# Review of Health System Performance Assessment in Low Income Countries: A mixed methods study of the Uganda District League Table

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# Outline

- Background
- Research Questions
- Methods
- Results
- Conclusion

# Background

- Global interest in Health Systems Performance Assessment (HSPA) over the last 3 decades
- A number of approaches & frameworks for HSPA have been developed: WHO 2000; Govt. of Canada; Dept. of Health UK; Sicotte *et al* 1998;
- Most documented experiences are in High Income Countries (HICs)
- The district is a key level in the national health system especially in Low Income Countries (LICs) and in sub-Saharan Africa

# Background

- Uganda District League Table (DLT) launched 2003
- Objectives – compare performance; determine good & poor performers; understand reasons behind performance; learn from best practice; improve local government ownership
- Composed of input, process and output indicators – e.g. deliveries in facilities, OPD attendance, latrine coverage etc. - in line with Strategic Plan and MDGs
- Composite index computed by weighting some of the indicators, ranks districts from best to worst performer
- DLT published in Annual Sector Report and discussed at national Sector Review meeting

# Research Question

## Over-arching Research Question

What would be an appropriate district health system performance assessment framework in a low income country like Uganda?

## Specific Research Question

How appropriate is the Uganda District League Table?

# METHODS

# Critiquing the Uganda DLT

- Data collection: documentary reviews, key informant interviews; HMIS & other MoH databases
- Historical approach: “tell the story” of the design, development and use of the DLT over time
- Use of attributes identified previously to critique DLT
- Exploring the use of Hierarchical Cluster Analysis (HCA) as alternative approach to analysis and presentation of district DLT data

# RESULTS

# How appropriate is the UDLT?

- KIs and Document Review indicated DLT partially achieved objectives
- Identified good & poor performers
- Findings used in some cases for decision-making at national and district level
- Appreciated for enabling system-wide view of the district health system
- Improved appreciation & management of data
- In use after 10 years

# How appropriate is the UDLT?

- Perceived as unfair by many district managers – Kampala district was on top for 6 years
- Inadequate analysis – nothing much beyond ranking from first to last
- Inadequate information in the DLT to explain observed performance – lack/inadequate process indicators, qualitative information
- Could be misleading – Gulu a conflict/immediate post conflict district was on top for 3 years
- Demotivating and embarrassing for those at the bottom
- Limited use in decision-making

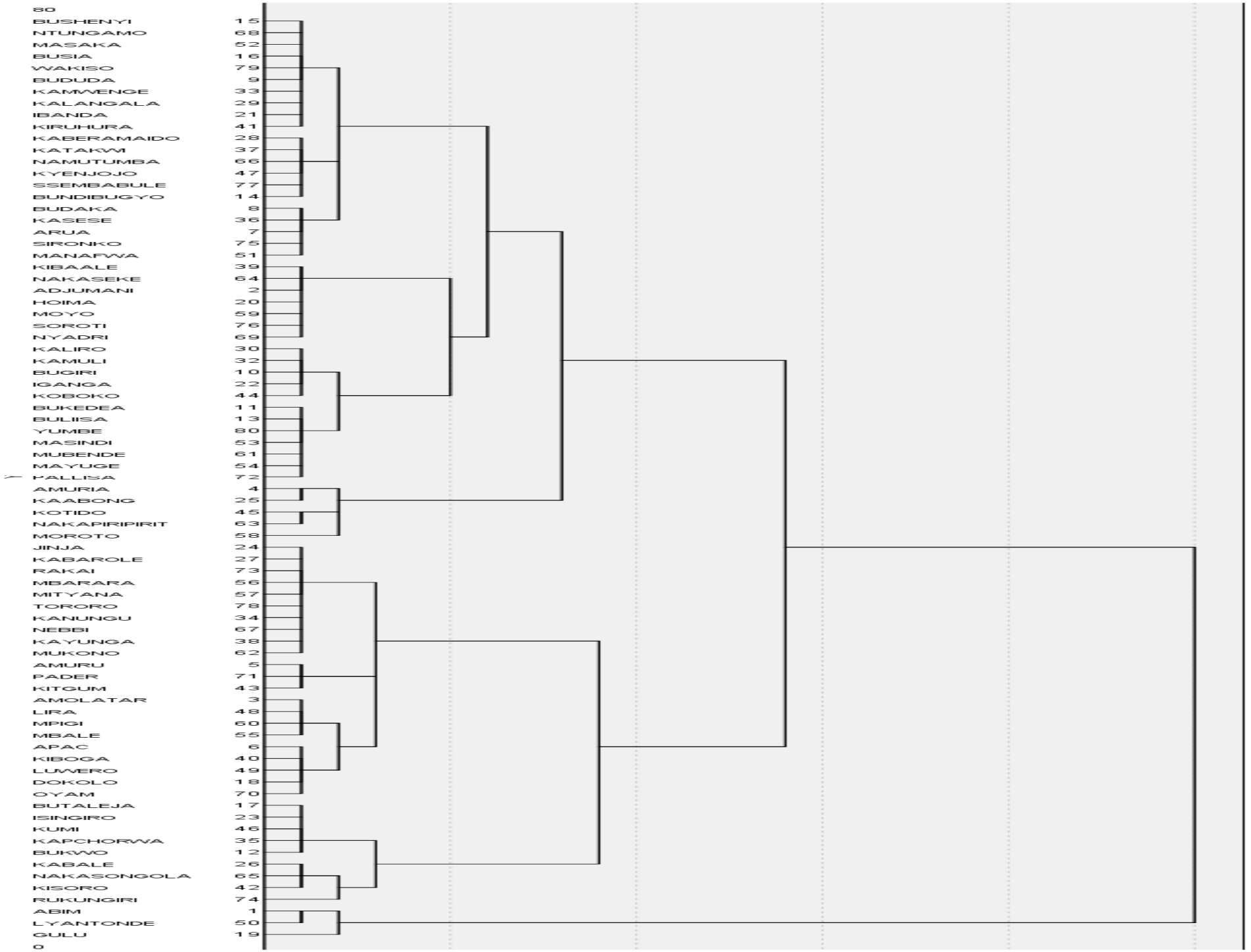
# How appropriate is the UDLT?

- Limited involvement of stakeholders in development & review processes – viewed as just technical, not political
- Increased number of districts – 56 in 2003 to 112 in 2011 – nomenclature of top 15, bottom 15; middle 82 – not very meaningful
- Many other changes/reforms have taken place over the 10 years with implications for the DLT
  - Decentralisation, Sector Coordination, Health Inputs Reforms
- Institutional Frameworks for HSPA inadequate
- Questionable Data Quality

# How appropriate is HCA?

- Hierarchical Cluster Analysis (HCA) was used to group together districts into 7 ‘performance clusters’ for each year
- Clusters determined by specific indicator performance magnitude & combination of performance across indicators
- ‘Performance Clusters’ seen to have an association with system inputs – HR, HI, HF
- However changes over the years– in indicators that determined clusters & membership of clusters by districts – dynamic rather than static

| Indicator/Item | Type of Indicator | Year Used in League Table | | | | | | | | Weighting | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 2002/03 | 2003/04 | 2004/05 | 2005/06 | 2006/07 | 2007/08 | 2008/09 | 2009/10 | factor | Year | |
| Population | Descriptive | √ | √ | √ | √ | √ | √ | √ | √ | | | |
| No. of Health sub-districts | Descriptive | √ | √ | √ | X | √ | √ | √ | √ | | | |
| No. of Hospitals | Input | √ | √ | √ | X | X | X | X | X | | | |
| Total number of health units (excluding hospitals) | Input | X | X | X | X | √ | √ | X | X | | | |
| Total number of health units | Input | X | X | X | X | X | X | √ | √ | | | |
| Total funding to Health per capita | Input | √ | X | X | X | X | X | X | X | | | |
| % Approved posts filled by trained health personell | Input | √ | √ | √ | X | X | X | X | X | 5 | 2005/06 | dropped |
| %District HMIS Outpatient returns submitted timely | Process | √ | √ | √ | √ | √ | √ | √ | √ | 5 | | |
| %District HMIS Outpatient returns submitted complete | Process | √ | √ | √ | X | X | X | X | X | 5 | 2005/06 | dropped |
| Proportion of PHC funds spent on drugs at NMS & JMS | Process | √ | √ | √ | √ | √ | √ | √ | √ | 10 | | |
| % Quarterly requests submitted timely | Process | √ | X | X | X | X | X | X | X | 10 | 2005/06 | dropped |
| % PHC funds disbursed that are expended | Process | X | √ | √ | √ | √ | √ | √ | √ | 5 | 2005/06 | introduced |
| FDS Flexibility Gain | Process | X | X | X | √ | √ | √ | √ | √ | 5 | 2005/06 | introduced |
| % children <1 rcvd 3 doses of DPT accordig to schedule | Output | √ | √ | √ | √ | √ | √ | √ | √ | 12.5 | | |
| Total Govt &NGO OPD utilization per person per year | Output | √ | √ | √ | √ | √ | √ | √ | √ | 12.5 | | |
| Pit Latrine Coverage | Output | √ | √ | √ | √ | √ | √ | √ | √ | 7.5 | | |
| % Deliveries in Govt and NGO health facilities | Output | √ | √ | √ | √ | √ | √ | √ | √ | 12.5 | | |
| Proportion of TB cases notified compared to expected | Output | √ | √ | √ | √ | √ | √ | √ | √ | 10 | | |
| % Pregnant women receiving 2nd dose Fansidar for IPT | Output | √ | √ | √ | √ | √ | √ | √ | √ | 10 | | |
| HIV/AIDS Service Availability | Composite | X | X | X | √ | √ | √ | √ | √ | 10 | 2005/06 | introduced |
| Weighted Score | Composite | √ | √ | √ | √ | √ | √ | √ | √ | | | |
| Ranking | Rank | √ | √ | √ | √ | √ | √ | √ | √ | | | |


80
BUSHENYI 15
NTUNGAMO 68
MASAKA 52
BUSIA 16
WAKISO 79
BUDUDA 9
KAMWENGE 33
KALANGALA 29
IBANDA 21
KIRUHURA 41
KABERAMAIDO 28
KATAKWI 37
NAMUTUMBA 66
KYENJOJO 47
SSEMBABULE 77
BUNDIBUGYO 14
BUDAKA 8
KASESE 36
ARUA 7
SIRONKO 75
MANAFWA 51
KIBAALE 39
NAKASEKE 64
ADJUMANI 2
HOIMA 20
MOYO 59
SOROTI 76
NYADRI 69
KALIRO 30
KAMULI 32
BUGIRI 10
IGANGA 22
KOBOKO 44
BUKEDEA 11
BULIISA 13
YUMBE 80
MASINDI 53
MUBENDE 61
MAYUGE 54
PALLISA 72
AMURIA 4
KAABONG 25
KOTIDO 45
NAKAPIRIPIRIT 63
MOROTO 58
JINJA 24
KABAROLE 27
RAKAI 73
MBARARA 56
MITYANA 57
TORORO 78
KANUNGU 34
NEBBI 67
KAYUNGA 38
MUKONO 62
AMURU 5
PADER 71
KITGUM 43
AMOLATAR 3
LIRA 48
MPIGI 60
MBALE 55
APAC 6
KIBOGA 40
LUWERO 49
DOKOLO 18
OYAM 70
BUTALEJA 17
ISINGIRO 23
KUMI 46
KAPCHORWA 35
BUKWO 12
KABALE 26
NAKASONGOLA 65
KISORO 42
RUKUNGIRI 74
ABIM 1
LYANTONDE 50
GULU 19
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# How appropriate is HCA ?

HCA provides some **advantages/opportunities**

- Clusters condense many data points to support decision-making
- Useful even when districts increase or decrease
- Provides opportunity for learning – e.g why high performance by a cluster on OPD & DPT3 & PMTCT – is it resources? Is it management? Is it level of development?
- Provides an opportunity for peer learning – districts in the same cluster – or even different clusters
- Likely to be viewed as more fair/less judgemental than DLT ranking; less embarrassing to poor performers;

# How appropriate is HCA?

HCA has some prerequisites/limitations

- Useful as part of a process of analysis and presentation  together with other mechanisms
- Raises questions – needs various pieces of data/information to answer them
- Requires good understanding of health systems and the context for the choice of indicators to include in the determination of clusters
- Dependent on data quality – not as much as league table ranking though

# CONCLUSIONS

# Conclusions

- Uganda has implemented the DLT for 10 years
- Study utilised a combination of research methods to review the DLT
- The DLT achieved some of its objectives & fulfils some attributes for a HSPA framework
- But a number of challenges/gaps have been noted

# Conclusions

## Proposals for adjustment

- More participatory review process – regularly
- Use of data to determine linkages/attribution
- Introduce new data (qualitative and quantitative) to explain observed performance
- Mechanism for change – improve analysis and presentation including use of HCA
- Improve Institutional Framework for HSPA – resources, linkages
- Learn from other frameworks and experiences - keep context in mind