Implementing a District Focal Person Model to Strengthen PMTCT Service Delivery: Early Lessons
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About the Elizabeth Glaser Pediatric AIDS Foundation Zimbabwe Program

Since 2001, EGPAF has been working to provide and support comprehensive PMTCT services in pursuit of the Zimbabwe Ministry of Health and Child Welfare’s goal to “promote delivery of comprehensive, high-quality PMTCT services that are integrated and linked to treatment, care, and support.” This support has been primarily funded by the U.S. President’s Emergency Plan for AIDS Relief through the U.S. Agency for International Development and the UK Department for International Development. In 2010, EGPAF was awarded a five-year grant by The Children’s Investment Fund Foundation, which significantly boosted EGPAF’s capacity in 2011 to rapidly scale up and expand the provision of high-quality comprehensive PMTCT services in line with the World Health Organization 2010 PMTCT guidelines, including the deployment of a new cadre of PMTCT district focal persons as described in this document.
BACKGROUND

District-level prevention of mother-to-child transmission of HIV (PMTCT) services in Zimbabwe are supervised and monitored by district nursing officers (DNOs), who also supervise a number of other maternal, newborn, and child health services including antenatal care (ANC), labor and delivery, postnatal care, the Expanded Program on Immunization, and growth monitoring, among others. To date, overburdened DNOs have been unable to prioritize PMTCT at the level needed to achieve Zimbabwe’s goal of reducing the rate of mother-to-child transmission of HIV to less than 5% by 2015 in line with its national plan for virtual elimination of pediatric HIV. To address this and other challenges, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)-supported Zimbabwe Family AIDS Initiative (FAI) consortium, in collaboration with the Zimbabwe Ministry of Health and Child Welfare (MOHCW), adopted and nationalized a PMTCT district focal person (DFP) model to support Zimbabwe’s national PMTCT program in 2011.

DFPs are experienced community health nurses based within districts who are charged with supporting the MOHCW district health teams (DHTs) in implementing the revised 2010 World Health Organization (WHO) PMTCT guidelines, which were adapted for national use in 2010. EGPAF recruited and trained 30 DFPs in April 2011 and an additional 4 DFPs in early 2012. Together, these 34 DFPs support a total of 60 districts, with each DFP supporting 1 to 3 districts. Each DFP undergoes an intensive six-week training before deployment (facilitated by EGPAF), which covers a wide variety of topics, from clinical care and program monitoring and evaluation (M&E) to logistics and computing (see Box 1 for a complete list of topics covered during the training).

BOX 1. TOPICS COVERED DURING THE SIX-WEEK INTENSIVE DISTRICT FOCAL PERSON TRAINING

- New hire orientation on EGPAF human resource and management policies and procedures
- District focal person roles and responsibilities
- Integrated Management of Adult and Adolescent Illness/Integrated Management of Pregnancy and Childbirth (IMAI/IMPAC; based on the generic WHO training materials)—covers delivery of integrated HIV prevention, care, and treatment services, including antiretroviral therapy and antiretroviral prophylaxis within routine maternal, neonatal, and child health settings
- Point-of-care CD4 testing
- Training methodology, including participant selection and training coordination
- Monitoring and evaluation, including data quality audits and collection of performance management indicators
- Advocacy and community mobilization
- Conducting district review meetings
- Principles of operations research
- Conducting baseline program assessments
- Operational and administrative management processes
- Basic computing
DFPs are seconded to the MOHCW and work as fully integrated members of the ministry's DHTs (see related sidebar, Building Local Ownership of the DFP Model). As district-level MOHCW staff members, they report directly to DNOs in their supported districts, while receiving additional supervision from two Harare-based DFP coordinators employed by EGPAF. Since DNOs are responsible for overseeing a variety of programs, deployment of DFPs is helping to ensure that implementation of the revised 2010 national PMTCT guidelines and monitoring of PMTCT program quality are prioritized at the district level.

**DFP Roles and Responsibilities**

DFPs are registered nurses and/or midwives with training in community health and extensive practical PMTCT and community nursing experience. Each DFP is recruited from one of the districts to which he or she is assigned in order to ensure that he or she is familiar with the districts and the district team and is not viewed as an outsider. Each DFP is provided with a vehicle for transport to health facilities and is expected to conduct supportive supervision visits at each health facility in his or her supported districts once per quarter. During supervision visits, the DFP is usually accompanied by a member of the MOHCW DHT, and he or she is occasionally accompanied by an EGPAF DFP coordinator or technical support team member from EGPAF or one of EGPAF’s three local sub-grantees. The DFP does not replace or supersede the DNO in his or her PMTCT supervisory role but rather functions as a PMTCT focal person under the direction of the DNO.
DFP site-level supportive supervision is aimed at achieving the following objectives:

1. To provide general support to health care workers in provision of PMTCT services at local health facilities
2. To coach and mentor health care workers on implementation of the PMTCT program and implementation of new program interventions (e.g., application of more efficacious antiretroviral [ARV] prophylaxis regimens for PMTCT, early infant diagnosis, integration of antiretroviral therapy [ART] in maternal and child health [MCH] settings, and collection and reporting of PMTCT service delivery data)
3. To strengthen community linkages with community health workers to improve uptake, retention, and follow-up of patients in the PMTCT program
4. To review the PMTCT cascade while identifying and planning corrective action to address program bottlenecks limiting the delivery or effectiveness of PMTCT services
5. To document achievements, lessons learned, and best practices during visits to share with fellow DFPs, as well as DHTs, other health care workers, and the EGPAF Zimbabwe program
6. To build the capacity of the DNOs and DHTs in providing routine site supportive supervision and prioritizing PMTCT at the district level

During a routine supportive supervision visit, the DFP will review findings from the previous visit with relevant health facility staff (typically nurses in the antenatal clinic and facility managers); provide and review the most recent site-specific M&E data, including a walk-through of the entire PMTCT cascade (via a printed report from the EGPAF GLASER [Global AIDS Systems for Evaluation and Reporting] database); and provide feedback and mentorship to care providers. The DFP discusses service delivery challenges and gaps, and encourages facility staff to develop recommended actions to address the gaps identified. After the visit, the DFP will regularly communicate with facility staff and offer technical assistance as needed. The next visit to the site is generally conducted within three months of the previous visit. As part of the follow-up visit, the DFP will assess steps taken and progress made by the site in addressing gaps identified during the previous visit.

Supervision visits are guided by the use of a comprehensive evaluation tool developed by the EGPAF team in collaboration with the MOHCW. Data collected using this paper-based tool are submitted to the DNO, with summaries submitted to EGPAF technical staff on a quarterly basis for review of program performance. Starting in mid-2012, an electronic version of this tool has been piloted in select districts with the aim of providing both MOHCW and EGPAF staff with real-time access to facility-level data on progress and challenges related to PMTCT service delivery for improved program monitoring and data use.
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Capacity-Development Approach

DFPs are not working in isolation. Throughout their day-to-day activities, DFPs are building the capacity of the DNOs and DHTs, as well as providing support to facility-based health care workers to strengthen delivery of PMTCT services. The following are examples of activities used by the DFPs to build capacity for PMTCT service provision within their supported districts:

1. **District baseline situation analysis**—DFPs worked closely with the district teams to collect data from all health facilities in the district for the EGPAF-led baseline PMTCT situation analysis conducted during 2011. Findings from this analysis provided DNOs and DHTs with a better understanding of the current state of PMTCT program implementation in their districts, as well as program gaps and strengths used to inform district planning.

2. **District planning**—DFPs and DNOs work together to develop annual district PMTCT plans, using information about gaps and priorities identified in the baseline situation analysis and during site support visits.

3. **Health worker training**—DFPs and DNOs collaborate to identify PMTCT training needs within the districts, develop training plans, and provide technical and coordination support during delivery of the trainings, as well as post-training mentorship and performance monitoring. Since implementation of the DFP model, EGPAF has facilitated the training of 2,653 health care workers in a variety of areas, including IMAI/IMPAC, rapid HIV testing, ART (adult and pediatric), and infant and young child feeding, among others.

4. **District review meetings**—DFPs and DNOs coordinate semiannual district review meetings, during which managers and care providers from all facilities in a district come together to review site-level data, share successes and lessons learned, and identify strategies to address key challenges.

5. **Site support and supervision**—DFP site supportive supervision and mentorship visits are conducted in conjunction with members of the DHTs to monitor program performance using both standard and specialized indicators, and to provide technical support to health care workers aimed at improving PMTCT service quality.

DFP Five-Year Plan and Long-Term Vision

The vast majority of the 1,354 EGPAF-supported health facilities are public hospitals and health centers, including those operated by faith-based groups. Working in this context, the program is building site-level capacity to provide quality PMTCT services and is putting monitoring and management systems and skills in place to ensure the program’s long-term sustainability beyond the period of EGPAF support. Transition capability has been built into the DFP model from the very start—local ownership by the MOHCW has already been established, and the eventual goal of the program is handover of all support functions from EGPAF and its FAI partners to the MOHCW once local capacity has been sufficiently established.

Since the DFP model was established in 2011, the MOHCW has understood and agreed that it will not permanently sustain the DFP model. Rather, the DFPs are envisioned as a temporary cadre established to provide a short-term infusion of support to DNOs and DHTs with the aim of supporting rapid national adoption and implementation of the 2010 WHO PMTCT guidelines as well as overall expansion and strengthening of the national PMTCT program. The DNOs hold a broad array of roles and responsibilities tied to multiple competing health priorities, limiting their ability to focus on PMTCT service delivery. Therefore, working in collaboration with
the DNOs, the DFPs are providing temporary enhanced support for achievement of Zimbabwe’s national goal of virtual elimination of pediatric HIV infections by 2015.

EGPAF’s five-year program plan includes two major phases. Phase 1 (October 2010–September 2012) will involve massive PMTCT program scale-up, geographic expansion of services to achieve national coverage, and national training and roll-out of the 2010 WHO PMTCT guidelines. DFPs are playing a key role in this first phase, functioning as a catalyst to support program expansion and optimization. Phase 2 (October 2012–September 2015) will focus on strengthening the delivery of quality, comprehensive PMTCT services through ongoing capacity building, on-the-job training, site-level supportive supervision, and mentorship of health care workers.

A key priority for this second phase is to ensure the long-term sustainability of all program activities. DFPs will play a critical role in ensuring that these second-phase objectives are met and that all components of the 2010 WHO PMTCT guidelines are being successfully implemented and routinely monitored to ensure optimal program performance.

Since the DFP position will be phased out at the end of the five-year program, DFPs will develop exit strategies and plans with their respective DNOs and DHTs at the end of year four to ensure the sustainable handover of day-to-day coordination and support for the PMTCT program at the district level. These handover plans will be implemented during the final year of the program (year five). Given that DNOs and DHTs have been working together hand in hand throughout the life of the project, it is expected that DHTs will have the capacity to continue providing routine site supportive supervision after the DFP position is phased out. By the end of the five-year program, it is expected that much of the intensive work required to build facility and health care worker capacity will have been completed, leaving the less intensive role of program maintenance in the hands of the DNOs and DHTs.
Several accomplishments and challenges associated with implementation of the DFP program model to date have been reported by the DFPs, DFP coordinators, and EGPAF Zimbabwe technical staff during the first year of the model’s implementation. Presented here are early lessons that can serve to inform those in other countries considering or embarking on similar district-level efforts to support quality PMTCT service provision.

**Site-Level Support for Provision of PMTCT Services**

One area in which DFPs have had a particularly visible impact is completeness of patient registers. DFPs from all provinces have reported that routine review of registers with clinical staff has improved facility staff performance in this area by increasing their accountability. In some instances, this follow-up has led to documented improvements in key aspects of service delivery (see related sidebar). However, site-level data quality continues to be a challenge, and DFPs are being encouraged to take a leading role in validating site-level data before they are sent to the districts.

DFPs also have observed that many nurses at MCH facilities trained in opportunistic infections and ART management have not yet begun initiating patients on ART. Currently Zimbabwe’s national ART guidelines do not contain explicit guidance for nurse-led ART initiation, and therefore some nurses do not feel comfortable proceeding without this guidance. DFPs continue to mentor nurses in this important area and to advocate for provincial medical directors in all provinces to formally communicate their support, and provide related mentorship, for nurse-led ART initiation.

ARV prophylaxis for PMTCT can be accessed at 99% of ANC facilities in Zimbabwe, while 89% of the 1,354 EGPAF-supported health facilities (as of March 2012) offer more efficacious multidrug ARV prophylaxis regimens for non-treatment-eligible pregnant women in accordance with the 2010 WHO PMTCT guidelines (Option A). Implementation of all components of the 2010 guidelines, however, varies greatly by district. In addition, the majority of pregnant women enter ANC later than 14 weeks, at a national average of 25 weeks. DFPs are addressing this gap by emphasizing the importance of early ANC booking to health care workers, as well as supporting related community-based educational outreach activities. In several districts, DFPs have worked alongside community health care workers to conduct community sensitization sessions, during which families are educated on the importance of enrolling in ANC during early pregnancy.

In July 2011, EGPAF supported the deployment of point-of-care (POC) CD4 analyzers at 50 facilities; deployment of an additional 104 machines occurred in early 2012. These machines, which have been placed in MCH clinics within high-volume health facilities (both those with and without laboratory-based CD4 testing on-site), are prioritized for use with pregnant and lactating HIV-positive women to determine their eligibility for ART. Early outcomes of the POC CD4 deployment have been promising—EGPAF-supported POC CD4 testing currently accounts for roughly 20% of all MCH clients receiving CD4 testing nationwide (as of March 31, 2012)—and DFPs are playing a key role in addressing challenges to delivering POC CD4 testing. These include shortages of trained health staff (resulting in no testing offered when trained staff members are off duty), shortages of commodities

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**PROMISING PRACTICE: INFANT Cotrimoxazole Prophylaxis**

In Mashonaland East Province, active follow-up of district focal persons on recording of cotrimoxazole (CTX) dispensing for infants in the infant dispensing registers resulted in an increase in the reported proportion of HIV-exposed infants receiving CTX from 32% in first quarter of 2011 to 97% in the fourth quarter of 2011.
(e.g., test cartridges), and, in a limited number of cases, machine breakdowns. DFPs also are actively reporting challenges as they arise to relevant district or provincial health authorities and EGPAF technical teams so that they can be addressed within a reasonable time frame. DFPs have found that it is often easier to address these challenges and perform related follow-up at facilities where a PMTCT focal person (a health care worker charged with oversight of PMTCT service delivery at a specific facility) has been appointed by the facility manager.

**Strengthening Health Facility–Community Linkages**

DFPs are actively encouraged to work together with local leadership and make use of local village health workers (VHWs) in support of stronger community–health facility linkages. Several community mobilization activities have been reported by DFPs, and communication and coordination between DFPs and VHWs has been working well. In some instances, DFPs have been able to piggyback on community events led by other partners on a variety of health issues to ensure that PMTCT messages are also included. Increases in male partner testing as a result of community-based activities were observed in some districts, with one DFP observing a man carrying an infant on his back to the health facility, which the DFP regarded as a promising break with traditional gender norms.

One key challenge being experienced by all DFPs is the lack of a standardized process for documenting community-based referrals and follow-up activities. However, EGPAF’s community mobilization officer has been training VHWs to record their activities in diaries, and EGPAF will soon be piloting the use of referral slips by VHWs. DFPs also have reported that some facility-based nurses have a limited understanding of the VHW role and therefore are not using them to maximum effect in facilitating client referrals and follow-up. In response to this challenge, DFPs are working to sensitize nurses on the importance of working together with the VHWs to ensure a strong continuum of care.

**Addressing Bottlenecks in the PMTCT Cascade Through District Planning**

DFPs have noted the important value of district review meetings. DFPs unanimously feel that the meetings, which are owned and led by DHTs, are resulting in improved district-level use of PMTCT program performance data for decision making. Each DFP has developed annual district plans that outline all activities that should be conducted by the districts to address gaps identified during the EGPAF-led baseline situation analysis. These plans were jointly developed with the DNO/district health executive and include all district PMTCT activities regardless of partner support.
Figure 1. Example of a typical presentation of PMTCT program management indicators, which are collected and used by DFPs and shared with facility and district staff for enhanced monitoring of program performance.

Note: Data presented are for demonstration purposes only.
ART=antiretroviral therapy; ARV=antiretroviral; DFPs=district focal persons; EID=early infant diagnosis

**Program M&E**

DFPs contribute significantly to program M&E. The expanded PMTCT program introduced a new set of routine program M&E indicators—program management indicators (PMIs)—which were not being collected through the national M&E system. PMIs have proven to be a highly useful tool for monitoring facilitators and barriers to service delivery and enabling course correction as issues arise (see Figure 1). A new data-collection mechanism was put in place for collection of PMIs when the DFP model was introduced, with DFPs being responsible for collecting these indicators during site support visits and submitting the data to the EGPAF M&E unit for analysis.

DFPs have been trained in M&E, including the use of data-collection tools, indicators, and PMTCT data analysis. Using this knowledge, they provide on-the-job M&E mentorship to facility staff during site visits that focuses on establishing a solid understanding of PMTCT indicator definitions as well as the importance of accurate and timely completion of PMTCT registers and related reports submitted to the DHT. DFPs also assist facility and district health staff to analyze and interpret routine service delivery data to facilitate thoughtful data use during PMTCT quarterly MOHCW program reviews conducted at the district and provincial levels.
KEY LESSONS LEARNED

The following key lessons have been culled from discussions and observations among EGPAF, its local partners, and MOHCW staff:

Improving PMTCT Program Performance

• While equal coverage of all sites by DFPs is important during program start-up, high-volume sites can be prioritized once the program is established to support the quality of PMTCT services reaching the widest swath of the population.

• DFP routine review of registers with clinical staff can increase staff accountability for register completeness.

• Discussion of site PMTCT cascade data should be an integral part of site support, as it enhances the local staff’s understanding of their program’s performance and motivates them to do better.

• Recommendations made as a team during site support visits improve coordination and ownership among all team members (e.g., DFPs, MCH clinic staff, auxiliary department staff).

• PMIs collected by DFPs during site support visits are a valuable source of data for EGPAF-FAI and MOHCW that help track program performance.

• Having a site-level PMTCT focal person facilitates the work of the DFP.

• Visiting each department during site support visits provides an opportunity to mentor more health care workers and gain a better understanding of the role each department plays in PMTCT service delivery.

• DFPs should be provided clear guidelines for the development of realistic district training plans so that health care worker training needs are not over- or underestimated.

Cooperation and Coordination with Provincial and District Health Authorities

• Early collaboration with and ownership of the DFP cadre and model by MOHCW leadership at the national and provincial levels was critical to their smooth implementation and acceptance in districts.

• Semi-annual district review meetings, which are owned and led by DHTs and attended by DFPs, support improved district-level data use for decision making.

• Meetings between DFP coordinators and provincial nursing officers preceding DFP site visits and post-visit feedback to provincial health executives foster enhanced provincial support for the PMTCT program and assist in setting provincial-level program priorities and objectives.

• Involvement of the district health executive, provincial MOHCW staff, and FAI partners during support visits enhances their ownership of and accountability for site-level performance.

• District medical officers should be informed of and participate in DFP coordinator site visits to secure their active support in addressing challenges.

• Full integration of DFPs into the DHT structure can be hampered if a DFP takes time transitioning from his or her previous role as a senior MOHCW staff member or if the DFP is viewed as an EGPAF employee.
Strengthening Health Facility–Community Linkages

- DFPs can piggyback on community events led by other partners on a variety of health issues to ensure that PMTCT messages are also included.

- DFPs play an important role in ensuring that health care workers understand the VHW role and are actively using this cadre to support PMTCT client follow-up.
CONCLUSION

Implementation of the DFP model has yielded promising results during its first year. These early lessons speak to the importance of strong partnerships between government and implementing partners as well as the effect that focused supportive supervision can have during a period of rapid national scale-up and strengthening of PMTCT service delivery. Applying the experience it has gained thus far, EGPAF will continue to work in close collaboration with existing MOHCW district-level health facility management structures to support Zimbabwe in achieving its national goal of eliminating new HIV infections in children by 2015 and keeping mothers alive.