RESEARCH ARTICLE

# National accreditation programmes for hospitals in the Eastern Mediterranean Region: Case studies from Egypt, Jordan, and Lebanon

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## Abstract

**Background:** Many countries use external evaluation programmes such as accreditation in order to improve quality and safety in their healthcare settings. Hospital accreditation has developed in many low-and-middle-income countries (LMICs); however, the implementation and sustainability of these programmes vary in each country. This study addresses design and implementation issues of national hospital accreditation programmes. It identifies factors which may explain why programmes can be implemented successfully in one country but not in another and derives lessons for the design and implementation of national accreditation programmes in poor-resource settings.

**Methods:** A multiple case study design was used, comprising three countries in the Eastern Mediterranean Region: Egypt, Lebanon and Jordan. In-depth semi-structured interviews were conducted with 27 key stakeholders in the three countries and experts from international organisations concerned with accreditation activities in LMICs.

**Results:** The hospital accreditation programme was successful and sustainable in Jordan but experienced some difficulties in Egypt and Lebanon. The premature end of external funding and devastating political instability after the Arab Spring were problematic for the programmes in

Egypt and Lebanon, but continuous funding and strong political will supported the implementation and sustainability of the programme in Jordan.

**Conclusions:** LMICs striving to improve their hospitals' performance through accreditation programmes should consider their vulnerability to a scarcity of financial resources and political instability. An important factor underpinning sustainability is recognising that the accreditation programme is an ongoing and developing quality improvement process that needs continuing and careful attention from funders and political systems if it is to survive and thrive.

## 1 | INTRODUCTION

Accreditation is "a public recognition by a healthcare accreditation body of the achievement of accreditation standards by a healthcare organisation (HCO), demonstrated through an independent external peer assessment of that organisation's level of performance in relation to the standards".[1]

Accreditation programmes can be described in terms of organisational structure and its governance, standards development, incentives, and the system for measuring performance against the standards.[2] The primary role of the accrediting body is to bring accreditation standards into active practice.[3] Accreditation standards describe acceptable performance levels.[4] Motivations for hospital participation in accreditation depend on the national context of each country and its HCOs. Specifically, designed incentives can include direct financial incentives such as linking accreditation to payments, or indirect incentives, such as offering training and technical assistance to staff.[5] Finally, the measurement system comprises the survey process which is a systematic and independent assessment to evaluate hospitals' compliance with standards, and surveyors who are healthcare professionals selected and trained by the accrediting body to conduct surveys.[1,6]

Low-and-middle-income countries (LMICs) face many challenges while trying to provide good quality and safe healthcare services,[7] especially with their scarce resources and the global rise in health expenditures.[6] Many governments subscribe to external evaluation systems, particularly accreditation, as an approach to improving healthcare quality.[8,9] Hence, accreditation programmes are increasingly being established in LMICs.[7]

The adherence to standards and provision of constructive feedback to HCOs can enhance a culture of quality and safety and promote continuous improvement.[7] However, implementing and sustaining accreditation programmes in LMICs is very challenging due to resource shortages and poor hospital infrastructure.[10–13] Therefore, there is a need to better understand accreditation programmes in poor-resource settings, through theoretically-informed empirical research exploring the formation, operation and consequences of accreditation programmes in LMICs.[13]

The aim of this study is to analyse design and implementation issues affecting national hospital accreditation programmes in three LMICs in the Eastern Mediterranean Region (EMR): Egypt, Jordan, and Lebanon. It explores the fit between international accreditation models and their national contexts of implementation and draws lessons for other LMICs seeking to establish their national accreditation programmes, providing practical recommendations

for their formulation and functionality in poor-resource settings. The study builds upon a literature review by Mansour et al which used the Dolowitz and Marsh policy transfer framework[14] to examine the development of hospital accreditation programmes in LMICs.[13] The same theoretical framework is used here to guide the empirical analysis in identifying and examining factors affecting the implementation and sustainability of accreditation programmes in LMICs which draw on apparently successful programmes developed in high-income countries (HICs).

## 2 | THE DEVELOPMENT OF ACCREDITATION IN THE EMR

Health systems in countries in the EMR are characterised by wide variation in healthcare quality. Some organisations offer an inadequate quality of health services and show poor performance and poor clinical outcomes.[15] Historically, licensure has been the main route to regulate HCOs in LMICS in the EMR. However, this is, done once by the Ministry of Health (MOH), when a service is established, without later follow-up to ensure quality and safety of the care that is, delivered.[16]

In 2000, the World Health Organisation (WHO) reported no existing accreditation programmes in the EMR.[2] Subsequently, healthcare quality was incorporated into the national health policies and quality plans of many countries in the region,[17] and quality improvement (QI) initiatives in hospitals started to be structured through accreditation programmes.[18] Many LMICs developed national accreditation programmes, despite the barriers to implementation and sustainability of accreditation programmes.[19]

In 2015 the WHO—Eastern Mediterranean Regional Office (EMRO) conducted another survey, to monitor the progression of QI initiatives in the region and explore how healthcare quality became institutionalised.[18] WHO received responses from Bahrain, Egypt, Islamic Republic of Iran, Iraq, Jordan, Lebanon, Morocco, Oman, Palestine, Pakistan, Saudi Arabia, Sudan, and Tunisia. The analysis showed the existence of national quality policies in 80% of the responses, yet 40% of respondents reported a lack of incentives for hospital participation. MOH ownership of most QI programmes in the region was explicit, and only a few countries had a separate national body to monitor the QI activities. Based on this survey, EMRO reported the need to develop well-defined QI programmes in the region and to institutionalise accreditation in hospitals to reinforce a quality culture through external assessment.[18]

Accreditation programmes have been used in many health settings in the EMR, such as hospitals (public and private), primary healthcare (PHC) centres, laboratories and other diagnostic services. HICs in the region commonly use international accreditation programmes in their organisations. Many governments in the region, including LMICs, have developed and adjusted these international standards for their hospitals, but there is a wide variation in the degree of implementation among countries.[16] This study examines the development of national hospital accreditation programmes in three LMICs in the EMR: Egypt, Jordan, and Lebanon and explores the implementation outcome in each case.

## 3 | METHODS

A multiple case study design was employed to explore the development of hospital accreditation in three EMR countries: Egypt, Lebanon, and Jordan. Jordan and Lebanon are classified by the World Bank as upper-middle-income countries while Egypt is classified as lower-middle-income.[20] All three countries had long track records in developing their national accreditation programmes. They are Arabic countries, that share numerous cultural, historical and social characteristics, but they vary in their health systems and their political and economic contexts which make the comparison interesting.

The study used two qualitative research methods for data collection: document review and interviews, in order to understand issues affecting the implementation of accreditation programmes, how these relate to key

characteristics of the programme design and the development process, and how they are influenced by contextual factors.

We analysed policy documents and organisational reports published up until 2018, which contained a substantial amount of information about the development and implementation of hospital accreditation in the three countries, and in the EMR more generally. The websites of the MOHs in the three countries were searched for policy documents, statements, briefs and announcements related to their national accreditation programmes. The websites of relevant international organisations were also searched, including WHO, Joint Commission International (JCI), United States Agency for International Development (USAID), and International Society for Quality in Healthcare (ISQua).

In-depth semi-structured interviews were conducted with 27 key informant stakeholders. The participants were selected purposively according to their role with regard to accreditation (Table 1). They included quality and accreditation experts in the region, policymakers, members of executive committees of accreditation at MOHs in the three countries, and experts at national and international accreditation bodies.

A few face-to-face interviews were conducted in Egypt; other interviews were conducted via Skype or phone. This was for two reasons. Firstly, many EMR countries were facing unfavourable political situations when the study was conducted in 2017–2018, which made it very risky to conduct conventional interviews. Secondly, many participants and international experts were located in different countries, which made access impractical. Each interview lasted for 60–90 min. The interviews were conducted in Arabic and English, and transcribed and translated by the lead author.

The study used 'method triangulation' to increase confidence in the findings. Document review was used to validate the explanations that interviews offered. This was supplemented by 'data source triangulation' through interviewing different stakeholders from the three countries and international organisations, so as to access different perspectives.[21]

These accreditation programmes can be regarded as policies that have transferred to LMICs from HICs. Our analytical framework therefore incorporated the Dolowitz and Marsh policy transfer framework[14] in order to

**TABLE 1** Interview participants

| Country/Organisation | Number | Affiliation |
| --- | --- | --- |
| Egypt | 6 | –Ministry of health and population (3)<br>–Academic (1)<br>–New accreditation body (GAHAR) (2) |
| Lebanon | 4 | –Ministry of public health (2)<br>–Academic (1)<br>–The Lebanese Society for Quality and Safety in Healthcare (1) |
| Jordan | 4 | –Ministry of Health (2)<br>–Health Care Accreditation Council (HCAC) (1)<br>–Hospital Association (1) |
| International organisations | 13 | –World Health Organisation (WHO) (4)<br>–International Society for Quality in Healthcare (ISQua) (2)<br>–United States Agency for International development (USAID) (3)<br>–Joint Commission International (JCI) (1)<br>–Australian Council on Healthcare Standards (ACHS) (1)<br>–Healthcare Standards Organisation (HSO) (1)<br>–Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) (1) |

analyse key characteristics of the accreditation programmes and their development and origins. Researchers have applied the Dolowitz and Marsh to a wide range of empirical cases, for example, social and welfare policy, crime, education, urban planning, transportation, and health.[22] It is the most widely used theoretical model to describe the transfer of policies across time and space.[13,14,22,23] It uses a series of questions to examine policy transfer including: Why does policy transfer? Who is involved in the transfer process? What is transferred? From where is policy transferred? What is the degree of transfer? What are the constraints on policy transfer? How does policy transfer lead to policy failure?[14] (Table 2).

Our interview schedule was designed to cover these questions, plus additional questions to examine three aspects of the success and failure of the programmes from an embedding point of view: designing the main components of an accreditation programme, progressing implementation, and sustaining accreditation activities despite limited resources (Table 3). The study also considered how MOHs planned to continue developing their programmes in the future.

Ethical approval for this study was obtained from the Ethics Committee at the University of Manchester, as part of the PhD study of the first author. All participants were contacted in advance by email with a participant information sheet so that they could give informed consent. Participation was voluntary. All interview transcripts were anonymised and stored securely, separate from the participant list. Each interview participant (IP) was coded with a number along with his/her country for example (IP#1: Egypt).

Data analysis passed through two stages: document analysis and analysis of interviews. A deductive coding scheme was developed based on the questions in the Dolowitz and Marsh framework and applied to the documents and interview transcripts to generate insights about the hospital accreditation programme and its implementation in each country. Document analysis was guided by the Miles and Huberman approach for qualitative data analysis that passes through three interacting phases which are reduction; display; and finally, drawing and verifying conclusions.[24] Document analysis was done manually by the main researcher. During document analysis, pieces of text that described accreditation activites in the studied countries, how and why accreditation was started, designed, implemented and sustained, or any factors that supported or hindered these processes were highlighted and coded. Nvivo qualitative data analysis software was used to conduct a thematic analysis of the interviews, first within each case and then across cases. This helped draw contextually sensitive lessons for other LMICs on the appropriate design and implementation of sustainable hospital accreditation programmes within poor-resource settings.

## 4 | RESULTS

The three countries developed their accreditation programmes over substantial periods of time. Background information about the prior history of hospital accreditation in each case study is reported in Appendix Table A1. The more recent development of hospital accreditation in each country is reported in detail in the following subsections, supported by quotations from interviewees. The results are articulated around six high-level themes: drivers for establishing accreditation programmes; the role of donor agencies; components of accreditation that were developed (standards, institutional arrangements, surveyors, incentives); constraining factors; facilitating factors; and implementation outcomes.

### 4.1 | Drivers for establishing accreditation programmes

The idea of continuous QI was the main driver behind the development of hospital accreditation in the studied countries, yet there were additional motives in each country.

**TABLE 2** Dolowitz and Marsh policy transfer framework[14]

| Why transfer? Want to ............have to | | | Who is involved in the transfer? | What is transferred? | From where? | | | Degree of transfer | Constraints on transfer | How to demonstrate policy Transfer? | How transfer leads to policy failure? |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Voluntary | Mixtures | Coercive | | | Past | Within a nation | Cross-national | | | | |
| Lesson drawing (perfect rationality) | Lesson drawing (bounded rationality) | Direct imposition | Elected officials | Policies | Internal | State | International organisations | Copying | Policy complexity | Media | Uninformed transfer |
| | International pressures | Conditionality | Bureaucrats | • Goals • Content • Instruments | Global | City governments | Regional | Emulation | Past policies | Reports | Incomplete transfer |
| | • Image • Consensus • Perceptions • Externalities | • Loans • Business activities • Obligations | Civil servants | | | Local authorities | State | Mixtures | Structural, institutional feasibility | • Commissioned • Un-commissioned | Inappropriate transfer |
| | | | Pressure groups | | | | Local Governments | Inspiration | • Ideology • Cultural proximity • Technology • Economic • Bureaucratic • Language | | |
| | | | Political parties | Programmes | | | Past Relations | | | Conferences | |
| | | | Policy entrepreneurs | Institutions | | | | | | Meetings | |
| | | | Experts | Ideologies | | | | | | Visits | |
| | | | Consultants | Attitudes | | | | | | Statements written | |
| | | | Think tanks | Cultural values | | | | | | Verbal | |
| | | | Transnational corporations | Negative lessons | | | | | | | |
| | | | Supranational institutions | | | | | | | | |

**TABLE 3** Interview questions

| Q1 | Why was accreditation developed in the country? |
| --- | --- |
| Prompts | Was it a voluntary decision by the national government? |
| | Was there any international pressure or direct imposition of the policy? |
| Q2 | Who was involved in the introduction and development of hospital accreditation in the country? |
| Prompts | National actors |
| | International actors |
| | How were the communication channels among the involved actors? |
| Q3 | Which components of accreditation have been developed in the country? |
| Prompts | National accreditation body |
| | National accreditation standards |
| | Surveyors and surveyor training programme |
| | Incentives |
| Q4 | From where accreditation was transferred to the country? |
| Prompts | Past experiences, internally within the country |
| | External that is, cross-national, regional, etc. |
| Q5 | What was the degree of transfer of hospital accreditation to the country? |
| Prompts | Direct copying of international model |
| | Copied but adapted to the notional context |
| | Inspired by international model and developed a new accreditation programme |
| | Using a mixtures of international accreditation models to develop a national programme |
| Q6 | What factors have most facilitated or hindered the success of the accreditation programme in the country? |
| Prompts | National context |
| | Original accreditation model, exporting countries, international organisations |
| Q7 | What is the outcome of accreditation transfer to the country? |
| Prompts | Success or failure |
| | What are the reasons behind either the success or failure? |
| | What are the country's future plans for the continuity of hospital accreditation? |

In Egypt, accreditation started as an essential requirement of the health reform project initiated by USAID. The Egyptian Ministry of Health and Population (MOHP), with the assistance of the USAID-funded 'Partners for Health Reformplus' (PHR*plus*; 1995–2001) successfully developed an accreditation programme to monitor the performance of PHC.[25] The MOHP sought to update the licensure policies for physicians and their continuing medical education, to achieve the objectives of reform and provide more comprehensive health services in PHC.[26,27,39] Building on this experience, the MOHP developed standards for hospital accreditation with technical assistance from USAID.[25,40]

In Jordan, accreditation began as a governmental initiative to improve the quality of care in HCOs.[30] The Jordan Healthcare Accreditation Project (JHAP) started in 2007 and ended in 2013, in collaboration with the

University Research Corporation (URC) and funded by USAID. The aim was to establish a sustainable and independent accreditation body, hence, the Health Care Accreditation Council (HCAC) was established in 2007 to manage all accreditation activities in Jordan.[31] The three components of the Jordanian accreditation programme are accredited by ISQua (the HCAC, surveyor training programme, and standards).[31,32] Later, accreditation has also been seen as a catalyst for medical tourism in Jordan.[31]

In Lebanon, after the civil war (1975–1992), the country experienced massive deterioration in its health sector especially with the unregulated private sector which was and continues to be the predominant healthcare provider.[35,36] The Ministry of Public Health (MOPH) used to contract private hospitals to offer healthcare services to uninsured patients but poor governmental control and deregulation of the private sector led to poor quality of care and clinical outcomes and increases in the cost of health services. These created public pressure on the government to improve performance. Accordingly, to enhance public accountability, in 2000, the MOPH launched a new hospital accreditation programme which was a clear shift from the old classification system. The MOPH used the programme as a regulatory tool for the private sector, linking it to reimbursement schemes to form an incentive-based regulation system and ensure value for money.[35]

## 4.2 | The role of donor agencies in the development of accreditation programmes

Donor agencies offered funding for a number of health reform projects in LMICs including countries in the EMR. USAID and its partner PHR*plus* funded many projects in Jordan and Egypt. They worked in partnership with MOHs to promote quality and safety and helped design the national quality strategies in both countries in collaboration with the WHO. Other donor agencies also supported accreditation in the EMR, including the World Bank in Egypt and Lebanon, and the French government in Lebanon.

> In Egypt, there were four sources of the fund of the health reform programme: USAID, the World Bank, the EU, and the African Bank. The first three are the main funders the reform programme started with. Each one of them was responsible for certain part of the reform; one for the infrastructure, one for the operation and one for the improvement plans, then the African Bank supported the whole reform programme in two governorates, Qena and Suez **(IP#4: Egypt)**.

In Jordan, the national accreditation programme started with USAID assistance in 2004. The initial aims were to develop national standards and accreditation body with 17 pilot hospitals from various sectors. In 2007, the project was awarded to the University Research Company (URC) to continue the work, establish an independent accreditation body and obtain ISQua accreditation. To meet these objectives, URC focused on capacity building, and from 2007–2011, the HCAC was established and became fully-functioning. To ensure the sustainability of both the programme and the HCAC, USAID extended its funding twice, in 2010 and 2013.[31]

In 2002, the Lebanese MOPH launched the new hospital accreditation policy in collaboration with the Australian Overseas Project Corporation of Victoria (OPCV) who helped the government to develop accreditation standards to monitor the performance in public and private hospitals.[17,35] The initial funding was from the World Bank, before the French government took over the project.

> The French government donated funding for the accreditation system in Lebanon and sent French consultants to help the Lebanese government develop national standards. The first set of standards was set by the Australian committee and during developing the second set of standards; the French MOH came over, reviewed our standards and added two chapters: quality and patient safety **(IP#10: Lebanon)**.

## 5 | COMPONENTS OF ACCREDITATION THAT WERE DEVELOPED

### 5.1 | Accreditation standards

The three countries emulated international accreditation standards, particularly the JCI programme, and adapted it to fit their hospitals. The process of standards development followed the same series of national and sub-regional meetings that were held for policy learning and revision until a basic set of standards was developed.

> We looked at standards from all over the world, made a draft of those standards, and then formed 15 taskforce groups made up from people of the 17 hospitals in addition to other experts in the field to look at the standards and give us their feedback [...] we compiled all the results and the work of the 15 taskforces into the first draft of the standards that went for external review **(IP#12: Jordan)**.

In Egypt, the first national hospital accreditation standards included 716 standards, classified into three groups: 69 critical standards, 322 core standards and 325 non-core standards. For a hospital to be accredited, it had to comply with all the critical standards and reach a cumulative score of 85% on the core standards. The non-core standards included standards that were hard to implement, and the hospital needed to get a cumulative score of 40% on these.[25] Subsequently, the accreditation standards were updated, and ISQua accredited them in 2007. After the 2011 revolution, the accreditation programme stopped for few years, but the government reactivated it and ISQua reaccredited the standards in 2017. An updated version of the hospital accreditation standards has also been issued in 2019.[28]

In Jordan, the HCAC developed accreditation standards that are divided into clusters with measurable elements for each standard to be used for hospital self-assessments. It also included the scoring mechanism that is, used by the surveyors when they perform a mock or accreditation survey. The third edition of the Hospital Accreditation Standards is patient-centred, containing 14 clusters, 347 standards and 1283 measurable elements.[33]

In Lebanon, the MOPH developed and pilot-tested accreditation standards in 2000–2001. The MOPH conducted three national surveys. The first cycle surveyed 128 hospitals from September 2001 to July 2002. The second cycle surveyed 142 hospitals in 2004, among which only 85 complied with standards.[35] The third cycle started in 2011 when hospitals were expected to show more compliance with accreditation standards and processes.[36] In 2019, the MOPH reviewed and updated the national accreditation standards to be evidence-based, reflect the international best practices and comply with ISQua requirements.[37]

### 5.2 | Institutional arrangements

Each country worked towards establishing an independent national accreditation body despite the financial obstacles and MOH ownership. Jordan has its national independent accreditation body (HCAC) functioning since 2007 and independent financially since 2013. In Lebanon and Egypt, establishing an independent accreditation body, free from any governmental authority, is a current aspiration. Nevertheless, there is a quality department at MOH concerned with QI initiatives in each country and a national committee represented by all stakeholders engaged in quality, safety, and accreditation processes in each country.

> With the start of the health sector reform programme in 1997, a quality department was established in the MOH in 1998 in response to the requirements of the reform programme. Then, the Executive Accreditation committee was formed headed by the Minister and with the membership of former ministers and representatives of different stakeholders and healthcare providers. This was the Supreme Committee of Quality which has an executive committee inside the MOH which formed a

focus group and developed the standards [...] In 2010 we made some improvements in this issue that we separated the accreditation committee from that quality department. So, there were two bodies inside the MOH; the quality department and the accreditation body, and both were reporting directly to the Minister. There is a plan to establish an independent body, but all depends on the new health insurance programme **(IP#3: Egypt).**

An independent accreditation body was established in Egypt in 2018—the General Authority for Healthcare Accreditation & Regulation (GAHAR)—as part of the universal health insurance project. GAHAR manages all accreditation activities in Egypt such as developing standards and regulations for healthcare quality, supervising and regulating all HCOs and health workforce, and implementing an inspection system to ensure the integrity and transparency of activities as well as compliance with healthcare quality and safety regulations.[28]

## 5.3 | The surveyors

Jordan and Egypt developed their national surveyors training programmes to graduate certified national surveyors who understand the standards, how to evaluate them and how to ensure a consistent surveying process. The surveyors are independent healthcare professionals who are selected and trained by the accrediting body to ensure they are skillful in surveying processes, and they are commonly part-time employed to run the survey at HCOs.[1] As reported by the interviewees, in 2017, Jordan had about 80 certified national surveyors who were trained by the HCAC, and their surveyor's training programme is accredited by ISQua. Egypt had 50 trained surveyors in 2006, those surveyors were trained by the Quality department at the MOPH. Currently, GAHAR took over the accreditation activities in Egypt including the training of national surveyors.[39] In Lebanon there are currently no national surveyors since surveying was contracted out to four companies, however, an accredited surveyors' training programme is planned especially after the programme was reactivated and standards were updated.

There is no accreditation body in Lebanon. There is the MOH that has been performing the operation. They passed through different stages. In the beginning, there was an Australian team. They had them as consultants. In the second wave, they have contracted out four companies to do only the surveys with oversight from a French team [...] However, they realised that four companies doing the surveys is not sustainable. Now, the ministry is working on developing a new governance model. Meanwhile, there is a national committee advises on implementation and decision making, but not on the deployment of surveyors. The operationalisation of the programme is not through the national committee, it only makes the final decisions **(IP#8: Lebanon)**.

## 5.4 | The incentive system

To motivate hospitals to join the programme, the government in Jordan used non-financial incentives such as recognition and branding that is 'preferred provider' status for hospitals and employers. In Lebanon, accreditation was linked to reimbursement schemes. In Egypt, no incentives for hospitals were reported in the interviews but with the introduction of the universal health insurance project, hospitals will compete to join the programme to receive insured patients.

We used to have a national day of quality in which staff was encouraged. It is a special day to celebrate and reward the achievements [...] Sometimes, we used to give a certificate of appreciation

for hospital's contribution to healthcare improvement and getting accreditation. It used to appear on their CV and made them pleased to have this certificate whenever they worked outside Jordan, in the Gulf area for example. **(IP#11: Jordan)**.

The incentive is that the ministry would increase the contracted services with those hospitals. The hospital that scores high on the accreditation system will get a higher rate of funding because they take care of the patients **(IP#10: Lebanon)**.

## 5.5 | Factors constraining accreditation

The main factors hindering the implementation of accreditation in all countries were the 'contextual' and 'application' factors.[23] The contextual factors refer to the cultural differences between HICs and LMICs while accreditation transfers between them; and the application factors refer to the organisational arrangements and institutionalisation of accreditation. The greatest challenge was the lack of financial resources and its impact on the application of accreditation. All countries depended mainly on health reform programmes funded by international donors.

The unfavourable economic conditions were exacerbated by difficult political situations, with many conflicts since the Arab Spring. This did not help sustainability of the implementation of accreditation in these countries, for example, accreditation has been discontinued in Egypt after the 2011 revolution. Although there was government commitment, there were certain periods of lag and ministries were changed repeatedly. This rapid turnover during such a short period had caused things to deteriorate with discontinuity of policies at ministerial level.

Each new minister comes with his new vision and wants new achievements. We have a problem in Egypt in the continuity of policies **(IP#4: Egypt)**.

It was also a challenge for hospitals to join the accreditation programme in the three countries with poor maintenance of hospital buildings and lack of well-established licencing and re-licencing systems of HCOs and professionals.[16] Additional finances were warranted for investment in continuous education programmes, training, and certification for health professionals, and in helping hospitals comply with standards including buying new medical equipment and furniture. The shortage of human resources was also a challenge mainly due to the 'brain drain' to the Gulf. Improvement of the infrastructure was supported in PHCs, but proved difficult in hospitals, which lacked incentives to participate. In fact, the lack of financial support generates unequal opportunities for HCOs, as the ones with good infrastructure have more chance to be accredited.[27,41] The situation was better in Jordan, where USAID funding was used for refurbishment works in selected hospitals.

We had many issues with infrastructure, internal building, infection prevention, operating room, isolation room, equipment, maintenance, and many other things. Infrastructure is one of the aspects that most benefitted from accreditation **(IP#11: Jordan)**.

There is no available fund to improve the infrastructure for the public hospitals […] that is why there are three levels for Egyptian accreditation standards and the foundation level has no standards concerning the infrastructure of the hospital. However, to get full accreditation, the hospital must improve its infrastructure to comply with all standards **(IP#6: Egypt)**.

At organisational level, there was some staff resistance because of the extra work needed to complete accreditation documentation without any financial compensation. There were also wider human resource issues reported by the interviewees, such as shortage of nurses; technicians and support services' staff lacking skills and qualifications; and high staff turnover with lack of orientation programmes. The high administrative costs to run the programme and its activities were an obstacle to many hospitals. Poor technological advancement also hindered implementation at hospital level when there was no hospital information system and no electronic medical record.

> We do not have an electronic medical record in Lebanon in all hospitals. Few hospitals have it now. On the first run of accreditation, all information system was documentation on hard copies, and still, the majority of hospitals in Lebanon do that. However, the problem was in the documentation itself [...] there is no accountability except when there is a medical-legal suit **(IP#9: Lebanon)**.

> The high turnover, especially among leaders and hospitals staff, was negatively affecting the sustainability of the programme, in addition to the lack of maintenance in hospitals [...] there was no budget at the MOH for quality projects and accreditation such as the continuous education and on-job training programmes ... **(IP#3: Egypt)**.

## 5.6 | Factors facilitating accreditation

The commitment of national healthcare leaders played an essential role in implementing accreditation programmes in the countries. MOH ownership helped maintain financial and political support for the programme. Linking accreditation to payments acted as an incentive for hospital participation, and mandating all hospitals to join the programme, as in Jordan and Lebanon, supported the implementation process.

> The facilitating factors included tying accreditation to regulation and linking it to hospitals' reimbursement, when you give time for hospitals to prepare when you promote capacity-building for hospitals to better implement accreditation standards, these would be facilitators **(IP#8: Lebanon)**.

> ... we had political support from the MOH. The MOH was supporting the programme because it was linked to the health sector reform programme and accreditation was a mandatory part of this reform **(IP#4: Egypt)**.

> We have his royal commitment in two ways [...] First; his majesty decreed that he wants one accredited hospital in each governorate in Jordan. Now, we have a project that should be finalised by the end of this year. This project includes nine to ten public hospitals and Royal medical services' hospitals that should be model accredited hospitals serving the whole country, one in each governorate. Second, his majesty mentioned in the royal letter of designation that the cabinet, the ministers and the Prime Minister are the royal backing for the initiative of accreditation in the country when there was a change of Parliament, **(IP#14: Jordan)**.

Adjusting international standards to the local context and developing different accreditation models also supported the implementation process. Having a multi-level incremental accreditation programme in Egypt and Jordan encouraged hospitals to join the programme, as did other indirect (non-financial) incentives. Partnerships

with international accreditation organisations and the role of donor agencies in supporting accreditation and its implementation were also significant factors.

> In 2012, when we started applying our hospital standards to hospitals, they were divided into three levels A, B, and C, we found out that the workload is too much and scoring system is complicated. Therefore, the scoring system was divided into three levels as well (foundation, basic and full accreditation) [...] This system has been adopted by the MOH and applied to all sectors [...] with the baseline assessment, the hospital with good performance will apply to stage 1 for accreditation preparation and implementation. Foundation level is valid for 1.5 years, the basic level is valid for 1.5, and therefore the hospital is obliged to reach the full accreditation level within three years. So, they voluntarily join the programme but they are obliged to finish it **(IP#2: Egypt)**.

> During the initial stage of the funded JHAP project, USAID brought in experts from JCI because they have been in the field since forever. JCI experts were like consultants. They worked hand in hand with the national project team to help them develop the standards specifically for Jordan **(IP#14: Jordan)**.

Promoting education and staff development created a culture of quality and safety which supported the development of national accreditation programmes. Jordan and Egypt introduced postgraduate studies and certificates in quality, patient safety, and accreditation. The Certified Professional Healthcare Quality Certificate (CPHQ) has become popular in the EMR, helping to spread knowledge about quality and accreditation.

> As HCAC, we offer four certification courses. We have an agreement with a couple of universities to award the equivalent of a diploma. One is in a quality practitioner, one executive leader in healthcare, one infection control preventionist 'certified professional', and one risk management. We are looking to add one more about patient safety **(IP#14: Jordan)**.

Additionally, the WHO and JCI provided technical support to governments, conducting various training programmes to explain the standards and survey process. The JCI also supported the development of surveyors' training programmes in Egypt and Jordan.

> We signed a contract with the JCI to train surveyors on our national standards and our survey guide, who would help us get ISQua accreditation of our surveyor's training programme. Therefore, we prepared this training programme and its curriculum and some JCI consultants train 20 TOT surveyors on PHC standards and another 20 surveyors on hospital accreditation whom would help train more surveyors afterwards **(IP#3: Egypt)**.

## 5.7 | Implementation outcomes

Jordan was the first to establish a successful hospital accreditation programme among LMICs in the EMR. The programme is sustainable, financially and operationally independent from any governmental authority. After the Arab Spring, however, political instability and the end of external funding meant that the programmes in Egypt and Lebanon lacked the resources needed to continue implementation.

Of the causes of policy failure identified by Dolowitz and Marsh,[14] 'incomplete transfer' of a crucial component of the accreditation programme (as explained in the introduction), in particular, the lack of incentives and a national

accreditation body, was an obstacle to having a fully functioning accreditation programme in the studied cases. There was no 'uninformed' transfer since information about accreditation was available and accessed, nor 'inappropriate' transfer, because governments in the three countries adjusted their accreditation programmes to fit their hospitals. All of the countries planned to continue with the implementation of their programmes, despite the difficulties they had encountered.

In Egypt, the future of accreditation programme and its expansion to hospitals are linked to a new health insurance project. The approved law act states that the contract with HCOs will be based on the performance and quality of care assessed by quality standards. This will indirectly make accreditation compulsory, if hospitals are to treat insured patients.

> Currently there is a plan, but all depends on the new health insurance law, which states that there should be three independent bodies: one is the health insurance organisation which will be the payer, and its job is to prepare the contracts and to manage the financial issues, and it will not provide any service. The second will be the governmental hospitals' organisation that includes all healthcare providers. Moreover, the last one is the independent accreditation body which will be the assessor **(IP#3: Egypt)**.

The programme in Egypt was reactivated in 2018 and the new accreditation body (GAHAR) has been established to manage all accreditation activities and inspection of HCOs and their health workforce. Hospital accreditation standards were further reviewed and updated in 2019.[28,42]

In Lebanon, the accreditation programme had been halted since the last national survey in 2011. The government reactivated the programme in 2018 and updated the national standards in 2019, complying with ISQua standards.

> We are in the final stages of developing the new standards. The pilot will occur in 2017, and the first survey with these new standards and the new system will take place in 2018 **(IP#8: Lebanon)**.

> We are in the third review of accreditation standards with the French and Haute Autorité de Santé. We are revising both the standards and procedures. Our objective is to come up with a system that is compliant with ISQua requirements **(IP#7: Lebanon)**.

In Jordan, the government aspires to make Jordan an international medical tourism destination. Therefore, the HCAC worked to extend accreditation to other healthcare settings than hospitals and PHC and developed standards for breast imaging units, medical transportation, cardiac care, diabetes mellitus, and centres of excellence model in family planning and reproductive health. According to the latest decree, as reported by the interviewees, accreditation will be mandatory for all healthcare facilities by law and both the HCAC and the High Health Council will work together to ensure the effectiveness of the law. The HCAC will provide training on accreditation standards and their implementation, and survey guide. They will also work on developing a national health information system to be able to collect national health indicators which will help provide informed decisions to improve the quality of care.

Finally, the HCAC will continue working on a regional level to promote accreditation and its activities across the EMR. The HCAC provides consultation and training to help countries establish their national accreditation programmes. In addition, it hosts a biennial international conference that brings together quality and accreditation actors from across the EMR for professional development and networking.

> HCAC has become an international organisation. It works at both the national and international level like the JCI. We are very proud of this accomplishment. We are now marketing for the HCAC in other

countries. We are conducting training programmes in Saudi Arabia, Palestine, Ramallah, Sudan, and Iraq. All facilities that are accredited by the HCAC now are national, but we are promoting for the HCAC to accredit bodies globally **(IP#13: Jordan)**.

## 6 | DISCUSSION

A key question emerging from the examination of the development of hospital accreditation programmes is to what extent are the structures and processes of national programmes drawn from international accreditation models perceived as successful and to what extent are they shaped by national policy contexts in LMICs? This study examines this question and explores the development and implementation of national accreditation programmes in the EMR, how accreditation programmes were adapted in three LMICs in the region and what was the implementation outcome in each case.

The implementation of accreditation depends on contextual factors in each country. Many countries, particularly LMICs, in the region, currently face multiple challenges in pursuing their national health plans and achieving their QI targets. The selected countries varied in their health systems, and they all experienced domestic unrest after the Arab Spring, which had a great impact on their political and economic situations, and in turn, affected the sustainability of their national accreditation programmes. The hospital accreditation programme was successful in Jordan but encountered some difficulties in implementation in Egypt and Lebanon after the Arab Spring. However, both countries worked to overcome the challenges and re-activated their programmes after they had been discontinued for some years.

International accreditation programmes were the first to be used in the EMR, mainly in the private sector. The JCI programme in particular was commonly used in the region. It has been adopted both in the private sector and by governments, who sought technical support to establish their national programmes. The active interactions and networking between WHO, ISQua, and JCI in the EMR helped support the development of accreditation, through sharing experiences, identifying common problems and developing a regional culture of quality and accreditation. This culture brought actors together and activated further communication channels that promoted the development of accreditation across the EMR countries, especially in LMICs where policymakers struggled to apply the basic concepts of quality and safety in their HCOs.

Government officials and policymakers in the three countries played a significant role in response to public pressure to improve the quality of care. They looked for remedies to poor hospital performance and introduced international accreditation standards to their hospitals. This helped improve the quality of care at hospitals, regulate the private sector, or reinforced other national policies such as Universal Health Coverage and medical tourism.[13] Governments in the EMR also linked accreditation to payment schemes (Lebanon), and health insurance funds (Egypt) to gain acceptance and enhance hospital participation.

Governments in the region supported the development of accreditation programmes that were mostly initiated and managed within MOHs. This ownership helped maintain political support for the programmes and alleviated the financial burden of establishing a new accreditation body. This is consistent with a previous study that looked at the development of accreditation in Pakistan, finding that it was difficult for the government to establish an independent accreditation body due to lack of resources.[43]

An important factor in the implementation of accreditation in the three countries was also the role played by international donors. The three countries started their projects with external funding, but only in Jordan was there sustained funding and technical support by USAID which enabled the national programme to become independent and sustainable. The programme also obtained international ISQua accreditation and expanded its scope of work to other health settings. These factors helped the HCAC to work on a regional level, providing technical support to other EMR countries, such as Sudan and Iraq as reported by the interviewees, and

encouraged the WHO to support the HCAC in promoting accreditation activities and sharing experiences across the EMR countries.

The lack of financial resources remained a major challenge. Other barriers included fragmented health systems and structure, frequent changes of ministers and consequently of national health policies, lack of incentives for hospitals to participate, poor hospital infrastructure, and most importantly, a volatile general political situation marked by conflicts and wars in the region, which created competing priorities in a number of countries, and delayed the implementation of national accreditation programmes.[44]

More specifically, the 2011 revolution in Egypt and political instability in Lebanon impeded sustained implementation of their national accreditation programmes. However, strong political will and recognition of the real benefits of accreditation were key motives behind the reactivation of the programmes in both countries. Backing from the king, and government commitment, were important to the success of the programme in Jordan, which encouraged the USAID to continue funding the project until HCAC could become independent. This supports the claim made by Shaw (2013) about the need for a strong governmental support, continuous allocation of funds to run accreditation activities, and provision of technical support to hospitals, in order to develop a successful accreditation programme.[45]

Political support is also critical to establishing a national accreditation programme and encouraging international donor agencies to provide on-going financial and technical support for the programme. Governments can raise awareness about accreditation in their countries through conducting training and seminars for hospital staff and seeking help from international actors to train national surveyors. A study evaluated the hospital QI in Yemen in 2006 concluded that, one important sustainability factor is to get external training and supervision through regular visits by external quality consultants.[46] Sharing success stories such as the Jordanian one and exchanging knowledge can facilitate cross-country learning and help understand accreditation and its prerequisites, which can reduce the time and cost required to establish a new programme. Accreditation organisations for example, HCAC could potentially take on this role in the EMR. The national stakeholders and individual donors can also play an important role in supporting their government's move towards implementing a national accreditation programme.[47] This would help maintain political and financial support of the programme and direct available national resources towards one common strategic objective of improving the quality of care. In addition, a realistic estimate of the funding required to establish the accreditation system is important. This should be a concern of both the national governments and donor agencies who need to provide financial support.

Licensure regulations are also an important foundation when developing a QI system such as accreditation. These can help avoid problems associated with the maintenance of infrastructure later. However, the overlap between the requirements of accreditation, and the licencing or contractual requirements, was perceived as another financial burden. In LMICs with limited resources and poor hospital infrastructure, the main focus is to ensure better and equal access to healthcare services by establishing basic health facilities with adequate staffing and equipment.[48]

International actors, particularly donor agencies, should consider providing ongoing support to countries with poor-resource settings to develop and sustain accreditation. This might be achieved by creating transnational networks and pooling resources and expertise, along with regular interactions to sustain accreditation systems, not only in countries with limited resources but also in those witnessing crises and conflicts. Governments can still work with international organisations to revive programmes that have been halted for any reason. Research also needs to focus not only on the introduction of accreditation programmes and their implementation processes but also on how to sustain them.[13]

Governments in poor-resource settings should perhaps also consider alternative accreditation models, such as incremental multi-level accreditation programmes, to encourage hospitals to comply with accreditation standards. In such programmes, hospitals can gradually proceed to full accreditation based on their infrastructure and the availability of funds.[13] For example, the governments in Jordan and Egypt adopted a multi-level accreditation

approach to encourage their hospitals to join the programme level that suits their internal conditions, with a hope to gradually improve their performance and achieve higher accreditation levels, until reaching full accreditation. With such a QI approach, accreditation standards facilitate ongoing identification of opportunities for improvement.

In short, hospital accreditation should be considered an ongoing development process rather than a one-off policy implementation. Some countries might encounter difficulties during the process of implementation, but this does not necessarily mean that the policy has failed. This is in accordance with ISQua's recommendations that, the real benefit of accreditation will be achieved when it is fully identified as an ongoing QI tool, capacity building instrument, and complementary to licencing processes.[49]

## 7 | STRENGTHS AND LIMITATIONS OF THE STUDY

The main domains in the Dolowitz and Marsh policy transfer framework helped explore the process of cross-national accreditation policy transfer to the EMR. Covering a variety of dimensions generated a detailed picture the implementation of hospital accreditation in each case study and facilitated comparisons between countries.

The study has some limitations that should be considered. The interviews were a retrospective examination of events taking place over a number of years, which may have introduced recall bias. Also, some participants had already changed their workplace since the time of the introduction of accreditation. This shift from one organisation to another might have changed the way they interpreted the events that led to the development of accreditation. However, data triangulation was used to validate the data and ensure the consistency of the results in the study.

## 8 | FUTURE RESEARCH

Further research on accreditation in poor-resource settings is needed to be able to generalise the findings, by comparing them across additional accreditation models and LMICs, perhaps in other regions with different contexts than the EMR. Since the lack of financial resources is the main constraint to the establishment of accreditation in LMICs, there is also a need to calculate the economic value and return on investment of accreditation programmes in countries with limited resources, to find out whether accreditation is a suitable approach for QI in these countries. Finally, future studies of accreditation might also examine how international actors can help sustain accreditation in LMICs, as well as initiating it.

## 9 | CONCLUSIONS

Political and economic factors can greatly influence the development of accreditation programmes and their outcomes, particularly in poor-resource settings. This study has highlighted relevant policy questions and identified lessons for LMICs looking to pursue their national accreditation programmes. Accreditation programmes should be regarded as on-going processes that need continuing and careful attention from funders and political systems if they are to survive and thrive.

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## CONFLICT OF INTEREST

No conflict of interest is declared for all authors.

## ETHICAL STATEMENT

Ethical approval for this study was obtained from the Ethics Committee at the University of Manchester, as part of the PhD study of the first author.

## DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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## APPENDIX

**T A B L E   A1**   The history of the development of accreditation programmes

| Egypt[25,27,28,35,47] | Jordan[30–32,36,48] | Lebanon[17,33,34,37,49] |
| --- | --- | --- |
| – In 1997, the Ministry of health and population (MOHP) launched an initiative to develop a national quality improvement programme, starting by primary health care (PHC)<br>– From 1998–2003, development of:<br>  • General Directorate for quality: The quality Improvement (QI) directorate<br>  • PHC accreditation programme policies and procedures Manual in cooperation with the USAID<br>  • PHC accreditation standards in cooperation with USAID<br>  • scoring system software<br>  • PHC survey and surveyor guide<br>  • PHC clinical guidelines<br>  • Training of surveyors & facilitators<br>  • accreditation of 30 PHC units<br>– Egyptian accreditation Board was launched in 2003<br>– A ministry decree was issued for supreme accreditation committee and Executive accreditation committee headed by QI directorate<br>– Accreditation programme was expanded to include hospitals in 2004<br>– ISQua accredited the Egyptian accreditation standards in July 2007<br>– The accreditation programme stopped after the 2011 revolution, but in 2017, ISQua reaccredited the hospital accreditation standards, and in 2018, the government reactivated the programme with the introduction of the universal health insurance system and the establishment of an independent accreditation body (GAHAR) in 2018.<br>– 2019: GAHAR issued a new updated version of hospital accreditation standards. | – Phase I in 2007, the healthcare accreditation council (HCAC) was established as a non-profit institution with the aim to raise the quality of health services, supported by USAID.<br>– Phase II (Jun 2007–Jan 2011): Jordan healthcare accreditation project (JHAP) was launched and conducted the first accreditation survey.<br>HCAC integrated family planning and Reproductive health standards into the HCAC PHC standards in 2010 and titled the revised set of standards 'HCAC PHC and family planning centres accreditation standards'.<br>Phase III (Jan 2011–Mar 2013): Developed new standards, surveyor training, and the HCAC was accredited by ISQua.<br>ISQua accredited hospital accreditation standards (2nd edition) for four years in February 2012.<br>ISQua accredits HCAC's surveyor training programme. It is the only approved surveyor training programme in the region.<br>ISQua accredits HCAC's surveyor training programme. It is the only approved surveyor training programme in the region.<br>In November 2013: HCAC conducted the re-accreditation survey for healthcare organisations<br>In Jun 2014: HCAC was re-accredited as an organisation for a four-year period.<br>In 2014: HCAC was pre-qualified by the European bank for reconstruction and development (EBRD) to provide advisory services in the area of quality Management under the EBRD business Advisory services programme.<br>HCAC developed social care standards specialised for people with disabilities and shelters. The standards were finalised by the end of 2016. | • In 2000, the Ministry of public health (MOPH) took the initiative to introduce a national hospital accreditation scheme as a systematic means for ensuring the quality of care, supported by an Australian consultant team named overseas project corporation of Victoria (OPCV).<br>• The MOPH implemented accreditation as follows:<br>  – Developing and pilot-testing standards and procedures (2000–2001)<br>  – First national survey spanned 128 hospitals in (2001–2002)<br>  – Standards revision (2002–2003)<br>  – Second national survey (2004–2005) accreditation standards and scoring mechanisms were reviewed and slightly amended. Among the 142 surveyed hospitals, only 85 met the requirements<br>The third cycle of national hospital accreditation was initiated in 2011<br>• The programme stopped for a few years, but it restarted its activities in 2018<br>• 2019: The MOPH reviewed and updated the national accreditation standards to be evidence-based, reflect the international best practices and to comply with ISQua requirements. The first accreditation visits started for voluntary hospitals in September 2019, and in a later stage, the visits will be mandatory for all hospitals |