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Setting up a National Hospital Accreditation Program: The Zambian Experience





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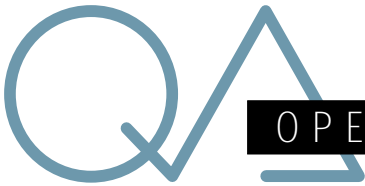
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Setting up a National Hospital Accreditation Program: The Zambian Experience

Abstract

In 1997, Zambia became one of the first countries in sub-Saharan Africa to launch a national hospital accreditation program. In mid-2000, the Quality Assurance Project (QAP) assembled a research team to document and assess the milestones and successes of the Zambian accreditation program and document the ongoing challenges it faces. The team's objective was to describe the development and progress of Zambia's hospital accreditation program, which is still in its growth phase, so that other countries could learn from Zambia's experience when developing their own programs. This documentation included reviewing relevant documents and budgets, interviewing key policy-makers and stakeholders, and examining accreditation survey data. To assess how well Zambia's program is functioning, the report referred to a framework of seven vital elements for an accreditation program's success, which had been developed by K.T. Donahue and Dennis O'Leary (1997). The research team compiled ten milestones of the Zambia program to date: recognizing the need to improve quality, choosing the right accreditation model, setting up the formal structure, developing and testing standards, training surveyors, conducting consultative surveys, refining policies and procedures, developing the database, conducting full

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accreditation surveys, and interpreting findings and making accreditation decisions. They also noted that the program is at a critical juncture and urgently needs to resolve several important issues. Most important of these is to finalize the accreditation manual for hospitals, to achieve legal status and an administrative structure for the Zambia Health Accreditation Council (the implementing body), to communicate the results of the first round of accreditation surveys, and to determine how to assist hospitals that do not achieve accreditation status.

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During hospital site visits, Dr. Mwanza, (Director of the Mukushi District Health Office and Link Facilitator for the Zambian QA program) and Mr. Chindongo (Clinical Officer in charge of Health Information Unit of the Choma Health District and Link Facilitator for the Zambian QA program) provided important guidance.

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Setting up a National Hospital Accreditation Program: The Zambian Experience

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Abbreviations

CBoH	Central Board of Health
CHS	Center for Human Services
GNC	General Nursing Council
ISQuA	International Society for Quality Assurance
JCR	Joint Commission Resources, Inc.
MCZ	Medical Council of Zambia
MOH	Ministry of Health
NGO	Nongovernmental Organization
QA	Quality Assurance
QAP	Quality Assurance Project
URC-CHS	University Research Co., LLC/ Center for Human Services
USAID	United States Agency for International Development
ZHAC	Zambia Health Accreditation Council

Introduction

In 1997, Zambia began laying the groundwork for a national hospital accreditation program. Because Zambia is one of the first countries in sub-Saharan Africa to carry out this kind of program, the Quality Assurance Program (QAP) thought it would be valuable to document the major milestones and challenges the Zambian program has faced so other countries can learn from Zambia's pioneering experiences.

In mid-2000, the QAP assembled a research team comprised of representatives from the Joint Commission Resources (JCR) and the Center for Human Services (CHS). This team joined a Zambian colleague from the Central Board of Health (CBoH) to review relevant documents and budgets, interview numerous policy-makers and stakeholders (including hospital personnel and patients), and examine the accreditation survey data that had been collected. This paper will describe the program and evaluate how it is meeting seven

elements of accreditation program success, as identified by K.T. Donahue and Dennis O'Leary (1997). Since the program is ongoing, the paper will not draw conclusions. Instead, it will identify the main challenges the program will face in the coming years.

For the purposes of this paper, the definition of accreditation will be drawn from the recent monograph titled *Licensure, Accreditation and Certification: Approaches to Health Services Quality Evaluation and Management* (Rooney and vanOstenberg 1999). This monograph provided a comprehensive definition of accreditation that is relevant to Zambia's program:

Accreditation is a formal process by which a recognized body, usually a non-governmental organization (NGO), assesses and recognizes that a health care organization meets applicable pre-determined and published standards. Accreditation standards are usually regarded as optimal and achievable, and are designed to encourage continuous improvement efforts within accredited organizations. An accreditation decision about a specific health care organization is made following a periodic on-site evaluation by a team of peer reviewers, typically conducted every two to three years.

Accreditation is often a voluntary process in which organizations choose to participate, rather than one required by law and regulation. (p. 6)

Success is not measured by the number of institutions a program accredits, but by the impact a program makes in stimulating improvements in care for patients and communities. Donahue and O'Leary identify the following elements as intrinsic to an accreditation program's success:

- Mission and philosophy
- Infrastructure and authority
- Published performance standards
- Management of field operations
- A framework for accreditation decision-making
- Accreditation database
- Accreditation program sustainability

While this report will use this framework for organizing the discussion of the Zambian program, it should be noted that an eighth element might be necessary for success: basic institutional resources or capacity. During the course of this research, it was found that hospitals need access to certain resources, such as skills and information, to be able to participate effectively in the program. This issue will be further discussed in the report's final two sections.

Background

As of 1999, Zambia's population was estimated at 10 million. Its per capita GNP was \$320 (World Bank, 2000). Health services are provided by the

government, missions, mining companies, semi-public organizations, private practitioners, and traditional healers. In 1990, Zambia had 1,024 health institutions, with a total of 20,665 beds and 3,907 cots. In the tertiary sector, Zambia has 79 hospitals, of which there are three central hospitals, nine general hospitals, 36 district hospitals, five specialized hospitals, 20 mission hospitals, and six industrial hospitals (Republic of Zambia, Ministry of Health, Health Information Unit, 1990).

A 1996 study commissioned by Zambia's Ministry of Health, through its Health Reform Implementation Team, revealed that Zambian health facilities had numerous deficiencies. Users complained about long waiting times (more than 60 minutes), high cost, irregularity in the availability of medicines, favoritism, rude behavior, and misuse and pilferage of medicines by health workers. Furthermore, health workers were not provided with frequent, continuing education courses to improve their skills. Overall, the effectiveness of the care being offered was seriously questioned (Foltz 1996).

Given the magnitude of its health problems, Zambia started a comprehensive reform of its health sector in 1993. This reform included a strong focus on improving the quality of care in primary healthcare. The goal of health reform was to provide "equity of access to cost-effective, quality healthcare to all people" (Foltz, 1996). External donors are supporting the reform effort through pooling resources for a sector-wide approach (Republic of Zambia, Country Strategy Note, 1997-2001). Reform was particularly urgent in the hospital sector, which experienced

setbacks due to Zambia's political and economic crises in the 1990s. Facilities' infrastructures were breaking down, certain disease epidemics were increasing, and labor strikes by health providers were attracting national attention. Interest arose in developing a mechanism for linking hospital funding with performance. Hence, Zambia felt the need to define and measure acceptable hospital standards on a national level.

Conducting an accreditation program emerged as a viable approach for improving quality in the hospital sector. With financial support from the U.S. Agency for International Development and technical assistance from QAP, Zambia initiated the development of hospital standards and a hospital accreditation program in 1997. At that time, several mechanisms were already in place for evaluating, inspecting, or certifying certain aspects of hospital performance. However, these activities focused on limited areas (such as equipment or laboratories), had diverse criteria for determining compliance with standards, and generally lacked an educative component. (Please refer to Appendix 1 for a profile of the various Zambian organizations involved in the inspection/evaluation of healthcare institutions.) As an overarching, comprehensive program, with standardized surveyors and transparency, accreditation appealed to many stakeholders. Accreditation was viewed more positively than other forms of evaluation because it includes consultation and education, rather than punitive inspections. It was expected that accreditation would lead to an integration of the efforts of the different "examiners" at any given hospital.

Research Design

The objective of this study was to document the development of the Zambian hospital accreditation program from 1997 onwards. This documentation includes the major milestones, important players, and sequence of events. The resource needs, including the level of effort and financial outlays, will be calculated when the program has completed a full accreditation cycle.

The data for the study was collected in two ways: (1) through a review and analysis of written documentation, and (2) through a field visit to Zambia in May/June of 2000 to interview major stakeholders in the accreditation program. Documentation reviewed for this study included: trip reports, quarterly and annual reports, surveyor materials, survey results, communication between

USAID and the Ministry of Health regarding the program's development, correspondence between the CBoH and hospitals, newspaper articles, and Zambian health policy documents.

Interviews and focus groups were conducted during the field visit using structured guides. These guides included structured, semi-structured, and open-ended questions. Focus group discussions were completed with these stakeholders: the Zambian Health Accreditation Council (ZHAC), surveyors, district hospital and management boards of four districts, management and administrative staff of four hospitals, and members of the public (outpatients and inpatients at the four hospital sites). Interviews were conducted with representatives of international agencies involved in the accreditation program in

Zambia, including USAID, JCR, CHS (Quality Assurance Project), and Abt Associates (Zambia Integrated Health Program). Interviews were also conducted with representatives from three divisions of the CBoH involved in the accreditation program: the Research, Monitoring and Evaluation Directorate; the Division for Clinical Diagnostic Services; and the Quality Assurance Unit.

Description of Major Milestones of the Zambia Accreditation Program

The research team has identified ten milestones in the development of the Zambia hospital accreditation program to date. In this section, each of these milestones will be described briefly.

Table 1
Chronology of Major Milestones in the Development of the Zambian Hospital Accreditation Program, as of First Quarter 2000

Major Milestones	1997	1998	1999	2000
1. Recognizing the need to improve quality and choosing accreditation as an approach to address the need	→			
2. Choosing the appropriate accreditation model to implement and making minor adaptations	→			
3. Setting up the formal structure to advise, operate, and manage the accreditation program	→	→		
4. Developing and testing standards to be used and the survey process	→	→		
5. Recruiting, hiring, and training surveyors		→	→	→
6. Conducting educational campaigns and consultative surveys		→	→	→
7. Refining rules, policies, and procedures for accreditation		→	→	→
8. Developing the accreditation database format		→	→	
9. Conducting accreditation decision surveys			→	→
10. Interpreting survey data and making accreditation decisions			→	→

1. Recognizing the Need to Improve Hospital Quality and Choosing Accreditation to Address This Need

As noted earlier, the hospital sector of Zambia deteriorated considerably in the 1980s and 1990s. When the new government took office, one of its mandates was to improve the state of the national healthcare system. This led to the passing of the Health Services Act in 1995—with the goal of providing equal access to quality, affordable healthcare—and the establishment of the CBoH.

After attending a conference sponsored by the International Society for Quality Assurance (ISQuA) in 1995, several prominent officials from the Quality Assurance section of the CBoH expressed interest in creating a hospital accreditation program. Having been involved in quality assurance for several years, they were now ready to measure quality comprehensively and feed the information back to health institutions. A USAID/Zambia technical advisor with prior knowledge of accreditation as practiced in the U.S. arranged for the CBoH to meet with representatives from the USAID-sponsored Quality Assurance Project to discuss potential collaboration. After this meeting, the CBoH obtained concurrence from the Minister of Health to request technical assistance from QAP to set up an accreditation program for Zambian hospitals. The officials hoped that the program would eventually extend to health centers.

2. Choosing the Appropriate Accreditation Model

Under the aegis of the QAP, in January 1997 a consultant conducted an initial assessment of the stakeholder interest and existing Zambian structures for quality healthcare evaluation. The specific purposes of the assessment were to:

1. Review the current practice of assuring quality of health services that are delivered by hospital and district boards;
2. Make recommendations to the CBoH on the mechanism of linking contracting of health services through hospital and district boards and the accreditation process;
3. Assess the feasibility of developing the Medical Council of Zambia (MCZ) as a semi-autonomous body that could conduct the accreditation process and report the results to CBoH; and
4. Make recommendations on the program of technical support required in developing the MCZ into an accrediting body.

During a meeting with the stakeholders, participants voiced their views and support for the accreditation program. The consultant discussed possible models for the accreditation program:

- The **partnership model** relies on a private organization to perform the task of evaluating the quality of care provided by hospitals. The government is represented at the policy and decision-making body of the private accrediting

organization. This is a public-private partnership between the government and a private organization.

- The **integrated model** recognizes existing government assets and uses them to build a functional program for hospitals. Government agencies pool their resources together to enhance the quality of health service provision and to avoid supporting professional “colonies.” This integrated approach endorses the creation of an accreditation council to govern the hospital accreditation program and provide overall direction, structure, and guidelines for the hospital accreditation program. Broad support for accreditation is achieved by addressing the interests of regulatory agencies, professional organizations, medical practitioners, and the public.
- The **phased model** involves a separation of the licensing and accreditation functions. All hospitals first seek licensure to stay open and then apply for accreditation to qualify for the annual grant. The government administers licensure. A government or private accrediting body conducts accreditation.

The stakeholders critiqued the different models that were presented and made recommendations to decision-makers about factors to take into account when selecting the final model. The Ministry of Health indicated that the integrated model seemed to fit the Zambian setting. Ultimately, the CBoH chose to adopt the **integrated model** for accreditation and to adapt it to Zambia.

3. Setting Up the Formal Structure to Advise and Manage the Accreditation Program

In Zambia, defining the organization and structure of the accreditation program was a critical milestone, particularly given the number of existing, albeit disparate, organizations that were already legally mandated to oversee certain aspects of the licensing, inspection, and evaluation of hospitals. These organizations included the CBoH, the Medical Council of Zambia, and the General Nursing Council, among others (see Appendix 1).

Since representatives from each of these organizations were to be involved in the accreditation standards development, it was important to clearly delineate the roles and contributions of each organization once accreditation standards became finalized. Namely, who would be responsible for conducting the surveys and overseeing the accreditation decision-making process. To maintain full participation, the Zambia Health Accreditation Council (ZHAC) was developed. The Council is composed of 12 members and is divided into three subcommittees and an Executive Committee. It is intended to have multidisciplinary representation from all of the regulatory bodies and health professionals' associations. Members of ZHAC were selected by the CBoH from names submitted by the major health professional associations in Zambia. These included:

- The Zambia Medical Association,
- The Zambia Dental Association,

- The Zambia Nurses Association,
- The Medical Council of Zambia,
- The General Nursing Council,
- Representatives from specialty areas such as nutrition, laboratory, pharmacy, and environmental services, and
- A female community representative.

The development of the ZHAC has occurred incrementally. Each quarterly stakeholder meeting has led to a clearer definition of the ZHAC, up to the current point where the ZHAC is in the process of seeking legal status and recognition as the primary organization responsible for hospital accreditation in the country. The main functions of ZHAC are to develop and review standards, to develop a legal framework for accreditation, to give advice to the CBoH on the direction of implementation, to analyze survey results and reach accreditation decisions, to implement decision rules, and to liaise with other regulatory bodies.

4. Developing and Testing Standards and Designing the Survey Process

Developing Standards

With the assistance of two QAP consultants, the CBoH oversaw the development and approval of a set of draft performance standards for hospitals in Zambia through a two-step group consensus process. The consultants toured two hospitals and one district health center to obtain baseline information about the structure, processes, and quality

concerns existing in the Zambian health system.

The consultants then held a four-day workshop to develop a first draft of performance standards for hospitals. Participants included several members of the newly proposed Zambia Health Accreditation Council, as well as several health professionals selected by the Central Board of Health because of their interest in quality assurance and standards. The consultants first presented an overview of the accreditation and standards principles. Next, they facilitated the group in identifying key patient and organizational functions (e.g., Patient Rights, Continuity of Care, Leadership) and problem areas in Zambian hospitals.

Once the key functions were identified, the participants worked in smaller groups to develop standards in each functional area. The entire group devoted the final day of the workshop to the review and revision of the draft standards. This set of standards was sent to all hospitals in Zambia as well as key stakeholder associations (e.g., Churches Medical Association of Zambia) for comments and feedback, which were incorporated into the draft standards. The final standards address 13 functional areas:

- Admission and Assessment
- Laboratory Service
- Radiology Service
- Pharmaceutical Services
- Patient Care
- Patient Rights
- Continuity of Care

- Management of the Environment of Care
- Infection Control
- Leadership
- Quality Assurance
- Human Resources
- Management of Information

A meeting of the Zambia Health Accreditation Council was called by the CBoH to review, revise, and approve the draft standards that were developed. The council approved the use of functional standards, and recommended a number of revisions, which were subsequently incorporated into the final standards document.

Testing Standards

The purpose of pilot testing hospital accreditation standards is to determine the feasibility, applicability, surveyability, and sustainability of the draft accreditation standards. Depending upon the results of the pilot testing, the standards could be introduced nationally, withdrawn, or sent back to the standards development stage for modifications.

For the Zambia program, four hospitals were selected for the pilot testing—these hospitals represented different types, sizes, and ownership types. A template agenda was used for the pilot testing. Surveyors, hospitals, and trainers were all involved in this testing process. Various meetings were held to suggest revisions, and the standards were revised accordingly.

Survey Process

Several survey agenda templates were developed that could be tailored to individual hospitals depending on their size and scope.

In addition, other survey guidelines and protocols were developed to assist surveyors and organizations in the survey process.

Consultants developed specific recommendations for the length of the survey and for surveyor composition. It was agreed that for even the smallest hospitals, a survey team would include at least two surveyors to ensure objectivity and reliability in the survey process. A rating for each of 258 measurable characteristics was developed by consensus among the on-site survey team. In addition, it was determined that each survey would be at least two days in length in order for the team to sufficiently complete the survey activities, compile its findings, and complete the scoring document prior to leaving the hospital.

From April to June 1998, surveys were piloted in eight hospitals and the survey process and scoring methodology was finalized.

Study Tour to the U.S.

In addition to the preparatory activities listed above, five Zambian health representatives traveled to the U.S. in January 1998 for a study tour focused on standards development, standards testing, and survey process development. The representatives were introduced to the Joint Commission on Accreditation of Healthcare Organizations' standards development process. They also learned about other aspects of accreditation program development, such as scheduling, survey activities, legal activities, field education issues, and surveyor education and management. The team observed actual hospital accreditation surveys while they were being conducted.

5. Recruiting, Hiring, and Training Surveyors

The formation of a cadre of trained professionals capable of conducting accreditation surveys was considered a central element of a strong accreditation program. Congruent with the Zambian program's approach to involve stakeholders in all major aspects of the accreditation program, the first group of six surveyors was formed through a process of nomination and selection by the ZHAC. All organizations represented in the ZHAC were responsible for nominating individuals to be trained as surveyors from within their respective organizations. The criteria for being a surveyor included professional competence, personal motivation, and expertise in various technical areas (e.g., pharmacy, medicine, nursing radiology, etc.). These individuals included professionals with full-time job commitments who would conduct surveys on an ad hoc basis and receive a nominal payment for their efforts (e.g., transportation and per diem). From these nominees, ZHAC selected the most qualified individuals. Subsequently, an additional 16 surveyors were trained. In the past year, however, the program has experienced attrition among surveyors, apparently due to the low pay. This has led ZHAC to use other channels, such as advertisements in the print media, to identify and recruit surveyor candidates.

The local cadre of trained trainers (the five Zambians who participated in the U.S. study tour) conducted surveyor training with some initial assistance from QAP consultants. Validation of these five trainers occurred in March-April 1998.

Training sessions generally consist of two parts: (1) a formal didactic component containing presentations on accreditation and building or developing surveyor skills (such as interviewing, critical thinking, and standards interpretation with extensive use of case studies), and (2) a series of practice surveys over a two-month period, to give surveyors experience with the survey process. Surveyor training was followed by a practicum in four hospitals. The results led to some revision of the standards and process to make them more feasible.

Training surveyors and maintaining their skills is one of ZHAC's main duties. To assist ZHAC in performing this function, QAP consultants developed a competency assessment form. Using this form provides feedback on surveyor performance, thus pointing to opportunities for further skill development and training. Two-day training updates for surveyors have been carried out, and plans have been made for refresher training courses, pending funding.

6. Conducting Educational Campaigns and Consultative Surveys

After surveyors had been trained, Zambia carried out 20 consultative surveys in the remainder of 1998. Consultative surveys are essentially accreditation surveys, except no accreditation decision is made on the basis of the score obtained. It is consultative because its intent is to familiarize the hospital with standards for accreditation and give the staff an idea of the hospital's current functioning. While no accreditation decision is made, the hospital

receives verbal and written feedback on the improvements that need to be made to achieve accreditation. It also receives a formal report of its scores from the ZHAC. According to one surveyor, "[This consultative component of the accreditation program] is more appreciated than the previous inspections and performance audits which are secretive and subjective ... Hospital teams seemed to appreciate the program because it is more educative and supportive; it encourages teamwork among staff from all departments; it is open...giving a hospital a chance to avail information which will be used to advise the hospital on how to use limited resources."

Consultative surveys were also to be linked with field education campaigns, including annual regional workshops. Limited field education was provided through the Quality Assurance Unit of the CBoH, in conjunction with training sessions in other topic areas (e.g., health information management system). This education provided an introduction to the accreditation program and the standards.

One year was expected to elapse between the hospital's consultative survey and when a formal accreditation survey would be conducted. The average time for the first eight hospitals to receive the full accreditation survey has been close to one year, though the written results from the consultative surveys also took about a year to be sent. (Originally, verbal feedback only from the consultative surveys was planned. However, hospitals receiving these surveys requested written feedback as well.)

One of the intents of these consultative surveys was to use the experience to develop scoring and decision rules for the formal accreditation program. Hence, the initial group of hospitals to receive consultative surveys was randomly selected after being stratified by hospital ownership, size, and location. Consultative surveys also had the benefit of affording newly trained surveyors the opportunity to practice the survey process under the guidance of more senior surveyors, ensuring mastery of the accreditation standards and survey process.

While it was planned that 20 hospitals would receive consultative surveys each year, as of mid-2000 only 35 hospitals had received these surveys. By the end of 2000 it is hoped that all 79 hospitals in Zambia will have received a consultative survey. For district level hospitals, surveys generally require three to four surveyors and last three days. For large central hospitals with multiple departments and units that are often scattered, up to six surveyors are required for four to five days. Reasons for the delay in conducting the consultative surveys have included the following: logistical challenges when arranging transportation to distant locations, surveyor availability to schedule a team, a smaller cadre of surveyors and the need to recruit new surveyors.

7. Refining Policies, Procedures, and Rules for Accreditation

In developing the accreditation program in Zambia, it was recognized that rules, policies, and

corresponding procedures were necessary for the following activities:

- How to make accreditation decisions and standardize the deliberation of these decisions
- How to manage the surveys and surveyors
- How to address the consequences of an accreditation decision
- How ZHAC should be administered

Drafting of initial decision rules for accreditation began in early 1999 during the final pilot testing of the surveys. Policies and procedures—including eligibility criteria for hospital accreditation, conflict of interest policies, travel policies, and the appeal process for accreditation—were then developed and reviewed by the ZHAC. Certain policies and procedures (e.g., maintenance and revisions of standards) remain to be finalized.

The process of developing and refining policies was goal-oriented and evidence-based. For example, ZHAC would start with a goal such as developing rules to guide decisions on whether to accredit a hospital. Then it would examine the evidence available from the results of the survey pilot tests in early 1998 during the training of trainers. The standards testing process yielded information on which standards were feasible and achievable. Using this evidence, ZHAC would determine how many measurable characteristics would need to be met in a functional area for a hospital to be accredited. The threshold for each functional area was also intended to encourage incremental improvements. ZHAC also decided that

hospitals must have scores of six or more (out of ten) in four critical functional areas to achieve “basic” accreditation. The critical functional areas were patient care, infection control, quality assurance, and management of the environment.

8. Developing the Accreditation Database Format

To enable the surveyors to score each standard consistently from survey to survey, consultants developed a survey scoring form. The scoring form lists each standard, its intent statement, and a list of measurable characteristics that are to be met. During the survey, the surveyors collect information through document review, interviews, and observation. They then examine each measurable characteristic and arrive at a consensus on whether it was fully met, partially met, or not met.

In developing the scoring form, the consultants considered local capacity to calculate standard scores and an overall score. To make the calculations as straightforward as possible, a database and decision algorithm was developed using Access software. The database assists with report writing, decreases the amount of manual labor required to compile survey findings, and produces an individual hospital report, which is shared with the hospital. The database also stores the findings from each survey and calculates the standard scores, function scores, and overall score for each hospital. It gives the ZHAC the ability to compare survey results for one hospital over time or to compare several similar hospitals in

a variety of ways. It also generates a report, which can be sent to the hospital, that summarizes the survey findings, the scores for each function, and the overall score. (For an example of a written accreditation report, see Appendix 2.)

9. Conducting Full Accreditation Surveys

Unlike the consultative surveys described earlier, formal or full accreditation surveys precipitate an accreditation decision. Like the consultative surveys, the accreditation surveys cover 13 functional areas—from admission and assessment to patient rights—and involve an intensive process of reviewing documents and conducting site tours, observations, and staff and patient interviews. Accreditation surveys vary in level of effort and duration based on the size of the hospital, but in each case will include the collection of data from primary or secondary sources of information, achieving scoring consensus among raters/surveyors, writing a report of findings, and completing an exit interview with hospital staff about the results of the survey. Trained surveyors carry out the completion of surveys and an effort is made for a team of surveyors to include at least one physician and a nurse. Generally, surveys have required limited or no investments on the part of hospitals, except for the time of staff members responding to surveyors’ questions.

As of September 2000, only eight full surveys had been completed, or one-fourth of the hospitals that received consultative surveys in 1998. These surveys were carried out between November 1999 and

Figure 1
Sample Hospital Accreditation Standard

Functional Area: Admission and Assessment

AA.1: There is an established process for admitting patients to the hospital which prioritizes care based on the assessed needs of the patient.*

Intent Statement:

The order in which patients are seen for admission is determined by their degree of need. Patients with immediate needs are prioritized for assessment and intervention. The hospital designs and implements an effective and efficient process for admitting patients which considers the following elements:

	Scoring			
	Met	Partially Met	Not Met	Not Applicable
a) Registration process is completed	a)			
b) Patients with immediate needs are prioritized for assessment and intervention	b)			
c) There is a standard for checking waiting times of patients in OPD and Admission	c)			
d) Communication of information between departments and staff involved in the care	d)			
e) Timely completion of requested diagnostic testing	e)			
f) All of these processes are documented in policies and procedures and standardized with in the hospital	f)			

Sources of Information:

1. Interviews with clinical and non-clinical staff and address the registration process
2. Observation of the admitting area
3. Interviews with patient/families
4. Patient records

* Standards that were identified as high priority during the field review.

January 2000. Of the eight surveyed hospitals, one achieved accreditation status, and another was almost accredited. The plan was to conduct

accreditation surveys every two years. Once a year was deemed too frequent both from the perspective of the hospitals—who would need

time to implement changes—and from that of the ZHAC, which is already struggling with the target of completing and reporting on 40 surveys annually (20 consultative, 20 full accreditation). The frequency of ZHAC meetings (once each quarter) is also insufficient for reviewing all accreditation reports in a timely manner. The possibility of surveying high-performing hospitals less frequently (once every three years) was also considered.

10. Interpreting Survey Data and Making Accreditation Decisions

Reviewing and deliberating on survey results is one of ZHAC's main responsibilities. The process includes (1) the review, discussion of, and agreement on survey results presented by surveyors, (2) the determination of accreditation scores based on criteria defined in ZHAC policies, and (3) the writing of a formal report to hospitals informing them of their scores. To date this process has been time consuming, particularly writing the formal reports. ZHAC also has not yet given the accreditation results to hospitals, because it still is trying to decide how best to communicate the results to the hospitals and from whom.¹ One looming difficulty the research team discovered is that hospitals participating in the full accreditation survey are expecting more from the program than just feedback on their status (accredited or not accredited). Other expectations include: more funding for correcting deficiencies in areas where standards were not met, increases in education and

¹ Although accreditation decisions on the first eight hospitals were made in April 2000, they were not yet communicated as of August 2000.

training programs, new equipment, and even money for construction of necessary amenities.

Reactions to the Accreditation Program

During the focus groups conducted by the research team, hospital staff expressed the need for technical assistance for meeting accreditation standards. They cited a lack of knowledge for the type of solutions or activities that need to be put in place in order to pass accreditation standards. While staff agreed that surveyors provide some insight into how a hospital can institutionalize quality assurance to meet specific standards, they also felt the need for more continuous support. Their frustration was echoed in the statement made by one hospital executive director: "Accreditation opened our eyes, but the logistics are missing."

Generally, hospital staff were satisfied with the way that the accreditation surveys were conducted. They had good feelings about their initial contact with surveyors, in contrast to supervisory visits, which they perceived as oriented to finding faults and blaming. The approach used by the surveyors during the accreditation survey was seen as more facilitative.

Most ambulatory and hospitalized patients were not aware of the hospital accreditation program. However, when the accreditation concept was introduced to them during the focus group, patients reacted in a positive way. They felt that the advantages of the program would be: improved quality of care, increased availability of medicines, improved quality of food for inpatients, improved cleanliness of health facilities, and better reception and friendlier treatment.

Discussion

In this next section, the Zambian program will be assessed on the basis of how well it has achieved to date those elements of an accreditation program as outlined by K.T. Donahue and Dennis O'Leary (1997).

Mission and Philosophy

The ZHAC established the following goal statements at its inception in 1997, all of which are still relevant:

- Develop and support an integrated approach to monitoring and improving the quality of hospital services, including infrastructure, performance of providers, laboratory services, pharmacy services, radiological services, and financial/administrative functions
- Develop and support an integrated approach to monitoring and improving the quality of health services provided by health facilities (including health centers, health posts, and private surgeries)
- Set and revise standards of performance that lead to the continuous improvement of quality care provided to all Zambians

From the start of the accreditation program, decision-makers foresaw the need for a participative approach, both in the design of the accreditation standards and in the development of the program. To ensure an ongoing commitment to holding hospitals accountable to standards for quality, key stakehold-

ers have played an essential role in the formation and implementation of the program.

From the perspective of the hospitals, consultative surveys have been the strongest feature of the Zambian accreditation program. Since a goal and philosophy of the accreditation program is to promote improvements in hospital care, these on-site evaluations using an educational and facilitative approach have been valuable. The opportunity to receive constructive suggestions on how to achieve accreditation—and not just a report card of inadequate performance—has been well received, though hospitals have indicated the need for further technical assistance. The surveys have also afforded the CBoH a better understanding of the areas that pose the greatest challenge for hospitals, thus enabling the CBoH to design a future support system for hospitals.

However, in hindsight, the underlying philosophy of the Zambian accreditation program may not be entirely congruent with the Zambian context. The program had assumed that hospitals would be able to marshal the knowledge, skills, and resources necessary to meet the standards, but this philosophy may be inappropriate. Furthermore, the program did not feel it was necessary to offer hospitals concrete incentives for achieving accreditation. Yet by not specifically articulating its policy on incentives, confusion about incentives has arisen that could ultimately lead to frustration. While policies and procedures for dealing with hospitals that are not accredited have been drafted, these measures are mostly punitive (e.g., a decrease in

funding) and only reward achievers of accreditation status. This could cause a disappointment among those hospitals that fail to meet accreditation standards and might diminish the positive reactions to the program.

In the short term, an important need to address is the “unrealistic” expectations that were expressed by hospitals, which could threaten the program’s sustainability. It is important to identify the full range of expectations hospitals have and correct any misconceptions as quickly as possible. Official policies from ZHAC that spell out the processes and likely outcomes from the accreditation program need to be communicated to hospitals. Also, hospitals probably need a forum to discuss their grievances and aspirations. This would assist ZHAC to plan how to assist hospitals better in the future.

Infrastructure and Authority

The ZHAC is a well-defined entity with clearly delineated responsibilities and functions. These functions are distinct from those of other existing organizations involved in the inspection and certification of hospital functions. To give it greater authority, ZHAC is to be recognized as a legal entity, potentially affording it access to its own funding, as well as independence from the CBoH.

The process of legalization is far from being achieved. The challenge for the ZHAC is to define a working process in the interim, when it must depend on CBoH for distribution of

funds for accreditation coming from external donors. ZHAC must also reconcile its work plans with those set externally by donors. ZHAC’s current structure and organization, while low cost, lacks a functioning secretariat independent of the CBoH. Its productivity depends on the voluntary participation and interest of members. While the motivation of members has been exemplary, the level of participation may wane due to growing constraints on resources and a lack of control over budgets. This concern was mentioned by a stakeholder in 1997 during the selection and design of the ZHAC: “[The proposed model for ZHAC] with part-time volunteers, not receiving extra funding, is probably the affordable option but is extra work for people who already have jobs ... Every time you call a meeting, you will have one-third who arrive on time, a third apologize for not attending, and a third who come late—all these experts are already fully employed” (Yan 1997).

Besides the potential financial constraint, another issue is the limited capacity of the ZHAC to handle the load of accreditation surveys and decisions. The ZHAC currently meets only once a quarter (four times a year), which is not sufficient to carry out all of its tasks (addressing administrative and policy issues, reviewing survey results, and reaching consensus on an accreditation decision for each of 40 hospitals slated to be surveyed every year). Moreover, as a voluntary body, the ZHAC could not be expected to provide the technical support to hospitals with the most need.

Published Performance Standards

Standards that are relevant, objective, and measurable are fundamental to improving healthcare quality. The effort put into the development of realistic and achievable standards in the first years of the program has been rewarded with a solid set of standards for hospital accreditation. The extensive testing and review/consensus process resulted in clear standards of quality to be attained by Zambian hospitals. Based on the findings from the pilot surveys, the group responsible for development of the standards felt that Zambian hospitals, given their limited resources, could demonstrate incremental improvements over time.

To date, eight hospitals have received both the consultative and accreditation surveys. Although some improvement in compliance with the standards was made by several hospitals between the consultative survey and the accreditation survey, overall compliance with the standards still remains low. Feedback from hospital staff indicates a need for technical support for meeting the standards. Even though surveyors offered some insight into changes the hospital could make, staff felt that more continuous support was necessary to help meet the intent of the standards. There is no mechanism in place through the ZHAC for hospitals to get information about how to implement a standard or get clarification if staff have questions.

Management of Field Operations

The approach used for training surveyors seemed to be efficient, including a train-the-trainer component and use of field consultative surveys as opportunities for surveyors to obtain practical experience in using the survey tools.

It should be noted that the selection process screened for, and recruited, talented surveyors with strong technical and managerial skills of direct relevance to the accreditation program. Additionally, there is a mechanism for strengthening the performance of surveyors through frequent and regular assessment of competence.

But the program has experienced a drop in the interest of surveyors in continuing to carry out surveys, mainly due to the level of work demanded and high opportunity costs for surveyors who have other jobs, mostly in the private sector.

Whereas the initial selection of surveyors was through nomination, now the ZHAC is in a costly situation of recruiting through advertisements. This puts the program at risk of losing the commitment from the member organizations of the ZHAC. It also raises the need to reconsider incentive and compensation packages for surveyors, as well as how to make the survey process less demanding on surveyors. The program did achieve slight increases in per diem rates for surveyors, but these were below acceptable levels (even by MOH standards). ZHAC also needs to evaluate its current surveyors and put effort into standardizing how they rate certain functional areas,

such as quality assurance, which may be unfamiliar to many of them.

ZHAC currently has no control over the budget for surveys or for training additional surveyors to compensate for the attrition. This erodes ZHAC's authority and makes it exceedingly difficult to stay on schedule for its consultative and full surveys.

With the high turnover, the need for a mechanism that will ensure the consistency and reliability of survey results is also critical. This underscores the importance of continuous assessment of inter-surveyor reliability by ZHAC.

Framework of Accreditation Decision Making

The fact that seven out of eight of the hospitals that received the full accreditation survey did not score high enough to achieve accreditation is cause for concern, both regarding achievability and how far the hospitals need to come. This is an issue the ZHAC struggles with. The program is now at a critical juncture, and there is a recognized need to better understand the reasons for this low performance and address problems with appropriate solutions (e.g., revision of standards or assistance to hospitals trying to achieve standards). In retrospect, it would have been advisable to implement pilot testing not only of the standards, but also for the entire process of making and communicating accreditation decisions. It is also urgent that the ZHAC finalize and distribute an accreditation manual to hospitals, so that they will understand precisely what to expect from the program

and what they need to do to achieve accreditation.

The delay in the feedback of consultative survey results to hospitals (currently about a year after the actual completion of a survey) also raises questions regarding the realistic feasibility of implementing policies and procedures set by the ZHAC. While some procedures have been applied (e.g., the completion of education workshops prior to consultative surveys) other procedures still need to be finalized (e.g., maintaining and revising standards, dealing with falsification of data or results, etc.). On the positive side, the ZHAC has designed a procedure for evaluating and reviewing its own performance that could address some of these issues.

Accreditation Database

The database became functional in January 1999. At that point, 12 survey scoring forms from consultative surveys were entered as test cases to demonstrate how the database and decision methodology functioned. Since then, several additional survey report forms have been entered. Some problems have arisen with the database—in some cases, the scoring form does not match the database. There has also been some difficulty in tracking scoring forms and determining whether they have been submitted for entry. However, these are administrative issues that can readily be addressed without additional resources. The basic structure for the database and decision rules and methodology have been sound.

Accreditation Program Sustainability

Even though the program is only in the growth phase of its development, questions of sustainability are already arising, and the ZHAC has begun to formulate some solutions. It recognizes the need to establish a clear and realistic plan for communicating the benefits and implications of accreditation. Still, these ideas need to be supported with financial, political, and technical support by all the stakeholders involved. ZHAC needs to have adequate financial, human, and information management resources in order to support its ongoing operations.

For the program to be sustained, it is also critically important that the hospitals' needs for assistance in accessing skills and resources to achieve accreditation be acknowledged. If hospitals are not given timely guidance, they may stop trying to improve. Creative approaches to assist hospitals, such as benchmarking and peer facilitation, as well as training workshops, need to be considered.

Conclusions

At the time of the documentation exercise, the program was at a critical juncture in its development. Several issues need to be addressed urgently:

- Helping hospitals achieve standards rather than punishing them for non-achievement
- Managing surveyor turnover and ensuring inter-rater reliability among surveyors
- Providing timely feedback to hospitals about the results of the survey
- Providing ongoing training and technical assistance to hospitals on how to meet the standards
- Official legal recognition and funding of the ZHAC so that accreditation operations can be independent and sustained

While the program's costs during the first three years of development have been primarily supported with USAID funding, a long-term plan for financial viability is imperative. Alternatives that have been

discussed include financial support from the MOH and the CBoH, as well as partial or complete payment of survey fees by the individual hospital participating in the accreditation process.

The Zambia Hospital Accreditation Program, now in its fourth year, has met and overcome many hurdles so far. It is a pioneering activity that deserves careful scrutiny from other countries interested in improving the quality of their hospital care. The next few years will test its creativity and resiliency. QAP intends to continue to document the progress of this seminal program.

Appendices

Appendix 1 Profile of Types of Inspection/Evaluation of Healthcare Institutions Occurring in Zambia Prior to the Accreditation Program

	Medical Council of Zambia	General Nursing Council	Laboratory Services	Radiation Protection Board
Target institutions	Private hospitals and clinics	Teaching institutions (schools and hospitals)	Specialized and reference labs in public hospitals; labs in private hospitals/clinics	All hospitals and clinics (both public and private) with radiation services
Number of institutions inspected	303 (3 hospitals and 300 clinics)	20	120	146 (only 12 inspected this year)
What is inspected?	Structure (basic infrastructure and staff competence)	Structure and patient care	Structure and quality control	Personnel services, radioactive waste management, safety, quality assurance
Frequency of inspection	2 times per year	Once every 3 years	Quarterly for specialized labs and 2 times per year for private labs	Yearly (intended)
Inspection process	Site visit, staff interviews, checklist	Site visit, document review, staff interviews	Site visit, staff interviews	Site visit
Length of inspection	1/2 to 1 day	3 days (minimum)	1/2 to 1 day	1/2 to 1 day
Inspection team	Physician (team leader), chief health inspector, chief laboratory technologist, pharmacist, and provincial health officer	Nurses from different specialties	Laboratory specialist from the Medical Council of Zambia	Radiology safety officers
Consequences of non-conformance	Follow-up, non-renewal of private facility or practitioner registration	Follow-up, closure of institution	Follow-up to check performance	Re-licensure not granted

Appendix 2
Sample of Accreditation Survey Summary Results for One Hospital

Decision Summary

SurveyID: XX

Survey start date: 00/00/00

Hospital: Hospital ABC

Surveyor 1: MRS A

City:

Surveyor 2: MS B

Country: Zambia

Status: Not Accredited

Surveyor 3: MR C

Standard Function/Standard (10=Meet, 0=Not)	# of Characteristics	# Meet	# Partially Meet	# Does Not Meet	# Not Applicable	# Not Scored	Average Score
AA Admission and Assessment							
1 Admission Process	12	1	3	2	0	6	4.17
2 Admission Assessment	10	4	0	1	0	5	8.00
3 Medical Assessment	9	2	1	1	0	5	6.25
4 Nursing Assessment	12	5	1	0	0	6	9.17
5 Other Assessments	10	5	0	0	0	5	10.00
Subtotals and Function Average	53	17	5	4	0	27	7.52
LS Laboratory Services							
1 Laboratory Processes	22	3	2	6	0	11	3.64
2 Blood Transfusion Process	2	0	0	0	1	1	
Subtotals and Function Average	24	3	2	6	1	12	3.64
RS Radiology Services							
1 Radiology Processes	22	5	2	4	0	11	5.45
Subtotal and Function Average	22	5	2	4	0	11	5.45
PS Pharmaceutical Services							
1 Pharmacy Processes	21	5	4	2	0	10	6.36
1.1 Emergency Medications	8	1	2	1	0	4	5.00
1.2 Essential Drug List	4	1	0	0	0	3	10.00
2 Medication Use Data Collection	6	0	0	3	3	0	0.00
Subtotals and Function Average	39	7	6	6	3	17	5.34
PC Patient Care							
1 Clinical Practices	21	11	0	0	0	10	10.00
2 Treatment Planned and Implemented	12	5	0	1	0	6	8.33
3 Patient Education	10	3	1	1	0	5	7.00
Subtotals and Function Average	43	19	1	2	0	21	8.44
PR Patient Rights							
1 Patient Respect and Clear Directions	4	1	0	1	0	2	5.00
2 Patient Rights and Responsibilities	18	5	3	1	0	9	7.22
3 Patient Satisfaction	8	0	0	4	0	4	0.00
Subtotals and Function Average	30	6	3	6	0	15	4.07
CC Continuity of Care							
1 Transfer Processes	12	3	2	1	0	6	6.67
2 Continuity of Care Processes	8	3	0	1	0	4	7.50
Subtotals and Function Average	20	6	2	2	0	10	7.08

Continued

Standard Function/Standard (10=Meet, 0=Not)	# of Characteristics	# Meet	# Partially Meet	# Does Not Meet	# Not Applicable	# Not Scored	Average Score
EC Management of the Environment of Care							
1 Fire Safety	20	0	0	10	0	10	0.00
2 Emergency Processes for Power	12	0	0	6	0	6	0.00
3 Epidemic and Disaster Plans	14	0	0	7	0	7	0.00
4 Potable Water	6	1	0	2	0	3	3.33
5 Medical Equipment Management	10	0	0	5	0	5	0.00
6 Hazardous Material Management	6	1	1	1	0	3	5.00
Subtotals and Function Average	68	2	1	31	0	34	1.39
IC Infection Control							
1 Infection Control Processes	28	10	2	2	0	14	7.86
2 Surveillance System	8	0	0	4	0	4	0.00
3 Staff Education on Infection Control	2	0	0	1	0	1	0.00
Subtotals and Function Average	38	10	2	7	0	19	2.62
LD Leadership							
1 Operational Policies and Procedures	12	2	2	2	0	6	5.00
2 Resource Planning and Staffing	4	0	1	1	0	2	2.50
3 Financial and Material Resource Management	6	0	2	1	0	3	3.33
Subtotals and Function Average	22	2	5	4	0	11	3.61
QA Quality Assurance							
1 Quality Assurance Program	4	0	0	2	0	2	0.00
1.1 Staff Participates in Quality Assurance	4	2	0	0	0	2	10.00
2 Data Collection and Analysis	8	0	0	4	0	4	0.00
2.1 Surgical, OBGYN, and Other Invasive	12	3	0	2	1	6	6.00
2.2 Blood and Blood Components	10	0	0	5	0	5	0.00
2.3 Incidents Involving Patients or Staff	10	0	0	5	0	5	0.00
3 Quality Is Improved	10	0	0	5	0	5	0.00
Subtotals and Function Average	58	5	0	23	1	29	2.29
HR Human Resources							
1 Staffing Meets Patient Needs	10	5	0	0	0	5	10.00
2 Hiring Processes	12	3	2	1	0	6	6.67
3 Staffing	2	0	1	0	0	1	5.00
4 Professional Licensure or Registration	2	1	0	0	0	1	10.00
5 Orientation	18	5	2	2	0	9	6.67
6 Ongoing Education	6	2	1	0	0	3	8.33
7 Performance Appraisal	8	4	0	0	0	4	10.00
Subtotals and Function Average	58	20	6	3	0	29	8.10
MI Management of Information							
1 Patient Record	30	12	2	1	0	15	8.67
1.1 Anesthesia Record	20	9	0	0	1	10	10.00
2 Data Collection with Health Management	18	9	0	0	0	9	10.00
Subtotals and Function Average	68	30	2	1	1	34	9.56
Totals and Survey Average	543	132	37	99	6	269	

Note: The Standard score is the average of the characteristic scores.

Continued

Survey Summary Score:

The Function score is the average of the standard scores.
The Survey score is the average of the Function scores.

5.32

(average of Function average scores)

Decision Rules:

Need average score of 6 in four critical standards: PC, IC, QA, and EC to achieve accreditation.
Need average score of 3 in rest of the standards to achieve accreditation.
Minimum total average to achieve accreditation is 3.92.

- One-star accreditation = 3.92 - 5.0.
 - Two-star accreditation = 5.10 - 6.0.
 - Three-star accreditation = 6.10 - 7.0.
 - Four-star accreditation = 7.10 - 8.0.
 - Five-star accreditation = 8.10 - 10.0.
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