COUNTRY NOTE

EVALUATION OF UNFPA SUPPORT TO FAMILY PLANNING 2008-2013

COUNTRY CASE STUDY
ZIMBABWE

EVALUATION OFFICE
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Evaluation of the UNFPA Support to Family Planning Services 2008-2013

Zimbabwe Case Study Note

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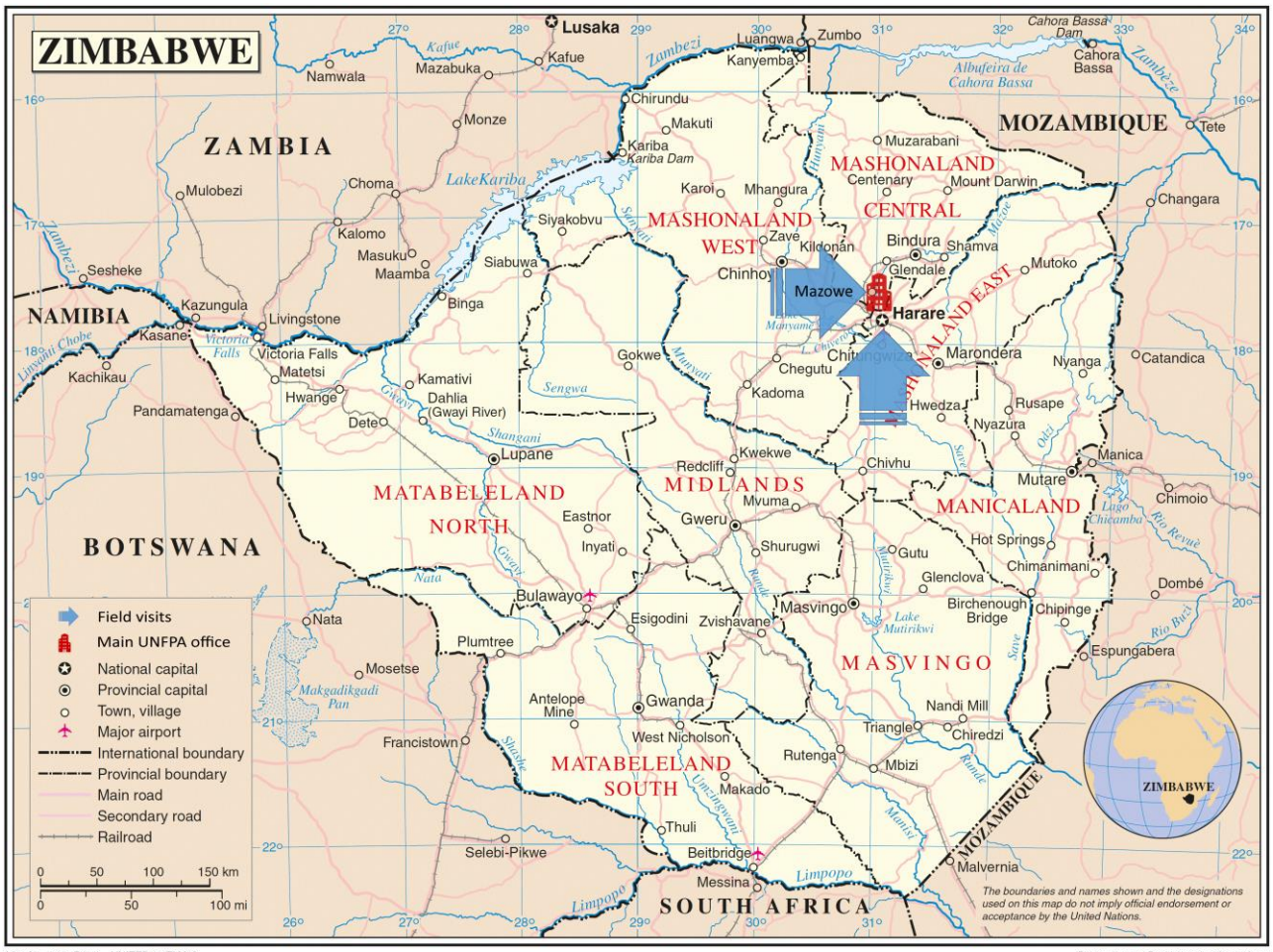
ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AfriYAN	African Youth and Adolescent Network
ANC	Ante-natal care
ART	Antiretroviral therapy
ASRH	Adolescent sexual and reproductive health
BCC	Behaviour change communication
BCF	Behaviour Change Facilitator
CaCx	Cervical cancer
CBD	Community-based distribution
CBO	Community-based organization
CCP	Comprehensive condom programming
CO	UNFPA Country Office
COAR	Country Office Annual Report
CP	Country Programme
CPD	Country programme document
CPE	Country Programme Evaluation
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organisation
CSW	Commercial sex workers
CYP	Couple Years of Protection
DFID	Department for International Development (United Kingdom)
DHO	District Health Office
DHS	Demographic Health Survey
DP	Development Partners
DTTU	Delivery Team Topping Up system
ESARO	UNFPA East and Southern Africa Regional Office
FGD	Focus Group Discussion
FHI	Family Health International
FP	Family Planning
FP2020	Family Planning 2020
FSW	Female Sex Worker
GBV	Gender Based Violence
GDP	Gross domestic product
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GII	Gender inequality index
GNP	Gross National Product
GoZ	Government of Zimbabwe
GPRHCS	Global Programme for Reproductive Health Commodity Security

HCT	HIV Counselling and Testing
HCW	Health Care Worker
HDI	Health development index
HIV	Human Immunodeficiency Virus
HQ	UNFPA Headquarters
HRBA	Human Rights Based Approach
HTF	Health Transition Fund
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
INGO	International Non-Government Organisation
IP	Implementing Partner
IPPF	International Planned Parenthood Federation
ISP	Integrated Support Programme
IU(C)D	Intra-Uterine (Contraceptive) Device
JSI	John Snow, Inc (US health NGO)
KII	Key Informant Interview
LAM	Lactational Amenorrhea Method
LA/PM	Long-acting and permanent methods of contraception
LARC	Long-acting reversible contraceptives
MCH	Mother and child health
MCHIP	Maternal and Child Health Integrated Project (USAID)
mCPR	Modern Contraceptive Prevalence Rate
MDG	Millennium Development Goals
MISP	Minimum integrated service package
MMR	Maternal mortality rate
MNCH	Maternal neonatal and child health
MNH	Maternal and Neonatal Health
MoHCC	Ministry of Health and Child Care
MSI	Marie Stopes International
MSM	Men who have sex with men
MWACD	Ministry of Women's Affairs, Gender and Community Development
NAC	National AIDS Council
NatPharm	National Pharmaceutical Company of Zimbabwe
NGO	Non-Government Organisation
OC	Oral Contraceptives
OI	Opportunistic Infections
OR	Operational Research
PEPFAR	(US) President's Emergency Plan for AIDS Relief
PLWHIV	People Living with HIV
PMD	Provincial Medical Directorate
PMTCT	Preventing mother to child transmission (of HIV)

PNC	post-natal care
PPFP	Postpartum Family Planning
PSI	Population Services International
PSZ	Population Services Zimbabwe (Marie Stopes International affiliate)
QA	Quality Assurance
RBA	Rights based approach
RBF	Results-based financing
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
RMNCH	Reproductive Maternal Neonatal and Child Health
RO	UNFPA Regional Office
SDP	Service Delivery Point
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually transmitted infection
TA	Technical Assistance
ToC	Theory of Change
ToR	Terms of Reference
ToT	Training of trainers
UNFPA	United Nations Populations Fund
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
VIAC	Visual inspection with acetic acid and cryotherapy
VMG	Vulnerable and Marginalised Group
WHO	World Health Organisation
YFS	Youth friendly services
ZIM-ASSET	Zimbabwe Agenda for Sustainable Socio-Economic Transformation
ZIMSTAT	Zimbabwe National Statistics Agency
ZLHR	Zimbabwe Lawyers for Human Rights
ZNFPC	Zimbabwe National Family Planning Council

INTERVENTION MAP



Map No. 4210 Rev. 1 UNITED NATIONS
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KEY FACTS – ZIMBABWE

Indicator	2014	Source of Data
Population and Development		
Population, total	15,245,855	World Bank[1]
Population growth (annual %)	2.3	World Bank[1]
Urban Population (% of total)	33	World Bank[1]
Population Density (per sq. km of land area)	39	World Bank[1]
Life Expectancy at birth, total (years)	56 (2013 data)	World Bank[1]
Literacy rate, population 15+ years (%)	-	World Bank[1]
Human Development Index (HDI)	0.509 (Rank 155 out of 188)	Human Development Report[2]
Economic growth rate (GDP growth annual %)	3.8	World Bank[1]
GINI Index	-	World Bank[1]
Gender Equality and Empowerment		
Gender Inequality Index	0.504 (Rank 112 out of 155)	Human Development Report[3]
Women representation in parliament, total (%)	32	World Bank[1]
Violence against women ever experienced (%)	43.4	Human Development Report[3]
Employment to population ratio, 15+, female (%) (modeled ILO estimate)	79	Human Development Report[5]
Ratio of girls to boys in primary and secondary education (%)[4]	-	World Bank[1]
Reproductive Rights and Reproductive Health		
Adolescent fertility rate (births per 1,000 women ages 15-19)	110	World Bank[1]
Teenage mothers (% of women ages 15-19 who have had children or are currently pregnant)	-	World Bank[1]
Prevalence of HIV, both sexes (% ages 15-49)	16.7	World Bank[1]
Maternal mortality rate (per 100,000 live births)	401	World Bank[1]
Under 5 mortality rate (per 1,000 live births)	72	World Bank[1]
Contraceptive use, modern methods (%)	67.5	UN DESA[5]
Unmet need for family planning (%)	10.1	UN DESA[6]
Births attended by skilled health staff (% of total)	-	World Bank[1]

[1] World Bank. (2016). Zimbabwe. Retrieved from http://data.worldbank.org/country/zimbabwe

[2] United Nations Development Programme. (2016). Zimbabwe. Retrieved from http://hdr.undp.org/en/countries/profiles

[3] United Nations Development Programme. (2016). Table 5: Gender Inequality Index. Retrieved from http://hdr.undp.org/en/composite/GII

[4] This indicator is also labeled as "*Gross enrolment ratio, primary and secondary, gender parity index (GPI)*" by the World Bank.

[5] United Nations. (2016). UN DESA Population Division Estimates and Projections of Family Planning Indicators. Retrieved from http://www.un.org/en/development/desa/population/theme/family-planning/cp_model.shtml

1 INTRODUCTION

Family planning (FP) is a principal focus of the work of UNFPA worldwide. This country case study is part of a thematic evaluation of UNFPA support to family planning 2008-2013, whose objective is to assess progress against past and current strategic plans and inform future decision-making and policy formulation in family planning.

1.1 Objectives of the evaluation

Purpose

The purpose of the evaluation is to assess the performance of UNFPA in the field of family planning during the period covered by the Strategic Plan 2008-2013 and to provide learning to inform the implementation of the current UNFPA Family Planning Strategy Choices not Chance (2012-2020). The evaluation will also inform other relevant programmes such as the Global Programme for Reproductive Health Commodity Security (GPRHCS) (2013-2020) and the HIV/Unintended pregnancies framework (2011-2015). Finally, the evaluation results will feed into the mid-term review of UNFPA current Strategic Plan 2014-2017.

Objectives

The primary objectives of the evaluation are to:

1. Assess how the framework as set out in UNFPA Strategic Plan (and revised Development Results Framework) 2008-2013 and further specified in the reproductive rights and sexual and reproductive health framework (2008-2011) as well as in the GPRHCS (2007-2012) and the HIV/Unintended Pregnancies framework (2011-2015), has guided the programming and implementation of UNFPA interventions in the field of FP.
2. Facilitate learning and capture good practices from UNFPA experience across a range of key programmatic interventions in the field of FP during the 2008-2013 period to inform the implementation of both outcome 1 of UNFPA current Strategic Plan and the Choices not Chance 2012-2020 strategy; inform the GPRHCS (2013-2020) and the HIV/Unintended Pregnancies framework (2011-2015) as well as future programming of interventions in the field of FP.

1.2 Scope of the evaluation

The evaluation covers the period 2008-2013, taking into account information from 2014 when pertinent and necessary. It is both retrospective and forward-looking, including evaluation of past performance, analysis of lessons learnt, and conclusions and recommendations for future interventions.

The geographical scope covers all countries where UNFPA has carried out FP interventions, focussing on the 69 poorest countries with low rates of contraception use and high unmet need for FP identified by the 2012 London Summit on Family Planning and FP2020 partnership, and also covering middle income countries where FP needs are still high due to inequality of access. Data collection and case studies cover all six UNFPA regions (Eastern and Southern Africa, Western and Central Africa, Asia and the Pacific, Latin America and the Caribbean, the Arab States, and Eastern Europe and Central Asia).

All UNFPA FP interventions are included in the evaluation, including those covered by core and non-core resources and those financed through the GPRHCS. Family planning is an integral part of UNFPA interventions in maternal health, adolescent and young people's sexual and reproductive health (SRH), HIV and AIDS, gender and humanitarian support. Family planning activities in these areas are included in the evaluation where appropriate, taking care not to duplicate work carried out in the Thematic Evaluation of UNFPA Support to Maternal Health 2000-2011, and the Adolescent and

Youth Sexual and Reproductive Health (AYSRH) evaluation which is being carried out concurrently with this evaluation.

The evaluation covers eight principal areas of investigation:

- UNFPA support to integration of FP with other sexual and reproductive health (SRH) services
- UNFPA efforts for coordination to ensure national ownership and institutionalisation of FP programmes
- Extent of UNFPA efforts as a broker to promote FP, with particular attention to partnerships
- Extent of UNFPA support to creation of an enabling environment
- Level of focus on the needs of the most vulnerable groups and marginalised populations
- Extent of implementation of a human-rights based approach
- UNFPA choice of different modes of engagement
- The extent to which UNFPA support for supply-side activities (including training, procurement and logistic systems) promotes rights-based and sustainable approaches and contributes to improved access

1.3 Overview

The evaluation uses a contribution analysis approach based on a reconstructed theory of change which is being tested through collection of data and information at different levels, and analysis of the eight evaluation areas and their associated assumptions.

There are twelve country case studies (five in-country and seven desk studies) in the data collection phase, which also includes review of documentation, key informant interviews (KIIs) at global and regional levels with UNFPA staff and other stakeholders, two on-line surveys and additional financial analysis.

The case studies are not evaluations of the FP effort in each country and do not present recommendations for on-going or future FP work. They are one important input into the data collection and analysis process for the eight areas of the UNFPA FP evaluation as a whole, and contribute to the overall evaluation through:

- Providing input from the country perspective for addressing the global evaluation questions
- Generating data for triangulation with other sources
- Contributing to identifying more clearly “how” and “why” change occurs and contributions of UNFPA to this
- Providing insights to the eight principal evaluation areas
- Identifying lessons learned across different contexts.

Contribution analysis was originally presented as an approach to programme design and monitoring and, to a lesser extent, to evaluation. This has left considerable freedom for evaluators to explore different approaches to operationalising contribution analysis and the use of Theories of Change (ToC). Different approaches have been used to apply contribution analysis in evaluations which include both country or sub-programme and global or synthesis levels of analysis.

For this evaluation’s work at country level, the team has organised the country case study notes around the eight evaluation areas and has attempted to address most or all of the key assumptions in the overall ToC as they are realised (or not) at the country level. This method has the following strengths:

- It draws a clear link from the overall ToC as developed and presented in the inception report while allowing the country cases to reflect local contexts and realities and the UNFPA response;

- It allows the country cases to include areas of UNFPA engagement and support and positive or negative results which may not have been captured in the reconstructed ToC[6]
- It simplifies the reporting of findings at country case level since it does not require the development of separate, country level ToC
- It still allows for a strong testing/challenge of the ToC at country level because it allows the evaluation team to verify the validity of key assumptions. In effect, this combines analysis of assumptions and risks (the main risks are usually that key assumptions are not realised)
- Using the common structure of the eight issues areas and their associated key assumptions will facilitate synthesizing the findings and conclusions of the country studies during the preparation of the overall evaluation report.

In this way the country case study notes are able to establish the link from the country level evaluation results to the overall Theory of Change for UNFPA support to FP.

This report covers the case study in Zimbabwe.

1.4 Structure of the country note

Section 2 of the report outlines the case study methodology. Section 3 gives a short overview of key elements of FP in Zimbabwe and the UNFPA response and provides the necessary context for discussion of the specific evaluation questions and UNFPA contributions. Section 4 presents the findings of the case study along the eight evaluation questions, including progress and changes during the evaluation period and the UNFPA contribution to those changes. Section 5 presents a set of conclusions.

2 METHODOLOGY

2.1 Selection of country case studies

The five in-country case studies include three from West and Central/Eastern and Southern Africa regions, one from Asia-Pacific region, and one from Latin America and Caribbean region. The sample maximises the breadth and depth of insights into the evaluation questions and gives a broad picture of the UNFPA contribution to family planning (FP) over time in different contexts, giving insights into the country perspective on the evaluation questions, providing examples of externalities and risks and how they have been addressed, and complementing the information collected from other sources. This section summarises the process and results of country selection for visits and desk studies. A full description of the case study selection is given in the Evaluation Inception Report (UNFPA 2014a).

The selection started with a purposeful sample based on criteria which cover the dual purpose of the evaluation: looking back to assess UNFPA performance in the field of FP, and providing learning for the on-going UNFPA Strategic Plan. Criteria included poverty indices, levels of UNFPA spending and past performance in FP taking into account both change in modern contraceptive prevalence rate (mCPR) and unmet need.

From the purposeful sample, countries were selected for in-country and desk studies taking into account the following criteria, to ensure a spread and contrast in the set of case studies:

[6] The reconstructed ToC was developed in the inception phase of the evaluation, based on the pertinent UNFPA strategy documents, which include family planning during the period. Expected pathways of change were identified and mapped for each of the 8 evaluation areas (see annex of inception report).

- Overall UNFPA spending per capita
- The need to include at least one country with Global Programme for Reproductive Health Commodity Security (GPRHCS) Phase 1 Stream 1 support[7]
- Availability of sufficient and sufficiently reliable data and information on past UNFPA support and the overall country context
- The need to include at least one fragile state or humanitarian situation, at least one high-population country and one or more countries with a One UN (delivering as one country) programme
- Varying degrees of government support for FP
- Changes in UNFPA modes of engagement and implementation risks
- The need to avoid concurrent implementation of in-country case studies with other UNFPA thematic and country evaluations and
- The potential of the country study to contribute to analysis of the hypotheses in the evaluation matrix.

The resulting sample is spread across the UNFPA Strategic Plan business model's four quadrants, which show need for FP interventions vs. capacity to finance such interventions, although application of the sample selection criteria clearly favours countries in the quadrants representing countries with relatively higher levels of need and lower levels of financing ability (UNFPA 2013). Aside from Zimbabwe, the other countries selected for the field phase are: Bolivia, Burkina Faso, Cambodia, and Ethiopia.[8]

2.2 Selection of Zimbabwe as a case study

Zimbabwe was selected for a case study as it has characteristics regarding UNFPA support to FP that offer important insights into the country perspective on the evaluation questions in a specific context. Relevant characteristics of the country and the UNFPA country programmes in the evaluation period include:

- A strong and successful family planning programme post-independence characterized by high contraceptive prevalence and nearly universal awareness of FP
- A fragile country context resulting from major economic crises in the recent past and a humanitarian crisis during the period under evaluation
- A mostly rural population with a generalised HIV epidemic, a very young population and a high level of gender-based violence
- A high level of donor dependency, with several large donor initiatives supporting sexual and reproductive health (SRH) service delivery
- Participation in the Global Programme for Reproductive Health Commodity Security.

2.3 Scope of the study and data collection methods

The country study covered all UNFPA FP work from 2008-2013, including projects fully dedicated to family planning as well as those in which FP activities are a component of other sexual and reproductive health (SRH) projects. Core and non-core funding (including funding from the GPRHCS thematic trust fund) were included within the analysis.

The study was carried out during June 2015 by a team of two consultants (one international and one national). UNFPA Country Office (CO) staff participated fully in the preparation of the study and

[7] Stream 1 countries are those selected for priority attention by GPRHCS for multi-year, flexible and predictable funds to help countries develop more sustainable approaches to Reproductive Health Commodity Security (RCHS)

[8] See inception report for discussion of country selection.

logistics, internal discussions and interviews within the CO, collection and analysis of information and financial data, and in the de-briefing workshop session. CO staff organised visits to health facilities in a rural area.

Preliminary work (prior to the country visit) included:

- Collection and review of key data of Zimbabwe including country background; country health sector and other sectors relevant for SRH/FP; health and other SRH/FP-relevant indicators
- Desk analysis of UNFPA response in the country; overview of UNFPA interventions (2008-2013)
- Preparation of detailed timetable for interviews and other activities during the country visit (in consultation with Country Office).

In-country work was designed to provide input to the eight evaluation areas. Activities included briefing and de-briefing with CO staff and interviews with UNFPA staff, government officers, bilateral donors, national and international non-government organisations (NGOs), health service delivery personnel and clients, to give a balance of different points of view of UNFPA support to FP and the current context of FP programmes and services. There was a one-day visit to Bindura where UNFPA has supported FP activities. The purpose was to gain insights on programme implementation challenges and to add context-specific examples to the overall country picture. Focus group discussions (FGDs) with FP users and non-users were planned, but were not held as there were very few clients at the facilities when the team arrived, although the team held brief interviews with staff and a few clients. The team worked with CO staff to identify FP budgets and spending over the evaluation period, including FP spending within other thematic areas.

Data and information collected from documents, interviews, field trips and FGDs was collated in an evaluation matrix (see Annex 3). Activities and progress in each evaluation area were analysed to identify the changes which have occurred and the UNFPA contribution to those changes. At the end of the visit the team presented preliminary findings to the UNFPA CO staff for their comments and feedback which are included in the analysis in section 4 of this report.

Documents consulted are shown in the list of references (Annex 1). A list of people interviewed and FGD participants is given in Annex 2. Interview guides and FGD guides are presented in the Evaluation Inception Report.

Limitations on the data collected include:

- Detailed financial information on FP spending within other SRH projects is based on estimates by CO staff. This approach was chosen due, primarily, to challenges in obtaining family planning expenditure through the use of the UNFPA financial management platform (Atlas). For the period under evaluation, the UNFPA financial management platform did not explicitly track family planning expenditures and, when it did so, did not capture the full range of family planning expenditure (which was often integrated with other projects).
- The number of sites visited and interviews of service providers and clients conducted during the field visit were minimal. Therefore, information regarding the service delivery context is limited to what could be gleaned second-hand from key informants and documents.

Despite the above limitations, the evaluative data and information gathered during the Zimbabwe country study provides a valid basis for the findings presented in section 4.

3 SHORT DESCRIPTION OF FAMILY PLANNING IN ZIMBABWE

Country background

Zimbabwe, a landlocked country in Southern Africa, was on the path to middle-income status in the mid-1990s following its independence in 1980, but has since suffered from a series of economic crises for the past two decades. The population, estimated at 13.1 million in 2012, has a young age structure with 41 percent below 15 years of age and 67 percent below the age of 25 (Jackson, Njovana et al. 2014). Two-thirds of the population lives in rural areas and experience widespread poverty, and there has been extensive rural-urban migration where urban poverty is also high. The economy depends heavily on the agriculture and mining sectors. Adult literacy rates are high at 83.6 percent and the Gender Inequality Index (GII) of 0.516 is only somewhat higher than the average for least developed countries (0.570) (UNDP 2014).

Zimbabwe received its lowest ranking of 173 out of 187 countries on the Human Development Index (HDI) in 2011 as a consequence of the economic challenges that reached crisis proportions in 2007-2008 when the country experienced record hyperinflation and the serious deterioration of critical public services for health care, education, water supply and sanitation. The situation has since stabilised since the formation of an inclusive government and the introduction of a multicurrency system in 2009. It also introduced a new development plan, the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZIM-ASSET) that prioritises building social services, food security and physical infrastructure (World Bank 2015). The gross domestic product (GDP) annual growth rate has improved from -4.1 percent in 2005 to 4.4 percent in 2012 (United Nations 2014). The HDI for Zimbabwe recovered to 156 in 2014 and in several key areas, the country has regained outcome levels of the early 1990s (UNDP 2014).

Health System

The delivery of health services in Zimbabwe is decentralised with health care provided at primary, secondary, tertiary and central levels. The Ministry of Health and Child Care (MoHCC),[9] is responsible for policy and administrative guidance, determining funding allocation, approving staff hires at district and provincial levels and overseeing central-level hospitals. At the provincial and district levels[10], the MoHCC is represented by provincial and district health offices. The Provincial Medical Directorate (PMD) office administers provincial hospitals and oversees all district health offices (DHOs) within the province. At the district level, DHOs have similar responsibilities in relation to managing primary care facilities. Primary care consists of village health workers, community-based distributors and rural health centres that provide basic prevention, maternity and curative services. There are over 1,100 primary health care facilities, comprising approximately 80 percent of all facilities in Zimbabwe. The system is designed for patients to first present at primary levels and then move up through referrals to higher-level facilities as appropriate (Osika, Altman et al. 2010: 14-15).

The Zimbabwean health system has retained many of the structures from its creation in the early 1980s. However, recent attrition of health workers caused by the economic difficulties has negatively affected the capacity of decentralised structures. An assessment in 2010 indicated that patients tended to go to whatever facility is more geographically convenient and the system for soliciting input from citizens at all levels of the health system had also been weakened by the economic decline. The National Health Strategy (2009-2013) identified the weak participatory structures as a significant barrier for community participation in health care policy and decision-making and to ensure that health care provision meets the needs of the surrounding population (Osika, Altman et al. 2010: 31). However, since 2010 and through efforts by the Health Transition

[9] Previously named the Ministry of Health and Child Welfare (MoHCW).

[10] The administrative structure in Zimbabwe consists of eight administrative divisions, two cities with provincial status, Harare and Bulowayo, and 62 districts.

Fund (HTF) and Results-based Financing (RBF) (discussed below), Health Centre Committees have been strengthened to obtain community inputs.

Health sector spending, overseas development assistance and UNFPA contributions

Following the economic decline of the health system in 2008, the government has relied on donor assistance to provide financial and human resources, including substantial support for commodities and service delivery. Donor funds for population assistance[11] have increased dramatically and have more than quintupled over the period of evaluation from US$50.8 million in 2008 to US$275.7 million in 2012 (UNFPA 2014b).

The total UNFPA spending on sexual and reproductive health and rights (SRHR) in Zimbabwe was estimated at US$85.1 million for the period 2008-2013, with approximately US$12.47 (15 percent) estimated for expenditure on family planning (FP) activities. Following the trends in increased donor funding for population assistance, UNFPA annual levels of expenditure on family planning increased from US$1.04 million in 2009 to US$4.1 million in 2013. UNFPA expenditures in 2012 (US$ 2.8 million) accounted for just 1 percent of the aforementioned amount of donor assistance in 2012 (67.9 million). Core funds accounted for 13.7 percent of UNFPA FP expenditures during the evaluation period, with the remaining coming from non-core funds, including Global Programme for Reproductive Health Commodity Security (GPRHCS).[12]

Three major donor-funded initiatives were undertaken during the period under evaluation; the Health Transition Fund, Results-Based Financing (RBF) for Health and the Integrated Support Programme. Each of these initiatives is intended to rebuild the capacity of the health system to provide maternal and child health and sexual and reproductive health services, including family planning. Following the economic and political crisis in 2008 and the reestablishment of donor relations, the priority in the health sector was to strengthen essential maternal and child health services which led to the Health Transition Fund (HTF). This pooled fund managed by UNICEF did not include FP, nor did it cover other areas such as HIV prevention, gender based violence (GBV) prevention and services, or adolescent sexual and reproductive health (ARSH).[13] The Integrated Support Programme (ISP) is a four-year $32 million initiative funded by the UK, Irish and Swedish governments to address these neglected areas.

Sexual and reproductive health and family planning

The modern contraceptive prevalence rate (mCPR) in Zimbabwe is one of the highest in Africa. It rose steadily post-Independence from 36.1 percent among currently married women in 1988 to 58.4 percent in 2005-06 where it remained steady at 57.3 percent in 2010-11 (DHS 2015).[14] Among currently married women, the contraceptive method most commonly used is the pill (41 percent), followed by injectables (eight percent), male condoms (three percent), implants (three percent), and female sterilisation (one percent). Use of female condoms, intra-uterine contraceptive device (IUCD) and the lactational amenorrhoea method (LAM) use are less than 1 percent. Almost three-quarters of contraceptive users obtained methods from the public sector (73 percent). Fourteen percent obtained contraceptives from the private medical sector, 4 percent from a mission facility, 4 percent from a retail outlet, and 2 percent from another private source (ZIMSTAT and ICF International 2012).

[11] Population assistance includes funding for family planning, maternal health programme and system related costs, HIV AIDS and basic research/data/policy analysis.

[12] Country Office financial data, Annex 4

[13] Annex 3, Assumption 2.1

[14] mCPR for all women (as opposed to currently married women) age 15-49 is 40.5 percent.

The total fertility rate for Zimbabwe is 4.1 children per woman and higher for women with less education (4.9), poor (5.3) and living in rural areas (4.8). Teenage fertility is on the rise. Although fertility has fallen among women over age 20 over the past two decades, it has increased for the 15-19 year age group. The teenage pregnancy rate in Zimbabwe has increased from 21 percent in 2005-06 to 24 percent in 2010-11, the highest rate recorded since 1984. Contraceptive use among sexually active women aged 15-19 is 10.3 percent, as compared to 45 percent for those aged 20-24 (ZIMSTAT and ICF International 2012).

Unmet need for contraception, although low compared to other African countries at 13 percent, is higher among women age 15-19 (17 percent). The skewed method mix toward short-acting, hormonal methods contributes to unmet need. Reducing discontinuation is also important to address unmet need (Jain, Obare et al. 2013). In Zimbabwe, discontinuation occurs most often because of health concerns or method-related side effects (17 percent) and method failure (12 percent). Broadening the method mix can contribute to meeting the needs of women and couples for contraception. Although the level of knowledge about FP is nearly universal, knowledge about long-acting and permanent methods is lower. For example, among all women currently not using contraception, knowledge of short-acting methods was 96 percent, as compared to knowledge of long-acting (68.2 percent) or permanent (43 percent) methods of contraception (EngenderHealth and Futures Institute 2014).

Zimbabwe has one of the largest HIV epidemics in the world with an estimated adult prevalence of 15 percent and 1.4 million people living with AIDS (UNAIDS 2014). The epidemic remains "generalised, feminised and homogenous" (National AIDS Council 2015: 1), however, the prevalence rate declined 3 percentage points between 2005-06 and 2010-11 (ZDHS). Young people age 15-24 generally have lower levels of knowledge than adults, and urban residents are more knowledgeable about prevention than rural residents (ZIMSTAT and ICF International 2012). Comprehensive correct knowledge about AIDS[15] among young women age 15-24 increased from 43.7 percent in 2005-06 to 51.9 percent in 2010-11. For young men age 15-24, comprehensive correct knowledge about AIDS increased from 45.6 to 47 percent during the same period (DHS 2015).

The maternal mortality ratio (MMR) increased from 283 maternal deaths per 100,000 live births in 1984 to 555 in 2005, 725 in 2007 (United Nations 2011) and reached its peak in 2010 at 960. The deteriorating trend has reversed to 614 maternal deaths per 100,000 live births in 2014, although this rate remains one of the highest in the region. This is due to the high burden of HIV and AIDS, and poor access to and quality of emergency obstetric and neonatal care services. Over 4.3 million women of reproductive age in Zimbabwe are at risk of developing cervical cancer, which is associated with high HIV prevalence (United Nations 2015).

Government policy on family planning

The principal policies and strategies relevant to family planning in Zimbabwe are shown in Table 1 below.

Table 1: Strategic documents related to family planning

1985	Zimbabwe National Family Planning Council Act
2003	National Reproductive Health Policy
2006	National HIV/AIDS Strategic Plan 2006-2010
2006	National Behaviour Change Strategy for the Prevention of Sexual

[15] Comprehensive correct knowledge about AIDS includes the mention by respondents of two ways to prevent AIDS and the rejection of three misconceptions.

	Transmission of HIV 2006-2010
2007	Zimbabwe Maternal and Neonatal Health Road Map 2007-2015
2009	National Health Strategy for Zimbabwe 2009-2013
2010	Zimbabwe National Adolescent Sexual and Reproductive Health Strategy 2010-2015
2012	Zimbabwe National Gender-based Violence Strategy 2012-2015
2013	MoHCC Service Guidelines on SRHR and HIV Linkages (and related training modules for health service providers, community health workers and health service managers)
2013	Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZIM-ASSET) 2013-2018
2014	Zimbabwe National Family Planning Strategy 2015-2020

The Zimbabwe National Family Planning Council (ZNFPC) was established in 1985 to lead and coordinate the implementation of family planning activities in Zimbabwe under the direction of the MoHCC. The development of the new, updated National FP Strategy 2015-2020 signals increased priority for FP on the development agenda and operationalises the GoZ commitment to FP 2020. This commitment, announced by the GoZ at the London FP Summit, includes the doubling of the budget for procurement of contraceptive commodities from the current 1.7 percent to 3 percent of the health budget.[16]

The strategy offers a logical framework to create an enabling environment for the provision of quality, comprehensive and integrated FP/SRH services. It also aims to contribute to the development and increased national commitment to FP and accelerate the achievement of the Millennium Development Goals (MDGs). The key challenges for achieving the strategy are the actual willingness or ability of the Government of Zimbabwe (GoZ) to allocate funding for FP, to take steps toward self-reliance on contraceptive commodity procurement, and to monitor and evaluate the implementation of existing FP/SRH policy within services and programmes, and to update and improve programmes accordingly (MoHCC 2013).

UNFPA responses

Overview

The period under evaluation (2008-2013) covers the 5th and 6th UNFPA Country Programmes (CPs) which ran from 2007 to 2011 (United Nations 2006) and 2012 to 2015 (United Nations 2011), respectively. Both programmes have two main outcomes, the increased use of reproductive health services and increased adoption of safer sexual behaviour and use of HIV prevention services. Both programmes also include youth-friendly services, gender sensitive programming and family planning as key components. Capacity building activities were evident throughout both programmes.

The 5th CP had a total budget of US$40.5 million, US$13.5 million from core resources and $27 million from non-core funding. Of the four components (reproductive health, population and development, gender equality and programme coordination and assistance), the reproductive health (RH) component had by far the largest share of the budget at US$29.5 million (78 percent from non-core resources). Outputs for the reproductive health component included enhanced national capacity to formulate and promote policies; increased availability of comprehensive RH services, including essential obstetric care and FP; increased capacity to plan, manage and monitor services, including the development of a national RH commodity security plan; promotion of behaviour

[16] Annex 3, Assumption 2.1

change targeted at risk groups; increased coverage of youth-friendly services; and creating an enabling environment for safer sexual practices. The 5th Country Programme Evaluation (CPE) concluded that the challenges from the deteriorating socio-economic and political situation compromised the ability of UNFPA to fully implement and achieve its programme goals, particularly in the area of training and capacity development. However, the country office (CO) successfully supported the MoHCC to formulate strategic documents, such as the MNH Road Map and the ARSH Strategy, and to mobilise resources to assist in managing the bare minimum package for maternal and newborn health service provision (UNFPA Zimbabwe 2010).

The 6th CP had a budget of US$39.6 million, with US$13.2 million from core and US$26.4 million from non-core resources, although the actual figure for non-core was double what was planned due to successful resource mobilisation by the CO. The RH component again received the largest share of resources at US$29.8 million (76.5 percent from non-core resources). Outcomes for the reproductive health component included strengthened capacity of government and civil society partners to deliver RH services, increased availability of RH services and commodities, increased demand at the community level for SRH services, increased coverage of behaviour change and communication for HIV prevention, and increased availability of HIV prevention services. The 6th CPE concluded that UNFPA made considerable contributions to support the MoHCC capacity in SRH and to support key vulnerable populations of adolescents and sex workers (Jackson, Njovana et al. 2014). Information collected during this case study triangulates well with the overall 5th and 6th CPE conclusions.

Global Programme for Enhancing Reproductive Health Commodity Security

During the period under evaluation, Zimbabwe received financial and technical support under the UNFPA flagship thematic GPRHCS. As a "stream 2" country, Zimbabwe received funding to strengthen targeted elements of reproductive health commodity security (RHCS) based on country context as compared to more robust, multi-year funding received by a small number of "stream 1" countries. (Starting in 2013, 46 countries, including Zimbabwe, were designated as focus countries under GPRHCS). GPRHCS funding in the approximate amount of US$175,000 was provided in 2009 for the development and implementation of a comprehensive condom programming (CCP) plan. In 2009, GPRHCS supported the development of an emergency plan to provide essential commodities to 57 rural district hospitals during a period when the health system had collapsed. GPRHCS provided technical assistance for the development of an RHCS strategy in 2010, and contraceptive commodities (injectables, IUCDs and implants) were procured on behalf of the Zimbabwe FP programme. In 2010, GPRHCS procured 18,000 units of injectables, 1,800 IUCDs, and 8,750 implants (UNFPA 2010). Similar levels of commodities were procured in 2011 as well (UNFPA 2011). With the previously noted priority given to revitalising FP within Zimbabwe, UNFPA dramatically increased commodity procurement in 2013, and procured 1,420,000 injectables, 6,000 IUCDs and 209,400 implants.[17] In addition to commodity procurement, resources allocated under GPRHCS covered capacity building interventions including advocacy.

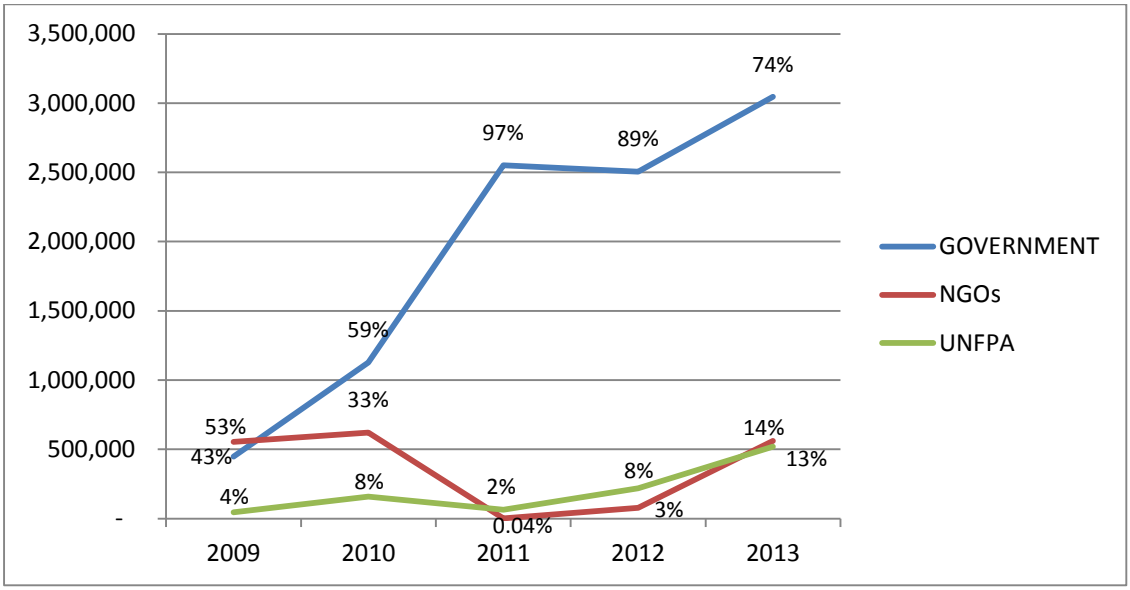
Implementing partners

UNFPA has worked with implementing partners (IPs) in the public and non-government organisation (NGO) sector; however, its main counterpart for SRH and FP work has been the government. Much of the work implemented during the period of evaluation was for integrated SRH and HIV linkages and GBV activities. Family planning was integrated within this work in varying degrees, with higher percentages of funding allocated for FP within activities conducted by public sector partners such as the MoHCC and ZNFPC. The NGO partners were engaged mainly to work on community-based HIV and GBV prevention, behaviour change activities and adolescent reproductive sexual and reproductive health. (See complete list of Implementing Partners in Annex 5).

[17] USAID and DFID are main suppliers of condoms and pills, respectively, as further discussed in Section 4.8.

Figure 1 shows trends in financial support to implementing sectors during the evaluation period. Overall UNFPA support for family planning activities increased from 2009 to 2013, with the government experiencing a more than six-fold increase in support over five years.

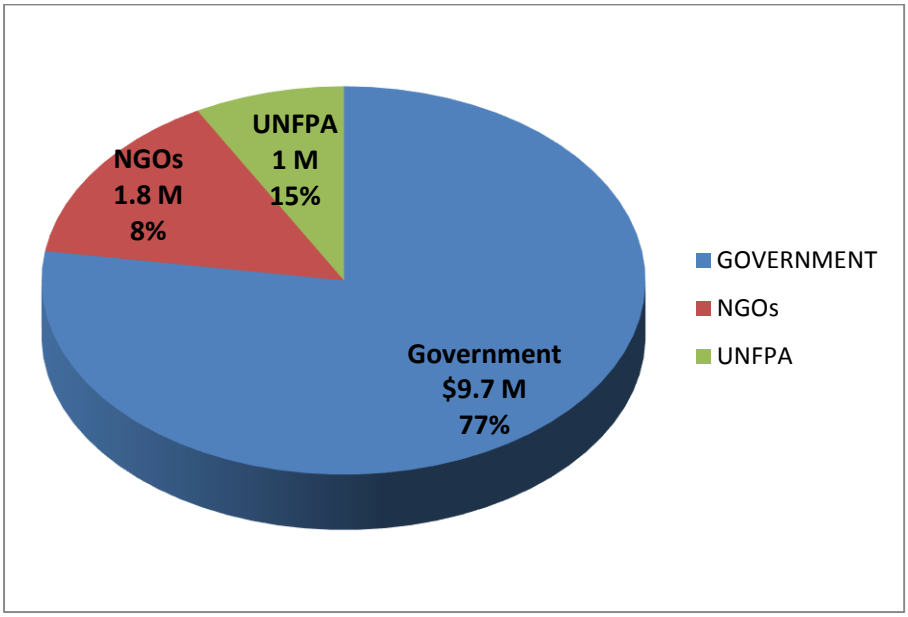
Figure 1: Support to Family Planning by Implementing Sectors (2009 – 2013) (US$)



	2009	2010	2011	2012	2013	TOTAL
GOVERNMENT	447,459	1,126,921	2,551,385	2,505,159	3,044,680	9,675,506
NGOs	553,186	621,513	1,116	77,963	561,011	1,814,789
UNFPA	46,065	159,214	64,352	219,709	518,172	1,007,512
TOTAL	1,046,710	1,907,549	2,616,854	2,802,831	4,123,863	12,497,807

Source: UNFPA Zimbabwe Country Office

Figure 2: Support to Family Planning by Implementing Sectors Total 2008-2013



UNFPA spending on family planning

Total expenditures on SRHR including FP during this period was US$82.5 million; of this, US$12.5 million or 14.5 percent was for FP activities. The top four recipients of funding for FP during this

period were (in order) the MoHCC (US$ 7.48 million), Zimbabwe National Statistics Agency (ZIMSTAT) (US$ 1.04 million), and ZNFPC (US$ 0.99 million), all public sector implementing partners. An additional US$ 1 million was for the direct implementation and coordination of activities by UNFPA. Annex 4 shows the estimated spending of UNFPA core and non-core resources within each of the projects implemented by the CO between 2009 and 2013.

4 FINDINGS

The country case study findings for each of the eight evaluation areas are presented in sub-sections 4.1 to 4.8 below. For each area we present an overview of progress and UNFPA responses in the period under evaluation, followed by an analysis of the contribution made by UNFPA. Each sub-section concludes with a paragraph relating the findings directly to the assumptions of the evaluation matrix presented in Annex 3. This approach allows the evaluation team to test the validity of the assumptions at the country level, and facilitates synthesis of the findings from the case studies and other data collection elements for the overall evaluation analysis and report.

The findings presented here build upon the information collected during fieldwork and document review; they also take into account feedback and comments from UNFPA Zimbabwe and other stakeholders. Points in the text are referenced through footnotes to the corresponding section of the Evaluation Matrix. Annex 3 shows the key data and information on which the analysis was based, ordered by evaluation question and by assumption.

The case study was designed to provide evaluative information and illustrative examples for the eight evaluation questions. It does not aim to assess the performance of the Zimbabwe country office (CO) in relation to the family planning (FP) outputs of the two country programmes, which span the period under evaluation.

4.1 Integration of family planning with other SRH services

Q1) To what extent has UNFPA supported integration of family planning with maternal health, HIV/STI and GBV services in health plans and at primary health care level, in services for adolescents, and in emergency and humanitarian situations?
Summary of the analysis in relation to the assumptions of the evaluation matrix: • UNFPA and partners agree on the importance of integration; however, definitions and parameters for what is included in SRH are not consistent. The major effort to operationalise integration in practice began in 2013 and UNFPA did some important assessment and advocacy work to lead up to the ISP. • UNFPA has stimulated integration at the policy and service delivery levels, but challenges remain for implementation, especially with long-acting methods and youth friendly services in the public sector. • There have been improvements in availability and access for integrated services through the ISP; but there is insufficient data to inform conclusions related to quality of care, particularly from a user perspective.

Progress and activities

The National family planning (FP) Strategy 2010-2015 calls for “quality, integrated services” with family planning integrated within maternal care and “selected” (but unspecified) sexual and reproductive health (SRH) and HIV and AIDS services.[18] In addition, other policies and strategies, such

[18] Annex 3, Assumption 1.1

as the Maternal and Neonatal Health Roadmap, the Adolescent and Reproductive Health Strategy (ARSH) 2010-2015, and the Behaviour Change Strategy, promote the integration of FP within SRH and HIV prevention activities. However, at least until 2012 there was no specific policy or operational guidance for national SRH and HIV integration.[19] UNFPA and its partners, including the Ministry of Health and Child Care (MoHCC), have a clear consensus about the importance of integration and SRH-HIV linkages given the high prevalence of HIV and AIDS among the general population in Zimbabwe. SRH-HIV linkages are especially important for two populations, adolescent girls and commercial sex workers (CSW). Addressing the health of these population groups requires attention to gender vulnerabilities and integration of gender-based prevention and services. However, some stakeholders spoke about the lack of clear definitions regarding SRH, whether it should include HIV or not, where FP fit in, and what does is the essential package of services.[20]

Even with the consensus regarding the importance of SRH-HIV linkages and the existence of high level policies and broad statements to this effect, the enabling environment to operationalise these linkages is weak. This is due in part to the historic parallel management of SRH and HIV national programming. Although both domains are under the leadership and direction of MoHCC, there are two parastatal coordinating bodies for this work – the National AIDS Council (NAC) for HIV and AIDS, and the Zimbabwe National Family Planning Council (ZNFPC) for SRH and FP activities. In addition, the MoHCC has its own HIV and AIDS and reproductive health units within its structure. Adding to the complexity are donor conditions on the use of funds for specific HIV or SRH outcomes and the channelling of resources through civil society organisations (CSOs), making it difficult to coordinate SRH and HIV linkages among all the various partners.[21] A further complication with regard to integrating FP with gender-based violence (GBV) is the fact that GBV issues are addressed in instruments such as the National GBV Strategy and the Domestic Violence Act, which are administered by the Ministry of Gender and Women's Affairs and which do not explicitly address the linkages between FP and GBV.

An assessment of the SRH-HIV linkage undertaken in 2012 (IPPF and UNFPA, 2012) identified many other challenges regarding the effective integration of services. The assessment found that there is some degree of integration at the service delivery level (in primary, district and tertiary level facilities); however, it was inconsistent, uncoordinated, uninformed by policies and delivered by inadequately skilled staff. Further, reporting was found to be poor and most monitoring tools not integrated. For example, FP registers do not indicate whether HIV counselling occurred, and antiretroviral therapy (ART) registers cannot be used to identify FP uptake. Users interviewed during the assessment felt integrated services were inefficient and caused unnecessary delays. Further, services for GBV and cervical cancer (CaCx) were virtually non-existent, while clients, especially among people living with HIV (PLWHIV), experienced stigma and discrimination.[22]

In 2013, several new activities to support SRH-HIV linkages were undertaken to address these challenges. The MoHCC issued service guidelines on sexual and reproductive health rights (SRHR) and HIV Linkages (MoHCC 2013), along with many training resource manuals to guide SRH-HIV linkages (IPPF 2014), with support from UNFPA under the linkages project. The linkages project supports "centres of excellence" in SRH-HIV integrated service delivery and training in Harare and Bulawayo.[23]

[19] Annex 3, Assumption 1.2
[20] Annex 3, Assumption 1.1
[21] Annex 3, Assumption 1.3
[22] Annex 3, Assumption 1.4
[23] Annex 3, Assumption 1.3

Also in 2013, the Integrated Support Programme (ISP) on SRH and HIV prevention was launched with funding from the UK, Irish and Swedish governments to address the SRH challenges faced by women and girls in Zimbabwe, such as unplanned pregnancies, increased sexual violations and new sexually transmitted infections (STIs) and HIV infections. It is a four-year, US$95 million initiative to provide integrated services in SRH, HIV prevention and gender-based violence (GBV) prevention and response. UNFPA is one of several implementing partners for the ISP and its role is to support government capacity to coordinate and deliver comprehensive reproductive health (RH) services.

ISP has four priority areas: FP, CaCx, GBV, and HIV prevention. It includes four pillars or strategies, namely: (i) the social marketing of integrated SRH, HIV and GBV services (Population Services International); (ii) public sector integration of FP, GBV, HIV prevention and CaCx services through community-based social and behaviour change promotion and strengthening public sector service delivery (UNFPA); (iii) procurement and nationwide distribution of FP and HIV commodities by Crown Agents; and (iv) monitoring, evaluation and research by the World Bank.[24] UNFPA leads on pillar two. The ISP undergoes annual reviews by the Department for International Development (DFID) and recently showed strong results in the third annual review.

Integration of FP within maternity settings is a critical component (prong 2) of preventing mother to child transmission (PMTCT) strategies and to prevent unintended pregnancies in women with HIV. There is a strong commitment to PMTCT of HIV and AIDS at the national level, with the US Government (through (US) President's Emergency Plan for AIDS Relief (PEPFAR) and United States Agency for International Development (USAID)) taking a leadership role complemented by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF), UNICEF and others (PEPFAR 2014). USAID supported Jhpiego[25] through the Maternal and Child Health Integrated Project (MCHIP) to develop postpartum family planning guidelines, and UNFPA supported a study tour for ZNFPC and MoHCC staff to Zambia to observe PPIUD programmes.[26] Many challenges to meeting the national targets for eliminating MTCT remain in 2015, including a high unmet need for family planning among HIV-positive women and limited capacity within Maternal Neonatal and Child Health (MNCH) services for the delivery of quality MNCH/PMTCT, antenatal and postnatal follow up care, including the integration of FP (IATT 2012).

Contribution of UNFPA to family planning outputs and outcomes

UNFPA programming in Zimbabwe related to SRH integration aligns with the global guidance from headquarters regarding integration approaches such as SRH-HIV linkages and comprehensive condom programming. Since the mid-2000s, UNFPA has been a key development partner (DP) at the forefront of advocacy and technical guidance on integration including the Framework for Priority Linkages in Sexual and Reproductive Health and HIV and AIDS (WHO, UNFPA et al. 2005), the Evidence Review on SRH and HIV Linkages (WHO, IPPF et al. 2009), Comprehensive Condom Programming,[27] and addressing GBV through SRH services (UNFPA 2009). UNFPA collaborated with the International Planned Parenthood Federation (IPPF) to conduct an assessment of SRH and HIV linkages in 2012,[28] which set the foundation for a coordinated initiative involving the government, bilateral and non-government organisation (NGO) development partners, and UNFPA to put in place key elements of integration through the ISP.

[24] Annex 3, Assumption 1.1

[25] Jhpiego is an international, non-profit health organisation affiliated with the Johns Hopkins University.

[26] Annex 3, Assumption 1.3

[27] Annex 3, Assumption 1.2

[28] Annex 3, Assumptions 1.3 and 1.4

The ISP provides approximately 80 percent of the CO programme budget and is the most extensive donor-funded activity for UNFPA in Zimbabwe; it cuts across and supports staff within the RH, HIV and gender units of the CO. The UNFPA implementation role in this project has resulted in an increased workload and strain on staff, particularly regarding its role as a coordinator. The ISP aims to strengthen the public sector integration of FP, GBV, HIV and CaCx services by expanding demand for these services through community-based social and behaviour change promotion and strengthening of public sector service delivery.[29]

The 6th UNFPA country programme evaluation (CPE) concluded that training of health providers in STIs, FP, condoms, cervical cancer screening and integrated services would not have proceeded at the same level without UNFPA financial and technical support, including the funding of key coordinating posts within the MoHCC.[30] UNFPA has contributed to good progress in its GBV work and excellent results on cervical cancer services.[31] A large part of the ISP is focused on adolescent sexual and reproductive health (ASRH), and has included the development of youth-friendly services (YFS) with youth corners, peer education and promoting youth leadership and participation.[32] The core strategy based on youth friendly corners in public facilities was assessed as not cost-effective. As a result, UNFPA has discontinued this and is considering other strategies with the assistance of the East and Southern Africa Regional Office (ESARO) as part of a regional assessment of existing YFS, standards and guidelines.[33] *Sista2Sista* is a mentoring programme for vulnerable girls to support life skills and health seeking behaviours. Other contributions of UNFPA to integrated SRH service delivery through the ISP will be covered under Sections 4.4 and 4.5.

With respect to FP within the ISP, the most recent annual review by DFID indicated that the programme has made its biggest contribution to maintaining, if not increasing, contraceptive prevalence rate (CPR) by procuring and delivering, and therefore keeping contraceptive stockouts low in facilities across Zimbabwe. ISP partners Population Services International (PSI) and Crown Agents have contributed significantly to this result, as has USAID and its partners working on contraceptive security. UNFPA contribution to FP results under the ISP has been mixed, given the challenges of supporting long-acting method contraception services in the public sector[34] and of documenting the impact of the door-to-door home visits.[35] As the major partner to the MoHCC and ZNFPC on SRH and FP issues, UNFPA has contributed to the development of technical guidance through the Linkages Project[36] and to condom programming.[37] By June 2015, over 4,000 health care providers were trained to deliver integrated SRH and HIV services through ISP funding.[38] In addition, UNFPA was able to be flexible in providing assistance to address the RH needs of women and girls during the humanitarian crisis in 2009 through procurement of RH commodities and by topping up salaries to ensure that maternity wards remained open.[39]

While the government and DPs have increased priority for FP programming since 2012, the CO has worked to mainstream FP into the other SRH technical areas supported through the ISP. However,

[29] Annex 3, Assumption 1.3
[30] Ibid.
[31] Annex 3, Assumption 1.4
[32] Annex 3, Assumption 5.1
[33] Annex 3, Assumption 4.3
[34] Annex 3, Assumption 1.4
[35] Annex 3, Assumption 4.2
[36] Annex 3, Assumption 1.3
[37] Annex 3, Assumption 4.1
[38] Annex 3, Assumption 1.3
[39] Annex 3, Assumption 7.2

key informant interviews (KIIs) noted that there could be more systematic attention to addressing opportunities for integration, as well as to ensuring that SRH issues (such as HIV and GBV prevention) could be more systematically integrated into FP training and community-based programming. Opportunities are missed, in part because of the different technical "silos" within the CO. As one KI offered, *"Integration starts at home."*[40]

4.2 Coordination and National Ownership

Q2) To what extent has UNFPA successfully contributed on its own and in coordination with others to strengthening national leadership of family planning and improving sustainability?
Summary of the analysis in relation to the assumptions of the evaluation matrix: • UNFPA has supported mechanisms to raise the profile of FP, especially since 2012. • UNFPA is the main partner of GoZ in SRH programming and capacity building and has supported the MoHCC and ZNFPC to lead in policy and plan development for FP. However, there still remain some major gaps in programme coordination. • UNFPA and other DPs have contributed to cultural and social sustainability, but financial sustainability will be difficult, given the lack of GoZ capacity to finance its procurement and training programmes.

Progress and activities

Family planning coordination is the purview of the ZNFPC, a parastatal organisation under the direction of the MoHCC. Established in 1985, it has the mandate to coordinate and monitor the provision of integrated SRH and FP services, procure and distribute contraceptives and RH commodities, provide leadership in FP and ASRH programmes and support the adherence of FP and ARSH standards and guidelines. The Zimbabwe FP effort post-independence was one of the first and most successful programmes in the region with modern contraceptive prevalence rising from 36.1 percent in 1988 to 58.4 percent among currently married women in 2005/06. However, in the face of a generalised HIV epidemic over two decades and the economic and political crises in 2008/9, priority for FP programming waned and contraceptive prevalence plateaued at 57.3 percent between 2005/06 2010/11 (DHS 2015).

The MoHCC heads the many different coordinating bodies and steering committees in place to manage the various SRH projects and programmes. The MoHCC is clearly leading and owning the agenda; however, key informants (KIs) spoke of there being too many overlapping committees and the need to streamline and clarify authorities and mandates particularly between the donor initiative steering committees (ISP, Health Transition Fund (HTF), results-based financing (RBF)) and those that are institutional (the Reproductive Health Technical Committee and the Contraceptive Security Steering Committee). Donor initiative steering committees also tend to focus on project-specific implementation, rather than the larger strategic issues that cut across projects and also need attention. Therefore, some KIs spoke of the need for a national coordinating body led by a strong and reformed ZNFPC that would have the capacity to address issues that go beyond implementation of specific projects, such as the analysis of trends over time and the mapping of needs, results and activities.[41]

The Government of Zimbabwe (GoZ) is highly dependent on donor support for the family planning programme. The government does not allocate a line item budget for contraceptive commodities. Its

[40] Annex 3, Assumption 1.3

[41] Annex 3, Assumption 2.1

entire budget is devoted to salary support for ZNFPC. Multilateral organisations provide direct financial support to the public sector, including salary support. However, the key FP bilateral donors, DFID and USAID, have statutory restrictions[42] against direct funding to the Zimbabwe government, and instead work through intermediaries. For FP activities, DFID channels funds to the ISP and USAID channels funds to PSI and Population Services Zimbabwe (PSZ) for outreach services and to the JSI DELIVER project for contraceptive security. Without a strong national coordinating body, this makes it more difficult for the ministry and ZNFPC to monitor and coordinate activities.[43]

UNFPA contribution to results on government leadership and sustainability
UNFPA has contributed to government leadership at the national level for family planning through support and assistance for the development of the National FP Strategy, the Adolescent SRH Strategy and the MNH Road Map, all of which include FP as a priority intervention. It has also contributed to supporting capacity within the RH unit of the MoHCC through the funding of salaried coordination positions. As the main counterpart to ZNFPC, UNFPA has contributed financial and technical assistance in support of ZNFPC training, community based distribution and youth-friendly service activities. UNFPA has worked to improve coverage and effectiveness of these activities, although both the CO and ZNFPC spoke about the need for improvement and reform within ZNFPC to build its capacity to more effectively coordinate.[44]

UNFPA is represented on the aforementioned steering committees and its input is highly valued. For example, although UNFPA does not lead the reproductive health commodity security (RHCS) committee, its input and insights on needs and projections are critically valued. UNFPA provided financial and technical support to the national RH steering committee. Partners see UNFPA as a practical and strategic voice, and the MoHCC appreciates the financial and technical support it receives. However, KIs spoke about the conflict of interest if and when UNFPA is in a coordination role. UNFPA initially had the role of coordination of all participating partners in the ISP, but was not able to manage both implementation and coordination. Additionally, since UNFPA receives donor funding, some KIs felt it was a conflict of interest to be in the position to both coordinate and receive funding. Discussions regarding UNFPA having the coordinating role under the follow-on project to the health transition fund (HTF) have caused concern for the same reason.

By contributing to the development of key policies and strategies, upgrading infrastructure and supporting capacity building for service delivery, UNFPA has supported some basic elements of a sustainable system. However, exit strategies for UNFPA support are not evident, and gains made during this period are unlikely to be sustained without continued support and scale-up.[45]

4.3 Brokerage and partnerships

Q3) To what extent has UNFPA acted as a broker at global, regional and country levels to promote family planning, acting in partnership with the public, private and non-state sector service providers?
Summary of the analysis in relation to the assumptions of the evaluation matrix:

[42] In the case of USAID, PEPFAR funding has a "notwithstanding" authority that allows USAID to provide assistance that would otherwise not be allowed. Population funds do not have this notwithstanding authority
[43] Annex 3, Assumption 2.2
[44] Annex 3, Assumption 2.1
[45] Annex 3, Assumption 2.3

- UNFPA has been an important broker of partnerships for FP and integrated SRH services. It has effectively leveraged its role as the main SRH partner of the government to advance its engagement in FP planning and engagement with FP2020.
- UNFPA has a sufficient profile and visibility and has used these effectively to advance programming in FP. The comparative advantage of UNFPA is in the partnership with government and the work on GBV, although the latter does not sufficiently integrate FP.

This section covers findings related to assumptions 3.2 and 3.3. Assumption 3.1 applies to the global and regional levels and will be covered in the synthesis report.

As noted in Section 4.2, there are many forums for leadership and coordination of SRH and family planning activities, each co-led by the MoHCC. UNFPA sits on all of them and has played a lead role in the support of the committees led by ZNFPC, notably the Reproductive Health Steering Committee and the Adolescent SRH Forum. Neither the US or UK governments, two key bilateral development partners with strong family planning interests, can provide direct funding assistance to the government for family planning activities because of political restrictions. Therefore, the role UNFPA plays as a broker is very important in Zimbabwe. UNFPA has also formed important partnerships with local implementing NGOs/CSOs in support of adolescent reproductive health and gender-based violence, although the CO has not effectively supported these partnerships to integrate and advance family planning access and use.

UNFPA contribution

Stakeholders and partners in Zimbabwe recognise the comparative advantage of UNFPA with regard to its role in supporting the public sector capacity and service provision and in particular its support for ZNFPC. UNFPA has leveraged this role effectively to support the repositioning of FP as a priority in the national development agenda through brokering the GoZ involvement in FP2020 in partnership with USAID and DFID at the July 2012 London FP Summit and beyond. UNFPA further brokered the involvement of two technical assistance groups, The Futures Group and FHI 360, to support the development of a gap analysis to determine resources required to fund the family planning from 2015 to 2020, although this occurred outside the period under evaluation. The gap analysis will contribute to the development of a costed implementation plan, a detailed workplan and budget for the implementation of the National FP Strategy 2015-2020.[46]

UNFPA is also recognised as the logical broker for supporting the proposed transformation of ZNFPC in order to strategically support the implementation of the National Family Planning Strategy 2015-2020. This is a long-standing and politically sensitive issue, and partners have expressed confidence in UNFPA to broker the dialogue between the MoHCC, the ZNFPC and the various donors and IPs.[47]

UNFPA also brokered the joint assessment of SRH and HIV linkages with IPPF and the MoHCC, which fed into the programme design for the ISP. UNFPA is further credited with mobilising resources for the Demographic Health Survey (DHS) to complement the USAID contribution, and for identifying donors to support the census.[48] UNFPA global visibility has supported its role in Zimbabwe as a broker to bring together partners and advocate for SRHR. This has been very effective in building a case for investment in GBV and adolescent SRH programming.[49] As noted previously, partners have some misgivings about UNFPA combining its brokering and coordination role with that of an implementing partner.

[46] Annex 3, Assumption 3.1
[47] Annex 3, Assumption 3.2
[48] Annex 3, Assumption 3.2
[49] Annex 3, Assumption 5.3

4.4 Enabling Environment

Q4) To what extent has UNFPA supported the creation of an enabling environment at national and community levels to ensure family planning information and exercise of rights?
Summary of the analysis in relation to the assumptions of the evaluation matrix: • UNFPA has identified key enabling factors at the policy and programme levels, and has addressed these effectively in FP, GBV and ASRH. • UNFPA has supported partners for demand creation; however, effectiveness of that support is either mixed or unknown given the lack of outcome data available. • Data was not collected on the role that UNFPA HQ or RO played in identifying and addressing key factors for an enabling environment.

Progress and activities

Enabling factors for family planning include already high levels of contraceptive use and knowledge and awareness of contraception, indicating that FP is positively regarded in general, even though the method mix is skewed towards short-acting hormonal methods.[50] As noted previously, the national policy environment for family planning has improved as a result of the re-emergence of FP as a development priority, followed by increased levels of donor engagement to support the GoZ FP2020 commitment.

Moreover, the stabilisation of the economy and subsequently the health sector following its near collapse during the political crises of 2008/9 has been an important positive factor in the enabling environment. More negative, although financial conditions have started to improve, the crisis resulted in the loss of trained health professionals, a deteriorating medical infrastructure, and the hiring freeze of new community-based distribution (CBD) workers under the ZNFPC.[51] The HTF and RBF were put in place to strengthen the diminished capacity of the health system to respond to the basic primary care needs of the population. Progress on addressing the CBD worker shortage is hampered by an inadequate budget and coordination by the ZNFPC.[52]

Challenges exist at the community level, especially in relation to the needs of adolescents. There is a long-standing stigma against young people's sexual activity and childbearing outside of marriage. Parents and providers fear that providing unmarried teens with SRH information will lead to increased sexual activity, contributing to girls' vulnerability to unintended pregnancy and HIV and STI infections.[53] The revised Adolescent Sexual and Reproductive Health Policy 2010-2015 committed to clarifying the misperception that adolescents younger than 18 need parental consent to receive contraceptive and HIV services and to developing and disseminating guidelines to give direction towards the provision of comprehensive SRH services to minors (Guttmacher Institute 2014).

The GoZ has made strong commitments to ending GBV at the policy level with the development of the National Gender-based Violence Strategy 2010-2015, including the promotion of an enabling environment for the non-tolerance of GBV. GBV is a serious issue in Zimbabwe, where 30 percent of women aged 15-49 have at some point in time experienced physical violence since age 15, and 18 percent of women experienced it within the past 12 months. Social norms, household poverty, religious customs and harmful traditional practices all contribute to the problem.[54]

[50] Annex 3, Assumption 4.1
[51] Annex 3, Assumption 4.2
[52] Annex 3, Assumption 2.1
[53] Annex 3, Assumption 5.3
[54] Annex 3, Assumption 6.1

UNFPA contribution to the development of an enabling environment for family planning information and exercise of rights

UNFPA has made contributions to the enabling environment for family planning and more broadly for SRHR in Zimbabwe at both the national policy level and in programming at the community level. These contributions are based on a solid understanding of the key enabling factors within the country context of Zimbabwe as evidenced by the situational analyses presented in the programme documents and action plans for the 5th and 6th Country Programmes (CPs).[55]

In family planning, the support to the MoHCC and ZNFPC to engage in the global FP2020 movement has contributed to the revitalisation of FP on the Zimbabwean development agenda and the development of the new national FP strategy. UNFPA support for the 2012 World Population Day to increase awareness on the importance of FP in reducing maternal mortality was linked to the MoHCC stated commitment to increase its budget allocation for FP, although this has not yet occurred.[56] UNFPA has promoted the integration of family planning in other SRH policies and plans, such as the MNH Road Map.[57] UNFPA efforts to strengthen the policy and coordination environment for FP also included support for the resource gap analysis and the development of the costed implementation plan (still in the preliminary stage) to improve the resource base and guide allocations for family planning through 2020.[58]

UNFPA was also instrumental in improving the policy environment for ASRH through the generation of key data on young people, advocacy campaigns and support for the development of policies that address issues related to parental notification and provider bias against adolescent use of SRH services, including contraception.[59] KIs considered UNFPA focus on prevention and response to gender-based violence as one of its main leadership areas and contributions overall to SRHR in Zimbabwe.[60]

UNFPA contributed to an enabling environment at the community level through a range of demand creation activities implemented under the ISP as part of the HIV prevention portfolio. These included training and deployment of behaviour change facilitators to conduct household visits, establishment of clubs for young people (e.g., Sista2Sista), and the use of social media to reach adolescents with SRH and HIV messages. These activities contributed to demand creation for FP services; however, an evaluation of these efforts concluded that there was not sufficient attention to the problem of unintended pregnancy and there is some duplication of effort among different NGOs without standardisation of messages. UNFPA has a strong set of partners under the GBV component. While these partners have contributed to demand creation, they are not supported to provide contraceptive services, leading to missed opportunities for addressing FP integration in community settings.[61]

UNFPA support for the community-based distribution programme to broaden access to services and increase demand has mixed reports of results. A study concluded that CBD-served areas performed no better than non-served areas across a range of indicators.[62] Reports on demand creation activities include numbers of home visits, materials distributed, attendance in groups, and person-exposures

[55] Annex 3, Assumption 4.1
[56] Annex 3, Assumption 8.2
[57] Annex 3, Assumption 1.2
[58] Annex 3, Assumption 2.2
[59] Annex 3, Assumption 5.1
[60] Annex 3, Assumption 5.2
[61] Annex 3, Assumption 4.2
[62] Annex 3, Assumption 4.2

but there is not adequate information about the outcomes of these activities. However, the innovative strategy used in the ISP to conduct door-to-door home visits to increase demand has achieved fairly high coverage in 26 districts although it is not known how this translates into improved access or uptake of services.[63]

4.5 Vulnerable and marginalised populations

Q5) To what extent has UNFPA focused on the family planning needs of the most vulnerable and marginalised groups, including identification of needs, allocation of resources, and promotion of rights, equity and access?
Summary of the analysis in relation to the assumptions of the evaluation matrix: • UNFPA has carried out important work on identifying needs of select VMGs and developed good practices based on global guidance, although improved strategies are needed for youth-friendly services. • UNFPA has supported programmes targeted to specific vulnerable groups (youth, sex workers PWDs and individuals who are threatened with or have survived GBV). • UNFPA has effectively advocated for and promoted the rights of select VMGs, but has not prioritised or addressed other excluded groups such as sexual minorities. • UNFPA has supported active participation of youth in advocacy activities. • UNFPA has limited data to demonstrate improvements in access and utilisation of services; however, narrative reports indicate that programmes supported by UNFPA are reaching some VMGs with relevant and appropriate services. These pilot efforts have potential for a best practice if systematically documented and evaluated.

Progress and activities

The principal vulnerable and marginalised groups (VMGs) in Zimbabwe are: young people, sex workers, persons living with HIV and AIDS (PLWHIV), people with disabilities (PWD) and urban and rural poor.[64] These groups have difficulties accessing SRH and FP services due to a range of factors, including stigma and discrimination, poor access and quality of services, inadequate health system capacity to address their needs, and social and cultural norms. Men who have sex with men (MSM) are particularly marginalised within the Zimbabwean society, as homosexuality is illegal and it is difficult for prevention programmes to reach MSM.

UNPFA has prioritised adolescents and sex workers as the key vulnerable populations for its SRHR work in Zimbabwe during the period under evaluation and its focus on these groups intensified with the inception of the Integrated Support Programme in 2013. The GBV programme has also targeted PWDs. Awareness of the SRH rights and needs of adolescents has gained particular traction during the period under evaluation given the high unmet need among adolescents (61 percent among single, sexually active and 19 percent among married adolescents) (Guttmacher Institute 2014). The adoption of the ASRH strategy is an important step in addressing the challenges Zimbabwean youth face to obtain dual protection methods and information.[65] Other groups working in SRH have also implemented strategies to support youth-friendly services, such as PSZ[66] and PSI. Both UNFPA and PSI have targeted sex workers for SRH services in Zimbabwe.

UNFPA contribution to family planning needs of vulnerable and marginalised groups

[63] Annex 3, Assumption 4.2

[64] Annex 3, Assumption 5.2

[65] Annex 3, Assumption 5.3

[66] PSZ is the Zimbabwean affiliate of Marie Stopes International

During the period under evaluation, UNFPA has made a contribution to improving SRH for vulnerable women and girls through its adolescent sexual and reproductive health, sex worker and gender based violence activities, at both the policy and service delivery level. Because gender is a crosscutting issue for UNFPA, the GBV activities carried out by UNFPA contribute to improved SRH outcomes for vulnerable girls.

The CO addressed all five prongs of the regional and global UNFPA adolescent strategy including advocacy, comprehensive sexuality education, capacity development in youth friendly services, reaching disadvantaged youth and promoting youth participation and leadership.[67] For example, the MNCH Road Map 2007-2015 included family planning as the first pillar in the road map, which called for major activities to increase the availability and use of youth-friendly FP and HIV prevention services.[68]

UNFPA provided technical and financial support for the national SHRH coordination forum and towards the establishment of the Young People's Network on HIV and AIDS and helped it grow to 1,800 members operating at national, provincial and district levels to mobilise youth and provide a meaningful voice in different forums.[69] It has supported workshops to build the capacity of youth in communication and advocacy skills and provided training to the Zimbabwe Youth Council in planning, monitoring and evaluation. The outcomes from these activities are not well documented. However, a national teenage pregnancy study is underway to understand the determinants of teenage pregnancy. An evaluation of ZNFPC and MOHCC ASRH programme supported by UNFPA is ongoing. These efforts will inform future programming.

UNFPA provided technical and financial assistance to the ZNFPC to extend YFS in sixteen targeted districts nationwide. The strategy combined facility- and community-based approaches and reached 73 out of a target of 75 service delivery points to offer youth-friendly, integrated SRHR services. Nurses were trained on YFS provision within health facilities; however, inadequate supervision and low prioritisation of the programme at the provincial and district levels were challenges to implementation. Overall, the outcomes from this activity were not strong. The strategy to develop youth friendly corners was flawed as the youth corners were embedded within facilities that were not considered youth-friendly. The approach is being discontinued and rethought under the 7th CP.[70] The duplication of leadership and coordination across various programmes and projects is also a major challenge to monitoring results and contribution of UNFPA and other partners. Several KIs mentioned the need for mapping, especially with regard to youth activities.[71]

To address the 13 percent of new HIV infections that occur in sex work settings, UNFPA supported a national sex worker programme, *Sisters with a Voice*, implemented by an NGO to provide HIV and SRH services to sex workers through a network of clinics (16 clinics as of mid-2013), including STI treatment, voluntary counselling and treatment (VCT), FP, male and female condom provision, primary care and assistance with referral to HIV treatment and care services. UNFPA also supported a media workshop to train journalists and encourage constructive reporting about sex worker issues and to raise awareness about the programme.[72] Sista2Sista is a pilot programme that established clubs to mentor and empower vulnerable girls aged 10-19 and educate them on life skills such as

[67] Annex 3, Assumption 5.1
[68] Annex 3, Assumption 2.2
[69] Annex 3, Assumption 5.3
[70] Annex 3, Assumption 1.3
[71] Annex 3, Assumption 2.1
[72] Annex 3, Assumption 5.5

decision-making, negotiation and problem solving, and health seeking behaviours to prevent pregnancy and infection.[73]

A major component of the UNFPA programme is the prevention of and response to gender-based violence. UNFPA supports community-based partners, Women's Action Group (WAG), Musasa and PADARE, to Support GBV prevention and services through community mobilisation, dialogues and services. WAG conducts dialogues targeting PWDs with messages on gender responsive laws and services. None of the GBV partners directly provide family planning as part of their service offerings and indicated this was a gap and a missed opportunity for integration and reducing unintended pregnancies. Individuals who attend one-stop centres run by Musasa receive training in life skills, counselling and referral for SRH services, and legal aid and referrals; those who are under threat of violence are referred to shelters where they receive medical care and protection orders, and a follow-up plan is developed. Sixty percent of shelter clients are aged 12-24. PADARE works with men and boys to end all forms of violence against women and girls. The organisation promotes men to support health-seeking behaviours for their partners and themselves, provides counselling for men and families on how to resolve differences and works with men in prison or released from prison in an attempt to reduce recidivism.[74]

4.6 Human rights-based approach

Q6) To what extent has UNFPA implemented a human rights-based approach to family planning, in particular regarding access to and quality of care, and through support from HQ and RO for a rights-based approach?
Summary of the analysis in relation to the assumptions of the evaluation matrix: • UNFPA, government and NGO partners share a common overall understanding but with some notable differences in application. A more common, holistic understanding is applied to broader HIV prevention and GBV services. • UNFPA programming explicitly incorporates human rights principles in HIV prevention, GBV and ASRH, but less so for mainstream FP interventions. • UNFPA has not documented results or lessons related to HRBA in FP. • UNFPA bases its programming on guidance from global strategies, especially regarding GBV and SRHR, but the CO has not received specific practical or operational guidance for FP. • Anecdotal information suggests UNFPA programming is contributing to increased awareness about SRH and FP rights among rights holders, particularly VMGs, and duty bearers.

Progress and activities

A human rights-based approach (HRBA) has been evident in programming by UNFPA to address SRH and HIV linkages and gender-based violence. The right of all individuals including youth to access comprehensive integrated SRH services, free of stigma and discrimination, underpins many of the activities described under Sections 4.1 and 4.5. It is widely recognised in Zimbabwe that GBV levels are unacceptably high and remain a serious impediment to women and girls exercising their rights. The Zimbabwe National Gender-based Violence Strategy 2012-2015 calls for the reduction of GBV by 20 percent through prevention, service delivery, research and increased coordination.[75]

The new National FP Strategy 2015-2020 uses the International Conference on Population and Development (ICPD) definition of a human rights-based approach as "the recognition of the basic

[73] Annex 3, Assumption 4.2
[74] Annex 3, Assumption 5.5
[75] Annex 3, Assumption 6.1

right 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". It explicitly includes "rights and choice-based FP", universal access and accountability as key values underpinning the strategy and calls for a range of strategies to improve the capacity of health workers to provide quality services, address cultural and religious perceptions to identify critical barriers, enhance equity for vulnerable groups and include within the communications and advocacy strategy attention to "young people, people living with disability and HIV, rural communities and other vulnerable communities".[76]

However, since the strategy is relatively new, an HRBA was not as explicitly evident in FP programming as it was for the HIV and GBV prevention activities during the period under evaluation. KIIs with NGOs noted a broader set of principles when describing what is meant by a rights-based approach for FP, including universal access, quality of care, reaching vulnerable and excluded populations, accountability, and participation. KIIs with government partners focused on increasing access (to youth) and improving method mix to improve individual choice and programme effectiveness. Quality of care as a priority focus area was notably absent in programming about family planning, except by NGO service organisations and the RBF initiative. There are several issues or weaknesses in FP service delivery that call for greater attention to quality, including anecdotal reports of high levels of discontinuation due to poor counselling regarding side effects, provider targets that result in a bias towards or against specific methods, poor quality of training, and lack of quality assurance (including indicators for tracking quality) and supervision support.[77]

One particular challenge noted was the incentive payments to providers for implant provision under the RBF scheme supported by the World Bank (currently at $1 for short-acting and $5 for long-acting methods). Originally, the payments for long-acting methods was set at $50 per case, but were reduced in response to concerns about the inability to sustain payments over time, but also because of concerns regarding the potential for coercion.[78] The RBF has a strong monitoring and evaluation system, and payments are provided based on confirmation of achieving qualitative and quantitative measures. Data is also being collected on client satisfaction. However, there remain concerns regarding how this adversely affects provider behaviours regarding informed choice and voluntarism, and on-going monitoring is indicated.

UNFPA contribution to results on a rights-based approach to family planning

UNFPA is leading efforts in Zimbabwe at the national, service and community levels to address gender-based violence and has explicitly framed its gender work within an HRBA. In 2009, UNFPA and UNICEF were designated co-leads for GBV within the Humanitarian Reform Agenda of the UN globally and in Zimbabwe. Since then, UNFPA has worked and made contributions to address sexual violence and exploitation, harmful traditional practices such as child marriage, improved access to services, and prevention and response.[79] In addition, the programming for SRH and HIV linkages includes components that address participation (ASRH Forum), empowerment (Sista2Sista, Sisters with a Voice, and Musasa), and stigma and discrimination (Sisters with a Voice, Musasa and Padare), and attention to VMGs as described in Section 4.5. The 6th CPE documented appreciation among these groups for the information and services received from the organisations supported by UNFPA.[80]

[76] Annex 3, Assumption 6.1
[77] Annex 3, Assumptions 6.2 and 8.1
[78] Annex 3, Assumptions 6.1 and 6.2
[79] Annex 3, Assumptions 6.1 and 6.2
[80] Annex 3, Assumption 5.2

The CO embraces human rights as an "enabling factor for the *bull's eye*", which is the graphic depicting of the goal of the organisation in the current UNFPA Strategic Plan 2014-2017.[81] In addition, all GPRHCS countries were introduced to the recently issued UNFPA/WHO joint implementation guide. However, there did not appear to be a consensus about what it means to operationalize a human rights approach within family planning, despite its mention in UNFPA documents without subsequent elaboration about what it means or how it is operationalized. Some in the CO consider they are taking a rights-based approach in FP by working to improve method choice (long-acting reversible contraception and female condoms) and by addressing access barriers, especially by adolescents and youth. However, there is no evidence of how UNFPA has strengthened accountability mechanisms, quality assurance, or protocols for monitoring voluntarism within the technical assistance provided to the public sector programme. Moreover, until the recent addition to the GPRHCS facility survey, there had been no efforts to assess user satisfaction or perspectives on FP. A study on barriers and facilitators to IUCD uptake is underway and will be used to inform future programming.

4.7 Different modes of engagement

Q7) To what extent has UNFPA adapted its mode of engagement[82] to evolving country needs in different settings, using evidence and best practice?
Summary of the analysis in relation to the assumptions of the evaluation matrix: • HQ and RO provide support and TA to the Zimbabwe CO aligned with thematic funds and/or organisational priorities of UNFPA. • UNFPA has monitored changes in country context and has responded strategically to needs; however, UNFPA modes of engagement have not moved upstream due to constraints in the political and economic context. • UNFPA has identified and applied good practices; however, there is room for improvement in evaluation and documentation of interventions to contribute to learning.

Changing country context and modes of engagement

During the period of evaluation there have been major changes in the country context, as discussed in Section 3. During the economic crisis in 2008, Zimbabwe experienced hyperinflation, which resulted in a humanitarian situation and contributed to a breakdown of social services and the health system. Urgent measures were needed to shore up the health system to halt the rising rates of maternal and child mortality. For example, UNFPA supported a "top up" salary scheme and procurement of vital RH commodities to ensure that maternity wards remained open during the crisis. Donor support, such as the ISP, creation of the HTF and the RBF project had the aim to re-build the capacity of and financing for the health system.[83] The situation has improved although the country context is still considered fragile.

During this time, UNFPA modes of engagement remained "downstream", meaning that the CO continued to focus its efforts on support for capacity building and service delivery, rather than shifting to "upstream" modes more characteristic of a national programme farther along in the sustainability continuum. The situation did not allow for a change in engagement modes. UNFPA

[81] *The bull's eye* is the goal of the UNFPA; the achievement of universal access to SRH, the realisation of reproductive rights, and the reduction in maternal mortality. The outer ring of the bull's eye contains the key factors that enable the attainment of the goal (human rights, gender equality, population dynamics).

[82] "Modes of engagement" refers to the four modes of engagement in the current UNFPA strategic plan (support for service delivery, capacity building, advocacy, knowledge management). This concept is fully discussed in the evaluation inception report (UNFPA 2014a: 14, 17).

[83] Annex 3, Assumption 2.1

investments in capacity building, service delivery and demand creation, and support for coordination posts within the MoHCC are likely to be needed for the foreseeable future, given the aforementioned fragility in the country context.

UNFPA contribution to the sustainability of family planning and SRH interventions
UNFPA has sought to contribute to the sustainability of FP in the public sector through its support to ZNFPC and MoHCC, and to SRH interventions in the public and NGO sector. However, sustainability is compromised by the challenges that exist with the coordination, implementation and quality of family planning interventions in the public sector, particularly given the dominance of the public sector in FP service delivery. At the time of the case study, the national FP strategy had not been approved, because the MoHCC wanted the new ZNFPC Board to be in place. There remains a lack of clarity regarding the role and financing of the ZNFPC, issues that UNFPA is positioned to support as the main provider of capacity TA to the government.[84] The NGO partners that UNFPA supports are dependent on donor financing, while they in turn support sustainability at a cultural level through efforts to change and transform gender norms.

The 6th CPE conclusions are aligned with information collected for the case study, namely that the CO has contributed to re-establishing a basically functional system which is still highly dependent on external financing through the development of key policies and strategies, refurbishment of facilities, support the DHS and census, and to a lesser extent through training. Until the national situation substantially improves, the current modes of engagement will continue to be maintained "downstream" and focused on direct support for services and capacity. Any gains made thus far in these areas are unlikely to be sustained without external support.[85]

UNFPA contribution to the identification and application of best practices
The identification and application of best practices is a collaborative effort among UNFPA HQ, regional and country offices. Examples of best practices applied by the CO based on technical guidance and input provided by the UNFPA HQ and the ESARO include the programme design for the gender-based violence and SRH and HIV linkages programmes, a workshop and technical assistance on how to develop advocacy for increasing investment in youth, based on the demographic dividend rational, and the upcoming assessment of youth friendly and in-service/pre-service training strategies. In the other direction, the work to scale up the Sisters with a Voice intervention has demonstrated significant results in reaching female sex workers and uptake in HIV Counselling and Testing (HCT), STI treatment, condom use and contraception. The programme includes operations research to measure outcomes and an innovative programme to address GBV and human rights of sex workers, and has been acknowledged as a best practice.[86]

However, the Reproductive Health Unit in the CO does not have the capacity to undertake operations research, which affects the availability of data for analysis of results across the range of programme interventions, and it does not allow for evidence-based documentation of lessons learned for contributing to best practice discussions.[87] A donor request to UNFPA to conduct an analysis of unmet need for family planning to support advocacy and demand creation was not completed.[88] Implementing partners are also calling for technical assistance from UNFPA to support monitoring and evaluation that goes beyond counting outputs (such as persons reached, materials distributed, and providers trained) and helps to document outcomes.[89]

[84] Annex 3, Assumption 2.1
[85] Annex 3, Assumption 2.3
[86] Annex 3, Assumption 5.5
[87] Annex 3, Assumption 6.3
[88] Annex 3, Assumption 6.5
[89] Annex 3, Assumption 8.1 and Assumption 5.5

4.8 Supply-side activities

Q8) To what extent has UNFPA support for supply-side activities promoted rights-based and sustainable approaches and contributed to improved access to quality family planning?
Summary of the analysis in relation to the assumptions of the evaluation matrix: • UNFPA has supported extensive provider training, but without adequate follow-up of quality and access outcomes; therefore it is not evident how training has affected (or not) service quality and access, nor whether it is client-centred and quality focused. • UNFPA has supported the development of a broadened method mix in the public and NGO sector (although impact won't be measured until the next DHS in 2015 currently underway). • UNFPA has contributed to contraceptive security, in coordination with other key providers of technical assistance; however RHCS is highly donor dependent for commodities and the DTTU. • The CO has received and utilized technical GPRHCS funding and technical assistance from HQ and RO.

Progress and activities

As noted in Section 3, unmet need for family planning in Zimbabwe is the lowest in Sub Saharan Africa, but it has remained stagnant for the past two decades. Furthermore, wide regional differences within the country persist. Awareness and use are high, but contraceptive prevalence rate (CPR) has also plateaued and the contraceptive method mix is skewed towards short-acting methods, limiting individual choice and programme effectiveness. There are many possible reasons for the plateau, and the most likely is that the two decades of economic and political challenges have affected the capacity of the Zimbabwean health system to deliver primary care, including family planning. However, it is remarkable that further erosions to modern contraception prevalence rate (mCPR) did not happen during this challenging period. It is also difficult for national programmes to provide access to the hard to reach and marginalised populations, once CPR has increased to levels over 50 percent. Finally, the AIDS epidemic has understandably drawn priority attention and resources from mother and child health (MCH) and FP programming. Zimbabwe has joined many other countries in revitalising attention to FP since 2012.

The majority of FP services (73.4 percent) are offered by the public sector primarily through MoHCC outlets. ZNFPC supports 13 provincial clinics, 26 dedicated district level youth friendly centres, and a network of community-based distributors; however, it accounts for a small percentage of couple years protection (CYP).[90] UNFPA and PSI support the MoHCC to provide long-acting methods in public sector facilities under the ISP. Population Services Zimbabwe (the national affiliate of Marie Stopes International) and PSI also support mobile outreach teams for long-acting and permanent methods with support from USAID and other organisational funding. Key informants expect that the work implemented by ISP partners to expand long-acting contraception in the public sector and through mobile outreach has improved the method mix, to be confirmed by the next DHS.

ZNFPC conducts in-service training for the public and NGO sectors; KIs expressed concern about the quality of training, the lack of outcome data, inadequate monitoring and follow-up and high cost of training. Training for IUCDs has been unsuccessful to date, as there is not a sufficient client caseload to support provider training. Moreover, the Training of Trainers (TOT) strategy was hindered because approximately 10-15% of individuals selected did not have qualifications to be trainers.

[90] Annex 3, Assumption 2.1

There has been no evaluation on the impact of training on service availability or user perspectives on quality.[91]

Donor agencies procure 100 percent of the contraceptives used in the Zimbabwean FP programme. The UK provides the pills and injectables, USAID provides condoms and UNFPA provides implants and IUCDs. Distribution of contraceptives happens within one coordinated logistics and supply chain through the delivery team topping-up (DTTU) system, implemented by ZNFPC with technical support from Crown Agents (funding through the ISP) and JSI DELIVER (with USAID support). The DTTU has resulted in strengthening of the procurement and logistics system. It is a system of 40 trucks and drivers, eight area managers at the provincial level that constitutes a "push" system with a mobile warehouse. Delivery trucks carry a set amount of health products, including contraceptives and condoms, determined by recent trends, and "top up" the facilities with the products they will need during the next time period. Prior to introducing the system, 20 percent of facilities experienced condom stockouts, however, after the system was introduced, only two percent of facilities have reported stockouts. The system has achieved 95% availability of condoms and contraceptives in 99 percent of the service delivery points (1,000 facilities) in the country.[92]

UNFPA contribution to supply side strengthening

The focus of UNFPA support on the supply side is to increase access to long-acting contraception to support an expanded method mix that is better able to meet the different client needs and reproductive intentions. UNFPA has contributed to the supply side through its support of ZNFPC for provider training and the procurement of injectables, implants and IUCDs. These activities are supported by the global programme for reproductive health commodity security (GPRHCS). As noted previously, there are major gaps in the training offered, with little or no documentation of quality and effectiveness of this training. To date, the main measurement used to monitor progress is the number of providers trained, and although follow-up occurs at six weeks, there are no provisions for longer term mentoring or supervision.[93] A 2011 study of the CBD programme identified many weaknesses that have not been addressed and have worsened with continued attrition, a hiring freeze, and poor training, supervision and monitoring.[94]

As the major public sector partner, UNFPA is in a position to influence how the ZNFPC conducts, monitors and evaluates these programmes.

5 CONCLUSIONS

5.1 UNFPA has integrated Family Planning within Sexual and Reproductive Health policy and service provision, although missed opportunities exist for integration of FP within maternity services.

UNFPA has played an important role in advocacy, technical support and implementation of activities for the integration of family planning (FP) within sexual and reproductive health (SRH) services, HIV prevention, adolescent services, prevention of gender-based violence (GBV) and emergency relief, leading to increased public sector capacity to mainstream FP into SRH services, especially since the advent of the integrated support programme (ISP) in 2013. However, missed opportunities exist for strengthening FP within maternity services and waiting homes, as well as mainstreaming HIV and GBV prevention within family planning services. The country office (CO) and its partners have not

[91] Annex 3, Assumption 8.1
[92] Annex 3, Assumption 8.3
[93] Annex 3, Assumption 8.1
[94] Annex 3, Assumption 4.2

evaluated the impact of integration on family planning outputs or outcomes, including on the quality of and access to FP services.

- Origin: Evaluation question 1 (Section 4.1)

5.2 Effective coordination and brokering advanced government action for family planning, yet challenges remain for national ownership and sustainability

UNFPA has a solid position as a key player in the global FP2020 movement, as the main partner for the Ministry of Health and Child Care (MoHCC) on sexual and reproductive health and rights (SRHR) matters. Furthermore, its willingness and capacity to serve as a broker has resulted in increased national attention for and ownership of FP. However, serious challenges remain to seeing this renewed commitment through e.g. overlapping coordination mechanisms; lack of capacity within the public sector to finance, coordinate, monitor and evaluate its programme without extensive technical assistance; and a continuing fragile country context. UNFPA is well positioned to support the MoHCC to navigate these challenges.

- Origin: Evaluation questions 2 and 3 (Sections 4.2 and 4.3)

5.3 Enabling environment, supply side and demand creation activities contribute to increased family planning availability and use

UNFPA has provided extensive support to the public sector to address key components required to advance access to services and the availability, acceptability and use of family planning. UNFPA supported the enabling environment through the development of key policies and strategies at the national level; the supply side through training and capacity building for facility based and community based services, and commodity support; and demand creation through a range of integrated behaviour change and communication approaches. However, weaknesses in monitoring and evaluation make it difficult to assess the outcome of these approaches and activities and affect the ability of the UNFPA and its implementing partners to make strategic choices about how best to move forward, especially to address issues related to improved access for youth, quality of care, social barriers to use long-acting method introduction and community-based distribution (CBD) reform. Moreover, while UNFPA has been fairly successful at the policy level and in raising awareness and facilitating policy change, it has been more difficult to identify success at implementing large-scale programmes that influence community level and behaviour change.

- Origin: Evaluation questions 4 and 8 (Sections 4.4 and 4.8)

5.4 UNFPA has contributed to addressing the needs of vulnerable and marginalised populations, gender-based violence prevention and response, as well as human rights, although results are not well-documented

UNFPA is recognised for the identification of needs, the design and implementation of appropriate programmes and the mobilisation of resources and partnerships to address the sexual reproductive health and rights of marginalised groups, with a strong focus on addressing gender-based violence. This signature work is considered a unique comparative advantage for UNFPA and is highly appreciated by stakeholders for the innovation and technical expertise it offers to partners. Within FP interventions, while UNFPA incorporates attention for youth-friendly services and improved method choice, there is little evidence about access and quality outcomes or how clients experience services. Further, FP is minimally integrated in GBV interventions, and GBV is not included in FP training. Lack of monitoring on client perspectives in FP hampers documentation of results and lessons learned, but more importantly, it could signal missed opportunities to improve rights-based FP.

- Origin: Evaluation questions 5 and 6 (Sections 4.5 and 4.6)

5.5 Strategic programming and use of modes of engagement are appropriate for the country context

The country office has monitored the country context and has responded in a strategic manner that has resulted in the mobilisation of resources, improved policy support and support to programme implementation. Along with its development partners, UNFPA contributed to shoring up the health system weakened by years of economic decline and political challenges. UNFPA has continued to prioritise capacity building and service delivery and plays a dual role as a broker and coordinator of resources and technical support for the public sector and as an implementer of donor funding to advance service delivery. The implementer role places some strains on UNFPA staff and their technical capacity. It also has the potential to limit its effectiveness as broker and coordinator with other partners, if UNFPA is seen as a competitor for resources.

The overall lack of data and research has resulted in limited contributions to an evidence base to support strategic advocacy, prioritisation and programming and makes it difficult for the CO to document results and share the lessons and best practices generally, but particularly for FP in a unique and challenging context which could be instructive for other African countries.

- Origin: Evaluation question 7 (Section 4.7)

5.6 Lack of results-oriented monitoring and evaluation system affect UNFPA capacity to assess results of its support

A recurring theme within the aforementioned conclusions is that the CO lacked an overall system for monitoring and evaluation of its programme activities. This issue has appeared in previous evaluations as well. This gap has affected negatively the capacity of the CO (and its implementing partners) to assess and refine strategies, reorient interventions and manage knowledge (and programme investments) effectively and in a timely manner. However, there are indications that the

CO is beginning to remedy this in part, given the few research activities that are currently underway and the fact that the CO dropped its youth corners strategy based on an assessment of poor results.

- Origin: Evaluation questions 1-7 (Sections 4.1 to 4.7)

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ANNEX 2 – LIST OF PEOPLE INTERVIEWED

Name	Title
UNFPA Zimbabwe	
Cheikh T. Cisse	Country Representative
Yu Yu	Deputy Country Representative
Tamisayi Chinhengo	Programme Specialist, ASRH
Choice Damiso	Programme Specialist, Gender
Dagmar Hanisch	Technical Specialist, HIV Prevention & SRH
Agnes Makoni	Programme Analyst, Maternal Health
Sunday Manyenya	Programme Analyst, Planning, Monitoring and Evaluation
Rudo Mhonde	Programme Analyst, Monitoring, Evaluation and Research
Piason Mlambo	Programme Specialist, Population and Development
Edwin Mpeta	Programme Specialist, Reproductive Health
Ministry of Health and Child Care	
Sister Machini	Registered General Nurse and Senior In-Charge, Midwife, Rosa Rural Hospital, Mazowe
Dr. Bernard Madzima	Director, Family Health Division
Ms. Muchaneta Mandara	Reproductive Health Officer
J Mhlanga	Registered General Nurse, Rosa Rural Hospital, Mazowe
Mutanaurwa	Registered General Nurse, Rosa Rural Hospital, Mazowe
Sr. Mutswiri	Registered General Nurse, Rosa Rural Hospital, Mazowe
Ms. Margaret Nyandoro	Deputy Director, Reproductive Health
Zimbabwe National Family Planning Council	
Dr. M. Murwira	Executive Director
Development Partners and NGOs	
Geoffrey Acaye	UNICEF, Health Manager
Goodshow Bote	PADARE, M&E Officer
Acton Chimera	PSZ, Deputy Director
Anthony Daly	DFID, Health Nutrition and HIV Advisor
Dr. Karin Hatzold	PSI, Deputy Director - Programmes
Kelvin Hazangwi	PADARE, National Director
Dr. Jo Keatinge	USAID, Development Health Specialist
Mavis Mabedhla	PSZ, Clinical Services Manager
Edinah Masiyiwa	WAG, Executive Director

Alson T. Mhazo	John Snow International/DELIVER PROJECT
Raguel Mthombeni	Crown Agents, Supply Chain Specialist
Vivian Murisa	Crown Agents, DTTU Project Executive
Netty Musanhu	MUSASA, Director
Nakai Nengomasha	PADARE, Programme Officer
Dadirayi Nguwo	PSZ
Chenjerai Sisimayi	World Bank, Health Specialist
Dr. Lucia Takundwa	USAID
Walter Vengesayi	PADARE, Programme Officer
Kathleen Webb	USAID, Health Officer

ANNEX 3 – EVALUATION MATRIX

The data and information produced through the document review, and collected through interviews in Zimbabwe are presented in the evaluation matrix below. Data and information are categorized along the evaluation questions and related assumptions for verifications and support the findings analysis presented in Section 4 of the present country note.

Area of Investigation 1: Integration

To what extent has UNFPA supported integration of family planning with maternal health, HIV/STI and GBV services in health plans and at primary health care level, in services for adolescents, and in emergency and humanitarian situations?

Date Collection Methods:
Document review
Key informant interviews (KII)
Focus Group Discussions (FGD)
Site Visits

Assumption 1.1: **UNFPA headquarters (HQ), regional office (RO) and country office (CO) staff and in-country partners are working towards a common understanding of the meaning and importance of service integration.**	**Information sources:**
Indicators: • Knowledge generated and shared regarding nature of and lessons learned from integration interventions • UNFPA staff, partners' and users' (women's and men's) perception of meaning and importance of service integration.	
Family planning (FP) is integrated into the 6th country programme (CP) in a variety of non-core activities, including the Integrated Support Programme (ISP) and the LINKAGES Project. The ISP comprises 80 percent of the CO portfolio; it was started in 2013 and includes financial and technical support for "neglected components" in the Health Transition Fund, a major health systems strengthening program implemented by UNICEF. The ISP is funded by Department for International Development (UK) (DFID), Irish AID, and Swedish International Development Agency (SIDA). The ISP has four pillars – pillar two, addressing the public sector integration of FP, gender based violence (GBV), HIV and cervical cancer (CaCx) services through community-based social and behaviour change promotion and strengthening public sector service delivery, is implemented by UNFPA. (Pillar one, focusing on social marketing of integrated sexual and reproductive health (SRH), HIV and GBV services, is implemented by Population Services International (PSI); pillar three, procurement and nationwide	CO staff

distribution of FP and HIV commodities, by Crown Agents; and pillar four, M&E and operational research (OR), by the World Bank). According to UNFPA staff, the ISP implementation is 55 percent HIV prevention, 25 percent GBV, 12 percent CaCx, and the remaining 8 percent FP. The focus of FP under the ISP is increasing access and use of long-acting methods, mainly implants. The CO estimates that implant prevalence has increased by 6 percent over three years, but no statistics were provided, nor is it clear what the relative contributions by the various actors: PSI, PSZ (MSI affiliate in Zimbabwe), UNFPA, World Bank, etc. Intra-uterine contraceptive devices (IUCDs) are considered a *"tough slog"* and a *"catch 22"* since there are no clients to have caseloads for training, and providers do not have the skills to offer the methods.	
The four-year (2012-2015) nationally owned ISP aims to improve SRH for women and girls and to reduce maternal morbidity and mortality as well as gender based violence. USD 95 million has been committed from the UK, Sweden and Ireland, with USD 29 million allocated to UNFPA for interventions in the areas of family planning, cervical cancer screening, and HIV and GBV prevention. Another significant initiative funded by the EU (and previously the Japanese Government) is to reduce maternal deaths by strengthening service provision and supporting institutional deliveries through maternity waiting homes. Overall strengthening of the health system nationwide is essential and underway.	(Jackson, Njovana et al. 2014: 8)
UNFPA considers FP work as part of its health portfolio; therefore, integration of FP into other health activities is key. However, FP does not appear as a core pillar into which other services are integrated, but rather is a service that is integrated into other activities, such as GBV, HIV prevention and maternal care. When this was noted with staff, they countered that UNFPA considers FP a core business, with much advocacy being done to convey the importance of FP for the protection of women's health. Given that so little of the CO resources are core, programme areas and allocations are done in consultation with donors. UNFPA described its FP component as having two components: (i) a "niche" programme with outputs focused on long-acting methods and (ii) an area to mainstream within other technical areas, such as in comprehensive condom programming, linkages, HIV prevention, GBV, maternal health waiting rooms (antenatal counselling), adolescent sexual and reproductive health (ASRH and advocacy on the demographic dividend.	UNFPA CO staff
The FP Strategy 2015-2020 includes objectives to increase demand for and improve availability and access to quality integrated FP/SRH services (FP integrated with maternal care, selected, but unspecified, SRH and HIV/AIDS services). However, it was noted that there is no clear definition or consensus on the boundaries of SRH – does it include HIV or not? Where does FP fit within this? What is the essential package of services? Given the many projects and steering committees, and considering that there are two government units "coordinating" FP activities (see Assumption 2), there is more confusion than consensus on this question.	Donors and government staff (MoHCC 2014)
"*Within UNFPA too, internal integration can be improved. The evaluation team did not find that the different programmes work optimally together. The UNFPA GBV Strategy refers to addressing GBV through UNFPA-supported SRH programmes as the minimum standard to which all UNFPA operations should be held accountable*".	(Jackson, Njovana et al. 2014: 64)

Assumption 1.2: **Country offices receive and put into practice technical guidance from HQ and ROs to support partners in delivering quality, integrated services.**	**Information sources:**
Indicators: • Number, frequency and type of technical assistance (TA) provided • RO plans address COs' needs for support in promoting service integration where appropriate • CO plans and programmes reflect current technical guidance and best practices for integrated services • Evidence-based guidance developed to support the integration of FP or more in the following SRH services (in policies, plans, actual service delivery): ▪ Maternal health ▪ HIV/STIs ▪ Gender-based violence (GBV) ▪ Level of emergency preparedness to address FP needs in emergency situations ▪ Adolescent SRH (girls and boys).	
The CO mentioned no instances of RO or HQ technical support or guidance for integration, other than the overall strategic vision of the "bullseye" and the priority given to protecting the health of women and youth. It was noted that the RO does not have specific technical expertise in FP.	CO staff
Regarding comprehensive condom programming (CCP), UNFPA provided financial and technical support to the Ministry of Health and Child Care (MoHCC) review of male and female condom programming in 2012, as the previous strategy was outdated. This review led to the development of the National Male and Female Condom Operational Plan 2012-2015.	(Jackson, Njovana et al. 2014: 34)
There is a weak policy environment for integration at the national level. The mandate of the National AIDS Council (NAC) is to coordinate the HIV response. Although a parastatal, NAC is a constituent of the MoHCC. The HIV and TB Unit is located within the MoHCC, and is responsible for providing policy direction for the health sector HIV response. The Reproductive Health (RH) Unit is also within the MoHCC and is responsible for providing national leadership on RH programming. Zimbabwe National Family Planning Council (ZNFPC) is responsible for the coordination and implementation of FP interventions. There is no specific policy or standard operating procedures to guide national SRH and HIV integration. While some policies call for SRH and HIV integration (such as the Maternal and Neonatal Health (MNH) Roadmap, RH Guidelines, Adolescent Sexual Reproductive Health/ASRH Strategy 2010–2015, ZNFPC Strategy, the Behaviour Change Strategy and the ART Guidelines), major policy documents guiding implementation of SRH and HIV interventions are weak on promoting integration, for example, the National Reproductive Health Policy 2003 and the National HIV/AIDS Strategic Plan 2006–2010.	(IPPF and UNFPA 2012)

The CO provided support to the MoHCC roll out the ten-step strategic approach articulated by UNFPA globally for comprehensive condom programming. Per UNFPA, the country has made significant progress by annually distributing male condoms (85 to 90 million) and increasing female condom distribution from 1.3 million in 2005 to 5.2 million in 2011. UNFPA also trained condom distributors in low performing districts in Matabeleland North and Matabeleland South on safer sex negotiation. An advocacy meeting was held with 65 parliamentarians highlighting the role of parliamentarians as community leaders in promoting male and female condom use and other safer sex practices. A review of the national male and female condom programme was also undertaken. Preliminary findings revealed progress in implementation of the ten-step strategic process, but also highlighted the need to strengthen condom programming for young people.	(UNFPA Zimbabwe 2012)
In 2012, UNFPA supported a learning tour to Kenya for the RH and HIV Units in the MoHCC to learn about the functions of *centres of excellence of SRH* and HIV linkages. This work is based on UNFPA guidance regarding SRH and HIV Linkages.	(UNFPA Zimbabwe 2012)
In 2013, UNFPA reported providing support to MoHCC to strengthen the integration of HIV and SRH services through placement of a linkages coordinator as well as the development and implementation of service guidelines on linking SRH and HIV programmes and services. Family planning guidelines were distributed to Integrated Support Programme (ISP) sites.	(UNFPA Zimbabwe 2013)

Assumption 1.3: **UNFPA support has been effective in stimulating service integration by in-country partners; government, civil society organisations (CSOs), private in policies, plans and actual services.**	**Information sources:**
Indicators: • Number and type of FP service providers trained on service integration • Number and percentage of service delivery points that offer FP integrated with other services (and acknowledge UNFPA guidance for this) • Integrated service provision included in provider training programmes (with acknowledgement of UNFPA guidance for this) • Inclusion of integrated service provision in government policies and health plans.	
In addition to the ISP, the other integrated programme managed by the CO is the Linkages Project, implemented in three *"centres of excellence"* in Harare and Bulawayo. This project focuses on the bi-directional linkages between HIV and sexual and reproductive health and rights (SRHR) and has supported the development of service guidelines, training reference manuals, training modules for community health workers, service providers and health service managers. The training is rolling out to 2500 health care providers and village health workers (VHWs). Training is carried out by MoHCC with financial and technical assistance from UNFPA.	CO staff (IPPF 2014)

Training of health providers in sexually transmitted infections (STIs), FP, condoms, visual inspection with acetic acid and cryotherapy (VIAC) and integrated services would not proceed at the same level without UNFPA financial and technical support, including the funding of key coordinating posts at the MoHCC. These are seen as having "sped up" service provision. The family planning outputs envisioned in the 6th CP are generally considered to be on track, e.g., 256 facilities (out or targeted 300) in the public health sector with at least one health care worker trained in FP provision, including implant insertion; 769 (out of targeted 850) trained in FP service provision; 23,817 implant insertions (out of targeted 49,650) at UNFPA supported sites. However, given the limitations of the M&E system, there is no way to know whether those trained are providing quality, integrated services, as trainee follow-up beyond six weeks post-training is not conducted.	(Jackson, Njovana et al. 2014: 25)
By June 2015, over 4,000 health care providers were trained to deliver integrated SRH and HIV services through ISP funding.	CO staff
FP is featured in the UNFPA strategy to support adolescent SRHR and HIV prevention, given the high teenage pregnancy rate and low contraceptive use among sexually active teens. UNFPA supported 73 (out of targeted 75) service delivery points to offer youth friendly SRHR services, but it is noted that the outcome results for this indicator are *"not strong".* The youth friendly services (YFS) or corners has not been effectively implemented or shown good results. The effort was poorly monitored by ZNFPC and most corners refer youth to adult clinics where providers may not be youth friendly. This approach is being discontinued, and a study is underway about youth fertility that will inform the design of the strategy in the 7th Country Programme.	CO staff (Jackson, Njovana et al. 2014: 25, 28-29)
Although there is discussion about integrating FP counselling within maternity waiting homes, very little has been done to advance post-partum family planning (PPFP), although it is acknowledged by several KIs as having potential for improving FP access within maternity settings. Maternal and Child Health Integrated Program (MCHIP) (a USAID maternal health global project, implemented by JHPIEGO) has supported the development of PPFP guidelines. UNFPA has supported a study tour of a team of MoHCC and ZNFPC officials to Zambia to observe PPIUCD programs.	CO staff
Integration of FP within GBV activities was discussed in several KIIs as an area that has potential but is being neglected because of the way UNFPA works in silos across the different technical areas. PADARE and MUSASA are both working on community-based services to address GBV (See Assumption 5); however, both said they could serve their clients better if they could add FP to the services offered in their centres and one-stop shops. One KI said, *"Integration starts at home,"* meaning there could be better integration of programming areas within UNFPA.	CO and NGO staff
The ISP is by far the most extensively funded programme that supports UNFPA to improve sexual and reproductive health and rights of women and girls, and to prevent HIV and to reduce GBV. Internationally, UNFPA and other stakeholders identify multiple benefits through integration of SRH and HIV services, including more streamlined provision to meet SRH/HIV needs of individual clients, potential for greater efficiencies and cost effectiveness, and strengthened service uptake if several services are available at one site. Three bilateral donors (the British, Swedish and Irish governments) provide most support for the ISP, at around 64 percent of all UNFPA external programme funding (Note – CO staff estimated this at 80 percent). The programme	(Jackson, Njovana et al. 2014: 21)

cuts across the RH, HIV and gender units of the CO, with overall management by the HIV and SRH technical specialist in the HIV Unit. The programme is nationally coordinated through the MoHCC, Ministry of Women's Affairs, Gender and Community Development (MWAGCD) and NAC. MoHCC established a coordination unit early 2104 with ZNFPC and funders also as co-chairs. The ISP addresses unmet SRHR needs of women and girls through focusing on maternal morbidity and mortality, FP services, cervical cancer screening and treatment, HIV prevention, GBV prevention and response, and related research and evaluation. It strengthens both health and community systems for improved service provision and community access to and utilisation of these services. These areas are all highly relevant in Zimbabwe given the extent of unmet needs and prevailing health indices.	
The family planning component is also highly relevant, including for adolescents amongst whom teenage pregnancies and maternal mortality are high. UNFPA CO is strengthening reproductive health commodity security (RHCS) also through the global programme for reproductive health commodity security (GPRHCS). This includes support for ZNFPC to develop the Zimbabwe National Family Planning Strategy, currently awaiting finalisation, as well as procurement of STI drugs.	(Jackson, Njovana et al. 2014)
There is a weak policy environment for integration at the national level. The mandate of NAC is to coordinate the HIV response. Although a parastatal, NAC is a constituent of the MoHCC. The ZNFPC is responsible for the coordination and implementation of FP interventions. There is no specific policy or standard operating procedures to guide national SRH and HIV integration. While some policies call for SRH and HIV integration (such as the MNH Roadmap, RH Guidelines, Adolescent Sexual Reproductive Health/ASRH Strategy 2010–2015, ZNFPC Strategy, the Behaviour Change Strategy and the ART Guidelines), major policy documents guiding implementation of SRH and HIV interventions are weak on promoting integration, for example, the National Reproductive Health Policy 2003 and the National HIV/AIDS Strategic Plan 2006– 2010.	(IPPF and UNFPA 2012: 4)
"Other challenges at the policy level include: • *Funding is inadequate and inequitable; HIV was reported to continue to receive more funding over time than SRH.* • *Donor-specific interests in HIV or SRH, and donor conditions on use of funds for specific HIV or SRH interventions.* • *With most donors channelling their funding through CSOs, the MoHCC was finding it increasingly difficult to coordinate SRH and HIV integration among development partners".*	(IPPF and UNFPA 2012: 4)
In 2009, the crisis in the health system was compounded by the cholera outbreak caused by the breakdown of water and sanitation systems in most urban areas, UNFPA mobilised more than $2 million from the Central Emergency Fund for emergency RH commodities to meet needs of vulnerable women and girls. The commodities were distributed to all district hospitals in the country. 100,000 vulnerable women and girls benefited from cotton wool that was distributed through AFRICARE. Through its partners, UNFPA also supported health facilities with basic requisites to be able to provide services to survivors of sexual violence including the establishment of a comprehensive one-stop centre in Harare. UNFPA also trained over 100 humanitarian workers in minimum initial service package (MISP) and GBV guidelines, and provided them with necessary tools to mainstream MISP and GBV prevention in their work. UNFPA secured a special waiver from the RO and HQ to be able to pay retention	(UNFPA Zimbabwe 2009)

allowances to health workers to return to work and be able to carry out their health duties including that of RH provision. Over 1,000 doctors, midwives and nurses working in maternity wards at district, provincial and central levels benefitted from this initiative. UNFPA also participated in a rapid assessment of internally displaced persons in Zimbabwe. UNFPA has procured 150,000 rapid syphilis test kits for all health facilities that did not have access to laboratory services including all peripheral health facilities.	
Through the Integrated Support Programme, UNFPA trained 1,730 behaviour change facilitators (BCFs) in 26 districts. Through the home visit approach, the BCFs facilitate interpersonal communication with families, couples and individuals and refer participants to the most appropriate service. 130 of the 1,730 BCFs were trained as mentors for adolescent girls. The girls will meet in groups with the aim of enhancing their sexual and reproductive health knowledge and empower them to make responsible health decisions. Other results regarding FP integration are: • A total of 42 trainers and 398 service providers from the public sectors as well as 92 behaviour change district officers were trained on condom promotion and safer sex negotiation • 52 nurses were trained on youth friendly service provision. Nurses are supporting the programming by ensuring that young people receive friendly services within health facilities and also collecting and collating data for the age group 10-24 years. Inadequate supervision of trained nurses as well as low prioritisation of the programme at provincial and district levels has been noted as a challenge to on-going implementation.	(UNFPA Zimbabwe 2013)
The ISP recently had its 3rd annual review by DFID, which concluded that UNFPA has progressively improved its performance of pillar 2. UNFPA achieved or surpassed 11 out of 15 indicators and its partnership across various departments in the public sector was deemed to contribute to public sector capacity. This is an improvement over prior reviews. KIs reported that UNFPA had the coordination role in year one, but *"did not do a good job"* so this was transferred to an independent coordination unit. Further, in year two, the male circumcision component implemented by UNFPA was transferred to PSI, as the UNFPA activities in six districts took too long to get underway. One of the reasons was that UNFPA was pulling together equipment and supplies for male circumcision that were "new" items to the procurement staff at UNFPA, while PSI was using male circumcision kits already packaged for distribution and use (from USAID). PSI has a deep expertise in clinical services in male circumcision, as well as SRH and FP service delivery, given the protocols and systems in place for external (HQs-led) and internal (CO-led) quality assurance. PSI is supporting 30 public sector sites under the ISP as part of a franchised public sector network called PROFAM, in addition to 25 outreach teams and 17 private clinics and is a heavy contributor to the FP and other service results contributed under the ISP. It is unfair, however, to compare UNFPA and PSI, as UNFPA works with the public sector and is responsible for carrying out two tasks simultaneously – building capacity of the public sector and implementing programmes directly.	CO and NGO staff (DFID 2015)
"*UNFPA's delivery so far has been less strong. Obstacles that they have faced include delays in procurement of resources and delays in proposed activities being signed off by MOHCC. M&E systems are being put in place but due to the reliance on government data, as yet there is limited performance data to demonstrate progress. UNFPA also has the role of coordination of*	(DFID 2013: 23)

the ISP. This role has yet to be established apart from the hiring in March of the Coordinator of the ISP. Given the challenges that UNFPA faces in monitoring its own pillar and the potential conflict between being an implementing partner and coordinator, one may question if UNFPA is best placed to also coordinate the entire project. The TOR for the coordination function is still under development but it needs to ensure clarity on roles and responsibilities. Contractually, there is no lead partner. Each implementing partner has a separate contract with DFID and therefore it would be difficult for PSI, Crown Agents or the World Bank to report to DFID via a coordination mechanism provided by UNFPA. Given the comparatively slow progress under UNFPA's pillar to date and lack of M&E data, it is more important for UNFPA to focus on its own implementation plans and for DFID and other funding partners to seek alternative arrangements for managing and coordinating the ISP […]. DFID may therefore consider limiting the tasks sub-contracted to UNFPA to include those of their core competence, i.e. SRH policy and strategy development, and technical support to MOHCC".	
"Progress is being made towards the overall outcome target of 'more women and girls being able to make choices about their sexual and reproductive health'. The programme has four specific outcome indicators; the most challenging is likely to be the first linked to increasing the contraceptive prevalence rate (CPR) from 59 to 68 percent, and there is no data from the first year of the programme to give any indication of progress".	(DFID 2013: 14)
"Pillar 2: UNFPA has improved performance from last year with good progress in its GBV work and excellent results on cervical cancer (especially in Bulawayo). Cervical cancer screening uses the cost effective VIAC visual inspection method for screening/diagnosis and treatment of early stages of cervical cancer. The UNFPA-supported cervical cancer-screening centre in the United Bulawayo Hospital was used to launch the national Zimbabwe screening programme in November 2013. Family planning and ARH remain off track. Seriously underperforming is UNFPA's work with MOHCC in male circumcision in six districts. Given the need for speed in meeting national VMMC goals as quickly as possible, this situation has become critical. Both PSI and UNFPA have been active in task-shifting policy work so that trained nurses are now able to perform MC. UNFPA's work in Gender-based violence is making good progress. UNFPA has chosen good partners with whom to work and made good inroads into this difficult and important area".	(DFID 2014: 17)
"This programme has probably made its biggest contribution to the CPR by procuring and delivering, and therefore keeping contraceptive stock-outs low in facilities across Zimbabwe. Zimbabwe's CPR is already the highest in sub-Saharan Africa (save South Africa and Swaziland) and simply maintaining this high rate should not fail to be recognised as a major achievement. A total fertility rate of 3.8 children per woman would imply that improving the efficiency of the family planning that women are already practising might be a more effective strategy. Zimbabwean women's high reliance on oral contraceptives means that their family planning practice is less effective than if more women used long-acting or permanent methods. This thinking should be built into the national family planning strategy".	(DFID 2014: 18)

Assumption 1.4: **Service integration leads to improved user access and quality of services.**	**Information sources:**
Indicators: • Evidence of user consultations • Perception of different user groups – women and men, vulnerable and marginalised groups (VMG), people living with HIV (PLHIV) that access[95] and quality have improved by integration.	
Support for family planning, cervical cancer screening and STI management, such as training of service providers, is supported by the ISP, by the GPRHCS programme and in the adolescent programmes, and is reported as on track. However, there remain significant gaps in FP, both for long acting methods and insufficient condom use. FP is constrained by a narrow range of options within each FP method, so that if one method, e.g. the contraceptive pill does not suit a beneficiary, there may be no alternative available. UNFPA supports training of care providers to provide long-acting and reversible methods, particularly implants. Community demand creation for FP, including for condoms, and promoting leadership support for adolescent access, are greatly needed (see ASRH). Demand generation and supply of cervical cancer screening services are generally on track in the 26 districts of the programme, except within the sex work programme where procurement of equipment is a year behind schedule but will be distributed to all static sites in late 2014. Currently, demand is being generated in an important and neglected area, particularly for female sex workers (FSWs) who are at high risk and for HIV-positive women, but this is not translating routinely into increased treatment access for the poor. Around 26 percent of women seeking screening are HIV positive, making this a highly strategic entry point to boost HIV treatment access.	(Jackson, Njovana et al. 2014: 27)
An assessment identified three types of integration in Zimbabwe: 1. Both SRH and HIV services were offered by the same provider at the same service point, for example, in family and child health (FCH) clinics, pregnant women received antenatal care and HIV counselling and testing services 2. Clients were referred within the same facility, for example from opportunistic infection (OI)/ART clinics, HIV-positive women were offered FP information, and those interested were referred to clinics for services 3. Clients were actively referred to another facility. For example, in one catholic mission hospital health care workers in the OI/ART clinic mentioned that as it was a catholic institution, HIV-positive women requiring FP services for PMTCT Prong 2 were referred to government health facilities.	(IPPF and UNFPA 2012: 6)

[95] Access: availability, accessibility (distance, transport, time), affordability (willingness and ability to pay incl. opportunity cost) and socio-cultural acceptability

While there is some degree of integration at the service delivery level, this, however, is uncoordinated, uninformed by policies, and health care workers were found to be inadequately trained. Respondents described *"integration by default," "just because there is only one service provider providing all the services."* Furthermore, SRH HIV integration was not routine in some facilities. Sometimes HCWs would forget to provide integrated services to client; for example, this was observed at one hospital family support centre, where a sexually abused child had not been offered HIV information, counselling and testing services. Integration was stronger in rural health facilities and district hospitals than in provincial hospitals, as in the former it is possible for clients to see one service provider. Some clients felt that integrated services, especially when one is used as an entry point to promote other services, caused unnecessary delays. For example, in MC clinics, male clients would not accept referrals to FP clinics as they felt that was unnecessary and a waste of time.	
An assessment identified the following: Challenges in services: • Stigma and discrimination, especially among people living with HIV referred to SRH service points within the same facility • Services for sexual gender-based violence and cervical cancer screening are virtually non-existent in most facilities • In some cases, especially in mission hospitals, there were no RH supplies such as modern contraceptives Challenges with referrals: • Even when clients were referred for services within the same facility, some did not reach the service they were referred to and were not followed up • Many clients would not go for the services mainly due to lack of time, money for transport, and also fear of stigma and discrimination • Some clients referred from lower-level health facilities were not offered integrated services at the higher levels, as it was assumed that they had already received the services • There is no clear follow-up mechanism to ensure that referred clients receive the services for which they were referred • Most HIV services are provided free of charge, while some SRH services were available on a user-pays basis, which discourages the uptake of SRH referrals The MoHCC, NAC and ZNFPC, with support from development partners (DPs), have established community-based cadres, including village health workers, community-based distributors of contraceptives, home-based care givers, behaviour change facilitators, and health promoters (urban areas). All community-based organizations and cadres interviewed stated that there is weak SRH and HIV integration within programmes, mainly due to limited capacity and poor SRH and HIV coordination at community level. Other barriers included: • Lack of basic resources for community-based agents to work, such as bicycles • Lack of an integrated community-based strategy to guide SRH and HIV integration; and in most areas there are no	(IPPF and UNFPA 2012: 6)

community-based distributors of contraceptives.	
Also see Assumption 5.5	

Area of Investigation 2: Coordination

To what extent has UNFPA successfully contributed on its own and in coordination with others to strengthening national leadership of family planning and improving sustainability?

Data collection methods:
Document review
Key informant interviews (KII)
Focus Group Discussions (FGD)
Site visits

Assumption 2.1: **UNFPA has developed and/or actively supported mechanisms to raise the profile of family planning in coordination with other FP/SRH stakeholders at:** • **Global** • **Regional** • **National levels.**	**Information sources:**
Indicators: • Type of existing and emerging coordination mechanisms at each level with evidence of UNFPA support and FP-relevant contents of meetings and initiatives.	
"ZNFPC and Zimbabwe family planning strategy. Many players in the Zimbabwe health sector believe that ZNFPC needs substantial institutional reform. It is protected by an Act of Parliament and has Ministry support. UNFPA has undertaken with donor funding to support ZNFPC reform in response to a Crown Agents assessment. ZNFPC, underfunded with a large staff complement, is trying to raise funds through training and commodity delivery fees. Reform of ZNFPC is unlikely to succeed unless it is taken on in a strategic and comprehensive way and championed at the highest level. *Linked to defining the future role and mandate for ZNFPC is the development of a National Family Planning Strategy, currently in draft. The document covers the enabling environment, improving contraceptive commodity supply, increasing service access, raising demand, and improving data systems. While these are sensible objectives or 'interventions', the document would benefit significantly from defining a strategic approach, covering how objectives will be achieved, as well as prioritising what is likely to*	(DFID 2014: 11)

be affordable and highest priority – getting a wide method mix as near to clients as possible. It is advisable that a panel of experts (national and international), without risk of conflict of interest, is asked to peer review and amend the document where necessary, ensuring it is based on the latest evidence".	
The Zimbabwe National Family Planning Council (ZNFPC) is a statutory body that was established in 1985, under the Zimbabwe National Family Planning Council Act, to lead and coordinate the implementation of family planning activities in Zimbabwe under the direction of the MoHCC. The specific functions of the Council as set out in section 22 of the Act are: • To popularise and promote the provision of adequate and suitable facilities in Zimbabwe for child spacing and family planning • To provide facilities for the investigation and treatment of infertility among persons in need of such investigation or treatment • To participate actively with other organizations or institutions in the formulation and implementation of primary health care programmes and other community development activities related to family health • To carry out or assist in the carrying out of research into reproduction health and the effects of contraceptives on the health of the users of contraceptives and other persons • To undertake work connected with the diagnosis and treatment of diseases, including, but not limited to, sexually transmitted diseases and cancer of the cervix • To stimulate and develop an awareness among medical students and medical personnel generally regarding the scientific basis of child spacing and family planning and the practical implementation of related programmes by medically acceptable methods and practices • To provide and manage facilities for performing surgical operations for infertility and sterilization, and develop and provide a cytology service to persons in need of such service • Generally, to encourage, foster and promote child spacing and take such measures as are necessary or desirable for alleviating the problems associated with infertility among persons.	CO staff
The ZNFPC plays the primary coordination role in FP; however, it was described as lacking in strategic vision and functionality. ZNFPC was created in 1985 during a different era, when the Zimbabwe health system was more functional. Its mandate is to coordinate, take leadership and support implementation of integrated FP/SRH services in Zimbabwe. The ZNFPC oversees the network of community-based distributors of condoms and pills, and has 13 free-standing clinics that offer services and training. However, ZNFPC accounts for only one percent of couple years protection "CYP". ZNFPC is the key training institution, and trains and certifies public and private providers. This mandate is recognised by the MoHCC; however, the ministry is also a key provider of services and is responsible for coordinating and leading many of the steering committees for FP activities and programmes implemented within the country.	Government, Development Partner and CO staff

Prior to the London Summit and UNFPA engagement as a key global player in FP2020, UNFPA did not provide much support to ZNFPC. Its support was mainly for the ASRH programme where HIV prevention and GBV have taken precedence. KIIs described the focus by UNFPA on FP prior to 2012 as minor, with greater attention paid to HIV prevention activities. ZNFPC welcomes the renewed interest by UNFPA in FP and desires support for capacity-building and resource mobilisation in support of the new FP strategy and the costed implementation plan. UNFPA is seen by stakeholders as the best organisation to support ZNFPC to become more effective in coordination of FP activities in the country, although some respondents worried that there is some inherent conflict in this because they are wearing two hats, one as a coordinator and the other as an implementer of donor funding. ZNFPC effectiveness and capacity to coordinate FP was described as an on-going issue that *"no one has been able to solve"* and requires someone who is *"strong and experienced"* in managing conflict (see Assumption 3). Some KIs urged UNFPA to consider its role as a coordinator above and beyond what is happening on the ISP and Health Transition Fund (HTF). The steering committees of these initiatives are used as coordinating bodies, but some KIs felt that another national body is needed to coordinate across and beyond individual steering committees that coordinate specific projects or initiatives. The steering meetings are focused on implementation issues and not about taking on broader cross-cutting themes and sharing and exchanging lessons and other information, nor about using data and evidence to underpin discussions. One KI opined, *"I never saw a good presentation of FP data presented at the RH Steering Committee."* Regular analyses of trends over time are needed to contribute to more strategic thinking in FP programming.	
"Government of Zimbabwe Commitment made at London FP Summit in 2012: Zimbabwe commits to ensuring that women and girls have greater access to quality sexual and reproductive health services and will reduce the unmet need for family planning from 13% to 6.5% by 2020. The family planning budget, including the procurement of contraceptive commodities, will be doubled from the current 1.7% to 3% of the health budget. This includes support for improved access for women and girls from the poorest wealth quintiles, including the removal of user fees for family planning services by 2013. Zimbabwe will improve method mix and strengthen the integration of family planning with reproductive health, HIV and maternal health services; develop innovative service delivery models to meet the needs and rights of adolescent girls; and reduce their unmet need from 16.9% to 8.5% by 2020. Zimbabwe will strengthen public-private partnerships, including civil society organizations in the provision of community-based and outreach services and implement a national campaign to increase national awareness of family planning, and health worker training and sensitization".	(UKAid 2013)
There are several key initiatives in Zimbabwe to support maternal and child health, including FP to a degree, including the HTF, the RBF scheme supported by the World Bank, and the ISP, coordinated first by UNFPA and now by a contracted independent coordination unit. Each of these initiatives is led by a steering committee that is co-led by the MoHCC. UNFPA is a key player in	CO and Development Partner staff

the ISP and sits on the coordinating committees of the other initiatives. The HTF is considered a health systems strengthening initiative for mother and child health (MCH), while the RBF is a financing mechanism.	
The Health Transition Fund (2011-2015) is a partnership created to support areas in MCH that were seriously underfunded (based on a bottleneck analysis) and to build capacity in the health system, rather than focus on disease (as was through PEPFAR and the Global Fund). The HTF is a pooled fund managed by an independent entity (UNICEF), with a steering committee led by the MoHCC. The health system in Zimbabwe, historically one of the best in Africa, was near collapse in 2007, from a lack of resources, a serious brain drain and outbreaks of diseases, including cholera. The purpose of the HTF was to improve maternal, neonatal and child health by strengthening health systems and scaling up the implementation of high impact interventions through support to the health sector. Family planning was not one of the interventions envisioned in this fund, hence the establishment of the ISP. The HTF will transition to the Health Development Fund (HDF) in 2016. The design of the pooled fund and how it will be coordinated is underway; UNICEF will remain the lead for the HDF, and UNFPA will be in charge of the SRH "pillar." There is discussion about how the HDF will be the main coordination mechanisms for maternal neonatal and child health (MNCH) in Zimbabwe, led by the MoHCC, for resources both within and outside the pooled fund. The HDF is considered to work effectively, because the Zimbabwe health system has the structure and "anatomy" in place, even if the resources are constrained. The idea would be to streamline the coordination process, problem-solving and decision-making; and also include partners that are not part of the HDF (e.g., USAID), but who are providing parallel funding. However, several KIs indicated concern about this being the coordination mechanism for all activities within and outside the pooled fund. Concerns about UNFPA coordinating SRH were expressed, because of the track record with the ISP (and the decision to establish a neutral coordinating mechanism instead of having UNFPA continue to coordinate while also implementing pillar 2). Others expressed concerns about the lack of consultation about the mechanics of how the HDF might work in practical terms.	CO, Development Partner and NGO staff
Given the general lack of leadership and coordination on the part of the ministry and ZNFPC regarding SRH and the large number of FP activities supported by the various programmes and donors in Zimbabwe, several KIs mentioned the need for mapping, particularly for youth activities. ZNFPC called a meeting in 2015 to review mapping, but it was cancelled without explanation. We later learned from UNFPA that it was cancelled because the ZNFPC realised (with UNFPA assistance) that they required more preparation for the meeting and in the meantime (just recently), ZNFPC has shown more interest and effort to support effective coordination.	CO and Development Partner staff
The MoHCC considers UNFPA a valued partner on the ISP, but does not deem the staff to be "technical" or any more technical than the ministry staff themselves, in part because some UNFPA CO staff previously worked at the ministry. They would like to see UNFPA draw technical input and innovation from the RO or HQs, and to support greater knowledge management and south-to-south exchanges. UNFPA has "stayed loyal" through the years, and is appreciated for its more streamlined funding than UNICEF under the HTF. Funding from the HTF pooled mechanism is released when all requirements are completed,	MoHCC and ZNFPC staff

whereas UNFPA support is considered to be more closely linked to the ministry's immediate implementation needs through the existing support via the ISP.	
UNFPA supported the establishment of the National ASRH Coordination Forum, which coordinates ASRH programs and the Young People's Network for HIV and AIDS. This forum promotes meaningful participation of young people in ASRH and HIV prevention. The Young People's Network has been decentralised in all 10 provinces in the country and to 16 districts. It has worked to mobilise young people for the uptake of HIV prevention services such as male circumcision and treatment of STI, and to raise awareness as well as to advocate for young people's sexual and reproductive health rights in national and international forums.	CO staff
In the public sector, the ZNFPC has been providing ASRH services in 16 districts around the country. It has also been noted that the response to ASRH needs has been varied due largely to many players responding in their own unique ways, in an uncoordinated manner. The country is making efforts to improve this response. A forum of key stakeholders in adolescent sexual and reproductive health (ASRH) has therefore been established to provide a coordinated approach to ASRH. The forum will serve to improve effective and efficient ASRH programme implementation to secure the right of young people to good sexual and reproductive health. The ASRH coordination forum will be closely linked to the already existing National Reproductive Health Steering Committee.	(WHO Zimbabwe 2009)
There is a national committee that works on contraceptive security – the Reproductive Health Commodity Security Committee. Groups represented on the committee include: MoHCC reproductive health Unit, the Logistics Unit of the Directorate of Pharmacy Services, ZNFPC, NatPharm, Medicine Control Authority of Zimbabwe, Crown Agents, USAID/DELIVER, PSI, PSZ, Elisabeth Glazer Pediatric AIDS Foundation (EGPAF), USAID, and DFID. It meets one to two times per year, led by ZNFPC.	CO, NGO and Development Partner staff
The 6th CPE concluded that the work of UNFPA partners is appreciated and answers practical and strategic needs of communities, however, they have not been fully exploiting the consortium of IPs. UNFPA did not coordinate the introduction of IPs into communities. The "weak implementing partner (IP) coordination" meant that they could not benefit from exchange and joint assessment and review of their work, nor could they "collectively deal with emerging issues and share information on effective programming strategies and approaches". Thus, they are not able to build on and harness the gains that the other partners are making to maximize impact. This conclusion is aligned with data collected from KIIs.	(Jackson, Njovana et al. 2014: 64)
UNFPA financially and technically supported the national RH steering committee meetings. UNFPA chaired the national male circumcision policy and advocacy technical working group. UNFPA also actively participated and technically contributed to various fora such as the Health Development Partners Group, Multi-Donor Trust Fund and Health Cluster. The CO also financially and technically supported National Health Information System Technical Committee meetings.	(UNFPA Zimbabwe 2009)

Assumption 2.2: **UNFPA and other donors (including those influenced by UNFPA advocacy) have effectively supported national governments to assume ownership of family planning-related policies and programmes.**	**Information sources:**
Indicators: • Existence of national FP policy and programme (separate or integrated with other SRH areas) • National budget allocations to FP • Number of other major donors actively supporting national ownership of FP, (on their own account or as a result of UNFPA advocacy).	
Zimbabwe has a favourable policy environment for the implementation of the MNCH programmes, including family planning. In addition to the FP Strategy (see Assumption 2.1), there is the Reproductive Health Policy (undated), a Maternal and Neonatal Health (MNH) Assessment and the 2007 to 2015 MNH costed "Roadmap". The FP strategy aims to guide the provision of quality FP services within the framework of sexual and reproductive health and rights. The major issue is increasing commitment of resources for the FP effort. However, the health system is seriously off track to meet health related millennium development goals (MDGs) as a result of the turbulent political and economic times and the under-investment in the health sector, leading to diminished institutional capacity, infrastructure deterioration, commodity shortages, outmigration of health workers and resulting in a deterioration of health indicators.	(DFID 2014)
UNFPA provided financial support for the development of the MNH Roadmap 2007-2015, which provides a strategic framework for addressing MNH challenges and scaling up the national response in line with MDG targets. The Roadmap calls for comprehensive MNH, FP, HIV and AIDS, and STI services. FP is the first pillar, with the overall goal to develop and sustain a strong FP programme response to prevent unwanted pregnancies and encourage child spacing. The plan identified four major activities to increase the availability and use of youth friendly FP and HIV prevention services: capacity building of health service providers on SRH, FP, and comprehensive HIV prevention services; strengthening youth friendly SRH services; expanding CBD systems; integrating STI, HIV and AIDS, and FP programmes and services; community mobilisation to increase demand and use of SRH and FP services.	(MoHCC 2007)
The financial commitment of the government under FP2020 is stated as follows: *"The family planning budget, including the procurement of contraceptive commodities, will be doubled from the current 1.7% to 3% of the health budget. This includes support for improved access for women and girls from the poorest wealth quintiles, including the removal of user fees for family planning services by 2013. Zimbabwe will improve method mix and strengthen the integration of family planning with reproductive health, HIV and maternal health services; develop innovative service delivery models to meet the needs and rights of adolescent girls; and reduce their unmet need from 16.9% to 8.5% by 2020. Zimbabwe will strengthen public-private partnerships, including civil society organizations in the provision of community-based and outreach services and implement a national campaign to increase national awareness of family planning, and health worker training and sensitization".*	(UKAid 2013: 16)

A funding gap analysis conducted by the Futures Group (brokered by UNFPA) estimated that the total cost of delivering FP services in 2014 was $9.9 million (including both commodity and non-commodity costs) and that this will grow to US$12.3 million annually by 2020 given population momentum. Regardless of the rate of scale-up, there are no current pledges to fund family planning beyond 2017 since donors in Zimbabwe commit resources only a few years in advance. However, even near-term planned funding for FP is estimated to fall short; the funding gap in 2014 is about US$1.2 million. Only two donors—DFID and USAID—have committed funding for family planning after 2014, leaving a gap of US$23 million from 2015 to 2017.	(Health Policy Project 2014)
The national budget allocation for FP is stated as US$7 million and is allocated to ZNFPC. Most of this funding goes for salary support; therefore, the bulk of funding for FP comes from donors. Commodities are 100 percent provided by donors, with USAID providing condoms, UK for oral contraceptives (OCs), and UNFPA for long-acting methods (coming from the US$6.6 million allocated from GPRHCS under the 6th Country Programme. The commodity budget is approximately US$3 million. USAID estimates its funding allocation for FP includes US$2 million in support to Population Services-Zimbabwe (the MSI local affiliate) and another US$6-7 million for condoms. Both the UK and the US have regulations against the direct support for the public sector, so funds are channelled through NGO implementing partners or arrangements.	CO and Development Partner staff
UNFPA and USAID are working to engage the MoHCC in the FP2020 process and travelled as a team together to the Istanbul FP 2020 focal point meeting in March 2015. Interestingly, ZNFPC was not invited to participate in the meeting.	CO and Development Partner staff
DFID called for a continued donor dialogue to ensure that the long term contraceptive funding strategy is in place beyond 2015. DFID will end this programme with a health contraceptive buffer stock in December 2015 but there is currently no funding plan beyond 2015. This problem is compounded by the fact that UNFPA is unable to buy the oral contraceptive brands currently used in Zimbabwe because they are not pre-qualified. There has been recent agreement, however, that UNFPA can supply *Marvelon*. DFID is looking to Crown Agents to facilitate this discussion.	(DFID 2014: 13)

Assumption 2.3: **Programmes are culturally/socially, institutionally and economically sustainable in different national contexts.**	**Information sources:**
Indicators: • Trends in modern contraceptive prevalence rate (mCPR) • Percent of FP provided by the public, NGO and private sector • Government spending as percent of total expenditure on FP • Evidence of participation by CSOs (including end user groups, VMGs) and private sector in FP policy, planning and accountability mechanisms at national level.	
The use of modern methods rose steadily post-Independence, but progress has plateaued in recent years. The Zimbabwe Demographic Health Survey (DHS) in 2010/11 estimated that the CPR among married women remained stagnant at 59	(MoHCC 2014)

percent. Further, the method mix is skewed predominantly towards short-term methods, with 41 percent using pills, 8.3 percent injectables, and 4 percent using long-acting and permanent methods. It is estimated that 73 percent of FP services are offered through the public sector, followed by 14 percent from the private medical sector, 4 percent from mission facilities, 4 percent from retail outlets and 2 percent from "other."	
Government spending on FP is estimated to be 1.3 percent of the health budget. (See Assumption 2.2)	GoZ FP 2020 commitment
It is estimated that all funds allocated for contraceptives, US$12.1 million, are from donors.	(JSI Deliver 2014)
Having government counterparts lead the Steering Committee for the HTF and RBF initiatives is a step in assuring sustainability in a context where the donors are financing the health sector in a large way. These two efforts are complementary, as the WB is implementing the RBF in 16 districts, and the HTF+ (the Health Development Fund, currently under development for an expanded scope which will incorporate the components of the ISP and bring UNFPA and the other ISP partners into the fold) will roll out the RBF financing mechanism to an additional 44 districts. The main "client" of RBF is the Ministry of Finance, and the medium to long-term picture is that RBF will be incorporated into the way the MoHCC "does business." Whether it is financially sustainable will depend on the macroeconomic picture in Zimbabwe. The government is interested in adopting results-based financing for health services.	Development Partners
With regard to sustainability, contributions by UNFPA include key policies and strategies, facility refurbishment, and achievement of crucial surveys (census and upcoming DHS); and, to a lesser extent, some training. However, until the national socioeconomic situation substantially improves, maintaining facilities and equipment, procurement, further training and mentoring, and coordination posts in the MoHCC will not be sustainable without external support, and exit strategies are not evident. Gains in gender equality and to reduce GBV are unlikely to be sustained without continued and scaled up efforts by UNFPA and other partners.	(Jackson, Njovana et al. 2014)

Area of Investigation 3: Brokerage and Partnership

To what extent has UNFPA acted as a broker at global, regional and country levels to promote family planning, acting in partnership with the public, private and non-state sector service providers?

Data collection methods:
Document review
Key Informant Interviews (KII)
Focus Group Discussions (FGD)
Site visits

Assumption 3.2: **At the country level, UNFPA COs brokered partnerships between public agencies, CSOs and private sector entities to promote FP and its integration with other SRH programmes.**	**Information sources:**
Indicators: • Number and type of partnership agreements, MOUs • Range of partners (government, CSO, private sector) • Effectiveness of UNFPA in triggering change and mobilising resources.	
UNFPA supported ZNFPC to develop an FP Strategy for 2015-2020 (still in draft, not yet approved by the MoHCC) which will serve as the framework for a costed implementation plan for the Zimbabwe government commitment to FP2020. UNFPA has brokered technical assistance from the Futures Group to analyse the resource gaps required to meet the Government of Zimbabwe FP2020 commitment, as well as from FHI to support the development of the plan. The overarching values for the FP strategy include universal access, contraceptive choice and rights, efficiency and accountability. The key objectives are to create an enabling environment; strengthen the supply chain; improve availability and access to quality, integrate FP and SRH services (defined as integration of FP services with MCH and selected SRH and HIV& AIDS services); improve demand for FP and related SRH services; and improve monitoring, evaluation and research for FP services in Zimbabwe.	CO, Government, NGO and Development Partner staff (MoHCC 2014)
The role that UNFPA plays in supporting ZNFPC requires it to serve as a broker with other key partners and donors on the overall issue of whether and how to support its capacity so that it can serve the FP programme effectively. There is a broad consensus among stakeholders that ZNFPC should be restructured although this will be difficult politically due to the large number of staff positions that are supported in the budget. The National FP Strategy should be the blueprint for this to happen, particularly to strengthen capacity in monitoring, evaluation and research as a key and necessary component for ZNFPC to play its important coordination role. ZNFPC functions as the training institute, manages the delivery team topping-up (DTTU) system, and supports a diminished network of community-based distributors. The role of ZNFPC as the training	CO, Government, NGO and Development Partner staff

and certification authority is considered by stakeholders to be ineffective. Partners complained about the high cost of certification and the poor quality of training (although we have no evidence to substantiate these claims). The DTTU is considered to be highly effective, but this could be transitioned to the National Pharmaceutical Company of Zimbabwe (NatPharm), especially given the desire to integrate the DTTU across eight different commodity systems. A key challenge in supporting the ZNFPC is that neither the UK nor the US governments can provide direct funding support for the government or parastatal organisations in Zimbabwe, leaving UNFPA in the logical position as a multilateral to provide direct support and possible leverage for changes. Stakeholders felt that restructuring must be MoHCC-led, and not donor-led, and should include all stakeholders, including the private sector. The MoHCC is supportive of the overall role of ZNFPC and would like to see UNFPA collaboration with ZNFPC improve, in particular to build the capacity of ZNFPC for coordination of the national FP strategy.	
UNFPA partners with a range of CSOs to address GBV, such as Padare and Musasa. However, this work does not include a robust family planning component even through there are opportunities to strengthen the integration of contraceptive information and services within the GBV services offered by these groups.	CO and NGO staff
Partners commented on the role UNFPA has played to broker resources, as in the case of the ISP. Given that the bulk of programme resources managed by UNFPA are non-core (90 percent), which attests to the COs ability to mobilise resources. Further, UNFPA mobilised approximately half of the funding from eight donors to complement USAID funding of the ZDHS. Partners felt that this is an important role for UNFPA to play in the future, particularly for FP given its visible leadership role in FP2020.	CO, Government and NGO staff

Assumption 3.3: **At the country level, The visibility of UNFPA is sufficiently high at global, regional and country levels to bring together potential partners to increase commitment to family planning.**	**Information sources:**
Indicators: • Other stakeholders and partners recognise the comparative advantages of UNFPA, its positioning and its potential contribution at global, regional and country levels, and respond to UNFPA initiatives in bringing them together • UNFPA participation and role in policy forums, networks, and other partnership mechanisms at global, regional and country levels.	
Stakeholders consider UNFPA to have a strong comparative advantage and a valued partner on gender-based violence programming. See Assumption 5.2 and 5.5 for description of UNFPA work to address GBV.	NGO and Development Partner staff

Stakeholders consider UNFPA to be a valued partner on commodity security, although USAID appears to be playing the lead role given its support for the JSI DELIVER project and condom procurement. The commodity security working group is thought to be the most functional of the different working groups, in large part due to the technical support from JSI and Crown Agents. The DTTU, a critical programme component that has been instrumental in reducing stockouts, is supported by USAID and DFID, with implementing partners JSI and Crown Agents. (See Assumption 8.)	CO, Government, NGO and Development Partner staff
See Assumption 2.1 on coordination regarding the ARSH Forum	

Area of Investigation 4: Enabling Environment

To what extent has UNFPA supported the creation of an enabling environment at national and community levels to ensure family planning information and exercise of rights?

Data collection methods:
Document review
Key Informant Interviews (KII)
Focus Group Discussions (FGD)
Site visits

Assumption 4.1: **UNFPA has identified key enabling factors in different country contexts and developed effective interventions to strengthen these.**	**Information sources:**
Indicators: • Identification of enabling factors in CO annual reports • Interventions in CO plans at the national and community levels designed to strengthen the enabling environment • Evidence of enablers being strengthened at national and community levels (e.g. political commitment, community support) • Evidence of how enablers have facilitated strengthened FP information and services.	
UNFPA FP efforts clearly link to the Zimbabwean context and factors that both hinder and support implementation, although these are not labelled “enabling factors” as such but are highlighted in the situation analysis sections of the planning documents reviewed. With regard to FP, the key factors include a relatively high, but stagnating contraceptive prevalence rate of 59 percent with a skewed method mix towards short-acting methods; a high literacy rate and high knowledge and awareness of contraception, but the quality and accuracy of that knowledge is poor; significant unmet need, particularly	(United Nations 2006, UNFPA Zimbabwe 2011b, United Nations 2011)

among youth, leading to a high teenage pregnancy rate; a generalised HIV epidemic, albeit one that is in decline; one of the highest cervical cancer rates in the world (47.4 per 100,000 women); persistent gender inequalities and a high percentage of women who have experienced physical or sexual violence (47 percent), despite several gender-responsive laws and policies; and a diminished health system and a decline in health indicators overall, due to the major political and economic challenges faced by the country between 2000 and 2008-9, and the resulting resource shortages and brain drain.	
The context and challenges inform the design and implementation of work conducted by UNFPA under the ISP, which includes interventions to build the capacity of the health system to provide integrated SRH services (FP, Cervical Cancer, youth-friendly services, GBV services). These include provider training in the different areas (for FP this is focused on implant insertions); funding coordinating positions in the MoHCC, including for SRH and FP; procurement of commodities (long-acting methods); community demand generation through home visits and activities implemented by behaviour change facilitators; and youth friendly services/corners. Activities in 2012 and 2013 also included extensive support for policy and strategy development, and guidelines and manuals, exceeding targets. The evaluation found, however, that UNFPA support is limited and not at scale for sufficient impact. Moreover, despite the extensive training conducted, including on FP, the outcomes on sustained improvements in service provision are insufficiently assessed. Although UNFPA is strategically positioned, there is a need to strengthen capacity to measure programme effectiveness beyond the process level in order to assess intended results and demonstrate value for money through a robust theory of change.	(Jackson, Njovana et al. 2014: 24-25)
At the national level, efforts to strengthen the policy and coordination environment for family planning (see Assumption 3.2), including the development of the National FP Strategy, the Resource Gap Analysis and Costed Implementation Plan are intended to increase the resource base and commitment for FP (Assumption 2.2).	
"Feedback from KIs indicates that the support from UNFPA for capacity building in the MoHCC through key coordinating and other support posts has been crucial. These posts could not be supported by the ministry and the training of health providers in STIs, FP, condoms, VIAC and integrated services would not proceed at the same level without UNFPA financial and technical support. Demonstrable benefits have accrued once coordinators were in place, an example being the recruitment of a VIAC and FP programme officer that has helped speed up service provision. Thus investment in these posts has been an efficient and effective use of resources. Ideally, further posts should also be supported. *However, the efficiency of support from UNFPA could be improved, for instance through reinstating quarterly meetings with UNFPA-supported staff that have stopped without explanation in 2014. These fora allowed early discussion of challenges and issues, e.g. regarding transport or regulations on workshop disbursements, and promoted integrated working and synergies, e.g. around training. On the other hand, the inclusion of the ministry staff for the first time in UNFPA's mid-year strategic planning meeting for the next CP was seen as a very positive development. Their inclusion in CO retreats has also reportedly been agreed but not implemented. Various ministry staff also raised other issues such as the need for further ministry staffing posts, and reflected that the balance of numbers of posts in UNFPA CO compared with the MoHCC appeared inappropriate,*	(Jackson, Njovana et al. 2014: 24-25)

given that the key need is for implementers. The heavy workload of UNFPA CO has already been noted, part of which is because the office has responsibility for fund management for work through the public sector".	
UNFPA supported MoHCC and ZNFPC to strengthen access to FP and to address unmet need, including for young people. The most significant activity was support for ZNFPC to develop the Zimbabwe National Family Planning Strategy, currently awaiting finalisation. Training was conducted in long-acting reversible contraceptives (LARCs). UNFPA also fills gaps in contraceptive and drug procurement for STIs and in contraceptive and related commodity procurement, including widening the range of choice within the overall method mix.	CO staff
"UNFPA provided financial and technical support to the review of male and female condom programming in 2012, as the previous strategy was outdated. This review led to the development of the National Male and Female Condom Operational Plan 2012-2015. In the review, condom programming in Zimbabwe is reported as relatively successful compared to many countries, with USAID the main procurer of male and female".	(Jackson, Njovana et al. 2014: 34)
UNFPA support has contributed to the development of *"key strategic documents such as the national health strategy, the national human resources for health strategy, the national health management information system and the costing of the maternal and newborn health road map. These frameworks will guide national efforts aimed at reducing maternal and newborn morbidity and mortality in line with the ICPD and Millennium Development goals."* UNFPA also *"mobilized resources from DFID to revitalize and expand the CBD network in order to increase access to contraceptives by women in disadvantaged areas".*	(UNFPA Zimbabwe 2008)

Assumption 4.2: **UNFPA has successfully supported partners at country and community levels to improve demand creation and access to services, thus enabling people to exercise their rights better.**	**Information sources:**
Indicators: • Improved service use and FP uptake (especially where unmet need is high and by VMG) • Change in unmet need of different groups • Access barriers reduced, equity improved • Increased responsiveness to the needs of VMG.	
Under the ISP, UNFPA carried out demand-creation activities using door to door awareness, clubs for young people, and social media. Community volunteers (behaviour change facilitators) visit households and begin conversations with family members in the private setting in the home. Adolescents are reached with SRH and HIV messages on Facebook and SMS texts. Sista2Sista is a mentoring programme for vulnerable girls, building on their self-esteem and educating them on life skills such as decision-making, negotiation and problem solving, and health-seeking behaviours (FP and HCT). In 2014, UNFPA met its	(DFID 2014, Jackson, Njovana et al. 2014: 29-30, 35)

targets on home visits, but reached only half of the estimated number of girls through Sista2Sista clubs and sex workers through messages on integrated services. FGDs with clubs and BCFs conducted as part of the 6th country programme evaluation (CPE) concluded that there was not sufficient attention to the problems on unintended pregnancy among youth; the Sista2Sista clubs focused on abstinence alone as a safer sexual behaviour and recommended that the balance of discussion and information around pregnancy prevention and HIV/STIs should improve. It was also noted that there was duplication of effort among different NGOs within the same geographical area providing similar services around SRHR, HIV and GBV, but without standardization of messages.	
The innovative strategy in the ISP of door to door home visits to raise demand for services has achieved fairly high coverage in the 26 roll out districts, but how far it translates into access to and uptake of comprehensive SRH and HIV prevention services is unclear. There is a risk that if a one-size-fits-all approach continues regardless of the actual availability of different services, the approach will generate high unmet demand and lose credibility; and one-off visits may not be ideal to achieve results.	(Jackson, Njovana et al. 2014: 63)
UNFPA has a robust set of NGO partners under the GBV component of the ISP at the community level. FP services, however, are not integrated within the services to victims provided by these organizations. (See Assumptions 1.3 and 5).	
"Refurbishment of maternity waiting homes is also coming on track after a slow start. *Women can attend ANC clinics for health education talks; further opportunities for sharing information on neonatal care, exclusive breastfeeding, and other SRH/HIV and/or GBV services could also be provided. The homes visited were also oversubscribed with women sharing beds or sleeping on the floor; levels of need and demand appear not to have been accurately assessed. Despite the drawbacks, however, FGDs with the women were positive; they felt the benefits greatly outweighed the limitations. The effectiveness of the programme over time in contributing to reduced maternal mortality and improved infant survival will be closely monitored and is potentially considerable, provided the actual service provision in the facilities meets minimum standards. In one interview a district nursing officer commented: 'In the past year we have recorded very few maternal deaths at our district hospital compared to past years. Those that we record will be having other illnesses besides emergencies of pregnancy, and so the facility is helping the women.* *Improving midwifery training schools has not taken place as planned by UNFPA, as other partners have come in (under the Health Transition Fund, HTF) who could contribute to this. UNFPA is supporting refurbishment of one provincial hospital for on site training for a range of reproductive health related services, including midwifery, EmONC, FP and other areas.* *However, given that reducing maternal mortality, MDG 5, falls under the mandate of UNFPA within the UN division of labour and that the HTF will come to an end, it is important that UNFPA show considerably stronger leadership and focus on this area than it is at present. This should include overall support for EmONC nationwide at all levels from policy through to service*	(Jackson, Njovana et al. 2014: 28)

provision, training, funding and technical assistance. H4+[96] is a platform from which to develop synergies and learning for what works, and it should help inform the way forward".	
Much of the demand creation work has been within the HIV programme. The CO has worked with critical population groups for social and behaviour change communication and demand generation for services. The integration of HIV with SRHR services are mainly implemented through GBV and for interventions with female sex workers and young people.	CO staff
An assessment of the CBD programme commissioned by DFID and conducted by the London School of Tropical Medicine identified many challenges faced by CBDs. The cadre is currently "frozen" and only approximately 400 CBDs are in place from the workforce of over 900 workers. However, even those workers that are in place are considered ineffective, e.g., for 91 percent of the indicators, CBD served areas performed no better than non-served areas and two percent of the non-served areas performed better than the CBD-served areas. Issues related to large catchment areas, inadequate training and supervision, and lack of monitoring were identified as reasons for poor performance. Others stated that the CBDs are older and do not relate effectively to the target population of youth.	(Valadez and Schwarz 2011)

Assumption 4.3: **HQ and ROs have supported COs in identifying needs, creating an enabling environment and promoting demand and access in different contexts.**	**Information sources:**
Indicators: • Frequency and nature of technical assistance (TA) visits and communications with focus on factors related to creation of enabling environment and promoting demand and access.	
The UNFPA East and Southern Africa Regional Office (ESARO), in partnership with the International Planned Parenthood Federation (IPPF) Africa Regional Office, the regional economic communities (Intergovernmental Authority on Development (IGAD), Southern African Development Community (SADC) and Economic Commission for Africa (ECA) and the Economic and Social Affairs (ESA) regional UN interagency Task Team for young people, is implementing a multi-year initiative (2015-2016) to improve and scale up youth friendly services and enhance quality of care for adolescents and young people. This will be a review to assess the institutionalisation of YFS in pre- and in-service training programmes and a regional assessment of existing YFS services, standards and guidelines. Zimbabwe will participate in this review and is interested in seeing how this can inform strategies for YFS under the 7th CP, given the challenges in implementation and the CO decision to withdraw direct support for youth friendly corners in favour of a more community-intensive approach.	CO staff

[96] H4+ is a multi-UN agency initiative with the goal to help participating agencies (UNFPA, UNICEF, WHO, World Bank, UNWOMEN and UNAIDS) harmonize and unify their actions to strengthen the capacity of national health systems to design and implement catalytic and strategic interventions to improve access to RMNCH information and integrated services, using an equitable, rights-based and participatory approach. H4+ also relies on the division of labour according to Agencies' core competencies along the continuum of care for RMNCH.

The RO and HQ have provided input regarding the experiences of other countries about how to advocate with ministries of planning and finance regarding the demographic dividend and the investments needed to take advantage of the cohort of youth entering their productive years. The RO is currently engaged to support scenario building on the investments needed to lead to increased GDP and to identify trade-offs.	CO staff

Area of Investigation 5: Vulnerable and Marginalised Groups

To what extent has UNFPA focused on the family planning needs of the most vulnerable and marginalised groups, including identification of needs, allocation of resources, and promotion of rights, equity and access?

Data collection methods:
Document review
Key Informant Interviews (KII)
Focus Group Discussions (FGD)
Site visits

Assumption 5.1: **UNFPA globally and at country-level performs situation analyses to identify needs, challenges and rights violations forms, and identifies good practices on how to address these.**	**Information sources:**
Indicators: • Evidence of gender-sensitive needs assessment of target groups for UNFPA supported interventions including identification of rights violations • Availability of accurate and sufficiently disaggregated data for targeting most vulnerable and marginalized groups • HQ/RO TA visits to support assessment, design, implementation, monitoring (including results-oriented monitoring) and evaluation of interventions to address the needs of VMGs • Evidence that good practices have been identified and disseminated.	
The CO is currently conducting a study on youth fertility to better understand the needs of youth for programme design of interventions.	CO staff
The Population and Development Unit of the CO has analysed census data to identify geographic pockets where child marriage is an issue, and trends in child marriage over time in order to support the targeting of interventions related to GBV and child marriage.	CO staff

Under the ISP, a study is being planned to test the difference in outcomes between a standard and an enhanced interventions on antiretroviral therapy (ART) provision (not related to FP).	CO staff
"UNFPA support for adolescents and young people is broad based within different programmes and funding sources, and integrated in all RH outcomes and outputs. The CP addresses all five prongs of the regional and global UNFPA adolescent and youth strategy. *i. Evidence based advocacy: UNFPA Zimbabwe has generated key data on young people, conducted advocacy campaigns and supported networking and coordination* *ii. Comprehensive sexuality education, CSE: UNFPA supported the Life Skills, Sexuality, HIV and AIDS Education Strategic Plan development in the 5th CP and has provided continued support for curriculum review, peer education in tertiary institutions, community dialogues and use of social media to reach young people* *iii. Capacity development for SRH services: this has involved youth friendly service provision with youth corners, peer education and clinic services, and support for youth interact stand-alone services* *iv. Reaching disadvantaged adolescents and youth: establishing Sista2sista clubs for at risk girls and young women through mentors, a pilot programme* *v. Promoting youth leadership and participation: support for the Young People's Network on SRH and HIV, affiliated to the regional African Youth and Adolescent Network, AfriYAN, and also recruiting youth internships with NAC.* *All these are highly relevant to the Zimbabwe situation, as ASRHR have not been sufficiently addressed to date. Linkage with adolescents and young people living with HIV is also being initiated".*	(Jackson, Njovana et al. 2014: 22-23)
"Continued adverse indicators, despite many years of support for ASRHR suggest that the core approach premised on youth friendly corners has not been efficient and effective. The parastatal Zimbabwe National Family Planning Council (ZNFPC) has claimed the space as custodian of adolescent sexual and reproductive health demand creation and service provision, but has been unable to produce statistics for the extent of programme roll out, numbers reached by peer educators and service uptake among adolescents and young people, or the quality of service provision. Many reasons are provided for this (KI interviews), but ultimately the failure to provide robust M&E and quality assurance leads to the conclusion that there needs to be a change in the modalities of reaching adolescents and in the institutional mechanisms and partners involved. At national level, although the Reproductive Health Unit in the Family Health Department of MoHCC reports close collaboration with ZNFPC (and the deputy of the Unit is on the board of ZNFPC), on the ground, KI interviews indicate that confusion does sometimes arise with the respective mandates of the two bodies overlapping".	(Jackson, Njovana et al. 2014: 23-24)

Assumption 5.2: **UNFPA allocates resources to effective and targeted programming for the most vulnerable and marginalised groups.**	**Information sources:**
Indicators: • Number and type of program interventions targeted to VMGs percent of total budget allocations to partner activities which focus on VMGs.	
The country programme defines youth and sex-workers as vulnerable population groups, two key population groups supported through the ISP (80 percent of the UNFPA overall budget). Support for adolescent SRHR addresses all five prongs of the global ASRHR strategy: evidence based advocacy, comprehensive sexuality education, capacity development for SRH services, reaching disadvantaged youth and promoting youth participation and leadership. The demand creation aspects of the ASRHR component were described under Assumption 4.2. Stand-alone youth centres were initiated in 2011, but dropped in 2013 when UNFPA realised that the youth ministry lacked sufficient capacity to implement them effectively.	(Jackson, Njovana et al. 2014: 28)
The sex worker component includes establishing a minimum package for SW service delivery supported by a network of peer educators. Although an annual review by DFID concluded that female sex worker peer education has seriously under-performed, there has been improved support and monitoring, and documented performance has substantially improved (155 peer educators trained by end of 2013; 4,393 female sex workers reached by first quarter of 2014). Technical support from UNFPA is highly valued as is the UNFPA-supported peer education manual.	(Jackson, Njovana et al. 2014: 29) CO staff
The 6th CP includes a major gender equality component that maintains a special focus on the prevention and response to gender based violence. Stakeholders consider UNFPA support at the policy and programme implementation level invaluable as one of the mainstay efforts to end GBV in Zimbabwe. The community dialogues conducted in the gender component of the ISP try to include the whole range of FP issues such as the availability of services and how FP use leads to GBV (mainly related to condom negotiation, issues related to discordant partners). UNFPA conducts advocacy to address child marriage as a form of GBV. Funding for GBV comes from donors, with little or no budget support from the government.	CO and NGO staff
"The Sista2sista clubs under the ISP aim to help empower vulnerable girls aged 10-19 in relation to SRHR/HIV/GBV. FGDs with three clubs found that the girls had good basic knowledge of SRHR/HIV and they reported no longer stigmatizing people living with HIV. However, they focused almost entirely on abstinence alone as a safer sexual behaviour. FGDs with BCFs confirmed the emphasis on abstinence, although they said they introduced condoms also and messaging around monogamy. The data overall are not sufficiently robust and there could be reporting biases, but the findings suggest that the balance of discussion and information giving around HIV, STI and pregnancy prevention needs to improve, taking account of the differing needs of sexually active and non-sexually active members, and age. Also of concern is the growing number of adolescents and young people living with HIV".	(Jackson, Njovana et al. 2014: 30)

UNFPA supports a network of young people in Zimbabwe that addresses HIV and AIDS and SRHR issues. The network is membership based and is affiliated to the regional network, African Youth and Adolescents Network (AfriYAN). In 2012, UNFPA supported a workshop to build the young-people's communications and advocacy skills. As a result the network has hosted a "Meet your leaders" meeting for 70 young people in leadership where they have met with the Vice-President and the Minister of Youth among other leaders. The Zimbabwe Youth Council has also had training in basic planning, monitoring and evaluation and results based management that will enable them to report effectively on their youth programming, including youth interact centres.	(UNFPA Zimbabwe 2012)

Assumption 5.3: **UNFPA promotes reproductive rights and supports capacity development to remove barriers and improve access, quality and integration of FP services with other services for the most vulnerable and marginalised groups.**	**Information sources:**
Indicators: • Rights of, and services for VMGs actively promoted in advocacy strategies with specific attention to gender issues • Type of capacity building interventions to address service barriers and improve access for, and enable exercise of rights by the most disadvantaged groups.	
The Young People's Network on SRH and HIV operates at national, provincial and district levels, and receives funding and technical support for network activities, including coordination meetings and advocacy. This network provides the "youth voice" to the ARSH coordination forum noted earlier.	CO staff
UNFPA collaborates with UNICEF to support comprehensive sexuality education, including life skills, in primary and secondary schools. A curriculum is in place but more work is to be done for it to be fully implemented. Challenges exist, such as resistance by school administrators and teachers to address sensitive topics.	CO and Development Partner staff
UNFPA has supported HIV and STI prevention for FSWs through a programme "Sisters with a Voice" funded via the ISP to address an estimated 13 percent of new infections taking place in sex work settings.	CO staff
In order to encourage positive reporting about sex worker issues and raise awareness about the programme, a media workshop to train journalists was conducted. Articles that appeared in the newspapers soon after the workshop indicated that journalists had taken positively to reporting on sex work issues. The journalists are no longer referring sex workers as prostitutes.	(UNFPA Zimbabwe 2013)
"The Zimbabwean government's denial of adolescents' concerns relating to unwanted pregnancy and STIs stems from cultural views regarding relations between parents and their children. Cultural values also promote sexual purity of young people to the extent that there are significant taboos against pre-marital sex. Yet Zimbabwean youths face dramatic real-life problems as a result of their inability to obtain dual protection methods and information.	(Child and Law Foundation 2002: 7)

The government's failure to adopt an effective legislative and policy framework that ensures access to dual protection for adolescents has tremendous implications for their lives. In Zimbabwe, the onset of sexual activity generally begins before marriage, typically by the age of 17 and often as early as 12. *Unfortunately, while it is clear that Zimbabwean adolescents are engaging in sexual activity both in and outside of marriage, they have a limited understanding of how to prevent pregnancy and reproductive health problems. Lack of access to dual protection methods and information leaves adolescents vulnerable to the grave health risks associated with early onset of sexual activity, including early pregnancy, unwanted pregnancies, unsafe abortions, and STIs, including HIV/AIDS. Moreover, such lack of access seriously affects adolescents' educational, occupational, and social opportunities.* *In an attempt to navigate the conflict between cultural values and the reality of adolescents' lives, the government has issued inconsistent and confusing laws and policies in recent years. Moreover, outdated laws remain on the books, further complicating the situation. In addition to a lack of clarity in the relevant norms, there is also a general tendency for laws and policies to cast parents as gatekeepers for their children's access to reproductive and sexual health services and information, and favor parental control over adolescent reproductive choices. Given that the government is the primary provider of health care, including reproductive health care, the problems adolescents face are compounded when public health service providers interpret applicable laws and policies restrictively".*	

Assumption 5.4: **UNFPA actively encourages VMGs to participate in programme planning, implementation and monitoring and VMGs receive capacity building to this end.**	**Information sources:**
Indicators: • Evidence for gender sensitive participation by VMG • Evidence for UNFPA support for training in participation.	
A community initiative under the ASRH component is the support to the Young People's Network on SRH and HIV (set up in 2008) which has 1,800 members and operates at national, provincial and district levels and provides a youth voice in different forums. The influence of this network has not been adequately assessed.	(Jackson, Njovana et al. 2014: 29)
"For the female sex workers (FSW), UNFPA is supporting a new initiative to train FSW peer educators as paralegals, with half of them recently trained and the remainder to follow. All this is building up towards the FSW network doing their own outreach and support work around human rights and GBV independent of the host organization. This is a significant development and supportive of sustainability and is good practice to share within UNFPA programmes".	(Jackson, Njovana et al. 2014: 48)
"In 2008, UNFPA, with funding support from the European Commission grant, continued to provide financial and technical assistance to the Zimbabwe National Family Planning Council that oversees the provision of Youth Friendly Sexual and	(UNFPA Zimbabwe 2008)

Reproductive Health (YF SRH) services in sixteen targeted districts countrywide. The project is both health facility- and community based. UNFPA specifically advances payments for project implementation, coordinates meetings, provide monitoring and evaluation technical support and facilitates linkages between ZNFPC and other organizations involved in the provision of SRH services to young people. In 2008, UNFPA also provided financial and technical support towards the establishment of the Young People's Network on HIV and AIDS. Following the establishment of the network at the national level, UNFPA financially and technically supported its decentralization to the provincial level. UNFPA provided financial support that enabled the Young People's Network on HIV and AIDS to commemorate the International Youth Day. The CO also provided financial and technical support towards the development of the network's website that is still in its infancy. - During the period under review, the CO provided financial and technical support to the MoHCC for carrying out the baseline assessment of Adolescent Sexual and Reproductive Health services to provide information that would be used for the development of the ASRH strategy and coordination forum".	
The CO provided financial and technical support for advocacy activities such as the World AIDS Day whose theme was "universal access to human rights, together we can make it". In order to increase awareness among policy makers, UNFPA supported a training workshop for senators on HIV and AIDS. UNFPA has facilitated setting-up a sex worker drop in centre in Harare. Four more drop in centres are being established along the Harare-Nyamapanda Highway. Forty-five peer educators have been trained to mobilise sex workers to access services at the drop in centres. The services include HIV prevention, RH information skills, STI screening and treatment, HCT, and primary health care for minor children of the sex workers. Linkages have also been established with PSI (condom distribution), Zimbabwe Lawyers for Human Rights (legal counsel) and Police Victim Unit (legal counsel). This work continued in 2012-2013 under the Integrated Support Programme.	(UNFPA Zimbabwe 2009)
"*A youth Festival to commemorate the world at 7 Billion was organized with technical and financial support from UNFPA. The festival engaged young people in dialogue on issues of sexual and reproductive health including family planning, unplanned pregnancies, and dangers of unsafe abortions. The Minister of Youth dialogued with young people who called on the state and civil society to commit to 7 Actions for young people; • Accessible and affordable youth friendly health services including for SRH • An accessible and non–partisan fund that addresses political, social and economic development of youth. • Youth participation in decision-making including by the marginalized. • Provision of comprehensive SRHR education for young people in and out of school • Provision of student's grants for tertiary education and subsidy of primary and secondary education to ensure access to education by all young people. • Research on the needs of young people to ensure implementation of evidence based programs for young people. • Harmonization, review and implementation of policies that govern programming and service delivery for young people to ensure these are indeed youth friendly".*	(UNFPA Zimbabwe 2011a)

Assumption 5.5: **Access to and utilisation of services by VMGs, according to their sexual and reproductive intentions, has improved.**	**Information sources:**
Indicators: • Documented evidence on improved VMG access and utilization of services (link with area 1 - integration) • VMG user (women and men) satisfaction with service access and quality.	
The sex worker programme is a national programme with six static and 30 outreach services; it has reached 20,000 individuals with an integrated approach, including referrals for GBV.	CO staff
PADARE works with men and boys to end all forms of violence against women and girls. It works to challenge the patriarchy from limiting women's opportunities in all sphere of life and promotes positive masculinities. The theory of change for PADARE is centred on community mobilisation and having men advocate for and influence national level policies in a constructive, feminist orientation. It considers itself both a movement and NGO to reach as many men as possible to assist women to access their rights. With respect to family planning, it works to sensitise boys on where to go for youth-friendly services, and makes referrals to YFS at PSZ. PADARE appreciates UNFPA technical support and approach to partnering, however, monitoring and evaluation support is not adequate.	CO and NGO staff
Musasa received UNFPA assistance for ten years for GBV prevention and services; support has evolved over time to include counselling, shelters, one-stop centres, community mobilisation and dialogues. Fifteen thousand women attend one-stop centres that provide training in life skills, medical services, legal aid and referrals; of these, 2,000 are considered to be under threat of violence and therefore referred to shelters. At a shelter, individuals receive medical care, protection orders, and a rehabilitation/ reintegration plan is developed. In shelters, 60 percent of clients are aged 12-24; adolescents spend more time in shelters than their adult counterparts. Family planning is not integrated into the one-stop shelters; stakeholders noted a need to help ZNFPC integrate GBV into FP and primary care, and for NGO partners to add FP services into the GBV services on site and not via referral.	NGO staff
Sisters with a Voice is a national sex worker programme that provides HIV and STI services to sex workers. In 2012, 3,802 sex workers visited clinical sites to access clinical and non-clinical services including RH services, STI treatment, VCT, family planning, primary health care, assistance with referral to HIV treatment and care services, as well as male and female condom provision. 1,360 clients were treated for STIs, 967 were tested for HIV while 933 of 1373 clients reported having used condoms. Non-clinical services provided included: HIV and AIDS and SRHR awareness through peer educators; SW sensitisation to empower and collectivise them to speak and act as one for realisation of their rights; and advocacy with local key stakeholders including Zimbabwe Republic Police (ZRP) Victim Friendly Unit officers to provide an enabling environment for the respect, protection and fulfilment of SW rights as well as access to legal representation through the Zimbabwe Lawyers for Human Rights (ZLHR).	(UNFPA Zimbabwe 2012)
HIV testing uptake by sex workers in the UNFPA-supported sex workers clinic has likely improved. • A few male sex-workers have presented themselves at the clinic	(DFID 2013: 11)

• With support from UNFPA, CeSHHAR (a local research and service-delivery NGO) has increased the number of sex-worker clinics from 13 to 16 in the first six months of 2013 • CeSHHAR, with funding from UNFPA in collaboration with University College London, the London School of Hygiene and Tropical Medicine and RTI International, is undertaking a clinical trial to enhance ART provision for sex workers through on-site provision of treatment and prevention of exposure prophylaxis.	
Direct feedback from beneficiaries was part of the DFID annual review as interviewed by the team leader. For example, interviews with sex workers revealed satisfaction with female condoms, including the price. Sex workers waiting outside a clinic in Murehwa, noted that they were happy with dedicated and free services offered, as they felt stigmatised in regular public health services and they also had to pay for FP there. In a meeting of a Sista2sista group in Gwanda, where participants were midway through the yearlong programme, a young girl said that the group made a difference to her self-esteem and life planning. In a shelter for victims of gender-based violence, the group was surprisingly young and many had infants or were pregnant. They spoke of how the centre took good care of them.	(DFID 2014: 15)
Beneficiary feedback is positive, with sex workers feeling empowered and valued. The programme includes strategic operations research to measure outcomes resulting from HCT, and for impacts on new HIV infection and treatment uptake, supported by UNFPA. It also includes an innovative programme to address GBV and the human rights of FSW. It is acknowledged internationally as good or best practice that UNFPA should continue to support.	(Jackson, Njovana et al. 2014: 78)

Area of Investigation 6: Rights-Based Approach

To what extent has UNFPA implemented a human rights-based approach to family planning, in particular regarding access to and quality of care, and through support from HQ and RO for a rights-based approach in country?

Data collection methods:
Document review
Key Informant Interviews (KII)
Focus Group Discussions (FGD)
Site visits

Assumption 6.1: **UNFPA staff and key partners have a shared understanding of the meaning and importance of a rights-based approach to FP.**	**Information sources:**
Indicators: • Identification of definitions/descriptions of rights-based approaches	

• Perception of UNFPA and partners' staff of the meaning and importance of the rights-based approach.	
Human rights in FP is considered by the UNFPA CO as an *"enabling factor for the bulls eye,"* and meeting the sexual and reproductive health and rights of hard to reach populations and youth is understood as an important part of the UNFPA mandate. CO staff framed human rights implicitly in terms of universal access and equity. UNFPA focuses much of its work on vulnerable and marginalised groups (VMGs), including youth and commercial sex workers (CSWs). However, one staff member indicated that human rights were "*mechanically*" used by UNFPA in documents; in other words, it does not translate into specific action within programmes. *"It comes down to ensuring choice/method mix and reaching marginalized populations."*	CO staff
UNFPA work on gender explicitly includes a human rights-based approach (HRBA). HRBA was defined as an approach that ensures that beneficiaries are offered the service from a perspective that they are entitled to it under human rights agreements; that the services are matched to individual needs, that individuals have the right to quality services, and that this should also apply to all SRHR services.	CO staff
In Zimbabwe, GBV levels are unacceptably high and remain a serious impediment to the empowerment of women and girls and their participation in development. Per the ZDHS 2010-11, 42 percent of women in Zimbabwe have experienced either physical, emotion and/or sexual violence at some point in their lives.	(ZIMSTAT and ICF International 2012)
UNFPA supported the government to develop the National Action Plan to End Rape and Sexual Violence launched in 2014 and the 2012-2015 National Gender-based Violence Strategy. Thirty percent of women aged 15-49 have experienced physical violence since age 15, and 18 percent of women experienced violence within the past 12 months. The 2012 census indicated that 31 percent of girls and boys were coerced into marriage. This is due to social norms such as denial of conjugal rights, manhood and bride price, household poverty, religious practices such as infidelity and polygamy and harmful traditional practices such as forced virginity testing.	(United Nations 2015)
The strategy aims to reduce GBV by 20 percent through four key results areas: 1. Prevention: through an enabling environment for non-tolerance of GBV 2. Services: improved utilisation of comprehensive quality services for the protection, care and support of GBV survivors 3. Research, documentation and monitoring and evaluation 4. Coordination, including increased participation of stakeholders in national GBV prevention and response	(MoWAGCD 2012)
Human rights is mentioned in the National FP Strategy 2015-2020 and will be featured in the Costed Implementation Plan. A rights-based approach is defined as "*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".* The National FP Strategy states its mission to provide rights-based integrated quality FP services through innovation and coordination. Stated values include universal access, rights	(MoHCC 2014: 5, 18, 31-32)

and choice based, efficiency and accountability. *"Rights and choice-based" FP is defined as "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 SRH matters".* Strategies related to a rights-based approach include improving the capacity of health workers to provide quality SRH services, addressing cultural and religious perceptions to identify critical barriers, enhancing equity for vulnerable groups, and include within the communications and advocacy strategy attention to young people, people living with disability and HIV, rural communities and other vulnerable communities.	
"There are several challenges/concerns in family planning. One includes the incentive payments under results based financing (not funded by this programme). These were recently reduced to $1 short term and $5 for long term methods. These payments are modest relative to the payments for other services. Women have the right to make an informed contraceptive choice after receiving individual counselling from a trained counsellor. Incentives risk skewing the providers' motivations to push one family planning method over another and so should be monitored. In addition, there were some issues in Mutoko District Hospital where some family planning outreach clients were coming to the hospital for Jadelle premature removal. Full and thorough Jadelle counselling is critical so women understand the side effects and are sure that they want to choose the method. These clients had been served by private sector outreach providers – again something to watch and investigate locally. Inter uterine contraceptive device (IUCD) training at the site has not been possible because there were inadequate women wanting IUCDs on which to practise. Finally, charging for family planning in the public sector remains a barrier for many women in Zimbabwe, though fortunately this is reducing in frequency".	(DFID 2014: 11)

Assumption 6.2: **UNFPA programming incorporates human rights principles in the assessment, design, implementation and evaluation of FP program interventions.**	**Information sources:**
Indicators: • Evidence of a rights-focused needs assessment, quality assurance mechanisms, participatory processes, and accountability mechanisms within programmes • Evidence of attention to barriers and protocols for addressing coercion • User satisfaction with FP access and quality (men, women, VMGs).	
In the family planning activities, the programmatic focus is on ensuring access to long-acting methods as a means of broadening method choice. This is mostly done through provider training and commodity procurement. Beyond a 6th week trainee follow-up, there was no mention of quality assurance mechanisms, discontinuation rates (although anecdotally, there were high levels of requests for implant removals because of unexpected side effects), or concerns about the incentives for implants ($50 per insertion, then reduced to $5 per insertion) via the RBF project. Stakeholders mentioned concerns about the impact these insertions had on provider behaviours and the potential for biasing provision towards implants. Anecdotes	CO, Government and Development Partner staff

about providers underplaying information about side effects were common among stakeholders and some tied the perceived high rates of discontinuation to the incentives for implants. Other than with USAID, there was no mention of concern of vulnerabilities in choice and voluntarism related to a push on long-acting methods or the incentives for implants.	
"Gender-based violence (GBV) is a gross human rights violation that particularly impacts women and children. GBV is exacerbated by emergencies, including displacements caused by both sudden onset disaster and conflict. Within the Humanitarian Reform agenda, UNFPA and UNICEF have been designated as co leads for the GBV Area of Responsibility (AoR) of the Protection Cluster. Thus, both agencies are mandated to take action to promote an effective response to GBV at the field level. During the recent GBV AoR annual retreat held in Geneva in January 2009, and the Regional GBV Task Force Steering Committee meeting in Nairobi held in January 2009, a joint UNICEF and UNFPA GBV field mission was suggested in response to the on-going crisis in Zimbabwe". Nature and scope of problem: • Sexual violence • Sexual exploitation (transactional sex and forced prostitution), including pressure by parents • Sexual violence in schools • Intimate partner violence • Harmful traditional practices • Access to services (fear of disclosure, stigma and discrimination, lack of information on where and how to access services), lack of trust of police, local clinic • Prevention and response – need for greater community education and awareness on GBV.	(Marsh, Kenny et al. 2009: 5, 10-14)

Assumption 6.3: **UNFPA is developing a body of evidence and lessons learned regarding human rights-based approaches for FP.**	**Information sources:**
Indicators: • Identification of evaluation and research and/or briefs on lessons learned related to human rights-based programming.	
The CO did not share documentation or evidence of operations or other research to contribute to the data collected through this evaluation. It was noted in the 6th CPE that UNFPA has started to work with the Zimbabwe Community Health Intervention Research Project and the Biomedical Research and Training Institute to conduct operations research. The CPE noted that the Reproductive Health Unit does not have the capacity to undertake OR, and as a result, there is insufficient data to allow the desired analysis of intended results and contributions by UNFPA in this and in other areas.	(Jackson, Njovana et al. 2014)

Assumption 6.4: **Country offices receive and put into practice technical guidance from HQs and ROs to support rights-based FP.**	**Information sources:**
Indicators: • Number, frequency and type of TA provided • RO plans address capacity gaps and support needs of COs, and ROs provide timely support • CO strategies and programmes reflect current technical guidance and best practices for rights-based FP.	
No data was collected on this assumption	

Assumption 6.5: **Rights holders consider that duty bearers understand their rights to family planning and SRH.**	**Information sources:**
Indicators: • User satisfaction with FP availability and quality (men, women, VMGs).	
DFID noted in its annual review several recommendations from previous reviews were not completed. This included a recommendation to UNFPA to conduct additional analysis of the target groups with unmet need for family planning and subsequent advocacy for (i) expansion of reach with family planning to these groups and (ii) efforts for additional uptake of long acting and permanent family planning methods. DFID discussed this at length with UNFPA. The analysis will largely be covered by planned work of UNFPA with the Futures Group, plus other analysis that UNFPA is planning to conduct or contract out.	(DFID 2014: 14)

Area of Investigation 7: Modes of Engagement

To what extent has UNFPA adapted its mode of engagement[97] to evolving country needs in different settings, using evidence and best practice?

Data collection methods:
Document review
Key Informant Interviews (KII)
Focus Group Discussions (FGD)
Site visits

Assumption 7.1: **UNFPA COs monitor changes in country context and needs over time and adapt their mode of engagement and programme development accordingly.**	**Information sources:**
Indicators: • Number of visits and TA input from ROs and HQ to collection and analysis of evidence on changing needs in FP engagement • Other activities (staff workshops, training, etc.) conducted by HQ and ROs to support program innovation and/or incorporation of best practices into programmes.	
ESARO is supporting the CO to assess its strategy for YFS as part of a regional assessment, the purpose of which is to assess pre- and in-service training programmes for health providers in the 23 countries in the East and Southern Africa region, including Zimbabwe. The assessment will serve as a baseline and provide recommendations for the development of national human resource training policies and a regional State of the Art (SOTA) in-service and pre-service YFS training courses which can then be adopted by the Regional Economic Communities, training institutions and ministries of health in the region.	(UNFPA 2015: 2)

Assumption7.2: **UNFPA monitors changes in country context and needs over time and adapt their mode of engagement and programme development accordingly.**	**Information sources:**
Indicators: • Evidence of continued monitoring of country context and needs • Evidence collected and analysed on the appropriateness of the mix	

[97] "Modes of engagement" refers to the four modes of engagement in the current UNFPA strategic plan (support for service delivery, capacity building, advocacy, knowledge management). These modes of engagement have been included in the ToC diagram and discussion in section 3.2.1

• Change of engagement modes used over time • Existence and frequency of coordination on engagement modes with national stakeholders and development partners.	
UNFPA CO reported that achievements in 2009 were a result of strong collaborative efforts and use of comparative advantage among health development partners in Zimbabwe. UNFPA used its comparative advantage in the area of reproductive health to address RH needs of women and girls during the humanitarian crisis. Through supporting the salary top up scheme and procurement of vital RH commodities, maternity wards at some central hospitals remained open during the health crisis, thereby averting a potential maternal and neonatal health disaster. An important lesson learnt is that programme implementation requires flexibility that enables introduction of new strategies, such as the payment of retention allowances to health workers, as this has helped avert a complete shut down of maternity wards in central hospitals. The failure by the inclusive government to conclude negotiations on outstanding global political agreement issues resulted in limited external resources to support the resuscitation of the nearly collapsed health sector. Skilled health professionals continued to leave the country due to poor remunerations and working conditions as the economic situation continues to improve at the snail's pace.	(UNFPA Zimbabwe 2009)

Area of Investigation 8: Supply-side Activities

To what extent has UNFPA support for supply-side activities promoted rights-based and sustainable approaches and contributed to improved access to quality voluntary family planning?

Data collection methods:
Document review
Key Informant Interviews (KII)
Focus Group Discussions (FGD)
Site visits

Assumption 8.1: **Provider training supported by UNFPA is client-centred, quality-focused and promoting rights and freedom of choice in family planning.**	**Information sources:**
Indicators: • Nature of training programmes offered by MoH and other partners • Behaviour change communication and client counselling included in training, including gender perspectives.	

The family planning effort by UNFPA has "two pushes", increasing access to and use of implants and IUCDs via interventions designed around commodity and training supported by GPRHCS. The focus on long-acting methods is to improve contraceptive method choice, given the overreliance in the method mix on pills.	CO staff
Quality assurance (QA) does not feature prominently in UNFPA descriptions of the ISP, its major capacity building effort in SRH and FP service delivery. QA is a major feature of the RBF, which makes payments conditional on meeting quality standards. The MoHCC acts as the regulator of quality, using a checklist to standardise supervision. Client satisfaction and community accountability mechanisms also provide data on quality of services under the RBF.	CO and Development Partner staff
UNFPA has provided extensive technical and financial support for provider training in the MoHCC, including for family planning, STI management, integrated services, emergency obstetric and neonatal care, and some for youth friendliness; however, there is no information on the outcome of training and if providers have made sustained improvements in service provision. The main measurement is number of providers trained, with some QA monitoring at six weeks, but there is no longer-term mentoring or supervision beyond this. The quality of the actual training itself is also not monitored.	CO staff
Service delivery issues, including those related to ZNFPC, include: • Lack of information about where and how to access services • Lack of research on uptake and barriers for IUCDs • Increase in discontinuation, but different theories including poor counselling, especially concerning side effects; pressure to reach targets; lack of options at service sites • Training of trainers (TOT) programme not effective, as 10-15% of the people selected to undergo the training at ZNFPC, did not have qualifications to be future trainers • Lack of strong quality assurance and supervision support • Unmet need among young people remains high, as evidenced by huge uptake of emergency contraception at tertiary institutions. • Pre-service training for FP needs improvement	Government, NGO and CO staff
"Training on FP methods is being provided by ZNFPC, but the current level of fees is considered too high to be good value for money. They are charging $430 for a 5 day course which doesn't include per diems, bringing to total cost to $1,000 per participant. This is well above the UNFPA internal benchmark of $600, and also when compared comparable training in other DFID-supported countries, e.g., $800 by a DFID Zambia programme (SUFT). UNFPA is negotiating to reduce the fees. The alternative is for ZNFPC to work closely with the Ministry of Health's RH Department to ensure necessary FP training is completed with a modality worked out for ZNFPC to accredit these trainings".	(DFID 2013: 16)
In 2008, UNFPA supported the use of multiple strategies including capacity building of service providers to widen family planning choices, strengthening of the community-based distribution network to increase access and coverage of services as	(UNFPA Zimbabwe 2008)

well as behaviour change communication on family planning to increase demand for services. UNFPA mobilised financial resources from DFID to support ZNFPC to revitalise and expand the CBD network in order to increase access to and utilization of family planning services by individuals and couples, especially in rural areas where clients have to travel long distances to the nearest service delivery points. UNFPA scaled up support for the training of health service providers in the insertion of implants, procured and distributed more implants in a bid to widen choice, improve method mix and reduce unmet need. UNFPA also supported the printing and distribution of the revised FP guidelines to all service delivery points.	
"The CBD programme was expanded in 2011, and CBDs are now mandated to deliver FP/RH, STI, HIV and AIDS messages and services to rural communities. With financial support from DFID, the CO provided technical assistance to ZNFPC to recruit and train 345 CBDs. This brought the total compliment of CBDs operating in the country to 655. In order to meet the family planning needs of young people, the ZNFPC made an effort to recruit younger men and women as CBDs. Procurement and distribution of job aids (IEC materials, uniforms, training manuals, depot holders' manuals, bicycles and tin boxes to store contraceptives) and revision of Management Information System (MIS) forms was done. A total of 5,000 family planning guidelines were printed and distributed. CBDs have reached a total of 1,981,258 clients for oral contraceptive and 148,843 for other services from 2009 to September 2011. Linkages of the CBD program with the adolescent sexual and reproductive health program were strengthened through expansion of the supervisory role of the CBD Group leaders over the peer educators as well as strengthening the referral chain between the two cadres".	(UNFPA Zimbabwe 2011a)
The country office provided financial and technical support for family planning TOT workshops and roll out of the trainings to the provinces. The trainings were aimed at improving contraceptive method mix with focus on long term FP methods. 60 people were trained in provision of long acting methods while 400 health service providers were trained to provide Jadelle implants insertions and removals. The country office also procured Jadelle implants and IUCDs that were used during the trainings. Distribution to the service delivery points is on-going through DTTU.	(UNFPA Zimbabwe 2013)
The country office provided financial support for the mass media campaign on family planning whose main focus was to increase the general public awareness and uptake of family planning services through education and information dissemination on FP. This was achieved through airing programmes on national television and radio, Star FM, TV Talk Show, print-media and information, education and communication (IEC) materials on benefits and methods of family planning. In addition, 930 behaviour change facilitators were trained in 26 districts and they are conducting awareness sessions on family planning. UNFPA is supporting 42 family planning sites throughout the country to enable them to provide long-acting methods through training of health service providers. Data from the health management information system (HMIS) shows that 2,533 (66 percent of target) women had implant insertions in the supported sites from January to September 2013 contributing to 12,854 Couple Years of Protection.	(UNFPA Zimbabwe 2013)

Assumption 8.2: **UNFPA support to procurement promotes availability of a wider method mix.**	**Information sources:**
Indicators: • Range of methods procured by UNFPA, development partners and national governments • Range of methods available at service delivery points for all user groups.	
All procurement is done by donors, with DFID providing the pills and injectables, USAID providing the condoms and UNFPA providing the implants and IUCDs.	CO staff
Method mix includes predominant use of pills (41 percent), followed by injectables (8.3 percent), long-acting and permanent methods (LA/PMs) (4 percent). LA/PM use is considered to be low due to inadequate health worker capacity, poorly equipped facilities, and insufficient efforts at demand creation. The ZDHS will be out at the end of 2015 and it is anticipated that the method mix will include more implant use than previously because of programme's push to diversify method mix.	(MoHCC 2014)
UNFPA is an active member of the RHCS Steering Committee that is co-chaired by MoHCC and ZNFPC. Through financial and technical support from UNFPA and other partners, ZNFPC successfully completed the roll out plan of the transition strategy from branded to generic oral contraceptives in Harare and Bulawayo provinces in 2008.	(UNFPA Zimbabwe 2008)
Through financial support from the RHCS thematic fund, the CO procured 5,000 Jadelle implants. 2,000 IUCDs and 2,000 Depo-provera and the commodities have been delivered to ZNFPC for distribution to service delivery points. The commodities complement those procured by DFID, USAID and other RH partners.	(UNFPA Zimbabwe 2011a)
Report on outcome 3: increased access to and utilization of quality FP services according to reproductive intention: a. National capacity development for averting stock-outs of modern contraceptives and essential life-saving maternal/RH medicines at SDPs: The country office provided financial and technical support to the department of pharmacy to conduct on the job training for primary health care staff in 62 districts to enable them to record and track stock outs and report life- saving maternal/FP/RH and other essential medicines information. b. Capacity development (both human and institutional) for expanding contraceptive method mix (that is making a broad range of modern methods available in more SDPs and with expanded national coverage): The country office mobilised resources to improve the contraceptive method mix. The CO has procured Jadelle implants and IUCDs in preparation for the trainings in 2013. Distribution to the SDPs is on-going through the DTTU system c. Implementation of key demand generation activities at the community levels (either in a specific rural settlement or a specific location in an urban area) for increased uptake of quality family planning services: The country office provided financial support during the commemoration of the 2012 World Population Day (WPD) whose	(UNFPA Zimbabwe 2012)

main focus was to raise awareness on the importance of family planning in reducing maternal mortality. The MoHCC committed to advocate for increased budget allocation to family planning services including procurement of contraceptives in 2012 and beyond. d. Advocacy and policy dialogue for government budget allocation for procurement of modern contraceptives and implementation of family planning interventions: The country office did not conduct any advocacy activities related to the allocation of Government budget.	
In 2013 under the ISP, UNFPA had a target to achieve 10,722 Couple-Year of Protections (CYPs) and achieved 7,966 (74.2 percent) as compared to PSI target of 69,342 with an achievement of 60,904 (87.8 percent). UNFPA also had a target of 25,308 new adolescent users of FP and achieved 22,205 (87.7 percent).	(DFID 2013: 8)

Assumption 8.3: **Strengthened procurement and logistics systems and related health system improvements are designed to be financially sustained by national governments.**	**Information sources:**
Indicators: • Trend in FP methods (as percentage of MoH budget) • Trends in contributions by other development partners • Value-for-money in method mix, which meets user needs (men and women, adolescents, VMGs).	
The MoHCC does not include a budget line for commodities. The contributions are made by DFID, USAID and UNFPA.	CO staff
Resource gap analysis conducted by Futures Group, indicates a major gap in commodities foreseen to meet the 2020 prevalence goals.	(Health Policy Project 2014)
The DTTU, designed and supported by JSI DELIVER with USAID funding, is considered by stakeholders to be the reason for strengthened procurement and logistics systems. It is housed within ZNFPC, which requires outside support to field the 40 trucks, drivers, eight area managers at the provincial level and a project executive and assistant. It is a "push" system with a mobile warehouse. The programme was developed as an interim strategy; it is not envisioned to be sustainable. Currently, there is an overstock of Jadelle, because they purchased more than could be "moved" given the lag in training. As a result, there is a corresponding shortage of pills. UNFPA sits on the coordinating committee for commodities; they are not directly involved in capacity-building for procurement and logistics. However, stakeholders value their insights as the main group liaising with the public sector on FP service delivery and for their global position and understanding of FP trends in programming and policy.	NGO staff
"Learning from the commercial sector, Zimbabwe's "delivery team topping up" system has ensured that condoms and contraceptives are available at health facilities. Under the system, delivery trucks carry a set amount of health products, including contraceptives and condoms, usually determined by recent trends. Delivery truck drivers or delivery staff team	(Gribble 2010)

members are responsible for calculating how much of a product has been used and for resupplying—or "topping off"—the facilities with the products they need during the next time period. This system is based on reliable drivers and vehicles and sufficient operating funds to keep the system working. Facilities involved in this distribution system are resupplied every two months and are "topped off" with a four-month supply of each of commodity. Prior to introducing the system in 2004, as many as 20 percent of health facilities experienced condom stockouts, but after the system was introduced, only 2 percent of facilities reported stockouts. The system reaches 99 percent of service delivery points—1,200 facilities—and has achieved more than a 95 percent availability of condoms and contraceptives".	
The CO provided financial support to the Department of Pharmaceutical Services in the MOHCC to conduct on the job training for primary health care staff in 62 districts to enable them to record, track stockouts and report life-saving maternal, FP, RH and other essential medicines.	(UNFPA Zimbabwe 2013)

Assumption 8.4 **At global level UNFPA has developed an improved and efficient procurement system to deliver quality contraceptives to countries.**	**Information source:**
Indicators: • Percentage of third party procurement (TPP) procurement by UNFPA • Cost per CYP for contraceptives procured and delivered to countries by UNFPA.	
As noted previously in Assumption 8.2, UNFPA procures the portion of third party procurement comprised of IUCD, injectables and implants.	CO staff
GPRHCS programme contributes to strengthening national capacity for coordinating the joint efforts in the country for achieving FP2020 commitments made by the government of Zimbabwe and contributes to commodity security of essential reproductive medicines and supplies. It has supported national efforts on strengthening contraceptive method mix, especially long acting methods by building capacity of 700 service providers and strengthening policy environment for integrated FP information and services, including support to the government to develop a national family planning strategy (2015-2020).	CO staff
In 2013, GPRHCS supported training for 930 behaviour change facilitators in 26 districts to conduct awareness sessions on family planning. In addition, it provided support for film screenings that reached more than 15,000 young people, and peer educators who conducted youth-friendly services at 37 service delivery points. (Funding allocated was $805,329.62).	(UNFPA 2014c)
The country office did not conduct any advocacy activities related to the allocation of government budget support for commodities.	(UNFPA Zimbabwe 2013)

ANNEX 4 – SRHR AND FAMILY PLANNING EXPENDITURE (2008-2013)

PROJECT	IMPLEMENTING PARTNERS	Total spending on SRHR INCL Family Planning by Project ID	2009	2010	2011	2012	2013	TOTAL FAMILY PLANNING SPENDING (2008-2013)
			FAMILY PLANNING SPENDING PER YEAR					
GRP6R43A: CCP Support in Zimbabwe		**$251,450**	**$175,424**					**$175,424**
Non-Core			$175,424					$175,424
ZIM5A101 (2 project titles)	**GOVT, NGO, UNFPA**	**$346,301**		**$31,996**	**$20,823**			**$52,819**
CP Planning, M&E and Admin Support								
Core	GOVT, UNFPA			$31,996				$31,996
Family Planning								
Core	NGO				$20,823			$20,823
ZIM5G101 (3 project titles)	**GOVT, NGO, UNFPA**	**$351,411**	**$156,385**	**$8,702**	**$6,849**			**$171,936**
GBV Prevention and system strengthening								
Core	GOVT				$6,849			$6,849
Sensitisation of Men on GBV Prevention								
Can not decipher	NGO, UNFPA		$156,385					$156,385
Sensitisation of Men on GBV Prevention								
Core	NGO			$8,702				$8,702
ZIM5G102 (2 project titles)	**GOVT, UNFPA**	**$560,751**	**$28,300**	**$27,703**				**$56,003**

PROJECT	IMPLEMENTING PARTNERS	Total spending on SRHR INCL Family Planning by Project ID	2009	2010	2011	2012	2013	TOTAL FAMILY PLANNING SPENDING (2008-2013)
			FAMILY PLANNING SPENDING PER YEAR					
Capacity building of counselors, nurses and police on GBV management								
Core	GOVT			$27,703				$27,703
Strengthen Ministry Capacity to implement GBV programs								
Can not decipher	GOVT, UNFPA		$28,300					$28,300
ZIM5G103 (2 project titles)	**NGO**	**$149,787**		**$9,832**	**$1,116**			**$10,948**
GBV Prevention and system strengthening								
Core	NGO				$1,116			$1,116
Sensitisation of women on GBV Prevention								
Core	NGO			$9,832				$9,832
ZIM5P101: Administration and Program support	**GOVT, UNFPA**	**$963,098**		**$89,736**				**$89,736**
Can not decipher				$89,736				$89,736
ZIM5R103 (4 project titles)	**GOVT, NGO, UNFPA**	**$979,873**	**$46,847**	**$25,884**	**$5,335**	**$2,646**		**$80,713**
BC Promotion and Monitoring								
Core	NGO, UNFPA			$25,884				$25,884
HIV Prevention								

PROJECT	IMPLEMENTING PARTNERS	Total spending on SRHR INCL Family Planning by Project ID	2009	2010	2011	2012	2013	TOTAL FAMILY PLANNING SPENDING (2008-2013)
			FAMILY PLANNING SPENDING PER YEAR					
Non-Core	NGO					$2,646		$2,646
HIV Prevention								
Core	GOVT				$5,335			$5,335
Strengthening MOHCC capacity to coordinate BC programme								
Can not decipher	GOVT, NGO, UNFPA		$46,847					$46,847
ZIM5R11B (2 project titles)	**GOVT**	**$125,000**	**$37,420**	**$17,200**				**$54,620**
Reproductive Health Safe Motherhood								
Can not decipher				$17,200				$17,200
Strengthening HMIS								
Core			$24,420					$24,420
Can not decipher			$13,000					$13,000
ZIM5R12B: Reproductive Health Safe Motherhood	**GOVT**	**$295,000**		**$36,200**	**$19,400**			**$55,600**
Core					$19,400			$19,400
Can not decipher				$36,200				$36,200
ZIM5R201 (2 project titles)	**NGO, GOVT, UNFPA**	**$470,000**	**$51,330**	**$78,600**				**$129,930**
Administration Support								

PROJECT	IMPLEMENTING PARTNERS	Total spending on SRHR INCL Family Planning by Project ID	2009	2010	2011	2012	2013	TOTAL FAMILY PLANNING SPENDING (2008-2013)
			FAMILY PLANNING SPENDING PER YEAR					
Can not decipher	GOVT, UNFPA			$78,600				$78,600
Strengthening Reproductive Health Commodity Security								
Can not decipher	GOVT, NGO, UFNPA		$51,330					$51,330
ZIM5R208 (2 project titles)	**GOVT**	**$1,564,986**	**$39,243**	**$160,179**	**$128,786**			**$328,208**
HIV Prevention								**$199,422**
Can not decipher				$160,179				$160,179
Can not decipher			$39,243					$39,243
HIV Prevention and SRH/HIV Linkages								
Core					$128,786			$128,786
ZIM5R22A (3 project titles)	**GOVT, NGO, UNFPA**	**$5,036,047**	**$103,000**	**$736,592**	**$1,253,054**	**$60,038**		**$2,152,684**
Availability and Utilisation of RH services								
Can not decipher						$60,038		$60,038
EmONC Trainings and Support								**$103,000**
Can not decipher			$103,000					$103,000
Reproductive Health Safe Motherhood								
Can not decipher				$736,592				$736,592
Can not decipher					$1,253,054			$1,253,054

PROJECT	IMPLEMENTING PARTNERS	Total spending on SRHR INCL Family Planning by Project ID	2009	2010	2011	2012	2013	TOTAL FAMILY PLANNING SPENDING (2008-2013)
			FAMILY PLANNING SPENDING PER YEAR					
ZIM5R303 (4 project titles)	**GOVT, NGO**	**$18,165,237**	**$420,511**	**$600,391**	**$1,110,288**	**$50,446**		**$2,181,637**
GBV Prevention and Behaviour change: training community leaders								
Non-Core	NGO		$420,511					$420,511
HIV Prevention								
Non-Core	GOVT, NGO					$50,446		$50,446
HIV Prevention								
Non-Core	NGO			$600,391				$600,391
Reproductive Health Safe Motherhood								
Non-Core	GOVT				$1,110,288			$1,110,288
ZIM5R33A: ASRH	**GOVT, UNFPA**	**$609,540**		**$85,438**	**$64,352**			**$149,790**
Core					$64,352			$64,352
Non-Core				$85,438				$85,438
ZIM6A100: Administration and Program support	**UNFPA**	**$449,232**				**$26,128**	**$14,965**	**$41,093**
Core							$14,965	$14,965
Non-Core						$26,128		$26,128
ZIM6A200: Administration and Program support	**UNFPA**	**$4,440,928**				**$152,456**	**$272,922**	**$425,378**

PROJECT	IMPLEMENTING PARTNERS	Total spending on SRHR INCL Family Planning by Project ID	2009	2010	2011	2012	2013	TOTAL FAMILY PLANNING SPENDING (2008-2013)
			FAMILY PLANNING SPENDING PER YEAR					
Can not decipher						$152,456	$272,922	$425,378
ZIM6U202: Availability and Utilisation of RH services	**GOVT, NGO, UNFPA**	**$18,819,598**				**$1,805,239**	**$2,766,978**	**$4,572,217**
Can not decipher						$1,805,239		$1,805,239
Can not decipher							$2,766,978	$2,766,978
ZIM6U405: ASRH	**NGO, UNFPA**	**$6,987,931**					**$467,063**	**$467,063**
Can not decipher							$467,063	$467,063
ZIM6U510: GBV Prevention and system strengthening	**GOVT, NGO, UNFPA**	**$4,424,922**				**$36,955**	**$163,850**	**$200,805**
Can not decipher						$36,955		$36,955
Can not decipher							$163,850	$163,850
ZIM6U707: Data for development	**GOVT, NGO, UNFPA**	**$17,524,588**				**$668,895**	**$423,782**	**$1,092,677**
Can not decipher						$668,895		$668,895
Non-Core							$423,782	$423,782
TOTAL SPENDING ON SRHR INCL FAMILY PLANNING (2008-2013)		**$82,515,680**						
TOTAL SPENDING ON FAMILY PLANNING			**$1,058,461**	**$1,908,453**	**$2,610,004**	**$2,802,803**	**$4,109,560**	**$12,489,281**

The information presented in the above table was contributed by the UNFPA Zimbabwe Country Office. Under the guidance of the UNFPA Evaluation Office, the CO identified projects in support of family planning – those fully dedicated to family planning as well as those in which family planning activities were mainstreamed – and reported the amount spent (annually) under each project. Project expenditure was disaggregated into core and non-core funding. The country office was then asked to estimate the percentage (%) of the project in support of family planning – 100% in cases where projects were fully dedicated to family planning and an estimated percentage for projects in which family planning activities were an aspect of the project (mainstreamed). The type of implementing partner (NGO, government and/or UNFPA) – information also provided by the country office - is captured in the table, as well.

The above approach was chosen due, primarily, to challenges in obtaining family planning expenditure through the use of the UNFPA financial management platform (Atlas). For the period under evaluation, the UNFPA financial management platform did not explicitly track family planning expenditure and, when it did so, did not capture all/the full range of family planning expenditure. Prior to 2011, there was no dedicated family planning project outcome code within Atlas. Instead, activities advancing family planning were embedded in other projects, posing significant challenges to capturing family planning expenditure. In 2012 this changed: reflecting a shift in UNFPA outcomes, a dedicated family planning project outcome code was introduced in Atlas (the U3 code). While this contributed to an improved ability to track family planning expenditure, the code does not capture expenses corresponding to family planning activities that are mainstreamed/ included within other interventions, with the attendant challenges remaining.

As mainstreaming poses particular challenges to accurately identifying the entirety of projects and activities in support of family planning in Atlas, and subsequently, in determining the amount spent in support of family planning, country offices – deeply familiar with the specifics of a project - were requested to report on family planning expenditure. A degree of subjectivity exists in, inter alia, selecting family planning projects and estimating/assigning the percentage of a project dedicated to family planning (in cases where the activities have been embedded). However, the country office is best positioned to address this, offering a sound determination based on intimate knowledge of a project and its implementation.

The country office was provided with two guidance notes: one focusing on which activities should be considered family planning and the other on estimating percentages. On the former, guidance listed the expenses that should be considered expenditure in support of family planning, including projects with a U3 code, projects funded through the Thematic Fund for Reproductive Health Commodity Security, expenses incurred to strengthen information systems pertaining to family planning or expenses incurred to create enabled environments for human-rights family planning.

A typology/percentage guidance note was also provided. This note listed activities - under different Strategic Plan (2014-2017) outputs - that can be considered to have a family planning component, with the corresponding suggested percentage included. While this was offered as a tool to support the country office, the country office was encouraged to offer the percentages that best reflected the actual expenses related to family planning in Zimbabwe.

ANNEX 5 – IMPLEMENTING PARTNERS

GOVERNMENT:	
Ministry of Health and Child Care	
GPR6R43A:	CCP Support in Zimbabwe
ZIM5R103:	Strengthen ministry capacity to coordinate behaviour change programme
	HIV Prevention
ZIM5R11B:	Strengthen HMIS
ZIM5R201:	Strengthen Reproductive Health Commodity Security
ZIM5R208:	HIV Prevention and SRH/HIV Linkages
ZIM5R22A:	EmONC Trainings and Support
	Reproductive Health Safe Motherhood
	Availability and Utilisation of RH Services
ZIM5A101:	CP Planning, M&E and Admin Support
ZIM5R11B:	Reproductive Health Safe Motherhood
ZIM5R12B:	Reproductive Health Safe Motherhood
ZIM5R33A:	Adolescent Sexual and Reproductive Health
ZIM5R303:	Reproductive Health Safe Motherhood
	HIV Prevention
ZIM6U202:	Availability and Utilisation of RH Services
ZIM6U204:	Availability and Utilisation of RH Services
Ministry of Women Affairs, Gender and Community Development	
ZIM5G102:	Strengthen ministry capacity to implement GBV programmes
	Capacity building of counsellors, nurses and police on GBV management
ZIM5G101:	GBV Prevention and system strengthening
ZIM6U707:	GBV Prevention and system strengthening
ZIM6U510:	GBV Prevention and system strengthening
Zimbabwe National Family Planning Council	
ZIM5R201:	Strengthening Reproductive Health Commodity Security
ZIM5A101:	Family Planning
ZIM5R22A:	Reproductive Health Safe Motherhood
ZIM6U202:	Availability and Utilisation of RH Services
ZIM6U203:	Availability and Utilisation of RH Services
ZIM6U405:	Adolescent Sexual and Reproductive Health
National AIDS Council	
ZIM6U205:	Availability and Utilisation of RH Services
ZIM6U405:	Adolescent Sexual and Reproductive Health

Zimbabwe National Statistics Agency (ZIMSTAT)	
ZIM5R208:	HIV Prevention
ZIM5R11B:	Reproductive Health Safe Motherhood
ZIM6U707:	HIV Prevention
Government of Zimbabwe (GoZ)	
ZIM5P101:	Administration and Programme Support
NGOs:	
World Vision	
ZIM5R303:	GBV Prevention and Behaviour Change: Training Community Leaders
	HIV Prevention
ZIM5R103:	Behaviour Change Promotion and Monitoring
ZIM6U405:	Adolescent Sexual and Reproductive Health
Padare	
ZIM5G101:	Sensitisation of Men on GBV Prevention
ZIM6U510:	GBV Prevention and System Strengthening
Musasa	
ZIM5G103:	Sensitisation of Women on GBV Prevention
	GBV Prevention and System Strengthening
ZIM6U510:	GBV Prevention and System Strengthening
National Faith-based Council of Zimbabwe	
ZIM5R103:	Strengthening MoHCC capacity to coordinate behaviour change programming
Batsirai Group	
ZIM5R303:	GBV Prevention and Behaviour Change: Training Community Leaders
	HIV Prevention
Matabeleland AIDS Council (MAC)	
ZIM5R303:	GBV Prevention and Behaviour Change: Training Community Leaders
	HIV Prevention
ZIM6U405:	Adolescent Sexual and Reproductive Health
Zimbabwe AIDS Prevention Project-DFID	
ZIM5R303:	GBV Prevention and Behaviour Change: Training Community Leaders
	HIV Prevention
ZIM6U405:	Adolescent Sexual and Reproductive Health

Family AIDS Caring Trust (FACT)	
ZIM5R303:	GBV Prevention and Behaviour Change: Training Community Leaders
	HIV Prevention
ZIM6U405:	Adolescent Sexual and Reproductive Health
Midlands AIDS Service Organization (MASO(	
ZIM5R303:	GBV Prevention and Behaviour Change: Training Community Leaders
	HIV Prevention
ZIM6U405:	Adolescent Sexual and Reproductive Health
Women's Action Group (WAG)	
ZIM6U510:	GBV Prevention and System Strengthening
Saywhat	
ZIM6U510:	GBV Prevention and System Strengthening
UNFPA	
GPR6R43A:	Comprehensive Condom Programming support in Zimbabwe
ZIM5G101:	Sensitisation of Men on GBV Prevention
ZIM5G102:	Strengthen ministry capacity to implement GBV programmes
ZIM5R103:	Strengthen ministry capacity to coordinate behaviour change programme
	Behaviour change promotion and monitoring
ZIM5R201:	Strengthen Reproductive Health Commodity Security
	Administration support to MoH
ZIM5R22A:	EmONC training and Support
	Availability and Utilisation of RH services
ZIM5A101:	CP planning, M&E and administrative support
ZIM5P101:	Administration and programme support
ZIM5R33A:	Adolescent Sexual and Reproductive Health
ZIM6A100:	Administration and programme support
ZIM6A200:	Administration and programme support
ZIM6U206:	Availability and Utilisation of RH services
ZIM6U405:	Adolescent Sexual and Reproductive Health
ZIM6U510:	GBV Prevention and system strengthening
ZIM6U707:	Unlabelled

ANNEX 6 – KEY FACTS, EXPANDED TABLE

Indicator	2012	2014	Source of Data
Population and Development			
Population, total	14,565,482	15,245,855	World Bank[1]
Population, aged 0-14 (% of total)	42	42	World Bank[1]
Population, aged 15-64 (% of total)	55	55	World Bank[1]
Population, ages 65+ (% of total)	3	3	World Bank[1]
Population growth (annual %)	2.2	2.3	World Bank[1]
Urban Population (% of total)	33	33	World Bank[1]
Population Density (per sq. km of land area)	38	39	World Bank[1]
Life Expectancy at birth, total (years)	54	-	World Bank[1]
Literacy rate, population 15+ years, both sexes (%)	-	-	World Bank[1]
Youth Literacy rate, population 15-24, both sexes (%)	-	-	World Bank[1]
Human Development Index (HDI)	0.397 (Rank 172 out of 187)	0.509 (Rank 155 out of 188)	Human Development Report[2]
Human Development Classification (very high, high, medium, low, upper middle, high)	-	Medium	Human Development Report[98]
Total GDP at market price (current US$)	12,392,715,462	14,196,912,535	World Bank[1]
Economic growth rate (GDP growth annual %)	10.6	3.8	World Bank[1]
GINI Index	-	-	World Bank[1]
Multidimensional Poverty Index (MPI), HDRO specifications	0.172	0.128	Human Development Report[3]
Government Effectiveness			
World Bank CPIA Quality of Public Administration rating (1=low to 6 = high)	2.0	2.5	World Bank[1]
UNFPA: Need and Ability to Finance			

[98] United Nations Development Programme. (2016). Country Classification. Retrieved from https://pharmacoepi.org/pub/1c08ab60-2354-d714-5192-9cc81d38354f

UNFPA country quadrant	-	Red	UNFPA Strategic Plan[99]
Gender Equality and Empowerment			
Gender Inequality Index	0.544 (Rank 116 out of 148)	0.504 (Rank 112 out of 155)	Human Development Report[3]
Women representation in parliament, total (%)	17.9	32	World Bank[1]
Violence against women ever experienced (%)	-	43.4	Human Development Report[3]
Employment to population ratio, 15+, female (%) (modeled ILO estimate)	78	79	Human Development Report[5]
Ratio of girls to boys in primary and secondary education (%)[4]	0.98	-	World Bank[1]
Reproductive Rights and Reproductive Health			
Fertility rate, total (births per woman)	4.0	-	World Bank[1]
Adolescent fertility rate (births per 1,000 women ages 15-19)	113	110	World Bank[1]
Teenage mothers (% of women ages 15-19 who have had children or are currently pregnant)	24 (2011 data)	-	World Bank[1]
Prevalence of HIV, female (% ages 15-49)	7.4	7.0	World Bank[1]
Prevalence of HIV, male (% ages 15-49)	4.9	4.8	World Bank[1]
Maternal mortality rate (per 100,000 live births)	379	401	World Bank[1]
Under 5 mortality rate (per 1,000 live births)	79	72	World Bank[1]
Contraceptive use, modern methods (%)	-	67.5	UN DESA Population Division Estimates and Projections of Family Planning Indicators[5]

[99] United Nations Population Fund. (2015). UNFPA Strategic Plan. Retrieved from https://webcache.googleusercontent.com/search?q=cache:PBcjL1D-HDYJ:https://www.unfpa.org/sites/default/files/about-us/Annex%25204%2520(funding%2520arrangements).docx+&cd=1&hl=en&ct=clnk&gl=ca

Unmet need for family planning (number of married or in-union women aged 15 to 49 who want to stop or delay childbearing but are not using a method of contraception, %)	-	10.1	UN DESA Population Division Estimates and Projections of Family Planning Indicators[5]
Demand for family planning satisfied (proportion of met need divided among total demand for family planning; total demand is sum of unmet need and met need with all methods)	-	79.4	UN DESA Population Division Estimates and Projections of Family Planning Indicators[5]
Births attended by skilled health staff (% of total)	66 (2011 data)	-	World Bank[1]
Antenatal care (any skilled provider)	-	-	World Bank[1]