The Adaptation and Roll out of the 3-Interlinked Patient Monitoring Systems for AIDS care/ART, TB and MCH/PMTCT in Uganda

Uganda Team
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Introduction

• Public Health approach to implementation of ART since 2004
• The scale up took effect and many patients were enrolled into care
• More facilities continued to be accredited
• Need for a data capture system arose
Patient Monitoring System for HIV Care

- HMIS: limitations on data variables and inability for longitudinal patient monitoring
- Additional vertical systems adopted for HIV care, TB, PMTCT and others to augment the HMIS
- Many IPs had separate Paper-based & electronic PMS of varying complexity
- HIV care/ART PMS adapted from WHO in 2006
- During implementation, weaknesses were noticed with the system
Revision of the HIV care/ART PM Forms

• In 2008, MOH planned to revise the forms to address the weaknesses identified
  – Redundant elements
  – Short follow up periods of ART clients
  – Inability to meet some programme monitoring needs and international reporting requirements
    • TB/HIV integration
    • Number of individuals in chronic care
    • PMTCT data etc
Revision of the HIV care/ART PM Forms

• During the same period, WHO released a protocol on the 3ILPMS

• MoH utilized the opportunity and organised to adapt and the process commenced in early 2009
Adaptation of the 3-Interlinked Patient Monitoring System in Uganda

- The adaptation process was led by MoH but involved multi-stakeholder consultations: facilities, IPs, DPs
- Separate processes for TB, PMTCT and HIV Care/ART
- The product went through the relevant committees for consensus and approval - M&E subcommittee and NAC
- Training manuals for health workers were updated
Major Changes to the PMS

– New data elements, particularly those facilitating inter-linkage, follow-up of HIV-exposed infants and monitoring of paediatric clients were added

– Provisions for improved follow-up of clients on chronic HIV/AIDS care

– Data elements necessary for tracking HIVDR EWIs and universal access indicators such as TB/HIV integration, etc were added
Major Changes (cont)

- HIV care / ART card redesigned to be more user friendly, including instructions
- Pre-ART Register revised to provide for quarterly follow-up, improve recording of cotrimoxazole prophylaxis, linkage to PMTCT, exposed infants and TB/HIV
- ART Register revised to improve linkage to PMTCT, TB/HIV, exposed infant follow up, longer follow-up period, and data for tracking HIVDR EWI
Major Changes (ctd)

• Cross Sectional Reporting Form
  – reporting frequency changed to quarterly
  – Incorporated ART outcomes of treatment cohorts
  – Provided for reporting of concurrent TB treatment
  – Removed redundant data elements

• Cohort Analysis Form
  – Merged with cross-sectional reporting form
  – Outcome parameters monitored updated including CD4 cut off from >200/ul to >250/ul
Main Changes (cont)

• PMTCT Information systems revised to capture
  – Routine clinical staging of antenatal women,
  – HIV-positive women started on ART,
  – Infants with confirmed diagnosis, started on ART
  – TB assessment status

• The Child Health Card updated to capture
  – Infant feeding practices,
  – HIV test result, and started on treatment

• TB Information systems updated to capture:
  – HIV screening of TB patients,
  – provision of ART, Cotrimoxazole to TB patients
Roll-out of the Revised ART Patient Monitoring System

• The MoH spearheaded the roll out

• Processes involved:
  – Production and distribution of the revised tools
  – Updating of the training manual
  – Training, supervision and mentoring of Health workers
  – Obtaining buy in from other IPs

• IPs (including USG-supported IPs) supported the roll-out of revised tools through production, distribution and training of health care workers
Roll out of 3-ILPMS

- By Mid 2010, the revised forms were in use in all active ART sites
- All IPs data capture and reporting were aligned to the new system
- The quarterly reports were reaching MoH promptly
- All health facilities providing PMTCT were using the interlinked forms
- TB and exposed infant data capture improved
- EWI data elements captured
Data Quality Procedures in the 3-ILPMS

• Processes for ensuring data quality included:
  – Guidelines on how to fill various forms
  – Mentoring and supervision by central and regional/district teams
  – Periodic data quality assessments (DQAs) / verification with feedback
  – Streamlining reporting from facilities with many IPs to rule out double counting
Challenges:

• Multiple information systems among IPs
• Lack of web based electronic versions of the 3-ILPMS
• Adaptation of the 3ILPMS by the the Programmes – HIV, TB
• Migration of data from the old system
• Heavy paper work burden and staff burn out
Emerging Trends

• MoH adopted OMRS to ease patient management as well as reporting – roll out has not been easy

• MoH decided to harmonise reporting in the whole health system using HMIS and DHIS2 – this eliminated the parallel reporting system, requires capacity building, access rights, soft and hardware acquisition etc