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Development and Implementation of the National Quality Policy and Strategy: Experience from Rwanda and Zambia

Local Health System Sustainability Project

Task Order 1, USAID Integrated Health Systems IDIQ

September 2022

Local Health System Sustainability Project

The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support universal health coverage. The project works with partner countries and local stakeholders to reduce financial barriers to care and treatment, ensure equitable access to essential health services for all people, and improve the quality of health services. Led by Abt Associates, the five-year, $209 million project will build local capacity to sustain strong health system performance, supporting countries on their journey to self-reliance and prosperity.

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Acronyms

HMIS	Health Management Information System
HSSP IV	(Republic of Rwanda's) Fourth Health Sector Strategic Plan
LHSS	Local Health System Sustainability Project
MOH	Ministry of Health
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organization
NQPS	National Quality Policies and Strategy
TWG	Technical Working Group
UHC	Universal Health Coverage
USAID	U.S. Agency for International Development
WHO	World Health Organization
ZNHSP	Zambia National Health Strategic Plan

Executive Summary

Background: USAID's Local Health System Sustainability Project (LHSS) supports low- and middle-income countries transition to sustainable, self-financed health systems as a means to support universal health coverage. Over the past two years, LHSS has been conducting activities to identify and disseminate governance reform lessons from operationalizing National Quality Policies and Strategy (NQPS). NPQS could be a document, or series of documents, which is used to outline quality priorities and guide a country's strategic direction and investment for quality improvement. LHSS conducted a 37-country stocktaking exercise in 2020 to assess progress implementing NQPS and other governance structures to support improved quality of care[4]. That study used an analytical lens framework developed in collaboration with WHO and derived from existing frameworks. The analytical lens is made up of the following 10 elements: National health priorities; Local definition of quality; Governance and organizational structure; Financing for quality; Stakeholder mapping and engagement; Situational analysis; Continuous quality improvement; Improvement methods and interventions; Quality indicators and core measures; and Health management information system (HMIS) and data systems. The country case studies captured in this report were conducted as a follow-on to that previous LHSS study and the analysis is based on the analytical lens framework. Two countries - Rwanda and Zambia - were selected based on criteria LHSS established to identify positive deviances from the 37-country data. The selection criteria are discussed under Section 2.

Case study objectives:

- To qualitatively understand why Rwanda and Zambia had greater success in governing the quality of care
- To document learnings around conditions and factors related to successes and challenges in effective NQPS development and implementation

Design: Qualitative research using semi-structured key informant interviews.

Summary of key findings and learnings: Both countries offer unique insights into the operationalization of NQPS within broader governance and quality of care reforms. The following cross-cutting learnings emerge from the findings:

- Fostering shared vision and goals for quality improvement is a key enabling factor.
- A government-led stakeholder engagement process for NQPS development facilitates sustained participation and ownership from multisectoral stakeholders.
- It is imperative to strengthen decentralized governance structures to be able to leverage them to standardize quality improvement and quality assurance across all levels of the health system.
- Data plays a central role in embedding learning and feedback loops within a system for quality governance, and thus development of data systems and data culture should be prioritized.
- There is a need for increasing investment in health workforce to create and empower adequately equipped champions for quality improvement at all levels.
- Financing for quality is a major challenge, particularly in low-resource settings where there are multiple competing priorities for the limited funds available. Part of addressing this

[4] Stanzler, Morgen, Brooks, Kathryn, Sampath, Bhargavi, Sodzi-Tettey, Sodzi[4], Haile, Mignote[4]. The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ. September 2022. *Strengthening Governance of Quality Health Service Delivery—Diagnostic Analysis of 37 USAID Priority Countries*. Rockville, MD: Abt Associates.

challenge should be integrating national quality priorities into domestic resource mobilization and budget allocation decisions, and directing funds to key functions of the health system that will ultimately impact quality of care.

Background

With increasing momentum toward achieving Universal Health Coverage (UHC), there has been global recognition that access to essential health services should be complemented with investment in ensuring the quality of those services in order to achieve desired health outcomes.[5] A key aspect of quality improvement efforts is establishing governance structures to effectively direct health system resources, performance, and stakeholder participation toward the goal of delivering care that is effective, efficient, people-centered, equitable, timely, integrated, and safe.[6] National quality policy and strategy (NPQS) provide an overarching framework to plan and articulate guidance for improved quality of care at all levels of a health system. NQPS can be used to define and promote priorities for quality, outline a cohesive roadmap and actions for improvement, set roles and responsibilities, and highlight linkages with other relevant policies and strategies. Thus, countries have been focusing on developing NPQS document(s) to catalyze and mobilize national efforts to improve quality in their context as part of their quality governance. This creates an opportunity to learn from emerging country experiences in NQPS design and operationalization, which can in turn inform global guidance and technical assistance around strengthening governance structures.

The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support access to universal health coverage. A previous study by the project conducted an analysis of governance structures to support quality of care improvement activities in 37 countries.[7] The analysis drew from a literature review and online survey to provide stocktaking data on countries' progress and challenges across the NQPS trajectory, from inception to institutionalization. It also offered insight into in-country stakeholders' perceptions around the process of operationalizing NQPS. These case studies build on that previous study by conducting a deeper dive into the NQPS journey of 2 of the 37 countries to identify and share learnings around the enablers and barriers for successful NQPS design and implementation.

The results of LHSS's previous 37-country analysis were organized around 10 governance of quality elements (see Figure 1 below). LHSS derived these elements by doing a comparative analysis of existing frameworks and adapting World Health Organization's (WHO's) NQPS framework.[8] The 10 elements, which are grouped around quality planning, quality improvement, and quality assurance, outline and define key parts that make up the complex architecture of quality governance and serve to understand country experience and progress with NPQS in a structured manner. As a follow on, this case study report maintains the 10 analytical lens elements to synthesize and present findings in sections below.

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5. World Health Organization, Organization for Economic Co-operation and Development & International Bank for Reconstruction and Development. 2018. Delivering quality health services: a global imperative for UHC. https://apps.who.int/iris/handle/10665/272465. License: CC BY-NC-SA 3.0 IGO.
6. Cico A., Laird K., and Tarantino L. September 2018. Defining institutional arrangements when linking financing to quality in health care: a practical guide. Bethesda, MD: Health Finance & Governance Project, Abt Associates.
7. The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ. 2022. Strengthening Governance of Quality Health Service Delivery—Diagnostic Analysis of 37 USAID Priority Countries. Rockville, MD: Abt Associates.
8. The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ. 2020. Strengthening Governance of Quality Health Service Delivery – a Lens to Analyze Progress. Rockville, MD: Abt Associates.

Case Study Country Selection

LHSS reviewed the collected primary and secondary data from the 37 countries that were included in the predecessor study. These data were reviewed against set criteria to identify countries that demonstrated positive deviance. Criteria for case study selection follow:

- Existence of an implementation plan for their national strategy
- Demonstration of broad stakeholder engagement in creating their health strategy
- Demonstration of linking quality to financing in some way
- Reported use of a reliable and high-quality data system
- Reported integration of community perspectives in the definition and delivery of quality health care
- Reported strong leadership to create a blame-free culture that promotes continuous quality improvement

Five countries aligned with the criteria in the list above. In consultation with USAID and considering Mission priorities, logistics, and strength of survey data, LHSS selected Rwanda and Zambia as case study countries.

Methods

Case Study Objectives

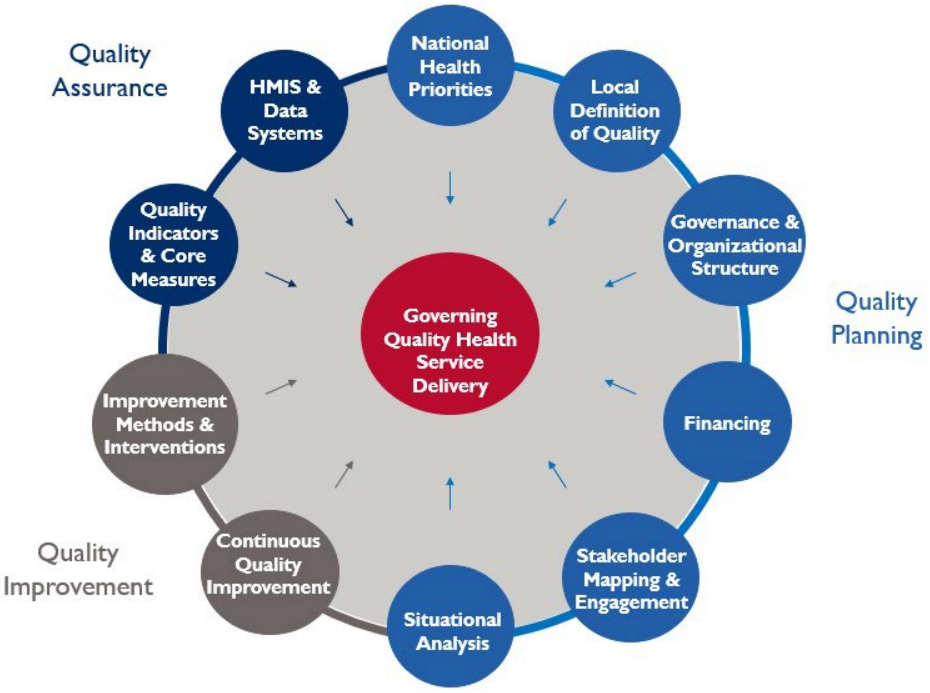
The goal of the country case studies was to better understand the existing structures in Rwanda and Zambia and capture learnings on what contributed to the observed positive deviance in governance of care. The primary objectives of this study were:

- To qualitatively understand why Rwanda and Zambia had greater success in governing the quality of care
- To document learnings around conditions and factors related to successes and challenges in effective NQPS development and implementation

Case Study Design

The case studies were qualitative and used in-depth interviews with quality experts at the national level. For each case study country, LHSS developed a tailored, semi-structured interview guide that focused on analytical lens elements that were continuously referenced in the predecessor study as either high impact, high importance, or both. The interview guide also covered elements that were cited to have persistent gaps or challenges. Consequently, while the questions explored all 10 elements listed as part of the governance of quality analytical lens in Figure 1, more focus was placed on stakeholder mapping and engagement, financing for quality, governance and organizational structure, health management information system (HMIS) and data systems, and continuous quality improvement. The interview guides can be found in the Annexes.

Figure 1: Governance of Quality Analytical Lens



Case Study Sampling

The target population for the case studies were policymakers, planners, and other technical experts at the national level who have experience in the design, implementation, or monitoring of NQPS and other quality governance efforts. LHSS used purposive sampling to identify respondents. A local researcher in each country, leveraging their subject matter expertise and professional networks, conducted outreach to potential respondents for 60-minute key informant interviews. Details on the types of participants interviewed in each country are presented in Table 1.

Table 1: Case Study Respondents

Type of Respondent	Rwanda (number of respondents)	Zambia (number of respondents)
Ministry of Health	3	1
Care providers	1	-
Professional associations	1	2
Development partners	3	1
Other stakeholders[9]	2	2
Total	10	6

[9] Requested to remain anonymous

Case Study Data Collection

In each country, LHSS sent recruitment emails to potential respondents to schedule and confirm interviews. The local researcher obtained verbal informed consent prior to each interview. Interviews were recorded and transcribed using Otter software.

All interviews were conducted in English. In Rwanda, the local interviewer sometimes used Kinyarwanda or French words for clarification, and these were translated into English in the final transcripts. Most interviews were conducted remotely due to the COVID-19 pandemic. All data were anonymized and underwent quality assurance spot checks prior to analysis.

Case Study Data Analysis

LHSS developed a codebook prior to data collection based on the 10 elements in the governance of quality analytical lens shown in Figure 1 (i.e., national health priorities, local definition of quality, governance and organizational structure, financing for quality, stakeholder mapping and engagement, situational analysis, continuous quality improvement, improvement methods and interventions, quality indicators and core measures, and HMIS and data systems). This codebook was further adapted and tailored for each country as data were coded and country-specific themes emerged.

All coded transcripts were analyzed using conventional thematic content analysis. The team held weekly data meetings to review key themes, iteratively adjust the interview questions and codes, and organize the results around the 10 governance of quality analytical lens elements.

The next section presents the context for each country, along with the salient findings across the 10 elements. The definition used for each element of the governance of quality analytical lens in this case study report can be found in table 2 below.

Table 2: Governance of quality analytical lens definition

Governance of quality analytical lenses	Definition
National Health Priorities	National health priorities are defined as the alignment of a quality policy or strategy with broader national health planning, including outlined national goals and priorities for the quality of care.
Local Definition of Quality	A local definition of quality is defined as a shared understanding of what “quality care” would mean and look like in a specific context. This definition should factor in available resources—human resources; levels of autonomy; and priority health services, diseases, and related standards.
Governance and Organizational Structure	Governance and organizational structure are defined as having mechanisms and institutions for accountability, lines of authority, and outlined responsibilities from the national to the community level to reinforce quality mandates across the health care sector.
Financing for Quality	Financing for quality is defined as costing the plan, design, implementation, and evaluation of the NQPS and ensuring there is reliable financing to pursue established goals for quality. Financing for quality also relates to the relationship between purchasing mechanisms and the quality of care delivered, including in relation to incentives, fraud, waste, and abuse.

Governance of quality analytical lenses	Definition
Stakeholder Mapping and Engagement	Stakeholder mapping and engagement are defined as purposeful and meaningful involvement of different types of stakeholders, such as national policymakers and managers, regional supervisors, facility providers, community members, community organizations, users, health workers, and other relevant stakeholders, in the prioritization, design, implementation, and evaluation of the NQPS. It also includes provisions to engage patients and communities in governance of quality to foster shared understanding, mutual ambition, and commitment toward goals for quality.
Situational Analysis	Situational analysis is defined as the process to build an understanding of the state of quality, identify strengths in the health care system, examine persistent challenges, and determine priorities to inform the development of the NQPS. It also includes consideration of contextual factors, barriers, and facilitators of success in thoughtfully designing, implementing, and evaluating the strategic direction of quality.
Continuous Quality Improvement	Continuous quality improvement is defined as a culture of learning, fostered by leaders, which produces an enabling environment for improvement leading to new levels of performance. This includes the use of data to guide improvement, iterative development and testing of solutions, and local contextualization. In such a climate, front line staff have the psychological safety and agency to self-report incidents of harm and error while remaining open to feedback on opportunities to improve the quality-of-care delivery.
Improvement Methods and Interventions	Improvement methods and interventions are defined as having change-oriented interventions across four broad areas: system environment; reducing harm; improving clinical care; and engaging and empowering patients, families, and communities.[10]
Quality Indicators and Core Measures	Quality indicators and core measures are defined as a coherent set of key indicators, adapted to the local context, which allows providers and policymakers to assess progress toward quality across all levels of the health care system. The indicators and corresponding measures should support a data-driven approach to policy development, decision-making, and improvement.
HMIS (Health Management Information System) and Data Systems	HMIS and data systems are defined as the development of a data collection system designed to support planning and implementation of an NQPS. This should include addressing

10. World Health Organization, Organization for Economic Co-operation and Development, International Bank for Reconstruction and Development. 2018. Delivering quality health services: a global imperative for universal health coverage. World Health Organization. https://apps.who.int/iris/handle/10665/272465. License: CC BY-NC-SA 3.0 IGO.

Governance of quality analytical lenses	Definition
	deficiencies in the HMIS and promoting pragmatic use of data to improve quality at the point of care.

Findings

Rwanda

Rwanda, an East African country of 13 million people, has had significant progress in expanding access to health services over the past few decades. This is demonstrated by the increase in healthcare coverage from 7 percent in 2003 to over 90 percent in 2015.[11] Rwanda has seen significant reductions in HIV prevalence, infectious diseases, and maternal and child mortality, among others. Rwanda operates a decentralized healthcare system made up of three levels: central, intermediary, and peripheral. The central level is represented by the system's governing entity, the Ministry of Health (MOH), Rwanda Biomedical Center, and five national referral hospitals. The intermediary level consists of provincial and district hospitals, recently upgraded to referral status to decrease the pressure of demand for services at the national referral hospitals. There are also private practices that operate alongside these institutions but are separate from the decentralized system. The peripheral level is represented by a district health unit, a district hospital, and a network of health centers and health posts at the lower administrative levels. At the village level, community health workers are integrated within their respective health centers and health posts. All levels are assigned their respective minimum package of services by the MOH, which serves as the overarching entity for policy-making, monitoring, capacity building, and resource mobilization.

Most Rwandans access care at the peripheral level, (i.e., health centers and health posts) leading to long wait times in care provision that is further compounded by shortages of health workforce, essential drugs, and supplies. As a response, Rwanda has expanded its strategic goals in recent years to move beyond coverage and invest in improving quality and equity of provided services. One key governing document articulating this priority is Rwanda's Fourth Health Sector Strategic Plan (HSSP IV). It is foundational for current health services in Rwanda. It prioritizes equitable and affordable quality health services as recommended by its global, regional, and national level development commitments, such as the Sustainable Development Goals 2030 and Rwanda Vision 2050[12]. The HSSP IV outlines the national strategic directions to improve the health standards of Rwandans for six years, from 2018 to 2024. The HSSP IV document was developed through the collaborative efforts of key health sector stakeholders, development partners, the private sector, and civil society organizations.

The Health Services Quality Assurance Unit, operating under the MOH, develops policies and strategies for quality improvement, implements and evaluates quality assurance and accreditation programs for the health care system. Rwanda launched a performance-based financing system in 2001 to link financing to quality of care and incentivize health workforce productivity. The system utilizes a web-based database to collect output indicators, and

11. Harvard International Review. 2022. Growth from Genocide: The Story of Rwanda's Healthcare System. https://hir.harvard.edu/growth-from-genocide-the-story-of-rwandas-healthcare-system/.
12. Ministry of Health Rwanda. 2019. Health Sector Strategic Plan 2018-2024. https://www.moh.gov.rw/fileadmin/user_upload/Moh/Publications/Strategic_Plan/FOURTH_HEALTH_SECTOR_STRATEGIC_PLAN_2018 2024.pdf.

quarterly data from quality evaluations to ensure that data and service quality are maintained. Rwanda also has a national 3-level accreditation program that set care standards. The performance-based financing and the national accreditation systems are complementary strategies implemented at each level of the healthcare system in accordance with the one of the HSSP IV goals to improve the quality of care in health facilities.

National Health Priorities

In interviews, respondents highlighted the key role Rwanda's cohesive and comprehensive national health priorities played by setting a clear vision for the country and informing resource allocation for Rwanda's HSSP IV. As one interviewee described, the national health priorities were set early and provided direction in identifying key performance indicators, designing national and subnational interventions, and allocating corresponding budgets. The HSSP IV development process closely engaged key multisectoral actors from design to the final document validation. Respondents highlighted the importance of having such strong stakeholder engagement in identifying and agreeing on national health priorities.

> "Because in quality improvement, you need to share information, you need to give [stakeholders] the voice … what works really well is to have a common understanding in terms of key priorities and key indicators."

Local Definition of Quality

While a local definition of quality is not explicitly included in Rwanda's HSSP IV, the idea did surface during interviews in relation to other elements. One respondent emphasized how having a common understanding of quality was critical to engaging stakeholders at all levels of the health care system—from international development partners to patients and community members. This was echoed by other respondents who discussed the role of subnational and local actors across Rwanda's tiered system in defining and monitoring quality according to established standards. In the decentralized context of Rwanda, this highlights the importance of contextualizing quality beyond the national level to be responsive to local priorities and challenges.

Governance and Organizational Structure

Respondents exhibited a shared understanding of Rwanda's governance and organizational design and structure in relation to quality of care. Rwanda's HSSP IV was designed to align with existing national policies and guidelines such as Vision 2020, Vision 2035, and Vision 2050. This enabled the MOH to build on the existing systems to identify technical and human resources and establish reporting and accountability practices at central, intermediary, and peripheral levels. In addition to MOH's Health Services Quality Assurance Unit that is responsible for quality improvement and quality assurance oversight, respondents noted that every facility has quality improvement officers or designated staff in charge of quality improvement. However, available training on quality improvement and assurance was reported to be inconsistent across facilities.

> "We trained almost 116 staff based on quality improvement, customer care, leadership, and development, after reviewing data that indicated a lack of trained staff to oversee quality in facilities. Staff were also trained to embed quality into the system and ensure that quality survives turnover. Quality units were embedded in each hospital to link health facilities, and there are quality improvement committees set up to oversee work on a quarterly basis."

While the HSSP IV outlined broad objectives and roles and responsibilities that are relevant for quality governance, responses were mixed on the accessibility and useability of the strategy. After the strategy was completed, it was shared with key stakeholders through a formal dissemination meeting. It was also posted to the MOH website for ease of reference. However, some respondents shared that these approaches were not adequate to cascade the strategic plan throughout the health system. Respondents at service delivery levels indicated a need to translate the strategic plan into a digestible format to summarize its key points and highlight relevant mandates for service delivery personnel. Respondents also suggested translation of the strategic plan and its future iterations into Kinyarwanda to facilitate increased dissemination and implementation.

Financing for Quality

Rwanda uses a mix of internal and donor funds to secure financial resources for the design, implementation, and evaluation of the HSSP IV and its related activities. This fund also supports quality planning by using quarterly data to assess needs across facilities. This is part of a broader effort to effectively direct required resources and prevent waste. Almost all respondents noted that a key success milestone for Rwanda has been the development of a costed plan for quality improvement activities. This has facilitated implementation by enabling health planners and managers to understand available internal resources, advocate for resources for priority goals, determine gaps, and coordinate with external partners on bridging gaps. This is further supported by a designated position within the MOH, the permanent secretary, which is tasked with coordinating with development partners to align their efforts with government priorities and mobilize resources to bridge gaps in financing.

Another key initiative on financing for quality is Rwanda's nationwide performance-based financing program. The program includes different models of performance-based financing (PBF) at the health center, district hospital, central MOH, and community levels. The PBF system is designed around verifying quality of provided services prior to incentive payments to facilities and providers. The verification process varies by the designated purchaser at each health system level and could include review of facility scorecards, monthly site visits, patient satisfaction surveys and reports, etc. While interviewed respondents did not have a close experience with the performance-based financing program, they highlighted that the MOH has created an intentional link between its performance-based financing program and accreditation requirements to further promote and institutionalize quality of care.

> "[service provision] numbers are not necessarily linked to quality services. [Providers] are pushed by the number but not necessarily the quality….so, combining the two aspects [performance-based financing program and accreditation] is very impactful for the [health] system. And we are seeing a lot of improvements [in service delivery outcomes]."

> "As long as it depends mostly on or there is a big part of external funds, which are not under our control, it makes it more difficult to sustainability respond to the current mandates for quality improvement in the health strategic plan."

Finally, respondents pointed out while donor funds are helping the country make progress toward current objectives, there is a need for long-term planning to achieve self-reliance and the ability to reliably continue to fund the activities described above. The country's success with community-based health insurance offers a potential avenue to further build and expand on sustainable health financing mechanisms.

Stakeholder Mapping and Engagement

All respondents emphasized that a wide range of stakeholders were involved in the design, implementation, and evaluation of the strategic plan. To ensure that engagement was systematic and meaningful, MOH led a comprehensive process of mapping out multisectoral stakeholders prior to the design phase. As part of this, leadership teams at all levels of the health system were consulted for inputs. Illustrative stakeholder groups included providers, facility administrators, non-governmental organizations (NGOs), private sector facilities, patient advocates, community health workers, elected officials, and global organizations. Patients and community members were specifically engaged in evaluation and feedback phases through a patient voice program at health centers. This program aims to continuously capture patient feedback to facilitate inclusive dialogue and accountability. MOH's ownership and leadership of the entire process was viewed as a distinguishing feature and enhanced the collective buy-in around the HSSP IV. Regular stakeholder consultation meetings are ongoing for budgeting, planning, and reporting. Technical working groups (TWGs) at the national and subnational level support quality oversight. This ongoing participation from stakeholders allows continued learning, adapting, and improvement.

> "The MOH itself [was] sending invitations for meetings, setting deadlines for feedback ... and leading technical working groups. [This] helped people to own the document."

Situational Analysis

Similar to the previous element, stakeholder mapping and engagement, Rwanda's situational analysis was also a ministry-led process. The MOH hired and managed consultants who gathered primary and secondary data through literature review, facility tours, stakeholder interviews, facility data review, and global databases such as Demographic and Health Surveys. As part of this analysis, a baseline assessment for quality improvement was also conducted in 26 facilities using the Strengths-Weakness-Opportunities-and-Threats analysis tool, among others. The situational analysis process was conducted in partnership with international partners such as WHO that provided technical and financial support.

Respondents shared that similar situational analyses were conducted for previous iterations of the HSSP IV. A key finding from these past analyses, which has since been addressed, is dedicated budget for quality improvement processes. As discussed under the financing for quality element, Rwanda now has a costed plan for quality along with funding streams for quality improvement and planning. This showcases the data-driven adaptive and learning health system Rwanda is fostering through its NQPS process.

Continuous Quality Improvement

While varying aspects of Rwanda's NQPS journey reflect efforts to facilitate learning and improvement, responses were mixed regarding a punitive culture that exists in the health system. Some shared that providers reported for misbehavior and/or malpractice were often subjected to punishments, which in turn has created a pervasive fear of retaliation that stifles opportunities for growth and improvement.

> "After many years of implementation, when people see that there is no sanction, they are more open, and they know it's something that is only being done to support desired improvements in the system."

However, others noted recent shifts toward a blame-free culture in health care that (1) puts greater emphasis on checks and balances for accountability and learning by leveraging committees at the facility level to review the circumstances that contributed to an adverse event and identify areas for improvement and learning, (2) changes quality improvement narratives from "you" to "we" as a way of framing initiatives as shared goals, and (3) supports policies that protect individuals from retaliation when reporting concerns.

Rwanda also has a mechanism that periodically brings facilities together to discuss best practices, share challenges, and exchange lessons learned. As part of this, a new system called *twinning* is being rolled out. This program will "twin" a high performing hospital with one that is performing poorly from the same district to facilitate peer learning and support. The "twinned" hospitals will be selected to have similar infrastructure and resources, allowing for similar contexts and capacities in continuous quality improvement efforts.

Improvement Methods and Interventions

Rwanda's current quality improvement interventions vary by heath service area and are implemented at both the national and facility levels. While interviewees did not describe specific improvement methods that are supporting current health programming, they did stress the broader value of using data in identifying gaps and designing responsive interventions.

One respondent particularly reflected on a change-oriented intervention that came about from one facility's review of its performance data. The review found that newborns were dying at a higher-than-average rate in this particular facility. Further examination indicated the limited number of nurses specifically trained to take care of newborns may be a contributing factor. The respondent described that this led to a wider initiative to train and deploy nurses from other units to support the neonatology team, resulting in reported improvement on newborn care.

This emphasis on data use and data culture is also reflected under the other elements of the governance of quality analytical lens for Rwanda, indicating a truly shared value and strategy in improving quality and overall health outcomes.

Quality Indicators and Core Measures

Respondents indicated that the strategic plan has been used to develop clear and measurable performance indicators at all levels of the health system. Identified technical experts, in consultation with stakeholders at national, district, and facility levels, are expected to periodically review these indicators against national and global benchmarks to inform ongoing priorities and programming. Patient satisfaction assessments are also conducted periodically at health centers as part of the performance-based financing program. These assessments use a structured template and primarily aim to gather information on perceived quality of maternal and child health services.

HMIS and Data Systems

Respondents shared that there is a national-level push to invest in and strengthen the health information system to ensure a data infrastructure capable of routinely collecting data that is precise and accurate, as well as using data to track progress, identify gaps, and inform decision-making.

Currently, each facility has designated personnel tasked with ensuring collected data is accurate and entered properly into the system. Facility-based quality teams reportedly use this routine

data to inform accountability measures and quality impartment practices. These teams have regular touchpoints: local teams meet weekly, regions meet monthly, and provinces meet quarterly.

Rwanda is continuing to invest in integrated data systems, with a dedicated unit within the MOH in charge of digitizing health care. As part of this objective, Rwanda has implemented either Open Clinic or OpenMRS in all facilities for electronic medical records. Community health workers are also equipped with tablets so they can easily collect and submit health information from community-based services to complement facility data.

> "Data will help us benchmark and determine where we went right or wrong. Then we need to act."

Most respondents also underscored that collecting data is only step one, and that there is a need to use that data to drive feedback loops and improved actions.

Zambia

Zambia has been undertaking several reforms to address inequalities and ensure access to and availability of quality health services for its population of over 18 million. The country's tiered health structure encompasses health posts, health centers, and district hospitals at the first level; provincial and general hospitals at the second level; and central and teaching hospitals and the tertiary level. The management of health services is distributed across the 10 administrative provinces through provincial health offices, and 105 districts through district health offices.[13] The health service delivery system complements the political administrative structure, whereby provincial health offices connect the national level to the district level (district health offices) and are responsible for the provision of hospital referral services. The district level is tasked with implementing health promotion, and offering preventive, curative, and rehabilitative services. Following the district level, health centers provide both health promotion and disease prevention services, including limited curative services, while complex cases are escalated to district level hospitals. Each health center offers services related to maternal, newborn and child health, communicable and non-communicable diseases (NCDs), water, sanitation, and hygiene services, school health and nutrition, and epidemic preparedness.

Zambia's public health challenges are characterized by high prevalence of preventable communicable diseases such as malaria, HIV, diarrheal diseases, and tuberculosis. There is also a growing burden of NCDs including cancers, hypertension, and cardiovascular diseases. A Strengths-Weakness-Opportunities-and-Threats analysis conducted by the MOH surfaced challenges such as inadequate coordination of referral systems, weak feedback mechanisms at all levels of service delivery facilities, centralized quality assurance structures with weak coordination at lower levels, shortage of health workforce trained in quality improvements concepts and models, and weak linkages between health management information systems and quality improvement initiatives.[14] Zambia's Performance Improvement and Quality Assurance Strategy 2019–2021 attempts to outline strategies to tackle these quality-of-care issues as part of the broader National Health Strategic Plan 2017–2021. As part of these efforts, there is a growing focus on strengthening the decentralized structure at the district level, particularly regarding decision-making capacities, to enhance service quality and standards. In 2018, the

13. Ministry of Health Zambia. 2018. Zambia National Health Strategic Plan 2017 -2021. https://www.moh.gov.zm/?wpfb_dl=83.
14. Ministry of Health Zambia. 2019. Performance Improvement and quality assurance strategy 2019 – 2021. https://www.moh.gov.zm/wp-content/uploads/filebase/strategies/Performance-Improvement-and-Quality-Assurance-Strategy-2019-2021.pdf.

MOH established the Performance Improvement and Quality Assurance Directorate. The Directorate is responsible for leading the coordination of performance improvement and quality assurance at the national level in collaboration with other public entities including the Health Profession Council of Zambia, which is responsible for the accreditation of health facilities. At each level of health service delivery, a TWG facilitates the coordination of performance improvement and quality assurance interventions by providing technical oversight and recommendations through a multi-sectoral approach.

While this case study primarily focuses on the design and implementation of the Zambia National Health Strategic Plan 2017–2021 (ZNHSP) as the broader document central to defining priorities, clarifying structure, outlining roles and responsibilities, engaging multisector stakeholders, and securing financing, it recognizes Zambia's Performance Improvement and Quality Assurance Strategy 2019–2021 as a key complementary and co-dependent document.

National Health Priorities

The ZNHSP was informed by international and national-level priorities to provide a framework for the health system's strategic goals and objectives. Respondents highlighted concentrated efforts by the government to align the plan with Sustainable Development Goals as well as the 7th National Development Plan, Vision 2030, and the National Health Policy.[8] This was complemented by consultations with representatives from NGOs, civil society organizations, and patient groups on identified priorities. The Performance Improvement and Quality Assurance Strategy 2019–2021 leveraged this process and builds off the priorities set in the ZNHSP.

> "…one of the key gaps is that there [is] very little research to improve our decision-making. Most of the references are from research done outside [of] the country, maybe [research completed] in the region, but I think even in the region, we don't have as much up-to-date data."

Respondents shared that, while Zambia has improved its research capacity in recent years, the country faced key challenges in conducting rigorous and comprehensive assessments during the national priority setting to aid the health strategic plan development process.

Local Definition of Quality

In Zambia, during the conceptualization of the ZNHSP, the government aligned its local definition of quality to the international standards by incorporating dimensions of quality, such as effectiveness, timeliness, safety, equity, efficiency, and patient-centeredness of services per WHO's definition.[15] This is further distilled to local contexts through disease-specific standard guidelines. These guidelines are tailored to each level of the health system to ensure they align with the available number and type of health workforce, as well as available equipment and supplies.

> "I don't think we can have an outright definition of what quality is that is entirely Zambian. So, you have a [definition] adapted to the country level or sub-country, but it has to put into consideration the existing international or regional standards requirements."

10. World Health Organization. n.d. Quality of Care. https://www.who.int/health-topics/quality-of-care#tab=tab_1.

Governance and Organizational Structure

To support the implementation and operationalization of the health strategic plan, the Government of Zambia and MOH appear to have well-defined governance structures in place. These governance structures are responsible for a wide scope of issues, including policy direction, regulations, standards, and provision of guidance. A hierarchy of national, provincial, and district governance structures and leadership exist for national health programs. One such key entity is the Performance Improvement and Quality Assurance Directorate at the MOH. The Directorate provides oversight of quality improvement and assurance. It works with TWGs at each level of service delivery to direct and facilitate quality improvement and assurance efforts. It also closely coordinates with a national level TWG tasked with developing the roles/responsibilities, scope of work, organization, and terms of reference for all other TWGs at the subnational level. The MOH's approach to knowledge management and capacity-building is top-down, i.e., the national-level staff train the provincial staff, and the provincial staff train the district staff, and the district staff train the health facility staff.

Zambia has both regulatory and professional bodies to ensure adherence to quality standards and quality service provision. These bodies are responsible for developing and monitoring adherence to clinical standards, identifying gaps, implementing improvement interventions, and offering technical support through accreditation and licensing. Such bodies include the Zambia Medical Association, whose main goal is to champion the practice of safe medicine through research and ethical practice; the Health Professional Council of Zambia, whose mandate is to register and regulate all health facilities in Zambia; and the National Health Insurance Management Authority, whose primary mandate is to provide innovative financing in pursuit of UHC.

Despite the outlined hierarchy of governance structures, respondents pointed out that the MOH tends to carry out most processes and decision-makings at the national level, leading to delay in taking action in response to issues and challenges that arise at lower levels.

> "Feedback from the community or issues raised by a particular facility sometimes take long to be acted on because key decisions need to be made at the central level…. I think more work has to be done in this area."

Financing for Quality

The ZNHSP has been fully costed. However, almost all respondents shared and agreed on the unavailability of adequate financing for the strategic plan to fully achieve its mandate for quality improvement for prioritized areas. For instance, during the development of plan, stakeholders identified and prioritized new health areas of focus for improvement, such as NCDs and neglected tropical diseases. However, the available resources did not match the identified need, leading to these two disease areas having little or no funding. However, given the rapidly increasing burden of NCDs in Zambia, there have been parallel efforts to advocate for the allocation of additional resources to this area. In 2019/2020 WHO supported the development of a costed national strategic plan for the prevention and control of cervical cancer, the highest burden cancer in Zambia. Respondents recommended similar initiatives for other priority NCD areas to help galvanize appropriate resource allocation given almost 30 percent of all mortality in Zambia are due to NCDs.[16]

16. World Health Organization. n.d. Zambia Investment Case. https://www.afro.who.int/sites/default/files/2020-10/Zambia%20Investment%20Case.pdf.

One of the major financing initiatives in recent years is the national health insurance mechanism, which was established in 2019 as a way to respond to the needs outlined in the ZNHSP. Managed by the National Health Insurance Management Authority, the scheme aims to provide over seven million members (35 percent of the population) with universal access to quality insured health care services. Currently, the scheme has a benefit package with essential services at the primary, secondary, tertiary, and specialized levels, including coverage for registration and consultation fees, prescriptions drugs, and specialized services including dental and surgical care. It targets public and private sector employees and there are plans to extend into the informal sector. One of the primary goals of this scheme is to influence quality of care. The plan is to achieve this goal by increasing facility-level financial flow through claim payments, which will then translate to increased investments for improved service provision. Services are exclusively provided by a network of accredited public and private providers. This network is also under the National Health Insurance Management Authority and all providers, including hospitals, pharmacies, and diagnostic laboratories, are required to go through an accreditation application process to join.[17]

Stakeholder Mapping and Engagement

Respondents shared that the MOH sought to involve different stakeholders throughout the development of the ZNHSP. Stakeholders involved included government line ministries, NGOs, civil society organizations, academic institutions, development partners, and patient groups. Most respondents further highlighted the importance of capturing and reflecting community voices through engagement with patients and patient advocacy groups.

> "Patient advocacy groups such as the one that deals with tuberculosis have been quite active. They are there when the ministry is planning, implementing, consulting, and [they also] participate in international conferences and deliberations [such as the] World Health Organization. The good thing about such groups [tuberculosis patients' group] is how they help the ministry bring down policies and strategies from a global perspective and interpret them to suit the local perspective."

However, respondents also shared challenges related to managing expectations for change in a limited resources setting following a broad engagement and consultation process. This perspective highlights the importance of continued dialogue and transparency throughout the design, implementation, and evaluation of NQPS as priorities and funding evolve.

Situational Analysis

> "We consult [patients' groups and other stakeholders] and sometimes people feel like we've left out what they wanted us to do. And so, there is a need to make key stakeholders understand that there are certain things that we cannot just sign to for many reasons, mostly funding reasons, [hence we] filter the recommendations to suit the resources that are available."

Respondents described a Strengths-Weakness-Opportunities-and-Threats analysis MOH led as part of the National Health Strategic Plan and Performance Improvement and Quality Assurance Strategy development to ensure a strategic direction that is responsive to the current status of the health sector. The situational analysis was supported by both domestic and external funding. The MOH involved the multisectoral partners listed above under the stakeholder mapping and engagement element in this analysis and received high participation. However, respondents

17. National Health Insurance Management Authority Zambia. https://www.nhima.co.zm/download/document/a6021d3f5120220303db89d805.pdf.

noted the process was skewed toward urban areas more than rural, leaving out representation from an important and underserved demographic.

Another key finding from Zambia is the continuous learning cycle through periodic situational analyses. Respondents shared that MOH, and other stakeholders analyze data regularly during key planning milestones at different health governance levels, such as the national, provincial, district, and facility level.

Zambia's situational analysis relied heavily on routine data collected from the HMIS. While this approach was able to leverage an existing system to identify gaps and opportunities to prioritize in the ZNHSP, respondents also pointed out perceived concerns related to quality, accuracy, and completes of the available data.

Continuous Quality Improvement

Continuous professional development initiatives, including those focused on quality improvement, are typically led by the central level. The central level also facilitates quarterly and yearly reviews with different stakeholders, including health professional associations, to discuss policy and implementation issues in an effort to foster participatory decision-making.

> "The Health Professional Council of Zambia has an opportunity to make recommendations for improvement, which are then either considered or not [during] the actual strategy making period, or during the actual strategy implementation period. These meetings usually happen quarterly."

Respondents shared that there has been recent effort to better incorporate patient feedback into clinical service delivery. Most facilities at the provincial and higher levels now have suggestion boxes and complaint desks have been instituted to promote the inclusion of patients' voices in performance improvement activities.

MOH also indicated intention to work through Performance Improvement and Quality Assurance Directorate and its related TWGs to institutionalize quality assurance and improvement as an ongoing, shared collaborative effort as opposed to an external audit.

> "…. we want to strongly emphasize collective action and the mutual benefits of improved performance"

Despite having set up clear systems to facilitate the culture of continuous learning and quality improvement, almost all respondents pointed to a persistent lack of adequate and stable funding to act accordingly and implement recommendations that would require increased technical skill and stronger operational infrastructure.

Improvement Methods and Interventions

Both the ZNHSP and the Quality Assurance Strategy focus on the following strategic areas as pillars for quality improvement. Some of these are reflected in initiatives and activities described under this case study and include[9]:

- Integrating quality planning at all levels and defining quality for each program area
- Developing and implementing quality-related performance indicators to institutionalize a culture of quality
- Creating a "joy at work" environment for the health workforce through supportive supervision, incentives, and a reward program
- Strengthening systems to monitor and ensure standards for physical health infrastructure as well as supply chain

- Instituting data-driven performance improvement and quality assurance monitoring and reporting system to improve bi-directional feedback loops
- Increasing transparency and accountability in resources allocation and utilization
- Strengthening decentralized governance and leadership structure to harmonize the quality improvement approach, including forming coordinating bodies at national, provincial, and district levels; developing standardized supervision tools with built-in quality management inputs; and holding periodic sector-wide reviews at the national level to assess performance
- Increasing awareness of patients' rights, developing systems for receiving and incorporating feedback, and supporting links with patient advocacy and/or interest groups

Quality Indicators and Core Measures

In line with both the ZNHSP and the Performance Improvement and Quality Assurance Strategy, there are several efforts underway to institutionalize and standardize quality of care within and across both public and private facilities. The development of the National Health Strategic Plan Monitoring and Evaluation Framework 2017–2021 provided a coherent framework to assess progress made on key quality-related indicators. Illustrative measures these indicators cover include availability and readiness of essential routine and emergency services, institutional maternal mortality rate and proportion of maternal deaths audited, downtime of basic equipment, proportion of facilities meeting safety and preparedness standards, proportion of facilities with basic amenities (water, electricity, etc.), and proportion of laboratory facilities conducting quality control testing.[18] The monitoring and evaluation framework prioritizes use of routine data from national HMIS, demographic health surveys, and censuses.

HMIS and Data Systems

HMIS data are crucial for evidence-based decision-making across the continuum of care. Zambia has a costed National eHealth Strategy (2017–2021) that aims to accelerate the adaptation and use of information and communication technologies in the delivery of quality health care services. The strategy defines clear roles and responsibilities at central and district levels. It pays attention to bridging the gap in data availability at the community level through investments in community health management information systems to collect data from community health workers; expanding use of electronic systems in facilities, coupled with increased trainings on eLearning and eHealth solutions; and strengthening innovative technologies for use in public health surveillance.

The MOH has data collection and reporting guidelines in place to facilitate the quality and timeliness of routine data. The MOH also coordinates quarterly data review meetings. These meetings provide a platform for identifying key lessons and recommendations to be applied to underperforming provinces, districts, and/or facilities.

"In terms of use of data for decision-making, these are limitations because if you don't have a lower unit level of analysis, you are limited in terms of putting resources into good use and reaching the most vulnerable.

Respondents shared that the private sector currently under reports to the national HMIS due to a lack of

18. Ministry of Health Zambia. 2019. National Health Strategic Plan Monitoring and Evaluation Framework 2017–2021. https://www.moh.gov.zm/wp-content/uploads/filebase/strategies/ME-Framework-and-Plan-Print-Version-19-july-2019.pdf.

access to and limited training on the system and its reporting codes. There also seems to be a lack of data from community-based health posts and other community health activities.

Discussion

The case studies identified several practices, challenges, and lessons that emerged from Rwanda and Zambia's experience in establishing and strengthening governance of quality infrastructure as part of their NPQS journey.

Shared vision and goals for quality improvement: A key enabling factor identified in both countries was having a clear vision and shared goals for quality. In Rwanda, this centered on having clear, data-informed national health priorities that were championed at all levels of the health system. In Zambia, this was reflected in comprehensive national strategy and policy documents that were used as frameworks to further tailor quality goals in local contexts. In both countries, leveraging existing infrastructures and aligning goals with other national priorities were cited as factors to creating consensus around quality improvement goals and strategies. Furthermore, the MOH was at the forefront of stakeholder mapping, coordination, and feedback solicitation in both Rwanda and Zambia. This appears to have fostered a sense of collective ownership among state and nonstate actors around national vision, objectives, approaches for quality assurance and improvement.

Sustained and multisectoral stakeholder engagement processes: Both experiences emphasize the importance of country-led, systematic, and continuously adapted stakeholder mapping and engagement. Engaging the right stakeholders in creating a NQPS document goes beyond having a meeting to introduce the strategy when it is launched. It requires a strategic assessment of which stakeholders should be engaged at what points, where their contribution will provide the most value, and how to best engage them to generate meaningful feedback and contextualize strategies to respond to unique needs across different sectors and health systems levels. In Rwanda and Zambia, this whole-of-society approach in stakeholder mapping and engagement allowed space for patient and community voices, though to different degrees.

Strengthening and leveraging decentralized governance structures: Adapting quality policy and strategy to respond to local needs requires localizing the responsibility to drive the work at subnational and community levels. While Rwanda and Zambia had different approaches in utilizing their decentralized structures to govern quality, findings in both countries offer a shared lesson of having to invest in those structures to be able to effectively use them in standardizing and institutionalizing quality improvement approaches.

Prioritizing the development of data systems and data culture for quality governance: Data and data use culture were reported as key success factors in the operationalization of Rwanda's HSSP IV. This is a result of increased national commitment to develop the country's digital health infrastructure and technical capacity, from having a comprehensive and costed national digital health strategic plan to establishing a dedicated MOH department to lead an oversee the digitizing all health data and supporting all facilities to adapt electronic medical records. Zambia is also making it a priority to strengthen their data infrastructure as part of the costed national eHealth strategy. In both cases, having a clear policy direction and framework appears to facilitate cohesive reforms in improving country data systems. This is a crucial step in effective quality governance given the need to capture, generate, and use accurate performance data to target critical area of quality improvement. This should be complemented by strategies to explicitly integrate quality improvement metrics into national and district routine data collection and management systems to ensure harmonization of efforts.

Increasing investment in health workforce to champion and support quality improvement: A shared ongoing challenge between Rwanda and Zambia was having limited workforce trained in quality improvement models and tools. While there are efforts to train more care providers in standard quality improvement practices, the findings reflect the importance of having both technical capacity and leadership for quality at all levels of the health system. A system-oriented approach to infuse quality across the health workforce development spectrum, from pre-service training to continuous professional initiatives at service delivery could facilitate a shift in culture that empowers individual leaders and providers while emphasizing teamwork, shared accountability, and learning, as well as valuing compassionate care.

Addressing the need for adequate and sustainable financing of quality improvement: Both countries have made progress in strengthening their health financing mechanisms to influence quality (e.g., performance-based financing in Rwanda and accreditation requirement for enrollment and payments under Zambia's health insurance scheme). However, there is a shared challenge in securing adequate and sustainable financing for quality improvement. It is hard to invest in quality assurance and improvement when there are critical gaps in essential service delivery inputs such as skilled workforce, essential medicines, and basic facility infrastructure. Integrating national quality priorities as one of the lenses for domestic resource mobilization efforts could facilitate allocation of funding to key parts of the health system, such as supply chain, which will ultimately impact the quality of provided services, and ensure the best use of existing and new resources.

Conclusion

The findings demonstrate the interconnections and interactions among the 10 governance of quality elements. The processes and approaches of NPQS journey are unique across countries, and countries will be at different stages of capacities across the governance of quality elements. However, the case study findings highlight common factors related to what worked well, what did not, and system-level influencing factors during the development and implementation of NQPS documents. This offers opportunities to share lessons learned and best practices across countries. It also enables the use of country experiences to inform global health systems strengthening guidance for improving quality of care and health outcomes.

Limitations

Budgetary and practical considerations during the COVID-19 pandemic limited the interviews planned to a maximum of 10 in each country. This limits the representativeness of the data that informed this report, but the interviewed stakeholders were chosen in a targeted manner to ensure that the case studies include the right people to the extent possible. Note that in Zambia, the team was only able to conduct six interviews because of unavailability of, or lack of response from, the identified interviewees despite several follow-ups. LHSS has, however, conducted targeted desk reviews for both countries in addition to the interviews to triangulate information and close gaps.

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Annexes

Case Study Interview Guide – Zambia

Begin Recording

Introduction/ Consent script

Hello, my name is [LHSS consultant]. I am working on a case study about the promising practices and related challenges in the governance of quality in health care. The study is being conducted by Institute for Healthcare Improvement (IHI) on behalf of USAID's Local Health System Sustainability Project.

Thank you for agreeing to discuss your reflections on Zambia's development of the Zambia National Health Strategic Plan (2017 – 2021). This interview is expected to last one hour, and your participation in answering these questions is completely voluntary. You may opt out at any point during the interview, and you do not have to answer all questions. There are no right answers; we are just looking for your perspective on these issues. I will be recording the interview for documentation and analysis purposes, but only authorized researchers will have access to the recording.

We are conducting this interview as part of a larger effort that seeks to identify the strengths, opportunities, weaknesses, and threats to National Quality Policy Strategy creation as part of a follow up to a multi-country survey [you/your colleagues at [MOH etc.] responded to earlier this year. Zambia's outstanding performance in certain areas of National Quality and Policy Strategy creation made it an ideal country to inform global learning on national policies, strategies, and infrastructure.

This interview will be analyzed, and information will be included in a case study summary of Zambia's efforts in NQPS development. We will combine the information you provide us with the information provided by 15-20 other people we interview. We will keep any personal information about you confidential to the best of our ability. Only authorized researchers will have access to your personal information. We will remove your personal information before we share your de-identified responses with anyone outside of the research team.

Can you please confirm your consent to participate by repeating the following? *I, [interviewee name], agree to voluntarily participate in this qualitative study about the Zambia National Health Strategic Plan.*

Interview Questions

Respondent's role

1. Can you tell me about your current position?
    a. How long have you worked there?
    b. How does your work relate to the national quality and policy strategy work in Zambia?

First, I would like to ask you some questions about the various stakeholders that participated in the creation of the National Health Strategic Plan…

1. Please give some examples of how subnational and organizational levels of the health system were engaged in the process of creating the National Health Strategic Plan?
    a. Were private sector stakeholders engaged (example: NGOs and for-profit)? If so, how?
    b. Can you provide an example of how specific feedback or recommendations were considered or used?
    c. What worked best when engaging stakeholders at this level?

2. Were patients, patient advocacy groups, and communities engaged throughout the process of creating the National Health Strategic Plan? If so, how?
    a. Can you provide an example of how specific suggestions from comment boxes, exit interviews, satisfaction surveys, or any other source of data were considered or used?
    b. In your opinion, were any groups missing from the engagement process? Which ones?
    c. What worked best when engaging stakeholders at this level?

3. What were the key challenges in engaging with these stakeholders while creating the Strategy?
    a. How were these challenges addressed?
    b. How would you improve engagement with these stakeholders in future iterations?
    c. Survey response indicates that patients and facility level staff were not engaged during implementation- why do you think that is?

Now I would like to shift our focus to the situational analysis, governance, and financing of the National Health Strategic Plan.

4. Please describe the process used to conduct a situational analysis, beginning with how the data was prioritized, collected, and analyzed to inform the activities and pursue quality goals.
    a. What were identified as the priority learning areas or knowledge gaps for the situational analysis (key stakeholders, potential financial support, current state of quality, etc.)?
    b. What financing was secured, if any?
    c. How was the data from situational analysis used to develop the Strategy, if at all?
    d. What worked well?
    e. What changes would you make to the situational analysis process, if any, for the next iteration of the Strategy?
5. How is the existing National Health Strategic Plan document made accessible to the health sector workforce and stakeholders?

a. Give me an example of how information is disseminated from the top of the national level to a frontline physician, nurse, or even patient.
b. What is working well?
c. What are the challenges associated with making it accessible?
d. Describe any plans or recommendations to improve accessibility in future iterations.

6. Please describe the relationship between the governance structures at the national, subnational, and facility level?
    a. Describe the system used to facilitate bi-directional learning or challenges, which is the frontline can inform up to the national level and the national level can share down to the frontline?
    b. How are gaps identified?
    c. The strategy describes technical working groups and significant quality assurance strategies to support oversee implementation- can you describe the structure in more detail, including who is involved in the groups, what kind of QA monitoring exists, and any key learnings so far?
    d. How were successes and challenges documented and utilized?

7. Describe how Zambia secured the necessary funds for the planning, design, implementation, and evaluation stages of the Strategy?
    a. Survey response indicates that resources were a consistent challenge for implementing the strategy- can you tell me more about that?
    b. How was it mitigated?
    c. What are the current gaps?
    d. How would you describe the effectiveness of the existing results-based financing for primary care?
    e. In your opinion, how does that compare to the current national insurance plan?
    f. Please describe any plans to ensure future funding.

Finally, I would like to discuss the culture of quality in the health system and Zambia's data systems that support it.

8. Describe any interventions that have been proposed or adopted to create an environment where questions can be raised, and mistakes can be reported without blame.
    a. Describe the challenges around creating this kind of culture.
    b. How have obstacles or challenges been addressed during implementation?
    c. What has worked well?
    d. What additional systems would be valuable in supporting this kind of culture?

9. Please describe how groups at the national, subnational, and local level are working to create a local definition of quality.
    a. How has this been done successfully?
    b. What could other countries learn from Zambia's experience?
    c. What challenges have surfaced during this iteration of the Strategy?

10. Give an example (or examples) of how data is being used to improve quality of care.
    a. Please share any systems used to support integrating analogue data into a digital data system.
    b. What is working well?
    c. Tell me more about the current challenges around collecting, analyzing, and sharing data collected from a paper-based system.
    d. Please share examples of how the Strategy is improving data collection or use.

In closing…

11. Is there anything else we have not discussed here that you would like to share?
12. Do you have any questions for us?
13. Is there anyone else you think we should talk to?

Thank you very much for your time!

End Recording

Case Study Interview Guide – Rwanda

Begin Recording

Introduction/ Consent script

Hello, my name is [LHSS consultant]. I am working on a case study about the promising practices and related challenges in the governance of quality in health care. The study is being conducted by Institute for Healthcare Improvement (IHI) on behalf of USAID's Local Health System Sustainability Project.

Thank you for agreeing to discuss your reflections on Rwanda's development of the Fourth Health Sector Strategic Plan (July 2018 – July 2024). This interview is expected to last one hour, and your participation in answering these questions is completely voluntary. You may opt out at any point during the interview, and you do not have to answer all questions. There are no right answers; we are just looking for your perspective on these issues. I will be recording the interview for documentation and analysis purposes but only authorized researchers will have access to the recording. I will be recording the interview for documentation and analysis purposes, but only authorized researchers will have access to the recording.

We are conducting this interview as part of a larger effort that seeks to identify the strengths, opportunities, weaknesses, and threats to National Quality Policy Strategy creation as part of a follow up to a multi-country survey [you/your colleagues at [MOH etc.] responded to earlier this year. Rwanda's outstanding performance in certain areas of National Quality and Policy Strategy creation made it an ideal country to inform global learning on national policies, strategies, and infrastructure.

This interview will be analyzed, and information will be included in a case study summary of Rwanda's efforts in NQPS development. We will combine the information you provide us with the information provided by 15-20 other people we interview. We will keep any personal information about you confidential to the best of our ability. Only authorized researchers will have access to your personal information. We will remove your personal information before we share your de-identified responses with anyone outside of the research team.

Can you please confirm your consent to participate by repeating the following? *I, [interviewee name], agree to voluntarily participate in this qualitative study about Rwanda's Fourth Health Sector Strategic Plan.*

Interview Questions

Respondent's role

1. Can you tell me about your current position?
    a. How long have you worked there?
    b. How does your work relate to the national quality and policy strategy work in Rwanda?

First, I would like to ask you some questions about the various stakeholders that participated in the creation of the Health Sector Strategic Plan…

2. Please give some examples of how subnational and organizational levels of the health system were engaged in the process of creating the Health Sector Strategic Plan?

   a. Were private sector stakeholders engaged (example: NGOs and for-profit)? If so, how? Were private sector stakeholders engaged (example: NGOs and for-profit)? If so, how?
   b. Can you provide an example of how specific feedback or recommendations were considered or used?
   c. What worked best when engaging stakeholders at this level?

3. Were patients, patient advocacy groups, and communities engaged throughout the process of creating the Health Sector Strategic Plan? OBJ If so, how? If so, how?
   a. Can you provide an example of how specific suggestions from comment boxes, exit interviews, satisfaction surveys, or any other source of data were considered or used?
   b. The strategy indicates patients were engaged at all levels of the design, implementation, and evaluation. Can you tell me a little more about how that was achieved?
   c. In your opinion, were any groups missing from the engagement process? Which ones?
   d. What worked best when engaging stakeholders at this level?

4. What were the key challenges in engaging with these stakeholders while creating the Strategy?
   a. How were these challenges addressed?
   b. How would you improve engagement with these stakeholders in future iterations?

Now I would like to shift our focus to the situational analysis, governance, and financing of the Health Sector Strategy…

5. Please describe the process used to conduct a situational analysis, beginning with how the data was prioritized, collected, and analyzed to inform the activities and pursue quality goals.
   a. What were identified as the priority learning areas or knowledge gaps for the situational analysis (key stakeholders, potential financial support, current state of quality, etc.)?
   b. What financing was secured, if any?
   c. How was the data from situational analysis used to develop the Strategy, if at all?
   d. What worked well?
   e. What changes would you make to the situational analysis process, if any, for the next iteration of the Strategy?
6. How is the existing Health Sector Strategic Plan document made accessible to the health sector workforce and stakeholders?
   a. Give me an example of how information is disseminated from the top of the national level to a frontline physician, nurse, or even patient.
   b. What is working well?

c. What are the challenges associated with making it accessible?

d. Describe any plans or recommendations to improve accessibility in future iterations.

7. Please describe the relationship between the governance structures at the national, subnational, and facility level?

    a. Describe the system used to facilitate bi-directional learning or challenges, which is the frontline can inform up to the national level and the national level can share down to the frontline?

    b. How are gaps identified?

    c. The strategy describes multiple working groups and activities to share learning- can you describe the structure in more detail, including who was involved in the groups, how often they met, where/ how they met, and any learnings that came from the groups?

    d. How were successes and challenges documented and utilized?

8. Describe how Rwanda secured the necessary funds for the planning, design, implementation, and evaluation stages of the Strategy?

    a. Survey response indicates sufficient resources were identified for implementation, can you talk more about financing for the planning/ design and evaluation of the Strategy?

    b. How would you describe the effectiveness of the financial mechanisms in place to encourage adoption of the Health Sector Strategy (selective contracting, provider payments, quality consideration in benefit packages, audits, accreditation, provider licensing, and differential payments)?

    c. Please describe any plans to ensure future funding.

Finally, I would like to discuss the culture of quality in the health system and Rwanda's data systems that support it….

9. Describe any interventions that have been proposed or adopted to create an environment where questions can be raised, and mistakes can be reported without blame.

    a. Describe the challenges around creating this kind of culture.

    b. How have obstacles or challenges been addressed during implementation?

    c. What has worked well?

    d. What additional systems would be valuable in supporting this kind of culture?

10. Please describe how linking performance-based financing and accreditation is impacting a culture of trust and transparency.

    a. How has this been done successfully?

    b. What challenges have surfaced during this iteration of the Strategy?

    c. Can you tell me more about how performance-based contracts having tailored to an individual's role has impacted quality

11. Give an example (or examples) of how data is being used to improve quality of care.

a. Please share any systems used to support integrating analogue data into a digital data system.
b. How is this working well?
c. Tell me more about the current process for digitalization at hospitals and facilities is rolling out on the frontlines.
d. Please share examples of how the Strategy is improving data collection or use.

In closing…

12. Is there anything else we have not discussed here that you would like to share?
13. Do you have any questions for us?

Thank you very much for your time!

End Recording