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
<table>
<thead>
<tr>
<th>Indicator/Item</th>
<th>Type of Indicator</th>
<th>Year Used in League Table</th>
<th>Weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>Descriptive</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>No. of Health sub-districts</td>
<td>Descriptive</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>No. of Hospitals</td>
<td>Input</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Total number of health units (excluding hospitals)</td>
<td>Input</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Total number of health units</td>
<td>Input</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Total funding to Health per capita</td>
<td>Input</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>% Approved posts filled by trained health personell</td>
<td>Input</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>%District HMIS Outpatient returns submitted timely</td>
<td>Process</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>%District HMIS Outpatient returns submitted complete</td>
<td>Process</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Proportion of PHC funds spent on drugs at NMS &amp; JMS</td>
<td>Process</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>% Quarterly requests submitted timely</td>
<td>Process</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>% PHC funds disbursed that are expended</td>
<td>Process</td>
<td>X</td>
<td>✓</td>
</tr>
<tr>
<td>FDS Flexibility Gain</td>
<td>Process</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>% children &lt;1 rcvd 3 doses of DPT accordig to schedule</td>
<td>Output</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Total Govt &amp; NGO OPD utilization per person per year</td>
<td>Output</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Pit Latrine Coverage</td>
<td>Output</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>% Deliveries in Govt and NGO health facilities</td>
<td>Output</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Proportion of TB cases notified compared to expected</td>
<td>Output</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>% Pregnant women receiving 2nd dose Fansidar for IPT</td>
<td>Output</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>HIV/AIDS Service Availability</td>
<td>Composite</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Weighted Score</td>
<td>Composite</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Ranking</td>
<td>Rank</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

Note: "✓" indicates data available for that year, "X" indicates data not available for that year. The weighting factor and year for each indicator are listed in the last column.
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