Establishing Routine Healthcare Quality Monitoring and Improvement
Lessons from Laos PDR

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Agenda

• Welcome and Housekeeping
• Presentation
• Discussion
Learnings from trying to

Apply effective coverage framework to the nation-wide healthcare facility quality assessment and improvement; Lao PDR

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Acknowledgement

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Background

Population: 7.4 million
MMR: 126/100,000 LB (2020 UN estimate)
U5MR: 44, NMR: 22/1,000 LB (2022 UN estimate)

Mainly public health facilities
Central hospitals
17 provincial hospitals
130 district hospitals (with or without operation)
About 1,060 health centers

In 2019-2022, Lao PDR has
(1) defined quality standard (RMNCAH and beyond)
(2) developed assessment tools and assessors,
(3) rolled out assessment nation-wide (for RMNCAH)
(4) routinized facility-based quality assessment and improvement support in selected provinces
Objectives and methods of the facility-based quality assessment

Objectives:
1) On-site technical support to providers
2) Hospital planning for quality improvement
3) Provincial planning
4) National long-term strategic planning
5) Scoring for hospital accreditation?

Example of anemia prevention/treatment in antenatal care:
- ANC protocol on anemia screening
- Allowing midwives to order blood test
- Procuring blood test equipment
- Revision of midwifery practice regulation

Data analysis and planning
Example results from Huaphan Province (all 10 districts, 2019-2022)

We tried to apply effective coverage

Antenatal care
Intrapartum care

BP control / eclampsia prevention
Anemia prevention, screening and treatment
Weight gain control / nutrition
Blood sugar control
Prevention of vertical transmissions
Fetal growth monitoring
Effective coverage - anemia prevention during ANC

- Service contact: 100.0%
- Input adjusted - Ready: 65.6%
- Intervention prescription - IFA: 63.4%
- Quality adjusted - IFA counselling all: 25.2%
- Adherence - followed instruction: 22.1%

This was not necessary in the process of identifying health system bottlenecks and solutions at each level (from provider to national).
## Identifying health system solution and responsible levels

**Data source/ Definition**
XK and HP 2022

### Essential RMNCAH service
- **Contraceptives**
  - **Target pop**
  - Service contact
  - Input (HR/Supply)
  - Intervention
  - Quality
  - User adherence
  - Outcome
  - Health system solution
  - Responsibility
  - **Implant 12%**
  - In WCC 77%
  - Counseling 58%
  - LARCs use 7.6%
  - Improve supply / counseling for LARCs
  - Province / providers

- **Antenatal care**
  - **ANC1 65-71%**
  - HR/equip 100%
  - 100%
  - Counseling 84%
  - SBA abt70%
  - Improve counseling for birth-preparedness
  - Providers / province

- **Delivery with SBA**
  - **SBA 49-62%**
  - HR82%, med100%
  - Oxytocin 91%
  - Timely Ox 46%
  - Health provider's practice
  - Providers / province

- **Immunization**
  - 77%
  - 100%
  - 100%
  - Counsel 46%
  - Improve counseling
  - Providers / province

- **Nutrition**
  - 77%
  - HR 53%
  - In WCC 22%
  - Full screen 34%
  - EBF 84%
  - Diet 21%
  - Integration of financing flow, in-facility operation
  - MoH / facility / providers

- **Sick child care**
  - Care seek 55%
  - HR meds 100%
  - Ax for LRI 94%
  - Counseling 52%
  - Readiness (medication, commodity, equipment)

**Colour code**
- **50-100%**
- **50-79%**
- **< 50%**
One way of using the cascade – High-level advocacy

E.g. Missed opportunities due to weak integration in delivery of immunization and nutrition services under Well Child Clinic

Almost 80% of children who came for immunization missed opportunity to receive essential nutrition service

⇒ Used to advocate reorganizing
(1) MoH structure
(2) donor’s funding streams

*BF: breastfeeding (target: under 6 months old), CF: complementary feeding (target: 6 months-3 years old)
Lessons

1. Linear? Matrix?
   • In reality, cascade does not simply go linear (cannot always frame one coverage a fraction of the previous coverage)
   • Matrix is more straightforward when identifying health system solutions and accountability.

2. Quality indicators that impact health outcomes are context-dependent
   E.g. Antenatal care: Counseling on birth preparedness was important in Laos because of the sharp drop from ANC 1 to SBA

3. Effective coverage was useful for advocacy, but have not found its use in facility-level planning
Lessons

4. How / where do we collect data changes the result dramatically.
E.g. Family planning at FP clinic or at well child clinic?

![Graphs showing data collection changes](image-url)
Summary on effective coverage

• Establishing routine facility-based quality assessment & improvement support
  “Quality measurement as a side product in quality improvement”
  ⇒ It is expensive BUT still more cost-effective if we integrate existing program-based technical supervision visits

• Data use should be “piled up” instead of “feedback”
  Use at each level: provider, facility, province, national

• Need to clarify use of linear cascade

• Decentralized capacity development of data-based planning and monitoring is the key
Now, more widely on health system for quality
People die more from low Quality than from non-utilization

Among 8.6 million deaths that could be prevented through health system

- Poor quality: 5 million
- Non-utilization: 3.6 million
Lessons from India’s Janani Suraksha Yojana (JSY)

One of the world’s largest demand-side financial incentive program (cash transfer)

JSY-supported institutional deliveries increased from 14% (2005) to 80% (2010) – larger positive effects on utilization among less educated and poorer women

Found no significant association with maternal mortality ratio reduction

“Demand-side programs like JSY will have a limited effect if the supply side is unable to deliver care of adequate Quality.”

Even with high service coverage, some countries have much higher mortalities than others.

ALL these countries achieved more than 80-90% delivery with skilled birth attendant.

We should not only monitor service coverage, but also Quality.

* Also, consider Social Determinants of Health, which are always reflected on neither coverage nor quality indicators.

Figure 6: Differences in maternal and neonatal mortality rates across low-income and middle-income countries with 80-90% skilled birth attendance coverage.
BUT.
SDG3 monitors health outcomes, service coverage, and health behavior.

3.1 maternal **mortality** / Skilled birth attendant **coverage**
3.2 Child **mortality**
3.3 HIV new cases / TB / Malaria / Hep B **incidence** etc.
3.4 Suicide **mortality rate**
3.5 **Coverage** of treatment interventions for substance use disorders
   Alcohol per capita **consumption**
3.6 **Death rate** due to road traffic injuries
3.7 Adolescent **birth rate**
3.8 **Coverage** of essential health services
   Proportion of population with large household expenditures
3.9 **Mortality rate** attributed to household and ambient air pollution / unsafe water, sanitation

**Quality of health care is NOT monitored globally**
Nor is it monitored **nationally** (in most cases)

<table>
<thead>
<tr>
<th></th>
<th>Population</th>
<th>Health outcome</th>
<th>Service quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every X years</td>
<td>Census</td>
<td>Census / DHS / MICS</td>
<td>?</td>
</tr>
<tr>
<td>Frequent / routine</td>
<td>CRVS</td>
<td>HMIS</td>
<td>?</td>
</tr>
</tbody>
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**Quality of health care is NOT monitored nationally**
This session focuses on integrating Quality into Health Information System. Same discussion should be (and will be) done for other health system pillars:

- **Health Finance**: How to leverage financing for quality?
- **Service delivery**: How to design service delivery that considers quality into account?
- **Human Resource for Health** planning is the key to sustainable quality improvement
- **Governance** can be designed to foster quality improvement