Raising a mirror to quality of care in Tanzania: the five-star assessment

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Despite substantial efforts to improve the quality of care in Tanzania, evidence suggests that most facilities struggle to deliver high-quality services.[1–5] Major barriers to accessing services include long distances to health facilities, poorly developed transportation systems, and unfriendly services. The referral system also has severe challenges, including a small number of ambulances, unreliable logistics and communications, and inadequate community-based facilitated referral.[6–10] In response to these challenges and the need for greater facility accountability, the Ministry of Health of Tanzania implemented five-star rating assessments, a facility rating system, in 2015.

The five-star rating system for health-care facilities was developed as part of the Big Results Now (borrowed from Malaysia's Big Fast Now) labs in 2014 through a participatory process that involved 138 stakeholders from 65 organisations. The objective of Big Results Now was to develop concrete plans in specific health-care areas, and align these plans with the Tanzania Development Vision 2025 targets. 12 key areas were chosen to address the common problems in primary health facilities (table). Building on various tools and guidelines that were already being used in the country, a small working group developed specific indicators that were then presented to the wider group for consensus.[11,12] The indicators were chosen to measure key issues that had been widely cited by the stakeholders to be the major bottlenecks to providing good quality care at health facilities. Other important stakeholders from outside the lab were invited at key stages of the development process; this was called syndication. The indicators were also presented to these stakeholders before being weighted. Presence of skilled workers, for example, was given a double score, because this factor is a crucial barrier to providing quality health care.

Through this process, several important decisions were made. Tanzanian public health facilities do not have a legal framework or body that governs registration (a legal framework is being finalised), so clear minimum standards for health facilities to adhere to are absent. Thus, defining minimum standards was important. First, scoring was done so that the rating was based on the score of the minimum scoring domain rather than total or average marks (0–19% no stars, 20–39% one star, 40–59% two stars, 60–79% three stars, 80–89% four stars, and 90–100% five stars). Second, the target of the improvement initiative was to have 80% of primary health facilities rated with three stars by 2017–18, thereby setting a minimum required standard of health facilities that is equivalent to a three-star facility. The idea at the time was that all zero-star facilities should be closed, because these facilities would be unsafe and unfit for providing service.

The assessment covered approximately 7000 primary facilities over a period of 1 year in 26 of the country's 31 regions. Assessment at the health facility involved two assessors accompanied by a member of the council health management team (CHMT) who took one day to assess and score the health facility, share the results with the health facility, and formulate a quality improvement plan on the basis of the gaps identified.

In addition to providing feedback to the facilities, the results were shared through progressively higher

	Percentage points for assessment area
Management of health facility and staff performance domain (20%)	
Legality and licensing	0%*
Health facility management	10%
Use of facility data for planning and service improvement	5%
Staff performance assessment	5%
Fulfillment of services charters and accountability domain (30%)	
Social accountability at the health facility level	10%
Client satisfaction	5%
Organisation of services	5%
Handling of emergency cases and referral system	10%
Safe and conducive facilities domain (20%)	
Health facility infrastructure	10%
Infection prevention and control	10%
Quality of care domain (30%)	
Clinical services	15%
Clinical support services	15%
Total	100%

*If a facility is not legal or licensed, it is not rated and the proper authorities are informed so that the facility is closed pending legal procedures.

Table: **Domains, assessment areas, and scoring criteria for the five-star rating system**

government levels. The feedback of all facilities in the council (about 30–70 facilities) was given to the CHMT and other government officials at a gathering at the end of the council assessment. These meetings highlighted the best and worst practices, including pictures of both types of practice, and a listing of the health facilities according to performance. Data for all councils in the region were then presented at the regional level. The health facilities are overseen in Tanzania by two ministries, one is the Ministry of Health, which writes policies and guidelines, and the other is the Ministry of Regional and Local Government, which controls the ownership and running of primary health facilities. Therefore, at the ministerial level, reports were shared with these two ministries and with members of parliament. The star rating was also linked with a national results-based financing programme, allowing facilities with one star or more to be enrolled into the scheme.

The results after nationwide assessment of 6993 facilities were shocking: only 2% of facilities met the minimum standard of quality of three stars or more, and 34% of health facilities received zero stars. Unwarranted variation among councils, and large disparities among facilities also raised the issue of inequity in services provided. Seeing this data led to action and change at all levels of the health system. An outcry at the ministry level led to the use of these results partly as a performance measurement of the councils and council health management, and of the health facilities. The data were used as a performance indicator in the Health Basket Funds (a health funding mechanism in which different donors pool funds for supporting primary health-care delivery), and as an indicator in the performance contracts that were signed between the ministry for regional and local government and the regional and council medical officers. Members of parliament were also eager to know the results and follow up on improvements. Parliamentarians were actively engaged on key issues such as the scarcity of medical supplies, skilled health workers, and water and electricity at the health facility, as well as the overall score of facilities in their constituencies. Because 34% of facilities scored zero stars, many of which were in hard to reach, disadvantaged areas, instead of being closed as per the original plan, the facilities received a readiness assessment fund to allow them to improve, after which they were reassessed and enrolled if they had attained one star or more. Regional and council leadership mobilised to support the improvement of facilities and specifically the facilities that were committed to improvements based on the assessments.

A culture of quality improvement developed in the health facilities. Some of the councils used the star-rating tool as a supportive supervision tool, and did self-assessments of the facilities in the council to monitor implementation of the quality improvement plans. But, more importantly, the results helped the CHMT to target their support and supervision to the worst performing facilities and to then measure improvements. All activities that needed funds were included in the comprehensive council health plans (CCHP), an annual plan for health facilities in a council comprising yearly budget, activities, and essential health interventions. For example, in one council, the district medical officer demanded that all health facility plans for inclusion into the CCHP had to attach the Quality Improvement Plan generated from the star rating assessment to ensure that activities had been budgeted for. In another council, all health facilities had scored poorly in the staff performance assessment service area, and the health secretary did not grant leave to any health worker unless they had submitted their performance appraisal forms signed by the supervisor.

In addition to the increased attention to quality and accountability and the shift in cultures of improvement, reassessments of all health facilities are underway. 1·5 years after baseline assessments, 21% of facilities are now scoring three stars or more, and only 4% are still zero-star facilities. A clear demand for data within governmental departments, ministries, and implementing partners has also developed, with multiple requests to obtain the data for planning and measurement of improvements in quality of care. We have now started rating regional-level hospitals with the aim of rating all hospitals.

The five-star assessment process has taught us several important lessons. Using a participatory process to create a facility assessment method and a minimum standard for quality is crucial to developing a process that resonated with system leaders, administrators, and providers. We are planning to share the information on a public portal and post the ratings at each health facility, with the hopes of engaging system users. We believe that using data for immediate feedback at the facility level was important

for shifting the culture of care towards one of data-driven quality improvement. Finally, sharing data across health systems created opportunities for system-wide improvements that we believe will move Tanzania closer to delivering truly high-quality care to all its citizens.

Talhiya Yahya, Mohamed Mohamed
Quality Management Unit (TY), Health Quality Assurance Department (MM), Ministry of Health, Dar es Salaam 11101, Tanzania
tyahya@moh.go.tz

We declare no competing interests.

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