IMPLEMENTING THE PEPFAR PIVOT: Experiences from Zimbabwe's Voluntary Medical Male Circumcision Program

In 2015, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) 3.0 implemented a strategic pivot to control the HIV epidemic by using data to prioritize geographic areas and populations for greatest impact. As a result, Zimbabwe’s PEPFAR-supported voluntary medical male circumcision (VMMC) program transitioned from national scale up to focus instead on reaching 80% of eligible men ages 15-29 with VMMC in high-priority districts. Since 2013, the ZAZIC consortium, under the International Training and Education Center for Health (I-TECH), Harare, Zimbabwe; International Training and Education Center for Health (I-TECH), Seattle, WA, USA; Department of Global Health, University of Washington, Seattle, WA, USA; US Centers for Disease Control and Prevention, Harare, Zimbabwe; Zimbabwe Ministry of Health and Child Care (MoHCC) in 21 districts in Zimbabwe. In all 21 districts, a performance-based financing (PBF) component was used to incentivize VMMC performance, paid directly to the health facilities. Under the PEPFAR pivot, ZAZIC’s VMMC implementation was reduced to 10 high priority districts. Ambitious VMMC numeric targets were maintained despite dramatic reductions in program reach, requiring a 200% increase in productivity for remaining districts to successfully reach 2015 targets. The pivot necessitated immediate program redirection from breadth to depth accompanied by a rapid shift from integrated delivery to a modular implementation approach.

DESCRIPTION
ZAZIC’s integrated VMMC approach used existing healthcare workers and MoHCC infrastructure, focusing on capacity building, continuous quality improvement, and sustainability. From October 2013 through September 2015, ZAZIC expanded from 2 to 36 static VMMC sites and performed a total of 14,738 VMMCs, averaging 53.30 per month. More than 85% of all VMMCs were completed independently by existing MoHCC staff in health facilities; approximately two-thirds of those occurred in outreach settings. ZAZIC exceeded the VMMC targets set by the donor in conjunction with the MoHCC in both 2014 and 2015.

PRIORITY DISTRICT CONSIDERATIONS:
CDC, in conjunction with the other US government partners, worked with ZAZIC and other local partners to review and analyze existing available MoHCC data to determine the priority districts for Zimbabwe PEPFAR funds under PEPFAR 3.0. The following considerations were taken into account for setting the priority districts:

- HIV prevalence
- ART priority districts - based on unmet need for ART
- % of circumcised men ages 15-29
- Current VMMC volume
- % of intervention staff reaching targets
- % of health facilities with sufficient VMMC supplies
- % of health facilities with VMMC providers
- % of health facilities with VMMC equipment
- % of health facilities with VMMC training
- % of health facilities with VMMC capacity
- % of health facilities with VMMC outreach
- % of health facilities with VMMC sustainability

RESULTS
To achieve the same VMMC outputs within a much smaller geographic area, ZAZIC rapidly transitioned to a hybrid implementation model, employing additional mobile and outreach teams using non-MoHCC staff in a variety of locations. Although the proportion of VMMCs occurring in outreach sites remained at approximately 85%, ZAZIC expanded the reach of VMMC services by delivering more outreach sites post-pivot. Vehicles were procured for all districts to address transportation challenges. In the first 6 months post-pivot, ZAZIC maintained an average of 3,776 per month with an average AE rate of 0.3%, demonstrating an impressive, safe transition in accordance with the pivot requirements.

LESSONS LEARNED
- The pivot required moving away from ZAZIC’s more integrated approach to a more modular and targeted model.
- ZAZIC demonstrated the flexibility and productivity required to achieve ambitious VMMC targets.
- Additional mobile teams using non-MoHCC staff contributed greatly to the success of the transition.
- Non-priority districts were not eligible for PBF payments post-pivot and did not maintain VMMC services.
- The additional mobile teams potentially depleted facilities of existing MoHCC staff who became employed as direct service providers for VMMC.

CONCLUSIONS
ZAZIC’s locally-led consortium successfully transitioned its program to meet changing PEPFAR priorities. ZAZIC continues to reach its targets and safely improve productivity. However, there is need to evaluate the implications of the pivot on VMMC service delivery as well as on other services within VMMC facilities. It is possible that additional moving teams necessary to meet the targets may decrease site engagement, reducing sustainability of the VMMC program overall. The impact of the pivot merits further study.

Acknowledgements:
This work took place under a non-research determination protocol entitled, “Scaling Up Voluntary Male Circumcision Service Delivery in Zimbabwe” (ZAZIC-3.0) and funded by CDC grant U335DA00007. The authors wish to thank the Zimbabwe Ministry of Health and Child Care and the MoHCC teams from its 21 districts for their dedication in implementing the VMMC program.

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