Evaluating the Impact on Clinics of an Output-Based Aid (OBA) Approach to the Treatment of Sexually Transmitted Infections in Southwestern Uganda

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I. Introduction

The Healthy Life program was implemented by Marie Stopes International (MSI), in collaboration with the Ugandan Ministry of Health (MOH) and the Kreditenstadt für Wiederaufbau (KfW) in July 2006 in four districts of southwestern Uganda, Mbarara, Ibanda, Kiruhura and Isingiro. The program operates under an output based aid (OBA) model in which providers treat sexually transmitted infections according to a stringent protocol and are then reimbursed for the cost of treatment after submitting evidence of treatment. Client treatment is monitored using a system of vouchers which are purchased at general retailers and drug shops in the community and then redeemed for STI treatment at contracted providers. During the client consultation, the provider completes a claim form which contains client demographics, the examination and laboratory results, a diagnosis and details of the course of treatment prescribed. Clients are entitled to a total of four visits to ensure that they have been successfully treated. A new claims form is completed at each visit. Claims forms are sent to the voucher management office in Mbarara. Following a review for irregularities and non-compliance with program treatment guidelines, the provider is reimbursed using an electronic transfer of funds to the provider’s bank account. A schematic of the program is shown in Figure 1.

Figure 1. Road Map of the OBA Voucher Program in Southwestern Uganda

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II. Clinic Evaluation

Venture Strategies for Health and Development was contracted to conduct an evaluation of the program. A baseline survey was run in 2006 and a follow-up is planned in the Fall of 2007. This evaluation was conducted between June and August 2007 and its purpose was to determine the impact of the OBA program on the participating provider clinics. Whilst the number of clients treated at each clinic under the OBA program can be determined from the information provided on the claims forms and recorded in the Voucher Management Utilization System (VMUS) database, the numbers of clients seeking STI treatment in the period preceding the program was unknown. The two time periods selected for study were July 2005-June 2006, the year directly preceding the implementation of the OBA program, and July 2006-June 2007, which represents completion of almost one year of the OBA program.\(^2\) Answers to a number of pertinent questions were sought and an evaluation strategy was designed with the following questions in mind.

1. Did clinics seeing greater numbers of STI patients in the first year of OBA compared to the year before OBA, and more importantly, did these clients represent a larger percentage of the total clients seen at the clinic?
2. Did a greater percentage of clients seeking STI diagnosis and treatment testing positive for a specific STI in the first year of OBA compared to the previous year?
3. Do clinics still see significant numbers of non-OBA clients seeking STI diagnosis and treatment or did most STI clients switch to the OBA voucher when seeking STI treatment?
4. Has the quality of STI diagnosis and treatment improved at the provider clinics as a result of the training of clinic staff in these areas?
5. Are clinics seeing an increase in overall client numbers as a result of advertising and marketing of the program through the Behavior Change and Communication (BCC) strategy?
6. Has the OBA program benefited clinics financially and is the reimbursement sufficient?

III. Data Sources

Laboratory and out-patient records from ten of 14 clinics provided information regarding numbers of clients who sought diagnosis and treatment for STIs. Records from four clinics were not reviewed given a lack of time. At the ten clinics, records of clients in the year prior to the OBA program (July 2005-June 2006) were compiled to provide a baseline picture of the situation in clinics before the program was implemented. Records of non-OBA clients seeking STI treatment during the first year of the OBA program (July 2006-June 2007) were also analyzed to determine whether, among other questions, significant numbers were still seeking treatment without OBA vouchers.

A short facility survey was carried out to investigate whether the facilities available at clinics have an impact on the numbers of clients seeking treatment, or on the ability of clinics to

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\(^2\) Clinics began serving clients on July 17, but vouchers were distributed to drug shops and retailers before this date. The timing of the evaluation (June – mid-August 2007) meant that it was not feasible to collect all clinic data up to July 17 2007. Records were compiled up to June 30 2007.
serve clients. The size and skills of the providers varies greatly among the 16 clinics and an effort was made to determine whether these factors affect the quality of service being provided. A semi-quantitative survey regarding the completion and handling of claims forms was also conducted. Together with informal discussions with clinical and laboratory staff they give information on providers’ impressions of the OBA system and the challenges and issues they face in providing STI diagnosis and treatment.

Information for OBA clients attending clinics was obtained from the VMUS database. This database was designed and is managed by Microcare of Uganda and was compiled from the information from claims forms completed by providers at the time of the client visit. Fifty two fields of information regarding demographics, presenting syndromes, results of laboratory findings, diagnoses and treatment details are created from the claim form and can be used to monitor the progress of the OBA scheme. Information from this database, together with the data collected from the clinics enabled us to draw comparisons between utilization of STI diagnosis and treatment services before OBA and during the first year of the OBA program.

IV. Data collection strategies

The selection of clinics from which to collect laboratory and/or outpatient data was based on three factors:

- numbers of clients seen at clinics up to the end of May 2007
- geographical location of clinics
- quality of record keeping at clinics

Preliminary discussions with clinicians and laboratory staff led us to realize that laboratory records rather than outpatient (OPD) records would provide the most useful indication of numbers of clients seeking treatment at clinics. Clients would often visit a clinic for the sole purpose of getting a laboratory test. They would then take the result of the test to a pharmacy or drug shop where advice on medications would be dispensed or just self-medicate based on the test result. To ensure that collection of laboratory records would provide an accurate picture of STI diagnosis in the year before OBA, it was crucial to establish whether clinicians had used a syndromic approach or laboratory-based approach to manage STIs in that period of time. Those that had only used a laboratory-based approach were selected for evaluation ahead of those that had used a syndromic approach. Using this approach, it was possible to determine numbers of clients who had sought a diagnosis at a particular clinic but not necessarily sought treatment.

V. Accessing Clinic Laboratory Records

Clinics selected for evaluation were approached and told of the reasons for the study and why their laboratory records would provide valuable information and lessons about the program and how it could be improved. They were told that only patient ages and gender together with the date of the tests, the types and the results would be collected.

In all cases, clinics allowed record books to be removed and returned later following collection of the data. For those clinics whose current record books were not complete, they often allowed us to remove them overnight and return them in the morning following data collection. For those clinics further afield, a two day trip was made to collect data on-site.
VI. Results

Laboratory and OPD data was collected from ten clinics participating in the program together with data from the VMUS database has been collected and is currently being analyzed. A number of questions will be answered by this data including the following:

- Did clinics seeing greater numbers of STI patients in the first year of OBA compared to the year before OBA, and more importantly, did these clients represent a larger percentage of the total clients seen at the clinic?
- Did a greater percentage of clients seeking STI diagnosis and treatment testing positive for a specific STI in the first year of OBA compared to the previous year?
- Do clinics still see significant numbers of non-OBA clients seeking STI diagnosis and treatment or did most STI clients switch to the OBA voucher when seeking STI treatment?
- Has the quality of STI diagnosis and treatment improved at the provider clinics as a result of the training of clinic staff in these areas?
- Are clinics seeing an increase in overall client numbers as a result of advertising and marketing of the program through the Behavior Change and Communication (BCC) strategy?
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Using the data from the VMUS database and census data from the Uganda Bureau of Statistics, an interactive map is being created with ArcGIS software. This will make it possible to answer a number of additional questions regarding patterns of use of the program among the population. It should also be possible to determine the effectiveness of BCC programs and provide information that could be useful in guiding future efforts for the program. The results of this analysis will be documented in a report to be distributed to the KfW, Marie Stopes International, Venture Strategies for Health and Development and David Griffiths, an independent consultant to the program.

In addition, two documents were prepared for the Marie Stopes International offices in Kampala and Mbarara. In Kampala, the Marie Stopes office is interested in conducting further research to evaluate the following aspects of the program:

1. Clinic performance in STI diagnosis and management
2. Effectiveness of Behavior Change and Communication (BCC) programs
3. Client satisfaction with the services offered in the OBA program

Detailed recommendations of studies that could be conducted using the data from the VMUS database were made. These studies could provide useful information on these aspects and would be considerably less costly and time-consuming than surveys and studies that might also provide similar answers. It was also suggested that continuous analysis of this data, probably on a monthly basis would provide useful insights into patterns of use among the clinics and help to detect irregularities that might indicate abuse of the program by the clinics.
The second document for the office in Mbarara outlined suggestions regarding the overall running of the program that would improve the recording of monthly client numbers at clinics and help to identify clinicians and laboratory staff who are in need of further training. Strategies to target further training to these providers as opposed to hosting further training programs for all of the staff at the providers were also outlined. The role of distributors in counseling and educating potential clients about STIs and whether they are eligible to purchase a voucher was also discussed. Improvements including the provision of a more detailed poster discussing signs and symptoms as well as ensuring that posters are clearly displayed were also described. Finally, a recommendation that MSI staff write informal reports in the style of a journal, documenting their experiences in the field when talking to clients, distributors and clinicians was made. Such rich information should prove valuable to the program in the future and would be a useful source of reference for other programs.

VII. Summary

An evaluation of the impact of the OBA program on participating clinics was carried out in June-August 2007. Ten weeks were spent in the field in four districts in southwestern Uganda in which the program was operating. Laboratory and OPD data from ten clinics was collected in that period and is currently undergoing analysis. Two surveys, a facility survey and one documenting the processes involved with completing and processing of claims forms were also carried out at 13 of the 14 clinics in the program.

Two documents containing suggestions and recommendations for future monitoring, evaluation and analysis of the data contained in the VMUS database were also prepared. These were distributed to the Marie Stopes International offices in Kampala and Mbarara respectively. A final report of the evaluation is being prepared for the KfW and Marie Stopes International and will also contain an interactive map which can be used to examine and document patterns of use of the program in the four districts included in the program.