THEME TWO: MANAGING HEALTH INFORMATION

THE CURSE OF LEAGUE TABLES: HOW UGANDA MISSED THE POINT

Komakech Innocent, Technical Assistant on District Health Services, Yumbe District, Uganda.

Abstract

This paper examines the criteria used by the Ministry of Health to determine the performance of the different districts as presented in the annual National Health Sector Performance Report. Using the winner of the 2004/2005, it attempts to analyze the health situation in the district and challenges the reliability of using HSSP input, process and output indicators as a measure of sector performance. The paper proposes that outcome indicators, like health status indicators, are a better measure of sector performance and should be the ones used for rating district performance. It also suggests that process indicators be used for technical forums and not political forums like the National Health Assembly. It ends with a cautionary remark on the likely misinterpretation of process indicators by the general public in districts with poor health status.

Introduction

With increasing expenditure on social services and competing demands for meager resources among sectors, many ministries are making concerted efforts to demonstrate by use of data the outputs from all their programs. Uganda's Ministry of Health, organizes an annual "National Health Assembly" composed of perceived major international, national and district level stakeholders in the health sector. Only healthcare consumers are absent and are deemed to be represented by district officials. The aim of the assembly is to put health issues on the agendas of these stakeholders. In the assembly, the stakeholders receive evidence on the sector outputs in the previous financial year and are requested to give their inputs towards improving health service delivery in the forthcoming years. The first such assembly was held in October 2003 and, since then, two others have taken place annually. Each year the performance of the district health sectors in different criteria is ranked in a form of league table. In the FY 2003/04 assembly held in October 2004 the war-torn district of Gulu in northern Uganda topped the country's league table, up from the 45th position in the previous financial year (MOH, 2003).

The indicators used for the ranking are proportion of health management information system (HMIS) forms submitted timely and complete; the proportion of the approved posts that are filled by trained health personnel; the proportion of PHC funds used for drugs; the percentage of children < 1 year receiving 3 doses of DPT; the total government and NGO outpatient (OPD) utilization per person per year; the percentage of deliveries taking place in government and NGO health units; the proportion of TB cases notified; the percentage of women getting a 2nd dose of sulfamethoxazole-pyrimethamine (SP or Fansidar) for intermittent presumptive treatment (IPT) of malaria; and pit latrine coverage (MOH, 2004). Most of these indicators are facility and management indicators derived from Uganda's first Health Sector Strategic Plan (HSSP I). Most of the data used for the ranking are obtained from the facility HMIS reporting forms submitted to the MOH. No mention is made in the MOH performance report on whether the data were triangulated with other sources.

Many scholars question the use of league tables for ranking the performance of disparate areas. The positions of Gulu District in these first two annual ratings have raised many questions. How can Gulu district top the league table when it has increasing disease prevalence and a number of new epidemics?

Are the indicators used a valid measure of the performance of the health sector? Are the indicators used appropriate for ranking the districts? Of what sensitivity and/or specificity are these HSSP input, process and output indicators in measuring improvement in health sector performance? To what extent do these indicators measure improvement in health status, which should be the main objective of the national health sector? And, should HSSP indicators be applied to all districts equally including those in a humanitarian emergency, like Gulu? It is our contention that the indicators, well intentioned as they may be, are less holistic for district health sector performance ranking.

Confounding factors such socioeconomic status, levels of education, water and sanitation situation, social policy implementation, nutritional situation and political stability parameters are not taken care of in the ranking. The table does not comprehensively capture the contribution of other sectors in the improvement of the health status of the community. Further, the indicators that assess the outcome of interventions resulting from the good or poor performance of the districts are lacking. In other words the table is more of 'paper accountability' than 'physical accountability' of the sector performance, which is a distance from the national health sector objective. We are of the opinion that health sector performance reports/district ranking should depict progress made towards the attainment of the National Health Sector objective as stipulated in the National Health Policy and the National health strategic plan to reduce morbidity and mortality from the major causes of ill health and the disparities therein (MOH 1999). This paper urges that in as far as the indicators used by the health ministry to develop the district league table do not assess actual improvements in attaining this national objective, they are aloof to reality and should not be used.

The winner's profile

Gulu district in northern Uganda harbors one of the world's 'longest and most forgotten emergencies' (Reuters as quoted in The New Vision news paper of Thursday, March 31, 2005 page 14). The humanitarian situation in the IDP camps is appalling. In the current situation many of the health units in the district have been closed down, health workers are on the run (MOH, 2003); the entire rural population is gathered in concentrated camps. In the camps, health service delivery and prompt referral of emergencies including obstetric cases is a major problem as road use is restricted by both sides in the conflict in most of the district roads. There has been increased numbers of epidemics since the camps were created. Malaria, respiratory tract infections and diarrheal diseases are occur at alarming rates. In studies conducted by the World Food Programme (WFP) and UNICEF, 50% of the IDPs reported to have had diarrheal episodes and 80% of the population interviewed had suffered from Malaria in the 2 weeks before the studies (WFP Uganda and UNICEF Uganda, 2004). Jan Egeland, a senior UN official thought this was 'the world's worst humanitarian crisis' in 2003 (Brown and Sayre, 2002). WFP estimates that over 90% of Gulu district's close to half a million people live in the pathetic weaverbird nest-like huts in crowded IDP camps scattered in the bushes and remote trading centres of the district.

In the camps, health problems range from total lack of health facilities in some camps to frequent disease epidemics, crippling malnutrition, unhygienic deliveries conducted by Traditional Birth Attendants (TBAs) and very poor water and sanitation situations. Health workers only supervise 15% of deliveries in the district leaving the rest of the mothers to be delivered by TBAs, other untrained assistants or on their own (Women Peace, 2004). The maternal mortality ratio in the district is one of the highest in the country. Gulu's District Directorate of Health Services (DDHS) reported in 2004 that the maternal mortality in the district was 700/100,000 live births. Large disparities exist in the maternal mortality ratios across the country and across data sources. UNICEF reported that the Maternal Mortality Ratio in the war torn districts Gulu and Kitgum nears 1,000/100,000 live births (GOU-UNICEF Country program, 2001-2005).

The infant mortality rate is high estimated at 172/1000 births in 2004. The national averages for both MMR and IMR stand at 506/100,000 and 88/1000 live births (DDHS Gulu, 2004). These proxy measures, maternal and infant mortality, gauge the conditions of living of both the mothers and children in the community where they live meaning that whereas the Ministry of Health is positive about Gulu's performance in the league table, the situation is still an obvious persistent tragedy. The maternal mortality and infant mortality rates observed in Gulu are similar to those observed in the emergency phase of mass population displacement before humanitarian intervention gets well organized, only that these are on a permanent basis and probably still worsening.

Action Contre la Faim (ACF), an international NGO operational in Gulu reported that 2.33 deaths/10,000/day occur among the IDPs (ACF-USA, 2003), an indication of a persistently poor humanitarian intervention. In organized humanitarian interventions such as those in a refugee emergency, a core set of 10

intervention areas is often undertaken consistently until a daily mortality of 1/10,000/day is achieved before broader intervention activities are implemented. The MOH, through its local DDHS, still implements all activities of health services in this humanitarian emergency using the nationally standardized HSSP I indicators & strategies for all districts. The HSSP I did not even recognize the IDP situation even though the plan was written 4 years after the creation of the camps. The IDP situation was acknowledged by the health minister in August, 2000 (MOH, 2000).

Nine years after the disaster happened, only draft number IV of HSSP II recognizes the IDPs in its Chapter 3 cluster 4 in the section on disaster-preparedness (MOH, Jan 2005). The strategies are clear but with less specific objectives targeting the IDPs. Only one passive core intervention particular to the IDPs is stated, being to 'establish an exit strategy for IDPs'. How about interventions targeting disease epidemic prevention, malnutrition, curative services, shelter, safe water and sanitation, emergency obstetric care, immunization, protection, mental health for the IDPs, HIV/AIDS prevention and control etc while the population is still displaced, since the factors that led to their incarceration in the camps are still around? This raises equity concerns in health care planning, policy redress of vulnerable groups and resource allocation. Equity concerns in humanitarian interventions for displaced persons have been expressed in many thick unread and now dusty reports, the IDP camps of Gulu being no exception. Toole clarifies that leaders are willing to justify the availability or need of enormous resources for displaced persons as a 'moral imperative', but that such displacements must have occurred in areas of greater political interest (Toole, 2002).

The stakes in a league table

The Ministry of Health has a privileged position during the National Health assemblies. They set the agenda for the Assembly and, in fact, come with draft resolutions for adoption by the plenary. They write the minutes of the Assembly and eventually implement the resolutions. The issues that form the agenda have a strong influence on the overall outcome of the discussions (Walt, 1994). In the past two health assemblies, the issues on the agenda have been mainly derived from the HMIS data received in Kampala by the health ministry on facility and management indicators (MOH, 2004) of the Health Sector strategic plan. These are the indicators that are used to rank districts in a league table. The MOH believes that the overall health sector performance in Uganda is a composite of the different health care delivery systems at district level. Therefore, by using selected HSSP indicators, the contribution of each district is exposed, the reasons behind poor and good performance are revealed and that it facilitates the identification of poorly performing districts for preferential support. The other reasons are that the ranking will provide a basis for discussion by local governments on the performance of each district and the overall health sector performance, enhance good innovative practices amongst the health workers and appropriate reporting (MOH, 2004). It does not mention the risk of neglect by the centre of districts reported to be performing well. It does not highlight the risk of basking in the victory by the districts reported to be performing well. Nor does it mention the risk of resignation of chronically poorly performing districts.

Health sector performance is not solely dependent on delivering those interventions that form the core of the HSSP. The health status of communities is determined by, among others, their level of education and income, water and sanitation, nutrition, housing, health services and social policies (WHO, 2003). The overall health sector performance is therefore influenced by these determinants of health. The indicators used in the Health Sector Performance Report can at best be described as "Health Ministry Performance Indicators". This is because the report does not use the true and internationally recognised health status indicators such as infant mortality rate, under 5 mortality rate, neonatal mortality rate, maternal mortality ratio, total fertility rate, HIV sero-prevalance and life expectancy. The latter group of indicators is used to assess health sector performance since they measure the health outcomes of the population taking into consideration the influence of the different determinants of health. In other words, the outcome health indicators assess the effectiveness of measures towards improving the health of women and children and are indicative of the performance of the health care delivery system (WHO, 2001). In addition, most of the indicators used for constructing the league table are entirely dependent on the performance of the Ministry itself. The Ministry determines how much money a district receives, how fast it receives that money, the expenditure ceilings, the supplies of some inputs, the facilities for timely and complete reporting etc, in short, the most important decisions to be taken about inputs are taken by the Ministry, not the district. How, then can failure to perform or good performance in the said indicators be said to be "district performance"? This paper therefore seeks to suggest that for future Assemblies the agenda for discussion and the basis for the league tables be based on the outcomes of health interventions.

The Health Assembly should be a forum to hear about and discuss the health status of the population not about incomplete reports. The Ministry could reserve those programmatic discussions about incomplete reports to a technical session of Directors of District Health Services or other similar forum. By concentrating the attention of the Assembly on process indicators, the MOH is, probably unintentionally, deviating wide away from the mark of its mission and the health sector objectives. Moreover, it is difficult to exaggerate the discrepancies often manifested by the wide disparities in data about Uganda. The poverty level figures by Government of Uganda sources and UNDP sources properly exemplify this. While UNDP reported that 82.2% of Ugandans live in extreme poverty, the government of Uganda had a figure of 35% over the same period of time (Okuonzi, 2003). The motive of the source seems to determine the data. It is therefore surprising how Gulu District becomes the league table winner from the 45th position in one year. The news is too good to be true and not borne out by the facts on the ground.

The World Health Organisation at the Economic and Social Council (ECOSOC) conference in New York expressed concern that many governments in countries with violent internal displacement of people by armed conflicts are unable or unwilling to report negative consequences resulting from the situation (WHO, 2000). Economic aspirations in terms of increased overseas investments in a country, positive balance of trade and booming tourism determines the information that countries present in the public arena. Gulu's top position was based on the HMIS records being readily available. This method is cheap but of debatable usefulness in detecting outcomes of the health care interventions, given the quality of the data. Most district HMIS data in Uganda are of poor quality (Driwale, 2005).

The implication of the top position are, however, quite enormous especially for the war-torn Gulu district. It portrays Gulu, probably correctly, as a district with committed and competent political and medical leadership who can effectively plan, implement, supervise and monitor health service delivery closely. Unfortunately, however, it also implies that health services are good in the district, including the IDP camps. This implication cannot be further from the truth. Looked at in the broader sense, the league table position attributed to Gulu also gives the wrong impression that the district health system in Gulu is resilient (which is not correct) and that it has survived the prolonged insecurity (which it has not). It portrays a positive image about a very bad situation brought about by the insistence by the Ugandan government on the military option to ending the northern conflict. This persistent thinking at the Ministry has led to the decision to take care of the IDPs from 'wherever they are'.

There are concerns that this position will introduce laxity in planning and delivering critical humanitarian interventions to the IDPs who still live on less than 5 litres of water per person per day, are severely malnourished, have increasing incidence of endemic and epidemic diseases and have to battle with increased gun trauma in situations of inaccessible health services. It is noteworthy that the MOH has only recently made a practical acknowledgement of the IDP situation by directing the districts affected by war to use conditional grants for health with some flexibility to allow for quicker responses to some affordable emergency health needs (Kezaala, 2003). This instruction however did not include any budget increases even though troop movement grossly affects the population size of war-affected areas with increased population influx (the troops, their wives and children), all of who require drugs and other medical attention. In the words of Deng, "*...the displaced persons (in northern Uganda) are struggling to survive and are in dire need of basic access to education, health, water and sanitation. The spread of HIV/AIDS also seems to be a matter of serious concern in the camps*" (Deng, 2003).

Conclusion

Gulu's health situation is still an obvious tragedy. The health indicators that are currently used in district ranking are of limited value in monitoring progress towards the attainment of the national health sector objective. Health data analysis is more revealing if it is done in light of detailed background understanding of the local health situation and experiences of the community from which the data is generated. Otherwise, central level health managers run the risk of overvaluing the importance of un-triangulated data obtained from the lower levels through the HMIS.

Reference

Action Contre la Faim (Action Against Hunger) - USA, 2003: *Nutritional survey in IDPs, Gulu district, Northern Uganda,* May 2003.

Barry B.S and Sidel V.W 2000: *War and public heath: displaced persons and war*; American Public health Association, pages 197-206.

Brown M. and Sayre N. 2002: *Uganda's Forgotten Conflict;* Refugees International, Nov. 2002 at http://

www.refugeeinternational.org/cgi.bin/ri/index?id (viewed 15th Dec.2003).

Deng F: Opening remarks on *Researching Internal Displacement*: state of the Art conference; 7-8 February 2003 Trondheim, Norway; Forced Migration Review; Norwegian University of Science and Technology (NTNU).

Driwale, Alfred, 2005; *Dirty data*: Disease surveillance in Arua District, Uganda. Health Policy and Development, Vol. 3. No. 1

Government of Uganda - UNICEF country program 2001-2005, *Master Plan of operation with program plans of operation*, Government of Uganda/UNICEF, Kampala.

Gulu District Health Profile at http://www.udg.or.ug/DIP/Gulu/overview/health.htm (viewed on 5th August, 2004).

Kezaala M.S., 2003, *Provision of services in districts experiencing insecurity and having internally displaced persons* (IDPs), (letter from the Permanent Secretary MOH, Kampala, to the Chief Administrative Officers).

Medecins Sans Frontières, 1997: *Refugee health: Approach to emergency situations*

MOH, Uganda, 1999, National Health Policy, MOH Kampala

MOH, Uganda, 2000, Health Sector Strategic Plan 2000/01-2004/05, MOH Kampala

MOH, Uganda, 2003, Annual Health Sector Performance report FY 2002/03, MOH Kampala.

MOH, Uganda, 2004, Annual Health Sector Performance Report FY 2003/04, MOH Kampala

MOH, Uganda, 2005, Planning for Reproductive Health in 2004-05, presentation for the Reproductive health convention held at Arua, reproductive health division, Ministry of Health.

Muhwezi J.K., 2004, Health Sector Strategic Plan 200/01-2004/05, Overall logical framework for sector program, Annex 2 page 3, MOH Kampala.

Ocwich. D., 2004, *A dog's life for mothers in Gulu protected camps*, PeaceWomen; Women's International League for Peace and Freedom at http://www.peacewomen.org/ (viewed on 3rd July 2004).

Okuonzi S.A., 2003; *Building social capital for health information*, Health policy and development, **Vol. 1 No.1**, Uganda Martyrs University, Nkozi-Kampala

Toole M 2002; *Protecting the Health of Conflict-Affected Populations: Lessons Learned*: 1976 - 2001; presented at the Global Health Council's Annual Conference, May 29, 2002: Centre for International Health Macfarlane Burnet Institute for Medical Research and Public Health, Melbourne, Australia

Walt, Gill: 1994; *The policy Agenda*, in Health Policy: An introduction to process and power; Zed Books Limited; 1994.

WFP and UNICEF Uganda 2003, *Nutrition and health assessment in the Internally Displaced Persons camps in Gulu District*, Kampala Sept/ Oct 2003.

WHO, 2000; *Internally Displaced Persons, Health and WHO 2000*, Paper presented at the Humanitarian Affairs Segment, ECOSOC 2000 New York, 19-20 July 2000

WHO, 2001; *Maternal mortality at the end of a decade: signs of progress?* Bulletin of the World Health Organization; vol.79 no.6 Geneva, 2001

Women Peace 2004: http://www.peacewomen.org/ July 3rd, 2004