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Abstract

Healthcare accreditation programs have been adopted internationally to maintain quality and safety of services, predominantly initiated by governments in the 2000s. Rwanda has begun this process; however, limited research exists on staff perceptions regarding accreditation impact and implementation barriers. The study targeted all 65 Rwinkwavu District Hospital staff, including management committee members, paraclinical workers, doctors, nurses, and midwives. A sample of 39 respondents was drawn using the Yamane formula with simple random sampling. Closed-ended questionnaires and observation were employed, with validity and reliability tested, and data analyzed using SPSS V21. Findings showed that 92.3% of staff were satisfied with the record system and the majority held positive perceptions overall. All respondents (100%) perceived lack of finance, behavior change, and inadequate training as barriers to accreditation implementation. Additionally, 69.9% had positive perceptions regarding building infrastructure availability, and 82.9% acknowledged that strong leadership was necessary. Overall, 71.4% held positive perceptions while 38.6% held negative perceptions. Gender was significantly associated with staff perception ($\chi^2=5.215$, $p=0.002$), as was age ($\chi^2=7.878$, $p=0.005$). The study recommends enhancing community participation in health management committees, encouraging internal self-assessments, and establishing performance tracking tools aligned with Hospital Accreditation Standards.

1 Introduction

Accreditation is aimed to promote the quality of care which is considered as permanent obligation and a priority for health service development and it is also a way to publically recognize that a health care organization has met national quality standards (Pomey, 2005). In different countries the ministry of health tries to maintain their skills and knowledge in order to adequately deliver quality health care due to their increased expectations for quality health care delivery, an increasing life expectancy, legal litigation, ethical and economic factors and a move towards evidence-based health care are all driving rapid change in health service delivery (Davis, 2007). Government needs a quality vision and policy with clear definitions of quality and quality assurance approaches for that the main method to promote the health care assurance. Health care accreditation programs have been adopted internationally to maintain the quality and safety of services. Accreditation assesses the compliance of organizations to a series of standards.

The accreditation programs were all introduced in the 2000s to improve quality and safety. Documents from each country outlined motivations for introducing an accreditation program, which was predominantly initiated by the government. Denmark initially reported that between 22% and 33% of the assessed general and specialist practitioners did not adhere to one or more standards. Other outcomes have been evaluated beyond adherence to the standards in each country. Australian hospital boards (84%) reported that as a result of the program, they understood and enacted their roles and responsibilities concerning patient safety and quality. One approach used to monitor the health care services is the accreditation, this is new method aimed to evaluate the effectiveness of health care services by which any intervention performed have to be implemented in the standard and the scope of its effectiveness, and it is examined through the approach of accreditation and also this approach aimed to take into account the cost effectiveness of health care services (Peter, 2010). The approach of accreditation has been taken and with different meeting done in different countries, the purpose was to enhance this process of accreditation as indicated by The Agenda for Leadership in Programs for Healthcare. Accreditation (ALPHA) that was launched in 1999 as the result of a series of annual meetings that started in 1994 in Treviso, Italy.

In effort to satisfy the needs and expectations of patients and clients, the Health Professional Councils have jointly developed guidelines and standards to be followed, for that the accreditation have been set in as the means of maintaining and updating professional competence and ensuring quality health services for the community (WHO, 2003). With this process and the purpose of this approach was to mandate the effectiveness of the quality of health care services for that the accreditation may be defined as a self-assessment and external peer assessment process used by health care organization to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve the quality of health care services for that the accreditation process is an integral part of health care systems in over 70 countries (Greenfield & Braithwaite, 2009). In USA this method has been used for assessing the effectiveness safety and quality of blood product that client receive and for that about 90% have been saved as the blood given to the client are safely given and the procedure used to provide them are safe for that the quality of health services provided. Ensuring the safety of blood products requires the implementation of effective control over manufacturing processes and systems this is an accreditation about blood

delivering. By accreditation there is an assessment of how the initiatives elaborated WHO for improving health system performance by using five indicators as follow the overall level of population health; health inequalities (or disparities) within the population; overall level of health system responsiveness (a combination of patient perception and how well the system performs); distribution of responsiveness within the population (how well people of varying economic status find that they are served by the health system); distribution of the health system's financial burden within the population (Brook alt, 2000). In the USA the accreditation has been set to ensure that standard elaborated are used to control the hospital the improvement of hospital environment and to enhance the development of health services this approach have been used since the early of 20th century (Wendy N 2015). In Scotland, part of the 1998 Acute Services Review (97) focused on the organization of quality management in the Scottish Health Service and led to the establishment of the Clinical Standards Board to oversee the definition and application of standards in clinical services and their organization (Devkaran, 2014). In Rwanda the approach of accreditation has been taken as one way to accommodate the quality of services received by the clients and effectiveness or safety used by the health care providers, this approach is very important component in patient safety. Rwanda has begun the process. However, there is limited understanding research knowledge on perception of staff in the impact of accreditation, this study intends to contribute to the evidence and knowledge on the impact of accreditation process in health service delivered in Rwanda.

1.1 Problem Statement

Less is known about accreditation and its impact. The necessities to improve health service have been accentuated by the HSSP III, vision 2020 document. The accreditation is one way to assess the quality services in the health domain, it facilitates us to compare what is being done and the standards elaborated. No one healthcare system has a monopoly of excellence and no one provider country or scheme can claim to be the total arbiter of quality. The same is true of healthcare accreditation schemes. For example, some countries (such as the USA) perform very poorly when it comes to providing anything close to universal access to healthcare of adequate quality to the population living within their own borders, while others (such as the UK) have tried to create state-funded systems which provide everything without the assistance of the private sector (Brauer, 2001: 30). Although the accreditation has been taken in different countries to mandate the activity provided based on policies, standards established and this approach was also taken in Rwanda. Prior to the accreditation process, some important area which are observed in the hospital were not performed and as consequences, the quality of services that are offered to the patients was not good. And the morbidity, the mortality of those patients was at the high level. The wellbeing of health care providers was at the lower level. We hope that with the accreditation the quality of services that is offered to our patients were increased and the conditions of working for district hospital, to the community level will be improved. Accreditation of health care organizations should be strongly encouraged with incentives, or indeed made mandatory, but choice of accreditation/certification/award approaches should be allowed. Whatever the mechanisms adopted, accreditation of health care organizations should require processes for continuous improvement, and achievement of quality enhancement outcomes.

2. Literature Review

2.1 Empirical Literature

Many countries have adopted external accreditation of health services as a vehicle for disseminating national standards and for public accountability. Traditionally, in Australia, Canada and the United States these programmes were begun by voluntary collaboration of clinical associations (especially medical) and hospital administrators as a means of organizational development. More recently, they have also been driven by reimbursement schemes, central control, and an emphasis on primary care, health networks and community-based services (Aryankhesal, 2023: 5). Some countries offer national quality awards that are specific to health care, or shared with other service sectors – these may be government-sponsored or independently funded, for example by national societies, publications or pharmaceutical companies (Aryankhesal, 2023: 7).

In accreditation process, Quality assessment compares performance with expectations, standards or goals and thus identifies opportunities to improve. However, it does not suggest imposing solutions and does not require any declared intention or ability to take corrective action and it relies upon available measurements. In Western countries, quality assurance (QA) became the common term during the 1980s and served well with the Donabedian concepts of examining health care quality as an element of structure, process and outcome. It fitted an era in the Western world when quality was widely assumed to be standard in health care and merely needed to be confirmed, but many later discarded the term because it was too static and suggested a guarantee that quality assurance systems might not fulfil. Many established journals changed their titles, but others kept the term as a generic description for common approaches going by a diversity of names or for use in specific connections such as transfusions, equipment and supplies (Alkhenizant, 2011: 43).

In 1977, the World Health Assembly adopted the global goal of Health for all by the year 2000. As part of this goal, the WHO European Region developed targets in 1984. These included target which urged every WHO Member State to build effective mechanisms for ensuring quality of patient care by 1990 and, by 2000, to provide structures and processes for ensuring continuous improvement in the quality of health care and appropriate development and use of new technologies. In 1998, the World Health Assembly adopted a revised strategy for the 21st century that continues to emphasize availability, accessibility and quality of care. The strategy promotes information systems for monitoring and calls for active surveillance by national governments, including the “implementation of international norms, standards and regulations”. In July 2008, Lebanon is the first country in the East Mediterranean Region to develop and implement accreditation standards, little is known yet on its impact on quality of care: To assess the perceived impact of accreditation on quality of care through the lens of health care professionals, specifically nurses. This paper also investigates the perceived contributing factors that can explain change in quality of care (Ammar, Wakim, and Hajj, 2007: 9).

2.2. Theoretical Framework

In Hospital Accreditation, to reach the quality of health care, some important strategies must be considered where Planning, organizing meetings, communication between team take a big part in preparation and implementation of accreditation, community participation as we will

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talk about primary care – and in perceptions of what constitutes quality in health care. These perceptions can be summarized as beginning with “hospital quality assurance”, moving to “health care quality improvement” and heading for “population health improvement”. The specific tools used for quality improvement in health care depend on local and national priorities, but some global concepts are generally applicable (Ovretveit J Health Care, 2000: 78). In general, improvement may target processes (such as infection control), systems (such as clinical indicators) or strategies (such as health reform). These concepts are not in themselves tools for developing, measuring or improving standards, but they provide overall frameworks for quality improvement. Many of them derive from manufacturing and service industries whose values and methods have been adapted to health care (Alkhenizan, 2011: 45)

Figure 2. 4.1 Health project Planning, model

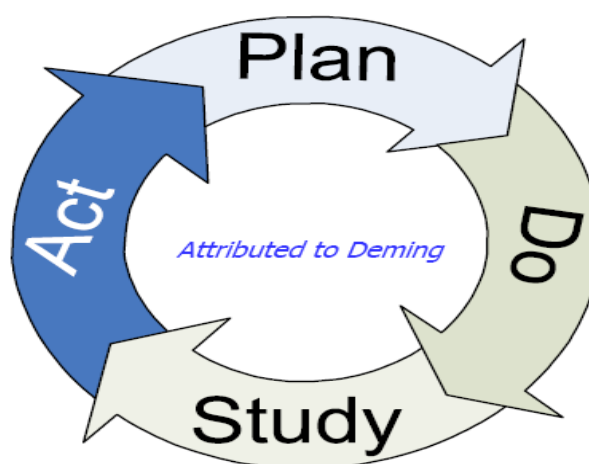


Table 2. 1 Barriers to Effective Communication and Possible Solutions

Barriers to communication	Possible Solutions
Cultural differences, beliefs, customs, norms, behaviour	Sensitisation, information giving
Technical, language barrier, illiteracy	Literacy campaign, visual aids, use simple and clear language; interpersonal communication, use of adult learning methods
Social economic status(Imbalance, poverty)	Sensitisation
Lack of tools for appropriate communication	Provision of tools
Competition of activities	Improvise appropriate tools
Age differences	Good planning and time management
Political influence	Delegation with authority
Inadequate knowledge, lack of confidence and poor respect for the community	Application of appropriate learning skills.
Poor timing	Sensitisation
	Establishment of interpersonal working relationship
	Have adequate knowledge of material to deliver.
	Make consultations
	Coordinate and adequate preparation
	Choose right time.

Joynt & Warner (1996: 16)

The following are some of the possible indicators of community participation that the trainer and the trainees can use for monitoring: People working together as a group e. g youth groups and clubs, more women participating on a day-to-day basis in decision making at household and community levels, Increased community contribution (in terms of labour, materials, money and time spent) in development activities / Projects, Records of activities and accomplishments. e. g: minutes of meetings, activity, Progress reports, Increased demand for services, Response to community mobilisation, Different roles among community leaders, Soliciting for external support (Alkhenizan, 2011: 42)

In leadership, supervision of health care facilities, we have to know factors that hinder community participation and how to overcome them. Those parameters should be considered in different ways priori accreditation and during accreditation

Table 2. 2 Factors that hinder community participation and how to overcome them

Factors that hinder	Possible solutions
Poor Leadership	Selecting good leaders Team Work
Political differences	Exercise mature politics
Lack of transparency	Transparency
Poor planning	Good planning
Failure to involve community members	Involvement of community members
Lower expectations	Increasing of expectations
Conflicts among beneficiaries and service providers	Continuous sensitization Listening carefully
Corruption	Transparency
Poor motivation	Motivation with encouragement Recognition and appreciation Effective sensitisation and training
Conflict with culture and traditions in the community	Knowledge of communities, culture, traditions and their respect
Disrespect towards community members.	Respect for community
Natural calamities e.g. earthquake, floods, drought.	Seek assistance of the leaders

Quality assessment

(KN Lohr, 1990: 32)

Quality assessment compares performance with expectations, standards or goals and thus identifies opportunities to improve. However, it does not suggest imposing solutions and does not require any declared intention or ability to take corrective action, and it relies upon available measurements (Alkhenizan, 2011: 48)

2.3 Conceptual Framework

To study the changes that took place in Rwinkwavu District Hospital, in leadership, Health care facilities supervision, Health care providers, Human resource department, Pharmacy and Maintenance department as a result of the accreditation process, we will be served by a Conceptual framework that will be used for analysis. We will be based on 3 specifics objectives of this study which are: To compare the health care services delivery prior to accreditation process and during accreditation process, to establish the barriers that district hospital may encounter during implementation of accreditation process and to examine the most important reasons for introducing accreditation in Rwinkwavu District Hospital

Figure 2.2: Conceptual Framework

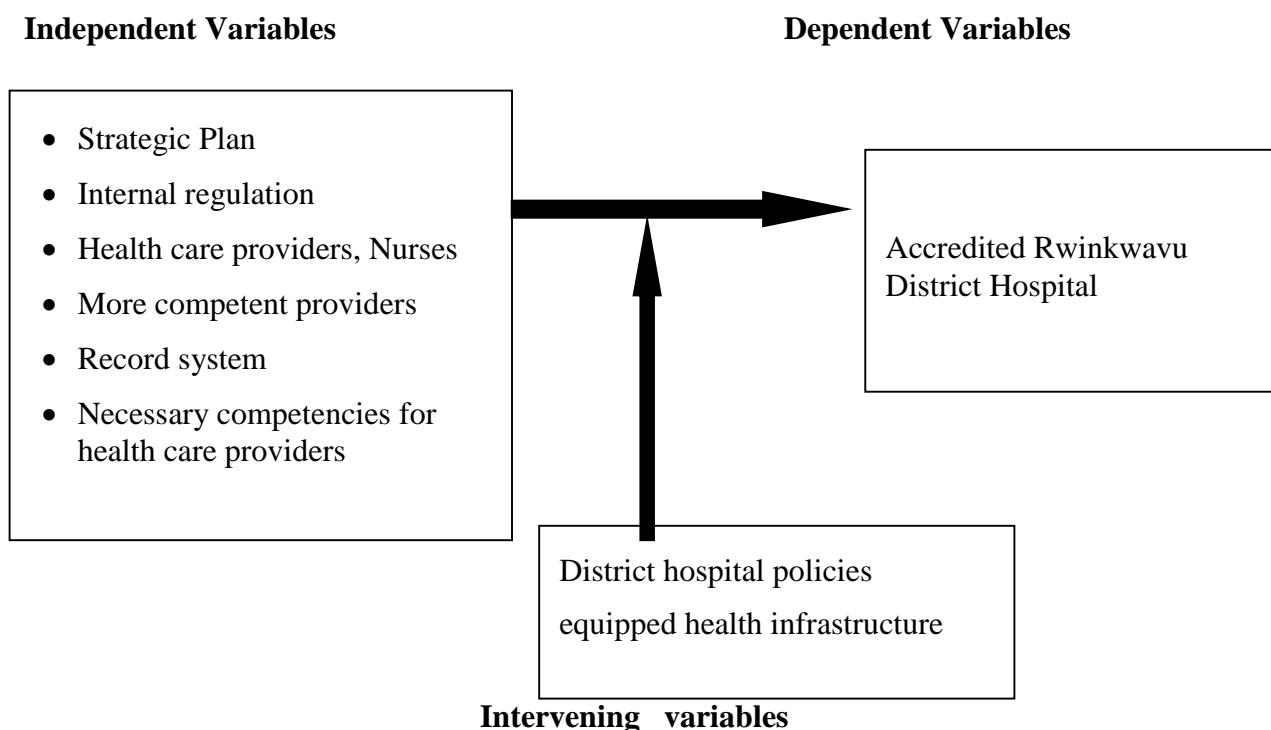


Figure 2. 2 Conceptual Framework

Source: Researcher, (2024)

2.3 Research Gap Identification

Different studies have been done concerning the standards and regulation of accreditation approach. A survey was undertaken in late 2000 of known national accreditation programmes (excluding those that were specialty-based or subnational, or that relate to certification under ISO). A one-page questionnaire, previously pilot-tested in Europe, was designed to obtain objective descriptions of each programme with existing data. The survey was distributed by electronic mail or fax to 36 known programmes in 33 countries and to academic or governmental contacts in 32 other countries. Twenty-eight programmes completed and

returned the survey. Six of the remaining eight known programmes are based in the United States. Additional data were gathered opportunistically from multiple sources, including the literature and Internet searches that were undertaken for Sections 1 and 2 of this report. These sources provided basic but unsystematic descriptions. This evolution is demonstrated by the term “efficiency”, which is increasingly understood to be a measure of the output of a system relative to the maximum possible output that could be achieved for a given level of input of the state of accreditation in 47 countries.

The Quality Assurance Project (QAP) was initiated in the United States in 1990 to help Developing countries to institutionalize quality assurance. It works with the University Research Corporation (URC) to provide technical support for quality improvement; to service delivery institutions, ministries of health, USAID missions, and field-based cooperating agencies. The study on accreditation process has been done in Arabic, French, Russian and Spanish but it was limited to: achieving quality through problem-solving and process improvement, training manager’s guide, improving interpersonal communication between health care providers and clients (*Cleveland, 2011: 273*). In the past some Authors have worked on the evaluation of accreditation but their study was limited that is to say some area like Leadership, Health care providers, Human resources, health safety and hygiene were not exactly covered in their study and also we need to know how is the situation in sub developed countries in which the country Rwanda takes part.

3. Research Methodology

3.1 Study Design

It is defined as “A framework, or the set of methods and procedures used to collect and analyze data on variables specified in a particular research problem”. The research design for this study will be Cross-section survey in which a group of people, institutions who have received the impact of accreditation system, in Rwinkwavu District was studied by collecting and analyzing data from only a few people who was picked to represented the entire group. In determining the specific people to be studied in a survey design, a method of selection called sampling was used whereby; the researcher selected few people in the area of the study who received assistance from accreditation system. The survey was undertaken using observation, Questionnaires, and interviews administrated to the beneficiaries to that system to generate data for research study and to show the role of accreditation system. This study compared the situation between before and after the availability of the new system of accreditation.

3.2 Target Population

The population is statistically the group on which information is being gathered and analyzed. The target population is also defined as that population to which a researcher wants to generalize the results of a study. The target population of this study will be composed of all Rwinkwavu Hospital management committee, Paraclinical workers and all health care providers at Rwinkwavu District Hospital including Doctors, nurses and midwives. In Rwinkwavu district hospital management committee, Paraclinical workers and all health care providers at Rwinkwavu District Hospital including Doctors, nurses and midwives were sampled and given questionnaire related to my research topic. The period considered was of

four years: from 2019 up to 2023. The study was done with the intention of helping the country to know the impact of accreditation process in district hospitals.

In this study, the issue of sampling dealt with selection of the informants and the sample size was constituted by people of Rwinkwavu District Hospital with inclusive criteria. There are scientific ways of determining a representative sample size from any given population, such as using Slovin' Formula. It gives the researcher an idea of how large his sample size needs to be to ensure reasonable accuracy of results. Therefore, the study used the sample size calculated according to the following formula of Yamane. In fact, the target population of the study will be 65 people. The questionnaire and observation will be focused on workers who have worked for Rwinkwavu District Hospital at least since 4 years ago and who present full time of contract in Human resources department. The calculus done on the basis of the above formula provided us the sample size of 39 respondents to be questioned for this study.

3.3 Research instruments

Several data collection methodologies are necessary for gathering information to complete the assessment. Some are outlined below. The facility leadership team can use observation to assess attitudes, knowledge and skills in clinical practice, including patient-provider interaction and patient management. Assessing the competence of staff is a crucial element of the quality of the service. An initial competence assessment is recommended during orientation for all staff members providing direct patient care services, based on the clinical treatment guidelines (protocols). Subsequently, the assessment of competence needs to become a routine part of the performance appraisal process, done on an annual basis. The team needs to determine which aspects of care require on-going competency assessments, e.g. family planning counseling or carrying out a high-risk protocol. An assessment tool, usually a checklist, can be developed based on the protocol. A supervisor or qualified peer may then assess the practitioner. The giving and receiving of feedback are important aspects of the process of improving quality. Feedback helps to create an atmosphere in which practitioners welcome the observations made. These observations should be documented and included in personnel files. The external assessor typically does not observe clinical practice as described in the previous paragraph. They determine competency by reviewing the process that the facility has put into place for competency assessments and the documentation in the personnel files. The types of observations made by an external assessor include maintenance of equipment, patient privacy, infection control practices and safety of the environment. We recommend that the members of the team make rounds together in order to carry out these observations.

One-on-one interviews may be conducted with managers, staff and patients. The assessment questions seek staff and patient perceptions on important aspects of their experiences in the hospital. The questions need to be linked to the mission and values. For instance, if the mission includes "patient-centered" care, then, some of the questions need to determine how the patients and families feel about their ability to participate in decision-making. The respondents must feel assured that they will not be identified and that the results will remain confidential. When patients are being questioned the approach should to be tailored to the needs of the patient, e.g. taking into account literacy, language and the location of the patient. These interactions provide some insights to the care provided and should be considered along with

the other observations; however, often the patient tries to accommodate the surveyor and may not be candid about their perceptions. Inventory is a process of inspection to determine whether the essential medicines, supplies and equipment are available and to assess the storage and maintenance of supplies and equipment. A variety of tools may be used to assist the surveyor to collect sufficient data to score the standards. Checklists can be useful but are not designed to be used to score standards, as various assessment approaches are used collectively to make this decision.

Much of the information to assess whether standards are met is obtained by reviewing documents, e.g. the patient register, medical records, personnel files, policies, procedures, protocols, reports and meeting minutes. The assessment findings should be communicated and acted on. HMIS, one of the methods of communicating information to the Central Level, although CBMIS is used to the community level. The results of the assessment need to be shared with all key parties. The team will first determine who needs the information, e.g. staff, supervisor, partners and patients may all be key parties. Each has different needs and therefore different levels of information are required. Before the research, tools were administered, the respondents, the researcher first pre-tested the questionnaire and the interviews to ensure the reliability and validity of them. Reliability is a measure of the degree to which a research instrument yield consists results or data after repeated trials. On the other hand, validity is the accuracy and meaningfulness of inferences, which are based on the research results. In other words, validity is the degree to which results obtained from the analysis of the data actually represent the phenomenon under study.

A small group of 39 respondents chosen randomly in clinical and para clinical departments at Rwinkwavu District Hospital, part of entire population from which the sample drawn was selected for pre test. The pre test was done to gauge the reaction and thus, whether the questions were clear or whether there were some missing items or tags which needed to be added to adjust the questionnaires and interviews. Though the views and attitudes of the respondents from piloting group were not present in the main study, they helped to improve some items that were not well formulated and enabled the researcher to ensure the accuracy and consistency of the questionnaires and the interviews. The pretest has been done at Muhima District Hospital in August 2015.

3.4 Data Analysis Procedure

The information collected from questionnaire will be edited, coded and tabulated. The data collected will be analyzed by frequency distribution of responses with percentage techniques. This will be done by coding the answers into categories process of translating information gathered from questionnaires into something that can be analyzed. Computer software known as SPSS will be used in order to analyze results and statistical analysis performed while analyzing the questionnaire. Given that the purpose of the statistical analysis in our research, it will be necessary to examine the features of a large amount of data generated from the questionnaire, descriptive statistics will be used to analyze such data. This will involve the use of statistical tools such as measures of central, frequency tables and histograms among others. By using those tools, a clear numerical interpretation of the results will be provided.

4.Presentation of Findings

Chapter four presents analyses and interprets the research findings obtained from the field research carried out in Rwinkwavu District Hospital located in Kayonza District of the Eastern Province. The researcher discussed with 39 respondents, in order to answer the research questions. The data presentation and analysis presented in this chapter served the process of bringing order, structure, and interpretation to the mass of collected data. For analyzing, presenting and interpreting the results, researcher used qualitative and quantitative methods to present data and comments on those findings to make clear understandings.

4.1 Socio-Demographic Characteristics of the Respondents

The researcher conducted the study with different respondents were in various ways. Some of them were individual professionals working in Rwinkwavu District Hospital.

Table 4. 1 Individual Characteristics of Respondents

Items		Frequency	Percentage
Gender	Male	30	75.7
	Female	9	24.3
Age	18-34	23	59.0
	≥35 Years	16	41.0
Education	Secondary School	12	31.0
	Diploma	17	43.0
	Bachelor	10	26.0
Team of Accreditation	Yes	23	59.0
	No	16	41.0
Category of Staff	Management Committee	5	13.0
	Health Care Providers	13	33.0
	Paraclinical workers	21	54.0

Source: Primary Data, 2024

In this research the respondent was account for 30(75.7%) of respondents. Results on age show that majority 59.0% of respondents were aged 18-34 years. This implies that majority of respondents were of considerable age and could understand the need for the study and therefore give rich information for accreditation process. The majority of the respondents 17(43.0%) have at least a diploma and 12(31.0%) of respondents had secondary school certificate. Team of accreditation is the paramount parameter in assessing their accreditation impact towards service delivered. In this regards, 23 (59.0%) respondents were in accreditation team. For category of staff, results show that the majority of the respondents 21(54.0%) reported that they were paraclinical workers.

4.2 Perception of staff towards care services delivery prior to accreditation process and during accreditation process.

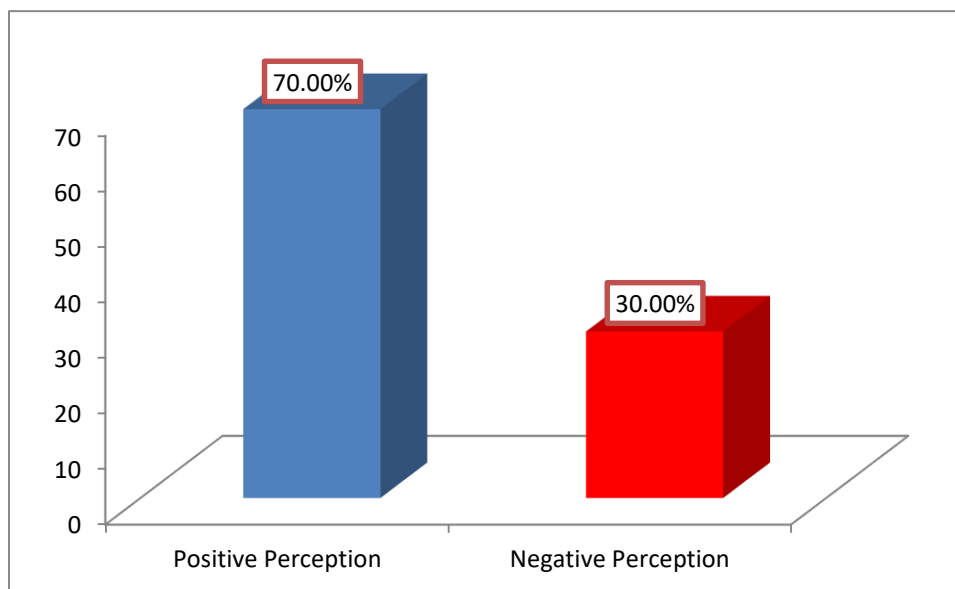
The first objective was to determine the perception of staff towards care services delivery prior to accreditation process and during accreditation process. Based on the reaction of respondents to each statement below tick (v) in the appropriate box to mark correctly the care service delivery with the following statements: Scale 1= Yes, 2=No.

Table 4. 2 Perception of staff towards care services delivery prior to accreditation

Level of Perception	Positive Perception		Negative Perception	
	Frequency	Percentage	Frequency	Percentage
IPC	26	66.7	13	33.3
Policies and Procedures	24	61.5	15	38.5
Internal regulation	5	12.8	34	87.2
Record system	36	92.3	3	7.7
Biomedical equipment and infrastructure	7	17.9	32	82.1
Leadership	32	82.1	7	17.9
Strategic Plan	24	61.5	15	38.5
Time management	34	87.2	5	12.8
Insurance medication	25	64.1	14	35.9
Accessibility to health care	17	43.6	22	56.4

Source: Primary Data, 2024

According to Table 4.2, 26 (66.7%) respondents have positive perception towards care services delivery prior to accreditation for IPC, 24 (61.5%) respondents were satisfied with policies and procedures, 5 (12.8%) respondents, were not satisfied with the policies and procedures. In addition, 36 (92.3%) respondents were satisfied with record system. However, 7 (17.9%) respondents were not satisfied with biomedical equipment and infrastructure while 32 (87.2%) respondents were satisfied with leadership. Moreover, 24(61.5%) respondents were having positive perception towards the consideration of strategic plan, 34 (87.2%) respondents have positive perception towards time management, for insurance medication, the results indicated that 25 (64.1%) respondents had positive perception while 18(43.6%) respondents were not satisfied with accessibility to health care.



Source: Primary Data, 2024

Figure 4. 1 Estimation of the overall Staff Perception

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Results presented in Figure 4.1 evidenced that the score of one was given to the positive responds and 0 was given to the not negative responds. The total score was 10 according to the number of items. The mean of total score was 11.27 where the overall perception level for satisfied responds was >11.27 while not perception was <11.27 . The results indicated that the majority of staff members, equal to 70.0% have positive perception while 30.0% of staffs have negative perception.

Table 4. 3 Perception of Staff towards Care Services Delivery during Accreditation Process

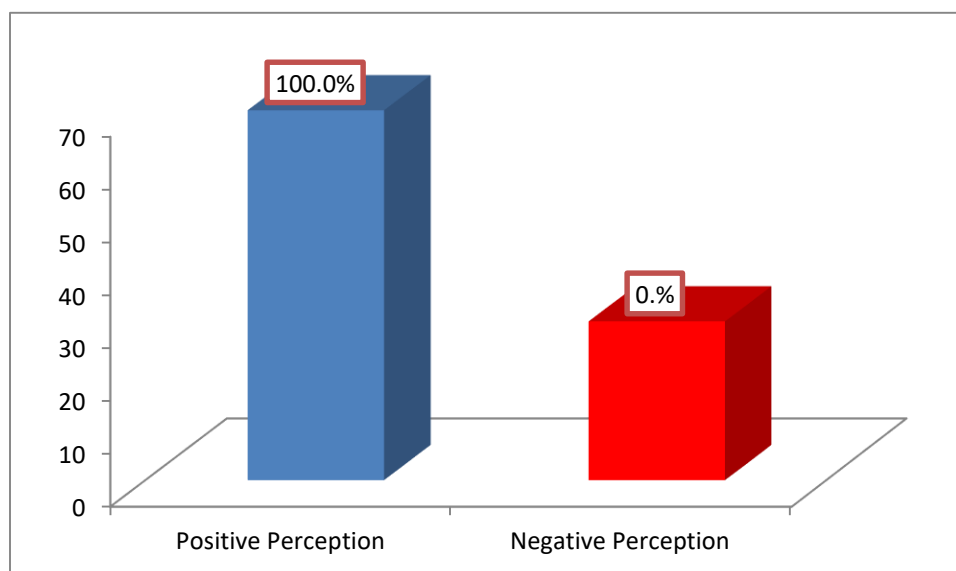
Level of Perception	Positive Perception		Negative Perception	
	Frequency	Percentage	Frequency	Percentage
IPC	36	92.0	3	8.0
Policies and Procedures	39	100.0	0	0.0
Internal regulation	37	95.0	2	5.0
Record system	39	100.0	0	0.0
Biomedical equipment and infrastructure	38	97.0	1	3.0
Leadership	36	92.0	3	8.0
Strategic Plan	39	100.0	0	0.0
Time management	35	90.0	4	10.0
Insurance medication	37	95.0	2	5.0
Accessibility to health care	39	100.0	0	0.0

Source: Primary Data, 2024

According to Table 4.3, 36 (92.0%) respondents have positive perception towards care services delivery prior the accreditation, for IPC, 100.0% of respondents were satisfied with policies and procedures, 95.0 of respondents, were satisfied with insurance medication. In addition,

100.0 of respondents were satisfied with record system. However, 97.0% of respondents were not satisfied with biomedical equipment and infrastructure while 92.0% of respondents were satisfied with leadership. Moreover, 100.0% of respondents were have positive perception towards the consideration of strategic plan, 90.0% of respondents have positive perception towards time management, while 100.0% respondents were satisfied with accessibility to health care. The following figure provides information related to the overall perception among staff members in Rwinkwavu District Hospital. Results were presented in Figure 4.2

The following figure provides information related to the overall perception among staff members in Rwinkwavu District Hospital. Results were presented in Figure 4.1.



Source: Primary Data, 2024

Figure 4. 2 Estimation of the overall Staff Perception

Results presented in Figure 4.2 evidenced that the score of one was given to the positive responds and 0 was given to the not negative responds. The total score was 10 according to the number of items. The results indicated that the majority of staff members, equal to 100.0% have positive perception.

4.3 Barriers that District Hospital may encounter during implementation of accreditation process

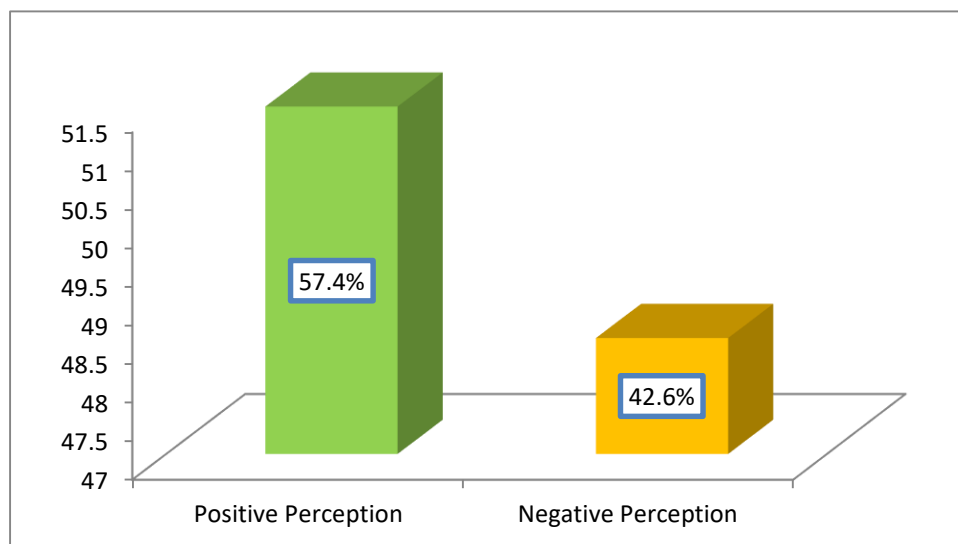
The second objective assessed the barriers that District Hospital may encounter during implementation of accreditation process. The following Table 4.3 depicts on the perception of respondents.

Table 4. 4 Barriers Encountered During Implementation of Accreditation Process

Level of Perception	Positive perception		Negative perception	
	Frequency	Percentage	Frequency	Percentage
Lack of Finance	39	100.0	0	0.0
Behavior change and lack of trainings	39	100.0	0	0.0
Lack of ethics	34	87.0	5	13.0
Impossibility of promoting positive working environment	5	12.8	34	87.2
Inability to influence subordinates for a common goal	17	42.6	22	57.4

Source: Primary Data, 2024

In table 4.4, results show that 100.0% of respondents have a positive perception towards the lack of finance as a barrier encountered during implementation of accreditation process, 100.0% have a positive perception on behavior change and lack of trainings as a barriers encountered during implementation of accreditation process. Furthermore, 87.0% positively evidenced lack of ethics as a barrier encountered during implementation of accreditation process, 87.2% have a negative perception on impossibility of promoting positive working environment. However, 57.4% have a negative perception on inability to influence subordinates for a common goal.



Source: Primary Data, 2024

Figure 4. 3 Estimation of the Level of perception

Results presented in Figure 4.3, indicated that 57.4% of respondents have positive perception (4 score) while 42.6 of respondents have negative perception on the Kayonza district hospital environment (3 score). Results presented in Figure 4.3 evidenced that the score of one was given to positive perception responses and 0 was given to the negative perception responses. The results indicated that the majority of patients, equal to 57.4% have a positive perception while 42.6% staff has a negative perception.

4.4 Most important reasons for introducing accreditation in Rwinkwavu District Hospital

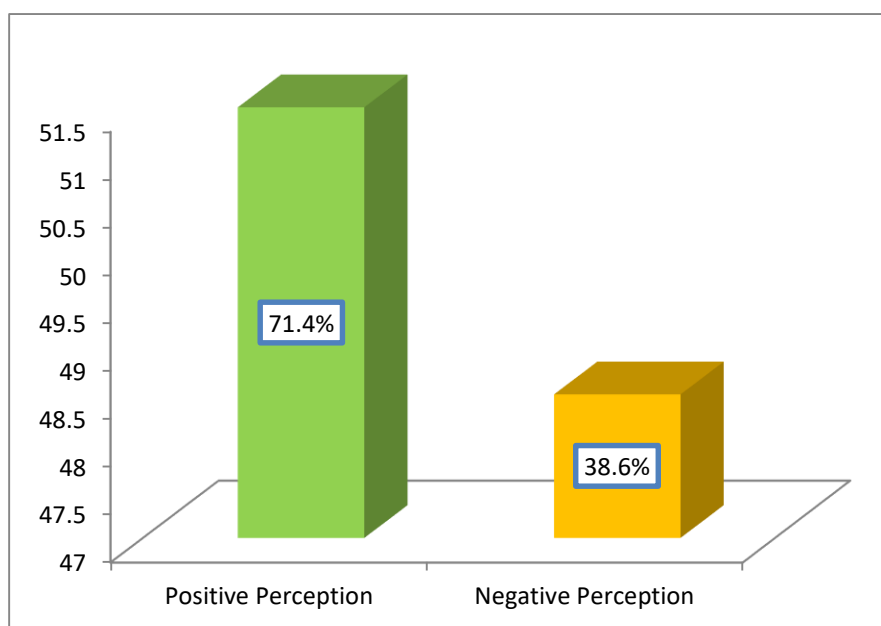
The third objective of the study established most important reasons for introducing accreditation in Rwinkwavu District Hospital. The following Table 4.5 depicts on the perception of respondents.

Table 4. 5 Reasons for Introducing accreditation

Level of Perception	Positive perception		Negative perception	
	Frequency	Percentage	Frequency	Percentage
The availability of buildings infrastructure	27	69.9	12	30.1
Strong leadership is necessary	32	82.5	7	17.5
Strong Measures Plan Ahead	25	65.0	14	35.0
Timing Management	26	67.0	13	33.0
Insurance Medication	20	50.5	19	49.5
Accessibility to Healthcare Services	13	33.0	26	67.0
Decreasing infant mortality rate	17	43.7	22	56.3

Source: Primary Data, 2024

In table 4.5, results show that 69.9% of respondents have a positive perception towards the way they were informed about the availability of buildings infrastructure, 82.5% have a positive perception on strong leadership is necessary. Furthermore, 65.0% positively evidenced that strong measures plan ahead, 67.0% have a positive perception on timing management were well displayed. However, 33% had negative perception on accessibility to healthcare services, 43.7% have a negative perception on decreasing infant mortality rate.



Source: Primary Data, 2024

Figure 4. 4 Estimation of the level of Perception

Results presented in Figure 4.4, indicated that 71.4% of respondents have positive perception while 38.6% of respondents have negative perception on Rwinkwavu District Hospital environment. Results presented in Figure 4.4 evidenced that the score of one was given to positive perception responses and 0 was given to the negative perception response. The results indicated that the majority of respondents, equal to 71.4% have a positive perception while

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38.6% of staffs have a negative perception. The table provides all responses but by taking into consideration, the reasons that have been scored as positive and appeared as positive which had more than 50% of score were considered as the influencing reasons.

Table 4. 6 Bivariate associated socio-demographic Characteristics with Staff perception

Variables	Description	Staff Perception				Chi-Square	P-Value
		Positive		Negative			
		N	%	N	%		
Gender	Male	6	11.2	26	88.9	5.215	0.002
	Female	5	31.3	2	24		
Age	18-34	2	46.3	23	75.0	7.858	0.005
	≥35 Years	10	53.7	4	25.0		
Education	Diploma	6	37.3	15	77.2	12.567	0.002
	Secondary School	7	44.8	2	13.9		
	Bachelor	6	17.9	3	13.9		
Team of Accreditation	Yes	18	34.3	11	69.4	12.702	0.002
	No						
Category of Accreditation	Management Committee	6	63.6	4	26.4	7.724	0.102
	Health Care Providers	11	40.3	7	19.4		
	Paraclinical workers	17	23.9	4	8.3		

Source: Primary Data, 2024

Refer to table 4.6, moreover, gender of respondents is associated with staff perception with $X^2 = 5.215$ at p-value 0.002; age of respondents is associated with staff perception with $X^2 = 7.878$ at p-value 0.005. Moreover, education level of staff influences their perception while profile of respondents is associate with their perception with a $X^2 = 12.567$ at a p value 0.002. Therefore, the study reveals that team of accreditation can lead to the level of perception with a $X^2 = 12.702$ at a p value 0.002. However, categories of accreditation were associated with their perception. In conclusion the socio-demographic variables illustrated in Table 4.6 were considered as factors associated with perception because their p value is significant (p value < 0.05).

Table 4. 7 Multivariable analysis of Factors Associated with Staff Perception

Variable	Description	AOR	95% C. I		P Value
			Lower	Upper	
Gender	Male	0.292	0.063	1.344	0.114
	Female	Ref.			
Age group	18-34	0.379	0.121	0.186	0.095
	≥35 Years	Ref			
Education	Secondary School	0.659	0.146	2.985	0.589
	Diploma	2.300	0.375	14.125	0.368
	Bachelor	Ref.			
Team of Accreditation	Yes	0.447	0.108	1.855	0.267
	No	Ref			
Category of Accreditation	Management Committee	1.444	0.189	11.032	0.723
	Health Care Providers	10.218	1.394	74.876	0.022
	Paraclinical workers Fourth category	Ref			

Source: Primary Data, 2024

As shown in Table 4.7, multivariate analysis indicates statistically significant association between socio-demographic factors staff perception. In this regard, the most influencing factors to perception were age of respondents with perception with AOR=0.379, confidential interval from 0.121 to 0.186 at a P value =0.095. There was less significant association with staff perception.

5. Discussion of findings

Results concerning the first objective which determined the assess the perception of staff towards care services delivery prior to accreditation process and during accreditation process. The present study reveals that 92.3% of respondents were satisfied with record system 87.2% of respondents were satisfied with leadership. This study is consistent with the conclusion from a study conducted in Nepal, which indicated that 63% who worked with in Islamabad Hospital were satisfied with how accreditation process was done (WHO, 2013).

However, the present study shows that 61.5% of respondents were satisfied with policies and procedures, 17.9% of respondents were not satisfied with biomedical equipment and infrastructure, 61.5% of respondents were have positive perception towards the consideration of strategic plan. Therefore, this study is inconstant with the findings of a study conducted by Alkhenizan, (2011) who contended that 72.6% of respondents were satisfied with how they participated and included in the management and leadership towards the accreditation and service delivery, However, the study is consistent with the findings contended that in Africa, few studies found that 55.0% of respondents are more likely to be satisfied with health care providers (Cleveland, 2011).

The second objective of this study was to identify the barriers that District Hospital may encounter during implementation of accreditation process. In this regard, 100.0% have a positive perception on behavior change and lack of trainings as a barrier encountered during implementation of accreditation process. Furthermore, 87.0% positively evidenced lack of ethics as a barrier encountered during implementation of accreditation process. This concurs with the findings of Directors suggested targeting the MOH and international agencies for sources of funding, conducting follow-up meetings, communication and collaboration with the MOH. Organizing meetings play an important role in accreditation. For development to take place, it is important that community members meet from time to time to plan, monitor, evaluate and update themselves on progress of their own initiated activities (Cleveland, 2011). Respectively the study contended that, 82.1% had negative perception on how the inability to influence subordinates for a common goal, 56.4% have a negative perception on inability to influence subordinates for a common goal. For them food was not enough. This study is consistent with Schoenfelder et al., (2011) who observed the determinants of perception among 39 hospitals in an in-staff setting in Germany. However, 62.1% had negative perception on how the ward was quiet, 49.5% have a negative perception on food. For them food was not enough.

The third objective was to examine the most important reasons for introducing accreditation in Rwinkwavu District Hospital. Results show that 69.9% of respondents have a positive perception towards the way they were informed about the availability of buildings infrastructure, 82.5% have a positive perception on strong leadership is necessary. Furthermore, 65.0% positively evidenced that strong measures plan ahead, 67.0% have a positive perception on timing management were well displayed.

However, a bivariate analysis show that gender of respondents is associated with staff perception with $X^2 = 5.215$ at p-value 0.002; age of respondents is associated with staff perception with $X^2 = 7.878$ at p-value 0.005. Therefore, the study reveals that team of accreditation can lead to the level of perception with a $X^2 = 12.702$ at a p value 0.002. However, categories of accreditation were associated with their perception. In conclusion the socio-demographic variables were considered as factors associated with staff perception because their p value is significant (p value < 0.005). This study contended high perception rate for old respondents, but it was not the case for young and children mental health staff member due to the fact that old people are more likely to establish rapport with services benefactors (Alkhenizan, 2011).

Results on multivariate analysis indicate statistical significant association between socio-demographic factors staff perception. In this regard, the most influencing factors to staff perception include education (AOR =1.444) confidential interval from 1.394 to 74.876 at a P value =0.022. This study is consistent with the findings from a study contended that mental health care providers including nurses, psychologists, and doctors influenced more accreditation process towards service delivery with special reference to women (El-Nasser et al, 2013). The present study argued that furthermore, gender of staff members is also associated with their perception with AOR=0.379, confidential interval from 0.121 to 0.186 at a P value =0.095. Findings from this study, is inconstant with the study conducted reveals a positive association between perception and gender of respondents (Ntirenganya, 2017).

6 Conclusion and Recommendations

The researcher found out that the perception level towards accreditation and service delivery at Rwinkwavu Hospital is 70.0%. In addition, different factors were found to influence the level of perception. Among those factors, the research contended the IPC, record system, biomedical equipment and infrastructure, leadership, strategic plan, time management, insurance medication, accessibility to health care. The researcher analyzed the perception barriers that district hospital may encounter during implementation of accreditation process. In this regards, results indicated that the overall perception level is 57.4% on the Kayonza District hospital environment. Confounding factors influencing the perception include lack of finance, behavior change and lack of trainings, lack of ethics, impossibility of promoting positive working environment, inability to influence subordinates for a common goal, inability to influence subordinates for a common goal and lack of community participation.

A bivariate analysis of the association between socio-demographic characteristics and accreditation perception discovered that gender profile of respondents is associated with their perception while, being women is positively correlated with positive perception. Furthermore, age. Multivariate analysis indicates statistical significant association between socio-demographic factors staff perception. In this regards, the most influencing factors to perception were age of respondents with perception. The present study concludes that accreditation is vital to ensure disciplined hospital management and to impart quality care and staff safety. It included various parameters related to perception, staff awareness and responsibilities, coordinated work, infection control practices and cleanliness, documentation, infrastructure care and management. The results indicate that accreditation has had an impact on hospitals in improvements.

Based on the study findings, the following recommendations were proposed: The challenge of poor infrastructure that indicates one of the challenges that front-line workers face that prevents them from giving quality services is shortage of resources would be overcome by developing health infrastructure. This can be overcome by involving them in accreditation programs and providing them with evidence-based literature. However, the need to educate healthcare professionals about the potential benefits of accreditation, which should resolve any cynical attitude of healthcare professionals towards accreditation, is of utmost importance

Community participation in health management committees can increase public accountability of health services. In this context, Rwinkwavu District Hospital Accreditation program appears as a possibility to promote changes among staff and influence their behaviour toward owning the process and guarantee achieving high level standard of care to their clients. This can be facilitated through training and sensitization of workers with the right information pre-accreditation and that of during the accreditation process, promotes capacity-building, professional development, and organizational learning

This study strongly indicates that accreditation is beneficial to Rwinkwavu District Hospital and from healthcare workers' perspective it is important to involve everyone in the process. Accreditation bodies should attempt to involve the entire Rwinkwavu District Hospital. Different factors influencing the level of perception: IPC, Record system, Biomedical equipment

Rwinkwavu District Hospital should establish a Calendar of required trainings of the organizations internal quality improvement team which can be beneficial to enhance the understanding of accreditation among the employees.

Most importantly before arranging a training session for staff, understand what is required to ensure that the resources invested are targeted at areas where training and development will yield positive return on the investment, this can be done through staff training needs assessment, to establish patient satisfaction surveys

Internal self-assessment should be encouraged and tools to carry out, establishing the hospital performance progress toward achieving accreditation based on the Hospital Accreditation Standards Develop, implement, and monitor improvement plans based on survey findings and recommendations, discussions about requirements of achieving Level 3 of the accreditation process.

Based on the study findings there is a need to conduct further research on of staff towards care services delivery prior to accreditation process and during accreditation process in other public hospitals and health centers in Rwanda. It should be very important to conduct a study on the impact of cultural beliefs on the of staff towards care services delivery after accreditation process. There is a need to undertake a research on effective management approaches for accreditation process. There is a need to focus in rural areas because the situation is not the same in urban areas as in rural areas.

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