ZIMBABWE NATIONAL FAMILY PLANNING STRATEGY (ZNFPS)

2016 - 2020

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune-deficiency Syndrome
ASRH	Adolescent Sexual and Reproductive Health
AVU	Audio Visual Unit
CBD	Community Based Distributor
CBW	Community Based Worker
CPR	Contraceptive Prevalence Rate
DTTU	Delivery Team Topping Up
FP	Family Planning
GoZ	Government of Zimbabwe
HIV	Human Immune-deficiency Virus
HMIS	Health Management Information System
IEC	Information, Education and Communication
IUCD	Intrauterine Contraceptive Device
LAPM	Long Acting and Permanent Methods
LMIS	Logistics Management Information System
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
M & E	Monitoring and Evaluation
MoHCC	Ministry of Health and Child Care
NGO	Non-Governmental Organisation
PESTLEG	Political Economic Social Technological Legal Ethical and Geographical
PPP	Public Private Partnership
RH	Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SWOT	Strengths, Weaknesses, Opportunities and Threats
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
VHW	Village Health Worker
ZDHS	Zimbabwe Demographic Health Survey
ZimASSET	Zimbabwe Agenda for Sustainable Socio-Economic Transformation

ZNASP	Zimbabwe National HIV & AIDS Strategic Plan
ZNBFP	Zimbabwe National Board of Family Planning
ZNFPC	Zimbabwe National Family Planning Council

DEFINITION OF TERMS

Knowledge of family planning: Percentage of women/ men of the reproductive age group who know at least one method of family planning

Contraceptive Prevalence Rate: Percentage of currently married women (15-49 years) who are using a contraceptive method

Unmet need of family planning: Percentage of currently married women (15-49 years) who are fecund and sexually active but are not using any method of contraception and report not wanting any more children or wanting to delay the next child.

Total Fertility Rate: The average number of children that would be born to a woman if she were to live to the end of her child bearing age and bear children in accordance with the current age specific fertility rate.

Maternal Mortality Ratio: The number of pregnancy related deaths per 100,000 live births.

Reproductive health: Is a state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or infirmity. Reproductive health deals with the reproductive processes, functions and system at all stages of life

Rights Based Approach: The recognition of the basic rights for all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to the highest attainable standard of sexual and reproductive health.

Young people /youths: Refers to persons within the composite age range of 10 – 24 years.

Integration: This refers to how different kinds of sexual and reproductive health (SRH) and HIV services or operational programmes can be connected together to improve the health outcomes of the people served. This may include referrals from one service provider to another. It is based on the need to offer comprehensive and integrated services.

FOREWORD

On the global scale, Zimbabwe's knowledge level of family planning (FP) among the sexually active population is almost universal at 99%. According to the 2010/11 Zimbabwe Demographic Health Survey (ZDHS), the contraception prevalence rate (CPR) increased from 54% in 1999 to 59% in 2010. However, the unmet need for FP has remained stagnant at 13% since 1999. Recognising the adverse impact that limited availability of vital integrated FP services would have on the socio-economic and health status of the nation, the Government of Zimbabwe has therefore developed a strategy that will guide the nation in the provision of integrated quality family planning, adolescent sexual and reproductive health, HIV & AIDS services from 2016-2020.

The strategy is in line with the Government of Zimbabwe's vision and economic blueprint; Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimASSET). Within the ZimASSET, FP falls under the Social Services and Poverty eradication cluster. Therefore the strategic document offers a clear logical framework to create an enabling environment conducive for the provision of quality, comprehensive and integrated FP and related SRHR services in Zimbabwe. Further it will ensure the provision of high quality sexual reproductive health care in Zimbabwe.

This strategy aims to improve on efficiency and effectiveness in the provision of integrated FP services in line with the government's commitments made at the London FP 2020 Global Summit in 2012. The policy document offers a logical framework to create an enabling environment necessary for the provision of quality, comprehensive and integrated FP and related SRHR services in Zimbabwe. It also aims to contribute to the development and increased national commitment to family planning and accelerate the achievement of the Millennium Development Goals (MDGs). This is also in sync with recognising the right to high quality reproductive health care.

Despite the high literacy rate (96%, 2012 Population Census National Report) among Zimbabweans, and the spread of accurate information about the use of FP methods at all levels, widespread religious and cultural beliefs still hinder the use of FP methods. These hindrances have resulted in a static unmet need of FP over the years. The strategy focuses on reform and re-organisation of the way FP services are delivered in Zimbabwe, in order to ensure high quality, comprehensive and integrated services associated with intended outcomes. It is envisaged that this will address the current findings of the static unmet need for FP. All this is embraced by our vision of a Zimbabwe where all individuals enjoy comprehensive quality integrated FP and related SRHR services and rights.

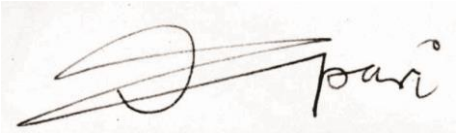
Increased access to integrated FP has many essential benefits for individuals, families, societies and the nation at large. By ensuring universal access to integrated FP and related SRHR services we can reduce the levels of maternal mortality, infant mortality, teenage pregnancies and the resulting unsafe abortions. Planned births will result in savings in maternal and child health care, and slower population growth thereby reducing the burden on social services and resource needs. Ultimately the country benefits in the form of broad-based economic growth, a productive and educated workforce, and a growing middle class. In this regard, FP plays a critical role in reducing poverty and driving economic growth.

The strategy was developed through an all stakeholders' consultative process and a joint national effort that builds on lessons learnt and cultivates on the achievements of the FP programme since Independence. It focuses on the operational environment, improving the quality of available integrated FP services, raising awareness and increasing demand for

integrated FP and related SRHR services. Based on scientific developments and best practices, resultant interventions, outputs, outcomes and impact will contribute to the achievement of national goals.

The government of Zimbabwe is committed to working untiringly focusing on all possible means to develop the individuals, families and the nation. We continue to cooperate, coordinate and consult with stakeholders and partners to ensure that all efforts of FP services are jointly planned and implemented to achieve the London FP 2020 Global Summit in 2012 Commitments.

Finally, Ministry of Health and Child Care would like to thank the United Nations Population Fund (UNFPA) for the financial and technical support for the development of this document.



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EXECUTIVE SUMMARY

The Zimbabwe National Family Planning Council's (ZNFPC), mandate is to coordinate, take leadership and support implementation of integrated FP and related SRHR services in Zimbabwe[1]. The expiry of the 2009-2014 national family planning strategy, the current socio-economic blueprint (ZimASSET) and the commitments the country made at the London FP 2020 Global Summit in 2012, necessitated the development of the 2016-2020 National FP Strategy.

The proposed strategies are cognisant of key observations that have the potential to increase unintended pregnancies and thereby a rise in maternal morbidity and mortality, if not addressed. These factors include a high youthful population, a differential high unmet need among the young people, several pockets of the hard to reach populations for integrated FP services and the need to provide comprehensive and culturally sensitive FP services. The national FP strategy is also cognisant of the need to create an enabling environment at every level through provision of integrated FP and related SRHR services under primary health care settings and above all the need to advocate for a strong central leadership for effective planning, coordination, monitoring and evaluation of the FP programme. All these observations are in the background of a significantly high knowledge level among the Zimbabwean population, a high FP commodity supply and distribution and a method mix skewed towards short acting methods.

The 2016-2020 National FP Strategy aims to guide the provision of quality integrated FP services within the framework of Sexual and Reproductive Health and Rights to Zimbabweans through creating an enabling environment, building linkages with other programmes, expanding partnerships and working with communities. A participatory process among the MoHCC, ZNFPC, United Nations agencies, bilateral agencies, implementing partners and other interested parties produced this strategy document. Five key strategies were identified and recommended in this strategy. These are: (i) Creating an enabling environment, (ii) Strengthening the supply chain management and security of all FP commodities, (iii) Improving availability and access to quality FP Services, (iv) Improving demand for integrated FP services, driven by comprehensive knowledge of FP methods and (v) Improving monitoring, evaluation and research for integrated FP services in Zimbabwe. A monitoring framework based on results will assist the tracking of this strategy document.

[1] ZNFPC Act, 1985

1. BACKGROUND

1.1. Introduction

Family planning has direct links with improving social, economic, health and environmental outcomes for communities. Family planning empowers people to take control of their lives, enjoy their basic sexual and reproductive rights contributing meaningfully to their overall development and that of their societies and nations. Family planning is one of the prominent interventions to reduce maternal and neonatal morbidity and mortality. It assists individuals and couples to attain their reproductive intention towards preventing unintended pregnancies and to promote healthy child spacing. It is estimated that provision of quality family planning services can avert one fourth of maternal mortality and up to forty percent (40%) of new-born deaths (Cleland et al). Meeting unmet need for family planning among HIV-infected women is a cost-effective means of prevention of mother to child transmission of HIV. Investing in family planning is therefore vital in strengthening health system for improved health outcomes.

This Strategy provides a national framework to guide improving access to and coverage of comprehensive quality integrated FP and related SRHR services in Zimbabwe.

1.2. Need for Zimbabwe National Family Planning Strategy

The new Zimbabwe National FP Strategy is necessitated by the fact that the previous Zimbabwe National FP Strategy (2009-2014) is already expired, that the Government of Zimbabwe needs renewed vigour in its FP programme to meet its FP2020 commitments made at the London FP2020 Global Summit in 2012 and that the specific FP needs of the country requires more attention to the equitable distribution of the integrated FP services in the country.

At the London FP 2020 Global Summit in 2012, the Government of Zimbabwe, recognising the right to high quality reproductive health care made a number of commitments that require effective strategies and targeted interventions. *The government committed itself to ensure that women and girls have greater access to quality sexual and reproductive health and rights services and to reduce the unmet need for family planning from 13% to 6.5% by 2020. The family planning budget, including the procurement of contraceptive commodities, would be doubled from 1.7% to 3% of the national health budget. Zimbabwe would improve method mix and strengthen the integration of family planning with reproductive health, HIV and maternal health services. Innovative service delivery models to meet the needs and rights of adolescent girls would be explored and the unmet need for this target group reduced from 16.9% to 8.5% by 2020.*

It is with this background that a Zimbabwe National FP Strategy was developed with contributions from all key stakeholders.

1.3. The Zimbabwe National FP Strategy Development Process

The ZNFP Strategy was developed through an extensive participatory process involving the Ministry of Health and Child Care (MoHCC), other government line ministries and departments, the Zimbabwe National Family Planning Council (ZNFPC), United Nations (UN), development agencies, implementing and technical partners, and civil society. The process involved a comprehensive desk review, rapid field assessment and several stakeholder consultative meetings. *(See Appendix 2).*

2. CONTEXT AND ENVIRONMENTAL SCAN

2.1. Current Situation

The ZNFPC is mandated to coordinate, take leadership and support implementation of integrated FP and related SRHR services in Zimbabwe. The development of the 2016-2020 National FP Strategy was necessitated by the expiry of the 2009-2014 national family planning strategy, the current socio-economic challenges and the commitments the country made at the Global FP 2020 London Summit in 2012. The following sections outline the current status of family planning in Zimbabwe.

General Fertility

The TFR for Zimbabwe is 4.1 children per woman (ZDHS 2010/11). It is markedly higher for women who are less educated (4.9), poor (5.3) and living in rural areas (4.8). It varies between 2.8 in Bulawayo and 4.8 in Manicaland province. General fertility has fallen among women over age 20 over the past two decades but has increased for those in the 15-19 age group.

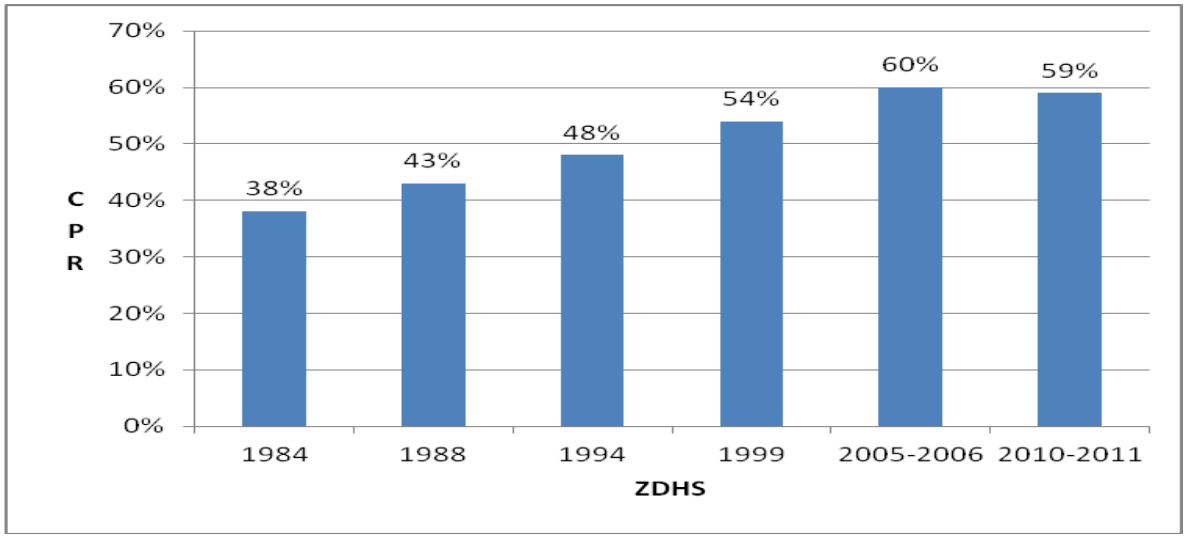
Adolescent Fertility and Teenage Pregnancy

Meeting the sexual and reproductive health and rights needs of young people is a challenge in Zimbabwe. Despite several recent initiatives, youth friendly reproductive and sexual health services either in outreach or in facilities are far from available to young people. The 2010/11 ZDHS reports that about half (48%) of the teenage girls have begun childbearing by age 19 and almost a quarter of the girls aged 15-19 years. Age specific Fertility rate for 15-19 years age group has increased from 99 births per 1000 women to 115 births per 1000 women from 2005/6 to 2010/11 respectively, manifested by high proportion of teenage pregnancies and lower mean age at first birth (ZDHS 2010/11). Zimbabwe's teenage pregnancy prevalence rate has increased from 21% in 2005-6 to 24% in 2010/11. This is the highest rate recorded since 1984. The rural-urban differential in teenage fertility is striking as rural girls are twice as likely (144/1000) to become a mother than their urban counterparts (70/1000). Access to information is also limited for adolescents: only about 13% adolescents have access to FP message in media compared to about 24% for the rest. Only 3% adolescents have access to FP advice when they come in contact with health services either in outreach or static facilities. Only 46% teenage girls and 41 % teenage boys have comprehensive knowledge about HIV & AIDS (compared to 56% for women and 52% for men overall).

Modern Contraceptive Use and Family Planning Method Mix

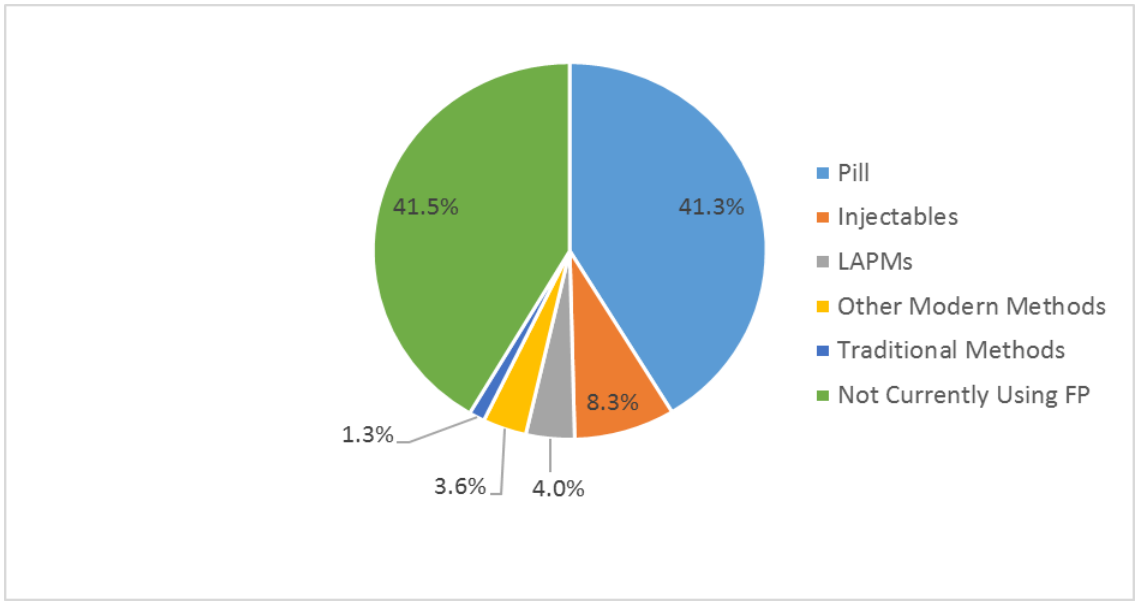
In Zimbabwe, use of modern family planning rose steadily Post-Independence but progress stagnated in recent years. According to the ZDHS 2010/11 the contraceptive prevalence rate among married women has remained unchanged around 60% from 2006 to 2011. The choice of family planning method in the country is greatly skewed to short term methods because of the limited method mix at most service delivery facilities.

Figure 1: Trend in Contraception Prevalence Rate (CPR)



Source: ZDHS 2010/11

Figure 2: Percent Women 15-49 Years Using FP by Method



Source: ZDHS 2010/2011

Currently, of the 59% of married users 41% are on the pill, Injectables (8.3%), while only 4% use Long Acting and Permanent Methods (LAPMs). Usage of LAPMs is very minimal: implants (2.7%), Intra-uterine contraceptive devices (IUCD) (0.2%), female sterilisation (1.1%) and 0% male sterilisation. Inadequate health care worker capacity to offer LAPM is the main reason for poor availability of LAPM. Ill-equipped facilities and poor demand creation also contribute to the low uptake. The high discontinuation rate of 24% of available contraceptives (mostly pills) further limits the access to integrated FP services. Across all contraceptive methods, the most common reason for discontinuation is the desire to become pregnant (40%) followed by concern over side effects/ health concerns at 17% (ZDHS report, 2010/11). It is therefore critical to broaden the available method mix as well as strengthen

pre-method uptake counselling to allow women to make more informed decisions on the method that best suits their needs.

Unmet Need for Family Planning

Although the country's unmet need for family planning of 13% is the lowest in Sub Saharan Africa, it has remained static for the past two decades. There are about 13% potential users of contraceptives who are not using either due to non-availability of contraceptives or because of limited access to FP services. They include potential users of both spacing (7%) and permanent (6%) methods. The unmet need varies in accordance with population groups and the geographical area. For example unmet need is at 9% in Mashonaland Central while in Matabeleland South is at 26%. For the young people aged 15 – 19, the unmet need is at 17% and 10% for 30 – 34 age group (ZDHS 2010/11). Though not captured in ZDHS, it could be significantly high among people with disabilities and people living with HIV & AIDS. Focus will be on people living with disabilities and people living with HIV & AIDS as availability of integrated FP services to HIV positive women (Prong 2) is reported to be poor according to the MoHCC PMTCT Programme Review Report, 2010. There is also need for the review of the FP Advocacy and Communication Strategy to strengthen the programme, with a focus on LAPM and reaching sections of population and specific geographies with low CPR and high unmet need.

Awareness of Family Planning

According to the ZDHS (2010/11), the knowledge of 'any' contraceptive method in Zimbabwe is universal with 98% of women and 99% of men knowing at least one method of contraception. However, the knowledge of long acting and permanent methods is low. While knowledge on the pill is above 90% among both men and women, only 50% of men and 43% of women know about female sterilization. Knowledge about male sterilization is even lower. Only two thirds of women and one third of men know about the implants, with 61% of the women and 44% of men knowing about intra-uterine contraceptive devices. The knowledge of emergency contraception is significantly the lowest among both men (29%) and women (20%). The awareness pattern matches fairly with the pattern of the method mix in the country suggesting gaps in the availability of LAPM, providing opportunity to focus on them through awareness raising and subsequent service provision. Therefore, there is need to review and implement the FP Advocacy and Communication Strategy so as to strengthen the programme.

Outreach integrated FP services require focused attention to optimally utilise existing resources at community level within the health system and designing innovative approaches. This will include community mobilisation on different aspects of integrated FP and related SRHR services, method mix, where to avail, side effects, myths and misconceptions. Most facilities are offering oral contraceptives and given that the system is promoting LAPM, it is important that the outreach services focus more on awareness generation and dissemination of comprehensive information on integrated FP and related SRHR. This focus of outreach services on information dissemination would require effective coordination.

Gaps in Existing Demand for Family Planning

As highlighted in above sections, the reach of FP programme is not as strong for certain sections of the society as for others. It is particularly weak for young people, people in rural areas and the poor and less educated people. Awareness about FP is also low among these

groups of people. Reach and the awareness about LAPM are in general low in the country. Addressing these gaps requires robust demand creation for FP services, especially LAPM.

Family Planning Service Delivery

While the bulk (73%) of FP services are offered through the public sector, 14% are obtained from private medical sector, 4% from mission facilities, 4% from a retail outlet and 2% from another private source (ZDHS 2010/11). The public sector supplies the majority of Injectables (88%), female sterilisation (66%), and implants and oral contraceptives (74%) each. The main source of supply for male condom is also the public sector (46%) although the retail outlets (27%) and private medical sector (15%) are also important sources. Also within the public sector, government hospitals/ clinics, rural/ municipal clinics and rural health centres are the most important sources for the pill, Injectables, implants and the male condoms. Therefore, there is need to develop national guidelines for engaging private sector focusing on regulation, accreditation, monitoring and reporting.

ZNFPC provides integrated FP services through its thirteen (13) stand alone static clinics at provincial level, and twenty six (26) dedicated youth friendly centres at district level. In addition, ZNFPC supports MoHCC as a technical partner in the provision of youth friendly services in some of the government health facilities across the country. There is need to strengthen programming with more focus on areas with low performing FP indicators as shown in Table1.

Table 1: Variation of Demographic Indicators by Residence - Rural and Urban

Indicator	Rural	Urban	Total
CPR for Modern Contraceptives (%)	56	60	57
Unmet Need (%)	13	12	13
Total Fertility Rate	4.8	3.8	4.1
LAPM (%)	3	6	4
Teenage Pregnancy (%)	28	16	24
Age At First Birth (Years)	20	21	20
Access to FP Message for Women through Radio (%)	18	26	21

Source: ZDHS 2010/11

Demographic indicators may vary by geographic location. These differences point to specific concerns requiring specific responses. Matebelenad North and South are two provinces which are sparsely populated and have low CPR, high unmet need and high teenage pregnancy. However, reach and access to integrated FP planning messages are generally poor across all provinces. Manicaland has high TFR, teenage pregnancy and unmet need; Mashonaland Central has high teenage pregnancy and Masvingo a very high TFR. It is clear that 3 provinces, viz., Matebeleland North (31%), Mashonaland Central (30%) and Manicaland (27%) have high teenage pregnancy that need focussed response. Table 4 shows the variations in selected demographic indicators by province.

Table 2: Variation of Demographic Indicators by Provinces

	TFR	Teenage Pregnancies (%)	Modern CPR (%)	Unmet Need (%)
Manicaland	4.8	27	55	15
Mashonaland Central	4.5	30	62	9
Mashonaland East	4.5	25	61	11
Mashonaland West	4.5	24	61	10
Matebeleland North	4.1	31	49	13
Matebeleland South	4.2	23	45	26
Midlands	4.2	23	58	14
Masvingo	4.7	23	54	12
Harare	3.1	20	58	13
Bulawayo	2.8	11	59	14
Total	**4.1**	**24**	**57**	**13**

Source: ZDHS 2010/11

Table 5 shows the age-specific and aggregate fertility measures calculated from the 2010/11 ZDHS. The total fertility rate for Zimbabwe is 4.1 children per woman. Peak childbearing occurs during ages 20 - 24 and 25 - 29, then drops sharply after age 39. Fertility among urban women is markedly lower (3.1 children per woman) than among rural women (4.8 children per woman). This pattern of lower fertility in urban areas is evident in every age group.

Table 3: Age-specific and TFRs by residence

Age Group	Residence		Total
	Urban	Rural	
15-19	71	144	115
20-24	167	245	212
25-29	160	217	194
30-34	120	167	149
35-39	79	117	104
40-44	14	46	35
45-49	5	15	12
TFR	**3.1**	**4.8**	**4.1**

Source: ZDHS 2010/11

ZNFPC manages the outreach FP programme of the country through Community Based Distributors (CBD). The CBD programme however, is in decline in the country due to natural attrition and the freezing of posts. Outreach FP services require focused attention to optimally utilise existing resources and innovative approaches. Integrated FP service delivery at all levels under different sectors, providers stands to gain immensely by integrating with SRHR /HIV services. In light of the fact that a high proportion of women in Zimbabwe are receiving postnatal care (77%), there is a huge potential for providing integrated FP and related SRHR services including counselling and post-partum IUCD insertions (MICS Report 2014). To

facilitate this, MoHCC has come out with national guidelines on integrated FP, HIV&AIDS and related SRHR service delivery.

Family Planning Commodities Supply Management

The supply of FP commodities is through the Delivery Team Topping Up System (DTTU) which is highly successful and has managed to reduce FP commodity stock out at below 5% with a supply coverage of 99%. According to the National Medicines Survey Report (2013) overall availability of condoms and contraceptives was 91% and 84% respectively. The system is however threatened by uncertainty given its complete funding dependence on external agencies.

A recent Funding Gap Analysis estimated that the total cost of delivering FP services in Zimbabwe as of 2014 was $9.9 million (commodity and non-commodity), which is short of 1.2 million.[2] According to the same analysis, cost is expected to grow to $12.3 million by 2020. These are minimal costs that the Government needs to meet to achieve FP 2020 goals. To enhance contraceptive security, the government needs to increase its investment in supply chain management of contraceptives in line with its FP 2020 goals. Efforts to build an integrated Medical Supply Chain Management system, covering medicines, medical commodities, and contraceptives by government, is currently being piloted in Manicaland Province. If successful, this may replace DTTU, paving the way for self-reliance on FP commodities. However, this process needs to be gradual providing sufficient time for smooth transition. In the short to medium term partners would need to continue to support the DTTU.

Enabling Environment

Creating an enabling environment through effective engagement with policy makers needs attention if effective delivery of integrated FP services across the country is to be achieved. Priority needs to be accorded to allocating more funds to ZNFPC, steering self-reliance on FP commodities, encouraging integrated FP and related SRHR policy / guidelines update and establishing better regulatory mechanism to improve access, availability and utilisation of quality integrated FP and related SRHR services.

Coordination of the FP Programme

ZNFPC as a parastatal body under MoHCC, established by an Act of Government of Zimbabwe in 1985, is the central FP coordinating body. However there is a limitation in the coordination process. This limitation is also due to the lack of adequate resources hence the need for funding. Ideally, a strengthened ZNFPC in terms of resourcing should be the national centre of excellence on integrated FP and related SRHR. This will steer capacity building on integrated FP and related SRHR in the country, to generate evidence through research to guide the programming, forge stronger alliance with national Health Management Information System (HMIS) to build strong FP monitoring framework and design and implement robust integrated FP communication strategy to strengthen the programme.

Monitoring and Evaluation

ZNFPC has a set of tools for data collection for integrated FP and related SRHR service provision. The MoHCC HMIS also collects FP data and has its own set of tools. Thus while

[2] UNFPA & Futures Group, 2014

some indicators are collected through the MoHCC, others are being collected through the ZNFPC system yet the two systems should be integrated. Therefore, there is a need for developing an integrated harmonised FP framework for the country. At present data verification and data quality audits is not being done due to limited resources. Flow of data into the HMIS from outreach clinics is not well defined and may lead to double or under-counting of services provided. All these point to the need for effective collaboration between RH and HMIS units of MoHCC and ZNFPC, which is currently missing. ZNFPC, being the national FP coordinating body, requires strengthening of its M&E unit through availing of adequate resources so as to enhance its coordinating role and improve accountability.

This 2016-2020 FP Strategy outlines specific strategies to address the issues articulated in the above situational analysis and is expected to close existing gaps by strengthening the FP programme towards meeting the FP 2020 targets.

2.2. PESTLEG Analysis

Table 4: PESTLEG Analysis

Political	Economic	Social
• Land Reform Programme has established new service area settlements • Government ownership and commitment to integrated FP and related SRHR programme and service provision • The existence of Zimbabwe National Board of FP which provides leadership • Policy inconsistence on user fees	• Total dependency on inadequate Government funding • Limited funding for integrated FP services by funding partners • Funding gap for FP commodities • Freezing of posts by government due to economic challenges • Economic growth • ZimAsset	• Religious and cultural practices which hinder access to integrated FP services • Myths and misconceptions on LAPMs contributing to low uptake of other FP methods • Hard to reach areas • Key populations • Demographics, age distribution and population growth rate • Health seeking behaviours • Literacy levels
Technological	**Legal**	**Geographical**
• Automation • Technological transfer rate • Life-cycle and speed of technological obsolescence • New inventions, internet, mobile technology and development • None functional FP operating theatres • Obsolete equipment • Inadequate IT resources	• A parastatal established through ACT of Parliament with clear mandates • Government commitment to international and regional conventions	• Cross border migration • Limited access to hard to reach and underserved areas • Limited area coverage by CBW

2.3. SWOT Analysis

Table 5: SWOT Analysis

STRENGTHS	WEAKNESSES
• Policy environment which is supportive of the provision of integrated FP and related SRHR service • Geographical representation • High knowledge levels of FP methods amongst the general population • Zimbabwe is a signatory to a number of regional and international conventions • Availability of coordination and collaborating platforms • Existence of a National FP Board • Existence of a coordinating board with a functional organogram • Availability of surveillance system with clear tools for collecting FP information on utilization	• Static unmet FP need of 13% for more than two decades • Poor method mix • Leadership, coordination and planning roles not prominent • High vacancy rate in the CBWs • High attrition of qualified staff • Failure to retain qualified staff • Uncompetitive staff remuneration • Low staff morale • Total dependency on inadequate Government funding • Funding gap for FP commodities • Undercapitalised business units • Low uptake of integrated FP trainings by service providers • ZNFPC Information System not linked to HMIS
OPPORTUNITIES	**THREATS**
• Global move to reposition FP • Increased government proportion on FP from 1.7% to 3% • Male and female sterilization low • Public Private Partnership window • Zimbabwe Assisted Pull System (ZAPS) • Land Reform Programme • CHW complementing ZNFPC CBD programme • Dissemination of the Advocacy and Communication Strategy	• Limited funding for FP • Low visibility of the organisation's programmes • No exit plan for donor pull out or fatigue for sustainability • High staff turnover • Post freezing • Lack of M&E Framework

3. GUIDING PRINCIPLES AND STRATEGIC FRAMEWORK

3.1. Vision

Quality integrated family planning services for all by 2020.

3.2. Mission

To provide rights based quality integrated FP services through innovation and co-ordination.

3.3. Values

a) **Universal Access**: Ensuring provision of rights based comprehensive integrated quality FP services are made gender sensitive, affordable and accessible to all
b) **Rights and Choice-based**: Affording each individual the right to make informed choice of FP method and to have a child as and when they decide. Each individual has the right to information, service and care on integrated SRHR
c) **Efficiency:** Embark on strategies that will bring most benefit with minimal costs. For achieving faster results, innovation, efficiency and quality should be encouraged for improving utilisation of integrated FP services and rapid scale up of effective interventions.
d) **Accountability**: The implementation of FP programme should ensure efficient and transparent use of resources by establishing mechanisms for holding service providers accountable at every level for the outcomes of the programme and the use of resources.

3.4. Overall Terms of Reference for FP Coordinating Body (ZNFPC)

1. Zimbabwe National Family Planning Council Act (Chapter 15:11) of 1985,
2. Health Professions Act (Chapter 27:19) of 2000,
3. Health Service Act (Chapter 15:) of 2004,
4. Medical, Dental and Allied Professions Act (Chapter 27:08) of 2001,
5. Medicines and Allied Substances Control Act (Chapter 15:03) of 2001,
6. Termination of Pregnancy Act (Chapter 15:10) of 1977,
7. The Public Health Act (Chapter 15:09) of 2002,
8. The Government Medical Stores (GMS) Commercialization Act (2000) and
9. National Occupational, Safety and Health Act.

3.5. Overall Functions for FP Coordinating Body

The functions of the FP coordinating body are derived from the amended ZNFPC Act of Parliament of 2004. The body is mandated to:

a) Popularise and promote the provision of adequate and suitable facilities in Zimbabwe for reproductive health and family planning;
b) Provide facilities for the investigation and treatment of infertility among persons in need of such investigation or treatment;
c) Participate actively with other organisations or institutions in the formulation and implementation of primary health care programmes and other community development activities related to family health;

d) Carry out or assist in the carrying out of research into reproductive health and the effects of contraceptives on the health of the users of contraceptives and other persons;
e) Undertake work connected with the diagnosis and treatment of diseases, including but not limited to sexually transmitted infections including HIV & AIDS and cancers of the reproductive systems;
f) Stimulate and develop an awareness among medical students and medical personnel generally regarding the scientific basis of reproductive health and family planning and the practical implementation of related programmes by medically acceptable methods and practices;
g) Provide and manage facilities for performing surgical operations for infertility and sterilization, and develop and provide a cytology services to persons in need of such services;
h) Encourage, foster and promote safe reproductive health practices and take such measures as are necessary or desirable for alleviating the problems associated with infertility among persons;
i) Coordinate and monitor the provision of integrated sexual reproductive health and family planning services in Zimbabwe;
j) Plan, design and implement adequate and sustainable reproductive health and family planning services for special target groups such as men and youths in Zimbabwe;
k) Procure and distribute adequate and appropriate contraceptive and reproductive health commodities in Zimbabwe;
l) Provide leadership in sexual and reproductive health programmes in Zimbabwe; and
m) Ensure that public, private and non-governmental organisations providing reproductive health and family planning services in Zimbabwe adhere to prescribed standards, guidelines and procedures.

3.6. FP Coordinating Body Structure and Functions

All ZNFPC opertaions are provided through three (3) technical units with support from the Administration, Finance and Human Resources unit, Internal Audit and Logistics departments. All the operations are directed at national level, implementation is carried out at provincial and community level.

a) Service Delivery and Training

The Service Delivery and Training Unit consists of three departments; Service Delivery, Training and ASRH Departments. The mandate of the Unit is to co-ordinate integrated FP service provision in the public and private sector.

The mandate of Service Delivery is to plan, coordinate, organise, implement, facilitate monitoring and evaluation of integrated FP service provision activities in the private and public sector. Service Delivery also includes the provision of technical assistance within and outside the coordinating body through development of Standard Operating Procedures in integrated FP and related SRHR services.

Training is mandated to coordinate and carry out integrated FP and related SRHR trainings for the public and private sector involved in the provision of these services. This also includes the development and review of training curricula for integrated FP, SRHR and ASRH,

development and establishment of training standards for the organization and the public sector in liaison with MoHCC and partners.

The ASRH's core business is to coordinate the planning and implementation of the youth programme through linking with donors, NGOs and the private sector. The broad objective of the ASRH programme is to ensure the rights and access of young people to quality comprehensive sexual and reproductive health information and services; including life skills and livelihoods.

b) Evaluation and Research

Broadly, the mandate of the Evaluation and Research is to coordinate and implement the planning, operations research, and monitoring and evaluation of integrated FP programmes by providing technical expertise, guidance and support to all implementing partners. It is also responsible for the programme management information system (MIS), a key tool for programme performance assessment and informed decision-making as well as spearheading the development and review of the FP strategic plan and conducting consultancy research work in FP.

c) Marketing and Communications

Marketing and Communications is mandated to create informed demand for integrated FP and related SRHR services and products through designing and promoting health seeking behaviour change communication strategies. Strategically, it is responsible for public relations, advocacy, social mobilization, marketing, localised campaigns, exhibitions and publicity. It is also responsible for the designing, packaging and dissemination of demand creation and promotional materials for organisations.

d) Human Resources and Administration

The role of the Human Resources and Administration (HRA) is to ensure effective and efficient management of human resources functions. HRA oversees the implementation of policies and procedures for recruitment, selection, and placement of personnel, performance management, staff development, remuneration, industrial relations, safety and health, general administration and insurance of assets for the coordinating body.

e) Finance

Finance is responsible for coordinating the overall planning and review of the finances, financial budgeting, financial accounting and control systems; and monitoring and evaluation of expenditure for the coordinating body. It is also responsible for monitoring the revenue collection and expenditure within the FP programme including ensuring a regular and appropriate review of fees and charges of services and ensuring timely and regular submission of statutory returns to MoHCC and the Auditor General.

f) Logistics

The mandate of the Logistics is to ensure that the integrated FP programme is getting the right quantities of the right goods to the right places in the right condition, at the right time, for the right cost and right quality. This includes procurement, forecasting, stock control, transport logistics and management of storage facilities for the FP commodities with support from donor partners.

g) Information Technology (IT)

Information Technology is involved in providing the infrastructure for automation, the governance for the use of the network and operating systems; and assistance in providing the IT functionality in line with e-government.

h) Internal Audit

The responsibility of the Internal Audit is to ensure accountability, probity and transparency in the management of public funds by testing the robustness of and compliance with procedures. This includes ensuring the efficient and economic use of resources available to the FP programme, ensuring that audit work fulfills the general purposes and responsibilities approved by management and as required by section 19 of the Public Finance Management Act (Cap.22:03).

3.7. Key Result Areas

Table 6: Key Result Areas

KRA No	Key Result Area	Weightage	Responsibility	Sector KRA Ref	National KRA Ref	MDG Ref
1	Coordination and provision of integrated FP and related SRHR services	100	Service Delivery and Training, Marketing & Communications, Evaluation & Research, Logistics	2	5 & 6	1, 4, 5, 6

3.8. Client Needs / Problems Analysis

Table 7: Client Needs / Problems Analysis

	Clients	Clients' Needs/Problems	Characteristics	Extent	Priorities
	Programme Client	**Programme Client Needs**	**Programme Client Characteristics of Needs**	**Programme Client Extent of the Needs**	
External	**Programme Client** 1. MoHCC	**Needs** • Coordination of integrated FP and related SRHR services • Taking a leading role in the provision of integrated FP and related SRHR services for citizens • Feedback on integrated FP and SRHR policy implementation • Development of standards, guidelines, policies and manuals • Procurement and distribute FP and SRHR commodities • Provide technical support on ASRH services • Capacity building and training of health workers on integrated FP and related SRHR service provision • Good corporate governance • Submissions into HMIS **Problems** • High Maternal Mortality Rate • Static FP unmet need • High HIV prevalence rate • High STI incidence • High teenage pregnancies • High incidence rate of Cancers of the RH system • Inadequate funding for integrated FP and related SRHR commodities	**Needs** • Good quality services that are provided in a timely manner. • Training of service providers in integrated FP • Accessible, accurate, complete, reliable and timely data • Technical evidence based advice • Adequate resources **Problems** • High burden of preventable diseases and conditions: • High maternal mortality • High morbidity and mortality due to HIV & AIDS, STIs • High death rate due to cancers of the reproductive health system • Lack of Government funding for FP programme	**Needs** • Need to provide services to the RH age group of the population • Clients need quality integrated FP and related SRHR services **Problems** ✓Deaths related to HIV ✓MMR 525 deaths per 100 000 live births (Population Census 2012) ✓Deaths related to cancers of the RH system ✓HIV prevalence rate 15% (ZDHS 2010/11)	1. Training of service providers 2. Provision of quality integrated FP and related SRHR services 3. Availability and accessibility of FP commodities 4. Availability of quality data 5. Adequate funding of FP programme

		Causes • Low access to integrated FP and related SRHR services in hard to reach areas • Low coverage by FP and related SRHR service providers especially in rural areas • Inadequate resources • Cultural and religious barriers	**Causes** • Long distances between SDP • Old/ dilapidated infrastructure • Obsolete and inadequate equipment • Funding gap for integrated FP and SRHR commodities • Inadequate number of staff trained in integrated FP and related SRHR service provision • Inadequate number of CBW due to freezing of posts	**Causes** • Most affected segments of the population are: ✓Pregnant women ✓Men & women of the reproductive age group ✓The adolescents ✓People suffering from specific diseases such as cancer ✓The poor and marginalised ✓People living in hard to reach and under-served areas ✓People living with disabilities • Service Delivery points need rehabilitation • Most clinics need equipment replacement • Vacancy rate for ZNFPC – 34% • Outreach services in hard to reach areas	

	Service Clients	Service Client Needs	Characteristics of Service Client Needs	Extent of Service Client Needs	
	2. Government Ministries, Local Authorities and Departments, Academia	**Needs** • Policies and policy guidance on FP & SRHR • Integrated FP and related SRHR services ✓ FP and related SRHR commodities ✓ Updated standards, guidelines, policies and manuals ✓ Provide technical support on ASRH ✓ Taking a leading role in FP and related SRHR coordination ✓ Capacity building and training in FP & SRHR ✓ FP and related SRHR demand creation materials **Problems** • Poor coordination mechanisms • Inadequate resources • Inadequate trained service providers in the provision of integrated FP and related SRHR services • Information not readily available and accessible • Donor attention shifting from FP to Humanitarian, HIV & AIDS programmes	**Needs** • Access to current policy documents • Access to complete, accurate and timely integrated FP and related SRHR information • Clear standards guidelines and procedures • Effective FP/ SRHR coordination • Training of service providers in the provision of integrated FP and related SRHR services • Readily available, accessible and affordable comprehensive FP and related SRHR services **Problems** • Untimely responses	**Needs** • Some enquiries on policy not responded to on time • Some enquiries on FP and related SRHR information not responded to on time	
		Causes • Limited resources • Lack of updated policy documents standards and procedures • Lack of integrated FP and SRHR information materials • Weak reporting system • Inadequate trained health workers	**Causes** • Inadequate financial resources		

	3. FP and related SRHR Consumers	**Needs** • Comprehensive FP and related SRHR information • Comprehensive FP and SRHR services **Problems** • FP method side effects • Poor uptake of integrated FP and related SRHR services • Unmet FP need • High MMR • High HIV prevalence rate, High STI incidence • High teenage pregnancies • High incidence rate of the Cancers of the RH system • Myths and misconceptions **Causes** • Limited knowledge and awareness • Limited access to integrated and related SRHR services • Inadequate number of CBWs • Cultural, religious, geographical barriers • Limited financial resources • Risk behaviour and intergenerational relationships • Delay in seeking screening services • Health worker attitude	**Needs** • Provision of quality accessible and affordable integrated FP & related SRHR services • A wide range of FP methods (FP method mix) and SRHR choices • Access to complete, accurate and timely integrated FP and related SRHR information (in vernacular languages) **Problems** • Information not readily available • Occurrence of FP methods related side effects • Limited number of FP methods on offer **Causes** Limited number of FP trained service providers		

	4. Private and Public Health Service Providers	**Needs** • Training of health workers in integrated FP • FP information • FP Commodities • Supervision and monitoring **Problems** • Inadequate trained service providers • Inadequate supervision and monitoring **Causes** • High Staff attrition rate • Weak monitoring mechanisms • Inadequate funding	**Needs** • Quality and timely trainings in integrated FP • Training health service providers in all FP methods • Accessible, accurate, complete, appropriate, timely data **Problems** • Inadequate training • Inadequate resources for training and supervision **Causes** • High staff attrition rate		
INTERNAL	1. ZNBFP	**Needs:** • Information/ feedback on service provision and operations for decision making **Problems:** • Information not readily available **Causes:** • Weak coordination structures • Limited resources	**Needs** • Access to information on service provision and operations **Problems:** • Information not readily available **Causes:** • Weak coordination structures • Limited resources	**Needs** Board not accessing comprehensive information on service delivery and operations on time	

	2. ZNFPC staff and immediate dependents & volunteers	**Needs** • Improved welfare • Integrated FP and related SRHR services • Capacity building in the provision of integrated FP and related SRHR **Problems** • Low staff morale • Staff attrition • Limited knowledge in FP methods/SRHR choices **Causes** • Inadequate financial resources • Uncompetitive remuneration • Inadequate training	**Needs** • Improved conditions of service and welfare of staff **Problems** • Low staff morale • Limited training in integrated FP & related SRHR **Causes** • Inadequate resources	**Needs** Low staff morale	

3.9. Stakeholder Analysis

Table 8: Stakeholder analysis

	External to the Organisation	Demands/ Extent	Characteristics
1	FP and related SRHR Development Partners	Feedback, compliance with client rights	Timely feedback, quality service provision to citizens
2	Office of the President and Cabinet		
3	Ministry of Health and Child Care		
4	Parliamentary Portfolio Committee on Health and Child Care		
5	State Procurement Board		
6	Line Government Ministries/ Departments/ SEPs		
7	Professional Regulatory Bodies		
8	Civil Society Organisations, NGOs, FBOs, UN		
9	Professional Associations		
10	Private and Public Health Service Providers		
11	Health Service Board		
12	FP and related SRHR Services Consumers		
13	Media	Information, Feedback, compliance with client rights	
14	Tertiary institutions and schools		
15	Business community/ Industrialists		
16	Community leaders		
Internal to the Organisation			
1	ZNBFP	• Information/ feedback	Timely feedback, quality service provision to citizens
2	ZNFPC Staff	• Improved welfare • FP and related SRHR	
3	Volunteers	• Capacity building in integrated FP and related SRHR	
4	Youth Centre Committees	• Capacity building in integrated FP and related SRHR	

3.10. Policy Requirements

Table 9: Policy Requirements

	External	KRA Ref		Internal	KRA Ref
1.	Constitution of Zimbabwe	1	1.	National FP guidelines	1
2.	ZimASSET	1	2.	Treatment Protocols	1
3.	International Conventions on FP and SRHR	1	3.	National FP Strategy	1
4.	Corporate Governance Framework	1	4.	Standard Operating Procedure Manuals, Policies and Guidelines	1
5.	Protocols, Memorandum of Agreement	1	5.	Circulars and general letters	1
6.	Population Policy	1	6.	Motor Vehicle and Fleet Management Policy	1
7.	National Occupational Safety and Health Policy	1	7.	Employment Regulations Manual	1
8.	Gender Policy	1	8.	Employment Code of Conduct	1
9.	Adolescence Sexual Reproductive Health Strategy	1	9.	ICT Policy	1
10.	National Reproductive Health Service Delivery Guidelines	1	10.	IPC, Occupational, Safety and Health Policy	1
11.	Zimbabwe National HIV & AIDS Strategic Plan	1	11.	HIV & AIDS Workplace Policy	1
12.	National Reproductive Health Behaviour Change Communication Strategy	1	12.	Client Service Charter	1
13.	National Reproductive Health Policy	1	13.	Audit Charter	1
14.	National Health Strategy	1	14.	Training Manuals	1
15.	National Youth Policy and Youth Charters	1	15.	FP Advocacy and Communication Strategy	1

3.11. Goals

1. To increase Contraceptive Prevalence Rate (CPR) from 59% in 2010 to 68% by 2020; and
2. Reduce teenage pregnancy rate from 24% in 2010 to 12% by 2020.

3.12. Objectives

1. To establish a national FP coordination, monitoring and evaluation mechanism by 2020;
2. To increase the proportion of the national health budget that is allocated to FP programme from 1.7% in 2010 to 3% by 2020;
3. Reduce unmet need for FP services from 15% in 2010 to 6.5% by 2020;
4. To increase availability, access and utilisation of integrated SRHR and HIV services for young people aged 10 – 24 years;
5. To increase the knowledge of LAPM among all women and men of the reproductive age group from 46% in 2010 to 51% by 2020; and
6. To maintain stock out levels of FP commodities below 5% between 2016 and 2020.

3.13. Strategies

Strategy 1: Creating an enabling environment

An 'enabled environment' is a positive and responsive environment at every level of service delivery particularly at policy and decision making levels that sets things in motion and facilitates implementation. By making adequate resources available, putting policy, guidelines and frameworks in place and by establishing an effective central coordination mechanism, 'enabled environment' sets the stage for effective implementation of this strategy.

Interventions

1. Advocating with political leadership for prioritising FP programme through:
    a. Increasing the national budgetary allocation to the FP programme and also leveraging other resources of funding from the National AIDS Trust Fund.
    b. Removal of user fees
    c. Establishing user friendly and integrated services for all clients including young people and men
    d. Ensuring the recruitment and retention of skilled human resource for effective implementation of the FP programme strategy

2. Advocating with key donors and development partners for continued financing for FP programme
    a. Leverage the results based financing model to improve access to integrated FP services
    b. Develop a comprehensive resource mobilisation plan
    c. Improve financing mechanisms for direct support for the FP programme by donors and development partners

3. Strengthening the coordination and leadership role of ZNFPC in FP programming by 2020. Specifically, by undertaking following tasks:
    a. Conduct national quarterly review meetings on FP together with MoHCC and key national stakeholders (Including FP2020 monitoring).
    b. Advocate for the restructuring of ZNFPC in line with the new strategy to improve funding and strengthening of the FP programme.
    c. ZNFPC provide quality assurance on integrated training and service delivery.
    d. Ensure ZNFPC operates as semi-autonomous and gradually moves into autonomy to enhance the realization of the objectives of ZNFPC with unparalleled efficiency and effectiveness.
    e. Ensure ZNFPC capacitates itself financially by raising loans to fund some of its functions as provided in the ZNFPC Act

Strategy 2: Strengthen the supply chain management and security of all FP commodities

There is a need to build the capacity within the country for establishing a reliable and sustainable Logistics Management Information System (LMIS) to ensure access to relevant comodities for an integrated FP programme nationally. There is also a need for continued engagement with key development partners for ensuring uninterrupted supply, distribution and monitoring of contraceptives in the country in the short and medium term.

Interventions

a. Advocate for and engage development partners to continue supporting the procurement, storage and distribution of FP commodities.
b. Strengthen collaboration with stakeholders in the new integrated supply chain management to ensure reliable supply of FP commodities
c. Advocate for increased budgetary (national budget) allocation for the FP commodities
d. Integration of the various supply chain systems.

Strategy 3: Improved availability and access to quality integrated FP and related SRHR Services

Quality and integrated FP services should be available as integrated SRHR – HIV & AIDS services through facilities and outreach across the country with special focus on underserved sections of the country. There is need for deliberate efforts to target areas and sub-populations with low CPR and high unmet need and young people. The range of contraceptives should meet people's choice, including both short term and long term methods (LAPM) and barrier methods. Ensuring skilled human resource, together with better post-training follow-up and monitoring and feedback are essential for ensuring service quality. Special attention is needed to all vulnerable groups which are young people, people living with HIV & AIDS, people living with disabilities and those living in peri-urban and new settlements. There is a need to expand Public Private Partnerships (PPPs) for improving access especially through innovative approaches for reaching the community including young people.

Interventions

1. Reviewing the training curriculum to address current issues in SRHR (both pre and in service training) to offer full range of quality integrated SRHR services including youth friendly services;
2. Diversifying availability of contraceptives focusing on LAPM;
3. Strengthening the provision of comprehensive fertility services;
4. Strengthening the promotion of both the male and female condom for protection against unintended pregnancy and STIs and HIV;
5. Expanding service delivery mechanisms through working with external experts in providing specialised services including accreditation of private providers;
6. Strengthening community based integrated FP and related SRHR services especially in hard to reach areas by:
    a. Improving district based outreach services
    b. Building the capacity of CBHW in the provision of integrated FP and related SRHR services;
7. Enhancing equity in services by improving access, availability and utilization of integrated FP and related SRHR services for vulnerable groups including young people, people living with HIV & AIDS, people living with disabilities and those living in peri-urban and new settlements and hard to reach areas; and
8. Strengthening integration of FP services with MCH, HIV & AIDS, screening of cancers of the RH system and other related SRHR services at all levels;
9. Strengtherning life skills training and livelihood programmes to young people to improve the quality of their lives;
10. Improving the availability of integrated Youth Friendly Services using appropriate and evidence based inclusive models.
11. Strengthening the school health programme to include comprehensive sexual health education
12. Strengthening quality of services (both technical and perceived) by:
    a. Introducing Quality Management System and improve client inflow
    b. Improving supportive supervision and mentorship
    c. Reinforcing client feedback mechanisms
    d. Capacitating FP service providers on work ethics, ethical practice and public relations

Strategy 4: Improved demand for integrated FP and related SRHR services, driven by comprehensive knowledge of FP and related SRHR issues

There is a need to strengthen information, education and communication on family planning through sustained, standardized and culturally sensitive messaging for stimulating demand for FP in all sections of the society covering different FP methods, including LAPM. The need for better demand creation is more for young people, people belonging to vulnerable sections and people in rural and hard to reach areas. Improved production of localised demand creation materials on integrated FP and related services at individual and community

levels require expanding the network of stakeholders at these levels and optimising the use of available community level workers by building their capacity.

Intervention

1. Review and improve the Advocacy and Communications Strategy to close the gap in knowledge and utilization of services particularly among the vulnerable populations.
   The Communications Strategy should:
   a. Include cultural & religious perceptions to identify critical barriers;
   b. Give attention to specific target groups like young people, males (male involvement), people living with disability and HIV , rural communities and other vulnerable communities;
   c. Identify specific demand generation interventions for different levels: individual, community, leaders, health system & mass media;
   d. Highlight comparative advantages of different players (NGOs, village, community level workers etc.) in different settings;
   e. Advocate for inclusion of more players to participate in integrated FP and related SRHR programming through the PPPs;
   f. Strengthen partnerships with media houses in awareness and demand creation in SRHR issues affecting young people;
   g. Improve access to information on integrated FP and related SRHR issues through a dynamic website and social media; and
   h. Consider PPPs for the Audio-Visual Unit (AVU) for production of localised integrated FP demand creation materials.
2. Develop and provide standard, targeted (e.g. age appropriate), and gender sensitive SRHR social and behaviour change communication package (both print and electronic)

Strategy 5: Improve monitoring, evaluation and research for integrated FP and related SRHR services in Zimbabwe

There is need to harmonise FP programme M&E frameworks across providers in the country to better guide the programme. Therefore, improved coordination between Reproductive Health and HMIS units of MoHCC and ZNFPC is critical. There is a need to ensure that all key FP data elements and indicators, disaggregated by background characteristics are included in the HMIS and systems are in place for recording and reporting them at every level of service delivery. ZNFPC's capacity also needs to be built to carry out operations research to generate evidence and guide the programme.

Interventions

1. Strengthening monitoring of the integrated FP and related SRHR services by:
   a. ZNFPC taking lead on coordination with HMIS unit of MoHCC to update FP and related SRHR MIS tools and reporting formats. ZNFPC to conduct periodic monitoring and quality assurance visits to improve quality of FP programme
   b. ZNFPC coordinating the planning and implementation of integrated FP and related SRHR M&E activities for other players in FP (private sector and NGOs);
2. Developing a harmonized integrated FP and related SRHR M&E framework;
3. ZNFPC to conduct operations research on integrated FP and related SRHR issues; and
4. Building capacity within ZNFPC for carrying out research and using latest data analyses software packages.

4. STRATEGIC RESULTS CHAIN AND MONITORING AND EVALUATION FRAMEWORK

4.1. Impact Plan

Table 10: Impact Plan

Impact Description		Impact Indicator	Measurement Unit/Criterion (%, no. rate, etc.)	Baseline (DHS 2010)	2016	2017	2018	2019	Target 2020	Allowable Variance	Goal Reference	KRA Reference
1	Reduced mortality and morbidity	Maternal Mortality Ratio	Ratio	960					480	5%	1 & 2	1
		Under 5 mortality Rate	Rate	84					56	5%	1 & 2	1
		Infant Mortality Rate	Rate	57					38	5%	1 & 2	1
		Neonatal Mortality Rate	Rate	31					21	5%	1 & 2	1
		Child Mortality Rate	Rate	29					19	5%	1 & 2	1

4.2. Outcomes Plan

Table 11: Outcomes Plan

Impact Reference		Outcome Description	Outcome Indicator	Measurement Unit/Criterion (%, no. rate, etc.)	Target						Allowable Variance	Objective Reference	Goal Reference	KRA Reference
					Baseline (DHS - 2010)	2016	2017	2018	2019	2020				
IMP 1	**1**		Teenage Pregnancy Rate	%	24%					12%	5%	4	2	1
			Adolescent Fertility Rate	Rate	115					99	5%	4	2	1
			CPR:											
			1. Any Method	%	59%					68%	5%	3	1	1
			2. Modern Contraceptive	%	57%					66%	5%	3	1	1
			a) Implants	%	3%					27%	5%	3	1	1
			b) IUCD	%	0.30%					7%	5%	3	1	1
			c) Injectables	%	8%					24%	5%	3	1	1
			Unmet Need-Total	%	13%					6.50%	5%	3	1	1
			HIV Prevalence Rate	%	15.20%					7.60%	5%	4	2	1
			Mean number of family planning methods known by all women age 15 – 49	Number	6					8	5%	5	1	1
IMP 2	**2**	Improved coordination in the design, implementation and financing of integrated family planning and related SRHR programmes	Stock out rate of FP commodities	%	<5%					<5%	5%	6	1	1
			Proportion of FP funding to the total health budget	%	1,7%					3%	5%	2	1	1
			Proportion of FP income from donors and development partners to the total annual government FP funding	%	4.50%					10%	5%	2	1	1

4.3. Outputs Plan

Table 12: Outputs Plan

Goal Ref	Outcome	Programme/Project/Outputs(s)	Unit	Budget/Cost										
				Baseline	2016	2017	2018	2019	2020	2016	2017	2018	2019	2020
1	1	FP commodities stock out rates at SDP	%	<5%	<5%	<5%	<5%	<5%	<5%					
1	1	Cycles of oral contraceptives issued	Cycles	TBA										
1	1	Implants inserted	Num	TBA										
1	1	IUCDs inserted	Num	TBA										
1	1	Depo provera/ Petogen administered	Num	TBA										
1	1	Vasectomies conducted	Num	TBA										
1	1	Tuba ligations conducted	Num	TBA										
1	1	Male condom pieces issued	Num	TBA										
1	1	Female condom pieces issues	Num	TBA										
1	1	Emergency contraception issued	Cycles	TBA										
1	1	Health facilities providing LAPM	Num	TBA										
1	1	Health workers trained on FP clinical course	Num	TBA										
1	1	Health workers trained in LAPM	Num	TBA										
1	1	Private sector facilities providing integrated FP services	Num	TBA										
1	1	Wards covered by community based outreach FP services	Num	TBA										
1	1	Certified health facilities providing youth friendly services	Num	TBA										

1	1	Private sector facilities accredited and providing FP services	Num	TBA											
1	1	New FP acceptors	Num	TBA											
1	1	Dissemination of National FP Advocacy and Communication Strategy	Num	0											
1	1	Health facilities offering integrated FP/ VIAAC services	Num	TBA											
1	1	Health facilities offering fertility services	Num	TBA											
1	1	Health facilities offering HTC services	Num	TBA											
2	2	Analysed FP reports produced and disseminated	Num	0											
2	2	Operational FP research conducted and disseminated	Num	TBA											
2	2	Integrated FP M&E framework established	Num	0											
2	2	Key National policy decisions taken on FP	Num	TBA											
2	2	New FP funding partners established	Num	TBA											
2	2	National Coordination meetings conducted	Num	2											
2	2	Provincial Coordination meetings conducted	Num	8											
2	2	National Coordination Meeting resolutions implemented	Num	0											
2	2	Provincial Coordination Meeting resolutions implemented	Num	0											

5. MANAGEMENT AND IMPLEMENTATION OF STRATEGY

This strategy provides a framework that will guide the development of annual implementation plans to all levels. The plans will clearly outline the annual priority activities, resource requirements and specific roles and responsibilities of stakeholders. Lessons learnt through monitoring and evaluation will inform the strategy periodic reviews, including the midterm review and planning processes. The Government of Zimbabwe, through the ZNFPC will provide overall leadership and responsibility over the implementation of the strategy at all levels. The successful implementation of this strategy will rely heavily on the participation of other line ministries, parastatals and NGOs, which will be responsible for implementing specific interventions that fall within their respective mandates. The FP coordination Forum will ensure that the proposed interventions are well integrated and coordinated. In order to evaluate the strategy there is need to strengthen the 'Three Ones' principle, namely, one strategy, one monitoring and evaluation system, and one coordinating authority.

6. APPENDICES

APPENDIX 1: STRATEGIES, ASSUMPTIONS AND RISKS

Period	Strategies/Interventions	Assumptions	Risks
Key Result Area: 1			
Goal: 1 & 2			
Strategy 1: Creating an enabling environment			
Budget Year	Advocating with key donors and development partners for continued financing for FP programme.	Donors will avail resources to finance access to all FP methods	1. Competing priorities - committing interests in other emerging emergencies e.g. Cancers or Ebola
	ZNFPC strengthening its coordination and leadership role in FP programming by 2020	The board will be in agreement to implement the outstanding recommendations of the Institutional Review conducted in 2012 and recommend them to the Minister to initiate e.g. the review of the Act	1. The Minister might disagree with the proposed amendments 2. There might be a new board with a different opinion
2-3 years	Advocating with political leadership for the prioritizing FP programme	1. Economic situation doesn't allow immediate funding to address the issues affecting the FP programme. 2. Removal of user fees and ability to retain staff dependent on availability of funding from government and partners	1. Current political climate characterized by uncertainty of funding 2. Partners and donors my not be will to support the FP strategy and channel funding to NGOs and other Organizations.
	Advocating with key donors and development partners for continued financing for FP programme.	Donors will avail resources to finance access to all FP methods	Failure to attract adequate donor funding Failure to attract funding from new donors Funding being diverted to other urgent emergencies e.g. Ebola.

4-6 years	Advocating with key donors and development partners for continued financing for FP programme	Donors will avail resources to finance access to all FP methods	Failure to attract adequate donor funding Failure to attract funding from new donors Funding being diverted to other urgent emergencies e.g. Ebola.
Period	**Strategies/Interventions**	**Assumptions**	**Risks**
Key Result Area: 1			
Goal: 1 & 2			
Strategy 2: Strengthen the supply chain management and security of all FP commodities			
Budget Year	Advocate for and engage development partners to continue supporting in the procurement, storage and distribution of commodities	Donors will avail resources for procurement ,storage and distribution of commodities	1. Competing priorities - committing interests in other emerging emergencies e.g. Cancers or Ebola.
	Strengthen collaboration with stakeholders in the new integrated supply chain management to ensure reliable supply of FP commodities	Challenges faced being addressed during the current pilot phase	The piloted system might fail to bring results
	Advocate for increased budgetary (national budget) allocation for the FP commodities	Government will avail resources for procurement, storage and distribution of commodities	The national economic environment underperforming thereby affecting the national budget allocation
	Integration of the various supply chain systems	Reduction of costs	1. Compromised quality in the distribution system 2. Potential stock out of FP commodities.

2-3 years	Strengthen collaboration with stakeholders in the new integrated supply chain management to ensure reliable supply of FP commodities	Challenges faced being addressed during the current pilot phase	If challenges persist it might create potential stock outs after pilot phase.
Period	**Strategies/Interventions**	**Assumptions**	**Risks**
Key Result Area: 1			
Goal: 1 & 2			
Strategy 3: Improved availability and access to quality integrated FP and related SRHR Services			
Budget Year	Improving the capacity of health workers (both pre and in service training) to offer full range of quality integrated FP services	1. Adequate funding to train service providers in the full range of FP methods 2. Training Institutions have the capacity to train on FP.	1. Inadequate funding for capacity building 2. Training Institutions might not have the capacity to train on integrated FP. 3. Staff attrition at institutions affecting training capacity
	Diversifying availability of contraceptives focusing on LAPM	1. Staff competent in providing LAPM at facilities 2. Availability of infrastructure and equipment in order to offer LAPM	1. Inadequate funding for capacity building 2. Institutions might not have the capacity to train on integrated FP
	Expanding service delivery models through strengthening Public Private Partnership (PPP) including accreditation of private providers by and ensuring provision of quality services	1. Availability of resources to train and equip private providers 2. Framework or Guidelines on PPP to be in place	1. Inadequate resources to train and equip private providers 2. Some service providers might fail to meet set standards of service provision

	Strengthening community based integrated FP services	1. Availability of resources to train Community Health Workers 2. Availability of resources for implementation of outreach services including job aides 3. Cadres under the auspices of other Organizations to be available for training 4. Existence of a defined scope of practice for Community Health Workers	1. Inadequate resources to train Community Health Workers 2. Inadequate resources for implementation of outreach services 3. Other cadres might not be available for training as all village health workers are not under the auspices on ZNFPC 4. Multiple roles and overlapping of responsibilities for different Community Health Worker can affect performance
	Enhancing equity in integrating FP services by improving access, availability and utilization of FP services for vulnerable groups which are young people, people living with HIV & AIDS, people living with disabilities and those living in peri-urban and new settlements and hard to reach areas	1. Defined and identified vulnerable groups 2. Availability of adequate resources for integrated FP service provision 3. Training of services providers with special skills to offer services to the specified vulnerable groups	1.Inadequte resources to conduct the process of identifying the vulnerable groups 2. Inadequate resources for integrated FP service provision 3. Lack of service providers with special skills to offer services to the specified vulnerable groups
	Strengthening integration of FP services with MCH and selected sexual reproductive health and HIV & AIDS services.	1. All service providers have the capacity to provide integration of FP services with MCH and selected sexual reproductive health and HIV & AIDS services. 2. Availability of supplies and commodities to offer the integrated service 3. Adequate infrastructure for the provision of integrated services	1. Limited resources 2. Resistance from service providers 3. Guidelines for intervention
	Improving the availability of integrated Youth Friendly Services using appropriate and	1. Availability of resources to train and equip service providers 2. Adequate infrastructure for the provision of	1. Limited resources for capacity building service providers and establishing adequate infrastructure

	evidence based inclusive models.	quality integrated services	
	Strengthening the school health programme to include comprehensive sexual health education	1. Availability of resources for implementation of CSE including job aides 2. Cadres under the auspices of relevant Ministries to be available for collaboration	1. Inadequate resources for implementation of CSE 2. Other cadres might not be available for training as education workers are not under the auspices on ZNFPC
	Strengthening quality of services (both technical and perceived)	1. Availability of resources for the development and implementation of Quality Management System 2. Availabilty of resources to capacitate FP service providers on work ethics, ethical practice and public relations	1. Inadequate resources for implementation of the Quality Management System and capacity building of FP service providers 2. Other cadres might not be available for training as some service providers are not under the auspices on ZNFPC
	Strengtherning life skills training and livelihood programmes to young people to improve the quality of their lives	1. Availability of resources for the implementation of livelihood programmes	1. Resistance from the community 2. Inadequate resources to implement the interventions
2-3 years	Improving the capacity of health workers (both pre and in service training) to offer full range of quality integrated FP services	1. Adequate funding to train service providers in the full range of FP methods 2. Training Institutions have the capacity to train on integrated FP.	1. Staff attrition at institutions affecting training capacity
	Diversifying availability of contraceptives focusing on LAPM	1.Staff competent in providing LAPM at facilities 2. Availability of infrastructure and equipment in order to offer LAPM	1. Inadequate funding for capacity building 2. Institutions might not have the capacity to train on integrated FP

	Expanding service delivery models through strengthening Public Private Partnership (PPP) including accreditation of private providers by and ensuring provision of quality services	1. Availability of resources to train and equip private providers 2. Framework or Guidelines on PPP to be in place	1. Some service providers might fail to meet set standards of service provision
	Enhancing equity in FP services by improving access, availability and utilization of FP services for vulnerable groups which are young people, people living with HIV & AIDS, people living with disabilities and those living in peri-urban and new settlements and hard to reach areas.	1. Defined and identified vulnerable groups 2. Availability of adequate resources for FP service provision 3. Training of services providers with special skills to offer services to the specified vulnerable groups	1. Resistance from cultural and religious groups
	Strengthening quality of services (both technical and perceived)	1. Availability of resources for the development and implementation of Quality Management System 2. Availabilty of resources to capacitate FP service providers on work ethics, ethical practice and public relations	1. Inadequate resources for implementation of the Quality Management System and capacity building of FP service providers 2. Other cadres might not be available for training as some service providers are not under the auspices on ZNFPC
	Strengtherning life skills training and livelihood programmes to young people to improve the quality of their lives	2. Availability of resources for the implementation of livelihood programmes	1. Resistance from the community 2. Inadequate resources to implement the interventions
	Strengthening the school health programme to include	1. Availability of resources for implementation of CSE including job aides	1. Inadequate resources for implementation of CSE

	comprehensive sexual health education	2. Cadres under the auspices of relevant Ministries to be available for collaboration	2. Other cadres might not be available for training as education workers are not under the auspices on ZNFPC
4-6 years	Improving the capacity of health workers (both pre and in service training) to offer full range of quality integrated FP services	1. Adequate funding to train service providers in the full range of FP methods 2. Training Institutions have the capacity to train on integrated FP.	1. Inadequate funding for capacity building 2. Training Institutions might not have the capacity to train on integrated FP. 3. Staff attrition at institutions affecting training capacity
	Diversifying availability of contraceptives focusing on LAPM	1.Staff competent in providing long acting and permanent methods at facilities 2.Availabilty of infrastructure and equipment in order to offer LAPM	1. Inadequate funding for capacity building 2. Institutions might not have the capacity to train on integrated FP
	Expanding service delivery models through strengthening Public Private Partnership (PPP) including accreditation of private providers by and ensuring provision of quality services	1. Availability of resources to train and equip private providers 2. Framework or Guidelines on PPP to be in place	1. Inadequate resources to train and equip private providers 2. Some service providers might fail meet set standards of service provision.
	Enhancing equity in integrated FP services by improving access, availability and utilization of integrated FP services for vulnerable groups which are young people, people living with HIV & AIDS, people living with disabilities and those living in peri-urban and new settlements and hard to reach areas.	1. Define and identify the vulnerable groups 2. Availability of adequate resources for integrated FP service provision 3. Training of services providers with special skills to offer services to the specified vulnerable groups	1.Inadequate resources to conduct the process of identifying the vulnerable groups 2. Inadequate resources for integrated FP service provision 3. Lack of service providers with special skills to offer services to the specified vulnerable groups

Period	Strategies/Interventions	Assumptions	Risks
Key Result Area: 1			
Goal: 1 & 2			
Strategy 4: Improved demand for integrated FP services, driven by comprehensive knowledge of FP methods			
Budget Year	Review & improve National FP Communications Strategy to close the gap in knowledge and utilization of integrated FP services particularly among the vulnerable populations	1. Acceptability of FP issues culturally & by religious groups 2. Participation of all stakeholders in the process of developing demand creation materials 3. People have access to the new ICT platforms.	1. Negative responses are common on social media platforms (not a stable platform) 2. Dissemination of inaccurate information by stakeholders 3. Some demand creation materials are overtaken by new developments 4. High costs of producing demand creation materials 6. resistance from the cultural and religious sectors 7. Lack of cooperation from the local people 8. Abuse of the social media by people
2-3 years	Review & improve National FP Communications Strategy to close the gap in knowledge and utilization of integrated FP services particularly among the vulnerable populations	1. Acceptability of FP issues cultural & by religious groups 2. Participation of all stakeholders in the process of developing demand creation materials 3. People have access to the new ICT platforms.	1. Non - acceptability of FP issues culturally & by religious groups 2. Non participation of all stakeholders in the process of developing demand creation materials 3. Negative responses are common on social media platforms (not a stable platform) 4. Dissemination of inaccurate information by stakeholders 5. Some demand creation materials are overtaken by new developments 6. High costs of producing demand creation materials

4-6 years	Review and improve National FP Communications Strategy to close the gap in knowledge and utilization of integrated FP services particularly among the vulnerable populations	1. Acceptability of FP issues cultural & by religious groups 2. Participation of all stakeholders in the process of developing demand creation materials 3. People have access to the new ICT platforms.	1. Non-acceptability of FP issues culturally & by religious groups 2. Non participation of all stakeholders in the process of developing demand creation materials 3. Negative responses are common on social media platforms (not a stable platform) 4. Dissemination of inaccurate information by stakeholders 5. Some denmand creation materials are overtaken by new developments 6. High costs of producing demand creation materials
Period	**Strategies**	**Assumptions**	**Risks**
Key Result Area: 1			
Goal: 1 & 2			
Strategy 5: Improve monitoring, evaluation and research for FP services in Zimbabwe			
Budget Year	Strengthening monitoring of the FP programme	1. Cordial working relations between ZNFPC, MoHCC and other stakeholders 2. Use of standardized indicators and MIS tools for the FP programme 3. Availability of resources to conduct M&E activities including data verification activities to all service delivery points 4. Adequately skilled M&E personnel within ZNFPC	1. resistance to use the standard data collection tools 2. High attrition of skilled M&E personnel 3. Low staff morale
	Develop a harmonized FP M&E framework	Availability of resources to develop the FP M&E framework	1. Non-cooperation of some stakeholders in the development of the Framework

	ZNFPC to conduct Operation Research on integrated FP.	Availability of resources for the research activities including training of research personnel, purchase of software and hardware and report writing, data analysis and report dissemination	1. Unavailability of complete data
2-3 years	Strengthening monitoring of the FP programme	1. Cordial working relations between ZNFPC, MoHCC and other stakeholders 2. Use of standardized indicators and data capturing tools for the FP programme 3. Availability of resources to conduct M&E activities including data verification activities to all service delivery points 4. Adequate skilled M&E personnel within ZNFPC	1. Poor cooperation between ZNFPC, MoHCC and other stakeholders 2. Potential use of different data collection tools by different partners making it difficult to track progress 3. Inadequate resources to conduct M&E activities including data verification activities to all service delivery points 4. Lack of skilled manpower with M&E skills within ZNFPC 5. Low staff morale
	Develop a harmonized FP M&E framework	Availability of resources to develop the FP M&E framework	Non-cooperation of some stakeholders in the development of the framework
	ZNFPC to conduct Operation Research on integrated FP.	Availability of resources for the research activities including training of research personnel, purchase of software and hardware and report writing, data analysis and report dissemination.	1.Limited resources to conduct research activities

4-6 years	Strengthening monitoring of the FP programme	1. Cordial working relations between ZNFPC, MoHCC and other stakeholders 2. Use of standardized indicators and data capturing tools for the FP programme 3. Availability of resources to conduct M&E activities including data verification activities to all service delivery points 4. Adequate skilled M&E personnel within ZNFPC	1. Poor cooperation between ZNFPC, MoHCC and other stakeholders 2. Potential use of different data collection tools by different partners making it difficult to track progress 3. Inadequate resources to conduct M&E activities including data verification activities to all service delivery points 4. Lack of skilled manpower with M&E skills within ZNFPC 5. Low staff morale
	ZNFPC to conduct Operation Research on FP.	Availability of resources for the research activities including training of research personnel, purchase of software and hardware and report writing, data analysis and report dissemination.	1. Limited resources to conduct research activities

APPENDIX 2: LIST OF PARTICIPANTS

Item	Name	Designation
1.	Rtd Brigadier General Dr G. Gwinji	Secretary for Health and Child Care
2.	Dr B. Madzima	Director Family health
3.	Ms M. Nyandoro	Deputy Director Reproductive Health
4.	ZNFP Board of Directors	ZNFPC
5.	Dr M. Murwira	Executive Director ZNFPC
6.	Dr E. Munongo	Director Technical Services ZNFPC
7.	Dr O. Mugurungi	AIDS and TB Unit MoHCC
8.	Mr J. Chigweremba	Director Admin and Finance ZNFPC
9.	Mrs T. Muzadzi	Service Delivery Manager ZNFPC
10.	Mr L. Gamba	Assistant Director Evaluation and Research ZNFPC
11.	Mr M. Mukaronda	Assistant Director Marketing & Comms ZNFPC
12.	Mr F. Machinga	Programme Manager - ZNFPC
13.	Dr A. Mushavi	AIDS and TB Unit MoHCC
14.	Dr B. Tambashe	UNFPA Country Representative
15.	Dr E. Mpeta	UNFPA Programme Specialist RH
16.	Dr. Vibhavendra S Raghuvanshi	UNFPA Technical Specialist
17.	Jo Keatine	USAID
18.	Reena	USAID
19.	Dr. M. Haile	PSZ Country Director
20.	Dr. R. Bonde	PSZ
21.	K. Kosinski	PSZ Project Manager
22.	M. Mabedla	PSZ Centre Coordinator
23.	K. Hatzold	PSI Deputy /Chief of Party
24.	Dr. N. Muhonde	PSI
25.	T. Chitsanzara	PSI Site Manager - Harare
26.	M Mwonzora	Crown Agents
27.	A. Daly	DFID
28.	D. Alt	JSI
29.	B. Senzanje	UNICEF
30.	S. E. Chitsungo	UNICEF
31.	National Programme Officer	Ministry of Women's Affairs, Gender and Employment Creation
32.	Acting Provincial Medical Director	Mashonaland Central
33.	Mr. N. Shoniwa	ZNFPC Mash Central Provincial Manager
34.	Dr. T.P. Goverwa	Provincial Maternal and Child Health Officer, Mat North Province

35.	Mr. F. Sibanda,	Reproductive Health Officer Mat North Province
36.	Mrs E. Mudzimwa	ZNFPC Mat North Provincial Manager
37.	Mr. S. Mundandishe	ZNFPC Mat North Accountant
38.	Mrs. J. Godzi	ZNFPC Mat North Service Delivery Coordinator
39.	Mr. B. Gumbi	Provincial Marketing and Communications Officer
40.	Miss N. Khumalo	ZNFPC HR Officer
41.	Mrs. P. Tasara	CBD Distributor
42.	Sister B. Chabikwa	Sister in Charge, Margran House
43.	Sister M. Moyo	PSZ Mpopoma Clinic
44.	Sister W. Nleya	Male Circumcision Clinic
45.	Mrs. B. Makhosa	African Apostolic Church, Mzilikazi Branch
46.	Sister R. Chore	Sister in Charge - Galen House Clinic
47.	Sister C. Sibanda	A/Chief Nursing Officer Bulawayo City Health
48.	Sister M. Sibanda	Acting Sister-in-Charge
49.	Sister B. Moyo	Nurse, Pelandaba Clinic
50.	Matron Makuyana	Matron, United Bulawayo Hospitals
51.	Sister A. Mudege	Sister, United Bulawayo Hospitals
52.	Sister B. Gowera,	SIC - United Bulawayo Hospitals
53.	Mr S. Garaweni	Pharmacy Technician, United Bulawayo Hospitals
54.	Provincial Administrator, Mashonaland Central province	Ministry of Women Affairs, Gender and Comm Development
55.	Sister in Charge	Chidodo Clinic
56.	Acting District Medical Officer	Shamva District Hospital Mash. Central
57.	J. Marembo	Provincial Nursing Officer Midlands
58.	W. Magwera	SRHR Focal Person Midlands
59.	Mr Majoni	Optician: Council for the Blind
60.	T. Chiwawa	Sister in charge: Dr Tayi Surgery
61.	Dr Mhene	Gokwe North-DMO
62.	Sr Chipindu	Gokwe North-Community Sister
63.	Sister C. Sibanda	Mvuma District Hospital
64.	Sister Gumbo	Chaka Rural Hospital
65.	Sister S. Moyo	St Theresa- Sister in Charge
66.	M. Nyakata	Admin Assistant PSZ Gokwe North
67.	Alice Masuka	Community Development Officer - Ministry of Women's Affairs Gokwe North District
68.	Cathrine Makombo	District Development Officer - Gokwe North District
69.	A. Chavhura	CBD Chirumhanzu
70.	C. Mukena	CBD Chirumhanzu
71.	J. Madondo	Depot Holder Chirumhanzu
72.	E. Sami	Kraal Head

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