

**EVALUATION OF IMPLEMENTATION PROCESS OF
STAR RATING ASSESSMENT AND QUALITY
IMPROVEMENT PLANS IN PRIMARY HEALTHCARE
FACILITIES IN TANZANIA-CASE OF KIBAHA TOWN
AND RUFJI DISTRICT COUNCILS**

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RATING ASSESSMENT AND QUALITY IMPROVEMENT PLANS
IN PRIMARY HEALTHCARE FACILITIES IN TANZANIA-CASE
OF KIBAHA TOWN AND RUFIJI DISTRICT COUNCILS**

By

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**Dissertation Submitted to School of Public Administration and
Management of Mzumbe University in Partial Fulfillment of
Requirements for the Award of Master of Science Degree in Health
Monitoring and Evaluation**

2019

CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a research report entitled ***“Evaluation of Implementation Process of Star Rating Assessment and Quality Improvement Plans in Primary Healthcare Facilities in Tanzania– Case Of Kibaha Town and Rufiji District Councils”*** in partial fulfillment of the requirements for award of Master of Science Degree in Health Monitoring and Evaluation of Mzumbe University.

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DECLARATION

I, **Chrisogone Justine**, declare that this dissertation is my original work and that it has not been presented and will not be presented to any other university for a similar or any other degree award.

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DEDICATION

This dissertation is dedicated to my beloved mother Ms. Helena Hilay and my late father, Justine German Baran (R.I.P).

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
APHFTA	Association of Private Health Facilities in Tanzania
BAKWATA	Baraza Kuu la Waislamu Tanzania (The National Muslim Council of Tanzania)
BEmONC	Basic Emergency Obstetric and Newborn Care
BRN	Big Results Now
CCHP	Comprehensive Council Health Plan
CDC	Centre for Disease Control and Prevention
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHMT	Council Health Management Team
CHW	Community Health Workers
CMS	Centre for Medicare and Medicaid Services
CSSC	Christian Social Services Commission
DANIDA	Danish International Development Agency
DC	District Council
DED	District Executive Director
DHFF	Direct Health Facility Financing
DMO	District Medical Officer
EGPAF	Elizabeth Glaser Paediatric AIDS Foundation
eTIQH	electronic Tool to Improving Quality of Healthcare
FGD	Focus Group Discussion
GIZ	Gesellschaft für Internationale Zusammenarbeit (German International Cooperation)

HCW	Health Care Workers
HFGCs	Health Facility Governing Committees
HFMT	Health Facility Management Team
HFR	Health Facility Registry
HIV	Human Immunodeficiency Virus
HSSP	Health Sector Strategic Plan
HSWNS	Health, Social Welfare and Nutrition Services
JICA	Japan International Cooperation Agency
LGA	Local Government Authority
MDH	Management and Development for Health
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MoHSW	Ministry of Health and Social Welfare
MSH	Management Science for Health
NAM	National Academy of Medicine
NBS	National Bureau of Statistics
NQIF	National Quality Improvement Framework
OECD	Organization for Economic Cooperation and Development
OPRAS	Open Performance Review and Appraisal System
PHC	Primary Health Care
PMO-RALG	Prime Ministers' Office - Regional Administration and Local Government
PO-RALG	President's Office - Regional Administration and Local Government
PPM	Planned Preventive Maintenance

QI	Quality Improvement
QIC	Quality Improvement Collaborative
QIT	Quality Improvement Team
RAS	Regional Administrative Secretary
RBF	Results-Based Financing
RHMT	Regional Health Management Team
RMNCH	Reproductive, Maternal, Neonatal, and Child Health
RMO	Regional Medical Officer
SOPAM	School of Public Administration and Management
SRA	Star Rating Assessment
SRT	Star Rating Tool
TA	Technical Assistance
TC	Town Council
TC - SWAp	Technical Committee –Sector Wide Approach
TDHS	Tanzania Demographic Health Survey
TQIF	Tanzania Quality Improvement Framework
TWG	Technical Working Group
UHC	Universal Health Coverage
URT	United Republic of Tanzania
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

ABSTRACT

The Government of Tanzania through Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) introduced the Star Rating Assessment (SRA) system as initiative under Big Results Now (BRN) to assess the quality of health services. The SRA system used standardized tools for assessing the quality of health services and the star level ranges from 0-5 stars depending on the quality of services provided. The SRA had a target of 80% of Primary Health Care (PHC) facilities be rated 3 stars and above by June 2018 but unfortunately only 20% of facilities attained this target countrywide. The study aimed at assessing the implementation process of SRA and Quality Improvement Plans (QIPs) as one of the initiatives in improving the quality of healthcare delivery in primary health facilities in Kibaha TC and Rufiji DC.

I adopted a descriptive cross-sectional study design whereby qualitative technique was employed to gain the experiences of individual healthcare providers and groups of Quality Improvement Teams (QITs) on implementation of SRA. Data was collected through Focus Group Discussions (FGDs) in which 4 FGDs were conducted comprising between 4-7 participants for QITs and in-depth interviews (with 19 participants) for facility in-charges, CHMTs (DMO or District Health Secretary), Council and Regional QI Focal Person, and SRA coordinators at national level (MoHCDGEC and PO-RALG). Data were analyzed using qualitative content analysis, which offers the development of categories from the text data inductively in capturing experiences from the key informants.

The study findings revealed mixed results regarding implementation of SRA and QIPs in PHC facilities. The results showed that the awareness on SRA system was low among healthcare providers, the QIT members were not aware of their roles in implementation of QIPs and the CHMTs were not including QIP follow up progress as part of their quarterly supportive supervision. Some of the reported challenges that were encountered during implementation of SRA and QIP included but not limited to shortage of staff, financial resources, inadequate training of staff on SRA system, and inadequate CHMTs support through supportive supervision.

The implementation of SRA has shown some improvement in the delivery of quality healthcare in the study sites. However, enhancing the proper implementation of SRA especially QIP follow up and overcoming the barriers to implementation will improve the quality healthcare in Tanzania. MoHCDGEC, PO-RALG, R/CHMTs, Facility in Charges and QITs should play their roles for effective implementation of SRA system in Tanzania.

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OPERATIONAL DEFINITIONS

Quality of Healthcare

WHO has defined the quality of care as “the extent to which health care services provided to individuals and patient populations improve desired health outcomes. To achieve this, health care must be safe, effective, timely, efficient, equitable and people-centered” (WHO, OECD & WB, 2018; NAM, 2018; Kruk, et al., 2018).

Donabedian defined the quality of healthcare as the application of medical science and technology in a manner that maximizes its benefit to health without correspondingly increasing the risk (Donabedian, 2005). Donabedian further differentiates quality healthcare into three sub-components as technical quality, interpersonal quality, and amenities (Mosadeghrad, 2012).

Øvretveit (2009) defined the quality of healthcare as the provision of care that exceeds patient expectations and achieves the highest possible clinical outcomes with the available resources. Øvretveit further clarified his definition in three dimensions as patient quality, professional quality and management quality (Øvretveit, 2009).

Khamis and Njau defined the quality health care as a degree of performance in relation to a defined standard of interventions known to be safe and have the capacity to improve health within available resources (Khamis & Njau, 2014).

Primary Healthcare (PHC)

PHC has been defined by different authors but for this context two definitions have been adapted, the first is profession-centered while the second, which was primarily developed by the WHO takes into account a societal perspective. Thus, PHC is:

“Health or medical care that begins at time of first contact between a physician or other health professional and a person seeking advice or treatment for an illness or an injury” (White, 2015).

“Essential health care made accessible at a cost that a country can afford, with methods that are practical, scientifically sound and socially acceptable. Everyone should have access to it and be involved in it, as should other sectors of society. It should include community participation and education on prevalent health problems, health promotion and disease prevention, provision of adequate food and nutrition, safe water, basic sanitation, maternal and child health care, family planning, prevention and control of endemic diseases, immunization against vaccine-preventable diseases, appropriate treatment of common diseases and injuries, and provision of essential drugs” (White, 2015; WHO, 2019).

In Tanzania PHC services form the basement of the pyramidal structure of health care services. It is made of a number of dispensaries, health centers and district hospitals at the district level (MoHSW, 2007).

Star Rating Assessment (SRA)

This is the system adopted by the MoHCDGEC in assessing the quality of healthcare for primary healthcare facilities. The system uses locally developed standards using star rating tools with 12 service areas for hospitals, health centres, and dispensaries. The facilities are rated from 0 to 5 stars depending on the quality of services provided (MoHCDGEC, 2014; MoHCDGEC, 2015; Yahya & Mohamed, 2018)

Quality Improvement Plans (QIPs)

QIP is an organization's framework for developing and improving processes. It includes the direction, timelines, activities, and assessment measures of quality and quality improvement within the organization. It is a formal, documented set of quality commitments aligned with system and government priorities that a health care organization makes to its patients/clients/residents, staff and community to improve quality through focused targets and actions. In the implementation of SRA, after assessment, the assessors in collaboration with the facility staff develop a QIP for the identified gaps during the assessment (English, et al., 2018; Brimer, 2015; MOHLTC, 2014).

CHAPTER ONE

INTRODUCTION

1.1 Background

In the Tanzania Vision 2025, health was one of the primary focus which emphasised on high quality livelihood. In the context of health, high quality livelihood will be attained through the following health service goals: access to quality primary healthcare for all, access to quality reproductive health service for all individuals of appropriate ages and reduction in infant and maternal mortality rates (URT, 2000). The access to primary health care is still a challenge as there is insufficient number of primary health facilities. For example, in the National Health Policy 2007, it was supposed that every village to have at least one dispensary and every ward to have at least one health centre (MoHSW, 2007) but as of February 2018, the number of primary healthcare (PHC) facilities were as follows: 695 (15.7%) health centres in 4,420 wards and 6,640 (53%) dispensaries in 12,545 villages (IPP Media, 2018). The access to reproductive health service is not to the fullest of the desired level as despite achieving MDG4 of reducing under five mortality rates from 166 per 1,000 live births in 1990 to 54 per 1,000 live births in 2015, the number of death of newborns and under-fives from preventable diseases is still high (MoHCDGEC, 2016). Also, challenges in access to reproductive health services has lead to persistent high maternal mortality rates (MMR), and as of December 2016, the MMR was estimated at 556 deaths per 100,000 live births (NBS (TDHS), 2016).

Due to inadequate access to quality healthcare leading to poor quality of health service delivery, the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) adopted the Big Results Now (BRN), an approach from Malaysia's model in 2014. The BRN approach focused on prioritization, detailed monitoring tools, and accountability for performance as a way of improving the quality of health care services in primary healthcare facilities (MoHCDGEC, 2014). BRN had four priority areas including Performance Management of Health facilities; Human Resources for Health; Health Commodities; and Reproductive, Maternal, Neonatal and Child Health (RMNCH) (MoHCDGEC, 2014).

SRA was one of the initiatives under the priority area of Performance Management of Health Facilities in BRN program. The SRA initiative aimed at assessing and rating the PHC facilities by assigning a star level based on the performance of specific health facilities. The stars levels ranges from zero stars which represent poor performance to five stars which shows the best performance (Yahya & Mohamed, 2018).

SRA system was introduced in the health sector in the financial year 2014/15 to fast track the implementation of identified health priorities during the BRN lab. The major identified challenges were: an inadequate human resources for health, inadequate availability and irrational use of medicines, medical supplies and equipment, and low annual reduction rate for maternal and neonatal mortalities (MoHCDGEC, 2014).

The SRA system is aligned with various existing government policies such as Health Policy of 2007, Tanzania Quality Improvement Framework (TQIF), Health Sector Strategic Plan III and Health Sector Strategic Plan IV (HSSP IV). For example, the health Policy 2007 had the mission of ensuring the provision of healthcare services, which are of high-quality standards, affordable and sustainable (MoHSW, 2007). Also, the HSSP IV has included the SRA system of certification approach as one initiative for improving the quality of healthcare through assessing; rating and developing quality improvement plans for specific health facilities (MoHCDGEC, 2015).

The SRA system uses structured tools known as Star Rating Tools (SRT) for assessing the quality of health facilities in various service areas in the healthcare facility. There are different tools for each level of healthcare facilities, thus there is SRT for hospitals at council level, health centres, and dispensaries. Each of the SRT has 12 service areas, which are divided into four (4) domains as shown in Table 1.1. The service areas and domains are similar for all SRT but the difference is the number of indicators depending on the level of service delivery. For example, the SRT for dispensary had 100 indicators whereby for the hospital at the council level the indicators were 112.

Table 1.1 The 12 Service Areas and domains in SRT

Domains	Service Area	Percentage points for assessment area	Main focus
A: Facility Management and Staff Performance	1. Legality	0 ¹	Private facilities are supposed to be legally registered and have a license to provide service while having Registration Number (known as MSIMBO number in Kiswahili) was adequate for public facilities.
	2. Facility Management	10	Availability of skilled healthcare workers, organization structure, staff attendance, HFMTs and QITs, facility planning and budgeting, operating bank accounts and housing and housing allowances.
	3. HMIS	5	Availability and proper use of HMIS (MTUHA) use of data for planning, and medical records.
	4. Staff Performance and Appraisal System	5	Availability of staff open performance review and appraisal system (OPRAS) and job descriptions.
B: Service Charters and Social Accountability	5. Organization of Services	10	Proper flow of services in each of the service points from entry to exit, display of services provided and prices, and health promotion and outreach services.
	6. Emergency and Referral System	5	Availability of emergency medicines and equipment, staff training on emergency and proper referral system.
	7. Client focus (Satisfaction)	5	Availability of proper mechanisms for handling clients' complaints such as suggestion box, client help desk, display of contact details for phone or SMS feedback.

¹If 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.

Domains	Service Area	Percentage points for assessment area	Main focus
	8. Social Accountability	10	Partnership between the health facility and community and participation of community through Health Facility Governing Committees (HFGC).
C: Safe and conducive facilities	9. Facility Infrastructures	10	Presence of Planned Preventive Maintenance (PPM), the status of the buildings, amenities (electricity and water), disability friendly facilities and adequacy of furniture and equipment in each of the service delivery points.
	10. Infection Prevention and Control (IPC)	10	Adherence to proper ways of implementing IPC in health facilities such as the use of PPE, PEP, standard base precautions, processing equipment, laundry services, and healthcare waste management.
D: Quality of care and services	11. Clinical Services	15	Proper adherence to treatment guidelines and RMNCH services.
	12. Clinical Support Services	15	The clinical support services included Pharmaceutical services, Laboratory, Radiology and Imaging, Operating Theatre, Food Services, and Mortuary.

Source: SRT for Dispensary, Health Centre and Hospitals at Council level (2015).

The SRA was conducted annually depending on the various factors but not limited to the availability of funds. After assessment the results of the assessments were shared at different managerial levels starting from a Health Facility Management Teams (HFMTs), the council (DED, DMO, and CHMTs), regional (RAS, RMO, and RHMTs) and national level (MoHCDGEC and PO-RALG) (English, et al., 2018; MoHCDGEC, 2014). The results were shared to different levels of service delivery in order to ensure ownership and accountability especially in the process of implementation of QIPs.

1.2 Problem Statement

SRA was planned to be implemented in all regions of Tanzania mainland covering dispensaries, health centres and hospitals at council level (MoHCDGEC, 2014). In this view, it was expected that by June 2018, 80% of health facilities at each level will have attained three stars and above. The attainment of the set target was by far to be achieved as in the baseline assessment which was conducted for all primary health facilities in Tanzania in the financial year 2015/16, 2412 (34%) of facilities scored zero star, 3594 (52%) scored one star, 850 (12%) scored two stars and 137 (2%) scored 3 stars and above (MoHCDGEC, 2016). In re-assessment conducted in 2017/18, only 1370 (20%) of health facilities reached the national target of having three stars and above, the remaining facilities scored as follows: 456 (6%) zero star, 2396 (32%) one star, and 3067 (42%) two stars (Yahya & Mohamed, 2018; MoHCDGEC, 2018; English et al., 2018).

The performance for the regions were not promising as the highest performing region was Kilimanjaro (40%) and the lowest performing was Songwe (3%) (MoHCDGEC, 2018). Pwani region had a national average of 18% for facilities rated three stars and above whereby Kibaha TC was the best performing in the region by achieving 38% of facilities having three stars and above and Rufiji DC being the poorly performing council with only 3% of facilities reaching the national target of having facilities with three stars and above (MoHCDGEC, 2018). These results signify that the program is lagging for about 60% at the national level and the situation is worse in most of the regions, councils, and individual health facilities as of June 2018.

After each assessment, the facilities are supposed to implement the QIP developed during the assessment (English et al., 2018; MoHCDGEC, 2016). The implementation of QIPs has been a challenge in most of the facilities as there was an insignificant improvement in the implementation of QIPs between baseline assessment and re-assessment. For example, during the supportive supervision conducted in 2017 to 304 sampled health facilities in 4 regions (Kigoma, Dodoma, Singida, and Tanga), the report showed that more than 80% of identified gaps during baseline assessment were not addressed by the facilities (MoHCDGEC, 2017). The observed reasons were inadequately skilled healthcare workers, lack of motivation, inadequate supportive supervision by CHMTs and inadequate medicines and medical supplies (MoHCDGEC, 2017).

Therefore, this study evaluated the implementation process of SRA in PHC facilities in Kibaha TC and Rufiji DC to ascertain whether the program was implemented as planned in terms of awareness of healthcare workers on SRA system, roles of QITs in implementation of QIPs, inclusion of QIPs in annual plans and roles of CHMTs on QIPs implementation during their quarterly supportive supervision. It also answers the question of factors that facilitated or impinged the implementation of QIPs in PHC facilities.

1.3 Broad Objective

The main objective was to assess the implementation processes of Star Rating Assessment (SRA) and Quality Improvement Plans (QIPs) for primary healthcare facilities in Kibaha Town and Rufiji District Councils.

1.3.1 Specific objectives

- i. To determine the extent to which primary health facilities have attained the set targets for SRA.
- ii. To examine the process for implementation of SRA in primary health facilities in Kibaha TC and Rufiji DC.
- iii. To examine factors facilitating or impinging processes for implementation of QIPs in primary health facilities in Kibaha TC and Rufiji DC.
- iv. To put forward the recommendations for improvement of the implementation of SRA and QIP in primary health facilities.

1.3.2 Monitoring and Evaluation Questions

- i. To what extent do primary health facilities attain the set targets for SRA at different levels of healthcare service delivery?
- ii. To examine the process for implementation of SRA:
 - ✓ Were the healthcare workers aware of the SRA system?
 - ✓ Was the implementation of QIPs conducted as planned?
 - ✓ Were the QITs aware on their roles in the implementation of QIPs left at their facilities?
 - ✓ Were the gaps identified during assessment and shown in QIP included in facility annual plans?
 - ✓ Were the CHMTs supportive supervisions amongst others included the follow up of the progress of implementation of QIPs?
- iii. What were the factors facilitated or impinged the processes for implementation of QIPs in primary health facilities?
- iv. What are the recommendations for effective implementation of SRA and QIP in primary health facilities?

1.4 Study significance

The SRA system is the first system to be introduced in the health system in Tanzania as part of the BRN initiative for assessing the quality of health service for underserved PHC facilities i.e., dispensaries, health centres, and hospitals at the council level. It is a locally developed system for assessing and rating the quality of healthcare service for PHC facilities in Tanzania.

The study report generated inputs to inform policymakers and policy implementers to make evidence based decisions on the implementation of SRA in primary health facilities. The findings and recommendations would direct the policymakers and other stakeholders to know how best the SRA system could be implemented in primary health facilities in Tanzania. Moreover, the study informed the proper ways of implementing the QIPs as the key component for improving the quality of health care in primary health facilities.

Furthermore, the findings generated from this study contribute to generation of new knowledge in the development of discourse and academic literature (Laiser, 2015). Major evaluation studies may emerge, as there are few studies conducted so far on SRA in Tanzania.

Finally, the evaluation enabled the evaluator to attain a Master of Science in Health Monitoring and Evaluation as an essential requirement to undertake the evaluation of a program of choice as partial fulfillment of criteria for acquiring the aforementioned qualification.

1.5 Description of the Evaluated Program

1.5.1 Introduction

Due to the unsatisfactory situation of quality of services in various sectors, the Government of Tanzania decided to introduce the approach known as BRN. The BRN approach was introduced to accelerate the implementation of national priority projects and facilitate the realization of the Tanzania Development Vision 2025 (MoHCDGEC, 2014). The approach was adopted in 2012 and the implementation started in July 2013 with a focus on 6 sectors (also referred to as National Key Result Areas - NKRAs) of Agriculture, Education, Energy, Resource Mobilization, Transport and Water (Janus & Keijzer, 2015). The Health sector was the 7th to be enrolled in the BRN approach from July 2014. BRN in the health sector was developed based on four workstreams namely (i) Human Resources for Health; (ii) Health Commodities; (iii) Reproductive, Maternal, Neonatal and Child Health (RMNCH); and (iv) Performance Management of Health Facilities (MoHSW, 2014).

Human Resources for Health was one of the workstream in which the priority (also known as the “true north”) set for the interventions was to improve the distribution of skilled health workers especially clinicians and nurses at the primary health facilities in nine regions namely: Tabora, Shinyanga, Kagera, Katavi, Rukwa, Geita, Kigoma, Singida and Simiyu with lower than national average density of skilled human resources (MoHCDGEC, 2014). The second workstream was *Health Commodities* in

which the key priority issues to be addressed were improving health commodities supply chain through finance and business model, procurement and distribution, inventory management as well as governance. The third workstream was *Reproductive, Maternal, Neonatal and Child Health (RMNCH)* and it focused on measuring the improvement in both coverage and quality of RMNCH along the continuum of care, which includes ensuring dispensaries and health centres meet Basic Emergency Obstetric and Neonatal Care (BEmONC) requirements; expanding Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) to selected hospitals and health centres; strengthening the corresponding satellite blood banks, which serve facilities with CEmONC; and extending RMNCH services to communities through the use of Community Health Workers (CHWs) and awareness campaigns. Five regions namely: Geita, Kigoma, Mara, Mwanza and Simiyu that were poorly performing on maternal and neonatal mortality indicators were selected for this priority focus (MoHCDGEC, 2014).

The fourth work stream was *Performance Management of Health Facilities*. This is the workstream where the SRA system belongs and it focuses on assessing the performance of health facilities and individual staff. The work stream had four (4) indicators and four (4) targets as shown in Table 1.2. The primary focus of the work stream was to assess twelve (12) regions namely Dar es Salaam, Pwani, Mwanza, Geita, Simiyu, Mara, Kagera, Singida, Tabora, Shinyanga, Katavi, and Kigoma but the assessment was done to all 26 regions of Tanzania mainland in order to ensure that the quality of services is adhered countrywide (MoHCDGEC, 2014).

Table 1.2 Indicators and targets for Performance Management of Health Facilities

SN	Indicators	Targets
1.	Assess, rate and develop specific facility improvement plans for 1- and 2-Star primary level health facilities	80% of health facilities at identified regions are elevated to level 3 & above by June 2018
2.	Implement fiscal decentralization by devolution from council level to health facility level	80% of health facilities achieve financial autonomy by June 2017
3.	Increase social accountability at the facility and community level to address local health priorities/concerns	80% of LGAs have functioning social accountability mechanisms by June 2017
4.	Introduce the use of performance targets and contracts at the primary facilities to address and enforce staff accountability in the delivery of quality health services	80% of health facilities have attained 75% customer satisfaction and above by June 2018

Source: MoHSW (2014) BRN Healthcare Lab: Summary of Lab Report

This evaluation study focused on the first indicator, which is about assessing, rating, and developing specific facility improvement plans for assessed primary health facilities. The other indicators are not focus of this study.

Furthermore, the SRA was conducted by trained assessors from the National, Regional and Local Government Authority (LGA). After assessment, the facility is assigned a star level based on the performance of each domain whereby if a facility scores 0-19% (zero star), 20%-39% (one star), 40%-59% (two stars), 60%-79% (three stars), 80%-89% (four stars) and 90%-100% (five stars) (Yahya & Mohamed, 2018). Then, the assessment team in collaboration with the HFMT developed QIPs for the identified gaps. The HFMT under the supervision of CHMTs immediately starts the implementation of QIPs and for those gaps requiring financial

support have to be included in their annual plans such as Comprehensive Council Health Plans (CCHP) (MoHCDGEC, 2016).

1.5.2 Program stakeholders

Stakeholders' analysis refers to persons, groups or organizations that must somehow be taken into account by leaders, managers and front-line staff (Bryson, 2004). The analysis is carried out to identify individuals or organizations with a vested interest in the program. In SRA, there are various stakeholders involved in the implementation of the process and QIP follow up. These stakeholders differ in their power of influence ranging from high, medium to low.

MoHCDGEC is the owner and designer of the program and the main role is the coordination of overall implementation of SRA in health sector. The Department of Health Quality Assurance is assigned to coordinate SRA for primary health facilities.

Presidents' Office-Regional Administration Local Government (PO-RALG) under its Department of Health, Social Welfare and Nutrition oversees the implementation of QIPs. PO-RALG has the duty of ensuring R/CHMTs are accountable for their day-to-day activities in implementation of QIPs.

The other stakeholders were R/CHMTs, Development Partners, Implementing Partners, facility in charges, healthcare workers and program beneficiaries. The roles and functions for each stakeholder are summarized in Table 1.3.

Table 1.3 Stakeholders Analysis Matrix

S/N	List of Stakeholders	Role of the stakeholders in the program and evaluation	Interest in utilization of evaluation findings	Means of communication	Level of Importance H, M, L ²
1.	MoHCDGEC- Directorate of Health Quality Assurance (DHQA)	- Project owners - Coordinating all activities concerning SRA - Provide guidelines, strategic plans - Training of National and LGA assessors - Providing TA in implementation of Quality - Improvement Plans (QIPs)	- Knowing the gap in the implementation of SRA - Use of the evaluation findings to improve the program	- Formal Reports - Emails - National Quality Improvement Forums - RMOs and DMOs conference (conducted annually) - TC - SWAp TWG Quality Management meetings	H
2.	PO-RALG-Health, Social Welfare and Nutrition Section (HSWNS)	- Follow up of QIPs - Implementation of guidelines, strategic plans - Provision of financial assistance for activities requiring funds - Ensure accountability to R/CHMTs	- Knowing the gap in the implementation of SRA - Provides frameworks for evaluation - Use of the evaluation findings to improve the strategies to improve proper allocation of resources	- Sharing study findings with - RMOs and DMOs conference (conducted annually) - Emails	H
3.	RHMT	- To support and supervise CHMTs in performing its duties in implementation of SRA - To report implementation of SRA implementation to higher levels.	- To know the gap of implementation in their region - To use findings to improve the supportive supervision on SRA	- Formal Reports - Briefing with RMO and RHMTs of Pwani	H
4.	CHMT	- To supervise all Health facilities - To report on quarterly basis to RHMTs and other authorities - Incorporation of QIP activities requiring budgets in annual plans	- To use the finding to improve the status of implementation SRA in their councils	- Sharing formal study reports with CHMTs of Kibaha TC and Rufiji DC - Emails - Presenting the findings to	H

Key: ²H=High, M=Medium and L=Low

S/N	List of Stakeholders	Role of the stakeholders in the program and evaluation	Interest in utilization of evaluation findings	Means of communication	Level of Importance H, M, L ²
				CHMTs of the two councils	
5.	Facility In charges	- Supervise the HCWs on implementation of daily activities - Report progress of QIP implementation to CHMTs on monthly basis.	- To use the findings in improving the quality of services at their facilities	- Sharing the formal reports - Clinical Meetings	H
6.	Health Care Workers	- Implementation of QIP activities on daily bases	- To use the findings in improving the quality of services at their facilities	- Clinical Meetings	M
7.	Implementing Partners (i.e. EGPAF, MSH, Deloitte, Boresha Afya, MDH, etc.)	- Support the Ministry in terms of financial and TA on implementation of program	- Findings will help to know the status of implementation and to see if there is value for money	- Sharing Formal Reports - PowerPoint Presentations - TC - SWAp TWG Quality Management meetings - National Quality Improvement Forum (NQIF)	M
8.	Development Partners (Donors-WB, DANIDA, CDC, GIZ, JICA, USAID)	- Financial support to the Ministry on implementation of program	- Findings will help to know the status of implementation and to see if there is value for money	- Sharing Formal Reports - PowerPoint Presentations during DPG Health meetings - TC - SWAp TWG Quality Management meetings - National Quality Improvement Forum (NQIF)	H
9.	Clients/Patients	- Receiving the services	- Improved service leading to client satisfaction	- Community Meetings	L

Source: Authors compilation (2019)

1.5.3 Expected program objectives

1.5.3.1 Broad objective

The broad objective was to assess, rate and develop QIPs for all Primary Health Care (PHC) facilities using SRT in order to achieve 3-stars and above by the end of June 2018.

1.5.3.2 Specific objectives

- i. To assess all primary health care facilities using SRT
- ii. To assign star level to each assessed primary health care facility
- iii. To identify strengths and gaps existing in the primary health care facilities
- iv. To develop QIPs for each primary health care facility based on the gaps identified

1.5.4 Major strategies

There are different strategies during implementation of SRA in primary healthcare facilities in Tanzania. These strategies include but not limited to:

- Training of assessors at different levels (i.e., national, regional and council level).
- Full engagement of private sectors through umbrella bodies such as APHFTA, CSSC and BAKWATA.
- Involving stakeholders who perform external performance assessments such as Pharm Access International (SafeCare), Ifakara Health Institute (eTIQH), etc.
- Use of electronic systems for data collection and analysis such as tablets and excel sheets.
- Ensuring quality data controls on DHIS2 for accuracy and completeness.
- Strong feedback loop during assessment to management teams at different levels starting from facility to national level.
- Ensuring facility supervision is done as planned and the emphasis is given to QIPs developed during assessment.

1.5.5 Program activities and resources

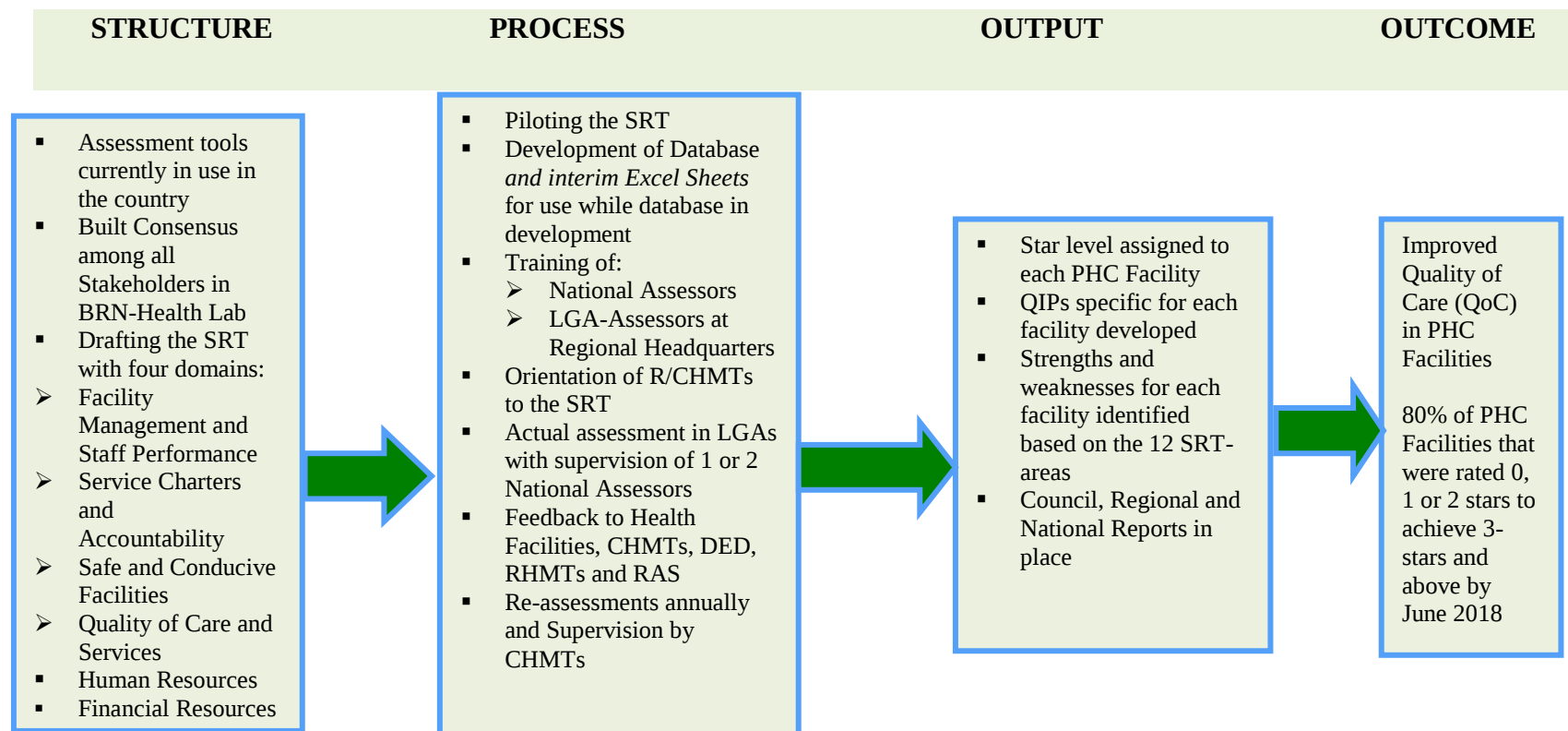
The program activities started from the BRN Lab where the initial stage was identifying the key priority areas. This was followed by development of SRT for Dispensary, Health Centres and Hospital at Council level. Piloting the tool to assess its suitability. The development of database was one of the important activities of the program but at the initial stage the excel sheet was used for data analysis.

Training of assessors was done before the implementation of the program where there were National Assessors who were trained at National level and LGAs assessors were trained at each Regional Headquarters. Regional and Council Health Management Teams (R/CHMTs) were oriented on SRT in their respective working areas. LGA assessors under supervision of National Assessors did the actual assessment in respective councils. After assessment the facilities were rated star levels and QIPs were developed for specific facilities. The comprehensive Council and Regional reports were prepared after assessment and the feedback was provided to CHMTs, District Executive Director (DED), RHMTs and Regional Administrative Secretary (RAS). The follow-up up for implementation of QIP was done by CHMTs with Technical Assistant (TA) from RHMTs. The re-assessment of health facilities was planned to be conducted annually depending on various factors but not limited to availability of funds.

1.5.6 Program logic model

The logic model for SRA system is based on available literature in assessing the quality of care building on the Donabedian framework for assessing quality of health care which contains the following elements - “structure, process, and outcome” (Liu, et al., 2011; Donabedian, 2005; Roemer & Montoya-Aguilar, 1988). The framework has added an element on immediate results of SRA system – “the outputs” which are essential in establishing baseline on the situation of quality of health care in PHC facilities (Veillard, et al., 2017; Haj, Lamrini, & Rais, 2013). Figure 1.1 presents details of the SRA framework.

Figure 1.1 Logic Model for the Star Rating Assessment (SRA) System



Source: SRA Protocol (MoHCDGEC, 2016)

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

In this chapter the focus was to know areas of concentration in identifying what was known in the evaluation study area and the methodological approaches used to generate that knowledge and its relevance. The literature review was based on theoretical and empirical approaches and both of these reviews were addressed in this chapter. In addition, the literature review aims to inform the evaluations in the light of other similar studies conducted in different contexts and allow comparisons or learn from them.

This chapter covers the following sections: Star Levels and Accreditation Systems, Quality of Healthcare in Different Perspectives, Challenges in attainment of Quality Health care in Tanzania, Supportive Supervision for PHC facilities, Policy Overview on Quality of Healthcare, and Donabedian theory as one of the theory where the program is developed.

2.2 Star Levels and Accreditation Systems

Stars are often used as a symbol for classification purposes of restaurants, hotels and airlines (Betts & Cruse, 2017). The star rating system is one method that is used in various countries to determine the quality of health care services, for example the in US the Centers for Medicare and Medicaid Services (CMS) uses this system to capture quality outcomes and patient safety at hospitals (Betts & Cruse, 2017). Higher star ratings indicate higher quality facilities and services (MoHSW, 2014).

A descriptive study comparing accredited and non-accredited home health agencies over a period of 3-year using the Centers for Medicare and Medicaid Services showed that the accredited facilities had higher star levels compared to non-accredited. Thus the accredited agencies had statistically higher star ratings than non-accredited organizations, and they were more likely to be categorized 4, 4.5, and 5 star organizations (Williams et al., 2018).

The study conducted by Gershby-Damet, et al., in 10 developing countries in Africa on establishing the laboratory quality standards showed that most of the laboratories fail to achieve the minimum score of 55%, which is equivalent to 1-star. The process of assessing the laboratories is stepwise process rather than passes and fails grading. The stars were ranging from 0 to 5 stars equivalent to 55%-95% respectively (Gershby-Damet, et al., 2010). The star rating system for primary healthcare facilities in Tanzania adopted the same system but using locally developed standards.

2.3 Quality of Healthcare in Different Perspectives

A paper published on assessing the quality of care in developing countries showed low interest in various stakeholders on quality of care. It has further been clarified that the concern of improving the quality of healthcare has been low priority for policy makers and technical agencies. The reasons for this low priority include a perceived priority of extending coverage at the expense of quality, the perception that it is difficult to implement quality in the absence of reliable documentation and health information system and the belief that improving quality is equivalent to increasing inputs hence costly. The authors recommended that it is important to improve the quality of care through quality assurance (QA) especially in developing countries (Reerink & Sauerborn, 1996).

The paper published by Jaribu et al., on describing the quality of primary healthcare facilities providing child healthcare in rural Southern Tanzania using Quality Improvement Collaborative (QIC) approach showed the gap in implementing QI methods in these facilities. The model brings together healthcare providers from different health facilities in interactive workshops by: applying QI methods to generate and test change ideas in their own facilities; using local data to monitor improvement and decision making; and health facility supervision visits by project and district mentors (Jaribu, et al., 2018).

A qualitative study conducted by Khamisi and Njau at Mwananyamala Hospital in Dar es Salaam on perception of healthcare workers on quality of care indicated that the quality of health care services may be influenced by either extrinsic and intrinsic

factors. The extrinsic factors included poor physical infrastructure, unavailability of medical equipment and/or essential drugs and poor staffing levels whereby the intrinsic factors were motivation for health care workers and workplace training opportunities (Khamis & Njau, 2016).

Another study conducted by Khamis and Njau on assessing the level of satisfaction with the quality of care at Mwananyamala Hospital reveals an overall dissatisfaction on quality of care. The satisfaction level was assessed using SERVQUAL questionnaire with 5 dimensions of reliability, tangibles, empathy, assurance and responsiveness (Khamis & Njau, 2014). This study is contrary to the study done by Muhondwa et al., at Muhimbili National Hospital, Dar es Salaam, where most of the clients were satisfied with quality of services they received. Despite high level of satisfaction, there are other service areas where the level of satisfactions was low. These include client-waiting time, high cost of treatment, poor level of hygiene in the wards and negative attitudes of staff towards patients (Muhondwa, et al., 2008).

2.4 Challenges in attainment of Quality Health care in Tanzania

Despite various efforts instilled in healthcare in Tanzania, there is still significant number of challenges hindering the attainment of quality healthcare delivery in Tanzania. Yahaya and Mohamed in their paper entitled raising a mirror to quality of care in Tanzania, the five-star assessment stipulated the major barriers in accessing the healthcare services include long distances to health facilities, poorly developed transportation systems, unfriendly services, and unreliable referral system (Yahya & Mohamed, 2018).

Poor patient retention and insufficient coordination has been reported as results of challenges, which are at the system level, which include safety, prevention, integration, and continuity. About half of the patients in low income countries reported negative experiences with their health system in the areas of attention, respect, communication, and duration of waiting, and the negative experience of was severe for vulnerable groups such as the poor, the less educated, adolescents, those

with stigmatized conditions, and those at the edges of health systems, such as people in prisons (Kruk, et al., 2018).

2.5 Supportive Supervision for PHC facilities

The implementation of SRA especially in the follow up of QIPs depend much on the regular supportive supervision, which is mostly done by CHMTs to the facilities on quarterly bases. The supportive supervision has persistently being inadequate due to due to barriers such as funding to support implementation, multiple or narrow focused supervision visits, ineffective supervision by RHMT/ CHMTs, multiple tools and inadequate follow up measures on the gaps identified (MoHCDGEC, 2017). The other challenges facing effective supportive supervision are chronic shortage of qualified human resources, overburdened healthcare providers, multiple roles of district managers, weak supply chains, high donor fragmentation and inefficient allocation of limited financial resources (Renggli, et al., 2018).

2.6 Policy Overview on Quality of Healthcare

The health Policy 2007 had the mission of ensuring the provision of healthcare services, which are of high-quality standards, affordable and sustainable (MoHSW, 2007). The quality of healthcare has been well postulated in the first edition of Tanzania Quality Improvement Framework (TQIF) in health care (MoH, 2004). The aim of the framework was to encourage healthcare workers at all levels and other stakeholders to develop a culture of quality in healthcare. The second edition of TQIF has further described the quality of healthcare in terms of principles, dimensions and institutionalization of quality in health system. Also, the Health Sector Strategic Plan IV (HSSP IV) has included Star Rating System of certification approach as one initiative for improving the quality of healthcare through assessing; rating and developing quality improvement plans for specific health facilities (MoHCDGEC, 2014). Furthermore, the SRA results were used as one of the indicators among 12 disbursement linked indicators for disbursement of basket funds to the primary health facilities.

2.7 Donabedian theory

This study applied the Donabedian model (developed by Avidis Donabedian), which adopts the culture of measurement and implements an evaluation process in order to improve the quality of care and the services delivered to the patients (Haj, et al., 2013). According to Donabedian theory, the triad of structure, process, and outcome is used to evaluate the quality of health care. Donabedian further defined “structure” as the settings, qualifications of providers, and administrative systems through which care takes place such as the hospital building or organizational infrastructures; “process” as the components of care delivered between patients and providers throughout the delivery of healthcare; and “outcome” as effects of healthcare on the health status of patients and populations. The model was adopted in this study because it has received substantial empirical support for its ability to generate information from which inferences can be drawn on quality of care (Donabedian, 2005; Ayanian & Markel, 2016; Khamis & Njau, 2016; Haj, Lamrini, & Rais, 2013).

In SRA, the triad of the model is described as follows: structures such as Star Rating Assessment Tools, Human Resources (national, regional and LGA assessors) and financial resources; processes such as trainings and actual assessments and outcomes such as proportion of health facilities with improved quality of health services.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Study area description

The evaluation study was conducted in primary healthcare facilities in Kibaha TC and Rufiji DC in Pwani Region. Pwani region is among 26 regions in Tanzania mainland with a population of 1,098,668 people according to 2012 population and housing census (NBS, 2013). The region has 9 administrative councils namely Kibaha TC, Kibaha DC, Mkuranga DC, Chalinze DC, Bagamoyo DC, Kisarawe DC, Kibiti DC, Mafia DC, and Rufiji DC. The region is bordered to the north by the Tanga Region, to the east by the Dar es Salaam region and the Indian Ocean, to the south by the Lindi region, and the west by the Morogoro region. According to Health Facility Registry (HFR), the region has a total of 360 health facilities (MoHCDGEC-HFR, 2018), which includes primary healthcare facilities (dispensaries, health centres, and hospitals at council level), stand alone and super specialized clinics and a regional referral hospital. In the SRA conducted in December 2018, a total of 333 primary health care facilities were assessed whereby 299 were dispensaries, 28 were Health Centres and 6 were hospitals at council level (MoHCDGEC, 2018).

Kibaha TC is among 9 councils in Pwani region and is the headquarters of the region. According to the 2012 population and housing census, the council had a population of 128,488 (NBS, 2013). The Council has an estimated area of 706 square Kilometres and lies between 6.8° South and longitude 38.2° and 38.5° East (Chima, 2011; PMO-RALG, 2012). Administratively, the Council has 1 division, 11 wards namely, Mailimoja, Mkuza, Kibaha, Pangani, Kongowe, Tumbi, Misugusugu, Visiga, Mwawa, Picha ya Ndege, and Msangani, and 53 Mtaa (PMO-RALG, 2012; Brinkhoff, 2017; Chima, 2011). The council is bordered to the North and West by Kibaha DC and Chalinze DC, to the east by Dar es Salaam region, and to the South by Kisarawe DC. The main economic activities include agriculture, livestock keeping, business and industrial works.

The council has a total of 47 health facilities including 29 dispensaries 6 health centers, 1 hospital (Tumbi Regional Referral Hospital), 3 clinics and 8 health laboratories (MoHCDGEC-HFR, 2018). Thirty four (34) primary health facilities were assessed in re-assessment, which was conducted in December 2018, which included 6 health centres and 28 dispensaries. Thirteen (13) out of 34 health facilities accounting for 38% attained the targets for having three stars and above making Kibaha TC the best performing council in the region (MoHCDGEC, 2018).

Rufiji DC among the councils in the Pwani region, which was included in this study. It is bordered to the North by the Kisarawe and Mkuranga Districts, to the East by the Indian Ocean, to the South by the Lindi region and to the West by the Morogoro region. The District was divided into two administrative councils in 2015 and formed Rufiji DC and Kibiti DC. Rufiji DC has an estimated area of 13,339 square kilometers with three (3) divisions namely Mkongo, Ikwiriri, and Mohoro; 13 wards namely Ikwiriri, Mgomba, Umwe, Mbwaru, Mkongo, Mwaseni, Ngorongo, Utete, Kipugira, Chemchem, Ngarambe, Mohoro, and Chumbi, 38 villages and 77 hamlets. According to comprehensive council health plan 2018/2019, the council has a population of 108,817 among which 55,497 are women and 53,320 men (Rufiji DC, 2018).

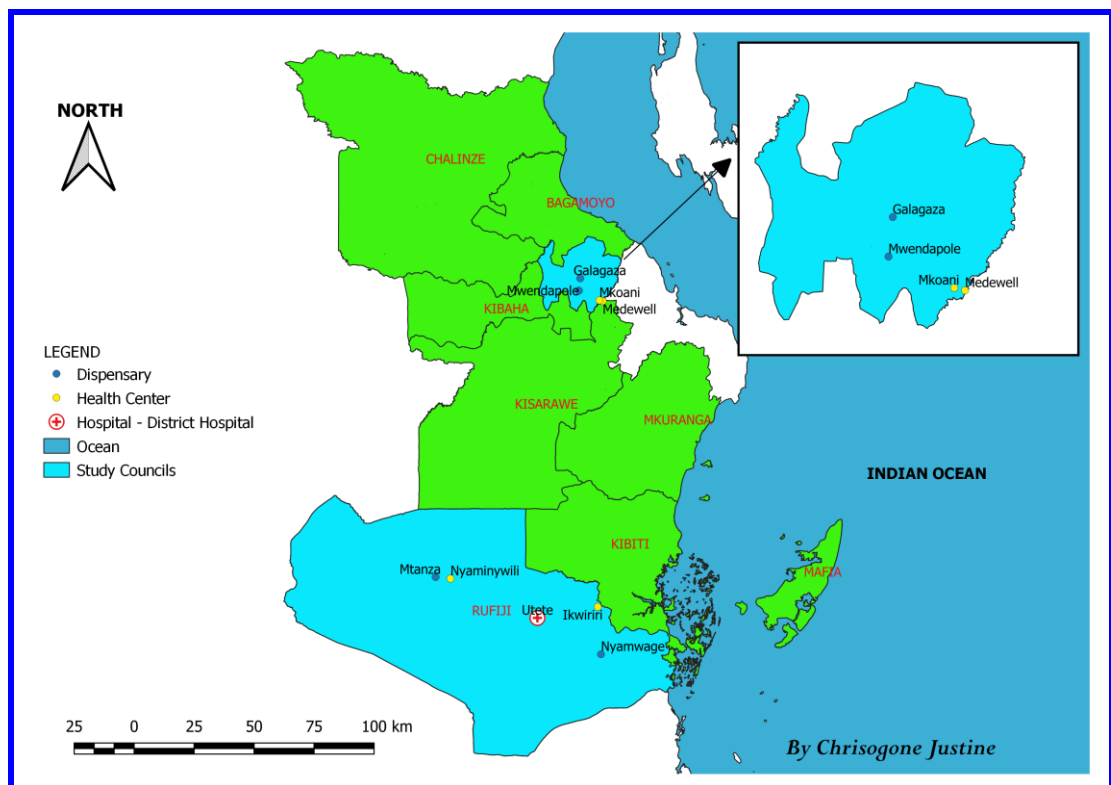
The major tribe in Rufiji district is “Wandengereko” and the other tribes include “Wanyagatwa” who are mainly found in the Rufiji Delta and “Wamatumbi” who are mainly found in the southern part of Rufiji. The main economic activities include agriculture carried out in many areas of the district and along the Rufiji River. Fishing is another activity carried out in the Rufiji River, the Delta and some inland lakes formed by the flooding of the river. The other economic activity is from forest products such as mangrove exploitation, charcoal production and logging (timber) (Mbiha & Senkondo, 2001). Also, the council is surrounded by Selous Game Reserve for tourism activity and is one of the sources of income.

The council has a total of 32 primary health facilities and in SRA conducted in December 2018; all health facilities were assessed including one (1) hospital, 3 health centres and 28 dispensaries. Rufiji DC is one of the councils that had poor

performance whereby only one facility out of 32 (3%) scored three stars and making it the poorest performing council in the region.

Therefore, the Pwani region was purposely selected as it is among the 26 regions of Tanzania mainland, which were involved in both baseline and reassessment. Kibaha TC and Rufiji DC were selected by using extreme sampling in which Kibaha TC was the best performing (38%) and Rufiji DC was the poor performing (3%). Also, the health facilities were selected by using clusters (hospitals, health centres and dispensaries) and in each cluster, an extreme sampling was conducted in which two health centres and two dispensaries from each council and from each category, the best performing and poor performing health facilities were selected (MoHCDGEC, 2018). The idea was to include district hospitals from each council but this was not possible, as Kibaha TC had no district hospital, thus only Utete District Hospital (for Rufiji DC) was included in the study.

Figure 3.1 The map of Pwani region showing study councils and facilities



Source: Researcher design (2019)

Table 3.1 Descriptive characteristics of councils selected for the study.

SN	Characteristics	Kibaha TC	Rufiji DC
1.	Region	Pwani	Pwani
2.	Location	Urban	Rural
3.	Population size	128,488	217,274
4.	Area (km ²)	706	13,339
5.	Accessibility	No hard-to-reach areas	Several hard to reach areas, including the Rufiji river delta
6.	Number of health facilities assessed in SRA 2017/2018 (hospital/ health centres/ dispensaries) (as of December 2017)	34 (0/6/28)	32 (1/3/28)
7.	Percentage of facilities scored 3 stars and above in the council (as of December 2017)	18%	3%

Source: Researcher (2019)

3.2 Evaluation Period

The study started from November 2018 through August 2019 whereby the proposal development was completed in April 2019, data collection was done in May and June 2019 and data analysis and report writing were conducted between July and August 2019.

3.3 Evaluation approach

The formative evaluation study was employed, which allowed the evaluation of the continuing program for purposes of improving performance or generating lessons learned during implementation (Rossi, et al., 2004). A formative evaluation was used to assess effectiveness, and to determine results and overall value after implementation of SRA for primary health facilities in Tanzania (World Bank, 2008). The formative approach informs the policymakers on how to expand the SRA system in order to improve the quality of health services in the country.

3.4 Evaluation design

To achieve my research objectives, I adopted a descriptive cross-sectional study design whereby qualitative technique was employed to get the experiences of individual healthcare providers and groups of QITs on implementation of SRA. The cross-sectional study involves the detailed description and analysis of a single group,

person, process or system or any other entity at one particular point in time and in great detail (Ritchie & Lewis, 2013). The objective is to determine how the objective of study works and to identify the factors or dynamics that leads to success or failure (Yin, 2013; Ritchie & Lewis, 2013; Creswell, 2013). Since this study aimed to assess the implementation process of SRA and QIPs in primary health facilities, a descriptive cross-sectional study was a suitable evaluation design to assess the success or failures of the SRA.

3.5 Focus of evaluation and dimensions

The main focus of this study was to evaluate the implementation process of SRA by determining to what extent the set targets were met as stipulated in program objectives which were focused on assessing, assigning star levels, identifying strengths and gaps. Also, development of specific QIPs for all primary healthcare facilities based on the gaps identified during assessment was another focus of this study.

3.6 Study population and unit of analysis

The study participants were selected healthcare workers and managers from different levels of healthcare delivery starting from facility to the national level. The participants included facility in-charges, QITs, CHMTs including DMO or District Health Secretary, RHMT including RMO, and QI Focal Persons for the Council and Regional level. Also, the national level (MoHCDGEC and PORALG) SRA coordinators were interviewed to get the insight of the program implementation, monitoring and evaluation.

The study units were selected public and faith based facilities in Kibaha TC and Rufiji DC whereby the sampling units were managers and healthcare providers at different levels of healthcare delivery from facility to national level.

3.7 Sample size determination and sampling procedures/techniques

The study participants were conveniently selected until the saturation was reached and the data was collected until all necessary information was gathered and no more

new information was evolving (Fowler, 2014; Vasileiou, et al., 2018; Anasel, 2017). The saturation was reached for both IDIs and FGDs. Also, the saturation was reached for the key informants at different level of healthcare delivery because all expected informants were either interviewed or participated in focus group discussion.

The study used a non-probability sampling technique to identify the key informants who provided the information for this study. Forty (40) healthcare workers were purposely selected depending on the key information required from them. The IDIs were conducted to DMO or district health secretary, the QI Focal Persons, and facility in charges for the selected facilities. FGDs were conducted to QITs for each of the health centres and hospitals. The reason for selecting key informants purposeful is to identify health managers depending on their ability to provide rich information and insight on SRA implementations in their council and meet the intent of this study (Fowler, 2014).

Therefore, a total of 9 health facilities were involved in the study in which 4 were from Kibaha TC (Mkoani Health Centre, Medewell Health Centre, Galagaza Dispensary and Mwendapole Dispensary) and 5 from Rufiji DC (Utete District Hospital, Ikwiriri Health Centre, Nyaminywili Health Centre, Nyamwage Dispensary, and Mtanza Dispensary). A total of 40 participants through FGDs and IDIs. Four (4) FGDs were conducted with 21 participants, 6 men, and 15 women while 19 participants, 7 men, and 12 women, took part in IDIs as summarized in table 3.2.

Table 3.2 Summary of the study participants

	Male	Female	Total
FGDs			
Kibaha TC			
Mkoani Health Centre	0	5	5
Medewell Health Centre	2	5	7
Galagaza Dispensary	0	0	0
Mwendapole Dispensary	0	0	0
Rufiji DC			
Utete District Hospital	2	3	5
Ikwiriri Health Centre	2	2	4
Nyaminywili Health Centre	0	0	0
Nyamwage Dispensary	0	0	0
Mtanza Dispensary	0	0	0
IDIs			
Kibaha TC			
Mkoani Health Centre	1	1	2
Medewell Health Centre	0	1	1
Galagaza Dispensary	0	2	2
Mwendapole Dispensary	1	0	1
CHMT Kibaha TC	2	0	2
Rufiji DC			
Utete District Hospital	1	0	1
Ikwiriri Health Centre	1	0	1
Nyaminywili Health Centre	0	1	1
Nyamwage Dispensary	0	1	1
Mtanza Dispensary	0	2	2
CHMT Rufiji DC	1	1	2
RHMTs Pwani	0	1	1
MoHCDGEC	0	1	1
PO-RALG	0	1	1
Total	13	27	40

Source: The Researcher (2019)

3.8 Descriptions of Evaluation participants

This study involved various participants from different levels of health care delivery ranging from national to health facility. At national level the national SRA coordinator from MoHCDGEC was interviewed and on the other hand the Curative Services Coordinator at PORALG was included in the study. The two experts are responsible for ensuring that SRA activities are implemented as planned in the program design.

At regional level, Regional QI Focal Person is one of the members in the Technical Committee of RHMT (PO-RALG, 2015) who is responsible for coordinating all

quality improvement activities in the region. Among other activities is coordinating the SRA for primary health care in the region in which he/she is responsible to ensure that all activities are coordinated at regional level and to provide technical advice to the councils in the region.

At council level, the District QI Focal Person and the DMO or District Health Secretary were involved in the study. The District QI Focal Person is one among 32 members of Technical Committee of CHMT and is responsible for coordinating all activities pertaining to quality management activities. In the SRA system is the one providing technical assistance to the facilities in collaboration with other CHMTs members (PO-RALG, 2015). The DMO is the overall in charge of all health-related activities in the council and is head of the health department in the council.

At the facility level, the facility in charges and QITs were involved in the study. Facilities in charges are the officers entitled to oversee day-to-day activities of the facility including SRA and implementation of QIPs. The QITs are teams composed of heads of departments/units to oversee the smooth running of the activities in their respective areas. The team is responsible to meet on a monthly basis to discuss the QI activities identified from each department (MoHSW, 2011).

3.9 Inclusion and exclusion criteria

The study included health managers from facility to national level who in one way or another participated in SRA in at least baseline or re-assessment, as this is important for the participant to have adequate knowledge on the SRA system. All health managers who did not participate in any of the assessments were excluded from the study. All QIT members who were available on the day of data collection were conveniently selected to participate in the study.

3.10 Data collection Methods

Data collection was done using IDI and FGDs guides. The IDI was conducted for National level coordinators, Regional and Council QI Focal Persons and facility in charges for hospitals and health centres. The FGD was conducted to QITs for Utete

Hospital and all selected Health Centres except for Nyaminywili Health Centre in which there were only three staff on the day of data collection, which make it difficult to conduct an FGD. For easy administration, the tools were tested for their suitability.

The researcher with a trained research assistant for each council conducted data collection from the key informants. The research assistants were selected based on their experience by participating in SRA in either baseline or re-assessment. To ensure the quality of data collected a one-day orientation was conducted to research assistants before the data collection.

3.11 Data management and analysis

Data collected from FGDs and IDIs through audiotape were first transcribed verbatim and then compared with the field notes. The transcription of recorded FGDs and IDIs were done within 24 hours of data collection. The recorded transcriptions were translated from Swahili to English and then were read repeatedly to ensure the quality of data and acquire the sense of overall data.

I analyzed the interviews and FGDs using qualitative content analysis (Graneheim & Lundman, 2004; Erlingsson & Brysiewicz, 2017). Qualitative content analysis offers the development of categories from the text data inductively; the inductive derivation of categories is important in capturing experiences from the key informants. The full transcripts and field notes were first read and re-read in order to become acquainted with the data and the context. Condensed meaning units were then formed through data reduction (Sirili, et al., 2019).

Subsequently, the transcribed texts were imported into the Atlas.ti version 8.2.4 (Smit, 2002), which is a program, developed by Atlas.ti Scientific Software Development GmbH for qualitative analysis. Then, the transcripts were inductively coded using pre-determined themes such as SRA targets, SRA implementation, factors facilitated, and the factors impinging, and the emerging themes during coding were deductively coded (Gale, et al., 2013). The texts were coded based on the objectives of the study and followed by grouping of codes in families that reflect the

four main objectives of the study. Finally, the outputs were created for all codes, quotations, memos and families for writing the final descriptive report (Anasel, 2017).

3.12 Ethical Issues

Ethical approval was obtained from different institutions required to provide the approval for this study. The first institution was Mzumbe University through Ethical Clearance Committee, which provided ethical approval by providing an approval letter to respective District Executive Directors (DED). The permission for the collection of data was obtained from DED of Kibaha TC and Rufiji DC. All participants were informed about the purpose of this study and assured that participating in this study is solely voluntary. Written consent was provided to the participants before interviews and verbal consent was asked during conversations. Furthermore, all data collected were kept in a safe place anonymously and only given a special identity to help during analysis. Privacy was maintained during data collection to give the participants the freedom to express themselves without external or internal interferences. Audio taped and paper-based data were carefully stored in a manner that wouldn't allow any unauthorized persons to access. The electronic materials and databases were stored and where appropriate a password was used.

3.13 Study Limitations

The study design, which is a qualitative approach, is difficult to generalize findings to other settings. The findings generated are contextual and hence can only apply to Kibaha TC and Rufiji DC. However, the fact that it cannot be replicable to other setting doesn't affect the importance of undertaking the study since it has potential implication in becoming a base for further studies on SRA in Tanzania and other countries.

CHAPTERFOUR

RESULTS

4.1 Introduction

This chapter aims to represent the study findings in the evaluation of SRA in Kibaha TC and Rufiji DC. The presentations of findings were presented alongside the objectives of this study to answer relevant evaluation questions. The chapter covers the following 4 themes: extent to which the set targets of SRA are attained, the implementation process of SRA (with 6 sub-themes, namely reported achievements and awards after SRA, awareness on SRA system, implementation of QIP, roles of QIT in implementation QIPs, inclusion of QIPs in annual plans and supportive supervisions by CHMTs), factor facilitated or impinged the SRA and QIPs and the recommendations put forward to improve the SRA system and QIP follow up in primary health facilities in the study area. Furthermore, after each theme and sub theme, the analytical reflections are provided to make sense of the findings.

4.2 Extent to which the set targets were achieved

The main target for SRA was at least 80% of health facilities in each level of healthcare delivery to achieve three stars and above by June 2018. Surprisingly, only 20% of facilities attained the set target and the situation is worse in some of the councils as exemplified by Rufiji DC where only one (1) facility (Ikiwiriri HC), which attained the target of 3 stars. Utete District Hospital, which is the referral centre for lower health facilities in the council, attained two stars. Despite the fact that most facilities didn't achieve the targets in Rufiji DC, the situation is a bit different in Kibaha TC whereby 11/12 (92%) of LGAs health facilities scored three stars and above (MoHCDGEC, 2018). The summary of the results of the assessments for the selected facilities is summarized in Table 4.1 shows the comparison between baseline assessments conducted in February 2016 and re-assessment, which was conducted in July 2017 (Kibaha TC) and December 2017 (Rufiji DC).

Table 4.1 Results for assessments for the study facilities

SN	Name of Facility/Council	Results			
		Baseline (Feb 2016)		Re-assessment (Dec 2017)	
		Star level	Average Score	Star level	Average Score
	Kibaha TC				
1.	Mkoani Health Centre	2-star	44	3-star	78
2.	Medewell Health Centre	1-star	51	3-star	75
3.	Galagaza Dispensary	0-star	26	3-star	66
4.	Mwendapole Dispensary	0-star	47	3-star	87
	Rufiji DC				
1.	Utete District Hospital	2-star	62	2-star	68
2.	Ikwiriri Health Centre	0-star	27	3-star	81
3.	Nyaminwili Health Centre	0-star	31	2-star	66
4.	Nyamwage Dispensary	1-star	46	2-star	74
5.	Mtanza Dispensary	1-star	59	1-star	36

Source: SRA Results (2018)

There are various reasons for most of the facilities fail to achieve the set targets as reported by cross-examined participants. One of the reasons mentioned by interviewed participants was inadequate training to staff during the implementation of the SRA system. During the implementation, staff in most of the facilities reported that they were not trained on the tools used to assess their health facilities. For example, one of the respondents reported that they were not aware of the criteria used for assessments:

“...you know what, they didn't train us on the tools used to assess us. We even don't know the criteria used so far, I heard there are different criteria used for dispensaries, health centres and hospitals. I don't have the book showing those criteria and knowing which criteria made us fail, is difficult to tell” (IDI, Facility in Charge-Kibaha TC, June 2019).

Failure to set realistic targets was one of the factors reported by some of the participants especially those participated in the BRN lab. The targets were set during the BRN lab conducted in 2014 where there was no baseline data to support the set targets. The targets were over ambitious and difficult to achieve. One participant mentioned:

“...BRN was planned under political pressure, we were planning even without data to support, and everything was planned on the table. The targets were over-ambitious. At that time the facilities did not have even

paracetamol, infrastructure was completely poor, do you think you can achieve a star in that situation? (IDI, National level, June 2019).

Inadequate training and failure to set realistic targets has been a problem as it was expected that 80% of primary health facilities to have three stars and above by June 2018. The facilities were not prepared in terms of capacity building of staff on SRA system and infrastructure was not supportive. Therefore, it was difficult to achieve those targets and thus why up to June 2018, only 20% of facilities achieved the set target of having 3 stars and above.

4.3 Implementation Process of SRA

4.3.1 Reported Achievements and Awards After SRA

The provision of awards for best performing facilities was reported to be one of the motivating aspect during implementation of SRA. The awards were divided into two categories, the first category was for best performing council in which the council is required to attain the target of at least 80% of its health facilities attaining three stars and above. In Pwani region there was no council, which reached this target. The second category was for the best performing health facilities in which the facility must have attained three stars and above and the award was given to the five best performing facilities in the region. In the assessment conducted in December 2018, the top five facilities were Nyota ya Bahari Health Centre (Mkuranga DC), Msata Dispensary (Chalinze DC), Mwendapole Dispensary (Kibaha TC), Mataya Dispensary (Bagamoyo DC) and Ikwiriri Health Centre (Rufiji DC). The awards were trophies for councils and certificates for health facilities. The facilities that received certificates were highly motivated and wish to achieve higher star ratings as explained by one of the health facility in charges in Kibaha TC. He pointed out that:

“I was just surprised, they brought this (pointing...) certificate and we were among the best performing facility in the region. The Deputy Minister of Health (Dr. Ndugulile) awarded this certificate and that day we gathered and celebrated and all our neighboring facilities (like Tumbi) were surprised. We are still struggling until we reach five stars” (IDI, Facility in Charge-Kibaha TC, June 2019).

Thus, the provision of awards has contributed to competitions among regions, councils and individual facilities, which facilitated improvement in the quality of health services in the country. This motivating factor should have to be promoted and sustained in the subsequent SRA.

Figure 4.1 Certificates provided for five best performing health facilities



Source: MoHCDGEC-DHQA (2018)

4.3.2 Awareness on SRA system

Among the preliminary questions asked to interviewees was their awareness on the star level achieved by their facilities in the latest previous assessments. Some of the interviewed staff were not aware of the star level achieved by their facilities and the lack of awareness was high among staff in health centres and hospitals. For example, among four health centres evaluated, none of the QIT members could be able to

mention without any hesitation the star level of their facilities. Also, the participants were not aware that the assessment was only for primary health facilities and not to regional referral hospitals like Tumbi Regional Referral Hospital.

“I think our facility (Facility X) had one star (in reality facility X scored 3 stars), but I am not sure because I did not participate in assessment. I heard Tumbi Hospital (a Regional Referral Hospital) got 2 stars” (Regional Referral Hospitals were not part of SRA) (FGD, Facility-Kibaha TC, June 2019)

On the other hand, facilities in charges who were supposed to take lead in implementation of SRA activities at the facility level were not aware of the star level of their facilities. One of the facility in charges responded that QI Focal Person at the CHMT office is responsible for keeping the results for the facilities. This is contrary to the actual practice because soon after assessment the results are shared with the facilities on the day of assessment and each facility knows their star levels. One of the facilities in charge in one of the Health Centre in Kibaha TC narrated:

“There was a conversation that the last assessment gave our facility two stars but we heard from CHMTs that we scored three stars but we wonder who gave us. Also, we heard that all facilities in the council have scored three stars. I continued to find the document showing the star level of my facility but could not be found anywhere”(IDI, Facility in Charge- Kibaha TC, June 2019).

Contrary to the facility in charge in Kibaha TC, one of the QIT members from one of the facilities in Rufiji DC was aware of the SRA and precisely explained the concept of SRA and even compared with ratings of hotels as follows:

“SRA is the system that aimed at improving the quality of services in our facilities. It was conducted in our hospitals (Utete District Hospitals), dispensaries and health centres and not in regional and national hospitals. The quality of services is assessed using a tool that determines the star level the facility, whether it is zero, one, two, four or up to 5 stars. The good thing is that the services are improved and the ratings are more less the same as ratings of the hotels where there are hotels of two, three or up to five stars”. (FGD, Rufiji DC, June 2019).

Paucities in of awareness in SRA system in primary health facilities have affected the implementation the program in some aspects. For example in Kibaha TC where

the awareness was comparatively high, the implementation of SRA was impressive and most of the facilities performed better in re-assessment compared to baseline assessment were most of the facilities scored zero stars.

4.3.3 Implementation of QIP

The implementation of QIP was one of the key components in the implementation process of SRA system. After the assessment, the assessors in collaboration with health facility management teams prepare the QIP for the gaps identified during assessment. The observation in most of the facilities showed that most of the facilities are no longer implementing the QIPs provided to them, which was supported by the evidence that most of the facilities do not have copies of QIPs. For example, out of 9 facilities evaluated, only 2 facilities had copies of QIPs, though the issue of evidence for implementation of the progress of implementation was missing. It was observed that most of the facilities have put more emphasis on Results Based Financing (RBF) indicators, and leaving out the SRA indicators, which are implemented through QIPs, developed for the facilities. One of the facility in charges commented:

“You know what? They gave us a green book with national flag (Star Rating Tool) and the CHMTs brought the checklist (QIP) but we were not told what to do with it. We were told that the SRA program is no longer existing and we have to deal with RBF, and we were given money every quarter. All renovations you are seeing here is through RBF”(IDI, Facility in charge-Rufiji DC, June 2019).

The issue of proper documentation was one of the challenges during implementation of QIPs. Most of the facilities were lacking proper documentation of clients’ records. After commencement of SRA the issue of documentation and data completeness has been addressed by some of the facilities as narrated by one of the facility in charges in Kibaha TC:

“The big problem is data, after seeing that I decided to choose few champions who we can work together and ensuring that all patients attended at OPD are entered in this MTUHA book and I ensured that all data seen at OPD must tally with that of the laboratory and if anyone misbehaves, I consider it as a criminal case. I also, order my staff to make sure the reports are valid and timely. Also,

the issue of environmental cleanliness for me is like a national anthem” (IDI, Facility in Charge, Kibaha TC, June 2019)

One of the big challenges at the beginning of the implementation of SRA was that some of the facilities’ buildings were dilapidated. The issue of renovation has been one of the focuses during SRA implementation using various sources of funds including RBF funds for Pwani region. Some of the facilities have started implementation in terms of renovation of infrastructure. Also, some facilities have continuously increased the procurement of medical equipment and ensure the availability of essential medicines. One of the facilities in charges echoed:

“At the beginning, this house was not in good state of repair, we renovated this building and toilets, and that incinerator we build after we were assessed and received RBF funds. Also, we have adequate essential medicines after we started buying medicines for ourselves”(IDI, Facility in Charge-Kibaha TC, June 2019).

Generally, the implementation of QIPs has been a challenge, which will be explained in detail in sub theme 4.5 in this chapter.

4.3.4 Roles of QIT in implementation of QIP

During the implementation of QIPs, the QIT play a major role in the implementation of gaps identified during assessment by ensuring that those gaps are assigned to the specific individual from the departments/units in the facility. One of the members of QIT showed good understanding of roles of QITs in implementation of QIPs by explaining how they identify gaps and find out the solutions of addressing the identified gaps. One respondent described the situation as follows:

“The QIT includes all representatives from each department, one individual from each department like I am from RCH, (pointing...) he is from the pharmacy, thus every one represents problems from their respective departments and then we sit down and find the solutions to address them. Also, the identified as gaps or those which are not in place during the assessment are included in QIP which will show the gap, responsible person (like facility in charge), timeframe and if there is that gap requires funds or not” (FGD, Rufiji DC, June 2019).

The other respondent added:

“...first of all we have that book which is used for assessment (SRT) for BRN, we identify gaps which are in our facility, we include those gaps in QIP for implementation” (FGD, Rufiji DC, June 2019).

On the other hand, some of the QIT members from some of the facilities such as Medewell Health Centre were not aware of their roles in the implementation of QIPs. Also, the QIT in most of the facilities were not aware of their routine roles, as they were not aware of monthly meetings, meeting schedules, and the documentation of QI activities in the facility.

“I think we meet once after every three months or whenever there are problems to be solved or if we are directed by our administrator” (FGD, Kibaha TC, June 2019).

One of the observed challenges in implementation of SRA is participation Council QI Focal Person (QI FP) in implementation of QI activities (including QIP implementation) in the council. The observations showed that the Council QI Focal Persons are not fully participated in the follow up of QI activities in their councils. For example, the QI FP for Rufiji DC is stationed at Ikwiriri Health Centre instead of being among the technical committee of the CHMTs. Being situated at Ikwiriri, he is considered as one of the QIT members of the facility instead of his role of coordinating the QI activities in the whole council. This brings difficulties in performing his duties as QI FP of the council and thus the observed gaps in the implementation of QIP in the facilities may have aroused due to him being situated in the wrong place.

4.3.5 Inclusion of QIPs in annual plans

PO-RALG has the mandate to oversee the plans and budgets for the primary health facilities in Tanzania. The annual plans start at the facility level and then compiled at council as Comprehensive Council Health Plans (CCHP). One of the agreements during SRA design was that the gaps requiring a budget in QIP should be included in the facility annual plans. In the planning process there are pre-determined indicators

commonly known as priority areas, which are used during the preparation of the facility planning processes.

In general, the findings show that some of the gaps are included in the plans. It has been explained that during the planning process some of the gaps are addressed automatically as some of the priority areas were similar to the gaps addressed in the QIPs.

The review of the facilities' plans showed that some of the gaps were addressed but the facility in charges were not aware of whether those gaps were originating from the QIPs developed during SRA.

4.3.6 Supportive supervisions by CHMTs

Supportive supervision is one of the primary roles of CHMTs and is conducted at least quarterly to the facilities in the council. The supervision is supposed to be conducted by a group of CHMTs instead of vertical programs or partners driven supervisions. One of the roles of CHMTs in implementation of QIP is to monitor the progress of QIPs during their quarterly supportive supervision and to make sure the gaps identified during the assessment are addressed. The proposed ways of addressing the gaps are through prioritization of those gaps depending on whether the gaps require financial support or not.

One of the facility in charges reported that the CHMT conduct the supportive supervision commonly on a quarterly basis but they are not dealing with the QIPs left rather they have their checklist with other indicators.

“They (CHMT), normally come for supervision, especially when distributing vaccines, they (CHMT) come with their checklist and after supervision they provide the feedback and write some recommendation in this register (MTUHA Book 2) but I am not sure if they were looking at BRN (SRA) issues” (IDI, Facility In Charge-Rufiji DC, June 2019)

On reviewing some of the supervision report by CHMTs in the facilities evaluated, there was no evidence of monitoring of QIPs in all facilities. The supervisions are

conducted using a standardized checklist but the checklist has no indicators for monitoring the progress of QIPs developed during SRA.

Therefore, the supervision done by CHMT does not include monitoring of the progress of QIPs and this may be due to lack of inclusion of this indicator in their supervision checklist.

4.4 Factors which facilitated the implementation of SRA and QIPs

One of the reported factors that facilitated the implementation of SRA is discipline and accountability among healthcare workers. One of the facilities in charges in Kibaha TC reported that he ensured that all the staff are disciplined by reporting to work on time and signing in the attendance register. He also reported that clients' complaints are handled immediately especially complaints concerning recurrent stock out of essentials medicines. He explained:

“...brother, do you think there are new things? It's discipline and accountability at work, if you are told to do something you have to do so. For example, if the assessment team comes to your facility you have to make sure that your documentation and data are clean, and in case of clients' complaints you have to act immediately. Most of the complaints increase when the medicines are missing, so as the facility in charge I have to make sure all essential medicines are available and no client is buying medicines in the pharmacies around Mwendapole” (IDI, Facility in Charge, Kibaha TC, June 2019).

Another factor, which was reported to facilitate the implementation of QIPs, is Results Based Financing (RBF) program. One of the criteria for the facility to be enrolled in RBF program is for the facility to have at least one star in SRA. During the baseline assessment most facilities in Pwani region score zero stars and failed to be enrolled in RBF program. In order to rescue the situation a startup funds of Tsh. 10 million was provided to the facilities that scored zero stars in order to improve the quality of services especially on making minor renovations and procurement of essential medicines and medical equipment. This was acknowledged by one of the facility in charges in Kibaha TC and in the same vein, the facility in-charge commented that:

“There was money provided by these partners (RBF funds) to improve the quality of service in our facility. I remember that was RBF funds and it is the one that made us achieve this little two stars you are seeing, before that the situation was very bad as we scored zero stars in the first assessment. That money we received (10 million Tsh.) in 2016 is the one used for renovation of this house and the incinerator you are seeing there (pointing to the incinerator)” (IDI, Facility in charge, Kibaha TC, June 2019).

The issue of Direct Health Facility Financing (DHFF) was reported as one of the factors that facilitated the smooth implementation of QIPs in primary health facilities. DHFF is the program in which the facilities were given autonomy to manage their funds and the funds are directly disbursed to the facility bank accounts. Due to direct disbursement of funds to the facility account, the facility in charge in collaboration with health facility governing committee were able to plan and budget for the needs of the facility instead of the previous system where planning and budgeting were conducted at council level. One of the facility in charges commented:

“Currently we are receiving money directly through our bank accounts, we sit together with my committee (HFGC) and prioritize the things we need for our facility, we send to DMOs office for approval. You can see now we have enough medicines in our shelves. Previously it reaches a time we fail to buy even a single glove for delivering the mothers, the situation was pathetic” (IDI, Facility in Charge, Rufiji DC, June 2019).

Similarly, one of the facilities in charges supported the contribution made by the introduction of DHFF in improving the provision health services in their facilities. She narrated that:

“The situation was bad when the budgets were being planned at council level, they (CHMTs) don't know our actual needs, they just decide for you, for example, they once decided to bring ALU (antimalarial) to Galagaza which was not needed for our facility at that time but for now we press order ourselves because we know the missing drugs and normally we order in bulky for fast moving drugs” (Facility in charge, Kibaha TC, June 2019).

Therefore, the most highly influencing factors that facilitated the implementation of SRA were funds from RBF program and the DHFF program but the issue of discipline and accountability had less influence on the implementation of SRA.

4.5 Factors impinging the implementation of SRA and QIP

Shortage of healthcare workers is about 52% in Tanzania and this was reported as a challenge in almost all facilities evaluated. Some of the facilities such as Galagaza dispensary had only two staff, which was a burden in the provision of quality healthcare.

“...lack of funds is a problem, but (during assessment) we also had very few staff, we were only two staff, me and my doctor (clinical assistant) and now we are four, thus two doctors (clinical assistants), one nurse and one medical attendant, also we have security guard who is being paid by village office” (Facility in Charge-Kibaha TC, June 2019).

In some of the facilities, the shortage of staff is severe as sometimes the medical attendant performs the duties of clinicians and nurses, which is contrary to the job descriptions of the medical attendants. One of the facilities in charge who is an enrolled nurse pointed out the following:

“Our major challenge here we don't have a doctor (clinician), I am an enrolled nurse (certificate level) and my colleague is a medical attendant. Every facility is supposed to have a doctor (clinician); currently I have become a doctor and the same to my colleague. When I am not around she becomes a doctor, she prescribes and even conduct deliveries. We need to have a doctor” (IDI, Facility in Charge, Rufiji DC, June 2019).

The situation of shortage of healthcare workers became severe when some of the healthcare workers were removed from civil services due to forged certificates (referred to as ghost workers). For example, Mtanza Dispensary in Rufiji DC remained with only one medical attendant who was to perform all activities at the facility such as consultations, which is supposed to be done by clinicians, nursing services and prescription of medications.

“I and my colleague who was an enrolled nurse had the problem with our certificates. I stopped working in the first round of assessment but fortunately; there was errors with those who were crosschecking my

certificate, I resumed my work on 28th January 2019. On the same day, I was resuming my work I met my colleague at Utete (headquarters of the district), she was called from the DMOs office that there is a problem with her certificates and still she is not back” (IDI, Facility in Charge, Rufiji DC, June 2019).

The issue of power supply was reported as one of the challenges during the implementation of SRA in such a way that some of the deliveries were conducted in dark rooms as it was reported by one of the health facility in charge in Kibaha TC.

“...also we had no electricity but now we are connected to national grid, during that time we sometimes conduct deliveries in dark room”(IDI, Facility in Charge, Kibaha TC, June 2019).

The SRT and QIPs were prepared in English language, these has been reported as one of the challenges especially to the staff of the lower carders. Thus, the use of English language has been reported by some of the participants as one factor that in one way or another has contributed to failure to implement QIPs successfully. One of the facilities in charges pointed out that:

“Some of us are not aware of those tools, the language used was also a challenge, it’s better to use Kiswahili because we have some facilities lead by medical attendants, do you think they will understand your English” (FGD, Rufiji DC, June 2019).

Another facilities in charges added the following:

“Hahaaaa... English is a problem my dear, I know how to write a bit but it is better if you use Kiswahili. Tell them to use our national language, it will be helpful to me and my friend (medical attendant)” (IDI, Facility in Charge, Rufiji DC, June 2019)

Therefore, an inadequate number of health care workers and financial resources were the most impinging factors in the implementation of SRA and QIPs in most of the facilities. The shortage was precipitated by removal of ghost workers from the civil services. The shortage of more than 52% had shown a negative impact on delivering quality health services. The other factors such shortage of social amenities such as electricity and water has also affected the implementation process of SRA. The use of SRT which were in English language had little effect on implementation as this affected the staff of the lower cadres.

4.6 Recommendations for improvement of the implementation of SRA and QIP

Most of the participants agreed the implementation of SRA and QIPs had number of challenges and came up with recommendations to improve the SRA system in different approaches as stipulated below.

4.6.1 Capacity building

Some of the participants reported that they were not trained on SRA system. The few who received the training did not deliver the knowledge as it was expected. In the initial design, the trainings of SRA was provided to a few number of health care workers from the facilities within the council and a one day orientation was given to team of CHMTs who then participated in the assessments of the facilities. Sharing of knowledge seems to be inadequate and one respondent described the situation as follows:

“We were not prepared at all in the first (baseline) assessment; they (assessors) just came with their checklist and rated our facility. There was no training at all especially in these faith based facilities, if we could have been trained and given the ABCs of BRN, the situation could have been better. I don't know if BRN is still existing but if they continue with this system we need to be trained at our facilities instead of just training the CHMTs who hardly come to our facilities” (IDI, Facility in Charge, Kibaha TC, June 2019).

One participant added the following explanation:

“They selected some of the people from our facility to attend the training but I am not sure if they brought feedback, I think the per diem syndrome was the problem” (FGD, Kibaha TC, June 2019).

Therefore, it is important to have properly arranged trainings which could involve the healthcare workers at their working stations instead of training the CHMTs who are usually overwhelmed by ad hoc activities at the council level.

4.6.2 Involvement of partners in the councils

The involvement of implementing partners in different councils has been seen as one opportunity of improving the implementation of SRA and QIPs. The partners can

help in implementing the gaps that require financial support. Implementing partners were reported to help in the implementation of QIP at Kibaha TC. One of the facilities in charges portrayed the situation as follows:

“I tried to talk to our partners and have helped in many ways, we have MDH who helped to renovate this building and that tent for male circumcision. We have a lot of partners but we don't utilize them to align with our priorities” (IDI, Facility in Charge, Kibaha TC, 2019)

One of the coordinators at national level reported that almost 80% of funds used for implementation of SRA were from implementing and development partners. She gave the following explanations:

“Oooo no... more than 80% of the funds were from DPs and IPs for conducting all these activities in both rounds (baseline and reassessment). I remember World Bank gave support in four regions (Tanga, Kigoma, Singida and Dodoma) for facilities that scored zero stars and this helped to improve the quality of healthcare and the star levels were improved in the second assessment” (IDI, National level, June 2019).

Therefore, the involvement of various stakeholders in the subsequent assessments is of paramount importance, as it will facilitate the process of SRA as well as proper implementation of QIPs.

4.6.3 Digitalization of SRA system

The process of SRA and follow up of QIPs is very demanding and time consuming. The process starts by assessing the facility using a paper based SRT, the data are entered into excels to get a star level of the facility. The next step was to develop a QIP for all identified gaps (marked No or Partial) for all 12 areas of the SRT and all these activities have to be done on a single day of assessment.

National SRA coordinators has pointed out that, in order to overcome these tedious activities, an online system for following up the QIP has been developed and rolled out to almost 20 regions. Currently, they are finalizing the mobile app that will be used for the assessment and follow up of QIPs and will have an online and offline mode for facilities with limited access to the internet.

“We have done a lot to digitalize the SRA system, as of now we are in the final stage of developing a mobile app on DHIS2 that will capture all SRA and QIP follow up to make life easier. It was a very difficult task to do all these activities manually” (IDI, National level, June 2019).

Generally, the recommendations made are very valuable in improving the subsequent implementation of SRA and QIP follow up in primary health facilities in Tanzania.

CHAPTER FIVE

DISCUSSION

5.1 Introduction

This chapter deals with the discussion and interpretation of data to respond to the evaluation objectives. A thematic analysis was used to create valuable insights in responding to evaluation objectives (Braun, et al., 2018). In chapter four the data analysis was based on the individual and group experience in describing the implementation of the SRA and QIPs in primary health facilities in Kibaha TC and Rufiji DC. Therefore, a thematic analysis has been employed in this chapter to generate answers to four evaluation objectives to determine the implementation of SRA and QIPs in health facilities.

5.2 Achievement of the set targets

The star rating system has been used in various countries to rate the quality of health services provided by health facilities (Betts & Cruse, 2017; Yahya & Mohamed, 2018). The Centers for Medicare & Medicaid Services (CMS) in the USA uses the star rating system to rate the nursing homes to provide residents and their families with an easy way to understand assessment of nursing home quality, making meaningful distinctions between high and low performing nursing homes (CMS, 2019).

The main target of the SRA system in Tanzania was at least 80% of health facilities are having three stars and above by June 2018. The attainment of this target has been a challenge in most of the facilities. For example, in the baseline assessment, about 34% of health facilities scored zero stars (MoHCDGEC, 2016) and in reassessment, the percentage of zero stars declined to 6% but the percentage of facilities that attained the target was only 20% (MoHCDGEC, 2018).

One of the reasons for failure to attain the set target was over ambitious targets set during the planning stage of the program (MoHCDGEC, 2014). The feasibility study was supposed to be conducted before the implementation, as all targets were set in

one sitting conducted at the Kunduchi Hotel for six consecutive weeks and part of BRN priorities. Also, the timeframe for implementation of BRN was only three years, which was relatively too short to achieve set targets.

The levels of attainment of set targets vary in different degrees in the study councils. For example, in Rufiji DC the situation was alarming as only one facility scored 3 stars making 3% of the assessed facilities. This may be associated with number of factors such as inadequate number of healthcare workers and inconsistent supportive supervision due to geographical location as some of the facilities are in the areas which are hard to reach especially during rainy seasons (Renggli, et al., 2018; Mboya, et al., 2016; Sirili, et al., 2019).

Contrary to Rufiji DC, the situation in Kibaha TC is promising as almost 40% of facilities scored 3 stars and above and the situation is even better for LGA facilities whereby out of 12 facilities it is only one facility (Galagaza Dispensary) that scored two stars in the re-assessment (MoHCDGEC, 2018). Kibaha TC has relatively good performance probably due to the fact that it is located in the urban area and it is near the commercial city of Dar es Salaam which contribute to most of the healthcare workers prefer working there compared to Rufiji DC which is in the rural area where the retention of healthcare worker becomes a challenge.

5.3 The implementation of the SRA system

The implementation of SRA system presented in the following sub themes: achievements and awards, staff awareness on SRA system, implementation of QIP, roles and responsibilities of QIT in implementation QIP, the inclusion of QIPs in annual plans and the supportive supervisions by CHMTs.

Starting with achievement and awards, it was observed that this was a motivating factor as most of the facilities awarded were enthusiastic to achieve higher star levels. This can be one of the good practices that were observed in ensuring that all stakeholders at different level of healthcare delivery strive to provide quality healthcare.

Awareness of staff on SRA system varied in different ways. One of the questions asked to assess the awareness of staff on SRA system was their awareness of star level of their facilities. The awareness was relatively high for staff who are at dispensary level compared to health centres and hospitals. The observed differences in level of awareness may be due to the large number of staff at health centres and hospitals or due to inadequate involvement of staff during feedbacks and clinical meetings. It was surprising that some of the facilities in charge were not aware of the star level of their facilities. This may be due to the fact that most of the in charges were newly appointed to their positions and probably due to lack of emphasis on SRA as currently most of the facilities were dealing with RBF which provide financial support to the facilities. Also, this may have been contributed by inadequate technical support by CHMT to facilities.

The implementation of QIPs was one of the key components in the implementation process of SRA in Tanzania. This is one of the areas which was partially done as most of the gaps were not addressed, even those gaps that do not require financial support. This was likely associated with lack of advocacy to various stakeholders such as political leaders who in one way or another has powers in supporting planning and budgeting for the health facilities.

The QITs who are the key implementers of QIPs seemed to lack awareness in their roles and responsibilities in the implementation of the SRA. This was attributed with recurrent changes made to these teams as most of the team members were changed from their roles from time to time. The recurrent changes have contributed for most of the QIT members not to consider QIP implementation as one of their roles in implementation of SRA system.

The inclusion of QIPs that require financial support in their annual plan was one of the agreed strategies in implementation of SRA system in BRN lab (MoHSW, 2014). The other strategy was DHFF where the facilities were given financial autonomy by receiving funds directly in their facility bank accounts. This has facilitated for the facilities to plan for their realistic plan instead of the previous system where the plans were done at the council level (URT, 2017). The inclusion of QIPs in the annual plan

was not done to the expected standards as most of the facilities in charges were not able to translate the QIPs with the priorities indicated in planning guidelines (PORALG, 2011).

Furthermore, the smooth implementation of SRA largely depends on quarterly supportive supervision conducted by CHMTs (MoHCDGEC, 2017). The supervision seems to be done as planned but the issue of monitoring the progress of QIPs was not given the high priority. CHMTs are guided by their locally developed checklists, which are not comprehensive enough to assess the quality of service in all areas of service delivery in the facility.

5.4 Factors facilitated or impinged the SRA system

Determination of factors facilitating the implementation of programs in health care are very subjective and depends much on the behavioral change of a particular society. The factors such as discipline and accountability of healthcare workers have been stipulated as one of the contributing factors in implementation of SRA though it is difficult to quantify the discipline and accountability as one of the measures of the contribution of the quality of healthcare delivered at health facilities.

Most of the participants considered RBF as one of the factors that contributed to the success in the implementation of QIP especially those requiring financial support. This contributing factor may be questionable because it is not clear if the motivation was due to the funds they were receiving or it is intrinsic factors as explained by (Khamis & Njau, 2016). Also, the issue of sustainability of funding from RBF program is questionable, for example, if the funding stops will the quality of health care delivery maintained (MoHCDGEC, 2014).

The implementation of SRA had encountered various challenges. The first and foremost challenge was the issue of shortage of skilled health care workers (Sirili, et al., 2019). The shortage of staff is very severe especially in remote area like Rufiji DC and the studies showed that as of 2012 the health sector in Tanzania was operating with less than 50% of required health care workers as exemplified by doctor to population ratio of 0.3 per 10,000 individuals countywide (Sirili, et al.,

2019). The reported shortage was associated with the number of health care workers (commonly referred to as ghost workers) who were removed from the civil services due to the forged certificates. The replacement for those workers was not adequately addressed, as the number of deployed staff did not match with those removed from the civil service. Therefore, in some health facilities like Mtanza Dispensary in Rufiji DC, there was only one enrolled nurse (certificate level) who was providing the services after one of the staff was removed from the government payroll. The shortage of staff has significantly affected the implementation of SRA especially in the area of implementation of QIPs.

Another reported challenge during the implementation of SRA was poor infrastructure especially buildings that were not in a good state of repair. Most of the buildings were built several years back where the services provided and the population receiving the services was small. For example, due to the scarcity of the rooms, the healthcare workers were forced to provide some of the services, which are supposed to be provided in different rooms to be provided in the same room something that may hinder the quality of services such as confidentiality.

Supportive supervision was one of the important pillars in the implementation of SRA at different level of healthcare delivery. As stipulated in National Supportive Supervision Guidelines (2017), the supportive supervision has persistently been inadequate due to barriers such as funding to support implementation, multiple or narrow focused supervision visits, ineffective supervision by R/CHMTs, multiple tools and inadequate follow up measures on the gaps identified (MoHCDGEC, 2017). Other factors associated with ineffective supportive supervision include the chronic shortage of qualified human resources, overburdened healthcare providers, multiple roles of district managers; weak supply chains, high donor fragmentation and inefficient allocation of limited financial resources (Renggli, et al., 2018). The findings in the NSSG, 2017 and those reported by Renggli *et al.*, (2018) were narrated by most of the participants interviewed.

The challenge of the language used in the tools used during SRA was reported as one of the factors that impinged the implementation of SRA. Most of the healthcare

workers especially those in lower cadres experienced difficulty in understanding the assessment tools and the QIPs developed during the assessment. The use of Kiswahili language in assessment tools has been emphasized by some of the health workers and this was observed in Kibaha TC where the assessment tools were translated to Kiswahili for easy understanding to all health care workers. The example of Kibaha TC can be replicated to all councils of Tanzania.

Training of staff on tools used was raised as one challenge during implementation of SRA. In the preparation stage, it was believed that if the CHMTs are well capacitated, they could transfer the knowledge to other health workers in their respective councils. But the expectations were not met, as most of the CHMTs were either not motivated or were not able to deliver the expected knowledge to the health care workers who are under their authority.

Therefore, the program stakeholders (identified in table 1.3) need to ensure the challenges that occurred during the implementation of SRA are taken into consideration in subsequent rounds of assessments.

5.5 Recommendations for improvement of SRA and QIPs

There are three recommendations, which were put forward by participants in order to improve the SRA system and implementation of QIPs. These recommendations were continued capacity building of healthcare workers, the involvement of various stakeholders, and digitalization of SRA system.

A study conducted by Couper et al., in four middle and low-income countries (MLIC) in Africa revealed that there is a significant concern regarding skills gaps and quality of training provided to middle level health (Couper, et al., 2018). The gap and quality of training have been a challenge in implementation of SRA system. The training is supposed to be more problem-solving approaches and practical procedures. If the SRA training will be conducted as suggested by most of the participants, the gaps observed during baseline and re-assessment will be reduced to a significant level.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

Since independence, the Government of the United Republic of Tanzania has been taking several measures in improving the quality of health care delivery in low resource settings. One of the recently taken measures was introducing SRA as an objective approach to assess the quality of health care delivery in Tanzania. This chapter entails the major conclusions, recommendations, policy implication and areas for further study.

6.2 Major conclusions

The latest countrywide assessment showed that only 20% of health facilities achieved the set targets. Also, the implementation of QIPs was inadequately done due to various factors but not limited to financial and human resources.

The major conclusions from this study are based on the study objectives and research questions as presented below:

The targets of star ratings were not met, as only 20% of health facilities achieved the target of having three stars and above by June 2018. In the study councils, the attainment of the council to have facilities that has scored three stars and above was very low and the situation is alarming in Rufiji DC where only 3% of facilities the set targets. The reported reasons included inadequate support on the training of staff especially during the baseline assessment. Furthermore, the set targets seem to overambitious and it was difficult for facilities to attain them in three years of BRN implementation. Therefore, the issue of attainment of set targets was not achieved and program implementers need to set realistic targets to ensure that the set targets do no discourage the program implementers.

The implementation process of SRA was based mainly on two aspects, which are actual assessment in which the facilities are rated and the QIP follow up after

assessment. The SRA was successfully implemented in study areas but the implementation of QIP showed to be challenging as most of the facilities poorly performed in implementation process, as about 80% of facilities did not implement the gap identified during SRA.

Various factors that facilitated the implementation of SRA in primary healthcare facilities in Tanzania and the major factor was commitment and discipline among healthcare workers. The RBF program has contributed in facilitation of implementation of QIPs that required financial support. The DHFF and RBF programs have contributed positively to the smooth implementation of SRA and QIPs in the study areas. For example, in Kibaha TC after the introduction of RBF, there was a drastic improvement of star levels in the second assessment whereby more than 90% of LGAs health facilities scored three stars and above.

The implementation of SRA was impinged by various factors and among which was the shortage of skilled healthcare providers, inadequate training and financial resources. Therefore, it is important for program implementers to ensure that the reported challenges are taken into high consideration for the betterment of further development of SRA system in Tanzania.

6.3 Recommendations

The health sector is drastically changing with increasing demand for improving the quality of health care in healthcare facilities. The improvement of quality of health care has become an integral part in achieving Universal Health Coverage (UHC). Therefore, MoHCDGEC introduced SRA as one of the strategies in objectively assesses the quality of health care in primary health facilities. The implementation of SRA has shown some improvement in improving the quality of health services in resource-constrained settings. Therefore:

1. MoHCDGEC in collaboration with PO-RALG (R/CHMTs) should strengthen the SRA system in terms of building capacity of health care providers through training.

2. CHMTs should strengthen QIP follow up by ensuring that quarterly supportive supervision is compressive enough to accommodate gaps identified during SRA.
3. Health Quality Assurance Unit (HQAU) of MoHCDGEC in collaboration with R/CHMTs should strengthen QIT, as they are the key personnel in implementation of QIPs at the facility level.
4. The motivations of healthcare providers by provision of recognitions such as certificates have shown to motivate them to struggle in improving the quality of health care. Therefore, HQAU and other stakeholders should sustain the good practice of rewarding best performing facilities and councils to catalyze the health care workers to strive in improving the quality of health care delivery in their facilities.

6.4 Policy Implications

The implementation of SRA was based on the agreements made during BRN lab in 2014 and HSSP IV (MoHCDGEC, 2014; MoHCDGEC, 2015). The countrywide assessment has paved the way for decision makers to know the extent to which the quality of healthcare delivery is unsatisfactorily delivered in primary health facilities. Therefore, SRA system has contributed in the transition from traditional ways of decision making to evidence-based decision-making in improving the quality of services delivery in primary healthcare facilities.

6.5 Area for Further Evaluation

This study has found gaps in implementation of SRA and QIPs in study areas. The gaps were ranging from knowledge perspective to resources such as human resources. Therefore, further studies are required to explore the extent to which the identified gaps have contributed to the failure to attain the set targets during the implementation of SRA and QIPs. Furthermore, since this study was done mainly in public facilities, it is important to involve private facilities in further studies so that we may see the insights from private facilities' perspectives.

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APPENDICES

ANNEXES

Annex 1: Work plan

SN	Activities	Responsible person	N	D	J	F	M	A	M	J	J	A
			2018		2019							
1.	Development of instruments	PI										
2.	Protocol and ethical consideration approval	PI										
3.	Meeting with program manager and health providers in study areas of common consensus on the utilization of judgment matrix	PI										
4.	Translation of questionnaires to local language	PI										
5.	Select data collectors, supervisors and training assistants	PI										
6.	Pretesting of tools and data collection, checking and editing	PI										
7.	Data summarizing and entry	PI										
8.	Analysis	PI										
9.	Write up	PI										
10.	Presentation to Mzumbe University	PI										

Source: Researcher (2018)

Annex 2: Budget of study

No	Activities	Inputs	Number of Units	Unit Cost	Total	Total
1	Research assistants training	Flip chart	1	15,000	15,000	336,000
		Note book	4	1,500	6,000	
		Marker pen	10	1,000	10,000	
		Ball pen	10	500	5,000	
		Allowance	2	50,000	100,000	
		Per diem	2	100,000	200,000	
2	Collection of data	Photocopying	500	100	50,000	1,000,000
		Per diem	5	100,000	500,000	
		Allowance	5	50,000	250,000	
		Fare &Fuel	1	200,000	200,000	
3	Submission of the first and second draft of the report	Per diem	3	100,000	300,000	600,000
		Fare &Fuel	1	300,000	300,000	
4	Submission of the final draft of the report	Per diem	4	100,000	400,000	750,000
		Fare & Fuel	2	150,000	150,000	
		Printing of the final thesis	2	100,000	200,000	
Grand Total						2,686,000

Source: Researcher (2018)

Annex 3: Interview Guide For DMOs, QI Focal Persons (Regional/Council) and National level SRA experts

Hello..... how are you today?

Thank you for agreeing to talk with me today, my name is Chrisogone Justine, a student from Mzumbe University pursuing MSc. Health Monitoring and Evaluation.

My study requires me to undertake an Evaluation of Implementation Process of Star Rating Assessment for Primary Healthcare Facilities in Tanzania in Kibaha Town and Rufiji District Councils, which will ultimately allow me to write a report as requirement for the partial fulfillment of the award of the Master Degree.

I want to assure you that any information acquired in the course of this session will only be used for the purposes of the study and not otherwise. No information given will be disclosed to unintended audiences but only to Mzumbe University, Kibaha TC and Rufiji DC and other relevant national authorities responsible for planning of health interventions. The information obtained will be treated in high anonymity and will be stored carefully. It is entirely voluntary to participate in this study and you are free to decline any time. You are free to ask me questions during our discussion for clarification and you can tell me to stop at any time when you feel tired. Our discussion will take hardly 30 to 45 minutes.

I hope we can start now. Can't we?

1. How long have you been working with (Region/Kibaha/Rufiji)?
2. Tell me briefly about health facilities in your region/council.
3. Have you participated in any of the SRA assessments?

Probe: Ask him/her to explain his or her participation in baseline and re-assessment, his or her roles

4. Do you know the number/percentage of facilities that attained three stars and above in your region/council?
5. In your opinion, why most of the facilities did not attained the set target of three stars and above?

6. Was the orientation conducted to R/CHMTs adequate before the assessment?
Probe: How many days the orientation was done? How many R/CHMTs were oriented? Was monitoring done after orientation?
7. Does your region/council has copies of quality improvement plans (for all facilities) developed after assessment?
 - a. Probe: Are you conducting QIP follow-up in the facilities? How are you organized within R/CHMTs?
 - b. What is the current status of implementation? (proportion of facilities with 3 stars and above)
 - c. Do you have copies of previous SRA reports for the region/council?
 - d. Do facilities have copies of QIPs?
 - e. Do you have monthly reports on progress of QIPs? (24 selected indicators), verify the availability.
8. In the past one-year have you conducted supportive supervision to your facilities?
 - a. Probe: How do you conduct SS, is it joint or by interventions based?
 - b. In quarterly supportive supervision *inter alia*, do you check the progress of SRA?
 - c. Do you get challenges in supervising the aspects of SRA during supportive supervision?
9. In your experience with the previous two assessments (baseline and re-assessment) conducted, what do you think facilitated the implementation of SRA in your region/council?
10. What were the challenges/problems encountered during implementation of SRA?
 - a. Probe: Challenges with regards to availability of skilled staff, training on SRA, TA from CHMTs, the understandability of SRA tools (Assessment tools, QIPs left at the facility, language used in the tools), behavioral change and communication, etc.
11. Was the QIPs developed during baseline and re-assessment included in facility plan or CCHP?
 - a. Probe: If Yes, what activities were included (verify)

b. If No, Why?

Thank you very much for taking your time to answer my questions. Once again, any information you have given will be strictly kept confidential. Have a pleasant day!

Annex 4: Interview Guide for Facility In charges

Hello..... how are you today?

Thank you for agreeing to talk with me today, my name is Chrisogone Justine, a student from Mzumbe University pursuing MSc. Health Monitoring and Evaluation.

My study requires me to undertake an Evaluation of Implementation Process of Star Rating Assessment for Primary Healthcare Facilities in Tanzania in Kibaha Town and Rufiji District Councils, which will ultimately allow me to write a report as requirement for the partial fulfillment of the award of the Master Degree.

I want to assure you that any information acquired in the course of this session will only be used for the purposes of the study and not otherwise. No information given will be disclosed to unintended audiences but only to Mzumbe University, Kibaha TC and Rufiji DC and other relevant national authorities responsible for planning of health interventions. The information obtained will be treated in high anonymity and will be stored carefully. It is entirely voluntary to participate in this study and you are free to decline any time.

You are free to ask me questions during our discussion for clarification and you can tell me to stop at any time when you feel tired. Our discussion will take hardly 30 to 45 minutes.

I hope we can start now. Can't we?

1. How long have you been working with this facility?
2. What is your cadre?
3. Have you participated in any of the SRA assessments?

Probe: Ask him/her to explain his or her participation in baseline and re-assessment, his or her roles

4. What was the score of your facility in the last assessment?
5. In your opinion, why your facility did or did not attain the set target of three stars and above?

Probe: Based on facility itself or from Council

6. Do you facility implement QIP developed after assessment?
 - a. Probe: Are you conducting QIP follow-up as one of the role of QITs?
 - b. What is the current status of implementation? (proportion of indicators completed out of selected 24 indicators).
 - c. Do you have monthly reports on progress of QIPs? (24 selected indicators), verify the availability.
 - d. Were the gap identified during baseline and re-assessment included in facility plan? (If Yes, what activities were included (verify) and If No, Why?).
7. Does the CHMT conduct quarterly supportive supervision to your facility?
 - a. Probe: How do the supervisors from (Ministry/region/council) conduct the supervision process? Is it joint or by interventions based?
 - b. During their supportive supervision, do they check the progress of QIPs developed during SRA?
8. In your experience with the previous two assessments (baseline and re-assessment) conducted, what do you think facilitated the implementation of SRA in your region/council?
9. What were the challenges/problems encountered during implementation of SRA?
 - a. Probe: Challenges with regards to availability of skilled staff, training on SRA, TA from CHMTs, the understandability of SRA tools (Assessment tools, QIPs left at the facility, language used in the tools), behavioral change and communication, attitudes, etc.

Thank you very much for taking your time to answer my questions. Once again, any information you have given will be strictly kept confidential.

Have a pleasant day!

Annex 5: FGD Guide for Quality Improvement Teams (QITs)

Ladies and gentlemen,how are you today?

Thank you for agreeing to talk to me today, my name is Chrisogone Justine, a student from Mzumbe University pursuing MSc. Health Monitoring and Evaluation.

I am here to obtain your opinion on Star Rating Assessment, which was conducted at your facility between 2015-2018. This study requires me to undertake an Evaluation of Implementation Process of Star Rating Assessment for Primary Healthcare Facilities in Tanzania in Kibaha Town and Rufiji District Councils, which will ultimately allow me to write a report as requirement for the partial fulfillment of the award of the Master Degree.

I want to assure you that any information acquired in the course of this session will only be used for the purposes of the study and not otherwise. No information given will be disclosed to unintended audiences.

Ground rules

Before we start, I would like to remind you that there are no right or wrong answers in this discussion. We are interested in knowing what each of you think, so please feel free to be frank and to share your point of view, regardless of whether you agree or disagree with what you hear. It is very important that we hear all your opinions.

You probably prefer that your comments not be repeated to people outside of this group. Please treat others in the group, as you want to be treated by not telling anyone about what you hear in this discussion today.

Let's start by going around the circle and having each of us introduces his/herself.

1. What do you think/know about the topic that has brought us here today (Star Rating Assessment for PHC facilities)?

Probe: When started? Who conducted it? Have you participated in any of the SRA assessments? What was the score of your facility in the last SRA? What was the target for SRA?

2. In your opinion, why most of the facilities did not attain the set target of three stars and above?

- a. HR? Laxity? Funds? Trainings? Tools used? Language used in tools? etc.

3. As members of Quality Improvement Teams, do you know your role in implementation of SRA?

Probe: Implementation of QIPs, reporting to HFMT, running day-to-day activities in each unit/section, etc.

4. Have you heard of Quality Improvement Plan (QIP)?

Probe: What is it? Who prepares it? Does your facility have copy of quality improvement plan left after assessment? What is the status of implementation?

5. What is the role of QIT in implementation of QIPs developed after assessment?

6. Were the gaps requiring budgets included in the annual plans of the facility?
If Yes, can you mention some the activities? And if No, why?

7. Do you facility prepare monthly reports on progress of QIPs? (24 selected indicators)

8. Does the CHMT conduct quarterly supportive supervision to your facility?

Probe: How do the supervisors from (Ministry/region/council) conduct the supervision process? Is it joint or interventions based?

During their supportive supervision, do they check the progress of QIPs developed during SRA?

- a. Probe: What is the current status of implementation?

- b. In quarterly supportive supervision *done by CHMTs* to you facility to check the progress of SRA?

9. In your experience with the previous two assessments conducted, describe the factors that facilitated the implementation of SRA in your region/council?

10. What were the challenges/problems encountered during implementation of SRA?

Probe: Challenges with regards to availability of skilled staff, training on SRA, TA from CHMTs, the understandability of SRA tools (Assessment tools, QIPs left at the facility, language used in the tools), behavioral change and communication, etc.

11. In your opinion what can be done to improve SRA system in Tanzania?

Thank you very much for taking your time to answer my questions. Once again, any information you have given will be strictly kept confidential.

Have a pleasant day!

Annex 6: Consent Form

My name is **Chrisogone Justine**, a student from Mzumbe University pursuing MSc Health Monitoring and Evaluation. My study requires me to undertake an Evaluation of Implementation Process of Star Rating Assessment for Primary Healthcare Facilities in Tanzania in Kibaha Town and Rufiji District Councils, which will ultimately allow me to write a report as requirement for the partial fulfillment of the award of the Master Degree. I am requesting you to participate in the interview, which will take hardly 30 to 45 minutes. During the interview, I will sit down with you in a comfortable place at the facility or your office.

I _____ voluntarily agree to participate in this research study. I understand that even if I agree to participate now, I can withdraw at any time or refuse to answer any question without any consequences of any kind. I understand that I can withdraw permission to use data from my interview within two weeks after the interview, in which case the material will be deleted. I understand that I will not benefit directly from participating in this research. I agree to my interview being audio-recorded. I understand that all information I provide for this study will be treated confidentially. I understand that in any report on the results of this research my identity will remain anonymous. I understand that signed consent forms and original audio recordings will be retained in the researcher's computer and no one has access to it until the examination board confirms the results of their dissertation. I understand that under freedom of information legalization I am entitled to access the information I have provided at any time while it is in storage as specified above. I understand that I am free to contact any of the people involved in the research to seek further clarification and information (adapted from (TCD, 2018).

Signature of research participant

Signature of participant

Date

To the best of my knowledge I believe the participant is giving informed consent to participate in this study

Signature of researcher

Date