by the Government to CHAL hospitals will eventually depend on whether or not CHAL hospitals are able to meet the accreditation standards. The importance of passing accreditation was clear to CHAL hospitals and the CHAL leadership regularly communicated this importance. One Lesotho MOHSW representative was aware that this was the case:

They have really bought into this accreditation more than Government hospitals have because CHAL, one, they know they have a price to pay if
they don’t pass. So they are trying their best, they are, you know, they are really trying but Government, the same cannot be said for Government. (LES-MOHSW4)

Hospital staff did describe other factors that they felt contributed to CHAL’s higher performance (e.g. decentralized management and “the staff are more committed” because they are “missionary-based”), but it was clear that the staff at the CHAL hospitals understood accreditation to be a priority.

The commitment from hospital management is reported as more or equally important. In Lesotho, staff and international partners described a lack of commitment among the senior management in the Government hospitals:

There’s not a lot of buy-in, I think, to this accreditation process at the moment. There’s no support for it. People don’t talk about it on a regular basis. It’s just kind of one of those things that happens once a year. Um, I mean, as you could, as you could see, the management wasn’t even there when the assessment team came, obviously, they’re not taking it very seriously. (LES-NG01)

Swaziland leadership, too, indicated that the reason some facilities are not performing as well is the lack of commitment among hospital leadership, reporting, “I think the challenge is with the leadership because if the leadership is dedicated and committed, definitely by now, they would be talking quality. All the facilities would be” (SWAZI-MOH). But any success experienced in both Lesotho and Swaziland hospitals was attributed primarily to leadership at the hospital level. When asked about the key factors affecting buy-in at the hospital level, Ministry of Health representatives responded “More than anything, the positiveness and unity amongst the leadership and the support that they have, has a positive impact” (SWAZI-MOH3) and “…definitely, if the management is in support, everything will be fine” (SWAZI-MOH). Staff agreed, “Without the
management, it’s hopeless. It’s hopeless!” (SWAZI-FG2). COHSASA, too, pointed to hospital leadership as the most important determinant of success.

**Providing implementation support**

Part of demonstrating this commitment is reinforcing it with implementation support. And the Lesotho MOHSW recognized that not providing implementation support is not “sending the right signals” as one representative from Lesotho’s MOHSW described: “What is lacking, actually, is the follow up to empower them. You know, that is not happening here. And, uh, it’s sort of not giving, sending the right signals” (LES-MOHSW4). Lesotho’s MCDI accreditation program did not offer any support to facilities between annual assessments. One Lesotho hospital staff member shared her concerns about the lack of follow-up visits:

There wasn’t enough follow-up. I don’t know what they had in mind, but I don’t think accreditation should just appear at, okay, the certain interval, go through the test, then they shall see whether we are going to pass or fail...So I think in between the rounds here, there should be follow-ups and feedback and everything like that to ensure that all the standards are, are implemented, yeah, throughout. (LES-MRS)

In fact, it was this lack of regular follow-up that prompted the Lesotho MOHSW to transition to the COHSASA accreditation program:

...the one element, which was really good about COHSASA was to bridge that capacity gap, which I mentioned for follow-ups because when you just assess, leave people alone, and come back next year, chances are you will get the same status or worse, so COHSASA was coming in with that capacity to make regular follow-ups to the facilities. (LES-MOHSW2)

But even some Swaziland staff complained about not receiving enough support from their national Quality Assurance team:
...we have a local, uh, quality improvement, um, team from the Ministry. They, they are supposed to be visiting us on a regular basis before the consultants from, are from South Africa, are coming. They are supposed to be coming and visiting us to assess what is happening before the South Africa team has put. But then, they don’t come. You find that they come when the South Africans come. So we’re in a, where we are, we drop it. Or we run away from them. (SWAZI-GRS)

Many staff and national leaders talked about the fact that this team lacked the transportation resources to visit facilities as well as the time since only one member of the team worked full time with the Quality Assurance Unit and all the others are performing their accreditation support duties in addition to already very demanding job responsibilities. But overall, Swaziland staff were much more satisfied than Lesotho staff with the amount of support they received, and as noted earlier, in some cases complained that visits were too frequent.

In addition to receiving implementation support in the form of follow-up visits from the Quality Assurance Units and COHSASA, support from development partners also made a difference in the progress made towards meeting standards:

So you find that that area where the partner is focusing will do well, you know, eh. You’ll have all these new things and all that, you know. So basically you’re more likely to have a lot of improvement in that area. Cause that’s where the resources and the effort are concentrated, unlike other areas where there is no active support. (SWAZI-NGO2)

Both Swaziland and Lesotho hospitals performed better in meeting HIV-related standards, and leaders and staff in both countries attributed this to the support from development partners. One national leader described how resources are funneled to HIV and told of her wish to see more support in other areas:
HIV, HIV is because all the money's in HIV. They get money from partners, so they are paid, they are fine, lucky them. And it's all programs, so they get funding. Everybody ....HIV, HIV, I wish they could look at the other interventions....It's about resources, my dear. They have financial resources, human resources, there are many partners supporting HIV... (SWAZI-MOH2)

Recognizing the significant impact that support from development partners has had on these standards of care, one Swaziland MOH representative described one innovative idea that the Ministry planned to pursue to help strengthen other service areas:

We are thinking of involving the partners, the, even the companies that are interested in health, like, um, we want to request those big companies to assist the Ministry. Like, uh, there would, for instance, if, I'll give an example of MTN14. If MTN is interested in partnering with the Ministry, MTN may decide to say, ah, I'll take the children's ward to then, I'll make sure that I help the children's ward with all the, the resources they need. Maybe we'll say they, they will say, I want to equip the children's ward. So if the children's ward is well equipped with enough resources, we think, the, the, the services provided in that ward would be of good quality. (SWAZI-MOH)

The laboratory is another area that was doing very well in both countries. Upon inquiry, Swaziland leaders and staff attributed the success as being a by-product of the support from development partners to HIV/AIDS:

...the lab is directly tied to the HIV/AIDS programs, you know. So if I'm running an HIV/AIDS program, I need to buy a CD4 machine, so there'll be ICAP, Columbia University, or EGPAF, Elizabeth Glaser Foundation, one of them will buy these machines, microscopes, CD4 machines and all that. So there's always a lot of activity, you know, eh? (SWAZI-NGO2)

But Lesotho's success in the Laboratory was only partly attributed to the support being received for HIV/AIDS. Much more of the discussion around Laboratories was related to a special initiative for the accreditation of laboratories led by the Clinton Foundation and

14 MTN is a global telecommunications company with a major focus in the Southern African region.
the World Health Organization. This initiative included a series of trainings over several months for all Laboratory personnel, a mentor from the Clinton Foundation for each Lab, a designated quality assurance department for laboratory at the MOHSW headquarters, the development of standard operating procedures and additional resources to guide staff through daily checklists, the introduction of a process for regular self-monitoring within Laboratory departments, and a system for recognizing continuous progress as they meet certain thresholds.

Finally, one form of implementation support that was not a big part of either country's experience was cooperation between developing countries. The Lesotho QAU staff were funded by World Bank to visit South Africa to learn about their quality assurance program and a few MOH and hospital staff in Swaziland were given the opportunity to visit COHSASA-accredited hospitals in South Africa. Staff reported these as valuable experiences, indicating "it tells us this is possible in Africa" (SWAZI-MUL), but also much more frequently noted the major differences in resources available in South Africa, which somewhat diminished the value of these exchanges. There were no exchanges with other developing countries in the region or elsewhere, but one representative from the Swaziland MOH suggested cooperation at this level as her main piece of advice to Lesotho as they move forward with implementation of the COHSASA model:

My advice to them, learning from each other, one good thing, they must come and learn. That is what I always do, technical cooperation among developing countries to see, yeah. You go and learn. Swaziland's done it. Instead of going to make the same mistakes, learn from Swaziland, find out we started here, we're doing this, what is it that went right. Instead of reinventing the wheel....Come and learn from Swaziland. It's just around
the corner. Learning by communicating, by even visiting and meeting with the, like here I, here, doing that. That's my advice in terms of sharing us countries in the SADC. Sharing information, sharing, you know, best practices, uh, best practices and then lessons learned and things that didn't work, learning from each other and not going back to repeat the same mistake. Instead, we should move forward. Yeah. That's my advice. (SWAZI-MOH2)

Lesotho also expressed a desire to share with other developing countries the lessons they have learned in their experiences implementing hospital accreditation. But neither country knew of how to make these connections.

**DISCUSSION**

**Appropriateness ratings**

This rating exercise identified the types of standards that are perceived as most and least appropriate in both countries. Of the three Lesotho standards that were given the highest rating by all reviewers, two related to the Laboratory and one was HIV/AIDS-related, which interview and focus group data helped to explain as being related to the implementation support received for these areas. Swaziland's highest rated standards (two in HIV and one in Physiotherapy service domains) also spoke to the demonstrated commitment at the central level and concentrated implementation support specific to these areas. Lesotho's 11 uncertain standards point to the major challenges with financial and human resources that were explained through comments, focus groups, and interviews. Swaziland's one inappropriate rating zeroed in on an area that is, at least for now, truly not applicable to the country since no organ donation takes place in Swaziland. The survey proved to be a valuable source for triangulation of data and contributed to a
deeper understanding of perceptions of appropriateness of standards in both Lesotho and Swaziland. Survey ratings corroborated strongly with interview and focus group data.

On the whole, the survey worked better in Lesotho than in Swaziland due to the large number of standards, which resulted in a larger expert panel, less opportunity to confirm understanding of instructions with experts, and therefore, poorer comprehension and lower response rates. All of Lesotho’s standards were rated by ten or more experts while only 54.9% of Swaziland’s standards had three or more ratings. However, the purpose of the survey was to contribute qualitatively to our understanding of perceptions of appropriateness, which it succeeded in doing for both countries albeit requiring different interpretations of the information.

The fact that 91.1% of Lesotho’s standards were classified as appropriate cannot be interpreted in the same way as the 48.5% that were classified as appropriate in Swaziland since experts clearly had a different understanding of what they were rating. Interpreted independently, we can say that 8.9% of Lesotho’s standards were classified as being of uncertain appropriateness as defined by the three OECD criteria (importance, relevance, and feasibility), and 51.5% of Swaziland’s standards with enough ratings to classify are perceived as presenting challenges with at least the feasibility criteria of appropriateness. Particularly valuable were the survey comments accompanying ratings for 58.9% of Lesotho’s standards and 63% of Swaziland’s standards. These comments in conjunction with interview and focus group data made possible a fuller understanding of perceptions of appropriateness of standards, which are discussed in greater detail in the following section.
Importance, relevance, and feasibility of standards

Overall, hospital accreditation standards are perceived as important in both Lesotho and Swaziland, but the state of the economy in each country gives staff a different perspective that compels them to distinguish between what is really essential and what is not, both in terms of standards relating to structural aspects of health care (e.g. number of certain items of equipment) and to health care processes (e.g. duplicative documentation). Staff recognize that in an environment of limited resources, most things have trade-offs and, at times, there are important unintended consequences that need to be considered before moving forward with implementation.

The different models of accreditation implemented in each country contributed to differences in the perceived relevance of standards in the two countries. Swaziland's adherence to a comprehensive set of internationally recognized standards led to the inclusion of certain services by default (e.g. organ donation, dialysis) that were not offered in the country and the introduction of specific positions with authority that is contrary to national policy (e.g. facility-level HIV Project Manager). Lesotho's approach of developing a smaller set of standards particularly customized to their own national context was not completely without relevance concerns, but no concerns had wide enough agreement to indicate serious deficiencies. Standards relating to the area of the protection of patient and family rights raised important issues for both countries with neither country having staff that are in full agreement in this area. Getting all staff on the same page here will likely require open discussion and consideration of various opinions,
establishment of a clear position on this nationally, and specific education of staff about the rationale for this position and the implications for health care service delivery.

Feasibility was the biggest factor in both countries contributing to a diminished perception of appropriateness of the standards. Limitations in financial and human resources play a very important role in the ability to implement many of the standards. Having so many standards that require financial resources that are not available makes the overall exercise of accreditation feel like it is something that is beyond the control of staff to successfully implement. Most hospitals are not empowered or encouraged to prioritize these standards within resources that are available. As a result, staff are forced to make difficult decisions about patient care that prioritize the level of risk to the patient, such as re-using nasal prongs to get oxygen to a patient in need.

Likewise, the considerable increase in the number of demands as a result of accreditation (e.g. documentation, writing policies, patient education) on the current limited supply of health workers leaves staff feeling even more overwhelmed with no direction on how to handle all these demands. Many of the human resource requirements fail to accommodate the necessary substitutions that these countries have made in response to their human resource crises, thereby missing opportunities to make more realistic improvements in these areas. For instance, instead of prohibiting nurses from prescribing medications, which fails to recognize the massive shortage of certified pharmacists in Swaziland that is unlikely to be completely resolved in the near future, standards could have been written to specify certain types of medications that must be prescribed by pharmacists and training requirements for nurses writing medication
orders. One could also argue that including these standards is important to drive the system to take the steps necessary to eventually reach these goals (e.g. developing training programs that would help produce the needed human resources), but having so many standards that are impossible for staff to reach is demotivating and may have important consequences for staff participation in other quality efforts as was discussed in Chapter 3. Instead, by recognizing that standards should be dynamic and by building in a process for continuous review and revision, national leaders can increase appropriateness by avoiding the inclusion of standards based on the belief that they will someday be relevant, but are not yet appropriate.

Staff also reported disturbing unintended consequences that should prompt a thorough review of each standard with particular thought given to any potential negative effects that might arise in this context. Rather than leaving health professionals with no way to dry their hands because of lack of funds to buy paper towels (which probably means less washing of hands), alternative “next best” standards could be explored that are more feasible within the limited resources available.

**Perceived appropriateness of accreditation processes**

*Introducing accreditation to hospital staff*

The considerable attention paid by Swaziland staff to the way accreditation had been introduced to them highlighted this as an important theme. The fact that this was not as much of a concern in Lesotho may be due to the rapid timeframe within which accreditation was initiated in Swaziland or it may have actually been due to the fact that
Swaziland's reviewers were foreigners, which was established as an important issue in Chapter 3. Comments from Swaziland hospital staff were consistent with my prior experiences working in this setting, where it often took numerous discussions with staff at all levels before any productive work could begin. Only after trust and a mutual understanding had been established through several years of regular collaboration could work progress at a more rapid pace (Babich et al., 2008). With outsiders very suddenly entering their territory to "point out their weaknesses," hospital staff were put in a position where they had no control over what was happening to them.

**Promoting a gradual implementation process**

Related to the importance of a proper introduction of accreditation to hospital staff, there were many proposals for a more gradual introduction of accreditation, which would better orient staff and give them time to address the standards before being assessed. Some even suggested starting with a smaller sub-set of standards. And despite COHSASA's insistence that the complexity of hospitals requires a large number of standards, COHSASA also points out that some deficiencies are more critical than others, which suggests that the standards could, in fact, be phased in more gradually. This would then minimize the enormity of the task felt by hospital staff and reduce feelings of having no control over the quality of care provided at their facilities.

It is, perhaps, worth remembering that the first "Minimum Standards for Hospitals" in the United States, published by the American College of Surgeons in 1919 listed only five essential standards (Myers, 2012). And the first set of standards
published by the then Joint Commission Accreditation of Hospitals (today's Joint Commission) in 1953 filled just eleven pages. It is all too common for developed nations to forget that the development process is a gradual one. But it seems that the importance of this gradual implementation process is being increasingly recognized. COHSASA's latest SafeCare Initiative, launched in March 2011 in partnership with Joint Commission International (JCI) and the European PharmAccess Foundation, places much greater emphasis on the stepwise approach (SafeCare, 2013a), which they referred to as their graded system of accreditation in their interview, but for which there was no awareness in Swaziland. With the SafeCare Initiative's stepwise certification, though, the follow-up is still regular but less frequent (every six months) and the language has been changed so that the first six month follow-up is a "progress visit" and the first certification assessment does not take place until one year after the baseline (SafeCare, 2013b). It will certainly be interesting to compare perceptions in countries where this new model is being implemented.

Including all hospital staff in the process

This third theme relates closely to the discussion in Chapter 3 around ownership. By failing to communicate with and involve frontline staff early in the implementation process, this left staff feeling as though they had no role in implementing the changes required by accreditation. This especially affected the buy-in experienced by hospital staff in Swaziland, and despite efforts to correct this error later, staff seemed to harbor some lingering resentment due to this oversight. And as mentioned in Chapter 3, with
accreditation as the first introduction of staff to quality improvement more generally, failure to include staff in accreditation activities could be establishing a dangerous precedent that staff have no role in other quality improvement work.

*Defining who is responsible for what*

Giving frontline staff a role in the implementation of accreditation is important, but equally important is defining clearly what that role entails with expectations that fit with that which staff can reasonably do. Staff are demotivated when they are given responsibility for tasks that require skills or knowledge beyond their capabilities without the training to give them the required skills and for tasks that are not within their power to change due to resource constraints or limited authority.

It is also important to note that the management structure made a significant difference in implementation with greater decentralized management resulting in greater success. Again, as described here and in Chapter 3, Swaziland’s mission hospitals, which operate the most autonomously, expressed the greatest sense of optimism about the feasibility of successfully implementing accreditation and the greatest sense of ownership. Decentralization has often been a key pillar of health sector reforms in recent decades, and indeed, it seems that decentralization may be an important antecedent in determining readiness for accreditation, or at least in predicting likelihood of success. However, this should not be taken as a blanket recommendation for decentralization as, like accreditation, success with decentralization is determined by fitting the particular model of decentralization and the approach to implementation of decentralization with
the national context rather than blindly transporting Western models of decentralization into the developing world (Omar, 2002).

Demonstrating leadership commitment

There has been a lot of research conducted that shows the importance of leadership commitment to the success of organizational improvement initiatives, and accreditation in the developing world is no exception. Experiences implementing accreditation in Latin America found that commitment from national leadership was essential to successful implementation (Novaes & Neuhauser, 2000). In this study, commitment at the highest level was important for the necessary resource mobilization as well as signaling to the management and staff at hospitals that this was a priority initiative and worth the attention to make it successful. And likewise, commitment from hospital leadership is known as and proven to be a major determinant of success (Parker, Wubbenhorst, Young, Desai & Chams, 1999), and nearly every interview and focus group in this study supported this. However, aside from the influence of commitment from national leadership on the commitment of hospital leadership, this study did not uncover successful strategies for increasing the commitment of hospital management.

Providing implementation support

One sign of commitment from leadership is the extent to which the national model for accreditation provides resources for regular follow-up and implementation support. The under-resourcing of Quality Assurance Units in both countries has not gone
unnoticed by hospital staff. The more frequent support that Swaziland received from COHSASA was certainly a facilitator, but it was clear that the staff preference was for more local support and more facilitative support rather than just repeated assessments and written reports.

Direct and indirect support from development partners can also have an impact. In the case of HIV/AIDS, development partners were not focused on the HIV-related accreditation standards, but the improvements that resulted from their efforts nonetheless made a measurable difference in progress towards meeting HIV-related standards. With Lesotho's Laboratory service, the support they received with the express purpose of working towards compliance with accreditation standards made a major difference, not just in terms of measured performance towards meeting these standards, but also in the extent to which Laboratory personnel had bought into accreditation and became active participants in its implementation. Every one of the four focus groups in Lesotho included a representative from the hospital's Laboratory. It was clear that the hospital leadership recognized that the Laboratory service has become a leader of accreditation.

Similar partnerships and other innovative approaches to involving partners as Swaziland hopes to do could help to increase the feasibility of successful implementation of accreditation in the developing world. However, as should always be the case, partnerships should carefully consider how partners can make the most positive impact that can be sustained.

Finally, it seems that there is a desire to learn from and share with neighboring countries facing similar contextual challenges. There are many areas in addition to
accreditation that would likely benefit from these peer exchanges. Ways to facilitate effective exchange should be considered while recognizing the negative consequences often associated with the frequent removal of staff from their regular duties. Improvements in technology infrastructure and increases in comfort levels using technology may facilitate a less costly, less disruptive, more continuous, and more fruitful exchange of information between peers in neighboring countries.

**Theoretical insights**

A thorough exploration of existing theory found that current theories of organizational change failed to provide a model or framework that could guide my research or help to explain my findings, which supported the use of grounded theory approaches for this study. After conducting the analysis, I looked across the six key factors that influence staff perceptions of appropriateness for any cross-cutting themes, and found that many of these factors were related to the extent to which staff felt that they were in control. Although a grounded theory approach generally aims to generate theory (Charmaz, 2006), applying inductive reasoning in this case led to the identification of a cross-cutting theme (being in control) that is also emphasized heavily in existing theory. This prompted a closer look at the theory of planned behavior (TPB), and an examination of study data against this theory deduced that all three of the elements of the TPB together supported all of the study findings despite the fact that it has rarely been applied at an organizational level. Where organizational theories tend to overlook the importance of the individuals nested within the organization, TPB takes into account the
individual units within an organization, which are vital to the successful implementation of an innovation. Below is an overview of the theory of planned behavior followed by a discussion of its application to this study’s findings.

Theory of planned behavior (TPB) overview

Ajzen’s theory of planned behavior (TPB) was first introduced in 1985 to expand the theory of reasoned action (TRA) beyond its two determinants of behavioral intentions (behavioral attitude and subjective norms) to include the importance of the role of perceived behavioral control in influencing behavior (Ajzen, 1991). Like the TRA, the theory starts with the empirically proven foundation that intention is a key predictor of behavior. It includes the TRA determinants of intention, behavioral attitude and subjective norms. Attitude is determined by the extent to which an individual believes a behavior will result in a particular outcome and the value the individual places on that outcome. Subjective norms are determined by the preferences and pressures to engage, or not engage, in a behavior by peers or authority figures who are important to the individual. The theory of planned behavior adds a third determinant of behavioral intention: perceived behavioral control. This perceived behavioral control is determined by an individual’s sense of access to the necessary internal (e.g. knowledge and skills) and external (e.g. funding, support) resources and the opportunity to successfully carry out the behavior (Ajzen, 1991). Perceived behavioral control operates both directly and indirectly on behavior through affecting intention and through the obstacles or
opportunities that act to hinder or facilitate behavior. There are also mutual interactive effects between perceived behavioral control and the other two determinants of intention.

In health care, TPB is most often applied to thinking about behaviors in which individuals engage that have an effect on their personal health (e.g. HIV prevention, smoking cessation) (Godin & Kok, 1996). However, more recently, TPB has often been applied in thinking about the introduction of information systems to health professionals and the use of new technology for improving organizational performance (Chau & Hu, 2001; Mun, Jackson, Park, & Probst, 2006). These studies showed that TPB can help to explain the decisions of health professionals to change, or not change, the established process of care for managing patient information.

Theory applications to implementation of hospital accreditation

Like information systems, much of hospital accreditation requires major changes in the day-to-day processes of patient care provision by health professionals. The findings from this study on the perceptions of appropriateness of hospital accreditation fit nicely into the TPB model's three determinants of behavioral intention and behavior.

Attitudes toward implementing accreditation are first influenced by their perceptions of the importance and relevance of the standards adopted by the country. The more strongly participants believed that adherence to the standards would result in positive patient outcomes, the greater was their intention to support the implementation of accreditation.
As described in Chapter 2, the decision to implement accreditation on a national level is strongly influenced by internationally driven subjective norms (institutional theory), but subjective norms are also an important factor in implementation at a more local level. Demonstrated leadership commitment was found to be an important factor affecting intention directly and also affecting attitudes in that staff members are more likely to believe in the likelihood of accreditation resulting in a valuable outcome if national leadership show signs of their own belief in accreditation’s ability to bring about positive changes to the quality of care. Implementation support, or lack thereof, also sends a powerful message about the extent to which there is really a preference for hospital accreditation to be implemented.

Finally, many of the themes that this study found to be important affect perceived behavioral control of staff and national leaders in implementing accreditation. Perceptions of the feasibility of standards are driven by a sense of access to the skills, financial resources, and human resources necessary to successfully implement them. The way accreditation is introduced to staff determines whether they have the information and the opportunity they need to participate. Promoting a gradual implementation process helps increases perceived behavioral control by giving staff the time they need to develop the necessary internal resources (e.g. knowledge and skills) and giving staff a scope of work that can mostly or fully be addressed within the available external resources (e.g. human and financial). Including hospital staff in the process and defining who is responsible for what is important for staff to feel that they have had the opportunity to assist in carrying out accreditation and again, the resources they need to do so. And
providing implementation support can also contribute to the sense of access to the necessary resources and opportunity for implementation of accreditation.

At this point, current accreditation standards and processes in both Lesotho and Swaziland produce mixed effects on these three determinants of behavior, which may help to explain the mixed results that the countries have experienced to date. But the TPB model can help guide those responsible for leading the implementation of accreditation in developing standards and processes that promote positive attitudes towards implementing accreditation, stimulate the establishment of clear preferences and pressure for implementing accreditation, and, most importantly, enhance perceived behavioral control. TPB could also be considered in the implementation of other quality improvement efforts where success depends on staff engagement.

CONCLUSION

Overall, perceptions of the appropriateness of accreditation were mixed. Perceptions of the appropriateness of standards were largely positive noting high importance in both countries, fairly strong relevance in both countries with a few key exceptions in Swaziland, and moderate feasibility due to limited financial and human resources. The study identified some common factors that influenced perceptions of appropriateness of standards, and also identified some important unintended consequences of implementation that make the case for greater scrutiny of the standards adopted by the country.
Perceptions of the appropriateness of accreditation processes were strongly influenced by six key factors: (1) introducing accreditation to hospital staff, (2) promoting a gradual implementation process, (3) including all hospital staff in the process, (4) defining who is responsible for what, (5) demonstrating leadership commitment, and (6) providing implementation support. Comparisons between Lesotho and Swaziland and between Government and mission hospitals helped to highlight some of the important effects that these factors can have on how accreditation is perceived.

Overall, this study found strong agreement among staff and national leaders that there is, indeed, a problem with the quality of care in hospitals, and there is a strong desire to change it. But there is mostly low perceived behavioral control in both countries, although due to different factors, which is hindering the successful implementation of accreditation. Developing standards and processes that improve this perceived behavioral control is the key to increasing staff support for the implementation of hospital accreditation, and perhaps other quality improvement efforts as well.
CHAPTER 5: CONCLUSION

SIGNIFICANCE OF STUDY FINDINGS

The first study explored at a global level why hospital accreditation is expanding so rapidly in developing countries and found that institutional theory helps to explain this phenomenon. Developing countries seeking legitimacy associate accreditation with good quality of care in developed countries, and are swayed by the endorsement of accreditation by key international players and substantial donor support for implementation of hospital accreditation, which helps to encourage adoption. How much institutional theory influences the decision to adopt varies from country to country, but understanding the extent to which it is a factor is important as adoption driven by external forces results in less local adaptation, which then reduces the likelihood of true assimilation and sustainability.

The second study examined the perceived connection between hospital accreditation and other quality improvement efforts at a national level. It found that in countries where hospital accreditation is being implemented, it is laying important groundwork for future quality efforts through (1) influencing staff perceptions about how quality initiatives impact the quality of care and (2) shaping staff perceptions about their role in improving quality. Namely, hospital accreditation is affecting the sense of ownership staff have over quality and influencing staff perceptions of the feasibility of achieving quality care.

Finally, the third study investigated the appropriateness of current practices in
accreditation based on staff experiences at the hospital level in both Lesotho and Swaziland. Standards were perceived to be of high importance, fairly strong relevance, and moderate feasibility with financial and human resource limitations creating the biggest challenges. A set of themes were identified as affecting staff perceptions of the appropriateness of accreditation processes, and these were unified through the theory of planned behavior with the most important element influencing staff buy-in to hospital accreditation being perceived behavioral control. Lower perceived behavioral control was linked to lower perceptions of appropriateness and lower staff engagement.

By connecting practical experiences with key theories, these studies provide a better understanding of key issues to consider related to the implementation of hospital accreditation in the developing world. The aim was to explore questions around the diffusion of hospital accreditation at the global, national, and hospital levels, which could offer useful information for international development partners, leaders of developing countries, and those responsible for implementing hospital accreditation in a resource-poor setting.

For international development partners

Chapter 2 presents evidence of the important role that development partners play in the diffusion of hospital accreditation into the developing world. Subjective norms lending legitimacy to hospital accreditation as a way to improve the quality of care, endorsement of key international players and, most especially, directed funding from foreign aid agencies have been highly influential in the decision of developing countries
to adopt hospital accreditation.

In Lesotho and Swaziland, international development partners also largely determined the specific model of accreditation to be adopted in each country, in terms of both the standards and processes that would be implemented. The international community of policy-makers, funders, and partners has a responsibility to ensure that hospital accreditation is appropriately translated as it is introduced into developing countries. This includes assisting countries in making a truly informed decision about whether to adopt hospital accreditation in the first place versus other alternatives for improving the quality of care, adjusting the particular standards and processes to best fit the national context, and encouraging the implementation of complementary QA/QI efforts to maximize the impact of hospital accreditation and overall improvements to the quality of care provided.

This responsibility begins with leading a process of truly informed decision-making that includes a discussion of the relative advantage, complexity, compatibility, trialability, and observability of hospital accreditation. Development partners can assist decision-makers in the process of weighing both the potential benefits and limitations of accreditation in addressing the problems faced by the specific country considering adoption, and alternatives to accreditation should also be considered. The various accreditation program options and their strengths and weaknesses should also be fully considered. One way to promote this process is by facilitating productive exchanges with other similar countries with experience implementing hospital accreditation during the decision-making stage. Development partners can encourage without being prescriptive,
which will help to promote greater ownership by and commitment from national leadership and implementation of a maximally appropriate accreditation model, thereby increasing the likelihood of sustainability.

The development of an appropriate set of standards is a crucial part of the successful translation of hospital accreditation into resource-poor settings. The process of developing standards for Western countries has involved an intense peer review and consensus process (Myers, 2012), but input from national providers was relatively minimal in Lesotho and even more so in Swaziland. The RAND Appropriateness Method is one such process for defining a set of standards (Fitch et al., 2001). In fact, by conducting a modified version of just the first stage of the RAND Appropriateness Method with experts in Lesotho and Swaziland, a considerable amount of information about the perceived appropriateness of the standards was gleaned that may have been useful in the initial development of the standards. Health care providers' perceptions of appropriateness in these countries are influenced by the limited financial and human resources and associated competing priorities. By collecting information on their perceptions of the importance, relevance, and feasibility of standards, areas requiring further staff education can be identified (e.g. on the protection of patient and family rights), the appropriateness of standards can be maximized (e.g. by eliminating standards related to services not offered by the country), missed opportunities for helping countries make more realistic improvements can be reduced (e.g. by acknowledging and setting standards for key personnel substitutions), and potentially negative consequences can be curtailed (e.g. ensuring staff are not left without a way to dry their hands). Where
countries choose to adopt internationally accredited standards, soliciting staff perceptions of standards from the onset can, at the very least, identify those areas that are likely to be most challenging and that are likely to require assistance from development partners to be successful.

Development partners, particularly those involved in directly supporting implementation of hospital accreditation, can also foster accreditation processes that are most likely to enhance the perceived behavioral control of hospital staff and increase the likelihood of success. Partners should be mindful of the importance of first establishing a relationship with local partners and should be sensitive to the concern that hospital leaders and staff will inevitably feel in having their performance assessed. This should include an emphasis on a thorough, more gradual introduction of accreditation that informs, orients, and aims to include staff. The type and nature of the assistance that development partners provide to support implementation is also very important. Areas where development partners focus most of their attention and resources (e.g. HIV/AIDS) received higher accreditation scores. And areas that received more concentrated, comprehensive support (e.g. Laboratory) had higher accreditation scores as well as the necessary processes and motivated staff to continue making regular improvements. Development partners can assist more by broadening their focus to include more service areas and by improving coordination so that partner activities are mutually supportive (e.g. engaging HIV/AIDS-focused partners directly in helping hospitals to address HIV/AIDS-related standards).

One other way that international partners can make a difference is by supporting
other quality assurance and quality improvement activities. Partners may not be aware of the lack of awareness on the subject. Partners can assist national leaders with the necessary education about QA/QI, with the development of a more comprehensive strategic plan for QA/QI, and with establishing a useful and sustainable infrastructure for QA/QI. This strategic plan may not include a comprehensive hospital accreditation program, at least not initially. For instance, after Zambia ended its accreditation program for its public hospitals, it continued to use a more limited set of standards, referred to as inspection guidelines, to aid in monitoring and evaluation and to guide technical support provided to hospitals from higher authorities. However, hospitals do undergo an accreditation process for some service areas, such as HIV/AIDS, where facilities must meet a set of minimum standards in order to provide antiretroviral therapy. But if a country does decide to adopt hospital accreditation, positioning it as one tool for improvement can maximize its effects by coupling it with other useful tools that can aid in its implementation (e.g., educating staff on problem solving), and the collective impact on the quality of care provided will be far greater.

**For developing country leaders**

Chapter 4 emphasizes the importance of a demonstrated commitment from national leaders, which will help to ensure that investment of the necessary financial and support resources is made a priority and will encourage hospital leadership to provide the necessary support to move the facility towards meeting accreditation. The role of national leaders is critical to ensuring that the decision to adopt accreditation is a
thoughtful one and, if adopted, that the specific standards and processes used fit the national context. Perhaps most importantly, the leaders of developing countries are responsible for leading efforts to establish a clear strategy for other quality assurance and quality improvement activities that can strengthen health care nationally, which may or may not include hospital accreditation.

National leaders in developing countries are all too familiar with the challenges involved in introducing any new initiative aimed at improving health care delivery. But having a better understanding of the particular threats involved when adopting isomorphic innovations, may assist leaders in taking extra care to minimize the associated risk. Although development partners have considerable influence in these situations and national leaders may feel pressured to adopt the innovations offered to them, the leaders of developing countries still play an important role in ensuring that the way the innovation – in this case, accreditation – is implemented translates appropriately to the national context. Paying attention to Rogers’ five stages of the innovation process (agenda-setting, matching, redefining/restructuring, clarifying, and routinizing) may assist national leaders in this task. Experiences from Lesotho and Swaziland showed that even in cases where adoption of accreditation was triggered by an external push, it may still be worthwhile for leaders to clearly define the specific problem that they hope to address. This will help with the matching stage, which assesses whether accreditation is, in fact, the best solution to the problem and whether it is possible to implement given the national context. This matching stage may also begin to clarify the specifics of the accreditation model that will work best given the problem that has been defined and any
resource or other constraints that may affect what will or will not work in the country. For instance, Lesotho's original model of a smaller, customized set of standards addressed the primary concern with holding CHAL hospitals accountable and permitted a peer review process that was thought to be sustainable within the resources available. The details of the accreditation model to be adapted for use, though, are really determined during the redefining/restructuring stage. Making this process explicit may help development partners and national leaders to work together more effectively with the aim of maximizing the fit of accreditation. National leaders can also build in a process during the clarifying stage for continuous assessment of how implementation of accreditation is progressing based on the reactions of those implementing accreditation and adjusting as needed to reach the ultimate goal of routinization.

Guidance for leaders of developing countries in defining an appropriate set of standards is much the same as that given to development partners in the previous section. Gathering input from national providers on their perceptions of the importance, relevance, and feasibility of standards through a peer review and consensus process can produce valuable insights. By recognizing that standards can be dynamic and then building in a process for continuous review and revision, national leaders can increase appropriateness by avoiding the inclusion of standards based on the belief that they will someday be relevant, but are not yet appropriate. For instance, Lesotho can wait until the MOHSW and Lesotho Medical Association have developed a continuing medical education (CME) program and defined CME requirements before instituting a standard requiring physician adherence to a national policy for CME that does not exist.
It is also important for national leaders to foster accreditation processes that enhance the sense of perceived behavioral control among staff. This can happen both indirectly by providing support to those responsible for leading implementation of accreditation nationally and directly, namely by demonstrating their commitment to hospital accreditation and by helping hospitals to prioritize those areas that are most critical to address and committing the resources required to address them. For those countries with more centralized governance, it may also be worthwhile to use hospital accreditation as an area to begin to introduce aspects of decentralization given the association of higher accreditation scores with decentralized management. For instance, Government hospitals could be given a set budget earmarked for tackling deficiencies in accreditation standards to be used at the discretion of the hospital.

The area where leaders of developing countries have the greatest opportunity to contribute, though, is in developing a clear national strategy for quality assurance and quality improvement that goes beyond hospital accreditation. It would be worthwhile for national leaders to learn more about the fundamentals of QA/QI and the real experiences of similar countries in implementing a range of QA/QI activities, including hospital accreditation. This information can help guide national leaders in defining the infrastructure and programs necessary to implement a more comprehensive program using complementary quality methods that will work together to strengthen the national health care system.
For accreditation implementers

The work of those leading the implementation of hospital accreditation in the facilities is perhaps most important to getting staff buy-in of accreditation and ensuring its true assimilation by the hospitals. Chapter 4 identifies the key factors that are associated with the perceived behavioral control that hospital staff experience related to implementation of accreditation. Those leading accreditation implementation have the potential to manage several of those factors in ways that will enhance perceived behavioral control among staff, thereby increasing receptivity to hospital accreditation. These implementers also are in a unique position to encourage staff engagement in quality efforts more generally.

The areas where leading implementers of accreditation have the greatest influence include introducing accreditation to hospital staff, promoting a gradual implementation process, including all hospital staff in the process, and defining who is responsible for what. Communication about the purpose of accreditation and expectations for hospital staff should be thorough and frequent. Lesotho staff reported many different means of learning about accreditation, which seemed to prevent staff from feeling caught off guard. If those leading accreditation implementation are non-nationals, the care with which staff are oriented to accreditation is even more important. Although implementers may not have control over national expectations for meeting standards, they can still facilitate implementation in a way that promotes gradual implementation by helping facilities to prioritize critical standards, set interim goals, and celebrate achievements along the way, as is the major focus of COHSASA’s more recent SafeCare
initiative (SafeCare, 2013b). Giving all staff an opportunity to be involved in the implementation of accreditation is also important. And finally, lead implementers can sort through the standards to clearly delineate who can contribute towards meeting each standard based on what staff can reasonably do within their power, skills, and other resources available to them.

Those leading implementation of accreditation can also take advantage of their role to educate staff more generally about quality assurance and quality improvement. Data from Lesotho and Swaziland indicate that QA/QI concepts such as standardization, patient safety, and efficiency, are being introduced along with accreditation but not in a way that staff have a clear understanding of their meaning. Educating staff about the fundamental concepts of QA/QI can help to increase staff understanding of hospital accreditation and also generate enthusiasm for quality efforts more broadly. At the very least, given the fact that accreditation standards often expect hospitals to develop quality improvement projects, capacity should be built for hospital staff on how to do quality improvement projects. Staff should be encouraged to address problems that they consider to be important that are not necessarily related to addressing unmet accreditation standards. This, too, should increase the overall sense of perceived behavioral control among staff in relation to accreditation and other quality efforts, which will increase the likelihood for staff intention to implement change and overall program success.

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CONTRIBUTIONS TO THEORY

The paucity of health research from developing countries is a well-known problem (Langer, Díaz-Olavarrieta, Berdichevsky & Villar, 2004). This shortage also pertains to research exploring hospital accreditation in developing countries and, more broadly, to research applying organizational theory in the study of health organizations in developing countries. This study contributes to a deeper understanding of the expansion of hospital accreditation into the developing world by exploring global trends along with national and hospital level perspectives on experiences with the implementation of hospital accreditation in Lesotho and Swaziland. But this research also makes important contributions to theory by challenging some common models and suggesting new applications for several existing theories. These contributions are summarized in Table 5.1 and discussed further below.
Table 5.3. Summary of study findings and theoretical contributions.

<table>
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<th>Question</th>
<th>Key Findings</th>
<th>Theoretical Contributions</th>
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| Global perspective: Why is hospital accreditation expanding so rapidly in developing countries? | • Institutional theory largely explains diffusion of hospital accreditation into developing world due to:  
  - Association with good quality of care in developed countries  
  - Endorsement by key international players  
  - Substantial donor support  
  • Adoption for this reason results in less redefinition, which may reduce likelihood of true assimilation sustainability. | • Institutional theory may help to explain the diffusion of many innovations into the developing world.  
• For isomorphic innovations (when diffusion is explained by institutional theory), special attention should be paid to the innovation process. Innovations should be: (1) evaluated for fit with specific circumstances and context, (2) redefined to improve fit and enhance perceived attributes, and (3) adjusted as needed to address concerns with implementation. |
| National perspective: What is the perceived connection between hospital accreditation and other QI efforts, and what are the effects of this? | • Hospital accreditation is laying important groundwork for future quality efforts  
  • Staff perceives that hospital accreditation is impacting quality of care through:  
    - Bringing attention to quality practices  
    - Giving direction on how to maximize quality  
    - Providing oversight  
    - Changing structures and processes of care  
  • Staff experiences with accreditation are shaping perceptions of their role in improving quality by:  
    - Affecting sense of ownership over quality  
    - Influencing perceived feasibility of achieving quality care | • This study is largely consistent with others that have failed to demonstrate connection between accreditation and patient outcomes. This challenges Donabedian's model connecting structures, processes, and outcomes, and confirms need for diverse methods to address all three dimensions of quality.  
• Models that place quality methods in a hierarchy suggesting sequential implementation (with accreditation either as a foundational, bottom-tier approach or a sophisticated, top-tier approach) should be replaced with a model placing quality methods along a cyclical pathway or in a Venn diagram, recognizing the benefits of simultaneous implementation of complementary methods of various levels of complexity. |
| Hospital perspective: Are current practices in accreditation in the developing world appropriate for this context, and if not, what would make them more appropriate? | • Standards were perceived to be of high importance, fairly strong relevance, and moderate feasibility due to limited financial and human resources.  
• Staff perceived that accreditation impacts quality through:  
  - Introducing accreditation to hospital staff  
  - Promoting a gradual implementation process  
  - Including all hospital staff in the process  
  - Defining who is responsible for what  
  - Demonstrating leadership commitment  
  - Providing implementation support  
• Lower perceived behavioral control, which was affected by these factors, was linked to lower perceptions of appropriateness and lower staff engagement. | • There were close connections between the factors influencing staff perceptions of appropriateness and the three determinants of behavioral intention and behavior as depicted in the theory of planned behavior (attitude toward behavior, subjective norm, and perceived behavioral control), with perceived behavioral control particularly important. This model may help guide those implementing hospital accreditation and other quality improvement efforts to focus on developing programs that will promote positive attitudes towards the program, stimulate the establishment of clear preferences and pressure for implementing the program, and, most importantly, enhance perceived behavioral control. |
The first study explores the complexities that arise when both institutional theory and diffusion of innovations are at work. First, by describing how institutional theory helps to explain the expansion of hospital accreditation into the developing world, it is easy to see how institutional theory may help to explain the diffusion of many other similar innovations into the developing world. The term "isomorphic innovation" is coined to designate instances when institutional theory explains the decision to adopt an innovation, which is so often the focus of diffusion of innovation research. This study then highlights the unique challenges posed in the process of implementing isomorphic innovations by following the experiences of Lesotho and Swaziland with hospital accreditation as it progressed through the stages of the innovation process. It concludes that special attention should be paid to the innovation process for isomorphic innovations, which should be: (1) evaluated for how well they fit with the specific circumstances and context, (2) redefined to improve fit with these circumstances and context and enhance the five perceived attributes (relative advantage, compatibility, complexity, trialability, and observability) that contribute most to assimilation of the innovation, and (3) adjusted as needed to address any concerns raised during the course of implementation.

The second study challenges some common conceptual models about the quality of care and quality improvement. Although this research was not intended to study the relationship between accreditation and patient outcomes, every interview and focus group solicited information on the impact of hospital accreditation and often probed further about whether there had specifically been any impact on patient outcomes. Study participants had a great deal to say about the impact of hospital accreditation, but with the
exception of some perceived improvements in patient satisfaction, participants did not—and even when asked directly, could not—describe any impacts of accreditation on patient outcomes. Donabedian’s model suggests that structures, processes, and outcomes of care are connected such that there should be some effect on outcomes of care as a result of improvements made to structures and processes, which is the focus of accreditation. However, this study is consistent with findings from other studies, which have failed to demonstrate the connection between accreditation and patient outcomes (see Chapter 3). This then highlights the need for implementing a variety of QA/QI methods in combination that will address all three dimensions of the quality of care.

Models of QA/QI approaches often place the various methodologies in a hierarchy suggesting that certain more basic methods must be incorporated before more advanced approaches can be implemented. There is some disagreement about where hospital accreditation falls in this hierarchy with some viewing it as a foundational, bottom-tier approach and others as a sophisticated, top-tier approach. However, these hierarchical models fail to recognize the benefits of simultaneous implementation of complementary methods. A conceptual model that places quality methods along a cyclical pathway or in a Venn diagram is likely a better way to portray the various quality methods available, suggesting that they are all important tools in the quality of care toolbox.

Finally, the third study identified a number of key factors influencing staff perceptions of appropriateness with many of these factors relating to the extent to which staff felt that they had control over the situation. It was this cross-cutting theme that prompted a closer look at the theory of planned behavior, despite the fact that this theory
had only been applied at an organizational level to the spread of information systems. Indeed, the factors influencing staff perceptions of appropriateness were closely connected to all three determinants of behavioral intention and behavior in the theory of planned behavior (attitude toward behavior, subjective norm, and perceived behavioral control), with perceived behavioral control the most important. By recognizing the relevance of this model to the implementation of hospital accreditation, standards and processes can be developed that consider the key factors identified in an effort to promote positive attitudes towards accreditation, stimulate the establishment of clear preferences and pressure for implementing accreditation, and most importantly, enhance perceived behavioral control. Furthermore, this same model could also be considered in the implementation of other quality improvement efforts where success depends on staff engagement.

LIMITATIONS

This study made some important practical and theoretical contributions, but it is not without its limitations. Several data sources were used to capture and report multiple perspectives in order to strengthen the credibility and dependability of the study findings, but collection for each type of data had its own share of challenges. And while many of this study’s findings are certainly transferrable beyond Lesotho and Swaziland, it is also important to understand the extent to which findings are generalizable.

Recent and readily available information was difficult to find when searching archival records and documentary sources for information on global and regional trends.
of the expansion of hospital accreditation outside of Lesotho and Swaziland. I did not have access to the gray literature that is so often the source of the most recent and reliable information in developing countries but is very difficult to access. But while specific details informing global or regional trends may be different from those of the archival records and documentary sources used in this study, overall trends and interpretations of those findings are not likely to be significantly different.

Overall, the purposeful sampling strategy for interviews and focus groups was effective at providing a rich set of data representing multiple perspectives with which to fulfill the purpose of the study. However, one perspective that was missing from these interviews and focus groups was that of hospital leadership. Although their input was given in expert surveys, it may have been useful to conduct interviews or focus groups with a sample of hospital leaders given the importance of their role in achieving successful implementation of accreditation. The number of interviews and focus groups was also appropriate in that we achieved saturation of the data usually by the fourth or fifth interview and by the third focus group in each country. Although interviews and focus groups explored different issues, where there were areas of overlap, reports from key informant leaders and hospital staff participants were largely consistent with each other. The majority of interviews were conducted in person with two interviewers, but for the two interviews with international partners conducted by telephone, there were challenges with the connection that disrupted the flow of the interview and made parts of the response difficult to hear. And in the one instance where the interviewer had never met the participant, it was also difficult to establish a good rapport that may have helped
the interviewee to speak more freely. Interviews and focus groups conducted in person were largely free from problems and had very good participation from all those present, but there were two instances of individuals who were less comfortable speaking in English and relied on colleagues to interpret for them when they wanted to contribute to the discussion. None of these issues, though, were likely to have had significant effects on the study findings and conclusions.

Some of the challenges with the surveys, in terms of survey burden and poor comprehension by some, were discussed earlier. Although the survey data produced important insights that contributed further to findings about the appropriateness of standards, it was not sufficient to address the question of appropriateness of standards on its own. The second phase of the RAND Appropriateness Method where experts are brought together for a discussion of ratings is an essential part of the process. Fortunately, the survey comments, interviews and focus groups together helped to fill this gap so that the study still produced a good understanding of perceptions of appropriateness.

Finally, Lesotho and Swaziland are two small Southern African countries with somewhat similar (though still unique) cultures and contexts. Many of the practical contributions from this study related to implementing hospital accreditation are likely to be highly transferrable to other similar developing countries in the region and neighboring regions and they may even extend to low-resource countries in other parts of the world implementing or considering implementation of hospital accreditation. But these practical contributions need to be considered in their original context in relation to
any new context where they might apply. This study's theoretical contributions, on the other hand, are far more generalizable to other developing world contexts and programs beyond hospital accreditation.

**FUTURE RESEARCH**

There are many possible directions for future research, but in my opinion, the most pressing and useful is studying hospital accreditation in the context of other more comprehensive quality assurance and quality improvement efforts in developing countries. Quality efforts in Lesotho and Swaziland were limited to hospital accreditation, so this could not be explored in these countries, but study findings showed that implementing hospital accreditation without other quality methods will have limited impact. It would be interesting to explore how experiences with hospital accreditation are affected when other quality approaches are being implemented and to understand experiences with implementing comprehensive QA/QI strategies in the developing world more generally, particularly in those places like Zambia and Uganda where accreditation was implemented but not sustained.

Experiences with quality assurance and quality improvement, including hospital accreditation, have been well-researched in the Western world, but little is known about how these translate into developing countries. By studying these issues, it is possible to contribute to a better understanding of issues to consider in facilitating the diffusion of these programs in a way that will help to strengthen health systems in the developing world.
This semi-structured interview guide was used flexibly in order to be responsive to each interview situation while remaining within the scope of the principle research questions.

**Hospital Accreditation Perceptions and Meaning**
1. Can you tell me what you know about hospital accreditation?
2. What does hospital accreditation mean to you? What impact has accreditation had on your work? What impact has accreditation had on COUNTRY?
3. What do you see as the pros and cons of hospital accreditation?

**Hospital Accreditation History**
1. If you were writing a history book on accreditation in COUNTRY, what would you say about the first years of implementation?
   a. How do you think the idea first got planted?
   b. When do you think the idea was planted? When did discussions start? When did you first hear about it?
   c. Who was involved in accreditation (individuals and/or organizations)? In the Government? In the region? Internationally?
   d. Did they have any help? Who assisted in these efforts? Within country? Outside of the country?
   e. Who did the actual accreditation? How many? What type of training was involved?
2. [If not covered above] Describe for me the progress in COUNTRY in each of the following areas:
   a. Choosing an accreditation configuration and adapting it to COUNTRY
   b. Setting up the formal structure to advise, operate, and manage the accreditation program
   c. Developing and testing standards
   d. Developing the survey process
   e. Recruiting, hiring, and training surveyors
   f. Conducting educational campaigns and surveys
   g. Refining rules, policies, and procedures for accreditation
   h. Interpreting survey data and making accreditation decisions
3. What have been the major successes and challenges in implementing hospital accreditation?

**Hospital Accreditation Purpose**
1. What do you think were the key reasons for introducing hospital accreditation? What was the motivation?
2. What were the key factors that really made hospital accreditation happen?
   a. People? Events? Other forces or pressures (social, political, economic)?
3. Knowing what you know about accreditation in COUNTRY, how well do you think accreditation is fulfilling [each of those purposes]?
4. In what ways might the purpose of hospital accreditation in COUNTRY differ from the purpose of hospital accreditation in other countries?

The Future of Hospital Accreditation
1. What do you think is the future of accreditation in COUNTRY? How will it be different in a year? Five years? Twenty years?
2. Let’s assume that hospital accreditation is here to stay, what are some changes you might propose to make it as effective as possible?
APPENDIX B: CODES WITH DEFINITIONS

- **Positive views on accreditation**: Positive feelings about and attitudes toward accreditation.

- **Changing perceptions of accreditation**: Mixed or uncertain views and/or the evolution (or non-evolution) of perceptions over time.

- **Negative views on accreditation**: Negative feelings about and attitudes toward accreditation.

- **Need for quality care**: Reports of widespread poor care delivery illustrated through statistics, stories, public complaints, etc. demonstrating the need for quality of care that motivated the introduction of accreditation as a potential solution.

- **Raising awareness of quality care practices**: Adding or refreshing knowledge about health care practices that result in good quality of care, which then may be translated into practice.

- **Changing delivery practices**: Making changes to various clinical and administrative structures and processes of care since accreditation was introduced.

- **Performance towards meeting standards**: Progress or lack thereof towards meeting specific standards or overall accreditation.

- **Difficulty changing established practice**: Tension or conflict created when instead of adopting proposed standards, existing care practices are maintained or returned to.

- **Sustaining gains**: Continued effort required to sustain changes implemented as a result of accreditation.

- **Futility of the effort**: Sense that targets are unreachable no matter how much effort is expended.

- **Unintended consequences**: Unanticipated (wanted and unwanted) effects on patient care due to implementing accreditation.

- **Facilitating factors**: People or other forces that have facilitated successful implementation of accreditation.

- **Impeding factors**: People or other forces that have impeded successful implementation of accreditation (other than inadequate resources).

- **Wanting perceived facilitators**: People or other forces that are believed to have the potential to facilitate successful implementation of accreditation (or expressed as the lack of these which has impeded successful implementation).

- **Incentives for compliance**: Positive and negative consequences (rewards and punishments) to motivate initial and continued implementation of accreditation.
• **Inadequate resources:** Not enough and/or the right kind of financial resources, technical support, human resources, and infrastructure to implement accreditation.

• **Accountability:** Thoughts and reactions to oversight of accreditation efforts.

• **Importance of measurement:** The role of measurement in accreditation efforts, including supporting tools such as IT.

• **Policing and criticizing:** Negative external regulation, control, pressure, and judgment brought on by accreditation.

• **Impersonal implementation support:** Nature and consequences of the largely impersonal relationship with those supporting implementation (e.g. nameless, constantly changing individuals).

• **Ours versus theirs:** The sense of ownership (or lack thereof) of the process of implementing accreditation as well as the standards.

• **Importing accreditation:** Bringing in accreditation itself (the good) and the support to develop and implement accreditation locally (the service) from outside the implementing country.

• **Meeting international standards:** The motivation for as well as the nature, process, and effects of implementing international standards.

• **Questioning definition of accreditation:** Clarifying or questioning what is and what is not accreditation.

• **Suitability of standards:** Relevance, feasibility, importance, and overall appropriateness of standards and changing standards to make them more suitable.

• **Accreditation synonymous with quality:** Indications of accreditation and accreditors representing or even being used interchangeably with “quality.”

• **Laying the groundwork:** Who, what, when, where, why, and how of generating awareness about and starting implementation of accreditation.

• **Including everyone:** Opportunities for broad-based participation by all relevant parties (or lack thereof).

• **Locus of responsibility:** Assignment or placement of accreditation goals with the appropriate level of authority.

• **Expanding accreditation:** The process of implementing accreditation throughout the country and associated successes and challenges as well as facilitators and barriers in doing this.

• **Recognizing accreditation as a gradual process:** The process of accepting and implementing accreditation and associated successes and challenges.

• **Other quality improvement:** Thoughts about and activities related to quality improvement efforts other than accreditation.
APPENDIX C: SAMPLE STANDARDS FROM EXPERT SURVEYS

Lesotho example standards ACC2.1 and ACC 2.2 as summarized in expert survey:

**Indicator 2: There is a process for discharge.**
Patients, and as appropriate, families receive understandable instructions on discharge. Clear instructions are given to the patient and/or their family, including when to return to follow up. This information should be included in the patient record. This is measured by the number of patient charts that contain information on when to return for follow-up and the medication to be taken.

**Indicator 2 Rating:** [ ]

*(Optional) Indicator 2 Comments:*

**Indicator 3: The patient record contains a discharge summary.**
The discharge summary contains the reason for admission, significant findings, procedures performed, medications and other treatments, condition at discharge, and medications and follow up instructions. This is measured by the number of patient records reviewed with a summary that includes all of these elements.

**Indicator 3 Rating:** [ ]

*(Optional) Indicator 3 Comments:*

Swaziland example standard 11.7.3 as summarized in expert survey:

**Standard 25: There is an organised process to appropriately discharge patients.**
11.7.3.1. There is a process, known to staff, to appropriately discharge patients.
11.7.3.2. The discharge is based on the patient's needs for continuity of care.
11.7.3.3. Planning for discharge, when appropriate, includes the family.
11.7.3.4. The organisation works with healthcare practitioners and agencies outside the organisation to ensure timely and appropriate discharge.
11.7.3.5. The process considers the need for support services and continuity of care.
11.7.3.6. Patients and, as appropriate, their families are given understandable follow-up instructions by the medical practitioner in the discharge note at referral or discharge. 11.7.3.7. Follow-up instructions in the discharge note include any return for follow-up care, and when and where to obtain urgent care.

Standard 25 Rating: 

(Optional) Standard 25 Comments:


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Sep 2004 – May 2005
Program Associate
Brookline Public Health Department

Jan 2004 – May 2004
Intern
Population Services International – Lesotho
Boston University School of Public Health (Lesotho)
Grants and contracts shown indicate a lead role in project design and/or implementation.

Title: Transforming District Health Services in Lesotho: A Feasible and Sustainable Way Forward
Position: Deputy Project Director
Source: W.K. Kellogg Foundation (Subcontract from Lesotho MOHSW)
Amount: $3,200,000
Project Period: January 2007 – December 2011
Project Summary:
BMC is working with the Ministry of Health and Social Welfare (MOHSW) over a period of five years to institute sustainable continuing medical and nursing education programs, initiate a Family Medicine residency program, increase the return of Basotho physicians to Lesotho, improve the retention of Basotho nurses and physicians in Lesotho, transform two pilot district hospitals into vibrant, sustainable, well-utilized hospitals providing services of good quality in support of primary care and lay the groundwork for transforming other district hospitals in Lesotho.

Title: Building HIV/AIDS Capacity in the Community
Position: Principal Investigator
Source: CDC (PSI Subcontract)
Amount: $50,000
Project Period: March 2008 – April 2009
Project Summary:
This award continues the work begun training Community Based Counselors in the Berea District of Lesotho to deliver needed HIV support services as part of the Know Your Status Campaign.

Title: Baseline Study for the Lesotho Hospital Public Private Partnership
Position: Deputy Project Director
Source: International Finance Corporation
Amount: $205,000
Project Summary:
This contract aims to develop measurable indicators to assess the availability, quantity, and quality of services existing at Lesotho’s national referral hospital (Queen Elizabeth II) and three filter clinics, develop benchmarks along which a selected private operator’s performance will be evaluated, conduct a comprehensive baseline study to determine current situation with availability, quantity, and quality of services, and, finally, measure the volume and amount of cross-border referrals.
Essential and Complementary Activities in Support of Transforming District Health Services in Lesotho

Deputy Project Director
W.K. Kellogg Foundation
$400,000
April 2007 – September 2009
This supplementary grant provides BMC with the resources and flexibility to undertake essential and complementary activities in support of “Transforming District Health Services in Lesotho.”

A Planning Grant for Strengthening District Hospitals and Health Centres in Lesotho

Project Manager
W.K. Kellogg Foundation
$195,000
January 2006 – December 2006
This award funded the development of a 5-year proposal with the Ministry of Health and Social Welfare for the sustainable strengthening of district hospitals and their associated health centers. A baseline assessment of nine district hospitals was performed, and more detailed assessments were conducted in the two selected focus districts.

Rapid Donor Survey for Lesotho Health Sector

Principal Investigator / Project Director
International Finance Corporation
~$18,000
October 2005 – January 2006
The Boston team undertook a survey of non-governmental organizations active in the health sector in the country of Lesotho, which focused on the capital city of Maseru. The purpose of this study was to identify the nature, scope and commitment of these health services so as to avoid duplication and/or identify synergies with the services and operation of the new national referral hospital.

Building HIV/AIDS Capacity and Improving Quality in the Context of Sustainable Primary Care

Co-Principal Investigator
USAID PACT
~$240,000
This project trains Community Based Counselors to provide needed HIV/AIDS counseling, testing and treatment support.
services of good quality and is developing appropriate systems for management, supervision, referral and logistics to further advance the national Know Your Status campaign.

| Title: | Developing the Lesotho Primary Health Care Workforce: Nurse Clinicians and Family Medicine Physicians |
| Position: | Project Manager |
| Source: | U.S. Department of State |
| Amount: | $133,000 |
| Project Period: | October 2004 – December 2006 |
| Project Summary: | This award enabled the Boston team to begin a process that will improve the quality and accessibility of affordable and sustainable primary care, increase the nation’s capacity to respond to the burgeoning medical care demands of the HIV/AIDS epidemic, and improve the recruitment and retention of nurses and physicians. |

| Title: | Urgent Need, Unique Opportunity: Teacher Training and Healthy Teachers |
| Position: | Project Manager |
| Source: | USAID Association Liaison Office |
| Amount: | $100,000 |
| Project Summary: | The aim of this partnership between Boston University and the Lesotho College of Education was to keep faculty, staff, and students HIV negative and if positive, maintain a healthy lifestyle until they begin ARV treatment in order to strengthen the education sector in Lesotho. This project developed the HIV/AIDS curriculum and successfully started a clinic on campus that provides VCT and ART. |

| Title: | Jump Starting Lesotho’s Response to HIV/AIDS: Problem Solving for Better Health (PSBH) |
| Position: | Project Manager / Facilitator |
| Source: | Dreyfus Health Foundation |
| Amount: | $172,000 |
| Project Period: | April 2004 – October 2006 |
| Project Summary: | This project introduced the Problem Solving for Better Health methodology to five groups of 50-60 individuals from the health sector, government ministries, schools, NGOs, FBOs, CBOs, private sector, and community leaders to identify and solve problems related to HIV/AIDS. |
PUBLICATIONS, PRESENTATIONS & POSTERS

Chams MP, Holmes SK, Babich LP, VanDeusen Lukas C. Building improvement capability through training and projects. Poster session presented at: 29th VA Health Services Research and Development Service (HSR&D) and Quality Enhancement Research Initiative (QUERI) National Conference; 2012 Jul 16-19; National Harbor, MD.


TEACHING EXPERIENCE

Jun 2004 Guest Lecturer: Problem Solving for Better Health (one day) Boston University School of Public Health
Boston University School of Public Health

Jun 2006 – Aug 2009  Practicum Supervisor: Lesotho-Boston Health Alliance Program  
Boston University School of Public Health

SPECIAL PROJECTS

Design Editor  Lesotho Medical Association Journal
Associate Producer  Lesotho Documentary Film Project: *Mountains of Hope.*
Author  *Puleng.* A children’s book currently being translated into Sesotho and illustrated for publication in Lesotho.

MEMBERSHIPS

<table>
<thead>
<tr>
<th>Year</th>
<th>Organization</th>
<th>Role</th>
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</thead>
<tbody>
<tr>
<td>2006 – 2010</td>
<td>Global Primary Care</td>
<td>Founding Member, Treasurer</td>
</tr>
<tr>
<td>2009 – Present</td>
<td>AcademyHealth</td>
<td>Member</td>
</tr>
<tr>
<td>2010 – Present</td>
<td>Academy of Management</td>
<td>Member</td>
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HONORS

Delta Omega (Public Health Honor Society), 2005