Zimbabwe National Family Planning Costed Implementation Plan 2016 – 2020

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ACRONYMS AND ABBREVIATIONS

ASRH	Adolescent Sexual and Reproductive Health
ATB	AIDS and Tuberculosis
CBD	Community-Based Distribution
CBHW	Community Based Health Worker
CIP	Costed Implementation Plan
CPR	Contraceptive Prevalence Rate
CPT	Contraceptive Procurement Table
DFID	Department for International Development
DHIS	District Health Information System
DTTU	Delivery Team Topping Up
FP	Family Planning
GoZ	Government of Zimbabwe
HIMS	Health Information Management System
IEC	Information, Education and Communication
IUCD	Intrauterine Contraceptive Device
JSI	John Snow, Inc.
LAPM	Long-Acting and Permanent Method
LARC	Long-Acting and Reversible Contraception
PMTCT	Prevention of Mother-to-Child Transmission
PSI	Population Services International
PSZ	Population Services Zimbabwe
MCAZ	Medicines Control Authority of Zimbabwe
MCH	Maternal and Child Health
mCPR	Modern Contraceptive Prevalence Rate
R,M&E	Research, Monitoring and Evaluation
MoHCC	Ministry of Health and Child Care
NAC	National AIDS Council
NGO	Nongovernmental Organisation
RMNCAH	Reproductive, Maternal, New-born, Child, and Adolescent Health
SBCC	Social and Behavioural Change Communication
SCMS	Supply Chain Management System
SDG	Sustainable Development Goal
SDP	Service Delivery Point
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
TFR	Total Fertility Rate
TMA	Total Market Approach
TWG	Technical Working Group
UNFPA	United Nations Population Fund
USAID	US Agency for International Development

WHO	World Health Organization
WRA	Women of Reproductive Age
YFHS	Youth Friendly Health Services
ZAPS	Zimbabwe Assisted Pull System
ZDHS	Zimbabwe Demographic and Health Survey
ZNFPCIP	Zimbabwe National Family Planning Costed Implementation Plan
ZimASSET	Zimbabwe Agenda for Sustainable Socio-Economic Transformation
ZIMSTAT	Zimbabwe National Statistics Agency
ZNBFP	Zimbabwe National Board of Family Planning
ZNFPC	Zimbabwe National Family Planning Council
ZNFPS	Zimbabwe National Family Planning Strategy

FOREWORD

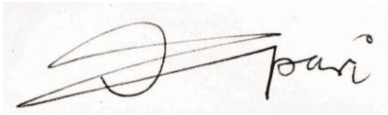
The Government of Zimbabwe, through the Ministry of Health and Child Care (MOHCC), has long been committed to providing access to contraceptive services, since independence. The enactment of the Zimbabwe National Family Planning Act 1985 and establishment of the Zimbabwe National Family Planning Council marked a heightened commitment by the government to offer family planning services as part of primary health care services. It is through this long-standing commitment that Zimbabwe achieved remarkable results in increasing the contraceptive prevalence rate to 67 percent, across all methods among married women in 2015, and earning our nation praise as one of the few countries in Africa with the highest rates of contraceptive use. The decline in the total fertility rate from 6.7 children per woman in 1984 to 4 children per woman in year 2015, is a sign of our nation's embrace of the national family planning programme after realising its associated benefits.

Building upon these successes, we intend to achieve universal access to quality integrated family planning services by 2020. By doing so, we aim to reduce teenage pregnancies and unmet need. Ensuring that all women and men of reproductive age have access to quality family planning services is a priority, as it contributes towards the nation's health and social development goals. To do so, we must address critical gaps, including provision of integrated family planning services, reaching out to the hardest-to-reach areas, strengthening provision of long-acting reversible contraception, and supporting young people to access and use family planning services.

On July 11, 2012, our country made commitments to increasing the modern contraceptive prevalence rate to 68 percent by 2020. Subsequently, the MOHCC developed the Zimbabwe National Family Planning Strategy 2016–2020 to guide efforts forward. This document, the Zimbabwe National Family Planning Costed Implementation Plan (ZNFPCIP), translates the Zimbabwe National Family Planning Strategy 2016–2020 into a results-based and actionable costed plan to guide intervention programming, resource mobilisation and allocation, and performance measurement. Also, the ZNFPCIP reflects actions to facilitate implementation of international commitments related to family planning, including commitments made for FP2020; Every Woman, Every Child, Every Adolescent; and Sustainable Development Goals. At the country level, the ZNFPCIP responds directly to the priorities included in key national strategies and policies, such as:

- ✓ National Health Strategy 2016–2020;
- ✓ National HIV and AIDS Strategic Plan 2016–2018;
- ✓ National Maternal and Neonatal Health Road Map 2005–2015;
- ✓ National Adolescent Sexual and Reproductive Health Strategy 2010–2015;
- ✓ Operational and Service Delivery Manual for Prevention, Care, and Treatment of HIV in Zimbabwe, June 2015.

Our government will continue to be strongly committed to the successful implementation of the ZNFPCIP, through the leadership of the MOHCC working closely with the Zimbabwe National Family Planning Council, in collaboration with all stakeholders. We would like to thank all stakeholders for working to achieve the development of this plan. Together we can improve the health of Zimbabwe's citizens, particularly mothers, babies, and young people, and build a stronger and more prosperous nation.



Dr P. D. Parirenyatwa (Senator)
MINISTER OF HEALTH AND CHILD CARE

PREFACE

The Government of Zimbabwe is committed to improving access to family planning, as it is a low-cost, high-dividend investment for addressing our country's high maternal mortality ratio and improving the health and welfare of women, men, and ultimately the nation. Family planning is an essential component in our national development agenda, which includes the fight against new HIV infections in children and universal primary education.

Increased access to and use of family planning has far-reaching benefits for families and the nation. As the fertility rate has begun to decline, and the country has realised an impressively high contraceptive prevalence rate (CPR) of 67 percent, a demographic dividend is on the horizon. As we plan to start growing our economy, we should utilise this opportunity and remember the African proverb that *"A bird's flight is determined by the last meal before take-off."* The demographic dividend refers to faster economic growth due in part to changes in the population's age structure that results in more skilled working-age adults and fewer dependents. This population shift can contribute to both national development and improved well-being for families and communities. However, if the demographic dividend is to be realised, there is need for substantial investments to improve health outcomes, including meeting family planning needs. At the same time, youth need to be empowered through education, employment creation, better governance, and economic stability.

We must therefore work together to ensure the health and wealth of our nation. By committing ourselves to the full financing and implementation of the Zimbabwe Family Planning Costed Implementation Plan (ZNFPCIP) 2016–2020, we can realise our goals of reducing unmet need for family planning to 6.5 percent, increasing the modern CPR to 68 percent, and improving the quality of family planning services by 2020. With a CPR at 67 percent, there is need to invest more in quality and in maintaining, a high CPR by strengthening the supply side of the programme.

The Government of Zimbabwe has a good reputation for moulding a highly educated nation, including achieving one of the highest literacy rates in Africa. Investing in and ensuring a strong family planning programme can improve the reputation. Modelling studies of the cost-benefit of family planning have shown that if investments are made to increase the uptake of family planning, in particular long-acting and permanent methods, the health system will save up to USD1.85 for each dollar spent on family planning interventions.[1] These savings could then be channelled to the government's vision of an educated nation (e.g., by investing in primary, secondary, and tertiary education) and to the implementation of the government's economic blueprint i.e. the Zimbabwe Agenda for Sustainable Social and Economic Transformation (ZimASSET).

Full and successful implementation of the Zimbabwe National Family Planning Costed Implementation Plan requires concerted and coordinated efforts of government (i.e., executive, legislature, and judiciary, including ministries and local government structures), the private sector, civil society, and development partners. We must all work together to ensure an enabling environment for policy, financing, service delivery, advocacy programmes, and the effective mobilisation of communities and individuals to overcome sociocultural barriers to accessing family planning services.

The Government of Zimbabwe through the Ministry of Health and Child Care and Zimbabwe National Family Planning Council is committed to providing the required leadership and coordination in the implementation of the costed implementation plan. This will ensure that every Zimbabwean has the right to health, education, autonomy, and personal decision making regarding the number of children and timing of childbearing.

Mrs M.N Mehlomakhulu
ZNBFP CHAIRPERSON

ACKNOWLEDGEMENTS

The Ministry of Health and Child Care (MoHCC) would like to express its appreciation to the many partners, groups, and individuals who supported the development of the Zimbabwe National Family Planning Costed Implementation Plan (ZNFPCIP) 2016–2020. This document is a result of extensive consultations with stakeholders working at all levels, including key sector ministries, development partners, implementing partners, professional associations, academia, and non-governmental organisations working in aligned areas. The MoHCC would like to acknowledge the contributions of other line ministries, parastatals and state enterprises.

Special acknowledgement goes to the United Nations Population Fund (UNFPA) Zimbabwe for funding and providing technical support for the development of the ZNFPCIP. Special thanks also go to respective governments of Ireland, Britain and Sweden who support the Integrated Support Programme under which the ZNFPCIP was developed.

The MoHCC would also like to acknowledge the contributions of individuals from the following organisations: Ministry of Health and Child Care, Zimbabwe National Family Planning Council, National AIDS Council, NatPharm, United Nations Population Fund, Department for International Development, US Agency for International Development, Crown Agents, John Snow, Inc. Zimbabwe, Population Services Zimbabwe, Maternal and Child Health Integrated Program Zimbabwe, Population Services International, Young Peoples Network, Ministry of Higher and Tertiary Education, Science and Technology Development, Ministry of Women Affairs, Gender and Community Development, Zimbabwe National Army and Avenir Health.

Special appreciation is also given to the task force that steered this process. These include Dr Benard Madzima, (Family Health Director – MoHCC); Dr Munyaradzi Murwira (Zimbabwe National Family Planning Council - Executive Director); Dr Nonhlanhla Zwangobani (Zimbabwe National Family Planning Council - Director of Technical Services); Dr Vibhavendra Raghuvanshi (Technical Specialist, Maternal Health and Family Planning – UNFPA); Ms Daisy Nyamukapa (Programme Analyst – UNFPA); and the FHI 360 technical team of Dr Edmore Munongo (In- country Lead Consultant), Mr Sammy Musunga, Dr Rick Homan, Christine Lasway, Tracy Orr, Dr Marsden Solomon and Patrick Olsen.

A special appreciation also go to ZNFPC for the support in providing the secretariat responsible for logistics and venue for Strategy Advisory Groups (SAG) consultations.

Brigadier General Dr G. Gwinji
SECRETARY FOR HEALTH AND CHILD CARE

EXECUTIVE SUMMARY

Zimbabwe aspires to have in place quality family planning services for all by the year 2020. The Zimbabwe National Family Planning Strategy (ZNFPS) was developed to guide the nation in the provision of integrated quality family planning, adolescent sexual and reproductive health, and HIV/AIDS services from 2015 to 2020. The ZNFPS builds upon the government's agenda for family planning under the social services and poverty eradication cluster as described in the Zimbabwe Agenda for Sustainable Socio-Economic Transformation.

The Zimbabwe National Family Planning Costed Implementation Plan (ZNFPCIP) 2016–2020 is intended to stipulate the yearly implementation plan and associated cost estimates for the implementation of the ZNFPS 2016–2020; FP2020 commitments; Every Woman, Every Child, Every Adolescent Commitments; Sustainable Development Goals; and other national commitments and goals related to family planning. The implementation plan also defines measurable results that need to be achieved, an implementation timeline, and metrics to facilitate performance measurement. Further, the ZNFPCIP delineates key institutional arrangements to support execution of the plan throughout the five-year period. The ZNFPCIP describes five strategy areas of implementation: enabling environment; commodity security; service delivery; demand creation; and research, monitoring, and evaluation. Cutting across these strategy areas are three key strategic priorities that will drive the family planning agenda forward: reducing teenage pregnancies, providing family planning services in integrated settings, and increasing utilisation of long-acting reversible contraception (LARC) and permanent methods.

The ZNFPCIP serves as an operational guide for all stakeholders involved in the family planning programme, across all government sectors including development partners and implementing partners. Specifically, the ZNFPCIP will:

- Support a unified country approach to family planning programming.
- Delineate financial resource requirements.
- Define success through indicators that the government can use to monitor performance.
- Establish a foundation for coordination.

THE CONTEXT

Globally, Zimbabwe is one of the family planning successes in Africa. For more than two decades, the modern contraceptive prevalence rate (mCPR) has been one of the highest in sub-Saharan Africa, currently estimated at 67 percent. Zimbabwe was one of the first sub-Saharan African countries, alongside Botswana and Kenya to experience a fertility transition from 6.7 to 4.0 births per woman between 1984 and 2015. The population growth rate showed a similar decline, from 2.6 percent to 0.82 percent between 1991 and 2009. At the same time, Zimbabwe has experienced a turnaround in family planning, including an increase in teenage pregnancies, a rise in the youth population and a continuing high-unmet need for family planning.

In the Vision 2020, Zimbabwe aspires to be a united, strong, democratic, prosperous, and egalitarian nation with a high quality of life for all by the year 2020. The achievement of this vision can be facilitated by a demographic dividend, which has also contributed to economic turnaround in Southeast Asia in the 1990s. This, however, needs an equally strong national family planning programme, which is so critical for the health of women and young people, including adolescents and hence the nation. A strong national family planning programme requires the government to carrying on the commendable work done by stakeholders, identifying and addressing the key challenges faced by the programme.

CHALLENGES FACED BY CURRENT NATIONAL FAMILY PLANNING PROGRAMME

Enabling Environment

An enabling environment - a range of interlinked policy, governance, sociocultural and economic factors forms the basis of a highly functioning and sustainable family planning programme. Left unaddressed desired results may not be gained from investments in supply and demand elements of a programme. The country's long-term success in sustaining an mCPR that is higher than average for sub-Saharan Africa indicates a conducive enabling environment for a thriving program. However, the inability to fulfil unmet needs, expand the method mix to include LARC such as implants and intrauterine contraceptive devices (IUCDs), and address resource inadequacies demonstrates inherent gaps and challenges.

Commodity Security

Achieving commodity security - a situation in which every person is able to choose, obtain and use quality contraceptives whenever they need them is of paramount importance to any family planning programme. Before 2004, contraceptive resupply was through a "traditional pull system" whereby service delivery points placed their orders of the required commodities. In 2004, a more informed push system called Delivery Team Topping Up (DTTU) was introduced based on past consumption patterns of the contraceptives per each service delivery point. In April 2014, MoHCC piloted the new Zimbabwe Assisted Pull System (ZAPS) consolidating DTTU and three other existing commodity distribution systems. The Manicaland pilot results informed the need to roll out the system nationwide with effect from January 2016. Despite these efforts to make contraceptive available in the country several key issues such as resources for procuring commodities, availability of a broad range of contraceptive products and management of the supply chain must still be addressed to make even more progress towards commodity security.

Service Delivery
Although Zimbabwe ranks high among sub-Saharan African countries in modern contraceptive use, several underlying service delivery challenges undermine further progress in ensuring voluntary, informed choice and access to a broad range of contraceptive methods. Current method use reflects a method mix skewed heavily toward short-acting methods (especially the pill), low uptake of LARC (especially in rural areas), a high-unmet need among young and unmarried sexually active women, and high contraceptive discontinuation rates.

Demand Creation
At least seven out of every ten married women is using either a contraceptive method or desires to do so, so demand for family planning appears to be high. However, satisfaction of demand needs to be critically analysed. For example, most women are using short-acting methods, which have their challenges. Discontinuation rates are high, non-users may not be receiving information about family planning from their health care providers, and method-related concerns have been increasing. As a function of the family planning programme, efforts to impart accurate and adequate information to facilitate contraceptive decision making face key challenges including lack of a national family planning advocacy and communication strategy. This is also due to low interpersonal communication on family planning by health workers, and the need of strong tailored programme to reach young people with information on sexual and reproductive health and rights, especially in rural and hard-to-reach areas.

Research, Monitoring and Evaluation
A research, monitoring and evaluation (R, M&E) function is an invaluable and integral part of the effective and efficient functioning of any programme. Information generated from R, M&E forms the basis for evidence-based decisions that drive the performance of a programme. It is on this premise that achieving the family planning programme's goals requires a robust R, M&E function. The Zimbabwe National Family Planning Council has a dedicated research and evaluation unit to carry out R, M&E in collaboration with the MoHCC and other implementing partners. However, capital and human resource constraints heavily affects effective and efficient execution of the unit's mandate. Limited resources also compromise the quality in data collection, sharing and coordination. There is need for a strong collaboration between the MoHCC and other implementing partners in order to improve data usage.

RESULTS TO BE ACHIEVED

The main goal of the ZNFPCIP is to increase the mCPR among married women from 65.6 percent in 2016 to 68 percent by 2020. A second goal is to reduce the teenage pregnancy rate from 24 percent to 12 percent by 2020. The key objectives of the plan are:

1 To establish a national family planning coordination, monitoring, and evaluation mechanism by 2020
2 To increase the proportion of the national health budget allocated to the family planning programme from 1.7 percent to 3 percent
3 To reduce unmet need for family planning services from 13 percent to 6.5 percent by 2020
4 To increase availability, access, and utilisation of HIV and other sexual and reproductive health services for young people
5 To increase the knowledge of long-acting and permanent methods among all women and men from 46 percent to 51 percent by 2020

6 To maintain stock-out levels of family planning commodities below 5 percent from 2016 to 2020

HEALTH AND DEMOGRAPHIC IMPACT

Full implementation of the ZNFPCIP will avert more than 3 million unintended pregnancies, more than 900,000 abortions, more than 7,000 maternal deaths, and more than 33,000 child deaths between 2016 and 2020, as shown in Table 1:

Table 1: Estimated Annual Demographic and Health Impact

	2016	2017	2018	2019	2020	Total
DEMOGRAPHIC IMPACT						
Unintended pregnancies averted	530,991	571,202	608,029	642,158	674,254	3,026,634
Abortions averted	164,607	177,073	188,489	199,069	209,019	938,257
HEALTH IMPACT						
Maternal deaths averted	1,580	1,544	1,479	1,387	1,273	7,263
Child deaths averted	5,848	6,291	6,697	7,073	7,426	33,335
Unsafe abortions averted	157,628	169,565	180,497	190,629	200,157	898,476

SHIFT IN METHOD MIX

Increasing the use of LARC and permanent methods is a priority intervention under this plan. Modelling studies of the cost-benefit of family planning have shown that if investments are made to increase uptake of family planning, and in particular long-acting and permanent methods, the health system will save up to USD1.85 for each dollar spent on family planning interventions. Implementation of strategic interventions to increase the use of LARC and permanent methods will result in a progressive shift in the contraceptive method mix as shown in Table 2:

Table 2: Method Mix among Married and All Women, Baseline (2015) and Projected (2020)

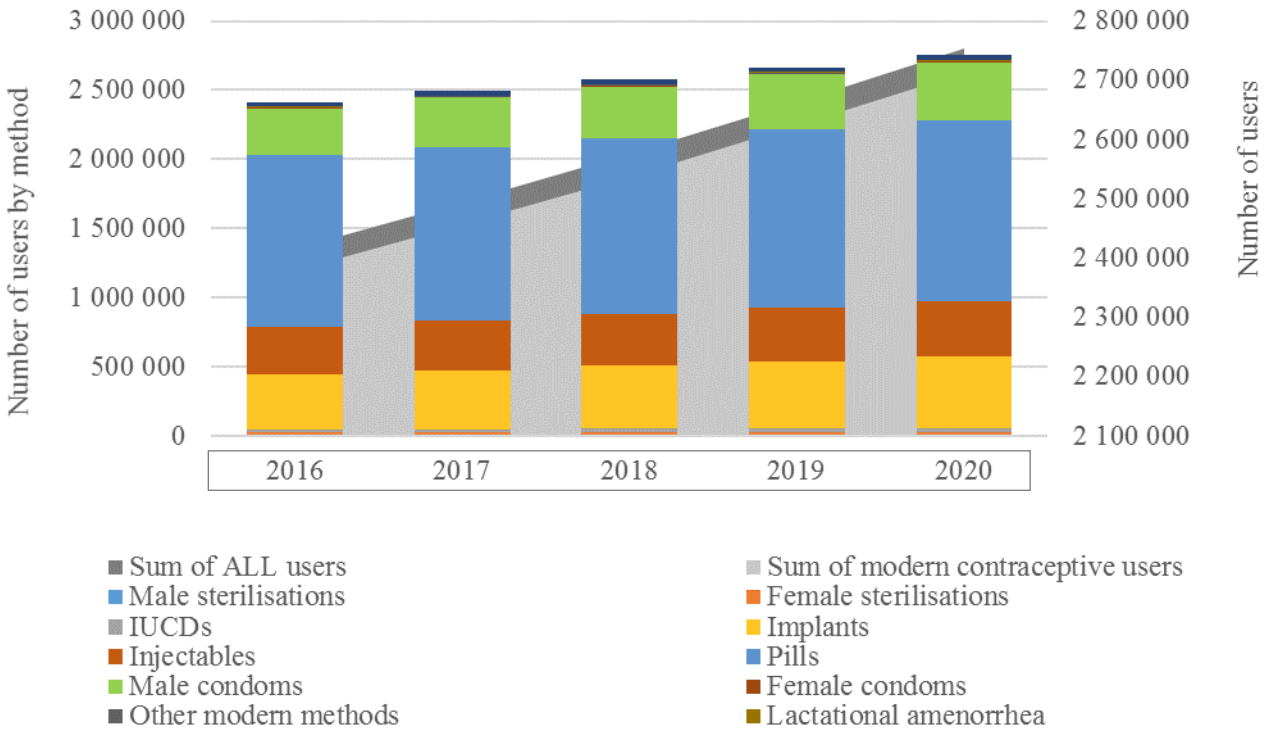
METHOD	BASELINE **(2015)**		PROJECTED **(2020)**	
	Married Women	All Women	Married Women	All Women
Male sterilization	--	--	--	--
Female sterilization	0.90%	0.6%	0.93%	0.6%
IUCD	0.70%	0.5%	0.86%	0.6%
Implant	9.60%	8.9%	11.80%	11.0%
Injectable	9.60%	7.7%	10.71%	8.7%
Pill	40.90%	28.9%	39.19%	27.9%
Male condom	3.80%	7.6%	4.39%	8.8%
Female condom	0.10%	0.1%	0.10%	0.1%
Other modern methods	--	0.1%	--	0.1%
Overall mCPR	**65.6%**	**54.4%**	**68%**	**57.8%**

Note: Estimates for method mix at baseline for all women have been generated using DHS 2015 data and WRA population

CONTRACEPTIVE REQUIREMENTS BY METHOD

Based on the above projected method mix for all women, an average of 2.5 million women of reproductive age (WRA) will need to be reached on an annual basis in the next five years to meet the mCPR goal. The majority of the women will be using pills; however, method use will increasingly shift to LARC, including IUCDs and implants, as shown Figure 1:

Figure 1: Trends in Contraceptive Requirements by Method



ROAD MAP TO ACHIEVING COUNTRY GOALS

Implementation of the ZNFPCIP will span five years, from 2016 to 2020, and involve a broad range of stakeholders under the stewardship of the Government of Zimbabwe. The goals and objectives of the ZNFPCIP will be carried out through effective and efficient implementation of interventions under five major strategy areas: enabling environment, commodity security, service delivery, demand creation and research, monitoring, and evaluation. Measurable outcomes and associated outputs have been defined for each strategy area resulting in seven (7) outcomes and 25 outputs.

Enabling Environment

Under the ZNFPCIP, Zimbabwe aims to mobilise adequate financial resources to meet recurring financial needs; improve the policy and normative environment (i.e. general perceptions and attitudes about family planning), and strengthen the leadership, management, and coordination capacity of the ZNFPC. Outcome performance targets are:

- At least 90 percent of the plan's annual budget funded on an annual basis
- New ZNFPC structure in place and operational

- Joint review, supportive supervision, monitoring, and quality assurance visits conducted by the ZNFPC and MOHCC in a year
- National quarterly coordination meetings held on an annual basis (jointly planned by the ZNFPC and MOHCC)
- New ZNFPC amendment promulgated by the government
- Key policy and strategic documents available

Commodity Security

Between 2016 and 2020, an average of 2.2 million Zimbabweans will need to be served with a family planning method every year to achieve an mCPR of 68 percent by 2020. Although this is only a small percentage change from the current 65.6 percent, the family planning programme will need to achieve a robust and reliable family planning commodity security system through a strengthened system for managing the supply chain. Outcome performance targets are:

- Adequate methods procured to fulfil demand for modern contraceptives by approximately 2 million WRA each year
- Quarterly stock-out rates for family planning products less than 4.8 percent at the national level
- 85 percent of primary-level service delivery points (SDPs) have at least three modern methods of contraception available on the day of assessment
- 85 percent of secondary- and tertiary-level SDPs have at least five modern methods of contraception available on the day of assessment

Service Delivery

To improve availability of and access to quality family planning services for all women, a comprehensive service delivery infrastructure that offers services through different modalities, in both rural and urban settings, must be functioning at optimal levels. It must have the requisite capabilities (i.e. staff, infrastructure, equipment) to offer a broad range of methods to fulfil demand, as well as address the needs of different segments of the population, including young people and those who cannot be reached by traditional family planning services.

Outcome performance targets are:

- An estimated 2 million WRA provided with family planning services, every year, up to 2020
- All WRA using modern contraceptives by 2020
- Unmet need among married women reduced from 10.4 percent to 6.5 percent
- Unmet need for family planning for adolescent girls reduced from 16 percent to 8.5 percent
- Demand for family planning satisfied by modern methods increased from 87 percent to 91 percent

Demand Creation
Robust, multi-faceted, tailored, and consistent social and behavioural change communication efforts will be used to improve equity in contraceptive access, increase knowledge and demand for LARC, empower youth with adequate knowledge to facilitate well-informed contraceptive decision making, and improve social norms influencing behaviour change. Outcome performance targets by 2020 include:

- Demand for family planning among WRA increased from 52.3 percent to 55 percent
- Demand for family planning among currently married women increased from 77 percent to 82 percent
- Unmet need among married women reduced from 10.4 percent to 6.5 percent
- Unmet need for family planning for adolescent girls, 15–19 years, reduced from 12.6 percent to 8.5 percent
- Unmet need for family planning among the rural population reduced from 10.9 percent to 9.5 percent
- Unmet need for family planning among populations with no education reduced from 22.3 percent to 15 percent

Research, Monitoring and Evaluation
Under the ZNFPCIP, data-driven decision-making will be enhanced to improve the family planning programme's effectiveness and efficiency. An effective Research M&E system requires that end users demand information. Thus, it has to be collected, processed, and made available in a timely manner to end users, and is eventually used to improve intended programme and health outcomes. Similarly, a programme that aims to satisfy demand and respond to client needs must pay particular attention to routine quality monitoring and improvements. Outcome performance targets are:

- 90 percent of family planning SDPs across public and private sectors report through the national health management information system (HMIS)
- Integrated family planning recording and reporting tools adopted and used by all family planning providers in the country
- Two-year national family planning research framework/road map developed
- M&E unit of ZNFPC strengthened

FINANCIAL RESOURCE REQUIREMENTS

The cost of the total plan is USD 177, 409,397, which will increase the number of women in currently using modern contraception from approximately 2.4 million to 2.7 million between 2016 and 2020. The average cost of reaching each woman of reproductive age per year to meet the country's goal is approximately USD 14.

Table 3 summarizes the plan costs by year. From 2016 to 2020, the average annual cost of the plan is about USD 35million. Overall, commodity security reflects the largest share of costs (55%), at USD 97,629,748.

Table 3: ZNFPCIP Annual Cost Estimates, 2016–2020

	2016	2017	2018	2019	2020	Total Costs by Strategy Area	% of Total Costs by Strategy Area
Enabling Environment	814,801	881,923	245,941	255,439	251,353	2,449,457	1.4%
Commodity Security	18,455,443	19,423,986	18,997,851	20,305,170	20,447,297	97,629,748	55.0%
Service Delivery	6,115,748	6,979,232	8,754,349	9,035,970	5,984,885	36,870,185	20.8%
Demand Creation	3,438,054	9,152,622	8,892,068	9,071,395	9,254,013	39,808,152	22.4%
M&E	85,313	102,874	222,264	79,904	161,501	651,856	0.4%
Total Costs Per Year	28,909,359	36,540,637	37,112,473	38,747,878	36,099,050	177,409,397	100%
% of Costs Per Year	16.30%	20.60%	20.92%	21.84%	20.35%		

IMPLEMENTATION ARRANGEMENTS

A multi-sectoral approach to implementing the plan will be adopted to create opportunities for broad and diverse stakeholder involvement to jointly prioritise family planning as a fundamental intervention for health, social, and economic development. In line with its vision to achieve the highest possible level of health and quality of life for all people, the MOHCC will be the final custodian of the ZNFPCIP's implementation. It will work with other line government ministries and departments, state enterprises and parastatals and development and implementing partners to ensure its implementation.

COORDINATION FRAMEWORK

The existing national and sub-national coordination structures will be used to coordinate the family planning programme in an integrated manner together with other reproductive, maternal, new-born child, and adolescent health programmes. The National Family Planning Coordination Forum will lead the process and will effectively engage other forums. In addition, the programme coordination will have linkages with existing donor coordination forums such as the Health Development Fund (HDF), Results Based Financing (RBF).

RESOURCE MOBILISATION FRAMEWORK

The success of the ZNFPCIP hinges on the ability to mobilise a considerable amount of resources in a short time and on a continuous basis throughout the implementation period.

There is need to put more effort to engage both traditional and non-traditional partners and to mobilise both domestic and external funds.

PERFORMANCE MONITORING AND ACCOUNTABILITY

Measuring performance against set targets in the ZNFPCIP is central to generating essential information to guide strategic investments and operational planning. The MoHCC will be responsible for this and will bring together all other available resources to build a robust accountability framework for the programme.

INTRODUCTION

Zimbabwe aspires to have in place quality family planning services for all by the year 2020. The Zimbabwe National Family Planning Strategy (ZNFPS) was developed to guide the nation in the provision of integrated quality family planning, adolescent sexual and reproductive health (ASRH), and HIV/AIDS services from 2016 to 2020. The ZNFPS builds upon the government's agenda for family planning under the social services and poverty eradication cluster as described in the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimASSET).

The Zimbabwe Family Planning Costed Implementation Plan (ZNFPCIP) 2016–2020 is intended to stipulate the yearly implementation plan and associated cost estimates for the implementation of the ZNFPS 2016 - 2020; FP2020 commitments; Every Woman, Every Child, Every Adolescent Commitments; Sustainable Development Goals; and other national commitments and goals related to family planning. The implementation plan also defines measurable results that need to be achieved, an implementation timeline, and metrics to facilitate performance measurement. Further, the ZNFPCIP delineates key institutional arrangements to support execution of the plan throughout the five-year period. The ZNFPCIP describes five strategy areas of implementation: enabling environment; commodity security; service delivery; demand creation; and research, monitoring, and evaluation. Cutting across these strategy areas are three key strategic priorities that will drive the family planning agenda forward: reducing teenage pregnancies, providing family planning services in integrated settings, and increasing utilisation of long-acting reversible contraception (LARC).

The ZNFPCIP serves as an operational guide for all stakeholders involved in the family planning programme, across all government sectors, development partners, and implementing partners. Specifically, the ZNFPCIP:

- **Supports a unified country approach to family planning programming:** The ZNFPCIP articulates the country's consensus-driven priorities for family planning based on a consultative process among key stakeholders of family planning. As such, stakeholders' family planning efforts must now align with the ZNFPCIP to ensure a coordinated and resource-efficient approach to implementation.
- **Delineates financial resource requirements:** The ZNFPCIP consists of annualized cost estimates to enable the government and partners to understand the family planning programme's budgetary needs for the next five years. The ZNFPCIP functions as a resource-mobilisation tool to secure donor and government commitments for the family planning programme, identify funding gaps, and strengthen advocacy to ensure adequate funds are raised.
- **Defines success:** The ZNFPCIP provides benchmarks and indicators that the government can use to monitor annual performance and progress towards its goals. It defines performance targets at different levels of the results framework, including goals, outcomes, and outputs. The ZNFPCIP includes estimates of the demographic, health, and economic impacts of the family planning programme, providing a strong rationale for the value of investment requirements.
- **Establishes a foundation for coordination:** The ZNFPCIP functions as a planning and management tool to support the government to effectively coordinate activities implemented by multiple stakeholders and to enhance accountability.

THE ZIMBABWE CONTEXT

Zimbabwe is globally acknowledged as one of the family planning successes in Africa. For more than two decades, the modern contraceptive prevalence (mCPR) has been one of the highest in sub-Saharan Africa, currently estimated at 65.6 percent[2]. Zimbabwe was one of the first sub-Saharan African countries alongside Botswana and Kenya to experience a fertility transition from 6.7 to 4.0 births per woman between 1984 and 2015[3]. The population growth rate showed a similar decline, from 2.6 percent to 0.82 percent between 1991 and 2009[4]. At the same time, Zimbabwe has experienced a turnaround in family planning including an increase in teenage pregnancies, a rise in the youth population and a continuing high-unmet need for family planning.

Macroeconomic and political factors, as well as the HIV/AIDS epidemic, are contributing factors to the observed loss in gains. Between 1997 and 2008, Zimbabwe underwent an unprecedented economic decline, its economy shrinking by more than half. As a result, the country faced hyperinflation, high unemployment, a collapse of social delivery, and reversed economic gains of the 80s and 90s. Key socioeconomic indicators before, during, and after the economic depression are summarized in Table 4.

Table 4: Socioeconomic Indicators

Indicator	Pre-Depression (1990s)	Depression (2000s)	Current (2010s)
*Human Development Index (rank)	121	151	155
**Population (millions)	11.7 (1998)	11.6 (2002)	13.1 (2012)
**Annual population growth rate	3.1 (1992)	1.1 (2002)	2.2 (2012)
**Youth population, 15–24 years		23.4% (2002)	20 % (2012)
Teenage pregnancies	21% (1999)	24% (2010-11)	22% (2015)
Adolescent fertility rate (ZDHS) (births per 1,000 women ages 15–19)	112 (1999)	115 (2010-11)	110 (2015)
Total fertility rate (ZDHS)	4.3 (1994)	3.8 (2005-6)	4.0 (2015)
CPR, currently married women, modern methods (ZDHS)	54% (1999)	60 (2005-6)	67% (2015)
Unmet need for family planning, currently married women (ZDHS)	9% (1999)	13% (2005-6)	10.4% (2015)
**Adult literacy	67%	89%	84%
Infant mortality rate (per 1,000) (ZDHS)	65	60	50
Under five mortality rate (per 1,000) (ZDHS)	102 (1999)	82 (2005-6)	75 (2015)
Maternal mortality ratio (per 100,000 births) (ZDHS)	695 (1999)	960 (2010)	651 (2015)
HIV prevalence, adult (ages 15–49), total		18.1% (2005-6)	***15% (2013)
Life expectancy (years)	60	41	58

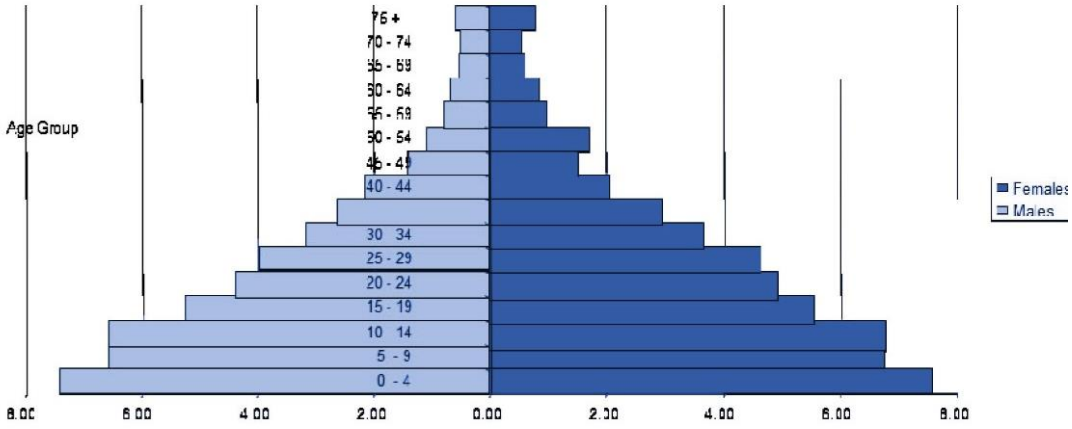
*Source: Data has been extracted from the Maternal, Neonatal and Child Health (MNCH) roadmap, * World Bank statistics, **Census Projections, ***UNAIDS 2013 Report.*

In the Vision 2020, Zimbabwe aspires to be a united, strong, democratic, prosperous, and egalitarian nation with a high quality of life for all Zimbabweans by the year 2020. The achievement of this vision can be facilitated by a demographic dividend, which has been acknowledged to contribute to economic miracles in Southeast Asia in the 1990s[4]. However, Zimbabwe runs the risk of losing the demographic dividend if population growth to facilitate a demographic transition is not effectively managed. Despite its achievements in education and health, Zimbabwe faces challenges that include high rates of early marriage; high rates of teenage pregnancy; high maternal mortality, especially among young girls; high rates of school dropout at the secondary level; and, most significantly, lack of employment opportunities, amongst the youth.

POPULATION

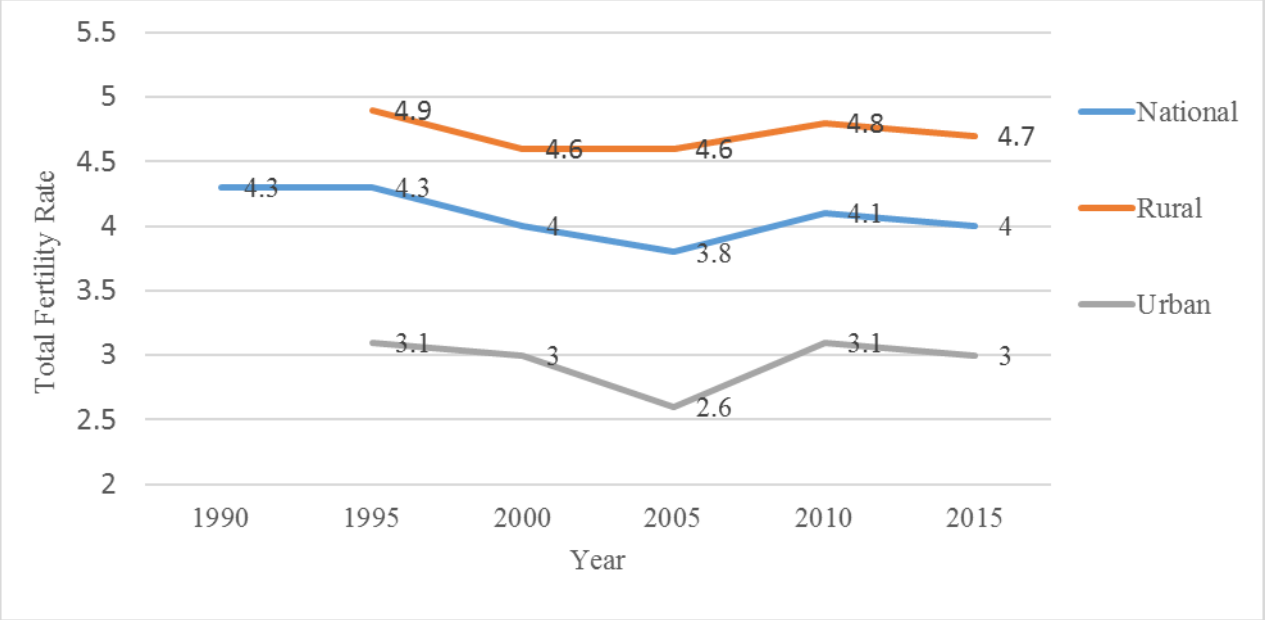
Zimbabwe's population is currently estimated at 15.2 million people,[5] based on the estimate of 13.06 million people in the 2012 census.[6] Although the annual population growth rate steadily declined between 1990 and 2006, a year thereafter saw a rising growth rate, reaching 2.2 percent in 2012[6.] At the current population growth rate, Zimbabwe is expected to reach 19.3 million people by 2032, representing a 30 percent increase in a 20-year period.[7] Most Zimbabweans (67 percent) reside in rural areas, and 41 percent are below the age of 15. Youth between the ages of 15 and 24 comprise 20 percent of the total population. When looking at the population by age, the sizes of the population groups decline steadily with increasing age (**Figure 2**). Zimbabwe has a very high literacy rate, which is the highest in Africa. According to the Zimbabwe Demographic and Health Survey (ZDHS) 2015, very few women and men (only 1 percent each) have not attended formal education in Zimbabwe.

Figure 2: Zimbabwe Population Pyramid, 2012



Fertility rates are a driving factor of population growth. The full participation of the government in family planning, by enacting the Zimbabwe National Family Planning Act of 1985, gave a great boost to the national family planning programme. The total fertility rate (TFR) however, shows that there is higher fertility among the rural population than among the urban population (**Figure 3**). Further, based on the 2010 ZDHS, the TFR was markedly higher for women who are less educated (4.9 births per woman) or poor (5.3 births per woman).[8]

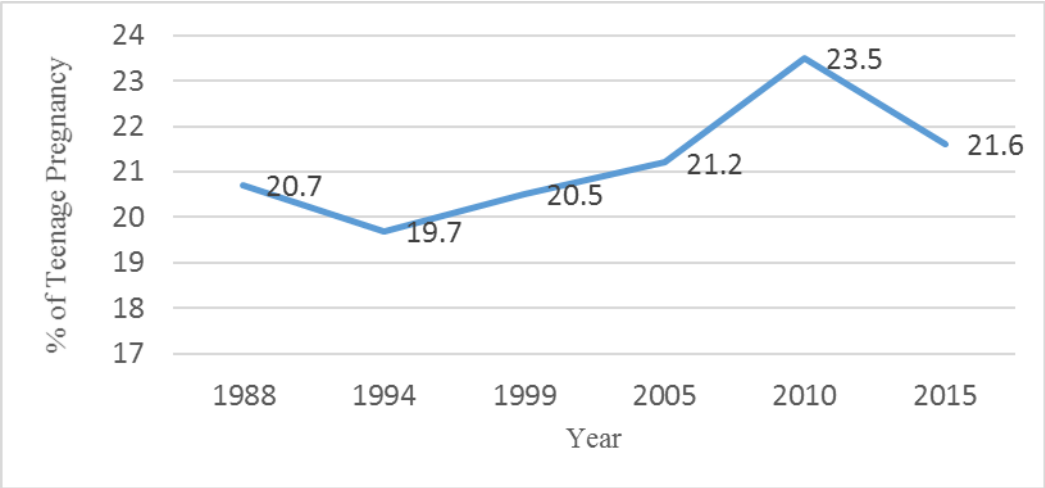
Figure 3: Trends in Total Fertility Rate, Zimbabwe 1988–2015



ADOLESCENT FERTILITY AND TEENAGE PREGNANCY

Meeting the sexual and reproductive health (SRH) needs of young people is a challenge, and is of great socioeconomic and health concern. Despite several recent initiatives, youth-friendly reproductive and sexual health services in outreach or static facilities are far from available to young people. More than one in five teenage girls between the ages of 15 and 19 are pregnant.[2] Trends over the past two decades show an increase in teenage pregnancy and a tidal change seems to have begun in 2015, with a small decline of 2 percentage points in a five-year period (**Figure 4**). The age-specific fertility rate for 15- 19 year olds has increased from 99 births per 1,000 women in 2005-6 to 110 births per 1,000 women in 2015. This manifested through a higher proportion of teenage pregnancies and a lower mean age at first birth[9]. The rural-urban differential in teenage fertility is striking as rural girls are more than twice as likely to become mothers as their urban counterparts[9]. Access to information is also limited for adolescents. Only 13 percent of adolescents have access to family planning messages in the media compared to 24 percent of the rest of the population[9]. In addition, only 3 percent of adolescents have access to family planning advice when they visit service delivery points in either outreach or static facilities[2].

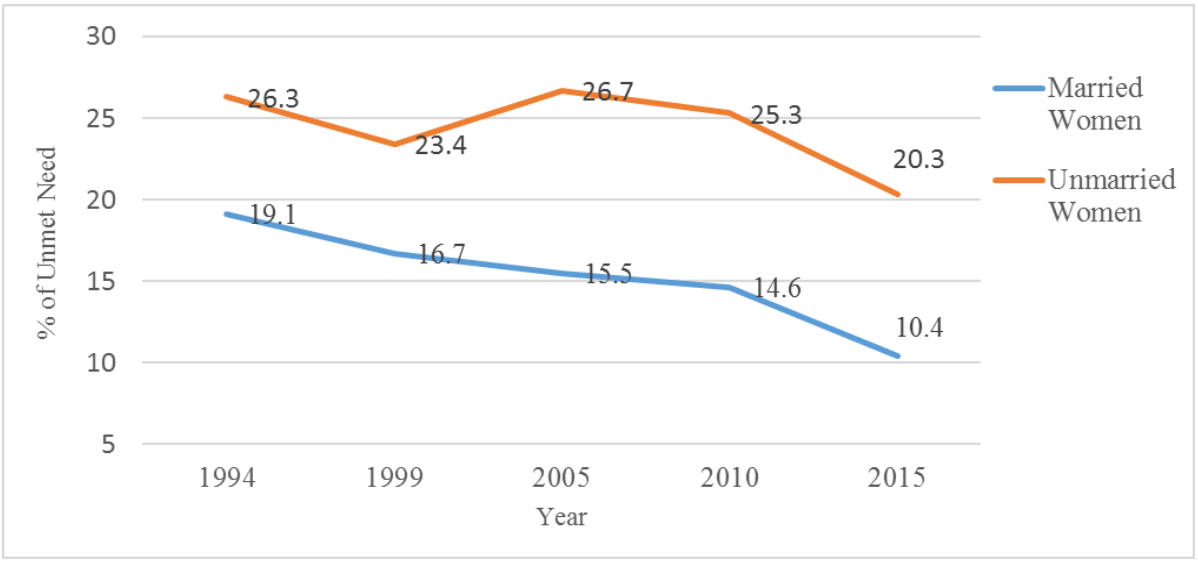
Figure 4: Trends in Teenage Pregnancies, 1988–2015
Percentage of teenagers 15–19 years old who have begun childbearing



DEMAND FOR FAMILY PLANNING

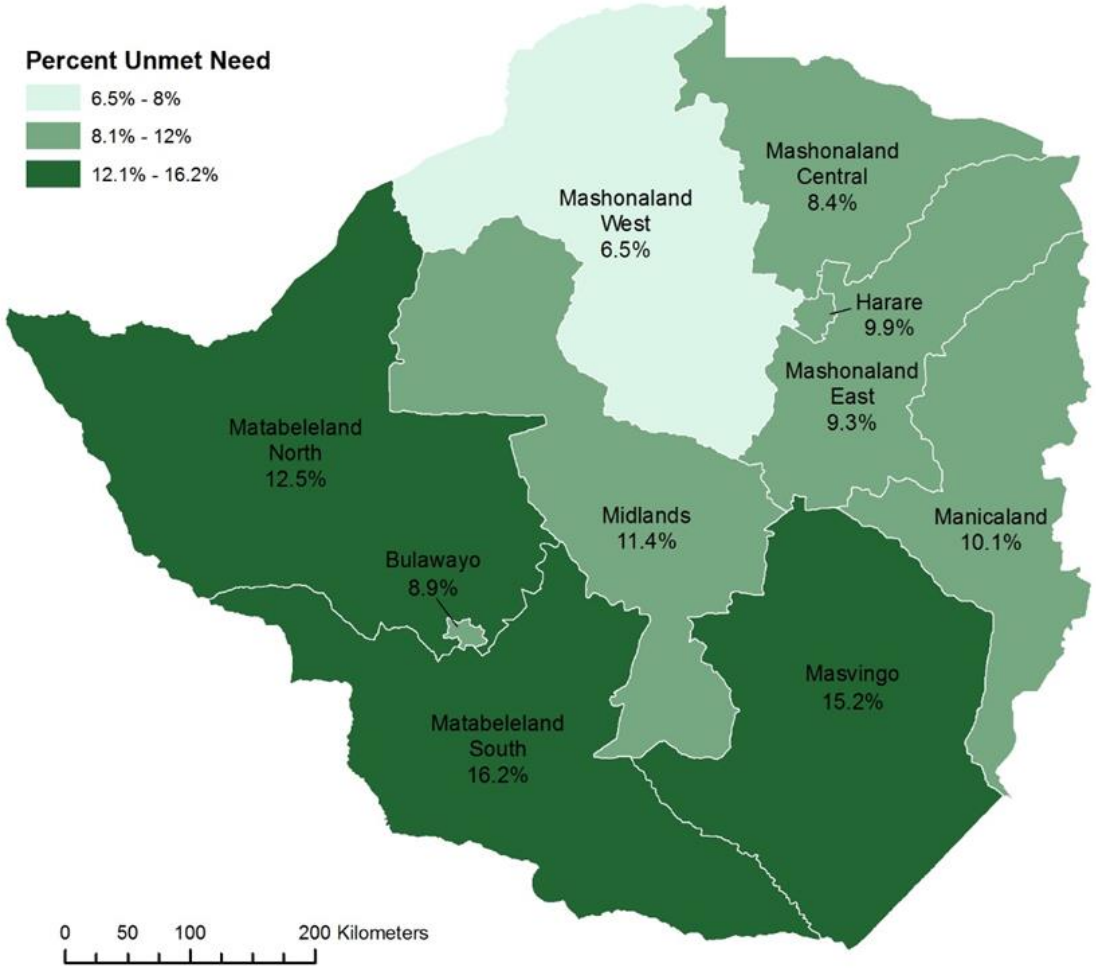
Demand for family planning can be reflected by the following metrics: unmet need, fertility preferences, and future use of contraception. Zimbabwe has seen some success in reducing unmet need among married women, with a drop of 2.4 percentage points in six years, even as overall demand for family planning has increased. Unmet need among married women of reproductive age (WRA) is currently 10.4 percent, down from 15.5 percent in 2005 (**Figure 5**)[9]. The unmet need varies in accordance with demographic indicators and geographical area. Married youth ages 15–19 and 20–24 have an unmet need of 12.6 percent and 10 percent, respectively. This has also slightly declined from five years ago. With heightened efforts to increase access to family planning in rural areas, the urban-rural gap for unmet need is contracting. Whereas the gap was 4.9 percentage points in 2005, it stood at only 1.5 percentage points in 2015 with rural and urban married women reporting unmet need of 10.9 percent and 9.4 percent respectively.

Figure 5: Trends in Unmet Needs among Married and Unmarried Women 1994-2015



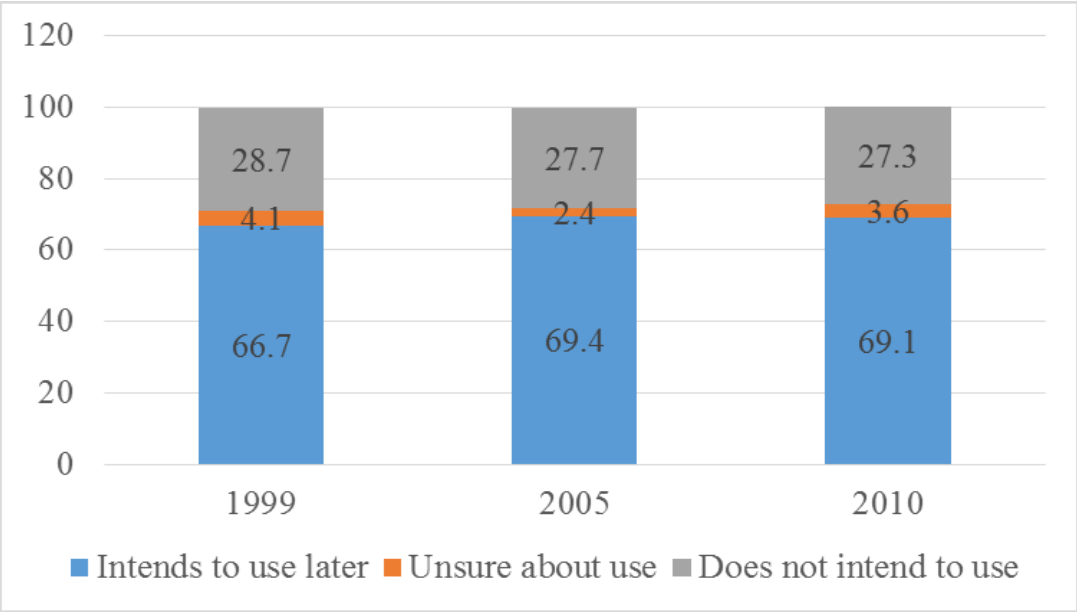
Interestingly, the reverse is true for sexually active unmarried women. Unmet need is higher among urban sexually active unmarried women (23 percent) than among their rural counterparts (18 percent). Wide disparities also exist across provinces, ranging from 7 percent in Mashonaland West to 16 percent in Matabeleland South (**Figure 6**). Further, married women with no education have the highest unmet need for family planning (22 percent) compared with 5 percent among women with at least a secondary education.

Figure 6: Percent of Married Women, 15–49 Years, with Unmet Need by Province, 2015



Future intent to use contraception is an important indicator of changing demand, and is a forecast of potential demand for services. Figure 7 shows that among non-users, intention "to use contraceptives in the future" changed very little between 1999 (66.1 percent) and 2010 (69.4 percent). The number of women desiring contraception in the future seems to remain static, a factor that signals a need for enhanced activities to create demand. Fertility reasons, method-related factors and lack of knowledge are the most common reasons why women are not accessing family planning services[2] .

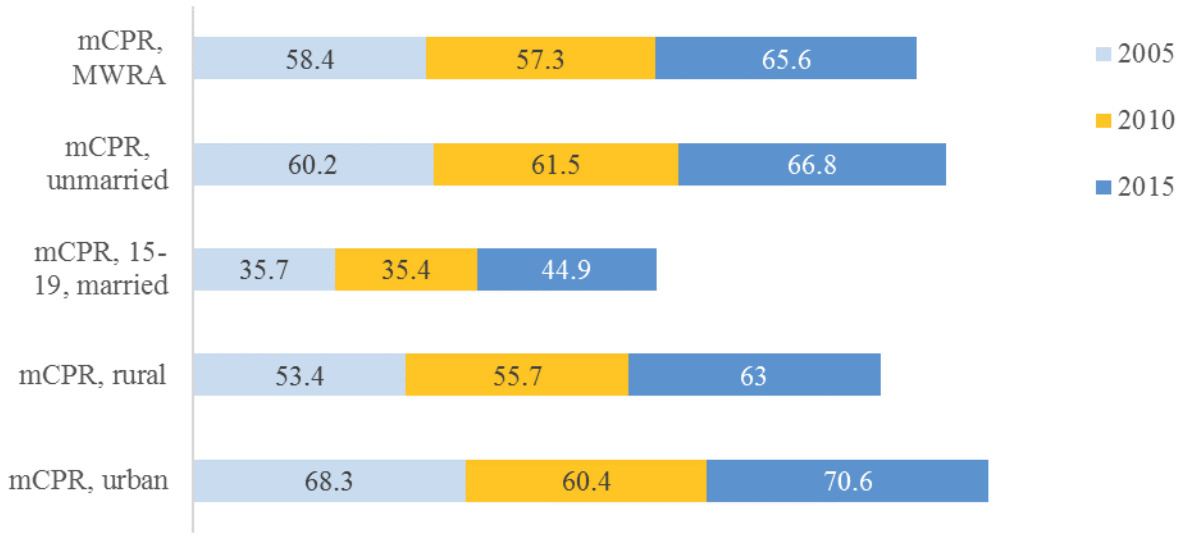
Figure 7: Trends (percent) in Future Intent to Use Contraception among non-users 1999-2010



CONTRACEPTIVE USE

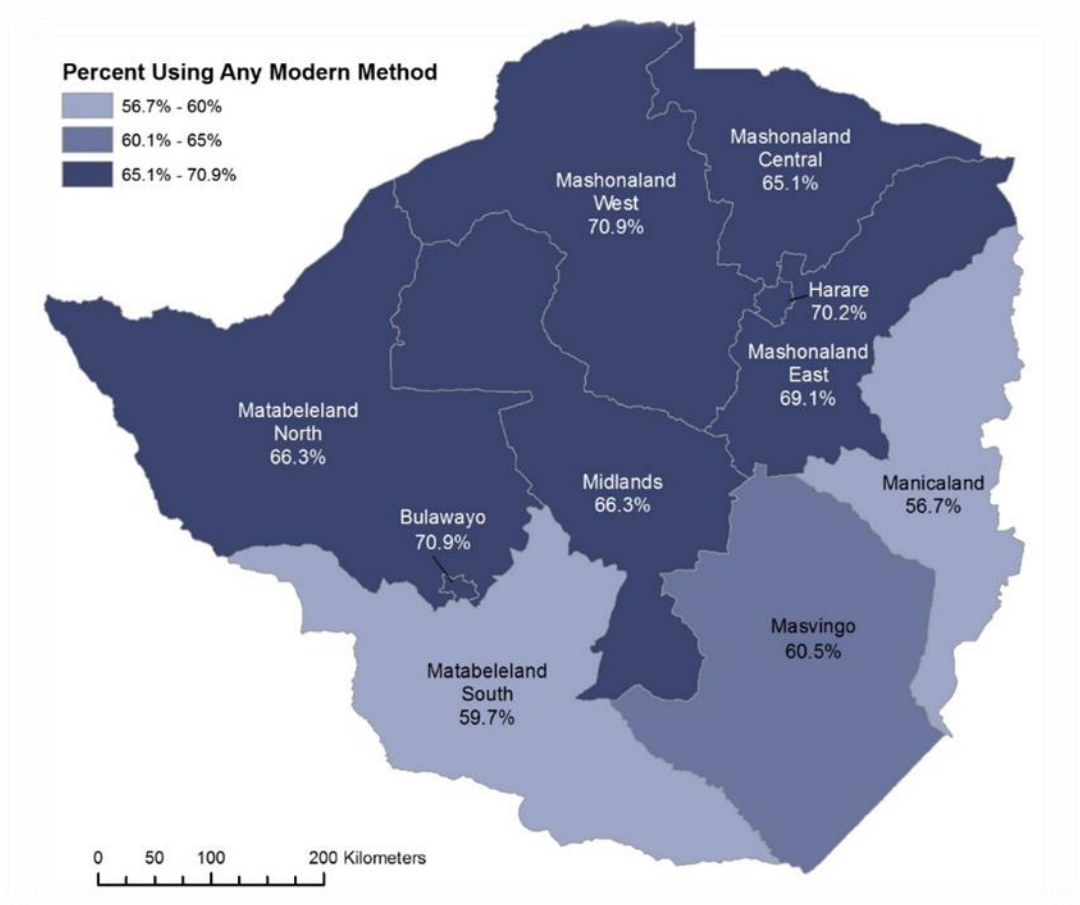
The mCPR rose steadily post-independence, followed by a period of stagnation around 60 percent between 2005 and 2010. In 2015, 67 percent of married WRA in Zimbabwe were using a method of contraception, and the majority were using modern methods (65.6 percent). This represents a considerable increase from 27 percent in 1984, and a growth of 1.6 percentage points per year since 2010. Trends show that despite the increase in the contraceptive prevalence rate (CPR), TFR has only been ranging from 3.8 to 4.3. Trends in modern contraceptive use among different population groups are shown in **Figure 8**. Among sexually active unmarried women, family planning use has also increased to 66.8 percent (from 61.5 percent in 2010). Contraceptive use among married adolescents, despite being stagnant between 2005 and 2010, has now also increased to 44.9 percent. The mCPR has also grown in both rural and urban areas, although the increase is more pronounced in the urban areas than in the rural areas.

Figure 8: Trends (percent) in Modern Contraceptive Prevalence Rates among Population Groups, 2005–2015



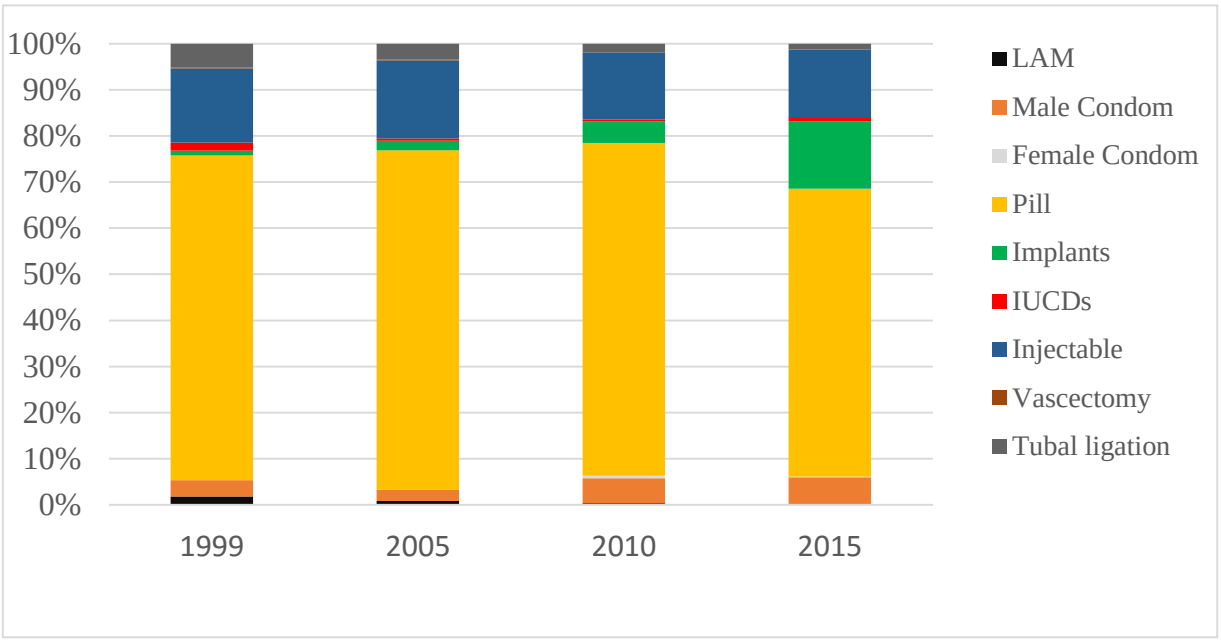
Family planning use also varies by province, with CPR ranging from 57 percent in Manicaland to 71 percent in Mashonaland West and Bulawayo (**Figure 9**). Religious, sociocultural, and health infrastructure profiles explain the variations across the different provinces.

Figure 9: Modern Contraceptive Use by Province, 2015



Despite positive advances in the adoption of family planning, the method mix in Zimbabwe continues to be highly skewed towards short-term methods, in particular oral contraceptives (**Figure 10**). At least 40.9 percent of contraceptive users report using oral contraceptives, followed by 9.6 percent using implants and 9.6 using injectables. The least used methods, with less than 1 percent use, in order of increasing use are male sterilisation, female condoms, the lactational amenorrhea method, intrauterine contraceptive devices (IUCDs), and female sterilisation. Compared with what was reported in the 2010 ZDHS, today there has been a considerable increase in the use of implants and IUCDs, but the proportion of IUCD users continues to be very small. Use of female sterilisation is increasingly declining, as is the use of female condoms. Use of vasectomy is negligible. An inadequate capacity of health care workers to offer LARC and long-acting and permanent methods (LAPMs) is the main reason for their poor availability. Ill-equipped facilities and poor demand creation also contribute to the low uptake. The high discontinuation rate of 24 percent for available contraceptives (mostly the pill) further limits the benefits of contraceptive protection against unintended pregnancies. Across all contraceptive methods, the most common reason for discontinuation is the desire to become pregnant (40 percent), followed by concern over either side effects or other health issues (17 percent)[8].

Figure 10: Trends in Method Mix, 1999–2015



KEY ISSUES AND CHALLENGES

ENABLING ENVIRONMENT

An enabling environment - a range of interlinked policy, governance, sociocultural, and economic factors - forms the basis of a highly functioning and sustainable family planning programme. Left unaddressed, desired results may not be gained from investments in supply and demand elements of a program. Zimbabwe's long-term success in sustaining a modern contraceptive prevalence rate higher than average for sub-Saharan Africa indicates a conducive enabling environment for a thriving program. Conversely, as described below, the inability to fulfil unmet need, expand the method mix (particularly implants and IUCDs), and address resource inadequacies demonstrate inherent gaps and challenges faced by the family planning programme.

Legal and Policy Environment

The Government of Zimbabwe (GoZ) has the political will to enable individuals and couples to have their desired number of children and to plan the spacing and timing of their births. This is well demonstrated by being a signatory to several international and regional conventions, including the International Conference on Population and Development, the Abuja Declaration, the Maputo Declaration, the Southern African Development Community Protocol on Health, the Millennium Development Goals, the SDGs, and commitment to the Every Woman, Every Child, Every Adolescent global strategy. Following the International Conference on Population and Development meeting in Cairo in 1994, the GoZ incorporated family planning and reproductive health into its rolling 3-5 year national development plans and enacted the national population policy in 1998. Subsequently, family planning has also been featured in five-year national development plans. The presence of these policies and plans reaffirms the GOZ's commitment and sets the country's agenda for population and development. Furthermore, the GoZ's political will manifests itself in being one of a few countries with a dedicated parastatal institution (ZNFPC) which focuses on the family planning programme. The National Maternal and Neonatal Health Road Map recognises this council as one of the key pillars for reducing maternal morbidity and mortality.

Box 1: Zimbabwe Country Commitments, FP 2020

1) Increase contraceptive prevalence among married women from 59 percent to 68 percent
2) Reduce unmet need for family planning from 13 percent to 6.5 percent
3) Reduce adolescent (15–19 years) girls' unmet need for family planning services from 16.9 percent to 8.5 percent
4) Increase the family planning budget from the current 1.7 percent to 3 percent of the health budget
5) Increase access to a comprehensive range of family planning methods at private and public health facilities
6) Increase the availability of male and female condoms
7) Integrate family planning services with prevention of mother-to-child transmission and maternal and child health services
8) Improve and scale up gender-sensitive family planning services for vulnerable groups, especially adolescent girls
9) Eliminate user fees for family planning services by 2013

Zimbabwe was one of the first countries that made commitments at the July 2012 London Summit on Family Planning (**Box 1**). A number of other national laws and policies exist to facilitate a supportive environment, as expounded in **Table 5**. The GoZ continues to refine its regulatory environment to support a conducive policy environment for family planning. For example, the recent revisions to the marriage act (changing the age of marriage from 16 to 18 years) will help reduce adolescent pregnancy, delay sexual debut, and improve maternal and child health (MCH) outcomes for women. Despite these policy advances, there are gaps and

weaknesses in the policy and regulatory environment, as well as in policy implementation, that impede access to contraceptive services for young people, medical termination of pregnancy, pre-qualification of contraceptives, and expansion of oral contraceptive pill brands to improve competition. One of the key national guiding documents that closely affects the family planning programme, the Zimbabwe National Family Planning Act is due for review and updating to in cooperate newer priorities and suit the changing environment. How to reposition the ZNFPC into a national institution of excellence for providing strategic leadership and direction to the family planning programme is an important question that needs answering. Another challenge is to improve implementation of the existing policies, which depend on the capacity within the country's existing implementation mechanisms and structures and are influenced by the availability of resources, leadership, skilled staff, and relationships that link them to programmatic action. Response to these challenges require political leadership, commitment, and willingness.

Table 5: Key Policies and Strategies in Zimbabwe

POLICIES AND STRATEGIES	IMPLICATION TO FAMILY PLANNING
National Health Strategy 2016–2020	Two objectives pertaining to family planning are included in the strategy. The first objective is to strengthen ASRH by improving the availability of integrated youth-friendly services using appropriate and evidence-based inclusive models, strengthening the school health programme, implementing comprehensive sexuality education and advocacy for legislation against child marriage, and enhancing community-level awareness of ASRH. The second objective is to reduce pregnancy-related risks among women of child-bearing age, including adolescents, through strengthening family planning, the method mix (especially LARC including post-partum IUCDs), and integration of family planning services with MCH and selected SRH and HIV/AIDS services.
National HIV and AIDS Strategic plan (ZNASP) 2015–2018	Family planning to be provided in an integrated manner into HIV services, including HIV testing and counselling; prevention of mother-to-child transmission (PMTCT); and treatment, care, and support services. Indicators to measure adoption included as percentage of HIV-positive women accessing family planning commodities of their choice.
National Maternal and Neonatal Health Road Map 2005–2015	Recognizes family planning as a key intervention for reducing maternal morbidity and mortality. Also, calls for family planning information provision at all levels where maternal and neonatal health services are provided, and through PMTCT and antenatal care services. It also calls for family planning provision (i.e., condoms and emergency contraceptives) through PMTCT services. The plan has a dedicated objective to increase availability and utilisation of youth-friendly family planning services through building the capacity of

	health service providers in the provision of integrated FP/SRHR and STIs including HIV.
National Adolescent Sexual and Reproductive Health Strategy 2010–2015	Family planning is included as part of the minimum package of services to be provided to adolescents at the facility and community levels. Education and counselling on pregnancy prevention to be provided in schools.
Service Guidelines on Integrating SRHR and HIV Programs and Services, 2013	Provides standardized guidelines on the integration of SRH and rights (SRHR) and HIV services at the community and facility levels. Family planning is recognised as a component of SRHR. Family planning provision is included as a service to be provided by community health workers beyond the traditional community-based distributors, including village health workers. Secondary caregivers of the community and home-based care and behaviour change facilitators are tasked to offer family planning information and refer. At the clinic level, the guidelines state that family planning education and counselling should be provided during HIV counselling and testing, antenatal care, postnatal care, and sexually transmitted infection prevention and control. The same applies to hospitals, with the exception of condom provision in opportunistic infection or antiretroviral therapy centres.

Leadership, Governance, and Coordination

The MoHCC, headed by a cabinet minister, is the highest institution that provides leadership to the family planning programme, like to any other health programme. The MoHCC is the programme's final policy and implementing authority. As the custodian of more than 1,500 health facilities, the ministry is also the largest provider and implementer of the family planning programme in Zimbabwe. The GoZ established the ZNFPC within the MoHCC through an Act of Parliament for coordinating the family planning programme. Although the majority of family planning services are offered through MoHCC facilities, the ZNFPC also has an operational role that includes coordination, service provision, commodity procurement and management. The ZNFPC has more than 1,000 employees, who are structurally organized into two operational divisions i.e. administration and finance and technical services. It has a presence in all the eight provinces and operates 13 family planning clinics and a network of community-based distributors. The ZNFPC has a successful record of accomplishment in providing family planning services. It has contributed considerably to the achievement of a high national mCPR. However, the ZNFPC also faces considerable challenges related to human resources and financial constraints.

For the family planning programme to be efficient, the ZNFPC and MoHCC, together with their relevant departments and units, need to work in a more collaborative manner. Since the family planning programme like any other programme within the MoHCC has components spread across areas like the health management information system, monitoring and evaluation, policy, planning, quality assurance, nursing, and pharmacy. Therefore, close collaboration between the ZNFPC and various departments and units within the MoHCC is essential. The Department of Family Health, being responsible for the family planning programme within the MOHCC, is the main programme contact point for the ZNFPC.

Further, the Reproductive Health Unit within this department, headed by a deputy director, is the direct counterpart of the ZNFPC for day-to-day work. The coordination and collaboration between the two can improve if there is better clarity of their roles. For the Department of Family Health to perform the oversight role (on better coordination between the ZNFPC and MOHCC, including the Reproductive Health Unit), there is a need to review the department's resource needs in terms of both human resources and equipment.

Issues related to strategic vision relate back to when the ZNFPC was established in 1985 and the ZNFPC Act did not spell out explicitly how the functions of the ZNFPC will interface with the functions of the Reproductive Health Unit of the MoHCC, within the ministry's Department of Family and Child Health. However, in the early years there was no problem in the functions of the Reproductive Health Unit and the ZNFPC due to abundant resources. When resources became heavily constrained there was loss of complementarity of roles between the ZNFPC and MoHCC which affected programming, coordination, and management of family planning programme; and this points to the importance of role clarification going into the future. A Board of Directors provides oversight to the ZNFPC; however, its role in contributing to advocacy and resource mobilisation needs to be strengthened. Further, there is a lack of a structured interaction between the Board and the Minister of Health to discuss matters on a regular basis. The interaction between the Board and the Minister is improving and needs to be further enhanced to ensure a strong relationship between the ZNFPC and the MoHCC.

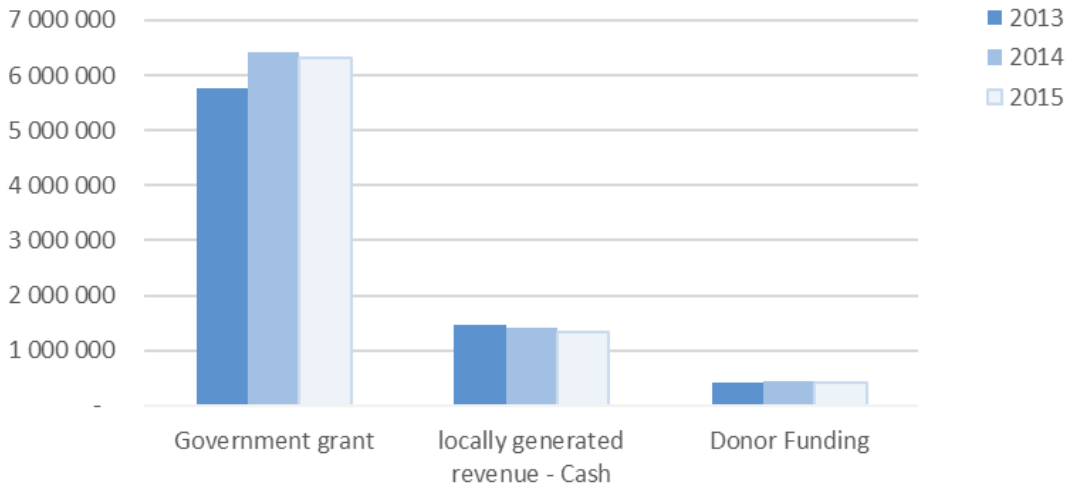
Coordination with provincial ZNFPC management occurs through senior management meetings, held three times a year. Several development and implementing partners in Zimbabwe currently contribute to different areas of the family planning programme. There is a quarterly Family Planning Coordination forum in place led by the ZNFPC. This engages donors, stakeholders, the MOHCC, and other relevant government entities to discuss family planning matters. Also a commodity security committee coordinates stakeholders to review commodity procurement needs and maintain the effectiveness of the supply chain system. These fora and the quality of their deliberations has gained momentum following FP2020 commitment by Zimbabwe. There is a need to strengthen collaboration between the ZNFPC and the Medicines Control Authority of Zimbabwe to ensure that high-quality commodities are available through different service delivery channels.

Financing for FP

The GOZ's financial resource allocation to the family planning programme is an important manifestation of its political will. Accordingly, the government allocates at least 1.7 percent of its health budget annually to fund the family planning programme, primarily to fund the ZNFPC. Because of economic challenges and competing development priorities, this amount does not meet the financial resource requirements needed to implement a holistic program, let alone sustain ZNFPC operations. An analysis of investment requirements conducted in 2014 projected a resource gap of USD23 million from 2015 to 2017.[9] Although the 2012 London Summit pledge was made to increase the budget allocation to 3 percent of the health budget, no substantial resource increases have yet been realized.[10] Inadequate resource allocation by the government is accounted for by the economic challenges faced by the country and competing development priorities. Review of trends in financing of the ZNFPC (**Figure 11**) show an increase in government financing by 9.5 percent, a decline in the ZNFPC's own generated revenues (through hosting workshops/conferences and user fees from service delivery) by 9 percent, and a slight increase in donor funding by 1.9 percent, over a three-year period. Despite this funding, the ZNFPC operates with a 55 percent resource gap in its

total annual budget of approximately USD18 million.[11] Although the government wishes to offer free health services, especially to low-income communities, user fees became a source of revenue for the ZNFPC in order to sustain operations. Also, the GOZ receives additional funding and support from the Department for International Development (DFID), the United Nations Population Fund (UNFPA), and the US Agency for International Development (USAID) for commodities/contraceptives and programme implementation. The DFID and USAID also fund the Delivery Team Topping Up (DTTU) system responsible for distributing contraceptives to MoHCC hospitals and health facilities throughout Zimbabwe. The government grant received from 2013 to 2015 was primarily for the salaries of ZNFPC staff and without any disbursements for capital and operations of the FP programme (Figure 11).

Figure 11: Trends in Sources of Income to ZNFPC, 2013-2015



Provincial staff are also required to determine the financial, material, and human resource needs of their catchment area for reporting to the central level. Each province/cost centre has its own budget and manages its own resources and operations as well as coordinates its own activities. However, each collaborates with the central level on a regular and structured basis.

COMMODITY SECURITY

Achieving commodity security - a situation in which every person can choose, obtain and use quality contraceptives whenever they need them is of paramount importance to any family planning programme. Concomitant with the observed high CPR, the family planning programme has made tremendous efforts to make contraceptives available up to service delivery points. The DTTU system was introduced in 2004 to address commodity security challenges brought about by a weak and inadequately resourced supply chain management system. The DTTU system is operating as a partnership among USAID|JSI DELIVER Project, the DFID-funded Crown Agents Zimbabwe, the ZNFPC, the MoHCC Logistics and the National Pharmaceutical Company. The ZNFPC provides overall leadership on commodity security and the supply chain at the national level by coordinating multi-stakeholder committees such as the Commodity Security Technical Working Group, the DTTU Logistics Technical Committee, the DTTU Policy Committee, the Contraceptive Procurement Tables (CPT) Committee and the Family Planning Coordination Forum. The committees and fora are made up of key supply chain implementing partners such as ZNFPC, Nat Pharm, Crown Agents Zimbabwe, USAID|JSI DELIVER Project, UNFPA, PSI, and PSZ. They meet to discuss stock status, status of shipments, quantification outputs, funding

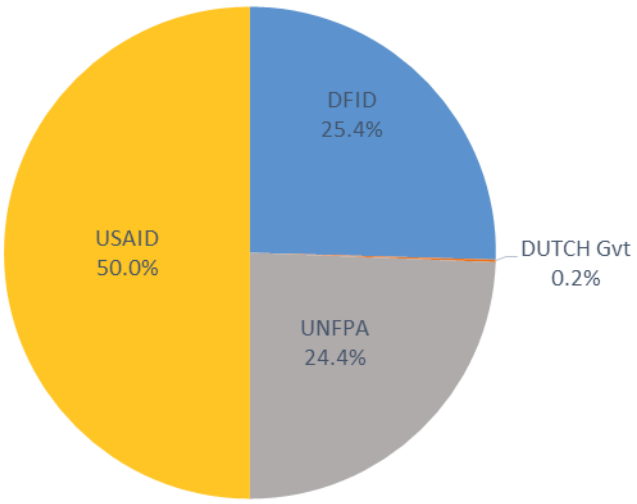
gaps and distribution status. They also deliberate on challenges, opportunities, lessons learnt and best practices in supply chain for health commodities (i.e. quantification, procurement, storage, distribution, logistic management and information system).

Before the inception of the DTTU system, resupply was based on a "traditional pull system" in which facilities placed orders and received their products. Several factors such as low order fill rates, minimally trained staff contributed to commodity stock out rates as orders were not being placed as regularly as they should have been. Even products that were in full supply at central level (mostly program-specific products mainly supplied by international partners) recorded stock-outs at the facility level. Under the push system of the DTTU, commodity resupply is based on predetermined quantity of a product usually calculated using the past consumption patterns. The DTTU system has proven to be highly successful since its inception in 2004. Stock-outs at the facility level fell below 5 percent and delivery coverage of commodities (measured as the number of facilities visited per quarter) and reporting rates reached 99 percent[12]. In addition, commodity loss rate for condoms and contraceptives has remained below 3 percent since the year 2004.

In April 2014, the MoHCC piloted the new Zimbabwe Assisted Pull System (ZAPS) which represents a consolidation of four existing health commodity distribution systems i.e. DTTU, Zimbabwe ARV Distribution Systems (ZADS), Zimbabwe Informed Push/Primary, Health Care Package (ZIP/PHCP), and the Essential Medicines Pull System (EMPS) into a single system for the primary health care facilities in Manicaland Province. Under ZAPS every quarter, an ordering team led by a district pharmacist visits all facilities within the catchment area to forecast the quantities required per health facility using an automated system (Auto-Order). Based on the findings from the ZAPS pilot exercise, the government recommended the national roll out of the ZAPS ordering system beginning of 2016. The essential logistics data elements captured under the DTTU system remain the same for family planning products under ZAPS. Despite many successes of efforts to achieve commodity security, several key issues and challenges prevail. The following issues must be addressed under this plan in order to make progress towards commodity security:

Resources for procuring commodities: Current sources of contraceptive commodity funding, as demonstrated by expenditures for shipments in 2015 (**Figure 12**) highlights a limited number of funders in the programme for sustainability. The dependence on few partners poses a threat to supply of FP commodities. Currently, USAID funds the procurement of male and female condoms; the DFID funds combined oral contraceptives, progestin-only contraceptives, IUCDs, implants, and emergency contraceptives; UNFPA funds implants, IUCDs, injectable, and combined oral contraceptives; and the Dutch government funds emergency contraceptives.

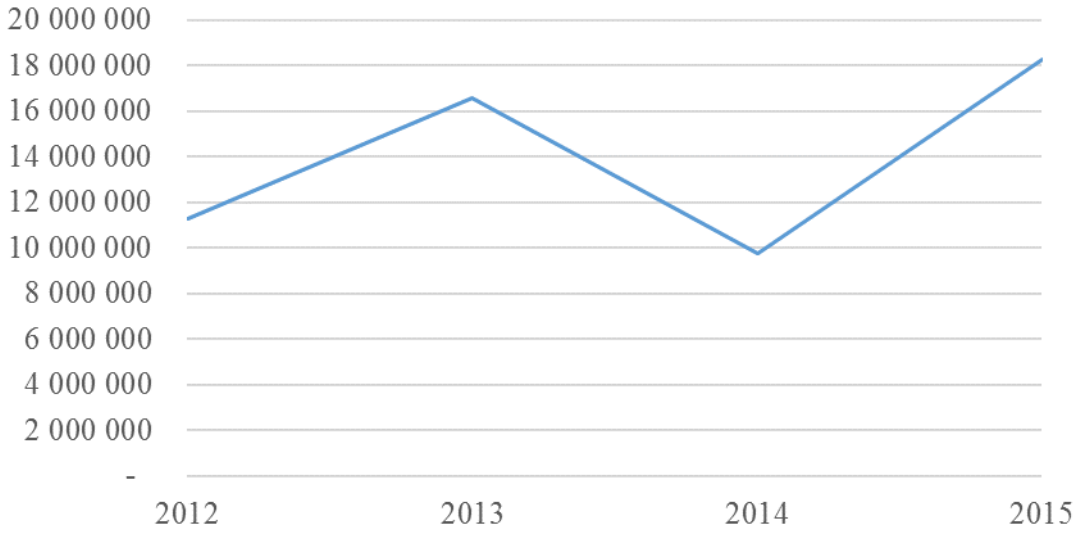
Figure 12: Source of Financing for Contraceptive Commodities, 2015



Source: ZNFPC Contraceptive Procurement Tables (CPTs) 2015

Further, trends over the past four years show that the level of funding from all sources has generally increased from USD 12 million to more than USD 18 million per year (Figure 13). Over the four-year period, there has not been a funding gap for commodities.

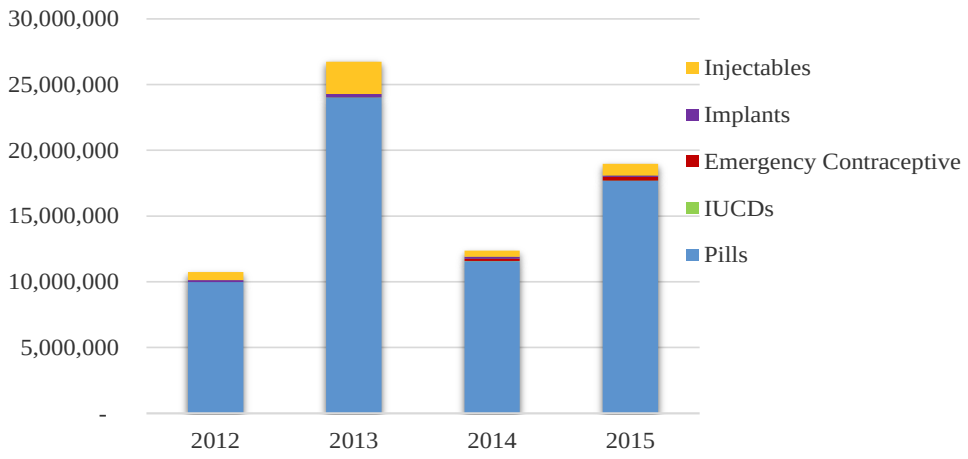
Figure 13: Trends in Annual Expenditures for Contraceptive Commodities, 2010–2015 (in US Dollars)



Availability of a broad range of products: One of the aims of the supply chain system is to match supply to demand for contraceptive commodities. Through the DTTU system, a broad range of products are procured, including oral contraceptives, emergency contraceptives, condoms, IUCDs, and implants. The type and amount of methods procured are informed by demand and measured by consumption rates at the facility level. The persistent skewing of the method mix towards short-acting methods has also skewed the procurement process in efforts to meet demand, resulting in a vicious cycle of more people using short-acting methods as they are the ones mostly available. **Figure 14** and **Figure 15** show procurements

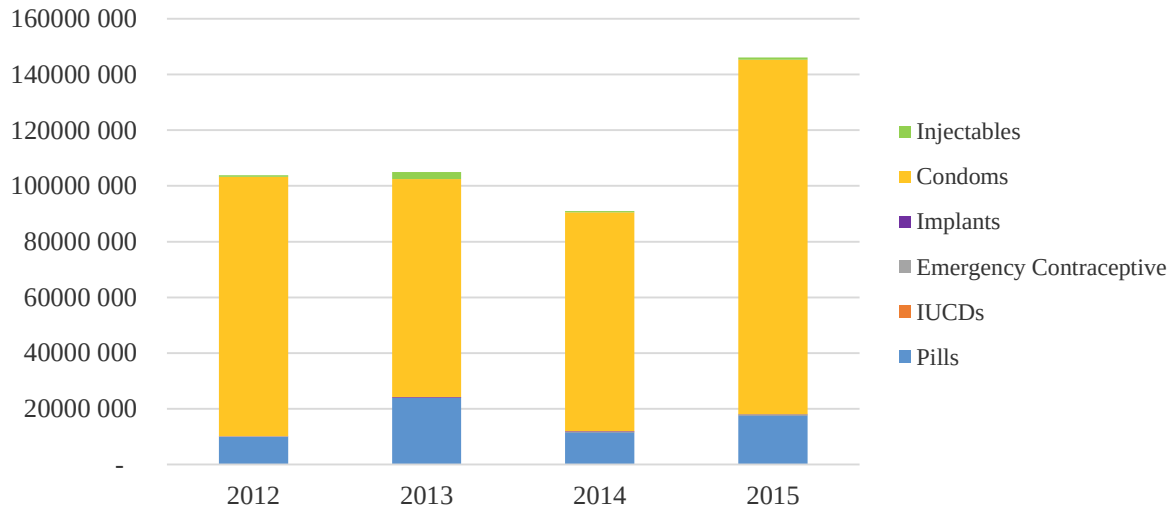
over the past four years. **Figure 14** shows annual shipments without condoms (which are typically procured for both the family planning and HIV/AIDS programmes), and Figure 15 shows procurements including condoms. In both figures, pills (the most consumed contraceptive method) dominate shipments. Increasingly, future procurement and resources will need to be increased and diversified, to address both demand and method-mix priorities. Currently, the quantification of family planning products (i.e., the preparation of CPTs) takes into account historical consumption and country strategies that can affect the method mix in the long term. For example, the FP2020 goals tilt quantification preferences towards long-term methods while assuming a slowdown in the use of short-term methods.

Figure 14: Trends in Annual Shipments of Contraceptive Commodities (Excluding Condoms), 2012–2015



Source: ZNFPC Contraceptive Procurement Tables (CPTs), 2012-2015

Figure 15: Trends in Annual Shipments for Contraceptive Commodities (Including Condoms), 2012–2015



Source: ZNFPC Contraceptive Procurement Tables, 2012–2015

Note: Condoms procured serve both the family Planning and HIV/AIDS programmes

Supply Chain Management: Quantification of commodities is conducted by the CPT Committee led by the ZNFPC, together with the supply chain-implementing partners, including the MoHCC, Crown Agents Zimbabwe, JSI's SCMS project, USAID|JSI DELIVER, UNFPA, PSI, and PSZ on a bi-annual basis. The quantification process informs procurement plans for partners and allows them to review their funding commitments. Currently, USAID funds the procurement of male and female condoms, the DFID funds combined oral contraceptives, progestin-only contraceptives, IUCDs, implants, and emergency contraceptives, UNFPA funds implants, IUCDs, injectables and combined oral contraceptives; and the Dutch government funds emergency contraceptives only. The dependence on few partners poses a threat to supply. Further, different partners have different procurement requirements for different FP commodities under same categories. As such, this poses a gap to other FP commodities, which do not meet the procurement requirements of development partners. In 2014, Marvelon28 pill was procured through UNFPA to cover the funding gap for combined oral contraceptives (control pill). Though the Marvelon pill was once used in Zimbabwe under a social franchise FP project, a well-planned national sensitisation programme was conducted to support its successful re-introduction between 2015 and 2016. Although there is always merit in having more than one brand available, which provides women options and choices, it is also important to have national branding, such as Control and Secure. It is therefore important to negotiate with potential pharmaceutical companies to brand their products as national brands (i.e., Control and Secure) before supplying the country.

As the family planning programme expands, demand for commodities is increasing, but warehouse facilities are also increasingly experiencing capacity constraints. At the central level, there is limited warehouse space and a need for equipment to support the logistics management information system (LMIS) and other handling equipment. Further, the rollout of ZAPS will increasingly shift warehousing requirements to provinces, which currently have no storage space. Therefore, there is need to mobilize resources to support the storage of family planning products at all levels.

Under the DTTU system and ZAPS), quarterly deliveries are made to more than 1,500 facilities. Over the years, DTTU delivery coverage has been consistently around 99 percent. The high delivery coverage has ensured high availability of commodities around 98 percent. Although delivery coverage and the delivery-reporting rate are expected to be at the same level as with the DTTU system, if funding remains at the same level, stock availability is expected to marginally drop from 98 percent to 95 percent because of the integrated nature of ZAPS.

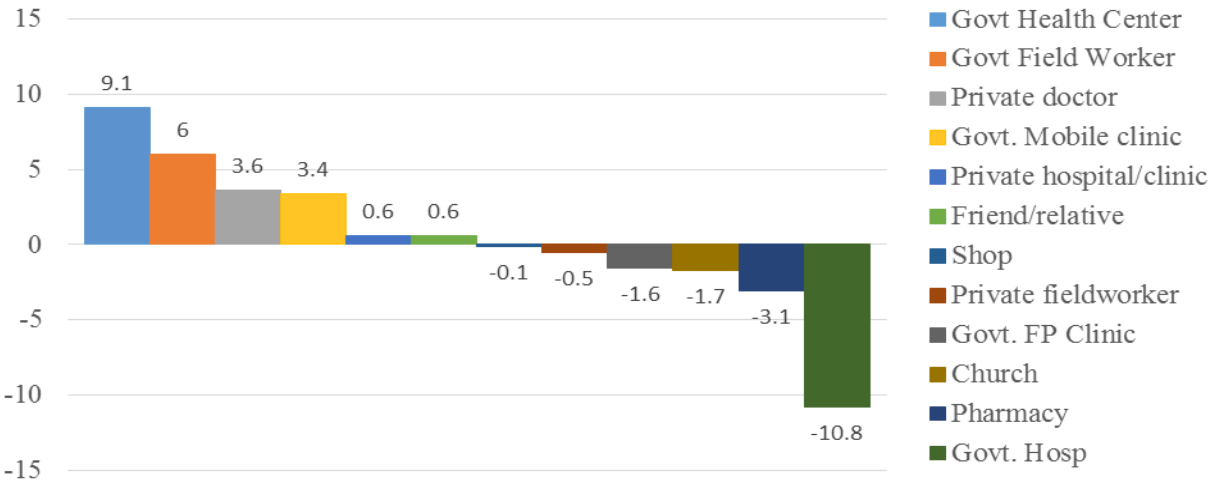
SERVICE DELIVERY

As compared with other Sub-Saharan African countries, Zimbabwe at 65.6 percent mCPR ranks high. However, several underlying service delivery challenges undermine further progress in ensuring voluntary, informed choice and access to a broad range of contraceptive methods a key measure of quality for family planning services. As further described below, method use reflects a skewed method mix leaning heavily towards short-acting methods, especially the pill; low uptake of LARC, particularly in rural areas; a high unmet need among young and unmarried sexually active women; and high contraceptive discontinuation rates.

Zimbabweans access family planning services from a vast range of service delivery points, from the tertiary level (hospitals) to community-based platforms in both the public and private sectors as shown in Figure 16. Most people (73 percent) access family planning services from the public sector, and this represents an increase from 68 percent[13] from five years prior. The government provides family planning services through a network of more than 1,500 facilities and outreach services. The ZNFPC provides complementary services through 13 stand-alone family planning clinics and 27 youth-friendly centres. In each of the rural provinces, the CBD programme provides pills and condoms. ZNFPC clinics offer comprehensive integrated services on family planning, reproductive health, and HIV prevention along with practical trainings on these areas. Outside the public sector, other sources of contraception include the private medical sector (14 percent), mission facilities (4 percent), retail outlets (4 percent), and other private sources (2 percent) [2].

Trends in the past 10 years show changes in the popularity of sources of family planning methods. Data from the ZDHS (2010-2011)[8] show that the number of family planning users reporting that they access family planning services from government mobile clinics, field workers, health centres, private doctors, private hospitals/clinics, and friends/relatives has increased from 1999. This trend is accounted for by improved service availability and delivery in the public sector, the growing size of the social marketing programme (which utilises a broad non-government network) and efforts to increase the supply of long-acting methods. Resource constraints have affected service delivery through government health centres, family planning clinics and fieldworker networks.

Figure 16: Trends in Source of Contraceptives
(Percentage Point Change Between 1999 and 2010)



Source: ZDHS 1999 to 2010[14]

Facility-based service delivery: Supply-side factors contributing to the observed method mix skewed towards short-acting methods include inadequately equipped facilities and insufficient personnel skilled to offer long-acting methods. Other factors such as provider time limitations, heavy workload, and provider biases also contribute to the skewed method mix. A situational analysis conducted in 2014 showed that 53 percent of facilities (a combination of hospitals, clinics, and centres in both the public and private sector) did not offer LARC, mainly because of a lack of skilled staff to insert implants and IUCDs, as well as a lack of functional theatres[14]. Lack of adequately skilled staff to offer integrated family planning services limits availability of these services in primary health care facilities (i.e. primarily rural health centres, clinics, and hospitals), especially in underserved areas.

Community-Based Distribution: The CBD program has long been an important contributor to family planning service delivery. Since 1967, the ZNFPC has operated a CBD programme of full-time salaried workers who provide family planning services to rural and urban populations. In addition, partners such as PSZ operate CBD programmes in select catchment areas (i.e. around the 11 clinics mostly located in urban areas). The key role of community-based distributors is to provide education and counselling on all family planning methods, and to supply pills and condoms in their catchment areas. With evolving trends, the programme has faced important challenges that have contributed to a decline in share of the CBD programme as a source of family planning services (as reported by users), from 7.5 percent in 1999[14] to 1.5 percent in 2010[8]. Several factors that contributed to the initial decline continue to persist. One of these is strengthened family planning delivery at public health facilities, which contributed in particular through enhanced integration of family planning in other health services; as a result, the community has had alternative channels to choose from to access family planning services beyond the CBD programme. Another factor is changing client needs and preferences in method type and service modality; as other methods become available, population needs change. For example, long-acting methods such as injectable and implants are becoming increasingly popular but are not provided by the CBD programme; hence, people seek them elsewhere. Furthermore, young people increasingly demand family planning services but find it uncomfortable to access them from both health facilities and community-based distributors. The government's embargo on hiring new community-based distributors has led to a decrease in the number of distributors creating vacancies in each province ranging between 22 percent in the Midlands to 78.3 percent in Matabeleland North in 2011 **(Table 6)**[15]**.**

Table 6: Active Community-based Distributors by Province, 1999,2011 and 2015

Province	Numbers 1999[I]	Number 2011[17]	Establishment 2015	Number On Post 2015	Vacant Post 2015	Vacancy Rate 2015
Midlands	73	49	63	46	17	27.0%
Mashonaland West	57	29	75	29	46	61.3%
Masvingo	91	49	116	51	65	56.0%
Mashonaland Central	46	33	72	33	39	54.2%
Matabeleland South	63	42	74	41	33	44.6%
Matabeleland North	71	26	120	27	93	77.5%
Mashonaland East	82	42	100	43	57	57.0%
Manicaland	88	45	96	48	48	50.0%
Total	**571**	**315**	**716**	**318**	**398**	**55.6%**

Youth Services. One of every five Zimbabweans (20 percent) is a youth between the age of 15 and 24 years[2.] Meeting the special needs of this population group is of paramount importance under the ZNFPCIP for several reasons. Approximately 42 percent of women of reproductive age are between the age of 15 and 24 years[10]. Thus, any change in mCPR will need to address their access issues. Teenage pregnancy and adolescent fertility rate continues to be high at 22% and 100 births per 1,000 women ages 15–19[2] respectively. More so, the same age group continue to bear the highest burden of maternal deaths, which is 34 percent of all maternal deaths[4]. Twelve percent of married adolescent girls have an unmet need for family planning and 20.3 percent of sexually active unmarried young women report having an unmet need (both higher than the national average of 10.4 percent)[2]. Contraceptive use among adolescents is lower than the national average (46 percent versus 67 percent) [2]

To serve young people, the ZNFPC has a network of 27 youth-friendly centres nationwide. In addition, the ZNFPC supports the MoHCC as a technical partner in the provision of youth-friendly services in some (63) of the government health facilities across the country, covering 5 percent of the health facilities.[16] Several studies have pointed out weaknesses in the current youth programme in effectively providing young people with comprehensive SRH services, including contraceptive services, in a sensitive and friendly manner. The key studies are the Hurungwe Teenage Pregnancy study,[17] Evaluation of the UNFPA-funded ARSH services implemented by MoHCC as in collaboration with ZNFPC, and the Review of National ARSH Strategic Plan by John Hopkins University and National Teenage Study. These studies have shown that youth largely remain underserved and that youth-friendly corners are expensive and not being effectively utilised by adolescents and young people. For instance, youth corners are operational at a very small scale to produce the desired impact.[18] The 2012 ZNFPC annual report[19] stated that youth corners reached only 7 percent of the target population within their catchment areas while peer educators in the same year covered only 3 percent of the target population. Further, the assessment showed youth corners were not very active hubs for information and services for youth. Further, there is inadequate coverage of youth-friendly health services (YFHS) including contraceptive services both in static facilities and in outreach sites in rural areas specifically hard-to-reach areas. Out of the 1,500

MOHCC-operated health facilities, only 63 are designated as youth-friendly health facilities [18]. Out of these 63 only 26 are functional. Those that are active have insufficient capacity to provide comprehensive YFHS covering the entire spectrum of ASRH services. A lack of updated, national guidelines for YFHS creates further challenges.

In a baseline survey of the ASRH youth-centre model conducted in 2011, 50 percent of the respondents cited challenges in accessing family planning services, with key reasons cited being disapproval by parents, the elderly or providers, discomfort in accessing methods in facilities serving adults in a youth friendly manner.[20] The situation analysis conducted in 2014 to inform the development of the 2016–2020 National Family Planning Strategy also revealed several factors inhibiting use of family planning among youth, including unfriendliness of the fixed clinics, leading youth to prefer accessing services from community-based outlets and other private providers; provider bias; religious beliefs and prohibitions; and social-cultural factors. Although efforts have been made to reach youth in educational institutions, the availability of integrated YFHS, including information and contraceptive services, at tertiary educational institutions is low. Similarly, although comprehensive sexuality education has been introduced to equip young people, both in school and out-of-school, with age-appropriate quality information on SRHR, it is still weak. The framework for both in school and out-of-school comprehensive sexuality education needs strengthening. In-school sexuality education has been focused mainly on abstinence-only life skills and requires expansion. To curb these issues, PSZ embarked on a voucher system whereby young people at tertiary institutions access pre-paid vouchers from a trained peer educator (Choice Champions) and use the vouchers to access services from an identified private clinic. Although the system has been successful in overcoming barriers to family planning access for young people in tertiary institutions, the current coverage of SRHR services including contraceptive services is only 20 to 25 percent and hence needs to be expanded.

Integrated Services: One way of increasing access to family planning services is maximising use of existing platforms that are reaching those who have a potential unmet need for family planning. Currently, family planning services are made available across the country through the primary health care system (static and outreach services), comprised of community health services, rural health centres, clinics, and hospitals, including tertiary hospitals. Within this system, bi-directional integration between and within various RMNCAH programmes can improve access to and efficiency of family planning services. An assessment conducted in 2011 revealed that although to some extent integration is occurring at the service delivery level, it is uncoordinated, non-routine, uninformed by policies, and involves inadequately trained health providers.[21] Where the same provider offers services, such as in rural health centres or other lower-/primary-level facilities, integration appeared to be stronger. Other issues facing integration are related to policies and systems. For example, the vertical structure of SRH and HIV services inhibits coordination among stakeholders. Guidelines for integrating SRH and HIV services, as well as integration training tools for managers, service providers, and community health workers, were developed in 2014. Although managers and service provider training commenced in 2015, mainly at the three learning sites in Harare and Bulawayo, training needs to be rolled out to reach saturation levels nationwide. Opportunities exist to advance family planning services through integration into other service delivery platforms, such as maternity waiting homes; PMTCT (prongs 1 and 2); and HIV testing and treatment services. At the community level, family planning can be integrated into ongoing work of community-based cadres, established by the MOHCC, the National AIDS Council, and other ministries, particularly the Ministry of Women Affairs, Gender and Community

Development. These cadres include village health workers, behaviour change facilitators, community-based advocates, home-based caregivers, youth peer educators, and health promoters.

Outreach Services: The majority (67 percent) of Zimbabweans live in rural areas.[2] Women at some clinics report walking distances beyond 20 to 30 km to access health services[16]. Outreach efforts are available however; they are not adequate in terms of coverage to serve the remote and hard-to-reach areas. In addition, because of shortages of staff and resources, facilities cannot meet the increasing demand of outreach services, which require more staff, skills, and resources.

Private Sector: As a source of family planning services, the private sector represents an increasingly important service delivery platform for Zimbabwe. However, its contribution to the national CPR has been inconsistent. Although the private medical sector increased its participation in family planning service delivery from 12 percent in 1994 to 22 percent in 2005 [14] its contribution dropped to 14 percent in 2010[8]. Limited mostly to urban areas, the private sector is made up of private hospitals, clinics, doctors, pharmacies, mission-owned facilities, and social marketing nongovernmental organisations (NGOs) such as PSZ and PSI/Zimbabwe. Among all users of family planning methods, the private sector is a source for 45 percent of male condom users, 24 percent of Tubal Ligation, 21 percent of pill users, 12 percent of implant users and 7 percent of injectable users[2]. Despite the private sector being a considerable source of family planning services, its engagement in the family planning programme is low. As such, family planning data from the sector is not regularly, systematically, and uniformly available within the government's national HMIS (i.e. the IT-based DHIS-2 platform). Since supportive monitoring and quality assurances tend to focus on the public sector, the private sector has received limited support for interventions to improve quality. Hence, the regulatory framework for private-sector delivery may also need to be enhanced to ensure that services provided by the private sector remain of adequate quality.

Method Mix: Supply-side factors that contribute to the observed skewed method mix include inadequately equipped facilities and lack of skilled personnel to offer long-acting methods. The 2014 situational analysis showed that 53 percent of facilities in the study (a combination of hospitals, clinics, centres in both the public and private sectors) did not offer LAPMs, mainly because of lack of skilled staff to insert implants and IUCDs, as well as lack of functional theatres.[16]

DEMAND CREATION

Most married women demand family planning services, as at least seven of every 10 married women (77.2 percent) either are using a contraceptive method or desire to do so.[9] Further analysis and review of trends in demand for and characteristics of family planning reveal the following key points:

- A positive trend in fulfilling contraceptive demand has been observed for the past two decades; as demand is increasingly satisfied, unmet need seems to be decreasing.[9]
- Although the family planning programme's multi-faceted efforts have satisfied contraceptive need for the majority of women (67 percent), it has yet to satisfy 10 percent of married women's need.[9]
- Demand among unmarried women is acutely high (88 percent), with every nine out of 10 of these women demanding a family planning service.[9] Similarly, services have yet

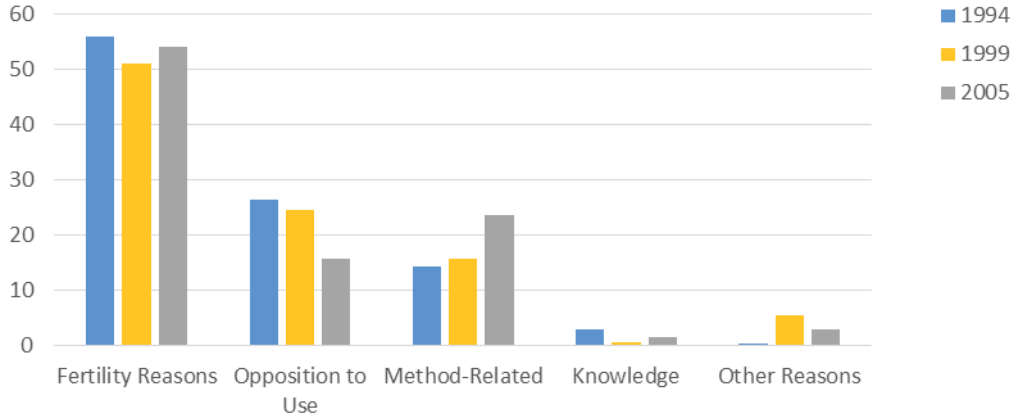
to adequately reach unmarried women in the same manner as married women, as one in five unmarried women (20 percent) has an unmet need.[9]

- There is considerable variation in unmet need among different population groups, relating to age, marital status, education, wealth quintiles, and geographical residence. For example, the unmet need of women ages 15–19 years is higher (12.6 percent) than the average unmet need (10.4 percent).[9]

However, satisfaction of demand needs to be examined critically. First, the majority of women are using short-acting methods. This is in a context in which 76 percent of married women either do not want any more children or want to delay their next birth for at least two years[9]. Secondly, high discontinuation rates persist with almost one in every four users (24 percent) discontinuing use because of side effects and health concerns[8] despite a desire to become pregnant. Thirdly, although users in 2010 reported to have been provided with information on a range of methods (61 percent) and on side effects (53.2 percent) there was no improvement from the preceding five years[8]. More so, a considerable portion of women whose partners used male condoms and discontinued use (7.9 percent) desire to use an alternative effective method[8]. Again, at least 10 percent and 12.5 percent of injectable and male condom users respectively who discontinued use switched to other FP methods. These factors reflect a scenario in which users who are not satisfied with their method and may not be well supported to continue use.

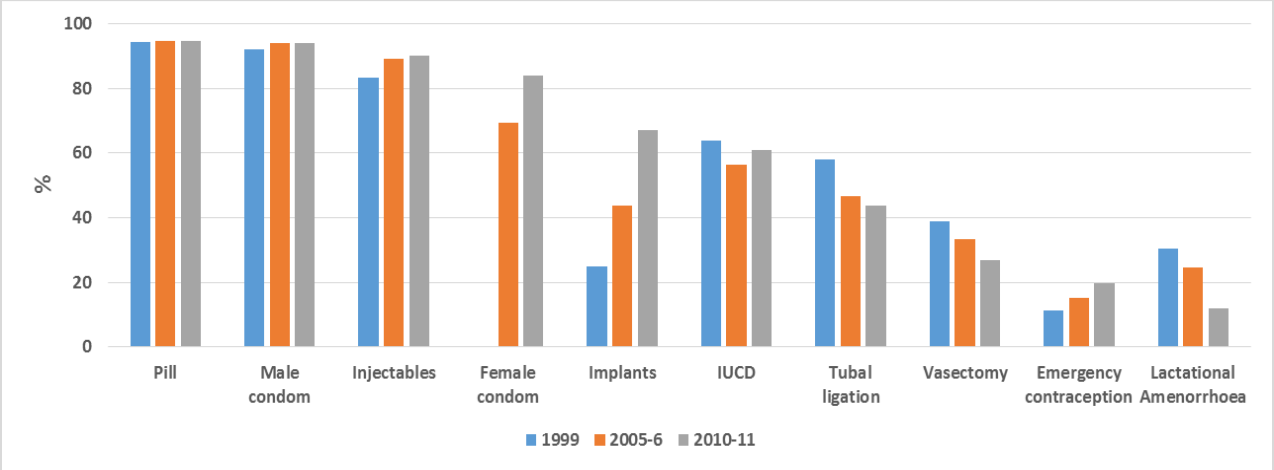
Further analysis of non-users (34 percent) also reveals important lessons to help understand potential demand for family planning. First, the percentage of people who do not intend to use contraceptive methods in the future has remained stagnant, ranging from 28.7 percent to 27.3 percent between 1999 and 2010[8, 14, 15]. Second, non-users may not be adequately receiving interpersonal communication from family planning providers representing a lost opportunity. For instance, 88 percent of non-users report having not discussed family planning with a provider at the facility or community level; of those who visited a health facility, only 9.4 percent discussed family planning with a provider. Third, besides fertility intentions, women who do not practice family planning do so because they face opposition to use from their partners/husbands/family, have method concerns, or have gaps in knowledge. Knowledge and opposition to use, however, have been declining as reasons for non-use, reflecting positive results from awareness-raising activities. On the contrary, method-related concerns have been increasing **(Figure 17).** The lack of contact with a health provider, as well as limited exposure to family planning messages via media may be contributing to these knowledge gaps, as 65.6 percent of women have neither seen nor heard a message on radio, on television or in newspapers/magazines.

Figure 17: Trends in Reasons for Non-Use of Family Planning, 1994–2010 (% of women reporting reason for non-use)



Knowledge is a pre-requisite for contraceptive decision making and continued use. Although most women are knowledgeable of family planning, awareness varies greatly across methods, with some methods (short-acting pills, male condoms, and injections) being more popular than others **(Figure 18)**. Further, awareness seems to be trending differently among methods, with some methods losing their popularity (female and male sterilisation and the lactational amenorrhea method) and some becoming increasingly popular (implants, emergency contraceptives, and female condoms). These are positive trends, showing the possibility of increased usage if certain methods are made available in the health system, as demonstrated by a significant increase in the usage of implants in the last five years.

Figure 18: Trends in Knowledge of Modern Contraceptives, 1999–2010(% of women reporting to be aware of method)



Source: Zimbabwe DHS 1999, 2005, 2010

As a function of the programme, efforts to impart accurate and adequate knowledge to facilitate contraceptive decision making face key challenges. These include a lack of an updated comprehensive Advocacy and Communication Strategy, weak interpersonal communication for social mobilisation and awareness offered through the existing community-based cadres, unavailability of demand generation materials at service delivery points because of financial constraints and a need for a better awareness-generation programme tailored to young people especially those in rural and hard-to-reach areas.

There is a need for strengthening interpersonal communication on family planning and contraceptive services at facility and community levels for behaviour change through the existing cadres of health workers, including community based workers such as village health workers and others in different ministries and NGOs. Both the CBD and peer education programmes, focusing on behaviour change at the community level, have been facing problems in recent times in terms of their reach and effectiveness. There are challenges in the peer education programme and it needs a holistic approach to address them including the provision of comprehensive sexuality education, which proves to be more effective and sustainable for reaching young people with information.

Further, activities to mobilize influential community leaders and key stakeholders to engage the community and foster positive attitudes towards family planning is limited. Culture and religious ties also serve as substantial barriers to increasing the mCPR, expanding the method mix, and reaching out to underserved populations and geographies. Moreover, the uptake of LARC, particularly IUCDs and implants, is challenged by myths, misconceptions, fear, and misinformation. Lack of male involvement (out of either negative perception or lack of interest by men) also hampers the use of family planning.

Young people, including teenagers, face greater barriers than other age groups in accessing SRH information and services, including contraceptives. This contributes to their higher unmet need for family planning, relative to the national average, and to teenage pregnancies. Many parents and providers fear that providing unmarried adolescents with information on contraception to prevent pregnancy in general will lead to their becoming sexually active at a young age.[22] These attitudes are consistent with cultural norms and religious faith that discourage access and use of SRH information and services.[23] The national life skills and comprehensive sexuality and education syllabus, which is mandated to be taught in primary and secondary schools, was recently revised and features information (including myths and misconceptions) on SRHR and methods of preventing pregnancy. A parent-child communication programme is also being piloted and is set to be rolled out to more districts. To foster a deeper understanding of the issues contributing to high teenage fertility, a national study is being finalised to eventually inform a national plan to address this concern.

RESEARCH, MONITORING & EVALUATION

A research, monitoring and evaluation (R, M&E) function is an invaluable and integral part of an effective and efficient component of any program. Information generated from R, M&E form the basis for evidence based decisions that drive performance of a program. It is on this premise, that achieving Zimbabwe's FP program goals requires a robust R, M&E function. The ZNFPC has a dedicated Research, Monitoring and Evaluation unit mandated to carry out this function in collaboration with the MoHCC and other implementing partners. In addition, the unit contributes to the preparations and implementation of the strategic and annual operation plans. It also works together with other complimenting technical units for planning, monitoring and evaluation of all programs and ensure that there is provision of quality integrated FP and related SRH services across the country at all levels

R, M&E function is currently being performed at suboptimal levels due to capital and human resource constraints and bears considerable opportunity for improvement. There is a greater need to capacity build the M&E personnel to steer this function. Inadequate resources and lack of a standalone budget for the M&E activities compound this. Coupled with this is the lack of a comprehensive FP M&E Framework (A draft document was developed in 2010 but has not been implemented due to financial constraints). This means that there are no

reference documents that guide the routine functioning of the unit. It also means that despite heavy investments on activities to meet FP goals, the unit is neither equipped with a mechanism to assess performance nor make improvements in a systematic manner. Similarly, the absence of a research agenda, also means stakeholders have no joint understanding of priority knowledge gaps that need to be addressed to advance the program. In such a context, operational inefficiencies arise and opportunities to maximize results are not optimized.

ZNFPC manages its own information systems parallel to the DHIS2, a web-based national health management information system (HMIS) operated by the MoHCC that was launched in 2014 and rolled nationally. The two systems are not linked and have different data collection tools thereby hindering data/information sharing and coordination. While DHIS-2 collects FP information from all the 1500 health facilities within MoHCC, the ZNFPC system collects the same for its own clinics and some other facilities, primarily operated by PSI and PSZ. The two systems have different data collection tools that have not yet been harmonized. However, a harmonization meeting was held in November 2015 to address this very issue and to introduce a standard FP data collection tools. Data is collected on a monthly and quarterly basis through manual paper-based reports submitted by the SDPs to the ZNFPC Technical Director. The manual nature of this data flow process is prone to data losses and errors throughout the data transmission chain. Since all 1500 MoHCC health facilities report through DHIS2, there is duplication of data as the SDPs also reports separately through ZNFPC. Data collected through the ZNFPC information system is analyzed and reports are submitted to MOHCC. However, since they are not aligned to the HMIS, they do not provide enough data to base decision on as they are not representative.

The ZNFPC R, M&E unit lacks adequate resources to perform systematic data quality audits on a consistent basis. Thus, the production of high quality statistics is questionable. Further, the capacity for data processing and analysis provides room for improvement. Similarly, knowledge management functions, including those related to information repository need to be improved. Whilst the M&E unit is expected to be the information hub for data, and reports resource constraints hinder its ability to deliver on this function. Utilization of data for decision-making is another challenge of the program. Decisions on program strategy and direction, as well as resource allocation are not well informed with historical data from operations. Moreover, data from routine service delivery is not adequately used to inform adjustments to the service delivery process, and does not migrate upwards to inform system and policy improvements. The collaboration between the R, M&E unit and the M&E department and HMIS unit of MoHCC is very weak as result of which, despite several opportunities, harmonization of FP data collection tools and data usage between ZNFPC and MoHCC have been poor.

Financial resources also hamper the unit's ability to execute its quality monitoring function. Whereas supervision visits are supposed to be carried out with SDP once per quarter, only two monitoring visits were completed in 2010. In 2015, most of the M&E, related activities were heavily dependent on the resources, which were availed for other activities such as the support and supervision visits under the ASRH programme. The situation is even bleaker with monitoring implementing partners. Furthermore, there is lack of updated tools and indicators for quality measurement.

Track 20 as part of FP2020 secretariat has supported a FP M&E officer in MoHCC, who is working closely with ZNFPC and other stakeholders to improve the FP component of the national HMIS. The effort, under the guidance of Track20, is to improve the quality and use

of data such that it guides the program. Through the support from Track20 Zimbabwe is expected to conduct two FP data consensus-building workshops. This is an opportunity for the country to review service statistics and survey data and come up with projections for the core indicators.

RESULTS FRAMEWORK

The GOZ aims to reach a CPR of 68 percent among married women by 2020. This goal reflects the government's continued commitment to realise its vision of universal access to quality family planning services by all who need it by 2020. As such, the ZNFPCIP provides a common roadmap to all stakeholders for the implementation of interventions to advance family planning uptake among all women and men who need or desire to plan childbearing. The GOZ acknowledges the fact that family planning is a life-saving intervention, particularly for women, new-borns, and adolescents, and that successful execution of this plan will generate demographic and health impacts beyond the core goal of reaching a 68 percent mCPR by 2020.

The ZNFPCIP translates the ZNFPS 2015–2020 into a results-based and actionable costed plan to guide intervention programming, resource mobilisation and allocation, and performance measurement. Also, the ZNFPCIP reflects actions to facilitate implementation of international commitments related to family planning, including commitments made for FP2020; Every Woman, Every Child, Every Adolescent; and SDGs. At the country level, the ZNFPCIP responds directly to the priorities included in key national strategies and policies. These include the National Health Strategy 2016–2020, the National HIV and AIDS Strategic Plan 2015–2018, the National Maternal and Neonatal Health Road Map 2005–2015, the National Adolescent Sexual and Reproductive Health Strategy 2010–2015 and the Operational and Service Delivery Manual for Prevention, Care, and Treatment of HIV in Zimbabwe - June 2015.

VISION

Quality integrated family planning services for all by 2020.

GOALS

1 To increase Contraceptive Prevalence Rate (CPR) from 59% in 2010 to 68% by 2020; and

2 Reduce teenage pregnancy rate from 24% in 2010 to 12% by 2020.

OBJECTIVES

The following objectives represent strategic priorities detailed in the ZNFPCIP, as well as key priority areas for financial resource allocation and implementation performance. The priorities reflect issues or interventions that must be addressed so as to reach the country goals.

1 To establish a national FP coordination, monitoring and evaluation mechanism by 2020;

2 To increase the proportion of the national health budget that is allocated to FP programme from 1.7% in 2010 to 3% by 2020;

3 Reduce unmet need for FP services from 15% in 2010 to 6.5% by 2020;

4 To increase availability, access and utilisation of integrated SRHR and HIV services for young people aged 10 – 24 years;

5 To increase the knowledge of LAPM among all women and men of the reproductive age group from 46% in 2010 to 51% by 2020; and

6 To maintain stock out levels of FP commodities below 5% between 2016 and 2020.

The goals and objectives will be achieved through effective and efficient implementation of interventions under five major strategic areas, outlined in the ZNFPCIP Results Framework (**Figure 19**). These are 1) Enabling Environment, 2) Commodity Security, 3) Service Delivery, 4) Demand Creation, and 5) R, M&E. Measurable outcomes and associated outputs have been defined for each strategic area resulting in a total of seven outcomes and 25 outputs. These strategic areas are aligned to the ZNFPS

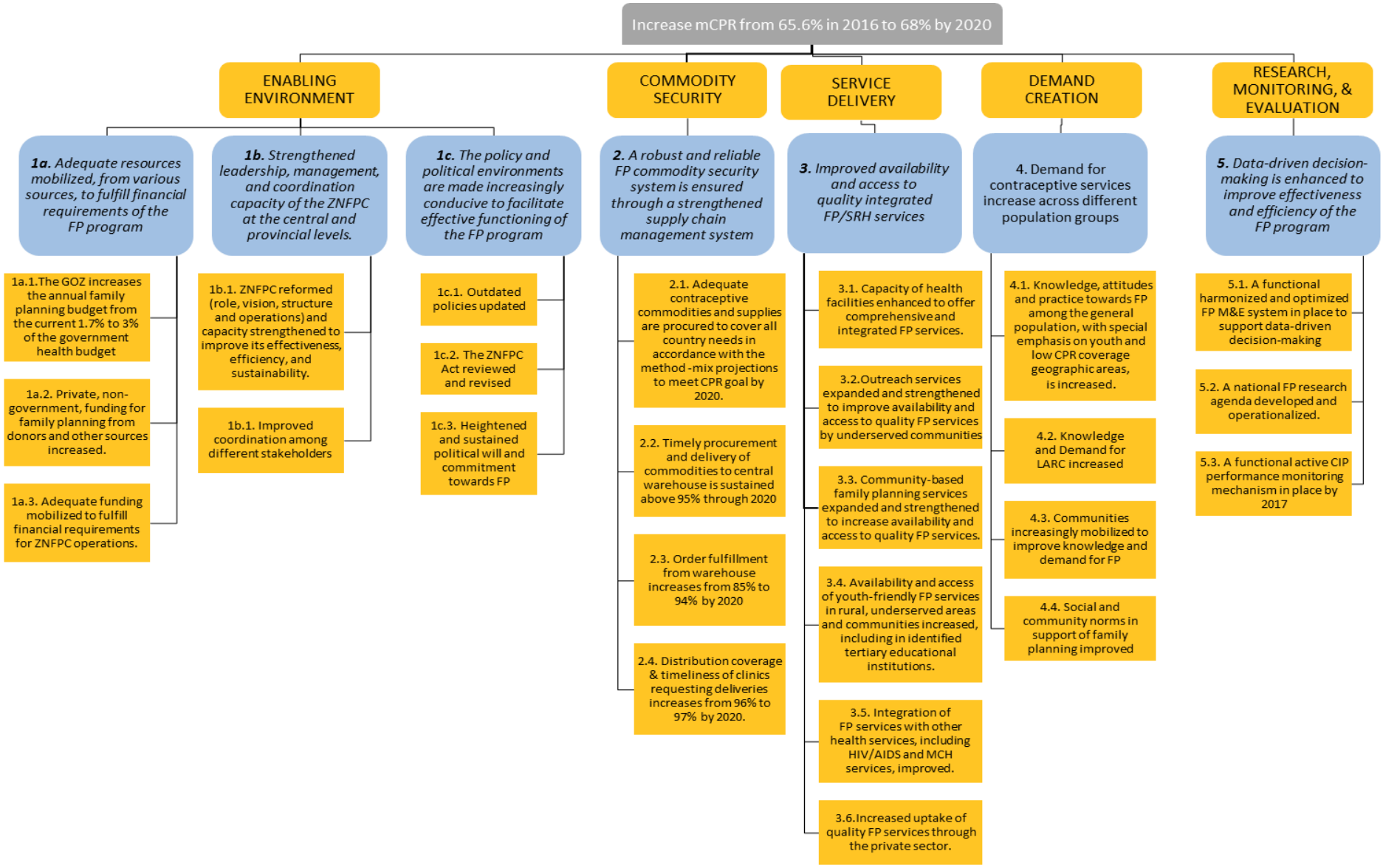


Figure 19: ZNFPCIP Results Framework, 2016–2020

HEALTH AND DEMOGRAPHIC IMPACT

Successful execution of this plan will generate demographic and health impacts beyond the core family planning goal of reaching 68% CPR by 2020, as further described below. Impact estimates were generated using the Impact2 model developed by Marie Stopes International, and using projected family planning users needed to be reached to meet the country's family planning goal by 2020. The model estimates that full implementation of the ZNFPCIP will avert more than 3 million unintended pregnancies, more than 900,000 abortions, more than 7,000 maternal deaths and more than 33,000 child deaths between 2016 and 2020. Table 7 presents the estimated annual impact on demographic and health indicators, as mCPR increases with time.

Table 7: Estimated Annual Demographic and Health Impact, 2016 to 2020

	2016	**2017**	**2018**	**2019**	**2020**	**Total**
DEMOGRAPHIC IMPACT						
Unintended pregnancies averted	530,991	571,202	608,029	642,158	674,254	3,026,634
Abortions averted	164,607	177,073	188,489	199,069	209,019	938,257
HEALTH IMPACT						
Maternal deaths averted	1,580	1,544	1,479	1,387	1,273	7,263
Child deaths averted	5,848	6,291	6,697	7,073	7,426	33,335
Unsafe abortions averted	157,628	169,565	180,497	190,629	200,157	898,476

Figure 20: Contribution of ZNFPCIP to other National Strategies and Policies

DEMOGRAPHIC AND COMMODITY PROJECTIONS

The design of the technical strategy, involving prioritization of the type of interventions to implement and the amount of investment per intervention, is guided by an understanding of demographic and commodity requirements of the program over the five-year period. A projection exercise was conducted to estimate: (i) the required annual rate of change in CPR to reach the goal; (ii) the number of users to reach the goal; (iii) the profile of the method mix each year; and (iv) the amount of contraceptive commodities needed each year, by method.

In order to increase the CPR among married women of reproductive age (MWRA) from 65.6% to 68% by 2020, while at the same time shifting method use away from oral contraceptives to more long acting and permanent methods, several assumptions were made as follows: oral contraceptives will slightly decrease by 4%, from 40.9% in 2015 to 39.2% in 2020. The decrease of oral contraceptive users will be reallocated to other FP methods like female sterilization, IUCDs, implants, female and male condoms. IUCDs and implants will see the largest increase, at 23% by 2020. Injectable and male condoms will have a slightly smaller increase at 11.6% and 15.6%, respectively, while a much smaller increase will occur with female sterilization and female condoms i.e., 3.7%. Table 8 shows the projected method mix among married and all women by 2020.

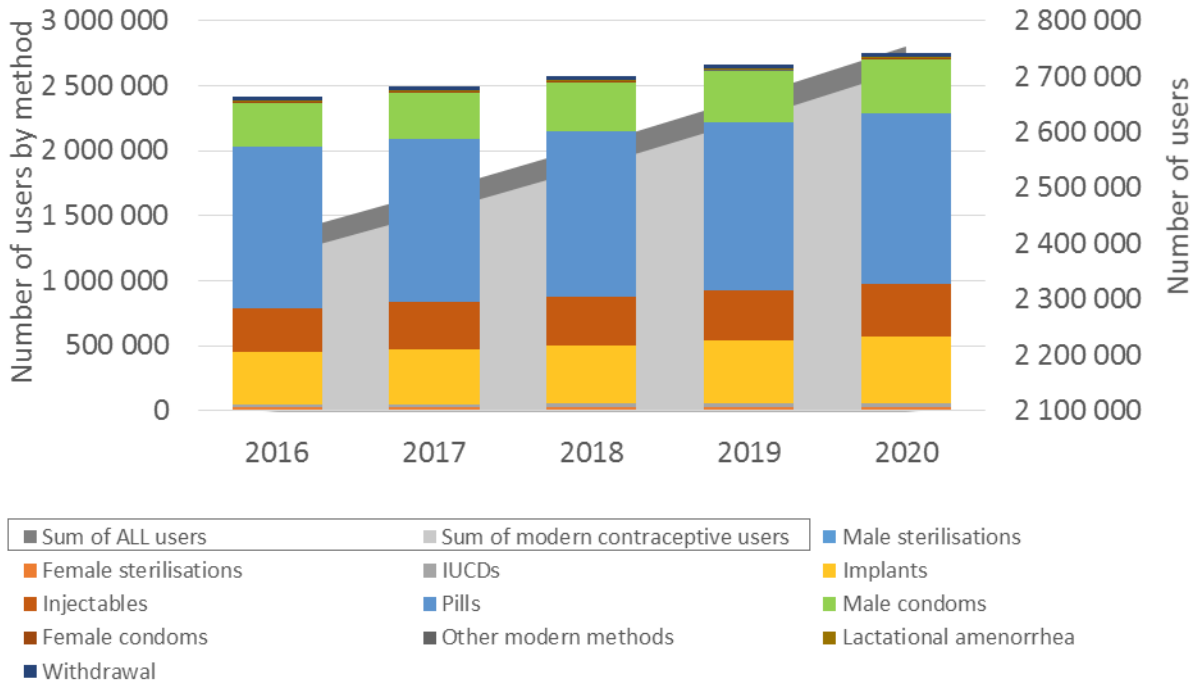
Table 8: Method Mix among Married and All Women, Baseline (2015) and Projected (2020)

METHOD	BASELINE **(2015)**		PROJECTED **(2020)**	
	MARRIED WOMEN	ALL WOMEN	MARRIED WOMEN	ALL WOMEN
Male sterilization	--	--	--	--
Female sterilization	0.90%	0.6%	0.93%	0.6%
IUCDS	0.70%	0.5%	0.86%	0.6%
Implants	9.60%	8.9%	11.80%	11.0%
Injectable	9.60%	7.7%	10.71%	8.7%
Pill	40.90%	28.9%	39.19%	27.9%
Male condoms	3.80%	7.6%	4.39%	8.8%
Female condoms	0.10%	0.1%	0.10%	0.1%
Other modern methods	--	0.1%	--	0.1%
Overall mCPR	**65.6%**	**54.4%**	**68%**	**57.8%**

Note: Estimates for method mix at baseline for all women have been generated using DHS 2015 data and WRA population

Based on the above projected method mix for all women, an average of 2.5 million women of reproductive age will need to be reached on annual basis in the next five years to meet the mCPR goal. Majority of the women will be using pills; however increasingly method use will be shifting to LARCs, including IUCDs and implants (**Figure 21**).

Figure 21: Projected Annual Number of Contraceptive Users by Modern Method, 2016–2020



COST SUMMARY

The cost of the total plan is USD177, 409,397, which will increase the number of women in currently using modern contraception from approximately 2.4 million to 2.7 million between 2016 and 2020. The average cost of reaching each woman of reproductive age per year to meet the country's goal is approximately USD14.

Table 9 summarizes the plan costs by year. From 2015 to 2020, the average annual cost of the plan is about USD 35million. Overall, commodity security reflects the largest share of costs (55%), at USD97 629,748.

Table 9: ZNFPCIP Annual Cost Estimates, 2015–2020

	2016	2017	2018	2019	2020	Total Costs by Strategy Area	% of Total Costs by Strategy Area
Enabling Environment	814,801	881,923	245,941	255,439	251,353	2,449,457	1.4%
Commodity Security	18,455,443	19,423,986	18,997,851	20,305,170	20,447,297	97,629,748	55.0%
Service Delivery	6,115,748	6,979,232	8,754,349	9,035,970	5,984,885	36,870,185	20.8%
Demand Creation	3,438,054	9,152,622	8,892,068	9,071,395	9,254,013	39,808,152	22.4%
M&E	85,313	102,874	222,264	79,904	161,501	651,856	0.4%
Total Costs Per Year	28,909,359	36,540,637	37,112,473	38,747,878	36,099,050	177,409,397	100%
% of Costs Per Year	**16.30%**	**20.60%**	**20.92%**	**21.84%**	**20.35%**		

KEY ASSUMPTIONS

The costing estimates were derived using an "ingredients" approach. For each activity identified by the Strategy Advisory Groups (SAGs), sub-activities and the resources required to support them were also identified. The ZNFPCIP is focused on identifying what needs to change in the current family planning programme in order to reach the FP2020 goal of an increased CPR of 68 percent among married women by 2020. Therefore, cost estimates were not assigned to existing resources that are already in place and can be assumed to persist over the plan period. This includes existing buildings, equipment, infrastructure, and staffing. However, cost estimates were assigned to expansions or modifications of these resources as well as to the costs of contraceptive commodities yet to be acquired.

The plan assumes an inflation rate of 2 percent per year for all unit costs assigned to resources. This may be lower or higher than what is experienced, and this assumption can be modified on the baseline data sheet of the CIP tool developed by the Palladium Group, which was used to organise the material from the Strategy Advisory Group activity identification workshops held in May 2016. The tool has been organised to provide cost estimates for specific sub-activities, activities, outputs, outcomes, and strategic areas and can present these estimates year by year as well as for the entire 2015–2020 period.

This flexibility can be used to help monitor progress of the ZNFPCIP, and to update the tool as the plan evolves (e.g., adding new activities, removing activities, changing the timing of activities).

The unit costs used in generating the cost estimates reflect current costs, the government's policies on per diems and allowances, and expert opinions about those resources that did not have readily available cost estimates. As the programme evolves and policies and economic circumstances change, these unit costs may need to be updated to provide more realistic estimates over time.

IMPLEMENTATION FRAMEWORK

ENABLING ENVIRONMENT

Building an enabling environment is an essential element to the success and sustainability of the family planning programme. Under the ZNFPCIP, Zimbabwe aims to mobilise adequate financial resources to fulfil additional requirements stipulated in the plan and to meet recurring financial needs; improve the policy and normative environment (general perceptions and attitudes about family planning); and strengthen the leadership, management, and coordination capacity of the ZNFPC. It is through these combined efforts that Zimbabwe will be able to reap the benefits of investments geared towards bolstering supply and demand. A summary of key outputs and performance targets contributing to each outcome is tabulated in Table 10. The total cost of implementing activities under this strategy area over the five-year period is USD2 449,457. More than 50 percent of the costs are within the first two years, appropriately reflecting the need to put an enabling platform for service uptake into place.

Outcome 1a. Adequate resources mobilised from various sources to fulfil financial requirements of the family planning programme.

1a.1. Annual family planning budget from the current 1.7 percent to 3 percent of the government health budget (inclusive of commodity costs).

Regular and targeted advocacy efforts at different levels of the system will be conducted with relevant institutions of the GOZ to support increased levels of funding for family planning. Target audiences for advocacy will include the Ministry of Finance, Parliamentarians, and the Policy and Planning Division of the MOHCC, headed by the principal director of planning and policy.

1a.2. Private, nongovernment funding for family planning from donors and other sources increased.

Efforts will be directed towards engaging other development partners to support family planning issues. Zimbabwe has diverse sources of funding for socioeconomic development. Although family planning substantially contributes to development, only a few donors support the family planning programme. The levels and types of donors could be increasingly leveraged once a clear case in support of family planning as a development tool is made. Particularly important making the case to senior GOZ leaders on the role of family planning in realising a demographic dividend, which will contribute to Vision 2020. Recent population projections estimated by the Zimbabwe National Statistics Agency (ZIMSTAT) indicated that a possible demographic transition is possible in the next five years, but can only be brought about if population growth can be effectively managed.[7]

1a.3. Adequate funding mobilised to fulfil financial requirements for ZNFPC operations.

Through advocacy, new income-generating mechanisms, and cost-cutting measures, resources will be mobilised to support ZNFPC operations in line with new structural reforms. To increase the budgetary allocation, family planning programmers need to get more resources from the government and also harness more resources from other development partners. The ZNFPC, as the national family planning coordinating body, also has to be more innovative in mobilizing and managing resources. Examples include becoming a leaner organization, enhancing its human resource capabilities to secure revenues from technical and

research services, generating revenues from its vast capital assets, i.e. training and lodging facilities, the audio-visual unit (becoming a centre of excellence on building family planning capacity), and creating strategic business units that will complement the external resources. To get a larger share of the national budget, the ZNFPC needs to advocate with parliamentarians and the relevant ministries from the pre-budgetary period to finalise the budget. The ZNFPC also needs to form public-private partnerships with the private sector to try to tap into the funding opportunities that this relationship creates. The increased budgetary allocation and other resources will be equitably distributed to the provinces, to carry out the family planning activities at the provincial and district levels. The budget and resources will also be distributed between the ZNFPC and the MOHCC, as per the roles and responsibilities of each.

Outcome 1b: Strengthened leadership, management, and coordination capacity of the ZNFPC at the central and provincial levels.

1b.1. ZNFPC (role, vision, structure, and operations) reformed and capacity strengthened to improve its effectiveness, efficiency, and sustainability.

The ZNFPC will first undergo an operational and structural review, leading to the development of a restructuring blueprint. At the operational level, the starting point will be to make sure that there is clarity between the operations of the ZNFPC and those of the Reproductive Health Unit of the MOHCC through the Department of Family Health. Efforts to improve coordination between the ZNFPC and the MOHCC's Reproductive Health Unit will be put in place based on the review recommendations. At the structural level, the ZNFPC will review its organisational structure to create a leaner and more efficient organisation to suit its revised mandate. The ZNFPC will be supported to undergo strategic reforms in alignment with recommendations from the review. In addition, technical and financial assistance will be leveraged to support the ZNFPC to effect reforms. Potential areas of reform include a human resource review and restructuring, expansion of revenue-generating avenues, a leaner and more efficient human resource structure, transformation from service delivery into centres of excellence, and improvement in the capacity of the ZNFPC to carry out independent research and other strategic functions.

1b.2. Improved coordination among stakeholders.

To promote coordination, the existing technical working groups on family planning will be strengthened. Based on the new family planning strategy and the ZNFPCIP, new technical working groups will also be created, as needed. As per need, these can be jointly chaired by the ZNFPC and the MOHCC, which will meet on a quarterly basis to review action plans, share progress, and discuss/resolve issues.

Outcome 1c: The policy and normative environment is made increasingly conducive to facilitate effective functioning of the family planning programme.

1c.1. Outdated policies updated (e.g., youth policy).

Key policies including operational policies, guidelines, and standard operating procedures will be reviewed or developed anew if currently non-existent. This will include policies that affect youth in accessing the family planning methods of their choice. In this respect, the ZNFPC and MOHCC will work with ministries of education, gender, and youth to make sure that a culturally sensitive policy, which does not compromise access to services by youth, is formulated.

1c.2. The ZNFPC Act reviewed and revised.

In line with anticipated reforms, a revised ZNFPC Act will be drafted and promulgated. Advocacy efforts will be conducted to get the act approved by parliamentarians.

1c.3. Heightened and sustained political will and commitment towards family planning.

Efforts will be directed towards harnessing multiple factors to capture political will and commitment for family planning. Particularly, the link between family planning and development provides a window of opportunity for family planning advocacy at the highest levels. Furthermore, high-level engagement on family planning issues will increase awareness of the role of family planning in socio-economic development. This will also help to dispel negative sentiments in some quarters of authority and in some segments of society.

Table 10: Enabling Environment: Summary of Performance Targets and Costs by Output

Outcome 1a: Adequate resources mobilised from various sources to fulfil financial requirements of the family planning programme		
Outcome Performance Targets: • At least 90% of planned ZNFPCIP annual budget is funded on an annual basis		
Outputs	Output Performance Targets	Cost (US Dollars)
1a.1. Annual family planning budget from the current 1.7% to 3% of the government health budget	• At least 3% of the GOZ annual health budget allocated to family planning by 2020 (incremental increase over the intervening years)	845,464
1a.2. Private, nongovernment funding for family planning from donors and other sources increased	• Increased number of development partners invested in family planning activities	160,484
1a.3. Adequate funding mobilised to fulfil financial requirements for ZNFPC operations	• GOZ provides capital and operations grant to support ZNFPC operations • ZNFPC income (top-line revenues) from various sources doubles by 2020 • At least 59.3% of ZNFPC budget is covered by income from the government	1,864
Outcome 1b: Strengthened leadership, management, and coordination capacity of the ZNFPC at the central and provincial levels		
Outcome Performance Targets: • New ZNFPC structure in place and operational • Joint family planning review, supportive supervision, monitoring, and quality assurance (visits) conducted by the ZNFPC and MOHCC in a year • National quarterly coordination meetings held on an annual basis (jointly planned by the ZNFPC and MOHCC)		

Outputs	Output Performance Targets	Cost (US Dollars)
1b.1. ZNFPC (role, vision, structure, and operations) reformed and capacity strengthened to improve its effectiveness, efficiency, and sustainability	• ZNFPC undergoes a structural and operational review • ZNFPC undergoes strategic reforms in alignment with recommendations from the review • Technical, financial, and human resource support provided to the ZNFPC to support reforms	1,258,267
1b.2. Improved coordination among stakeholders	• National family planning technical working groups strengthened • Quarterly meetings of the technical working groups and national family planning coordination forums convened to facilitate information sharing and coordination • Joint annual planning, review, and monitoring occur between partners and GOZ to maximise results from limited resources • Coordination between the Reproductive Health Unit of the MOHCC through the Department of Family Health and ZNFPC improved	338
Outcome 1c: The policy and political environments are made increasingly conducive to facilitate effective functioning of the family planning programme		
Outcome Performance Targets: • The GOZ promulgates new ZNFPC Act. • Key policy and strategic documents available (alignment of youth policy across ministries, innovative approaches to family planning trainings, availability and access to contraceptive services and integrated SRHR services for young people, and revised family planning training/operational guidelines available)		
Outputs	Output Performance Targets	Cost (US Dollars)
1c.1. Outdated policies updated (e.g., youth policy)	• Youth policy reviewed and revised to include SRHR issues, including comprehensive sexuality education and aligned across various ministries • Policy on access to contraceptive services for youth developed • National family planning training framework developed, incorporating newer approaches, modular training, and e-learning • National family planning research	36,928

	agenda framed and reviewed at least every two years • Family planning training guideline reviewed • A strategic national position paper developed on commodity security, covering issues like pre-qualification, allocation of internal resources for commodities, ZAPS versus DTTU, electronic logistics management system, expansion of oral contraceptive brands, and warehousing • Family planning communication strategy developed • ZNFPC vision statement/document developed	
1c.2. The ZNFPC Act reviewed and revised	• New ZNFPC Act reviewed and promulgated	120,101
1c.3. Heightened and sustained political will and commitment towards family planning	• Advocacy meetings/consultations conducted with key political and community leaders • Demonstration of commitment/support of family planning through public speeches by senior GOZ officials	26,011

COMMODITY SECURITY

Between 2016 and 2020, an average of 2.5 million people per year will need to receive a family planning method in order to achieve a CPR of 68 percent by 2020. Although the percentage change from the current mCPR of 65.6 percent is relatively small (2.4 percent), the family planning programme has to meet the challenge of sustaining contraceptive use and reduce the skewed nature of the current method mix, heavily dominated by short-acting methods.

Zimbabwe also aims to achieve a robust and reliable family planning commodity security system through a strengthened supply chain management system. This implies operating an effective and efficient supply chain management system in which the right products, in the right quantities and right condition, are delivered to the right place at the right time, for the right costs. The tenet behind achieving these results will require that the combined functions of a supply chain system quantification, procurement, inventory management, and distribution work harmoniously together and that adequate resources (i.e. financial, human, technical) are available to support their effective functioning. Further, it will require that a range of methods are available for clients to choose from in the context of informed choice, and that clients can correctly use the products they select. Therefore, achieving commodity security requires interventions that transcend all five strategy areas in this plan.

A summary of key outputs and performance targets contributing to this outcome are described and summarized in **Table 12**. The total cost estimate for commodity security over the five-year period is USD 97 629,748. Annual costs increase progressively over time, reflecting increasing commodity requirements with an increasing number of users needed to meet the mCPR goal.

2.1. Adequate contraceptive commodities and supplies are procured to cover all country needs in accordance with the method-mix projections to meet the CPR goal by 2020.

During the five years, substantial growth is anticipated in the overall volume of family planning commodities used by the programme to provide services to the growing population of WRA (married and unmarried). Table 11 estimates the actual family planning commodities REQUIREMENTS during the life of the plan, by year and type of commodity. These estimates will be updated semi-annually through CPTs and shared with development partners to inform the actual procurement on a semi-annual basis. Purchasing quality products, particularly those that are locally registered and have received WHO prequalification, will be a tenant in the procurement process.

Table 11: Projected Required Quantities of Contraceptive Commodities for All Women, 2016–2020

METHODS	2016	2017	2018	2019	2020
Male condom	91,078,542	93,355,506	95,689,394	98,081,628	100,533,669
Female condom	4,388,970	4,388,970	4,388,970	4,388,970	4,388,970
Combined oral contraceptive pill	11,291,304	11,441,625	11,593,947	11,748,298	11,904,703
Progestin-only pill	4,839,130	4,903,554	4,968,836	5,034,985	5,102,015
Emergency contraceptive	64,728	59,956	60,456	60,456	60,456
Implants	142,838	150,956	160,788	171,259	182,413
Injectable	1,364,733	1,425,721	1,489,434	1,555,995	1,625,530
IUCDs	5,841	6,123	6,522	6,947	7,399
Tubal ligation	2,783	2,720	2,800	2,882	2,967
Other modern methods	5,100	5,249	5,403	5,562	5,725
Total Contraceptives	**113,183,969**	**115,740,380**	**118,366,550**	**121,056,982**	**123,813,847**

Increasing the amount of resources mobilised from development partners is crucial for meeting the financial gap for the procurement, storage, and distribution of family planning commodities. Assuring that all key partners are aware of the growing need for commodity procurement is a first step towards commodity security. Key activities in support of this goal include an improvement in the information about family planning commodity requirements that is produced and shared with development partners and the actual procurement of family planning commodities. The family planning forum will hold quarterly meetings with development partners to discuss family planning commodity requirements; share results of the semi-annual quantification exercise for commodity requirements via standardised CPTs; and, based on documented achievements and forecasted needs, undertake the semi-annual procurement of commodities. By increasing the visibility of commodity flows and sharing information about the increasing commitment of the government to the family planning programme, development partners will hopefully continue their strong support for family planning commodity procurement throughout the plan.

2.2. Timely procurement and delivery of commodities to the central warehouse is sustained above 95 percent through 2020

Being able to effectively manage the increased flow of commodities and their storage under proper conditions, along with timely quality assurance and clearance of commodities as they enter the country, reduces the risk of bottlenecks or supply chain disruptions. Such disruptions can lead to stock-outs and unintended method discontinuation when a woman is unable to obtain the family planning service she desires. Activities include expanding storage capacity for family planning commodities, training staff, and improving the timeliness of in-country quality assurance activities and clearance of family planning commodities. In the short term (2016 and 2017), the increased storage capacity for family planning commodities will need to be outsourced to an existing warehouse in Harare. There is also a need to invest in and maintain a computerized warehousing system (in addition to the physical space) that includes barcoding of inventory for better, up-to-date information on stock levels and commodity flows. It has also been suggested to add an additional delivery truck to better handle the increased flow of commodities and improve the timeliness of deliveries. Three ZNFPC staff will attend a one-week basic supply chain management-training course

sponsored by the US government in 2016. Four ZNFPC staff will then attend a one-week procurement-training course offered through AccessRH, sponsored by UNFPA, in 2017 and 2019.

Finally, additional funds will be allocated annually to improve the timeliness of in-country quality assurance activities and clearance of commodities, as this can lead to bottlenecks in the supply chain, preventing procured commodities from reaching the warehouse in a timely manner after they have been procured and arrived in country.

2.3. Order fulfilment from warehouse increased from 85 percent to 94 percent by 2020

Order fulfilment is calculated as the quantity of commodities delivered over the quantity of commodities requested, and this is already being monitored by product on a quarterly basis. If SDPs cannot be confident that the commodities they request will be delivered on time, then this provides an incentive to hoard commodities as a hedge against stock-outs or costly additional shipments in response to stock-outs. Activities will be directed to improve the picking and packing of orders via the implementation and training of warehouse personnel in the computerised warehousing system described above and via further investments in the warehouse handling equipment. Furthermore, storage capacity will be expanded and enhanced to accommodate larger space needs. Technology-enabled functions will be introduced for inventory management.

2.4. Distribution coverage and timeliness of clinics requesting deliveries increased from 96 percent to 97 percent by 2020

This output refers to maintaining the distribution coverage and timeliness of deliveries to clinics above 96 percent, so that clinics receive their orders in the same quarter in which they are placed and no more than 90 days from their prior delivery. Assuring a dependable resupply schedule assists in planning commodity flow and avoids shocks to the distribution system. Predictability at the SDPs gives the staff confidence that commodities will be received in a timely manner and that they do not need to hoard inventory as a hedge against stock-outs. Activities contributing to this output are improved monitoring and supportive supervision of the supply chain, and improvements to the ordering and delivery of commodities. As the visibility of supervisory staff increases, the other staff in the supply chain will likely realise the importance of their efforts and appreciate the role they play in assuring that products are where they need to be when they need to be.

Table 12: Commodity Security: Summary of Performance Targets and Costs by Output

Outcome 2: A robust and reliable family planning commodity security system is ensured through a strengthened supply chain management system		
Outcome Performance Targets: • Adequate methods are procured to fulfil demands for modern contraceptives by approximately 2 million WRA each year • Quarterly stock-out rates at the national level by family planning product (e.g., pills, injectable, implants, male and female condoms, other family planning products in ZAPS) is less than 4.8% • 85% of primary-level SDPs with at least three modern methods of contraception available on day of assessment (date of last logistics report or day of visit) • 85% of secondary- or tertiary-level SDPs with at least five modern methods of contraception available on day of assessment (reporting day or day of visit)		
Outputs	**Output Performance Targets**	**Cost (US Dollars)**
2.1. Adequate contraceptive commodities and supplies are procured to cover all country needs in accordance with the method-mix projections to meet CPR goal by 2020	• Adequate financing is mobilised to support procurement of methods to meet contraceptive commodity requirements as specified under this plan • Adequate commodities procured to match demands and country priorities as specified under this plan	78,024,552
2.2. Timely procurement and delivery of commodities to central warehouse is sustained above 95% through 2020	• 95% of shipments received in full at central level warehouse within four weeks of planned date	1,264,820
2.3. Order fulfilment from warehouse increases from 85% to 94% by 2020	• 94% of orders shipped are complete (as requested) by due date	1,268,548
2.4. Distribution coverage and timeliness of clinics requesting deliveries increases from 96% to 97% by 2020	• 97% of clinics receive orders within three months (quarterly basis/90 days) from the last delivery date	13,271,678

SERVICE DELIVERY

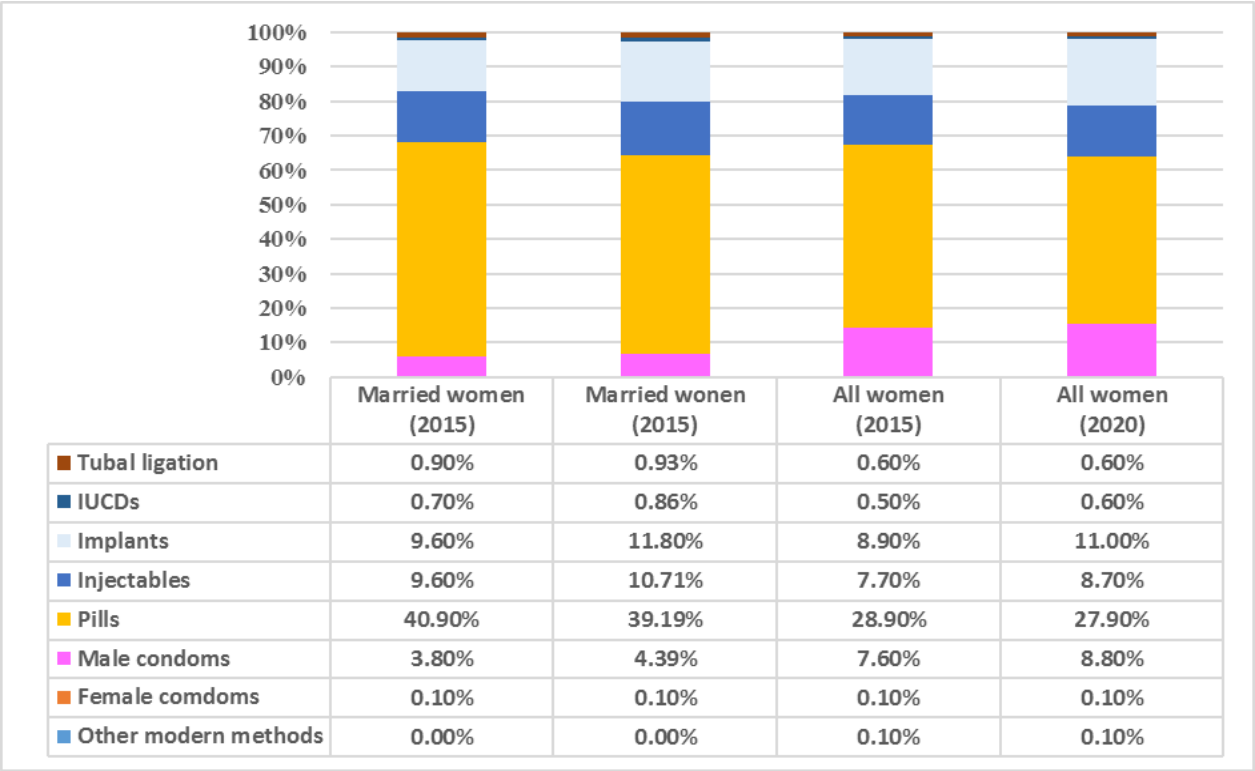
Between 2016 and 2020, concerted efforts to improve the availability of and access to quality integrated family planning and SRH services will need to be implemented in order to increase the use of modern contraceptives from approximately 2.4 million to 2.7 million WRA (**Table 13**).

Table 13: Projected Number of Contraceptive Users by Method by Year, 2016–2020

Method	2016	2017	2018	2019	2020
Vasectomy	0	0	0	0	0
Tubal ligation	25,594	26,345	27,118	27,915	28,734
IUCDs	21,673	23,084	24,588	26,189	27,895
Implants	399,748	425,783	453,513	483,050	514,510
Injectable	341,183	356,430	372,359	388,999	406,382
Pill	1,240,803	1,257,321	1,274,060	1,291,022	1,308,209
Male condom	338,744	356,409	374,996	394,551	415,127
Female condom	5,299	5,455	5,615	5,780	5,949
Other modern methods	5,100	5,249	5,403	5,562	5,725
Lactational amenorrhea	6,149	6,330	6,515	6,707	6,904
Other natural FP methods	30,693	31,594	32,522	33,477	34,459
Sum of ALL users	2,414,985	2,494,001	2,576,689	2,663,250	2,753,895
Sum of mCPR users	2,378,143	2,456,077	2,537,652	2,623,067	2,712,532

To achieve a balanced method mix, Zimbabwe will strive to increase the use of LARC to 18.7 percent for implants, 14.8 percent for injectable, and 1 percent for IUCDs among all women (**Figure 22**). To achieve this outcome, a comprehensive service delivery infrastructure that offers family planning services through different modalities, in both rural and urban settings, must be functioning at optimal levels. It must have the requisite capabilities (staff, infrastructure, equipment) to offer a broad range of methods to fulfil demand, as well as address the needs of different segments of the population, including young people and those who cannot be reached by traditional family planning services. A summary of key outputs and activities contributing to this outcome are summarized in **Table 14**. The total estimated cost for service delivery during the five-year period is USD36 870,185.

Figure 22: Method Mix Changes among Married and All Women 2015 (Current) and 2020 (Projected)



	Married women (2015)	Married wonen (2015)	All women (2015)	All women (2020)
Tubal ligation	0.90%	0.93%	0.60%	0.60%
IUCDs	0.70%	0.86%	0.50%	0.60%
Implants	9.60%	11.80%	8.90%	11.00%
Injectables	9.60%	10.71%	7.70%	8.70%
Pills	40.90%	39.19%	28.90%	27.90%
Male condoms	3.80%	4.39%	7.60%	8.80%
Female comdoms	0.10%	0.10%	0.10%	0.10%
Other modern methods	0.00%	0.00%	0.10%	0.10%

3.1. Capacity of health facilities enhanced to offer a full range of methods.

This refers to ensuring there is an optimal number of skilled providers to offer a full range of methods across different facility-based SDPs, in both public and private sectors. To achieve this, service delivery protocols, operational guidelines, and training materials will be updated to meet new WHO recommendations and align with national priorities. Further, the capacity of institutions responsible for pre-service and in-service training will be strengthened to offer quality family planning trainings. Bolstering family planning training in pre-service institutions, medical schools, and midwifery schools is key to ensuring that new health providers are equipped with the requisite knowledge and skills to provide quality family planning services after graduation. Pre-service tutors will be kept up to date with developments in family planning service provision by establishing close working relationships with academia and professional associations, and by offering continuing education seminars. The pool of trainers from both public and private sectors will also be expanded to meet the heightened need for provider trainings, and existing trainers will receive refresher trainings.

To close the human resource gap of skilled family planning providers, in-service health providers will be trained in the comprehensive provision of family planning services (including infection prevention practices) using the MOHCC's Integrated Family Planning Clinical Course. Emphasis will be put on increasing the number of providers with clinical skills to provide LARC services. In addition, primary health facilities located in underserved communities will be given priority in trainee selection. To increase efficiencies, including reducing costs and time, newer approaches like modular trainings and technology will be

leveraged to facilitate digital learning approaches, through Internet and mobile platforms. Further, tools to track and monitor training efforts will ensure a balanced selection of trainees and reduce duplications during training sessions. The existing in-service training structures, primarily 10 ZNFPC provincial family planning clinics, will be strengthened in terms of minor renovations, one-time capital investment, and need-based human resource support to transform them into centres of excellence on comprehensive family planning trainings, post-training follow-up, clinical mentorship, and supportive supervision. ZNFPC will be supported to start innovative refresher/certificate courses on contraceptive updates for both public- and private-sector family planning providers. Further, efforts to monitor training of providers will be introduced to reduce overlap; a web-based database will enable accurate tracking of data about training programs, trainers, and trainees, to better evaluate programs and report activities to stakeholders.

Clinical service support/clinical mentorship visits will be conducted at lower-level health facilities that do not offer LAPMs. These visits will be conducted by providers from higher-level facilities. There will be continued provincial mapping of facilities to determine which ones to receive support from the MOHCC, the ZNFPC and partners through quarterly provincial meetings, in order to coordinate clinical service support visits.

3.2. Outreach services expanded and strengthened to improve availability of and access to quality family planning services by underserved communities.

Mobile outreach is an essential intervention under this plan to improve access to family planning services by underserved communities.[1] Strengthening outreach services will focus on establishing new outreach points to increase coverage of communities, improving efficiency and effectiveness of operations, and improving the quality of services provided. The ZNFPCIP will focus on establishing integrated family planning outreach services in the country. For this, the family planning programme will leverage lessons learned from the existing RMNCAH programmes that have strong outreach components, like the Expanded Programme on Immunization. The outreach points of this particular programme will increasingly be adopted by the family planning programme to deliver integrated immunisations and family planning services particularly extending the type of methods provided to include LARCs. To maximise benefits from outreach campaigns, activities will also include strengthening coordination among outreach partners, joint planning, and harmonising guidance for outreach implementation.

3.3. Community-based family planning services expanded and strengthened to increase availability of and access to quality family planning services.

Community-based integrated family planning services will complement facility-based services by educating, mobilising, and referring potential users. Furthermore, through the provision of select methods (condoms and pills), community-based services will expand access and reduce client overload for facilities, leaving them time to focus on providing clinical methods, particularly LARC. Under this plan, efforts will be directed to maximise the utilisation of this important service delivery modality. Building the capacity of community health workers including village health workers, behaviour change facilitators, and youth

[1] Underserved communities are defined as those in which facilities providing family planning services are located more than 10 km away.

peer educators to deliver integrated family planning services, including YFHS, will be prioritised. For this, either the existing training package will be strengthened or new need-based packages will be developed (particularly for YFHS).

3.4. Availability of and access to youth-friendly family planning services in rural, urban, and underserved areas and communities (e.g., farming, mining, resettlement) increased.

This plan will tackle the fundamental barriers contributing to low availability of and access to family planning services among youth. In 2016, the MOHCC will finalise a national adolescent fertility study that will provide further evidence to support a comprehensive programme to tackle the challenge of high rates of teenage pregnancy. This will also guide the development of a new national ARSH strategy. To support the provision of youth-friendly clinical services, national standards for YFHS will be developed and disseminated. Efforts will be directed towards enabling existing health facilities to be more welcoming to youth, in terms of improving provider knowledge, provider skills and attitudes, and facility infrastructure and service delivery operations. Furthermore, since community-based services (through community health workers) and outreach efforts are key service delivery modalities, efforts will be made to improve their responsiveness to the needs of youth, especially those who are out of school. (These activities are addressed under outputs 3.2 and 3.3, respectively.)

Increasing availability and access, however, are insufficient to increase uptake. Hence, demand generation and mobilisation interventions are intended to complement interventions under this output. Considering different settings for young people (both in and out of school), interventions will be prioritised to develop/strengthen comprehensive sexuality education to provide age-appropriate information and skills to young people. Collaboration with relevant line ministries, parastatals, and NGOs needs to be strengthened to reach more young people with information on SRHR and services. Further, given the dynamism and evolving preferences and needs of young people, continuous improvement strategies will be adopted to ensure that the family planning programme keeps pace with new developments.

3.5. Integration of family planning services with other health services, including HIV/AIDS and MCH services, improved.

Interventions will focus on reducing bottlenecks at the policy, system, and service delivery levels to facilitate systematic and routine integration of family planning services into HIV/AIDS (PMTCT, HIV testing, and Opportunistic Infections/Antiretroviral (OI/ART) services and MCH services. The focus will be on bi-directional integration, which emphasises both intra- and inter-programme integration. The intention is to reach people who may not necessarily be reached through traditional family planning services, and thereby increase access. National guidelines, training curricula, and provider and operational tools (including M&E and supervision forms) used by managers and service providers will be updated, and those missing will be developed. At the service delivery level, integration will occur in phases, first prioritising those geographic areas that will benefit most from integrated services, those service delivery platforms that are likely to reach many people with unmet need, and those operational modalities that have been locally piloted, albeit on a small scale, and shown to work. For example, integration can be prioritised in maternity waiting homes,

PMTCT, Opportunistic Infections/Antiretroviral (OI/ART) clinics, HIV testing services, cervical cancer screening programme clinics, immunisation services, community work by village health workers, and community HIV work being done through behaviour change facilitators. Provincial and district health managers, as well as implementing partners, will be sensitised on the rationale, benefits, and role in facilitating integration of services. Finally, provider capacity to deliver integrated services will be enhanced through trainings and supportive supervision. As part of integration, efforts will be made to promote family planning during the postpartum period. An ongoing postpartum IUCD pilot in Harare, Bulawayo and Mutare will help guide the scale-up of postpartum IUCDs in maternal wards of clinics and hospitals across the country. Family planning can further be integrated into the first postpartum year when a woman comes in contact with postnatal care and other RMNCAH services as part of the continuum of care.

3.6. Increased uptake of quality family planning services through the private sector.

Under this plan, the growing private health sector platform will be leveraged to increase access to family planning services. The main aim is to reduce the burden on the public sector by increasing the private sector's (subsidised and commercial) share of product and service provision. Through public-private partnerships, private-sector providers will be supported to offer quality family planning services according to nationally set standards. This will be done through the development and implementation of an accreditation system that involves implementing quality improvement approaches, routine monitoring, and mentoring. The accreditation system will take into account already existing regulatory mechanisms governing the private health sector and ensure that a barrier to family planning service delivery is not introduced by the additional hurdle of accreditation, but rather that the private sector is supported and engaged, as a partner, to provide quality services. Regulation of private-sector activities concerning health falls under the purview of the MOHCC, as guided by relevant legislation, including the Health Service Act and the Health Professions Act. Private-sector doctors and nurses must abide by the same registration procedures as public-sector doctors and nurses, in line with the Medical and Dental Practitioners Council of Zimbabwe and the Nurses Council of Zimbabwe requirements. Lessons from franchising health facilities from private-sector partners will be used to inform the accreditation process, and will be conducted with full engagement of both public and private sectors.

The contribution and engagement of the private sector in family planning provision will also be enhanced. Through adoption of a total market approach (TMA), the public and private sectors will work together to coordinate service delivery, policies, and programmes for greater impact and sustainability. Specifically, the TMA will take into account free, subsidised, and private commercial delivery methods to advance equitable and efficient access to services, and optimal use of finite resources. A market segmentation analysis study to inform adoption of a TMA will be conducted, followed by coordination between the public and private sectors on the approach and systems to put in place. The study will also assess willingness to pay for different contraceptives to understand who should be served through different service delivery channels. Lessons learned from condom programmes will be leveraged to inform the most optimal approach for Zimbabwe to adopt. Through these efforts, reporting mechanisms will be harmonised to promote reporting of the private sector to the GOZ's HMIS. Further, expansion of social marketing efforts by involving more partners and

broadening the method mix (e.g., to include IUCDs) will be prioritised. Activities to engage retailers (pharmacies and other outlets) to sensitise them on the family planning programme and encourage them to provide a broad range of contraceptives will also be implemented.

Table 14: Service Delivery: Summary of Performance Targets and Costs by Output

Outcome 3: Improved availability of and access to quality integrated family planning and SRH services **Outcome Performance Targets:** • By 2020, 2,334,172 WRA are provided with family planning services • By 2020, of all women of reproductive age using modern contraceptives: ○ 18.7% are using implants ○ 1.0% are using IUCDs ○ 1.0% are using tubal ligation ○ 14.8% are using injectable ○ 47.5% are using oral contraceptives • Unmet need among married women is reduced from 10.4% to 6.5% • Unmet need for family planning for adolescent girls is increased from 16% to 8.5% • Demand for family planning satisfied by modern methods is increased from 87% (2015) to 91% (2020)		
Outputs	**Output Performance Targets**	**Cost (US Dollars)**
3.1. Capacity of health facilities enhanced to offer comprehensive and integrated family planning services	• 4,000 providers trained in clinical provision of family planning • 100 trainers recruited and trained to become family planning trainers • Training curriculum and operational guidelines revised and disseminated • Pre-service (medical school and midwifery school) curriculum reviewed to include integrated family planning services • 53% of public-sector facilities from which LARC can be accessed (continuously and intermittently through clinical service support visits)	14,951,971
3.2. Outreach services expanded and strengthened to improve availability of and access to quality family planning services by underserved communities	• Outreach points identified by health facilities in the country together with the MOHCC, the ZNFPC, and partners (Note: This has to be done for each of approx. 1,500 health facilities; district and provincial authorities have to lead this as a micro-planning exercise) • 30% of people (39,18,371) are reached via outreach services by 2020 (783,674 annually) • At least 20% of people reached via outreach services are youth (20% of total population is between 15 and 24 years old, as per 2012 census) • Users reporting receiving modern contraceptives from a mobile clinic increases from 3% (2010) to at least 6% (2020)	18,802,802

3.3. Community-based family planning services expanded and strengthened to increase availability of and access to quality family planning services	• Percentage of women who are visited by a fieldworker who discusses family planning increases from 4.1% (2010/11) to 5.3% (2020) • Percentage of users who obtain contraceptive methods from community-based family planning services increases from 1.6% (2010) to 4.32% (2020) • At least 2,100 village health workers trained on providing family planning services	94,568
3.4. Availability of and access to of youth-friendly family planning services in rural, underserved areas and communities (e.g., farming, mining, resettlement) increased, including in identified tertiary educational institutions	• At least 11 percent of adolescents ages 15–19 years and 46% of women ages 20–24 years are using a modern method of contraceptive by 2020 • 25% of health facilities offering YFHS • 103 tertiary educational institutions (including universities; vocational training centres; private colleges; and health, education, and agricultural training colleges) are providing YFHS by 2020	2,132,218
3.5. Integration of family planning services with other health services, including MCH, HIV&AIDS services improved	• 95% of health facilities have health care workers who have demonstrated ability to provide the minimum package of SRHR and HIV services (including family planning) • 75% of HIV-positive women are receiving family planning services in ART facilities/SDPs • 80% of OI/ART SDPs/clinics providing integrated family planning services • 90% of maternity homes providing postpartum IUCDs • 75% of voluntary counselling and testing facilities offering integrated family planning services	597,544
3.6. Increased uptake of quality family planning services through the private sector	• Percentage of people accessing family planning services from the private sector increases from 14% in 2010 to 25% in 2020 • Accreditation guidelines developed and rolled out to at least 5% to 10% of private facilities At least 20% of private-sector facilities report through the national HMIS (i.e. DHIS-2)	291,082

DEMAND CREATION

Achievement of key priorities under this plan are encouraging uptake of LARC, increasing focus on interpersonal communication for inculcating positive behaviour about family planning and contraceptive services in communities, increasing family planning utilisation among young people, reaching hard-to-reach populations and changing mind sets about family planning among influential community members. These will all require robust, multi-faceted, tailored, and consistent social and behavioural change communication (SBCC) efforts. This plan aims to reduce unmet need, expand contraceptive choice with a focus on LARC (particularly IUCDs and implants), and increase demand for contraceptive methods. Specifically, Zimbabwe will strive to improve equity in contraceptive access, increase knowledge and demand for LARC, empower youth with adequate knowledge to facilitate well-informed contraceptive decision making, and improve social norms influencing behaviour change. To achieve this, several communication channels will be used, including interpersonal communication, mass media (e.g. radio, TV, newspapers), and digital and social media. A summary of key outputs and performance targets contributing to this outcome are in **Table 15**. The total estimated cost for demand creation delivery during the five-year period is USD 39,808,152.

4.1. Knowledge, attitudes, and practices towards family planning among the general population, with special emphasis on youth and geographic areas/population groups with low CPR coverage, is increased.

Comprehensive formative research to understand the drivers of use and non-use of contraceptives will be conducted to inform development of an SBCC strategy to help close the gap in knowledge and utilisation of family planning services, with a focus on LARC, youth, and areas/population groups with lower CPRs. This assessment will complement a recent study on the determinants of use and non-use of IUCDs. Findings from the ongoing adolescent fertility study will also inform revisions to the strategy. In addition, the revised strategy will include gender and age-appropriate approaches to address particular developmental issues at key stages in the life cycle. High-impact, demand-generating activities will be included to close the knowledge-use gap by addressing cultural and religious beliefs that affect family planning uptake and utilisation, myths, misconceptions and misinformation, fear of side effects, and health concerns that impede its adoption and continuous use. Interpersonal communication, together with innovative technology and multimedia channels such as mobile health platforms and social media, will be integrated to maximise the success of the initiatives, in particular to target youth. Additional strategies including bringing health information to the youth will be designed and implemented to reach out-of-school youth who are at risk of teenage pregnancies. Further, a Communication & Advocacy Technical Working Group will be established and operationalized, to support revisions to the Comprehensive Communication and Advocacy strategy.

4.2. Knowledge and demand for LARC increased.

Evidence obtained from the formative research on knowledge, attitudes, and practices in output 4.1 above will be used to inform the development and implementation of tailored and multimedia campaigns (including interpersonal communication) to promote knowledge and use of LARC.

4.3. Communities increasingly mobilised and sensitised to improve knowledge and demand for family planning.

A tactical action plan and guidelines will be developed and implemented to direct community mobilisation in a strategic manner to achieve desired results. Community health workers will be oriented to perform effective community mobilisation activities using these guidelines. Training and supporting community mobilisers will be critical to their success; hence, demand-creation materials and other tools to facilitate their work, including use of technology, will be supported. To give visibility to family planning and further elevate community mobilisation efforts, community health workers will be helped to run family planning campaigns during special events such as World Population Day and World Contraception Day. Patrons, brand ambassadors, and family planning champions will be identified, mobilised and supported to bring family planning to the attention of the general population. The action plan will tailor activities to different segments of society, with a particular focus on reaching the underserved sections. Youth, urban sexually active unmarried women (who have a high unmet need), people from rural areas and hard-to-reach populations, and users of short-acting contraceptives who could benefit from shifting to LARC all represent different needs and belong to different population segments, thus requiring different approaches and channels for the community mobilisers to reach. Key community stakeholders and gatekeepers like religious/community leaders, in-laws, and husbands will be reached through interpersonal communication on family planning. Youth peer educators will use targeted messages that address the issues that different youth populations face in regards to their SRH. For youth who are attending tertiary education institutions, access to quality SRHR information (and services) will be improved within the institutions by strengthening/establishing youth centres. To facilitate a referral system, a voucher system for family planning services will be operated within the local health centres of the tertiary education institutions. Furthermore, resource centres where young people, in and out of school, can access SRH information will be created.

4.4. Social and community norms, among the community at large, in support of family planning improved.

General advocacy efforts will be improved by developing family planning champions drawn from local, cultural, and religious leaders. These champions will be sensitised on family planning rights, and any misconceptions will be corrected to ensure they have more positive attitudes towards family planning. With changed attitudes, these key community figures can bring about changes in social norms about family planning by hosting community dialogue and thus creating an enabling environment for increased demand and uptake of family planning services and products.

Beyond the individuals, the institutional capacity of community and religious leaders' organisations and groups will be built based on their needs to reduce stigma about family planning and contraceptives and to raise awareness of family planning and reproductive health rights. Similarly, journalists will be oriented on family planning topics, including SRHR and access to and utilisation of these by youth for better coverage of these topics in the media.

Table 15: Demand Creation: Summary of Performance Targets and Costs by Output

Outcome 1: Demand for contraceptive services increases across different population groups		
Outcome Performance Targets: • Demand for family planning among WRA increases from 52% in 2010 to 55% by 2020 • Demand for family planning among currently married women increases from 77% in 2015 to 82% by 2020 • Unmet need among married women is reduced from 10.4% (2015) to 6.5% (2020) • Unmet need for family planning for adolescent girls, ages 15–19 years, is reduced from 12.6% (2015) to 8.5% (2020) • Unmet need for family planning among the rural population is reduced from 10.9% (2015) to 9.5% (2020) • Unmet need for family planning among populations with no education is reduced from 22.3% (2015) to 15% (2020)		
Outputs	**Output Performance Targets**	**Cost (US Dollars)**
4.1. Knowledge, attitudes, and practices towards family planning among the general population, with special emphasis on youth and geographic areas/population groups with low CPR coverage, is increased	• Percentage of women not currently using a method of contraception who intend to use a method in the future increases to 75% • Lack of knowledge of family planning as a reason for non-use of contraceptive methods is reduced from 1.4% (2005) to < 0.5% (2020) • Method-related factors (e.g., misconceptions, costs, side effects) as a reason for non-use of contraceptives is reduced from 23.8% (2005) to ≤ 10% (2020) • Percentage of recent/current users reporting they were informed about side effects or problems of method used increases from 53.2% (2010) to ≥ 65% (2020) • Percentage of women ages 15–49 reporting they received family planning information from a provider who visited them in the past 12 months increases from 4.1% (2010) to 6.5% (2020) • Percentage of women ages 15–49 reporting non-exposure to family planning messages on radio, on television, or in print in past 12 months decreases from 65.6% (2010) to ≤ 60% (2020)	1,676,701
***4.2.* Knowledge and demand for LARC increased**	• Knowledge on implants increases from 61% (2010) to 87% (2020) • Knowledge on IUCDs increases from 61% (2010) to 70% (2020)	22,273,415

4.3. Communities increasingly mobilised and sensitised to improve knowledge and demand for family planning	• Percentage of women not currently using a method of contraception who intend to use a method in the future increases to 75% • Lack of knowledge of family planning as a reason for non-use of contraceptive methods is reduced from 1.4% (2005) to < 0.5% (2020) • Method-related factors (e.g., misconceptions, costs, side effects) as a reason for non-use of contraceptives is reduced from 23.8% (2005) to ≤ 10% (2020)	5,778,827
4.4. Social and community norms in support of family planning improved	• Opposition to use as a reason for non-use of contraceptives is reduced to < 15% • Percentage of women not currently using a method of contraception who intend to use a method in the future increases to 75%	10,079,208

RESEARCH, MONITORING AND EVALUATION

Under this plan, data-driven decision making will be enhanced to improve the effectiveness and efficiency of the family planning programme. Enhancements will be brought about through efforts to strengthen the R, M&E function of the family planning programme. An impactful R, M&E system requires that information is demanded by end users, collected, processed, and made available in a timely manner to end users, and is eventually used to improve intended programme and health outcomes. Similarly, a programme that is responsive to client needs and that aims to satisfy demand must pay particular attention to routine quality monitoring and improvements. A summary of key outputs and performance targets contributing to this outcome are described and summarized in **Table 16**. The total cost estimate for R, M&E for the five-year period is USD651,856.

5.1. A harmonised and optimised family planning M&E system is in place to support data-driven decision making

The family planning M&E system refers to the structure, processes, resources, and tools involved in monitoring and evaluating the family planning programme, from data collection to data processing and use. "Harmonised" refers to ensuring that the system is coherent, synergised, and coordinated at all levels; "optimised" refers to functioning with high efficiency. A comprehensive M&E framework will be developed and disseminated to provide overall guidance on the function, structure, process, and tools of the M&E system. The system will also define the process for defining annual operational targets, as well as key performance indicators to be tracked. Further, the system will describe and provide the necessary tools for presenting the information to various stakeholders to facilitate decision making. An M&E technical working group will be strengthened to support coordination and provide technical advisory to the MOHCC and the ZNFPC. Considerable efforts will be dedicated to building the capacity of the existing M&E unit of the ZNFPC. For example, ZNFPC staff would benefit from being trained to conduct secondary analysis of surveys such as the Multiple Indicator Cluster Surveys (MICS) and ZDHS to inform programming. Resources will be put aside to strengthen the capacity of implementing partners to implement the new M&E system. The national HMIS-related trainings, including training of the provincial health information officers, will incorporate the use of new family planning registers and support the use of the T 5 reporting form.

Resources will be dedicated to the performance of routine data quality assessments to improve the quality of data reported. This will be done through coordination with the MOHCC's M&E unit and the Epidemiology and Disease Control Directorate. In addition, and above all, a culture of data for decision making will be cultivated at various levels to increase demand and use of data. Platforms for information sharing, decision making, and action setting will be facilitated through forums such as monthly meetings at every level (i.e., district, provincial, national), meetings of technical working groups, high-level dialogue, and joint reviews. Specifically, national monthly review mechanisms of the family planning programme, involving the MOHCC, the ZNFPC, and key national stakeholders, will be strengthened (using DHIS-2 data to conduct the reviews).

5.2. *A national family planning research agenda developed, disseminated, and used.*

A two-year national family planning research framework will be developed to outline the major areas of family planning research based on the current status of the programme; this framework will be the basis for carrying out the research. The research framework would later be published and disseminated through family planning fora. Use of the research agenda will be demonstrated through dedicated resources directed towards operations research informed by the national research agenda, and sharing of key findings in regular family planning forums. Further, the capacity of the R, M&E unit of the ZNFPC would be enhanced by hiring additional staff and encouraging/organising trainings on carrying out research for the existing staff.

5.3. *An active ZNFPCIP performance monitoring mechanism in place by 2017*

Performance monitoring will be a critical component of the ZNFPCIP's execution phase. This monitoring will include tracking results and resource flows to inform implementation and resource gaps, engaging stakeholders to focus on and account for results, supporting informed decision making to improve implementation performance and resource mobilisation, supporting accountability to report on progress with goals and global commitments, and facilitating needed plan adaptations and collective learning. Although performance targets and indicators have been included in the plan, efforts will be directed towards creating tools for data collection and analysis, a data management and analysis plan, and a data use plan. Semi-annual progress review meetings will be held to assess progress and identify performance and resource gaps. Mid-term and end-term evaluations of the programme will also be conducted.

Table 16: Research, Monitoring & Evaluation:
Summary of Performance Targets and Costs by Output

Outcome 5: Data-driven decision making is enhanced to improve the effectiveness and efficiency of the family planning programme

Outcome Performance Targets:

- 90% of family planning SDPs across all sectors (public and private) report through the national HMIS (i.e., the DHIS-2)
- Integrated family planning recording and reporting tools adopted and in use by all family planning providers in the country (both public and private sectors)
- Two-year national family planning research framework/roadmap developed
- M&E unit of the ZNFPC strengthened

Outputs	Output Performance Targets	Cost (US Dollars)
5.1. A functional, harmonised, and optimised family planning M&E system in place to support data-driven decision	• Quarterly review of national family planning data is conducted • Monthly review of provincial family planning data is conducted • Family planning M&E technical working group strengthened and fully operationalised by 2016 • Quarterly data quality audits are conducted	448,568

making	• Harmonised family planning data flow system established and operationalised • Data quality improved through data quality assurance activities/visits • Baseline data collected (as per need) for indicators in the results framework through assessment studies	
5.2. A national family planning research agenda developed and operationalised	• National family planning research agenda developed by 2017 and updated once in two years • At least two family planning-related operation research studies conducted and disseminated annually	190,832
5.3. A functional, active ZNFPCIP performance monitoring mechanism in place by 2017	• ZNFPCIP monitoring plan in place	12,456

IMPLEMENTATION ARRANGEMENTS

Implementation of the ZNFPCIP will span a period of five years, from 2016 to 2020, and involve a broad range of stakeholders under the stewardship of the GOZ. A multi-sectoral approach to implementation of the plan will be adopted to create opportunities for broad and diverse stakeholder involvement, to jointly address family planning as a fundamental intervention for health, social, and economic development. This section seeks to describe institutional arrangements for operationalising the ZNFPCIP to bring about sustained action and results, by delineating who and how several functions of execution will be carried out, including leadership and governance, stakeholder coordination, resource mobilisation, and performance monitoring.

Leadership and Governance

In line with its vision to achieve the highest possible level of health and quality of life for all people, the MOHCC has the overall mandate to lead and oversee efforts to ensure informed and universal access to family planning services by all citizens. Accordingly, the MOHCC will provide overall leadership and responsibility over the implementation of the ZNFPCIP at all levels. The successful implementation of the plan will rely heavily on the participation of other line ministries, State enterprise and parastatals, and development and implementing partners, which will be responsible for implementing specific interventions that fall within their respective mandates.

THE KEY ROLES AND RESPONSIBILITIES OF DIFFERENT ACTORS ARE DESCRIBED AS FOLLOWS:

Ministry of Health and Child Care

The MOHCC is responsible and accountable for providing oversight to effectively and efficiently implement the ZNFPCIP. Specifically, the MOHCC will manage, coordinate, and monitor implementation of the plan to ensure attainment of performance targets; mobilize, monitor, and ensure efficient use of resources; formulate and implement enabling policies, laws, and regulations; and set forth guidelines and standards for programme and service delivery.

The permanent secretary will assume the highest level of operational governance within the MOHCC for the ZNFPCIP. Specifically, the permanent secretary will ensure that adequate resources are directed towards achieving plan outcomes, as well as elevate family planning as a priority area within the MOHCC; foster strong linkages with non-health ministries to realise a multi-sectoral approach in implementing the plan; and ensure the provision of quality family planning services throughout the country, including through the chain of approximately 1,500 health facilities within the MOHCC.

Department of Family Health

The Department of Family Health will be the key MOHCC department to provide overall leadership to the family planning programme (as guided by the ZNFPCIP), working closely with the ZNFPC, other departments within MOHCC, other ministries, and partners. The principal director of preventive services of the MOHCC, through the Department of Family Health and the Reproductive Health Unit within the department, will spearhead planning,

resource mobilisation, implementation, and performance monitoring of the ZNFPCIP within existing governance structures. Through its operational unit, the Reproductive Health Unit, will oversee policy and programme development and assure coordination of the activities among different players.

Reproductive Health Unit

The Reproductive Health Unit within the MOHCC's Department of Family Health will provide operational leadership to the family planning programme, particularly family planning service delivery, through the 1,500 health facilities nationwide. It will manage day-to-day operations of the family planning programme's implementation and monitoring, including liaising with the ZNFPC and other stakeholders on implementing approved work plans. Apart from overall operational responsibility, the Reproductive Health Unit will give greater attention to the ZNFPCIP in performing such functions as ensuring the availability and optimal distribution of skilled human resources and managing and making available HMIS data to aid in planning and coordination.

The Reproductive Health Unit will work in collaboration with other departments within the MOHCC, being responsible for such functions as nursing, epidemiology, and disease surveillance; M&E; quality assurance; and pharmacy. Working relationships with these departments will be facilitated by the permanent secretary of the MOHCC, through the principal director for preventive medicine and the director of the Family Health Department.

Zimbabwe National Family Planning Council

The ZNFPC will perform the following functions, especially in the context of the ZNFPCIP:

- Coordinate the family planning programme through joint planning, implementation, and monitoring. One of the key activities under this will be to convene quarterly national family planning coordination forums.
- Coordinate procurement and distribution of contraceptive commodities in alignment with the new ZAPS.
- Conduct proper forecasting of family planning commodities, in alignment with ZAPS.
- Ensure that public and private organisations and NGOs providing family planning services in Zimbabwe adhere to prescribed standards, guidelines, and procedures set forth by the MOHCC.
- Through established training centres of excellence will coordinate, manage, and provide evidence and context-based, updated decentralised training to service providers.
- Lead implementation of quality improvement approaches to ensure quality service delivery.
- Carry out family planning research to improve service delivery practice and policy.
- Provide integrated reproductive health services in its network of SDPs nationwide.

The role of the ZNFPC may evolve with time in alignment with future anticipated amendments to the ZNFPC Act, as outlined under the Enabling Environment strategy.

National Pharmaceutical Company

In accordance with its mandate, the National Pharmaceutical Company through ZAPS will procure, store, and distribute medicines and medical supplies to public and private health facilities. Specifically, the company will work with the ZNFPC to ensure that procurement, distribution, and warehousing systems for contraceptives and other reproductive health

commodities are effective and efficient to foster reproductive health commodity security at all levels of health care.

Medicine Control Authority of Zimbabwe

In accordance to its mandate under the Medicines and Allied Substances Control Act and the Medicines and Allied Substances Control Regulations SI 150 of 1991, the Medicine Control Authority of Zimbabwe (MCAZ) will ensure quality, safety, and efficacy of contraceptive commodities by ensuring and regulating their production, importation, distribution, and use. MCAZ will also ensure that the national list of essential drugs features an adequate mix of priority contraceptive products according to established needs of the ZNFPCIP and the population.

Other Sectoral Ministries and Institutions

Since successful implementation of the ZNFPCIP requires multi-sectoral engagement, other key ministries and institutions shall also be responsible for contributing towards the achievement of results in accordance with their respective mandates.

Key ministries include the Ministry of Primary and Secondary Education; Ministry of Higher and Tertiary Education, Science and Technology; Ministry of Women's Affairs, Gender and Community Development; Ministry of Youth Development, Indigenisation and Empowerment; and the Ministry of Economic Planning and investment Promotion. Other key institutions include ZIMSTAT.

Ministry of Finance and Economic Planning

This ministry will, in accordance with its mandate, collaborate closely with the MOHCC in budget planning, disbursement of funds, and accounting for expenditures. Improved coordination and communication between this ministry and the MOHCC will ensure timely disbursement of funds needed for implementation of the ZNFPCIP. In its role of coordinating the implementation of the ZimASSET, this ministry will also mobilise and allocate optimal levels of resources towards the ZNFPCIP, with recognition that these investments will contribute to the achievement of the overall goal of the ZimASSET. This ministry will support family planning as a key development intervention to harness the demographic dividend to achieve Agenda 2063. The ministry will promote integration of population variables into development policies, plans, and programmes, and will support provinces to allocate resources for implementation of the ZNFPCIP.

Ministry of Primary and Secondary Education

This ministry will work closely with the MOHCC to foster enabling policy environment in school systems. Comprehensive sexuality, gender, and health education at primary and secondary levels, as well as outside of school settings, are the primary investments for empowering people to prevent unintended pregnancies.

Ministry of Higher and Tertiary Education, Science and Technology Development

This ministry will work closely with the ZNFPC to support effective implementation of youth resource centres for young people enrolled in tertiary education institutions to achieve a mutual goal of reducing pregnancy-related school dropouts. The MOHCC will support availability of youth-friendly SRH services within the tertiary institutions.

Ministry of Women's Affairs, Gender and Community Development

This ministry is responsible for mainstreaming gender in all government policies and plans, which is an important component to facilitate achievement of results under the ZNFPCIP. The ministry will also focus on the existing social and cultural contexts in the society to reduce women's risk of unintended pregnancies.

Ministry of Youth, Indigenisation and Economic Empowerment

The Ministry is responsible of for the creation of an enabling environment and opportunities for the development and empowerment of all Zimbabwean youths and this includes youth participation, leadership development and skills training

The Zimbabwe National Statistics Agency

ZimSTAT will provide core demographic and health statistics that are critical for monitoring and evaluating the ZNFPCIP. These statistics will be generated through national demographic household surveys and the census.

Parliamentarians

Parliamentarians will generate general awareness on population issues at all levels, lobby for the inclusion of family planning issues in government priority programmes, and advocate for an enabling environment, including promoting investments in family planning projects.

Research and Academia

Research and academic institutions play an important role in the national effort to increase use of family planning services, through technical guidance, research, and training of future professionals. Academic institutions will integrate family planning into a wide range of programmes, especially in pre-service institutions for service providers. Research institutions will be encouraged to generate new research evidence to improve operational performance and quality of service delivery.

Professional Associations

Through various professional bodies and technical agencies, the MOHCC will monitor compliance to the laws and set standards to allow the ministry to concentrate on policy and strategic issues.

Development Partners

Development partners and United Nations agencies are instrumental in the successful implementation of the ZNFPCIP by providing the necessary financial resources and technical expertise. Development partners and United Nations agencies will work in close collaboration with the government to facilitate planning, implementation, and monitoring of the family planning programme.

Civil Society and Nongovernmental Organisations

Civil society includes a diverse group of organisations, including faith-based organizations, cultural and local organisations, media, the private sector, and academia. Collectively, civil society plays critical roles in accelerating access and utilisation of quality family planning services and thus is a key implementer of the ZNFPCIP. Civil society entities will also complement the public sector in delivering services at facility and community levels,

mobilising resources, and exercising their role as advocates by playing the role of "watchdogs" to ensure social accountability and responsibility.

COORDINATION FRAMEWORK

Given the diversity and multitude of stakeholders required to implement the ZNFPCIP, the need for harmonization of resources and activities will be paramount. A clear and active coordination framework at all levels is necessary to prevent duplication of efforts, enhance efficient use of resources, track progress and results, and facilitate knowledge sharing. As far as possible, the existing national and sub-national coordination structures will be used to include family planning as an integral part, which will facilitate planning, coordination, implementation, and monitoring of RMNCAH programmes in an integrated manner. The important forums include the national family planning coordination forum, the Meeting of Donor and Government, and provincial and districts health executive meetings and review meetings.

The MOHCC will lead ZNFPCIP coordination, including stakeholder engagement and the new and existing coordination structures at the central and district levels of the health system, described below. Coordination also includes ensuring that the strategic priorities and activities of the ZNFPCIP are integrated and harmonised with and supported by other health and non-health programmes.

The Development Partners Group

This group will be strengthened, and family planning will be included as an integral part of the terms of reference of this group. This will help to promote harmonisation of donor investments and address alignment issues with government priorities. It will also advise the MOHCC on policy issues and participate in joint annual reviews of the performance of the ZNFPC.

Implementing Partners Forum

The Implementing Partners' forum is a multi-sectoral partnership platform chaired by the designated focal point of the ZNFPCIP. The forum strives to achieve efficiencies and collective effectiveness of different stakeholders by clarifying roles and responsibilities for implementation, creating stronger synergies among implementing partner efforts, optimising the flow of information across different stakeholders, and requiring accountability for performance and results from all partners.

All implementing and development partners of the MOHCC will be convened under the forum, which is expected to continue to play an important role during implementation of the plan. The forum will play an advisory and guidance role to the MOHCC and family planning stakeholders, support effective implementation of the ZNFPCIP through a variety of strategies, and provide a forum for stakeholders to share information and technical updates. The terms of reference and working modalities will be reviewed, and appropriate revisions will be made to ensure that its mandate and priority activities align with the ZNFPCIP's attainment of results.

Five strategy area co-leaders, reporting to the forum, will be assigned to steer and coordinate efforts for the five strategies: enabling environment; demand creation; service delivery; contraceptive security; and research, monitoring, and evaluation. The co-leaders, one nominated from the MOHCC and the another a representative of implementing partners, will

serve as the lead technical resources for developing the annual objectives and implementation plan for their respective priority areas based on the ZNFPCIP. They will also coordinate the implementation of priority strategies in their strategy areas and report back during forum meetings on progress and challenges with implementation.

Resource Mobilisation Framework

The success of the ZNFPCIP hinges on the ability to mobilise a considerable amount of resources within a short time frame and on a continuous basis throughout the implementation period. After the launch of the ZNFPCIP, the forum will explore different strategies, including broadening the donor base, enhancing advocacy at levels for increased allocation of funds to family planning, mobilising resources and support from the private sector (and foundations), and increasing efficiency in use of funds.

Performance Monitoring and Accountability

Measuring performance against set targets in the ZNFPCIP is central to generating essential information to guide strategic investments and operational planning. The MOHCC will assign responsibility of managing the performance monitoring function to the family planning M&E officer, supported by Track20/FP2020, within the MOHCC. The family planning M&E officer will have the primary responsibility for day-to-day monitoring of the implementation of the ZNFPCIP under the direct supervision of the director of the MOHCC's Department of Family Health.

M&E of the ZNFPCIP will rely on a variety of systems and data sources (routine and periodic), supported and maintained by numerous stakeholders. Soon after the launch of the ZNFPCIP, performance monitoring tools will be developed and established.

Although service utilisation data will be collected through the HMIS and from Track20, a mechanism to collect and review process monitoring data will be established. A system will be developed to collect and report on quarterly data related to financial expenditures, sources of funds, geographic location and coverage of implemented activities, and output-level results based on indicators. The information generated from this quarterly data collection will be routinely used by the MOHCC and the FP Partners' forum to track progress in mobilisation of financial resources for implementation of the programme and achievement of results against set programme targets. This mechanism will help assure that efforts conform to the plan and ensure that results achieved align with performance targets. Also, process monitoring will allow for corrective and preventive action along the way, including fine-tuning of strategies, planning, and coordination.

APPENDIX 1: IMPLEMENTATION PLAN

Output	Activities	Sub-activities	2016	2017	2018	2019	2020
ENABLING ENVIRONMENT							
Outcome 1a. Adequate resources mobilised from various sources to fulfil financial requirements of the family planning programme							
1a.1. The GOZ increases the annual family planning budget from the current 1.7% to 3% of the government health budget	Advocate with the MOHCC, including the National AIDS Council (NAC) and the AIDS and Tuberculosis Unit (ATB); parliamentarians; and the ZNFPC board to mobilise family planning resources	Develop an investment case for family planning to support advocacy efforts (include impact of family planning on population and development; and rationale for role of family planning in demographic dividend)	X	X			
		Advocacy for joint financing with NAC and ATB for family planning services as part of PMTCT and HIV prevention	X	X	X	X	X
		Advocacy workshops for parliamentarians for resource allocation to family planning (including conducting pre-budgetary consultations with parliamentary portfolio committees including presentation of "value for money" proposition of family planning investments)	X	X	X	X	X
		Identify, sensitise, and build capacity of select parliamentarians to be family planning champions (includes annual review meeting to discuss and track progress). Areas for advocacy include resource mobilisation and parliamentarians holding the national government accountable for international commitments	X	X	X	X	X

Output	Activities	Sub-activities	2016	2017	2018	2019	2020
		Hold sensitisation workshops with key non-health sector stakeholders (e.g., Ministry of Education; Ministry of Women Affairs, Gender and Community Development) to reposition family planning as a multi-sectoral tool for socioeconomic development	X	X	X	X	X

1a.2. Private, nongovernment funding for family planning from donors and other sources increased	Advocate targeting development partners to increase level of resources allocated to family planning and expanding the family planning donor base	Conduct direct advocacy with donor community using developed investment case materials in one-on-one meetings	X	X			
		Identify GOZ and donor champion in Health Development Fund (HDF) and other donor platforms (e.g., health partner's forum) to ensure a family planning voice in such platforms	X	X			
		Coordinate work plan development with implementing partners (e.g., PSZ, PSI, UNFPA)	X	X	X	X	X
		Annual review and planning meeting with all key implementing partners based on national family planning budget (beginning of 4th quarter)		X	X	X	X
	Sensitise and advocate for private, for-profit community to invest in family planning	Explore access to corporate social responsibility funds	X	X	X	X	X
	Develop champions within the business community to mobilise resources from the private sector	Develop a business case and advocacy messages for the business community		X			
		Identify and orient champions for the business community		X		X	
	Leverage the results-based platform to mobilise resources for family planning	Ensure representation of family planning stakeholders in Results-Based Financing (RBF) Steering Committee					
1a.3. Adequate funding mobilised to fulfil financial	Prepare annual budget requests and justification to the MOHCC and	Develop provincial budgets for family planning	X	X	X	X	X
		Consolidation at national level by ZNFPC budget committee	X	X	X	X	X

requirements for ZNFPC operations	Ministry of Finance	Convene annual meetings (1st quarter of year) with donors and partners to discuss national family planning budget to ascertain and coordinate funding commitments	X	X			
		Submission to ministry with justification and coordination within the MOHCC prior to meeting with Ministry of Finance	X	X	X	X	X
		Consult with the Ministry of Finance to defend annual funding requests for family planning, including presentation of "value for money" proposition of family planning investments					
	Advocate for enhanced engagement of the ZNFPC board in resource mobilisation efforts	Advocacy workshops with ZNFPC board for increased engagement in resource mobilisation	X	X	X	X	X
		Participate in site visits, other activities		X	X	X	X
	Increasing revenues within the ZNFPC through development of strategic business units	Recruit a business development person to lead and oversee resource mobilisation efforts and enhancing revenue generation					
Outcome 1b: Strengthened leadership, management, and coordination capacity of the ZNFPC at the central and provincial levels							
1b.1. ZNFPC (role, vision, structure, and operations) reformed and capacity strengthened to improve its effectiveness, efficiency, and sustainability	Conduct a structural and operational review of the ZNFPC and generate recommendations	Engage a consultant to conduct an organisation-wide structural and operational review of the ZNFPC and generate recommendations	X	X			
	Implement restructuring recommendations from review	Human resources: Job grading and remuneration framework review (linked to ZNFPC restructuring below)	X	X			
		Transform the regional training centres in Harare and Bulawayo into training centres of excellence	X	X			
		Upgrade SPILHAUS and FIFE Avenue clinics to become practice centres for the training centres of excellence	X	X			

		Upgrade ZNFPC clinics		X			
		Upgrade library @ ZNFPC headquarters		X			
		Upgrade accommodation and catering		X			
		Support international training and exchanges for staff in East and Southern Africa, and in the United Kingdom	X	X	X	X	X
		Build capacity of R, M&E unit		X	X	X	X
		Hosting conferences within training centre		X	X	X	X
		Commercialise the audio visual unit		X			
1b.2. Improved coordination among different stakeholders	Improve coordination and role clarification between the ZNFPC and the MOHCC's Reproductive Health Unit through the Department of Family Health	Convene meeting between ZNFPC and MOH RH Unit to discuss SOPs for collaboration	X	X			
Outcome 1c: The policy and political environments are made increasingly conducive to facilitate effective functioning of the family planning programme							
1c.1. Outdated policies updated (e.g., youth policy)	Conduct a review of the relevant policies for inclusion of specific language to foster access to family planning by youth and other marginalised populations	Hire a consultant to assess existing policies within key ministries (e.g., youth, education, gender), and hold a multi-sectoral workshop to share findings and develop ministerial recommendations	X	X			
		Advocate with ministries to address any gaps identified through one-on-one dialogues		X	X	X	X
		Provide technical input to policy revision as requested	X	X	X	X	X
1c.2. The ZNFPC Act reviewed and revised	Advocate for the review of the ZNFPC Act	Roles and responsibilities of the ZNFPC within the Act reviewed by the year 2020		X	X	X	X
		Convene workshop to share draft ZNFPC	X	X	X	X	X

		Amendment Act with policymakers/advocacy groups					
		Advocate with parliamentarians to incorporate draft language as amendment to ZNFPC Act	X	X	X	X	X
1c.3. Heightened and sustained political will and commitment towards family planning	Build capacity of media houses to properly represent family planning issues in their reporting	Annual full-day capacity building workshop followed by a full-day media tour		X	X		
	Work closely with media houses to positively promote family planning and dispel myths from the general public	Build relationships between the ZNFPC Marketing and Communications Department with media houses to strengthen engagement	X	X	X	X	X
	Work with traditional and religious leaders at the national level to express positive attitudes towards family planning	Convene a half-day sensitisation meeting with each group annually		X		X	
	ZNFPC engages MOHCC in continuous dialogue regarding the issue of user fees	Hold internal meetings with the MoHCC to discuss approaches to handle user fees	X	X	X	X	X
	Conduct dialogues with key multi-sectoral partners, including the NAC, Ministry of Education, and others to support the provision of family planning education in their settings			X		X	

Output	Activities	Sub-activities	2016	2017	2018	2019	2020
COMMODITY SECURITY							
Outcome 2. A robust and reliable commodity security system is ensured through a strengthened supply chain management system							
2.1. Adequate contraceptive commodities and supplies are procured to cover all country needs in accordance with the method mix projections to meet CPR goal by 2020	Conduct quantification exercises and share results with stakeholders on a quarterly basis	Quantification exercise for commodity requirements (bi-annual) CPTs	X	X	X	X	X
		Family planning forum meetings with development partners (quarterly) to discuss requirements	X	X	X	X	X
		Present quantification results to partners (bi-annual)	X	X	X	X	X
	Determine and share comprehensive funding requirements and gaps during quarterly family planning forum meetings	Solicit funding requests for in-country quality assurance activities during family planning forum meetings	X	X	X	X	X
	Procure family planning commodities and equipment	Procure family planning commodities	X	X	X	X	X
		Provide equipment required for LARC services		X		X	
	Advocate for harmonisation of brand choice for family planning commodities to meet procurement conditions of all partners	Consult with commodity security partners contributing to procurement of commodities	X	X	X	X	X
2.2. Timely procurement and delivery of commodities to	Expand storage capacity for family planning commodities	Outsource warehousing in Harare on a short-term basis (i.e. years 1,2,3)	X	X	X		
		Capital investment for improvements of the warehouses	X	X	X	X	X

Output	Activities	Sub-activities	2016	2017	2018	2019	2020
central warehouse is sustained above 95% through 2020		Expand the ZNFPC's Harare and Masvingo warehouses		X	X	X	X
	Train staff on supply chain management	Basic supply chain management for health commodities (three ZNFPC staff sponsored by the USAID) —annually	X	X			
		Conduct training through AccessRH for family planning products (sponsored by UNFPA) — Int'l bi-annually		X		X	
2.3. Order fulfilment from warehouse increases from 85% to 94% by 2020	Improve picking and packing of orders	Conduct on-the-job training of warehouse personnel in warehouse management		X		X	
		Invest in warehouse handling equipment		X			
	Improve storage capacity at the provincial level	Mobilise resources to pay for storage charges	X	X	X	X	X
2.4. Distribution coverage and timeliness of clinics requesting deliveries increases from 96% to 99% by 2020	Conduct monitoring and supportive supervision of supply chain	Site visits from central level	X	X	X	X	X
		Site visits from province headquarters	X	X	X	X	X
	Distribute commodities to facilities	Ordering round	X	X	X	X	X
		Delivery of commodities	X	X	X	X	X

Output	Activities	Sub-activities	2016	2017	2018	2019	2020
SERVICE DELIVERY							
Outcome 3. Improved availability and access to quality integrated family planning and SRH services							
3.1. Capacity of health facilities enhanced to offer a full range of methods	Revise in-service training manual and materials for all family planning methods, including procedure manuals	Hire consultant to review and make recommendations on revisions and improvements	X	X			
		Convene stakeholder workshops to review and discuss recommendations	X	X			
		Print final copies		X			
	Review and revise pre-service training curriculum	Hold a two-day workshop to review curricula for nurses, midwives, and doctors		X			
		Hold three-day workshops to develop course content and include components of family planning in pre-service curricula		X			
		Hold continuing education seminars for academia and professional association members		X			
	Revise operational guidelines for family planning services	Through technical working group members, revise operational guidelines for family planning services		X			
	Increase pool of family planning trainers	Recruit and train trainers at regional level		X			
	Train 4,000 providers to provide clinical family planning services	Convene training workshops in clinical service provision for service providers (1,000 trained per year)		X	X	X	X
	Train 3,000 providers on LARC (IUCD and implant) services	Training workshops in LARC for service providers (1,000 trained per year)		X	X	X	

Output	Activities	Sub-activities	2016	2017	2018	2019	2020
	provision						
	Train 4,000 providers on infection prevention and control	Training workshops on infection prevention and control	X	X	X	X	
	Support and mentor newly trained service providers	Conduct post training follow-up and support	X	X	X	X	
	Adapt TrainSmart or TrainTrack to support monitoring of trainees and trainers	Engage ITECH to adapt and introduce TrainSmart to support tracking of family planning trainings	X	X			
		Conduct a one-day workshop for different partners to support roll out of TrainSmart		X			
	Conduct clinical service provision support visits from higher-level facilities to lower-level facilities	Conduct continued provincial mapping of facilities requiring support by the MOHCC, the ZNFPC, and partners	X	X	X	X	X
		Conduct quarterly supportive supervision visits for clinical service provision	X	X	X	X	X
	Development and hosting of paper-based self-learning module; tests and assessment checklists	Conduct workshops to develop modules		X	X		
	Conduct quality assurance visits at facilities throughout the country	Conduct quarterly quality assurance visits at facilities	X	X	X	X	X
	Host in-country (province-to-province) and international study tours	Local	X	X	X	X	X
		International	X	X	X	X	

Output	Activities	Sub-activities	2016	2017	2018	2019	2020
3.2. Outreach services expanded and strengthened to improve availability and access to quality family planning services by underserved communities	Develop outreach guidelines, including establishing criteria for what will constitute an outreach point	Stakeholder workshop to identify outreach by facilities and reach consensus	X	X			
		Draft the new criteria, guidelines, and supporting documentation	X	X			
		Print and disseminate the new criteria and guidelines through rollout workshop	X	X			
		Establish an outreach coordination group at the national level to liaise with provinces and districts to monitor the family planning outreach programme	X	X			
	Coordinate at the provincial level to establish outreach points and service provision	Conduct a mapping exercise to describe underserved areas.	X	X	X	X	X
		Family planning technical working group hosts series of one-day meetings with provincial stakeholders to identify potential outreach points, based on mapping exercise (annual exercise)	X	X	X	X	X
		Recruit and train additional outreach teams to support outreach events (base = two teams per province increasing to four teams per province)		X	X	X	X
		Each district disbursed annual lump sum (e.g., USD2000/year) to be provided to the reproductive health clinics within the district to carry out family planning outreach sessions	X	X	X	X	X
		Make capital investments for establishing at least one mobile family planning clinic in each province		X			
		Support additional outreach events (i.e., IEC materials, branding) from provincial		X	X	X	X

Output	Activities	Sub-activities	2016	2017	2018	2019	2020
		headquarters					
3.3. Community-based family planning services expanded and strengthened to increase availability and access to quality family planning services	Identify and recruit community-based health workers (CBHWs)	Conduct advocacy meetings with community leaders	X	X	X	X	X
		Identify the existing CBHWs in the community		X		X	X
		Conduct training workshops for CBHWs	X	X	X	X	X
		Develop and produce job aids	X	X	X	X	X
		Develop and procure working tools for community-based distributors	X	X	X	X	X
		Conduct post follow-up training	X	X	X	X	X
3.4. Availability and access of youth-friendly family planning services in rural, underserved areas and communities (farming, mining, and resettlement) increased, including in identified tertiary education institutions	Develop national standards for youth-friendly service provision	Engage consultants for approximately 30 days, two one-day stakeholder meetings, printing, and determination of standards.	X	X			
			X	X			
			X	X			
			X	X			
		Review ASRH training manual to incorporate national standards on YFHS	X	X			
			X	X			
			X	X			
			X	X			
	Sensitize health workers on national standards for YHFS	Conduct sensitization workshops for health facility staff	X	X	X	X	X
	Conduct quality assurance exercises for YFHS	Conduct client satisfaction survey, client exit interviews and mystery client interviews	X	X	X	X	X
	Build capacity of service providers on YFHS	Train health care workers on provision of youth-friendly services at the facility level		X	X	X	

Output	Activities	Sub-activities	2016	2017	2018	2019	2020
		Hold refresher courses for service providers in the year 2019				X	X
		Train community-based workers (e.g. peer educators, village health workers, behaviour change facilitators) to create demand for family planning services among young people	X	X	X	X	X
	Expansion of the voucher system for young people to increase SRHR service uptake in tertiary institutions	Conduct Youth needs assessment	X	X			
		Advocate incorporation of medical insurance in the fee structure in tertiary institutions		X	X	X	
		Develop a voucher system for family planning services for students of tertiary education institutions		X	X	X	X
		Procurement of the vouchers	X	X	X	X	X
3.5. Integration of family planning services with other health services, including HIV/AIDS and MCH, improved	Provider capacity to deliver integrated family planning, reproductive health, and HIV services improved	Conduct Workshops per province		X	X	X	X
		Conduct Quarterly post-training follow-ups per district		X	X	X	X
		Provide of integration commodities	X	X	X	X	
3.6. Increased uptake of quality family	Support private-sector reporting to HMIS	Orient meeting with private sector at the provincial level		X	X	X	

Output	Activities	Sub-activities	2016	2017	2018	2019	2020
planning services through the private sector		Provide with management information system forms		X	X	X	
		Provide HMIS site IDs to private service provider sites to enable monthly data reporting to HMIS	X	X	X	X	
	Development and rollout of an accreditation system for private family planning providers (as much as possible the accreditation system should ride on existing regulatory mechanisms such as the Health Professions Authority, Medicines Control Authority of Zimbabwe, Medical and Dental Practitioners' Council of Zimbabwe, Nurses Council for sustainability)	Consultant hired to assess the extent of quality service provision and adherence to family planning guidelines and standards by the private sector		X			
		Conduct consultative workshops to engage stakeholders and get buy-in on the proposed accreditation process. Stakeholders include private facilities, public sector, and regulatory authorities. Assessment findings presented during workshop		X			
		Assessment findings inform development of an accreditation system, process, and package for private facilities		X			
		Accreditation package is rolled out as a pilot to a sample of 10 facilities based on established criteria			X		
		Lessons learned from the pilot used to improve the accreditation process. Accreditation guidelines developed			X	X	X
		Private sector oriented to new accreditation requirements, process, and guidelines			X	X	X
	Cultivate adoption of a TMA approach to family	Sensitize and consult with different stakeholders on the TMA	X	X			

Output	Activities	Sub-activities	2016	2017	2018	2019	2020
	planning service delivery	Conduct a market segmentation analysis		X			
		Develop a TMA implementation plan		X			
		Establish and implement public-private partnership coordination mechanism to implement the TMA		X	X	X	X

Output	Activities	Sub-activities	2016	2017	2018	2019	2020
DEMAND CREATION							
Outcome 4. Demand for contraceptive services increase across different population groups							
4.1. Knowledge, attitudes, and practice towards family planning among the general population, with special emphasis on youth and geographic areas with low CPR coverage, are increased	Introduce and sustain a comprehensive social and behaviour change communication strategy targeting different segments of the population, including the general population, youth, and those in hard-to-reach areas	Conduct a comprehensive formative research study to inform the SBCC strategy	X	X			
		Review existing materials and messages (e.g., identifying gaps, outdated information)	X	X			
		Update and develop new messages (including pre-testing)	X	X			
		Package messages for different media channels (e.g., radio, TV, road shows, IEC, print media, social media) and develop media plan	X	X	X	X	X
		Production and placement articles in the media (i.e. purchase/acquire media access)		X	X	X	X
		Adapt messages and implement an engaging digital communication strategy		X	X	X	X
		Monitor media rollout and reach		X	X	X	X

Output	Activities	Sub-activities	2016	2017	2018	2019	2020
	Communication and advocacy technical working group strengthened/established and operationalised by end of 2016	Convene a meeting (MOHCC, ZNFPC, UNFPA) to draft Terms of Reference and then share with potential communication and advocacy technical working group members for review/input	X	X			
		Convene a meeting with potential communication and advocacy technical working group members to incorporate review comments and finalise Terms of Reference	X	X			
	Regular meetings of communication and advocacy technical working group	Bi-monthly meetings of communication and advocacy technical working group to review latest M&E data being reported	X	X	X	X	X
	Updated comprehensive communication and advocacy strategy	Review existing communication and advocacy strategy	X	X	X	X	X
		Draft the new strategy and supporting documentation	X	X	X	X	X
		Disseminate the new strategy through a rollout workshop		X	X	X	X
4.2 Knowledge and demand for LARCs increased	Develop and implement a comprehensive SBCC strategy to increase demand for LARC (as part of the SBCC strategy for family planning for the country)	Conduct comprehensive formative research (an in-depth assessment) of drivers of choice and method preferences among users of long-acting methods for implants and IUCDs		X			
		Develop an SBCC strategy to increase demand for LARC		X			
		Implement a targeted campaign across different channels to create demand for LARC		X	X	X	X

Output	Activities	Sub-activities	2016	2017	2018	2019	2020
4.3 Communities increasingly mobilised and sensitised to improve knowledge of and demand for family planning	Conduct community mobilisation and sensitisation efforts to promote uptake of family planning services	Develop action plan and guidelines for community mobilisation and sensitisation	X	X			
		Develop standardised family planning information materials (job aids) for advocacy, provision, and referral for community health cadres.	X	X			
		Build capacity of community health workers to generate demand for family planning using standardised family planning job aids		X			
		Periodic family planning campaigns (World Contraception Day, World Population Day) with service provision availability	X	X	X	X	X
		Exhibition participation	X	X	X	X	X
		Advocacy through patrons, champions, and brand ambassadors	X	X	X	X	X
	Tertiary education institution outreach	Advocacy to tertiary institution leadership to permit (engagement of leadership for buy-in)	X				
		Recruit and train youth peer educators	X	X	X	X	X
		Create resource centres where young people access SRH information	X	X	X	X	X
4.4. Social and community norms in support of family planning improved	Social mobilisation by community leaders (e.g., traditional, faith-based, political) for family planning	Train community leaders in delivery of community dialogues	X	X	X	X	X
		Provide community dialogues	X	X	X	X	X

Output	Activities	Sub-activities	2016	2017	2018	2019	2020
RESEARCH, MONITORING & EVALUATION							
Outcome 5. Data-driven decision making is enhanced to improve effectiveness and efficiency of the family planning programme							
5.1. A functional, harmonised, and optimised family planning M&E system is in place to support data-driven decision making	Develop a comprehensive family planning M&E framework (indicators, data flow, data collection tools, research, evaluation, capacity building)	Develop a family planning M&E framework through contracting a consultant and holding workshops and individual stakeholder consultation meetings		X			
		Print of family planning M&E framework		X	X		
		Train M&E staff to be able to implement and monitor the framework		X	X		
		Conduct mid-term and end-term programme evaluations			X		X
	Develop TOR (includes members and roles, mandate and guiding principles, and meeting timelines)	Convene a meeting (MOHCC, ZNFPC, UNFPA) to draft Terms of Reference and then share with potential M&E technical working group members for review/input	X	X			
		Convene a meeting with potential M&E technical working group members to incorporate review comments and finalise Terms of Reference	X	X			
	Conduct quarterly meetings of the M&E technical working group	Conduct quarterly meetings of the M&E technical working group to review latest M&E data being reported and monitor ZNFPCIP performance	X	X	X	X	X
	Compile recommendations from research studies bi-annually	Convene a meeting to review recent research results or secondary analyses to identify any programmatic recommendations	X	X	X	X	X

Output	Activities	Sub-activities	2016	2017	2018	2019	2020
	Conduct secondary data analysis of national family planning and related SRHR studies	Convene a meeting to disseminate survey/ secondary data analysis results to stakeholders.	X	X	X	X	X
		As needed, commission secondary analyses from technical experts		X		X	
	Conduct quarterly M&E data quality audits	Develop data quality audit plan	X	X	X	X	X
		Train M&E staff and Health Information Officers (HIOs) on new family planning data collection tools	X	X	X	X	X
			X	X	X	X	X
			X	X	X	X	X
			X	X	X	X	X
			X	X	X	X	X
		Support planned training activities of HMIS to incorporate new family planning registers and use of T5 reporting form	X		X		X
		Coordinate with HMIS technical working group to standardise data quality audits for the data reported on the T5 form	X	X	X	X	X
		Conduct joint assessment using new standard data quality audit tools in two districts for five SDPs per district	X	X	X	X	X
5.2. A national family planning research agenda developed and operationalised	Develop national family planning research agenda	Identify research needs from family planning forum members	X	X	X	X	X
			X	X	X	X	X
		Prioritise research needs	X	X	X	X	X
		Disseminate prioritised research needs through family planning forum	X	X	X	X	X

Output	Activities	Sub-activities	2016	2017	2018	2019	2020
	Conduct at least two operations research studies related to family planning	Generate research protocols in support of priority research needs as identified in the national family planning research agenda		X	X	X	X
		Conduct family planning programmatic research		X	X	X	X
		Present research findings to stakeholders.		X	X	X	X
5.3 A functional CIP performance monitoring mechanism in place by 2017	Develop a performance monitoring dashboard	Conduct a workshop with M&E technical working group on development of ZNFPCIP dashboard. Finalise and operationalise the dashboard. Sensitise ZNFPCIP steering committee members on the use and interpretation of the dashboard	X	X			
	Collect ZNFPCIP progress data for the dashboard and analyse results on a quarterly basis	M&E staff at ZNFPC/MOHCC collect data on a quarterly basis	X	X	X	X	X
	Conduct quarterly reviews of the implementation of ZNFPCIP activities through national family planning forum	Host one-day meetings each quarter	X	X	X	X	X

SUMMARY

Table 17: Summary of Costs by Strategy Area and Year of Plan (in US Dollars)

	2016	2017	2018	2019	2020	Total Costs by Strategy Area	% of Total Costs by Strategy Area
Enabling Environment	814,801	881,923	245,941	255,439	251,353	2,449,457	1.4%
Commodity Security	18,455,443	19,423,986	18,997,851	20,305,170	20,447,297	97,629,748	55.0%
Service Delivery	6,115,748	6,979,232	8,754,349	9,035,970	5,984,885	36,870,185	20.8%
Demand Creation	3,438,054	9,152,622	8,892,068	9,071,395	9,254,013	39,808,152	22.4%
Research, Monitoring and Evaluation	85,313	102,874	222,264	79,904	161,501	651,856	0.4%
Total Costs Per Year	**28,909,359**	**36,540,637**	**37,112,473**	**38,747,878**	**36,099,050**	177,409,397	100%
% of Costs Per Year	16.30%	20.60%	20.92%	21.84%	20.35%		

APPENDIX 2: COST TABLES BY STRATEGY AREA

ENABLING ENVIRONMENT

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total Costs
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
Outcome 1a. Adequate resources mobilized from various sources to fulfil financial requirements of the family planning programme																	
Output 1a.1. The GOZ increases the annual family planning budget from the current 1.7% to 3% of the government health budget																	
Advocate to MOHCC (e.g., NAC, ATB), parliamentarians, and ZNFPC board to mobilise family planning resources	Develop an investment case for family planning to support advocacy efforts (including the impact of family planning on population and development and a rationale for role of family planning in demographic dividend)	Consultant fee	300	1	Per day	50	1	15,000									15,000
		Capitol hotel conference package	35	10	Per person	2	1	700									700
		Tea break	4.50	11	Per person	2	1	99									99
		Factsheets, folder, pamphlet - 100 (includes material/production)	5000	1	Per unit	1	1	5,000									5,000
	Advocacy for joint financing with NAC and ATB for family planning services as part of PMTCT and HIV prevention	Lunch	9	15	Per person	1	1	135	1	138	1	140	1	143	1	146	703
		Tea break	4.50	15	Per person	1	1	68	1	69	1	70	1	72	1	73	351
		Lunch	9	25	Per person	1	1	225	1	230	1	234	1	239	1	244	1,171
		Tea break	4.50	25	Per person	1	1	113	1	115	1	117	1	119	1	122	585
	Advocacy workshops for parliamentarians for resource allocation to family planning (including conducting pre-budgetary consultations with parliamentary portfolio committees including presentation of "value for money"	Capitol hotel conference package	35	100	Per person	3	2	21,000	2	21,420	2	21,848	2	22,285	2	22,731	109,285
		Per diems and accommodation - national	100	101	Per person	4	2	80,800	2	82,416	2	84,064	2	85,746	2	87,461	420,486
		Transport - litre of fuel	1.15	80	Per litre	20	2	3,680	2	3,754	2	3,829	2	3,905	2	3,983	19,151

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total Costs
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
	proposition of family planning investments)																
	Identify, sensitise, and build capacity of select parliamentarians to be family planning champions (includes annual review meeting to discuss and track progress). Areas for advocacy include resource mobilisation and parliamentarians holding the national government accountable for international commitments	Capitol hotel conference package	35	22	Per person	3	1	2,310	1	2,356	1	2,403	1	2,451	1	2,500	12,021
		Per diems and accommodation - national	100	22	Per person	4	1	8,800	1	8,976	1	9,156	1	9,339	1	9,525	45,796
		Transport - litre of fuel	1.15	15	Per litre	15	1	259	1	264	1	269	1	275	1	280	1,347
		Transport allowance – workshop	60	22	Per person	3	1	3,960	1	4,039	1	4,120	1	4,202	1	4,286	20,608
		Token of appreciation	75	20	Per unit	4	2	12,000	2	12,240	2	12,485	2	12,734	2	12,989	62,448
	Hold sensitisation workshops with key non-health sector stakeholders (e.g., Ministry of Education; Ministry of Women Affairs, Gender and Community Development) to reposition family planning as a multi-sectoral tool for socioeconomic development	Capitol hotel conference package	35	20	Per person	3	2	4,200	2	4,284	2	4,370	2	4,457	2	4,546	21,857
		Per diems and accommodation – national	100	21	Per person	4	2	16,800	2	17,136	2	17,479	2	17,828	2	18,185	87,428
		Transport - litre of fuel	1.15	15	Per litre	15	2	518	2	528	2	538	2	549	2	560	2,693
		Transport allowance – workshop	60	20	Per person	3	1	3,600	1	3,672	1	3,745	1	3,820	1	3,897	18,735
Subtotal								**179,265**		**161,636**		**164,868**		**168,166**		**171,529**	**845,464**
Advocate targeting development partners	Conduct direct advocacy with donor community using developed	No additional resources required															

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total Costs
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
to increase level of resources allocated to family planning and expanding the family planning donor base	investment case materials in one-on-one meetings																
	Identify GOZ and donor champions in Health Development Fund (HDF) and other donor platforms (e.g. health partners' forum) to ensure a family planning voice in such platforms	No additional resources required															
	Coordinate work plan development with implementing partners (e.g., PSZ, PSI, UNFPA)	Convene quarterly coordination forums hosted by ZNFPC M&E technical working group - national level															
		Lunch	9	60	Per person	1	4	2,160	4	2,203	4	2,247	4	2,292	4	2,338	11,241
		Tea break	4.50	60	Per person	1	4	1,080	4	1,102	4	1,124	4	1,146	4	1,169	5,620
		Quarterly coordination forums hosted by ZNFPC M&E technical working group - provincial level															
		Lunch	9	25	Per person	1	4	900	4	918	4	936	4	955	4	974	4,684
		Tea break	4.50	25	Per person	1	4	450	4	459	4	468	4	478	4	487	2,342
		Per diems and accommodation - national	100	12	Per person	2	4	9,600	4	9,792	4	9,988	4	10,188	4	10,391	49,959

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total Costs
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
		Transport allowance - workshop	60	25	Per person	1	4	6,000	4	6,120	4	6,242	4	6,367	4	6,495	31,224
	Annual review and planning meeting with all key implementing partners based on national family planning budget (beginning of 4th quarter)	Lunch	9	60	Per person	1		0	1	551	1	562	1	573	1	585	2,270
		Tea break	4.50	60	Per person	1		0	1	275	1	281	1	287	1	292	1,135
Sensitise and advocate for private, for-profit, community to invest in family planning	Explore access to corporate social responsibility funds: breakfast meetings with corps with interest in health/young people at national and provincial levels	hotel conference package	35	10	Per person	1	4	1,400	4	1,428	4	1,457	4	1,486	4	1,515	7,286
		hotel conference package	35	10	Per person	1	16	5,600	16	5,712	16	5,826	16	5,943	16	6,062	29,143
Develop champions within the business community to mobilise resources from the private sector	Develop a business case and advocacy messages for the business community	Consultant fee	300	1	Per day	50		0	1	15,300		0		0		0	15,300
	Identify and orient champions for business community	Lunch	9	10	Per person	1		0	1	92		0	1	96		0	187
		Tea break	4.50	10	Per person	1		0	1	46		0	1	48		0	94

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total Costs
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
Leverage the results based platform to mobilise resources for family planning	Ensure representation of family planning stakeholders in Results-based Financing (RBF) steering committee	No additional resources required	0					0		0		0		0		0	0
Subtotal							**44**	**27,190**	**49**	**43,998**	**46**	**29,131**	**48**	**29,857**	**46**	**30,308**	**160,484**
1a.2. Private, non-government funding for family planning from donors and other sources increased																	
Prepare annual budget requests and justification to MOHCC and Ministry of Finance	Develop provincial budgets for family planning	No additional resources required															
	Consolidation at national level by ZNFPC budget committee	No additional resources required															
	Convene annual meetings (1st quarter of year) with donors and partners to discuss national family planning budget to ascertain and coordinate funding commitments	Lunch	9	60	Per person	1	1	540		0		0		0		0	540
		Tea break	4.50	60	Per person	1	1	270		0		0		0		0	270
	Submission to ministry with justification and coordination within MOHCC prior to meeting with Ministry of Finance	Lunch	9	15	Per person	1	1	135	1	138	1	140	1	143	1	146	703
		Tea break	4.50	15	Per person	1	1	68	1	69	1	70	1	72	1	73	351
	Consult with the Ministry of Finance to defend annual funding requests for family	No additional resources required															

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total Costs
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
	planning, including presentation of "value for money" proposition of family planning investments																
Advocate for enhanced engagement of the ZNFPC board in resource mobilisation efforts	Advocacy workshops with ZNFPC board for increased engagement in resource mobilisation	No additional resources required															
Increasing revenues within ZNFPC through development of strategic business units	Recruit a business development person to lead and oversee resource mobilisation efforts and enhancing revenue generation	No additional resources required															
Subtotal								**1,013**		**207**		**211**		**215**		**219**	**1,864**
Outcome 1b. Strengthened leadership, management, and coordination capacity of the ZNFPC at the central and provincial levels																	
1a.3. Adequate funding mobilised to fulfil financial requirements for ZNFPC operations																	
Conduct a structural and operational review of ZNFPC, and generate recommendations	Engage a consultant to conduct an organisation-wide structural and operational review of ZNFPC and generate recommendations	Consultant fee	300	1	Per day	30	1	9,000		0		0		0		0	9,000
		Capitol hotel conference package	35	9	Per person	1	1	315		0		0		0		0	315
			0					0		0		0		0		0	0
		Lunch	9	15	Per person	1	1	135		0		0		0		0	135
		Tea break	4.50	15	Per person	1	1	68		0		0		0		0	68
		Transport - litre of fuel	1.15	40	Per litre	1	2	92		0		0		0		0	92

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total Costs
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
Implement restructuring recommendations from review	Human resources: job grading and remuneration framework review (linked to ZNFPC restructuring below)	Consultant fee	300	1	Per day	30	1	9,000		0		0		0		0	9,000
		Capitol hotel conference package	35	9	Per person	1	1	315		0		0		0		0	315
		Lunch	9	15	Per person	1	1	135		0		0		0		0	135
		Tea break	4.50	15	Per person	1	1	68		0		0		0		0	68
		Transport - litre of fuel	1.15	40	Per litre	1	2	92		0		0		0		0	92
	Transform the regional training centers in Harare and Bulawayo into training centres of excellence	Salary - training officer	18.60	2	Per day	1	1	37		0		0		0		0	37
		Salary - senior training officer	19.10	4	Per day	1	1	76		0		0		0		0	76
		Salary - urologist	520	2	Per day	1	1	1,040		0		0		0		0	1,040
		Salary - OBGYN	720	2	Per day	1	1	1,440		0		0		0		0	1,440
		Salary - theatre nurse	17.70	1	Per day	1	1	18		0		0		0		0	18
		Salary - nurse anaesthiology	17.70	1	Per day	1	1	18		0		0		0		0	18
		Equipment (all 11 clinics)	0				1	0		0		0		0		0	0
		Implant training model	100	4	Per unit	1	1	400		0		0		0		0	400
		IUCD training model	150	4	Per unit	1	1	600		0		0		0		0	600
		Laptops	900	20	Per unit	1	1	18,000		0		0		0		0	18,000
		Printer	1500	2	Per unit	1	1	3,000		0		0		0		0	3,000
		Book binder	300	2	Per unit	1	1	600		0		0		0		0	600
		Photocopier machine	5500	2	Per unit	1	1	11,000		0		0		0		0	11,000
		Toner	200	8	Per unit	1	1	1,600		0		0		0		0	1,600
		Paper rims	5	100	Per unit	1	1	500		0		0		0		0	500
		External hard drives/flashes	110	10	Per unit	1	1	1,100		0		0		0		0	1,100

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total Costs
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
		Renovations	0					0		0		0		0		0	0
		Chairs and tables	4000	1	Per unit	1	1	4,000		0		0		0		0	4,000
		Curtains	1200	1	Per unit	1	1	1,200		0		0		0		0	1,200
		Storage cabinets	2500	1	Per unit	1	1	2,500		0		0		0		0	2,500
		Air conditioners	2450	1	Per unit	1	1	2,450		0		0		0		0	2,450
		Flooring	4700	1	Per unit	1	1	4,700		0		0		0		0	4,700
		Repainting	2500	1	Per unit	1	1	2,500		0		0		0		0	2,500
		Large desk and chair (trainers)	1000	1	Per unit	1	1	1,000		0		0		0		0	1,000
		Public Announcement (PA) system	8100	1	Per unit	1	1	8,100		0		0		0		0	8,100
		Separate chairs, create alley in between	500	1	Per unit	1	1	500		0		0		0		0	500
		Theatre bed	25000	2	Per unit	1	1	50,000		0		0		0		0	50,000
		Anaesthetic machine	2000	2	Per unit	1	1	4,000		0		0		0		0	4,000
		Minibus	50000	2	Per unit	1	1	100,000		0		0		0		0	100,000
		Mobile caravan for outreach	65000	2	Per unit	1	1	130,000		0		0		0		0	130,000
	Upgrade SPILHAUS and FIFE Avenue clinics to become practice centres for the training centres of excellence	Repainting of clinic walls	6100	1	Per clinic	1	1	6,100		0		0		0		0	6,100
		Wall repair	2330	1	Per clinic	1	1	2,330		0		0		0		0	2,330
		Floor tiles for entire clinic	8400	1	Per clinic	1	1	8,400		0		0		0		0	8,400
		Replace waiting area Benches	2500	1	Per clinic	1	1	2,500		0		0		0		0	2,500
		Plumbing repairs	4000	4	Per clinic	4	1	64,000		0		0		0		0	64,000
		New sink for	800	1	Per unit	1	1	800		0		0		0		0	800

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total Costs
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
		sluice room															
		Air conditioners (waiting room)	2500	3	Per unit	1	1	7,500		0		0		0		0	7,500
		New autoclave machine	18000	2	Per unit	1	1	36,000		0		0		0		0	36,000
		Desks and chairs for consultation rooms (two rooms)	1000	6	Per unit	1	1	6,000		0		0		0		0	6,000
		Shade construction for incinerator (plus certification from Environment Management Agency (EMA))	3500	1	Per clinic	1	1	3,500		0		0		0		0	3,500
		Water reserve tank, 7500 litres	450	2	Per unit	1	1	900		0		0		0		0	900
		Electric generator	4000	1	Per unit	1	1	4,000		0		0		0		0	4,000
		Examination lamps (per Room, all clinics)	100	22	Per unit	1	1	2,200		0		0		0		0	2,200
		Oxygen Cylinder, emergency	200	13	Per unit	1	1	2,600		0		0		0		0	2,600
	Upgrade ZNFPC clinics	Speculum	10	55	Per unit	55		0	1	30,855		0		0		0	30,855
		Crocodile forceps	7	55	Per unit	1		0	1	393		0		0		0	393
		Blood pressure machines	15	55	Per unit	1		0	1	842		0		0		0	842
		Weighing scale	80	28	Per unit	1		0	1	2,285		0		0		0	2,285
		Soap	70	28	Per unit	1		0	1	1,999		0		0		0	1,999

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total Costs
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
		dispensers															
		Linens for rooms	20	28	Per unit	1		0	1	571		0		0		0	571
		Linen carriers (dirty linens)	30	28	Per unit	1		0	1	857		0		0		0	857
		Screens for client privacy	130	11	Per unit	1		0	1	1,459		0		0		0	1,459
		TV and DVD for waiting rooms	300	28	Per unit	1		0	1	8,568		0		0		0	8,568
		Water dispensers	270	11	Per unit	1		0	1	3,029		0		0		0	3,029
		Waste bins	60	11	Per unit	1		0	1	673		0		0		0	673
		Foot stools	100	28	Per unit	1		0	1	2,856		0		0		0	2,856
		Desktop computers for HMIS	800	28	Per unit	1		0	1	22,848		0		0		0	22,848
		Personal protective equipment	80	11	Per unit	1		0	1	898		0		0		0	898
		Family planning client cards	0.10	11	Per unit	1		0	1	1		0		0		0	1
		Breast exam training models	170	11	Per unit	1		0	1	1,907		0		0		0	1,907
		Reprinting community health worker data reporting tools	50	13	Per unit	1		0	1	663		0		0		0	663
	Upgrade library at ZNFPC headquarters	Software for library management system	1500	1	Per unit	1		0	1	1,530		0		0		0	1,530
		Desktops	800	4	Per unit	1		0	1	3,264		0		0		0	3,264
		E-learning software	5000	1	Per unit	1		0	1	5,100		0		0		0	5,100
	Upgrade	Industrial	730	2	Per unit	1		0	1	1,489		0		0		0	1,489

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total Costs
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
	Accommodations and catering	washing machines															
		Irons	50	2	Per unit	1		0	1	102		0		0		0	102
		Dryers	1050	2	Per unit	1		0	1	2,142		0		0		0	2,142
		Four- plate industrial stove with oven	650	1	Per unit	1		0	1	663		0		0		0	663
		Double bowl chip fryer	280	1	Per unit	1		0	1	286		0		0		0	286
		Generator big - 5 KA	703	1	Per unit	1		0	1	717		0		0		0	717
		Gas stove	550	1	Per unit	1		0	1	561		0		0		0	561
		Shaving dishes	5	10	Per unit	1		0	1	51		0		0		0	51
		Entertainment (four TV sets and radio at central place)	2120	1	Per unit	1		0	1	2,162		0		0		0	2,162
		Pool table	1200	1	Per unit	1		0	1	1,224		0		0		0	1,224
		Braai stand	150	1	Per unit	1		0	1	153		0		0		0	153
		Bar chairs	120	15	Per unit	1		0	1	1,836		0		0		0	1,836
		Single beds	255	80	Per unit	1		0	1	20,808		0		0		0	20,808
		Double bed	700	80	Per unit	1		0	1	57,120		0		0		0	57,120
		Blankets	55	80	Per unit	1		0	1	4,488		0		0		0	4,488
		Sheets	25	80	Per unit	1		0	1	2,040		0		0		0	2,040
		Bedspreads	100	80	Per unit	1		0	1	8,160		0		0		0	8,160
		Pillows and pillow Cases	20	160	Per unit	1		0	1	3,264		0		0		0	3,264
		Undercover	80	80	Per unit	1		0	1	6,528		0		0		0	6,528
		Chair	65	41	Per unit	1		0	1	2,718		0		0		0	2,718
		Tables	300	41	Per unit	1		0	1	12,546		0		0		0	12,546
		Wall painting	2300	2	Per clinic	1		0	1	4,692		0		0		0	4,692
		Dual decoders	200	2	Per unit	1		0	1	408		0		0		0	408

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total Costs
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
		Tea-making facility (electric kettle, tray, and cup)	45	41	Per unit	1		0	1	1,882		0		0		0	1,882
	Support international training and exchanges for staff in East and Southern Africa, and in the United Kingdom	Transport - international flight HRE-LHR	933	2	Per person	2	2	7,464	2	7,613	2	7,766	2	7,921	2	8,079	38,843
		Projector	1500	1	Per unit	1	1	1,500		0		0		0		0	1,500
		Laptops	900	6	Per unit	1	1	5,400		0		0		0		0	5,400
		Printer	1500	1	Per unit	1	1	1,500		0		0		0		0	1,500
		Scanner	400	1	Per unit	1	1	400		0		0		0		0	400
		Tablets	325	25	Per unit	1	1	8,125		0		0		0		0	8,125
		Desktop computers for HMIS	800	2	Per unit	1	1	1,600		0		0		0		0	1,600
		Server with UPS	5500	1	Per unit	1	1	5,500		0		0		0		0	5,500
		Software (site licenses)	0					0		0		0		0		0	0
		STATA	1700	1	Per license	1		0	1	1,734		0		0		0	1,734
		CSPRO	0	1	Per license	1		0	1	0		0		0		0	0
		SPSS	2690	1	Per license	1		0	1	2,744		0		0		0	2,744
		ArcGIS	2500	1	Per license	1		0	1	2,550		0		0		0	2,550
	Hosting conferences within training centre	Budget for marketing the ZNFPC centre as a conference package	15000	1	Per unit	1		0	1	15,300	1	15,606	1	15,918	1	16,236	63,061

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total Costs
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
	Commercialize the Audio Visual Unit	Equipment investments (commercialize AV unit)	374750	1	Per unit	1		0	1	382,245		0		0		0	382,245
Subtotal								**547,917**		**638,824**		**23,372**		**23,839**		**24,316**	**1,258,267**
1b.2. Improved coordination among different stakeholders																	
Improve coordination and role clarification between ZNFPC and MOHCC's Reproductive Health Unit	Convene meeting between ZNFPC and MOHCC's Reproductive Health Unit to discuss standard operating procedures for collaboration	Lunch	9	10	Per person	1	1	90									90
		Tea break	4.50	10	Per person	1	1	45									45
		Lunch	9	15	Per person	1	1	135									135
		Tea break	4.50	15	Per person	1	1	68									68
Subtotal								**338**									**338**
Outcome 1c. The policy and political environments are made increasingly conducive to facilitate effective functioning of the family planning programme																	
1c.1. Outdated policies updated (e.g., youth policy)																	
Conduct a review of the relevant policies for inclusion of specific language to foster access to family planning by youth and other marginalised populations	Hire a consultant to assess existing policies within key ministries (e.g., youth, education, gender) and hold a multi-sectoral workshop to share findings and develop ministerial recommendations	Consultant fee	300	1	Per day	120	1	36,000		0		0		0		0	36,000
		hotel conference package	35	26	Per person	1		0	1	928		0		0		0	928
	Advocate with ministries to address any gaps identified through one-on-one dialogue	No additional resources required															
	Provide technical input to policy revision as requested	No additional resources required															

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total Costs
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
Subtotal								**36,000**		**928**		**0**		**0**		**0**	**36,928**
1c.2. The ZNFPC Act reviewed and revised																	
Advocate for the review of the ZNFPC Act	Roles and responsibilities of the ZNFPC within the Act reviewed by the year 2016	No additional resources required	0					0		0		0		0		0	0
	Convene workshop to share draft ZNFPC Act with policymakers/advocacy groups	Capitol hotel conference package	35	20	Per person	1	1	700	1	714	1	728	1	743	1	758	3,643
		Per diems and Accommodations - national	100	21	Per person	1	1	2,100	1	2,142	1	2,185	1	2,229	1	2,273	10,928
		Transport - litre of fuel	1.15	80	Per litre	20	1	1,840	1	1,877	1	1,914	1	1,953	1	1,992	9,575
		Transport - land cruiser rate per km	0.44	784	Per litre	20	1	6,899	1	7,037	1	7,178	1	7,321	1	7,468	35,904
								0		0		0		0		0	0
	Advocate with parliamentarians to incorporate draft language as amendment to ZNFPC Act	Capitol hotel conference package	35	20	Per person	1	1	700	1	714	1	728	1	743	1	758	3,643
		Per diems and Accommodations - national	100	21	Per person	1	1	2,100	1	2,142	1	2,185	1	2,229	1	2,273	10,928
		Transport - litre of fuel	1.15	80	Per litre	20	1	1,840	1	1,877	1	1,914	1	1,953	1	1,992	9,575
		Transport - land cruiser rate per km	0.44	784	Per km	20	1	6,899	1	7,037	1	7,178	1	7,321	1	7,468	35,904
			0					0		0		0		0		0	0
Subtotal								**23,078**		**23,540**		**24,011**		**24,491**		**24,981**	**120,101**
1c.3. Heightened and sustained political will and commitment towards family planning																	

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total Costs
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
Build capacity of media houses to properly represent family planning issues in their reporting	Annual full-day capacity building workshop followed by a full-day media tour	Capitol hotel conference package	35	22	Per person	2		0	1	1,571	1	1,602		0		0	3,173
		Transport allowance - workshop	60	22	Per person	2		0	1	2,693	1	2,747		0		0	5,439
Work closely with media houses to positively promote family planning and dispel myths from the general public	Build relationships between ZNFPC Marketing and Communications Department with media houses to strengthen engagement	No additional resources required	0					0		0		0		0		0	0
Work with traditional and religious leaders at national level to express positive attitudes towards family planning	Convene a half-day sensitisation meeting with each group annually	Capitol hotel conference package	35	22	Per person	2		0	2	3,142		0	2	3,269		0	6,410
		Transport allowance - workshop	60	22	Per person	2		0	2	5,386		0	2	5,603		0	10,989
ZNFPC engage MoHCC in continuous dialogue regarding	Hold internal meetings with MOHCC to discuss approaches to handle user fees	No additional resources required	0					0		0		0		0		0	0

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total Costs
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
the issue of user fees																	
Subtotal							0	0	6	12,791	2	4,349	4	8,872	0	0	26,011
TOTAL								814,801		881,923		245,941		255,439		251,353	2,449,457

COMMODITY SECURITY

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total Costs
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
Outcome 2.1. Adequate contraceptive commodities and supplies are procured to cover all country needs in accordance with the method-mix projections to meet CPR goal by 2020																	
Conduct quantification exercises and share results with stakeholders on a quarterly basis	Quantification exercise for commodity requirements (bi-annual)	Lunch	9	12	Per person	1	2	216	2	220	2	225	2	229	2	234	1,124
	CPTs (contraceptive procurement tables)	Tea break	4.50	12	Per person	1	2	108	2	110	2	112	2	115	2	117	562
	Family planning forum meetings with development partners (quarterly) to discuss requirements	Lunch	9	40	Per person	1	4	1,440	4	1,469	4	1,498	4	1,528	4	1,559	7,494
		Tea break	4.50	40	Per person	1	4	720	4	734	4	749	4	764	4	779	3,747
	Present quantification results to partners (bi-annual)	no additional resources required						0		0		0		0		0	0
Determine and share comprehensive funding requirements and gaps during quarterly family planning forum meetings	Solicit funding requests for in-country quality assurance activities during family planning forum meetings	MCAZ condom testing	50,000	1	Per unit	1	1	50,000	1	51,000	1	52,020	1	53,060	1	54,122	260,202
Procure family	Procurement of FP	Male condoms	0.04	22769635.50	Per unit	1	4	4,276,733	4	4,471,325	4	4,674,770	4	4,887,472	22,400,911	4,090,611	22,400,911

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total Costs
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
planning commodities and equipment	commodities	Female condoms	0.68	1097242.50	Per unit	1	4	3,062,634	4	3,123,886	4	3,186,364	4	3,250,091	15,625,558	3,002,582	4
		Progestin-only pill	0.27	2419565	Per unit	1	2	1,325,581	2	1,379,147	2	1,416,099	2	1,463,651	6,866,992	1,282,515	2
		Implants	11.61	71419	Per unit	1	2	1,786,893	2	1,941,341	2	2,109,122	2	2,291,418	9,786,420	1,657,645	2
		Injectable	1.11	682367	Per unit	1	2	1,611,293	2	1,716,965	2	1,829,568	2	1,949,555	8,619,504	1,512,124	2
		IUCDS	1	5841	Per unit	1	1	6,268	1	6,810	1	7,399	1	8,038	34,379	5,862	1
		Female sterilisation		2783	Per unit	1	1	0	1	0	1	0	1	0	0	0	1
		Combined oral contraceptive pill	0.26	5645652	Per unit	1	2	3,087,069	2	3,190,731	2	3,297,873	2	3,408,614	15,971,063	2,986,776	2
		Emergency contraceptive	0.35	64728	Per unit	1	1	21,338	1	21,947	1	22,385	1	22,833	111,088	22,585	1
		Other modern methods		5100	Per unit	1	1	0	1	0	1	0	1	0	0	0	1
		Repackaging of female condoms	1225	1	Per unit	1	4	49,000	1	51,000	1	52,020	1	53,060	1	54,122	259,202
	Provide equipment required for LARC services	*Implant insertion kits*				1		0		0		0		0		0	0
		Medium receivers	15.50	6000	Per unit	1	1	93,000	1	94,860		0	1	98,692		0	286,552
		Gallipots	10.50	6000	Per unit	1	1	63,000	1	64,260		0	1	66,856		0	194,116
		Mosquito forceps	7	6000	Per unit	1	1	42,000	1	42,840		0	1	44,571		0	129,411
		Artery forceps	8	6000	Per unit	1	1	48,000	1	48,960		0	1	50,938		0	147,898
		Green towels	5	12000	Per unit	1	1	60,000	1	61,200		0	1	63,672		0	184,872
		IUCD insertion Kits						0		0		0		0		0	0

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total Costs
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
		Large receivers	2	2000	Per unit	1	1	40,000	1	40,800		0	1	42,448		0	123,248
		Gallipots	10.50	2000	Per unit	1	1	21,000	1	21,420		0	1	22,285		0	64,705
		Silver tray (small)	58	2000	Per unit	1	1	116,000	1	118,320		0	1	123,100		0	357,420
		Uterine sound	35	2000	Per unit	1	1	70,000	1	71,400		0	1	74,285		0	215,685
		Sponge holding forceps	13	2000	Per unit	1	1	26,000	1	26,520		0	1	27,591		0	80,111
		Green towels	5	4000	Per unit	1	1	20,000	1	20,400		0	1	21,224		0	61,624
		Scissors	5	2000	Per unit	1	1	10,000	1	10,200		0	1	10,612		0	30,812
Advocate for harmonisation of brand choice for family planning commodities to meet procurement conditions of all partners	Consult with commodity security partners contributing to procurement of commodities	No additional resources required						0		0		0		0		0	0
Subtotal								**15,271,184**		**15,903,523**		**15,958,776**		**17,298,614**		**17,392,604**	**81,824,701**
Outcome 2.2. Timely procurement and delivery of commodities to central warehouse is sustained above 95% through 2020																	
Expand storage capacity for family planning commodities	Outsource warehousing in Harare on a short-term basis (i.e. years 1 and 2)	Private warehouse (lease)	684	4	Per unit	1	4	109,440	4	111,629		0		0		0	221,069
		Additional insurance charges	1500	4	Per unit	1	4	240,000	4	244,800		0		0		0	484,800
		Additional handling charges	800	1	Per unit	1	1	8,000	1	8,160		0		0		0	16,160
	Undertake capital	Vehicle - delivery	6000	1	Per unit	1		0	1	61,200		0		0		0	61,200

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total Costs
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
	improvements of the warehouses	truck															
		Computerised warehousing system w/ barcoding of inventory	14500	1	Per unit	1	0	29,000	0	29,580	0	30,172	0	30,775	0	31,391	150,917
	Expand ZNFPC Harare and Masvingo warehouses	Costed works and bill of quantities	30000	1	Per unit	1		0	1	201,960	0	103,000		0		0	304,960
Train staff on supply chain management	Basic supply chain management for health commodities (three ZNFPC staff sponsored by US government) – annual	Per diems and Accommodations – national	10	3	Per person	7	1	2,100		0		0		0		0	2,100
		Capitol hotel conference package	35	3	Per person	5	1	525		0		0		0		0	525
		Transport - bus fare	3	1	Per day	1	1	30		0		0		0		0	30
	Procurement training through AccessRH for family planning products (sponsored by UNFPA) - int'l bi-annually	International per diem	439	4	Per person	5		0	1	8,956		0	1	9,317		0	18,273
		Capitol hotel conference package	35	4	Per person	5		0	1	714		0	1	743		0	1,457
		Transport - International flight HRE-JNB	40	4	Per person	1		0	1	1,632		0	1	1,698		0	3,330

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total Costs
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
Subtotal								389,095		668,630		133,171		42,533		31,391	1,264,820
Outcome 2.3. Order fulfilment from warehouse increases from 85% to 94% by 2020																	
Improve picking and packing of orders	Conduct on-the-job training of warehouse personnel in warehouse management (price included in software installation)	No additional resources required					1	0	1	0		0		0		0	0
	Invest in warehouse handling equipment	Hydraulic jack	75	3	Per unit	1		0	1	2,295		0		0		0	2,295
		Thermometers (temperature and humidity logging)	10	6	Per unit	1		0	1	612		0		0		0	612
		Fumigation	20	2	Per unit	1	4	1,600	4	1,632	4	1,665	4	1,698	4	1,732	8,326
		Fire extinguishers	6	10	Per unit	1	1	600		0		0		0		0	600
		Hose	375	4	Per unit	1	1	1,500		0		0		0		0	1,500
		Uniforms for warehouse staff	75	8	Per unit	1	2	1,200	2	1,224	2	1,248	2	1,273	2	1,299	6,245
Improve storage capacity at provincial level	Mobilise resources to pay for storage charges	Invoice from outsourced Warehouses at provincial level	60,000	6	Per unit	1	4	240,000	4	244,800	4	249,696	4	254,690	4	259,784	1,248,970

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total Costs
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
Subtotal								**244,900**		**250,563**		**252,609**		**257,661**		**262,815**	**1,268,548**
Outcome 2.4. Distribution coverage and timeliness of clinics requesting deliveries increases from 96% to 97% by 2020																	
Conduct monitoring and supportive supervision of supply chain	Site visits from central level	Per diems and Accommodations – national	10	3	Per person	7	4	8,400	4	8,568	4	8,739	4	8,914	4	9,092	43,714
		Transport - litre of fuel	1.15	310	Per litre	1	4	1,426	4	1,455	4	1,484	4	1,513	4	1,544	7,421
		Transport - Land Cruiser rate per km	0.44	3038	Per km	7	4	37,428	4	38,177	4	38,940	4	39,719	4	40,513	194,778
	Site visits from province headquarters	Per diems and Accommodation - national	10	5	Per person	7	4	14,000	4	14,280	4	14,566	4	14,857	4	15,154	72,857
		Transport - litre of fuel	1.15	210	Per litre	1	4	966	4	985	4	1,005	4	1,025	4	1,046	5,027
		Transport - land cruiser rate per km	0.44	2058	Per km	7	4	25,355	4	25,862	4	26,379	4	26,906	4	27,445	131,946
Distribute commodities to facilities	Ordering round	Salary - district pharmacy manager	17.70	1	Per day	10	248	43,896	248	44,774	248	45,669	248	46,583	248	47,514	228,437
		Transport - litre of fuel	1.15	150	Per litre	1	248	42,780	248	43,636	248	44,508	248	45,398	248	46,306	222,629
		Transpo	0.44	1470	Per km	10	248	1,604,064	248	1,636,14	248	1,668,868	248	1,702,246	248	1,736,29	8,347,613

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total Costs
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
		rt - land cruiser rate per km								5						0	
		Per diems and Accommodations - national	10	3	Per person	10	248	744,000	248	758,880	248	774,058	248	789,539	248	805,330	3,871,806
		Dispatch clerk (head office)	16.10	1	Per day	7	248	27,950	248	28,509	248	29,079	248	29,660	248	30,254	145,451
Subtotal								**2,550,264**		**2,601,270**		**2,653,295**		**2,706,361**		**2,760,488**	**13,271,678**
TOTAL								**18,455,443**		**19,423,986**		**18,997,851**		**20,305,170**		**20,447,297**	**93,829,598**

SERVICE DELIVERY

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total costs
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
Outcome 3.1. Capacity of health facilities enhanced to offer comprehensive and integrated family planning services																	
Revise in-service training manual and materials for all family planning methods, including procedure manuals	Hire consultant to review and make recommendations on revisions and improvements	Consultant fee	300	1	Per day	120	3	108,000	2	73,440		0		0		0	181,440
	Convene stakeholder workshops to review and discuss recommendations	Capitol hotel conference package	35	25	Per person	1	3	2,625	2	1,785		0		0		0	4,410
		Per diems and Accommodations - national	100	25	Per person	2	3	15,000	2	10,200		0		0		0	25,200
		Transport allowance - workshop	60	25	Per person	2	2	6,000	2	6,120		0		0		0	12,120
	Print final copies	Family planning training manual	0.25	5000	Per unit	1		0	1	1,275		0		0		0	1,275
		Procedure manual	0.25	5000	Per unit	1		0	1	1,275		0		0		0	1,275
Revise operational guidelines for family planning services	Through technical working group members, revise operational guidelines for family planning services	Capitol hotel conference package	35	15	Per person	3		0	1	1,607		0		0		0	1,607
		Per diems and Accommodations - national	100	15	Per person	4		0	1	6,120		0		0		0	6,120
		Transport allowance	60	15	Per person	4		0	1	3,672		0		0		0	3,672

Activity	Sub-activity	Input	Item	Quantity	Metric	Frequenc	2016		2017		2018		2019		2020		Total costs
		– workshop															
		Consultant fee	300	1	Per day	50		0	1	15,300		0		0		0	15,300
		Operational guidelines	1					0		0		0		0		0	0
Increase pool of family planning trainers	Recruit and train trainers at regional level	Regional hotel conference package	35	25	Per person	10		0	4	35,700		0		0		0	35,700
		Per diems and Accommodations – provincial	90	25	Per person	13		0	4	119,340		0		0		0	119,340
		Transport - litre of fuel	1.15	200	Per litre	4		0	4	3,754		0		0		0	3,754
		Lunch per diem/person – capital	9	25	Per person	10		0	4	9,180		0		0		0	9,180
		Transport allowance - RT	20	60	Per person	6		0	4	29,376		0		0		0	29,376
Train 4,000 providers in clinical service provision of family planning	Convene training workshops in clinical service provision for service providers (1,000 trained per year from year 2 to year 4)	Capitol hotel conference package	35	25	Per person	10	10	87,500	20	178,500	40	364,140	40	371,423	10	94,713	1,096,276
		Per diems and Accommodation - National	100	25	Per person	10	10	250,000	20	510,000	40	1,040,400	40	1,061,208	10	270,608	3,132,216
		Transport allowance - workshop	60	25	Per person	10	10	150,000	20	306,000	40	624,240	40	636,725	10	162,365	1,879,330
Train 4,000 providers on LARC (IUCD	Training workshops in LARC for	Capitol hotel conferenc	35	25	Per person	10	10	87,500	20	178,500	40	364,140	40	371,423	10	94,713	1,096,276

Activity	Sub-activity	Input	Item	Quantity	Metric	Frequenc	2016		2017		2018		2019		2020		Total costs
and Implant) service provision	service providers (1,000 trained per year from year 2 to year 4)	e package															
		Per diems and Accommodation - National	100	25	Per person	10	10	250,000	20	510,000	40	1,040,400	40	1,061,208	10	270,608	3,132,216
		Transport allowance - workshop	60	25	Per person	10	10	150,000	20	306,000	40	624,240	40	636,725	10	162,365	1,879,330
Train 4,000 providers on infection prevention and control	Training workshops on infection prevention and control	Capitol hotel conference package	35	25	Per person	5	4	17,500	9	40,163	9	40,966	9	41,785	5	23,678	164,092
		Per diems and Accommodations - national	100	25	Per person	5	4	50,000	9	114,750	9	117,045	9	119,386	5	67,652	468,833
		Transport allowance - workshop	60	25	Per person	1	4	6,000	9	13,770	9	14,045	9	14,326	5	8,118	56,260
Support and mentor newly trained service providers	Post training follow-up and support	Pen	0.20	3	Per unit	5	20	60	20	61	40	125	40	127		0	373
		Notepad	1	3	Per unit	5	20	300	20	306	40	624	40	637		0	1,867
		Transport - litre of fuel	1.15	140	Per litre	3	20	9,660	20	9,853	40	20,101	40	20,503		0	60,116
Adapt TrainSmart or TrainTrack to support monitoring of trainees and trainers	Engage ITECH to adapt and introduce TrainSmart to support tracking of family planning trainings	No additional resources required	0					0		0		0		0		0	0
	Conduct a one-day workshop for different partners to support rollout of TrainSmart	Lunch per diem/person – capital	9	40	Per person	1		0	1	367		0		0		0	367
		Tea break	4.50	40	Per person	1		0	1	184		0		0		0	184

Activity	Sub-activity	Input	Item	Quantity	Metric	Frequenc	2016		2017		2018		2019		2020		Total costs
Conduct clinical service provision support visits from higher-level facilities to lower-level facilities	Conduct continued provincial mapping of facilities requiring support by MOHCC, ZNFPC, and partners	Capitol hotel conference package	35	35	Per person	1	9	11,025		0		0		0		0	11,025
		Transport - litre of fuel	1.15	10	Per litre	1	9	104		0		0		0		0	104
		Transport allowance - workshop	60	5	Per person	1	9	2,700		0		0		0		0	2,700
	Conduct quarterly clinical service provision support visits	Transport allowance - workshop	60	5	Per person	7	9	18,900		0		0		0		0	18,900
		Transport - litre of fuel	1.15	5	Per litre	7	9	362		0		0		0		0	362
		Stationery - pen, notepad	1.20	5	Per unit	1	9	54		0		0		0		0	54
Development and hosting of paper-based self-learning module	Conduct workshops to develop modules	Capitol hotel conference package	35	24	Per person	3		0	3	7,711	3	7,865		0		0	15,577
		Per diems and Accommodation - National	100	4	Per person	3		0	3	3,672	3	3,745		0		0	7,417
		Transport - litre of fuel	1.15	140	Per litre	4		0	3	1,971	3	2,010		0		0	3,981
		Transport allowance - workshop	60	24	Per person	3		0	3	13,219	3	13,484		0		0	26,703
Conduct quality assurance visits at facilities throughout the country	Conduct quarterly quality assurance visits at facilities	Per diems and accommodations - national	100	8	Per person	6	36	172,800	36	176,256	36	179,781	36	183,377	36	187,044	899,258
		Tea break	4.50	8	Per person	6	36	7,776	36	7,932	36	8,090	36	8,252	36	8,417	40,467

Activity	Sub-activity	Input	Item	Quantity	Metric	Frequenc	2016		2017		2018		2019		2020		Total costs
		Transport - litre of fuel	1.15	2	Per Litre	6	36	497	36	507	36	517	36	527	36	538	2,585
Host in-country (province-to-province) and international study tours		Transport - domestic flight	200	20	Per person	3		0		0	3	37,454		0		0	37,454
		Per diems and accommodations - national	100	20	Per person	3		0		0	3	18,727		0		0	18,727
		Transport - International Flight HRE-LHR	933	10	Per person	7	1	65,310	1	66,616	1	67,949	1	69,307		0	269,182
		International per diem	439	10	Per person	7	1	30,730	1	31,345	1	31,971	1	32,611		0	126,657
Review and revise pre-service training curriculum	Hold a two-day workshop to review curricula for nurses, midwives, and doctors	Consultant Fee	300	1	Per day	30		0	1	9,180		0		0		0	9,180
		Capitol hotel conference package	35	15	Per person	2		0	1	1,071		0		0		0	1,071
		Per diems and Accommodation - national	100	21	Per person	3		0	1	6,426		0		0		0	6,426
		Transport - litre of fuel	1.15	100	Per Litre	9		0	1	1,056		0		0		0	1,056
		Transport allowance - workshop	60	15	per person	2	1	1,800	1	1,836		0		0		0	3,636
	Hold three-day workshops to develop course content and include components of	Consultant Fee	300	1	Per day	60		0	1	18,360		0		0		0	18,360
		Capitol hotel conference package	35	15	Per person	3		0	1	1,607		0		0		0	1,607

Activity	Sub-activity	Input	Item	Quantity	Metric	Frequenc	2016		2017		2018		2019		2020		Total costs
	family planning in pre-service curricula	Per diems and Accommodation - National	100	15	Per person	3		0	1	4,590		0		0		0	4,590
		Transport - litre of fuel	1.15	100	Per litre	9		0	1	1,056		0		0		0	1,056
		Transport allowance - workshop	60	15	Per person	3		0	2	5,508		0		0		0	5,508
	Hold continuing education seminars for academia and professional association members	Tea break	4.50	1	Per person	60		0	1	275		0		0		0	275
		Lunch	9	1	Per person	60		0	1	551		0		0		0	551
Subtotal								**1,502,203**		**2,847,340**		**4,622,060**		**4,629,549**		**1,350,819**	**14,951,971**
Outcome 3.2. Outreach services expanded and strengthened to improve availability and access to quality family planning services by underserved communities																	
Develop outreach guidelines, including establishing criteria for what will constitute an outreach point	Stakeholder workshop to reach consensus	Consultant fee	300	1	Per day	10	1	3,000		0		0		0		0	3,000
		Capitol hotel conference package	35	25	Per person	3	1	2,625		0		0		0		0	2,625
		Per diems and Accommodations - national	100	5	Per person	4	1	2,000		0		0		0		0	2,000
		Transport allowance - workshop	60	25	Per person	3	2	9,000		0		0		0		0	9,000
		Transport - litre of fuel	1.15	140	Per litre	4	1	644		0		0		0		0	644
	Draft the new criteria,	Consultant fee	300	1	Per day	10	1	3,000		0		0		0		0	3,000

Activity	Sub-activity	Input	Item	Quantity	Metric	Frequenc	2016		2017		2018		2019		2020		Total costs
	guidelines, and supporting documentation	Capitol hotel conference package	35	25	Per person	3	1	2,625		0		0		0		0	2,625
		Per diems and Accommodations - national	100	5	Per person	4	1	2,000		0		0		0		0	2,000
		Transport - litre of fuel	1.15	140	Per litre	4	1	644		0		0		0		0	644
		Transport allowance - workshop	60	25	Per person	3	1	4,500		0		0		0		0	4,500
	Disseminate the new criteria and guidelines through rollout workshop	Guidelines doc	0.25	200	Per page	1	1	50		0		0		0		0	50
		Capitol hotel conference package	35	31	Per person	1	1	1,085		0		0		0		0	1,085
		Hotel per diem/person – capitol	70	31	Per person	1	1	2,170		0		0		0		0	2,170
		Transport - litre of fuel	1.15	100	Per litre	1	1	115		0		0		0		0	115
		Transport allowance - workshop	60	31	Per person	1	1	1,860		0		0		0		0	1,860
	Establish and implement an outreach coordination committee to ensure joint planning of outreach activities	Tea break	4.50	30	Per person	1	3	405	6	826	6	843	6	860	6	877	3,810
		Lunch	9	30	Per person	1	3	810	6	1,652	6	1,685	6	1,719	6	1,754	7,621
Coordinate with provincial	Family planning	Capitol hotel	35	25	Per person	1	9	7,875	9	8,033	9	8,193	9	8,357	9	8,524	40,982

Activity	Sub-activity	Input	Item	Quantity	Metric	Frequenc	2016		2017		2018		2019		2020		Total costs
level on establishment of outreach points and service provision	technical working group hosts series of one-day meetings with provincial stakeholders to identify potential outreach points (annual exercise)	conference package															
		Per diems and Accommodation - National	100	5	Per person	2	9	9,000	9	9,180	9	9,364	9	9,551	9	9,742	46,836
		Transport - litre of fuel	1.15	140	Per litre	1	9	1,449	9	1,478	9	1,508	9	1,538	9	1,568	7,541
		Transport allowance - workshop	60	25	Per person	1	9	13,500	9	13,770	9	14,045	9	14,326	9	14,613	70,255
	Conduct a mapping exercise to describe underserved areas	Consultant fee	300	1	Per day	50	1	15,000		0		0		0		0	15,000
	Recruit and train additional outreach teams to support outreach events (base = ~2 teams per province increasing to 4 teams per province)	Transport allowance - provincial	100	125	Per person	1	1	12,500		0		0		0		0	12,500
		Per diems and accommodations - national	100	90	Per person	13	1	117,000		0		0		0		0	117,000
		Clinical training	0					0		0		0		0		0	0
		Per diems and accommodations - national	100	35	Per person	10	1	35,000		0		0		0		0	35,000
		Transport allowance - workshop	60	35	Per person	10	1	21,000		0		0		0		0	21,000
		Capitol hotel conference package	35	35	Per person	10	1	12,250		0		0		0		0	12,250

Activity	Sub-activity	Input	Item	Quantity	Metric	Frequenc	2016		2017		2018		2019		2020		Total costs
		LAPM training	0					0		0		0		0		0	0
		Per diems and accommodations - national	100	35	Per person	10	1	35,000		0		0		0		0	35,000
		Transport allowance - workshop	60	35	Per person	10	1	21,000		0		0		0		0	21,000
		Capitol hotel conference package	35	35	Per person	10	1	12,250		0		0		0		0	12,250
		Counselling training															
		Transport allowance - workshop	60	20	Per person	10	1	12,000		0		0		0		0	12,000
		Capitol hotel conference package	35	20	Per person	10	1	7,000		0		0		0		0	7,000
		Driver and promoter orientation	0					0		0		0		0		0	0
		Capitol hotel conference package	35	35	Per person	2	1	2,450		0		0		0		0	2,450
		Per diems and accommodations - national	100	35	Per person	3	1	10,500		0		0		0		0	10,500
		Transport allowance - workshop	60	35	Per person	3	1	6,300		0		0		0		0	6,300
	Support	No	0					0				0				0	0

Activity	Sub-activity	Input	Item	Quantity	Metric	Frequenc	2016		2017		2018		2019		2020		Total costs
	additional outreach events (e.g., IEC materials, branding) from provincial headquarters	additional resources required															
		No additional resources required	0					0				0				0	0
		Salary - nurse providers	17.70	2	Per day	1	4,488	158,875	4,488	162,053	4,488	165,294	4,488	168,600	4,488	171,972	826,793
		Promoter	14.20	1	Per day	1	4,488	63,730	4,488	65,004	4,488	66,304	4,488	67,630	4,488	68,983	331,651
		Tent	600	1	Per unit	1	4,488	2,692,800	4,488	2,746,656	4,488	2,801,589	4,488	2,857,621	4,488	2,914,773	14,013,439
		Transport - litre of fuel	1.15	100	Per litre	1	4,488	516,120	4,488	526,442	4,488	536,971	4,488	547,711	4,488	558,665	2,685,909
		Salary - nurse counsellor	17.70	1	Per day	1	4,488	79,438	4,488	81,026	4,488	82,647	4,488	84,300	4,488	85,986	413,396
Subtotal								**3,898,569**		**3,616,121**		**3,688,443**		**3,762,212**		**3,837,456**	**18,802,802**
Outcome 3.3. Community-based family planning services expanded and strengthened to increase availability and access to quality FP services.																	
Identify and recruit CBHWs	Conduct advocacy meetings with community leaders	Transport - litre of fuel	1.15	71	Per litre	2	4	653	4	666	4	680	4	693	4	707	3,399
		Tea break	4.50	21	Per person	2	4	756	4	771	4	787	4	802	4	818	3,934
		Lunch	9	21	Per person	2	4	1,512	4	1,542	4	1,573	4	1,605	4	1,637	7,869
	Select new CBHWs	Transport - litre of fuel	1.15	71	Per litre	7	3	1,715	3	1,749	3	1,784	3	1,820	3	1,856	8,923
		Transport - land cruiser rate per km	0.44	969	Per km	7	3	8,954	3	9,133	3	9,315	3	9,502	3	9,692	46,595
	Post follow-up training	Transport - land cruiser rate per km	0.44	2450	Per km	1	4	4,312	4	4,398	4	4,486	4	0	4	4,667	17,864

Activity	Sub-activity	Input	Item	Quantity	Metric	Frequenc	2016		2017		2018		2019		2020		Total costs
		Transport - litre of fuel	1.15	250	Per litre	1	4	1,150	4	1,173	4	1,196	4	1,220	4	1,245	5,985
Subtotal							**26**	**19,051**	**26**	**19,432**	**34**	**19,821**	**34**	**15,642**	**26**	**20,622**	**94,568**
Outcome 3.4. Availability of and access to youth-friendly family planning services in rural, underserved areas and communities (e.g., farming, mining, resettlement) increased, including in identified tertiary education institutions																	
Develop national standards for youth-friendly service provision	Engage consultants for approximately 30 days for two-one-day stakeholder meetings, printing, and dissemination of standards	Consultant fee	300	1	Per day	30	1	9,000		0		0		0		0	9,000
		Capitol hotel conference package	35	30	Per person	1	2	2,100		0		0		0		0	2,100
		Transport allowance - workshop	60	15	Per person	1	2	1,800		0		0		0		0	1,800
		Guidelines document	0.25	1500	Per page	1	1	375		0		0		0		0	375
	Review of ASRH training manual to incorporate national standards on youth-friendly service provision	Consultant fee	300	1	Per day	30	1	9,000		0		0		0		0	9,000
		Capitol hotel conference package	35	30	Per person	1	2	2,100		0		0		0		0	2,100
		Transport allowance - workshop	60	15	Per person	1	2	1,800		0		0		0		0	1,800
		ASRH training manual - printing	0.25	1500	Per unit	1	1	375		0		0		0		0	375
Sensitise health workers on national standards for YFHS	Conduct sensitisation workshops for health facility staff	Capitol hotel conference package	35	25	Per person	10	4	35,000	4	35,700	4	36,414	4	37,142	4	37,885	182,141
		Per diems and accommodations - national	100	25	Per person	13	4	130,000	4	132,600	4	135,252	4	137,957	4	140,716	676,525
Institute an		No	0					0		0		0		0		0	0

Activity	Sub-activity	Input	Item	Quantity	Metric	Frequenc	2016		2017		2018		2019		2020		Total costs
accountability framework (e.g., exit interview, mystery clients)		additional resources required															
Build capacity of service providers on YFHS	Train health care workers on provision of youth-friendly services at facility level	Capitol hotel conference package	35	21	Per person	5		0	50	187,425	50	191,174	50	194,997	50	198,897	772,492
		Transport - litre of fuel	1.15	200	Per litre	1		0	50	11,730	50	11,965	50	12,204	50	12,448	48,346
		Stationery - pen, notepad	1.20	20	Per unit	1		0	50	1,224	50	1,248	50	1,273	50	1,299	5,045
	Hold refresher courses for service providers in the year 2019	Capitol hotel conference package	35	21	Per person	5		0		0		0	50	194,997	50	198,897	393,894
		Transport - litre of fuel	1.15	200	Per litre	1		0		0		0	50	12,204	50	12,448	24,652
		Stationery - pen, notepad	1.20	20	Per unit	1		0		0		0	50	1,273	50	1,299	2,572
	Training of community based workers (e.g., peer educators, village health workers, behavioural change facilitators) to create demand for family planning services among young people	Included in training on YFHS for service providers	0					0		0		0		0		0	0

Activity	Sub-activity	Input	Item	Quantity	Metric	Frequenc	2016		2017		2018		2019		2020		Total costs
Development of a voucher system for young people			0					0		0		0		0		0	0
Subtotal								**191,550**		**368,679**		**376,053**		**592,048**		**603,889**	**2,132,218**
Outcome 3.5. Integration of family planning services with other health services, including HIV/AIDS and MCH services, improved																	
Provider capacity to deliver integrated family planning, reproductive health, and HIV services improved	Workshops per province	Capitol hotel conference package	35	2	Per person	1		0	2	143	2	146	2	149	2	152	589
		Per diems and accommodations - national	100	21	Per person	2		0	2	8,568	2	8,739	2	8,914	2	9,092	35,314
		Stationery - pen, notepad	1.20	20	Per unit	2		0	2	98	2	100	2	102	2	104	404
		Transport - litre of fuel	1.15	50	Per litre	2		0	2	235	2	239	2	244	2	249	967
		Transport - bus fare	30	16	Per person	2		0	2	1,958	2	1,998	2	2,038	2	2,078	8,072
	Post-training follow-ups quarterly per district	Transport - land cruiser rate per km	0.44	1960	Per Km	4		0	2	7,037	2	7,178	2	7,321	2	7,468	29,005
		Transport - litre of fuel	1.15	200	Per litre	4		0	2	1,877	2	1,914	2	1,953	2	1,992	7,735
		Per diems and accommodations - national	100	6	Per person	5		0	2	6,120	2	6,242	2	6,367	2	6,495	25,224
		Stationery - pen, notepad	1.20	5	Per unit	4		0	2	49	2	50	2	51	2	52	202
	Provision of commodities for integration	HIV test kits	7.93	1	Per unit	1		0	1	8	1	8	1	8	1	9	33
		Pima machine	10000	49	Per unit	1	1	490,000		0		0		0		0	490,000

Activity	Sub-activity	Input	Item	Quantity	Metric	Frequenc	2016		2017		2018		2019		2020		Total costs
		Tuberculosis testing equipment	0	5	Per unit	1	1	0		0		0		0		0	0
Subtotal								490,000		26,093		26,615		27,147		27,690	597,544
Outcome 3.6. Increased uptake of quality family planning services through the private sector																	
Support private-sector reporting to HMIS	Orientation meeting with private sector at provincial level	Capitol hotel conference package	35	25	Per person	1		0	1	893		0		0		0	893
		Transport - litre of fuel	1.15	20	Per litre	2		0	1	47		0		0		0	47
	Provide with management information system forms	Stationery - pen, notepad	1.20	25	Per unit	1		0	1	31		0		0		0	31
	Provide HMIS site IDs to private service provider sites to enable monthly data reporting to HMIS	No additional resources required	0					0		0		0		0		0	0
Develop and roll out an accreditation system for private family planning providers (as much as possible the accreditation system should ride on existing regulatory mechanisms such as the Health Professions	Consultant hired to assess the extent of quality service provision and adherence to family planning guidelines and standards by the private sector	Consultant fee	300	1	Per day	40	1	12,000		0		0		0		0	12,000
	Conduct consultative workshops to engage stakeholders and get buy-in	Capitol hotel conference package	35	25	Per person	2		0	1	1,785		0		0		0	1,785
		Per diems and	100	25	Per person	2		0	2	10,200		0		0		0	10,200

Activity	Sub-activity	Input	Item	Quantity	Metric	Frequenc	2016		2017		2018		2019		2020		Total costs
Authority (HPA), Medicines Control Authority of Zimbabwe (MCAZ), Medical and Dental Practice (MDPCZ), and Nurses Council for sustainability)	on the proposed accreditation process. Stakeholders include private facilities, the public sector, and regulatory authorities. Assessment findings presented during workshop	Accommodation – National															
		Transport allowance – workshop	60	25	Per person	2		0	2	6,120		0		0		0	6,120
		Transport - litre of fuel	1.15	25	Per litre	2		0	2	117		0		0		0	117
	Assessment findings inform development of an accreditation system, process, and package for private facilities	Consultant fee	300	1	Per day	60		0	1	18,360		0		0		0	18,360
		Capitol hotel conference package	35	25	Per person	3		0	2	5,355		0		0		0	5,355
		Per diems and accommodations - national	100	25	Per person	3		0	2	15,300		0		0		0	15,300
		Transport allowance - workshop	60	25	Per person	3		0	2	9,180		0		0		0	9,180
		Transport - litre of fuel	1.15	200	Per litre	3		0	2	1,408		0		0		0	1,408
	Accreditation package is rolled out as a pilot to a sample of 10 facilities based on established criteria	Capitol hotel conference package	35	20	Per person	2		0		0	1	1,457		0		0	1,457
		Transport allowance - workshop	60	20	Per person	2		0		0	1	2,497		0		0	2,497
		Transport - litre of fuel	1.15	300	Per litre	4		0		0	1	1,436		0		0	1,436

Activity	Sub-activity	Input	Item	Quantity	Metric	Frequenc	2016		2017		2018		2019		2020		Total costs
		Per diems and accommodations - national	100	21	Per person	1		0		0	1	2,185		0		0	2,185
	Lessons learned from the pilot used to improve the accreditation process. Accreditation guidelines developed	Consultant fee	300	1	Per day	50		0		0		0		0	1	16,236	16,236
		Capitol hotel conference package	35	20	Per person	4		0		0		0		0	1	3,031	3,031
		Transport - litre of fuel	1.15	200	Per litre	1		0		0		0		0	1	249	249
		Transport allowance - workshop	60	20	Per person	4		0		0		0		0	1	5,196	5,196
		Per diems and accommodations - national	100	21	Per person	1		0		0		0		0	1	2,273	2,273
	Private sector oriented to new accreditation requirement, process, and guidelines	Capitol hotel conference package	35	50	Per person	10	0	0		0		0		0	1	18,943	18,943
		Transport allowance - workshop	60	50	Per person	10		0		0		0		0	1	32,473	32,473
		Transport - litre of fuel	1.15	100	Per litre	10		0		0		0		0	1	1,245	1,245
		Per diems and accommodations - national	100	51	Per person	10		0		0		0		0	1	55,204	55,204
Cultivate adoption of a TMA approach to family planning	Sensitise and consult with different stakeholders on the TMA	Capitol hotel conference package	35	25	Per person	1	1	875		0		0		0		0	875
		Transport	60	25	Per	1	1	1,500		0		0		0		0	1,500

Activity	Sub-activity	Input	Item	Quantity	Metric	Frequenc	2016		2017		2018		2019		2020		Total costs
service delivery		allowance - workshop			person												
	Conduct a market segmentation analysis	Consultant fee	300	1	Per day	45		0	1	13,770		0		0		0	13,770
	Develop a TMA implementation plan	Consultant fee	300	1	Per day	35		0	1	10,710		0		0		0	10,710
		Capitol hotel conference package	35	40	Per person	1		0	1	1,428		0		0		0	1,428
		Transport allowance - workshop	60	40	Per person	1		0	1	2,448		0		0		0	2,448
		Transport - litre of fuel	1.15	200	Per litre	1		0	1	235		0		0		0	235
		Per diems and accommodations - national	100	41	Per person	1		0	1	4,182		0		0		0	4,182
	Establish and implement public-private partnership coordination mechanism to implement the TMA	Capitol hotel conference package	35	10	Per person	1		0		0	6	2,185	4	1,486	4	1,515	5,186
		Transport allowance - workshop	60	10	Per person	1		0		0	6	3,745	4	2,547	4	2,598	8,890
		Transport - litre of fuel	1.15	20	Per litre	1		0		0	6	144	4	98	4	100	341
		Per diems and accommodations - national	100	11	Per person	1		0		0	6	6,867	4	4,669	4	4,763	16,299
		Lunch	9	10	Per person	1		0		0	6	562	4	382	4	390	1,334
		Tea break	4.50	10	Per	1		0		0	6	281	4	191	4	195	667

Activity	Sub-activity	Input	Item	Quantity	Metric	Frequenc	2016		2017		2018		2019		2020		Total costs
					person												
Subtotal								14,375		101,568		21,357		9,373		144,409	291,082
TOTAL								6,115,748		6,979,232		8,754,349		9,035,970		5,984,885	36,870,185

DEMAND CREATION

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total cost
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
Outcome 4.1. Knowledge, attitudes and practice towards family planning among the general population, with special emphasis on youth and areas/population groups with low CPR coverage, is increased																	
Introduce and sustain a comprehensive SBCC strategy targeting different segments of the population, including the general population, youth, and those in hard-to-reach areas	Conduct a comprehensive formative research study to inform the SBCC strategy	Consultant fee	300	1	Per day	120	1	36,000		0		0		0		0	36,000
	Review existing materials and messages (e.g., identifying gaps, outdated information)	Capitol hotel conference package	35	25	Per person	3	1	2,625		0		0		0		0	2,625
		Per diems and accommodations - national	100	5	Per person	4	1	2,000		0		0		0		0	2,000
		Transport allowance - workshop	60	25	Per person	4	1	6,000		0		0		0		0	6,000
		Consultant fee	300	1	Per day	10	1	3,000		0		0		0		0	3,000
	Update and develop new messages (including pre-testing)	Capitol hotel conference package	35	25	Per person	1	1	875		0		0		0		0	875
		Per diems and accommodations - national	100	3	Per person	4	1	1,200		0		0		0		0	1,200
		Transport - litre of fuel	1.15	140	Per litre	4	1	644		0		0		0		0	644
		Transport - land cruiser rate per km	0.44	1372	Per km	4	1	2,415		0		0		0		0	2,415

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total cost
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
		Consultant fee	300	1	Per day	10	1	3,000		0		0		0		0	3,000
		Multi-media campaign (pre-testing)	7500	1	Per campaign	1	1	7,500		0		0		0		0	7,500
	Package messages for different media channels (radio, TV, road shows, IEC, print media) and develop media plan	Translation (two languages for multi-media campaign)	40	8	Per translation	2	1	640		0		0		0		0	640
		Purchase marketing data (Zimbabwe All Media and Products Survey (ZAMPS) data	50	1	Per unit	1	1	50		0		0		0		0	50
		Multi-media - contract with agency	8000	1	Per contract	1	1	8,000		0		0		0		0	8,000
	Production and placement (Purchase/ acquire media access)	Print media - newspaper (multi-media campaign)	1280	1	Per newspaper	1	1	1,280	1	1,306	1	1,332	1	1,358	1	1,386	6,661
		Print IEC materials - pamphlet (multi-media campaign)	0.10	800000	Per pamphlet	1	1	80,000	1	81,600	1	83,232	1	84,897	1	86,595	416,323
		Print IEC materials -	0.20	20000	Per poster	1	1	4,000	1	4,080	1	4,162	1	4,245	1	4,330	20,816

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total cost
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
		poster (multi-media campaign)															
		Radio Spot (multi-media campaign)	50000	1	Per spot	1	1	50,000	1	51,000	1	52,020	1	53,060	1	54,122	260,202
		TV spot	50000	1	Per spot	1	1	50,000	1	51,000	1	52,020	1	53,060	1	54,122	260,202
		Road show (multi-media campaign)	100000	1	Per campaign	1	1	100,000	1	102,000	1	104,040	1	106,121	1	108,243	520,404
		Lunch	9	100	Per person	2		0	1	1,836		0		0		0	1,836
		Tea break	4.50	100	Per person	2		0	1	918		0		0		0	918
		Travel allowance - district	75	100	Per person	2		0	1	15,300		0		0		0	15,300
		SMS costs	0.06	250000	Per unit	1		0	1	15,300	1	15,606	1	15,918	1	16,236	63,061
Development of Terms of Reference (TOR) (including members and roles, mandate and guiding principles, and meeting timelines)	Convene a meeting (MOHCC, ZNFPC, UNFPA) to draft Terms of Reference (TOR) and share with potential communication & advocacy technical working group members for review/input	Lunch	9	12	Per person	1	1	108		0		0		0		0	108
		Tea break	4.50	12	Per person	1	1	54		0		0		0		0	54

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total cost
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
	Convene a meeting with potential communication and advocacy technical working group members to incorporate review comments and finalise Terms of Reference (TOR)	Lunch	9	20	Per person	1	1	180		0		0		0		0	180
		Tea break	4.50	20	Per person	1	1	90		0		0		0		0	90
Regular meetings of communication and advocacy technical working group	Bi-monthly meetings of communication and advocacy technical working group to review latest M&E data being reported	Lunch	9	10	Per person	1	3	270	6	551	6	562	6	573	6	585	2,540
		Tea break	4.50	10	Per person	1	3	135	6	275	6	281	6	287	6	292	1,270
Subtotal								**837**		**826**		**843**		**860**		**877**	**4,242**
Develop a comprehensive communication and advocacy strategy by 2016	Review existing communication an advocacy strategy	Consultant fee	300	1	Per day	10	1	3,000		0		0		0		0	3,000
		Capitol hotel conference package	35	25	Per person	3	1	2,625		0		0		0		0	2,625
		Per diems and accommodations - national	100	5	Per person	4	1	2,000		0		0		0		0	2,000

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total cost
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
		Transport allowance - workshop	60	25	Per person	3	1	4,500		0		0		0		0	4,500
	Draft the new strategy and supporting documentation	Consultant fee	300	1	Per day	10	1	3,000		0		0		0		0	3,000
		Capitol hotel conference package	35	25	Per person	3	1	2,625		0		0		0		0	2,625
		Per diems and accommodations - national	100	5	Per person	2	1	1,000		0		0		0		0	1,000
		Transport allowance - workshop	60	25	Per person	3	1	4,500		0		0		0		0	4,500
	Disseminate the new strategy through rollout workshop	Print communication and advocacy strategy guide	0.25	200	Per page	1		0	1	51		0		0		0	51
		Capitol hotel conference package	35	30	Per person	1		0	1	1,071		0		0		0	1,071
		Per diems and accommodations - national	100	30	Per person	1		0	1	3,060		0		0		0	3,060
		Transport - litre of fuel	1.15	100	Per litre	30		0	1	3,519		0		0		0	3,519
		Transport allowance - workshop	60	30	Per person	1		0	1	1,836		0		0		0	1,836
Subtotal								**382,479**		**333,877**		**312,411**		**318,660**		**325,033**	**1,672,459**
Outcome 4.2. Knowledge and demand for LARC increased																	
Develop and implement a	Conduct comprehensiv	Consultant fee	300	1	Per day	120		0	1	36,720		0		0		0	36,720

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total cost
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
comprehensive SBCC strategy to increase demand for LARC	e formative research (an in-depth assessment) of drivers of choice and method preferences among users of long-acting methods (implants and IUCDs)																
	Develop a SBCC strategy to increase demand for LARC	Capitol hotel conference package	35	25	Per person	1		0	1	893		0		0		0	893
		Per diems and accommodations – national	100	5	Per person	1		0	1	510		0		0		0	510
		Transport - litre of fuel	1.15	140	Per liter	1		0	1	164		0		0		0	164
		Transport - land cruiser rate per km	0.44	1372	Per km	1		0	1	616		0		0		0	616
	Implement a targeted campaign across different channels to create demand for LARC	Print media - newspaper (multi-media campaign)	1280	1	Per newspaper	4		0	6	31,334	6	31,961	6	32,600	6	33,252	129,148
		Printing - IEC - pamphlet	0.25	120000	Per pamphlet	3		0		0		0		0		0	0
		Printing - IEC - A3 poster	10		Per poster			0		0		0		0		0	0
		Printing - IEC - fact	5		Per sheet			0		0		0		0		0	0

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total cost
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
		sheet															
		LARC radio spot	360	2	Per spot	10		0	91	668,304	91	681,670	91	695,303	91	709,210	2,754,487
		TV spot	50000	1	Per spot	1		0	91	4,641,000	91	4,733,820	91	4,828,496	91	4,925,066	19,128,383
		TV programme	375	1	Per programme	1		0	13	4,973	13	5,072	13	5,173	13	5,277	20,495
		Road show (multi-media campaign)	100000	1	Per campaign	1	1	100,000	1	102,000		0		0		0	202,000
Subtotal								**100,000**		**5,486,513**		**5,452,523**		**5,561,574**		**5,672,805**	**22,273,415**
Outcome 4.3. Communities increasingly mobilised and sensitised to improve knowledge and demand for family planning																	
Conduct community mobilisation and sensitisation efforts to promote uptake of family planning services	Develop action plan and guidelines for community mobilisation and sensitisation		0					0		0		0		0		0	0
	Develop standardized family planning information materials (job aids) for advocacy, provision, and referral for community health cadres	Consultant fee	300	1	Per day	45	1	13,500		0		0		0		0	13,500
		Lunch	9	20	Per person	1	1	180		0		0		0		0	180
		Tea break	4.50	20	Per person	1	1	90		0		0		0		0	90
		Transport - litre of fuel	1.15	40	Per litre	5	1	230		0		0		0		0	230
		Lunch	9	15	Per person	1		0	1	138		0		0		0	138
		Tea break	4.50	15	Per person	1		0	1	69		0		0		0	69
	Build capacity of community health	Job aids (CBHWs)	6	20000	Per aid	1		0	1	122,400		0		0		0	122,400
		Capitol hotel	35	28	Per person	3		0	8	23,990		0		0		0	23,990

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total cost
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
	workers to generate demand for family planning using standardised family planning job aids	conference package															
		Per diems and accommodations - national	100	29	Per person	4		0	8	94,656		0		0		0	94,656
		Transport - litre of fuel	1.15	100	Per litre	3		0	8	2,815		0		0		0	2,815
		Transport - land cruiser rate per km	0.44	980	Per km	3		0	8	10,556		0		0		0	10,556
		Transport allowance - RT	20	27	Per person	3		0	8	13,219		0		0		0	13,219
	Periodic family planning campaigns (World Contraception Day, Family Planning Day, World Population Day) with service provision availability	Per diems and accommodations – national	100	13	Per person	3	3	11,700	3	11,934	3	12,173	3	12,416	3	12,664	60,887
		Transport - Land cruiser rate per km	0.44	196	Per km	3	3	776	3	792	3	808	3	824	3	840	4,039
		Transport - litre of fuel	1.15	20	Per litre	3	3	207	3	211	3	215	3	220	3	224	1,077
		Sound system rental (family planning campaign)	250	1	Per campaign	1	3	750	3	765	3	780	3	796	3	812	3,903
		Refreshments (family planning campaign)	4.50	1	Per campaign	1	3	14	3	14	3	14	3	14	3	15	70
		VIP appearance fees (family planning campaign)	500	1	Per campaign	1	3	1,500	3	1,530	3	1,561	3	1,592	3	1,624	7,806
		Tent/venue	500	1	Per	1	3	1,500	3	1,530	3	1,561	3	1,592	3	1,624	7,806

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total cost
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
		/chairs (family planning campaign)			campaign												
		Family planning commodities	0					0		0		0		0		0	0
		Male condoms	0.04	100	Per unit	1	3	13	3	14	3	14	3	14	3	15	70
		Progestin-only pills	0.27	50	Per unit	1	4	53	4	54	4	55	4	56	4	57	276
		Combined-oral contraceptive pills	0.26	50	Per unit	1	3	40	3	40	3	41	3	42	3	43	206
		Entertainment (family planning campaign)	400	1	Per campaign	1	3	1,200	3	1,224	3	1,248	3	1,273	3	1,299	6,245
		Promotional materials (family planning campaign)	1000	1	Per campaign	1	3	3,000	3	3,060	3	3,121	3	3,184	3	3,247	15,612
	Exhibition participation	Exhibition participation – national	24000	2	Per exhibition	1	1	48,000	1	48,960	1	49,939	1	50,938	1	51,957	249,794
		Exhibition participation - provincial	3000	8	Per exhibition	1	1	24,000	1	24,480	1	24,970	1	25,469	1	25,978	124,897
	Advocacy through patrons, champions, and brand ambassadors	Patrons	200	1	Per person	1	4	800	4	816	4	832	4	849	4	866	4,163
		Brand Ambassadors (family planning campaign)	6000	1	Per campaign	1	1	6,000	0	0	0	0	0	0	0	0	6,000
		Brand ambassadors, per performance (family	500	1	Per campaign	1	2	1,000	2	1,020	2	1,040	2	1,061	2	1,082	5,204

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total cost
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
		planning campaign)															
		Champions (family planning campaign)	100	10	Per campaign	1	4	4,000	4	4,080	4	4,162	4	4,245	4	4,330	20,816
Tertiary education institution outreach	Advocacy to tertiary institution leadership to permit (engagement of leadership for buy-in)	Meetings with university leadership	0					0		0		0		0		0	0
		Transport - litre of fuel	1.15	2	Per litre	2	1	5		0		0		0		0	5
		Transport - land cruiser rate per km	0.44	20	Per km	2	1	18		0		0		0		0	18
	Recruit and train youth peer educators	Youth information centre at university	0					0		0		0		0		0	0
		Peer educator – officer	200	1	Per training	12	1	2,400	1	2,448	1	2,497	1	2,547	1	2,598	12,490
		Training of peer educators	0					0		0		0		0		0	0
		Lunch	9	25	Per person	14	1	3,150	1	3,213	1	3,277	1	3,343	1	3,410	16,393
		Tea break	4.50	25	Per person	14	1	1,575	1	1,607	1	1,639	1	1,671	1	1,705	8,196
		T-shirt, hat, and bag (peer educators training)	22	25	Per person	1	1	550	1	561	1	572	1	584	1	595	2,862
		IEC materials	0					0		0		0		0		0	0
		Print IEC materials - pamphlet (multi-media campaign)	0.10	3000	Per pamphlet	4	4	4,800	4	4,896	4	4,994	4	5,094	4	5,196	24,979

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total cost
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
		Print IEC materials - poster (multi-media campaign)	0.20	2000	Per poster	4	4	6,400	4	6,528	4	6,659	4	6,792	4	6,928	33,306
		Print IEC materials - flyer	0.05	5000	Per flyer	4	4	4,000	4	4,080	4	4,162	4	4,245	4	4,330	20,816
		Peer educator - training manual	0.25	25	Per manual	1	4	25	4	26	4	26	4	27	4	27	130
		Peer educator - female model	100	25	Per model	1	4	10,000	4	10,200	4	10,404	4	10,612	4	10,824	52,040
		Peer educator - male model	100	25	Per model	1	4	10,000	4	10,200	4	10,404	4	10,612	4	10,824	52,040
	Creating resource centres where young people access SRH information	*Office furniture*	0					0		0		0		0		0	0
		Chair	65	6	Per unit	4		0	1	1,591	1	1,623	1	1,655	1	1,689	6,558
		Desk	150	2	Per unit	4		0	1	1,224	1	1,248	1	1,273	1	1,299	5,045
		Shelves	200	7	Per unit	4		0	1	5,712	1	5,826	1	5,943	1	6,062	23,543
		Computer	800	1	Per unit	4		0	1	3,264	1	3,329	1	3,396	1	3,464	13,453
		Television	1000	1	Per unit	4		0	1	4,080	1	4,162	1	4,245	1	4,330	16,816
		Decoder	150	1	Per unit	4		0	1	612	1	624	1	637	1	649	2,522
		Internet connection	2000	1	Per unit	4		0	1	8,160	1	8,323	1	8,490	1	8,659	33,632
		Library	0					0		0		0		0		0	0
		Desk	150	8	Per unit	4		0	1	4,896	1	4,994	1	5,094	1	5,196	20,179
		Chair	65	40	Per unit	4		0	1	10,608	1	10,820	1	11,037	1	11,257	43,722
		Reading materials	0					0		0		0		0		0	0
		Computer	800	4	Per unit	4		0	1	13,056	1	13,317	1	13,583	1	13,855	53,812
		Indoor	0		Per unit			0		0		0		0		0	0

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total cost
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
		Dartboard	120	2	Per unit	4		0	1	979	1	999	1	1,019	1	1,039	4,036
		Arrows	15	6	Per unit	4		0	1	367	1	375	1	382	1	390	1,513
		Table tennis	500	1	Per unit	4		0	1	2,040	1	2,081	1	2,122	1	2,165	8,408
		Pool table	1200	1	Per unit	4		0	1	4,896	1	4,994	1	5,094	1	5,196	20,179
		Chess board	40	2	Per unit	4		0	1	326	1	333	1	340	1	346	1,345
		Playing cards	5	10	Per unit	4		0	1	204	1	208	1	212	1	216	841
		Counselling room	0					0		0		0		0		0	0
		Tables	300	1	Per unit	4		0	1	1,224	1	1,248	1	1,273	1	1,299	5,045
		Chair	65	3	Per unit	4		0	1	796	1	812	1	828	1	844	3,279
		Treatment room	0					0		0		0		0		0	0
		Drugs	1000	1	Per room	4		0	1	4,080	1	4,162	1	4,245	1	4,330	16,816
		Family planning commodities (SRH)	1000	1	Per room	4		0	1	4,080	1	4,162	1	4,245	1	4,330	16,816
		Reception area	0					0		0		0		0		0	0
		Desk	150	1	Per unit	4		0	1	612	1	624	1	637	1	649	2,522
		Chair	65	3	per unit	4		0	1	796	1	812	1	828	1	844	3,279
		Benches	40	3	Per unit	4		0	1	490	1	499	1	509	1	520	2,018
	Develop a voucher system for family planning services for students of tertiary education institutions	Per diem – voucher	75	2850	Per voucher	1	4	855,000	4	872,100	4	889,542	4	907,333	4	925,479	4,449,454
Subtotal								**1,016,475**		**1,358,318**		**1,112,284**		**1,134,530**		**1,157,220**	**5,778,827**
Outcome 4.4. Social and community norms in support of family planning improved																	

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total cost
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
Social mobilisation by community leaders (e.g., traditional, faith-based, political) for family planning	Train in delivery of community dialogues	ZNFPC carries out supportive and monitoring visits once a quarter	100000	1	Per quarter	1	1	100,000	1	102,000	1	104,040	1	106,121	1	108,243	520,404
		Social mobilisation by community leaders for family planning (district level)	24000	63	Per quarter	1	1	1,512,000	1	1,542,240	1	1,573,085	1	1,604,546	1	1,636,637	7,868,509
		Provincial level carries out supportive and monitoring visits once a quarter	40000	8	Per quarter	1	1	320,000	1	326,400	1	332,928	1	339,587	1	346,378	1,665,293
	Develop ASRH conversation guide	Transport - litre of fuel	1.15	20	Per litre	1	1	23		0		0		0		0	23
		Lunch	9	3	Per person	1	1	27		0		0		0		0	27
		Tea break	4.50	3	Per person	1	1	14		0		0		0		0	14
		Photo shoot	500	10	Per unit	1	1	5,000		0		0		0		0	5,000
		Flipchart	2	100	Per unit	1	1	200		0		0		0		0	200
	Provide community dialogues	Refreshments (community dialogues)	25	10	Per campaign	1	4	1,000	4	2,448	4	3,954	4	5,518	4	6,819	19,739
Subtotal								**1,938,264**		**1,973,088**		**2,014,006**		**2,055,772**		**2,098,078**	**10,079,208**
TOTAL								3,438,054		**9,152,622**		**8,892,068**		**9,071,395**		**9,254,013**	39,808,152

RESEARCH, MONITORING AND EVALUATION

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total cost
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
Outcome 5.1. A functional harmonised and optimised family planning M&E system in place to support data-driven decision making																	
Develop a comprehensive family planning M&E framework (i.e., indicators, data flow, data collection tools, research, evaluation, capacity building)	Develop a family planning M&E framework through contracting a consultant, holding a workshop, and holding individual stakeholder consultations	Consultant fee	300	1	Per day	30		0	1	9,180		0		0		0	9,180
		Workshop	0					0		0		0		0		0	0
		Lunch	9	50	Per person	1		0	2	918		0		0		0	918
		Tea break	4.50	50	Per person	1		0	2	459		0		0		0	459
		Transport - litre of fuel	1.15	50	Per litre	16		0	2	1,877		0		0		0	1,877
	Print family planning M&E framework	Print family planning M&E framework	0.25	200	Per page	1		0		0	1	52		0		0	52
			0					0		0		0		0		0	0
	Rollout of family planning M&E framework through workshop	*Workshop*	0					0		0		0		0		0	0
		Capitol hotel conference package	35	50	Per person	1		0		0	1	1,821		0		0	1,821
		Per diems and accommodations - national	100	17	Per person	2		0		0	1	3,537		0		0	3,537
		Transport - litre of fuel	1.15	50	Per litre	16		0		0	1	957		0		0	957
		Transport - land cruiser rate per km	0.44	490	Per km	16		0		0	1	3,589		0		0	3,589
	Train M&E	Consultant	300	1	Per day	10		0		0	1	3,121		0		0	3,121

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total cost
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
	staff to implement and monitor the framework	fee															
		Capitol hotel conference package	35	30	Per person	5	1	5,250		0		0		0		0	5,250
		Per diems and accommodations - national	100	13	Per person	6		0		0	1	8,115		0		0	8,115
		Transport - litre of fuel	1.15	50	Per litre	12		0		0	1	718		0		0	718
		Short course training	10000	1	Per training	1	1	10,000	1	10,200	1	10,404	1	10,612	1	10,824	52,040
	Conduct mid-term and end-term programme evaluations	Salary - consultant team	30000	1	Per team	1		0		0	1	31,212		0		0	31,212
		Travel to field for data collection	0					0		0		0		0		0	0
		Transport - land cruiser rate per km	0.44	3038	Per km	10		0		0	2	27,814		0	2	28,938	56,753
		Transport - litre of fuel	1.15	310	Per litre	10		0		0	2	7,418		0	2	7,718	15,136
		Per diems and accommodations - national	100	5	Per person	10		0		0	2	10,404		0	2	10,824	21,228
		Dissemination workshop	0					0		0	1	0		0	1	0	0
		Capitol hotel conference package	35	50	Per person	1		0		0	1	1,821		0	1	1,894	3,715
		Per diems and accommodations -	100	16	Per person	2		0		0	1	3,329		0	1	3,464	6,793

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total cost
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
		national															
		Transport - litre of fuel	1.15	50	Per litre	16		0		0	1	957		0	1	996	1,953
		Transport allowance - workshop	60	50	Per person	1		0		0	1	3,121		0	1	3,247	6,368
		Print - dissemination workshop materials	0.25	50	Per page	1		0		0	1	13		0	1	14	27
Develop Terms of Reference (TOR) (includes members and roles, mandate and guiding principles, and meeting timelines)	Convene a meeting (MOHCC, ZNFPC, UNFPA) to draft Terms of Reference (TOR) and share with potential M&E technical working group members for review/input	Lunch	9	12	Per person	1	1	108		0		0		0		0	108
		Tea break	4.50	12	Per person	1	1	54		0		0		0		0	54
	Convene a meeting with potential M&E technical working group members to incorporate review comments and finalise TOR	Lunch	9	20	Per person	1	1	180		0		0		0		0	180
		Tea break	4.50	20	Per person	1	1	90		0		0		0		0	90

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total cost
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
Conduct quarterly meetings of M&E technical working group	Conduct quarterly meetings of M&E technical working group to review latest M&E data being reported & monitor ZNFPCIP performance	Lunch	9	10	Per person	1	3	270	6	551	6	562	6	573	6	585	2,540
		Tea break	4.50	10	Per person	1	3	135	6	275	6	281	6	287	6	292	1,270
Compile recommendations from research studies bi-annually	Convene a meeting to review recent research results or secondary analyses to identify any programmatic recommendations	Lunch	9	10	Per person	1	1	90	2	184	2	187	2	191	2	195	847
		Tea break	4.50	10	Per person	1	1	45	2	92	2	94	2	96	2	97	423
Conduct secondary data analysis of national family planning and related SRHR studies	Convene a meeting to disseminate survey/ secondary data analysis results to stakeholders	Lunch	9	10	Per person	1	1	90	1	92	1	94	1	96	1	97	468
		Tea break	4.50	10	Per person	1	1	45	1	46	1	47	1	48	1	49	234
	As needed, commission secondary analyses from technical experts	Consultant fee	300	1	Per day	10		0	1	3,060		0	1	3,184		0	6,244

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total cost
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
Conduct quarterly M&E data quality audits	Develop data quality audit plan. Train M&E staff and Health Information Office (HIOs) on new family planning data collection tools	Travel allowance – regional	75	9	Per person	1	1	675	1	689	1	702	1	716	1	731	3,513
		per diems and accommodations – national	100	10	Per person	2	1	2,000	1	2,040	1	2,081	1	2,122	1	2,165	10,408
		Transport - litre of fuel	1.15	50	Per litre	9	1	518	1	528	1	538	1	549	1	560	2,693
		Transport allowance - workshop	60	10	Per person	2	1	1,200	1	1,224	1	1,248	1	1,273	1	1,299	6,245
		Planning meetings with directorate staff	0					0		0		0		0		0	0
		Lunch	9	25	Per person	1	1	225	1	230	1	234	1	239	1	244	1,171
		Tea break	4.50	25	Per person	1	1	113	1	115	1	117	1	119	1	122	585
	Support planned training activities of HMIS to incorporate new family planning registers and use of T5 reporting form	Printing of family planning registers	0.75	5000	Per register	1	1	3,750	1	3,825	1	3,902	1	3,980	1	4,059	19,515
		Printing of T5 forms	0.25	30000	Per form	1	1	7,500		0		0		0		0	7,500
		ZNFPC resource person at HMIS provincial level trainings	0					0		0		0		0		0	0
		Per diems and accommodations - national	100	2	Per person	8	8	12,800		0	8	13,317		0	8	13,855	39,972
		Transport - litre of fuel	1.15	50	Per liter	8	8	3,680		0	8	3,829		0	8	3,983	11,492

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total cost
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
		Transport allowance - workshop	60	2	Per person	8	8	7,680		0	8	7,990		0	8	8,313	23,983
	Coordinate with HMIS technical working group to standardise data quality audits for the data reported on the T5 form	Lunch	9	25	Per person	1	1	225	1	230	1	234	1	239	1	244	1,171
		Tea break	4.50	25	Per person	1	1	113	1	115	1	117	1	119	1	122	585
	Conduct joint assessment using new standard data quality audit tools in two districts for five SDPs per district	*ZNFPC and partner staff*	0					0		0		0		0		0	0
		Per diems and accommodations - national	100	6	Per person	7	2	8,400	2	8,568	2	8,739	2	8,914	2	9,092	43,714
		Transport allowance - workshop	60	6	Per person	7	2	5,040	2	5,141	2	5,244	2	5,348	2	5,455	26,228
		Transport - litre of fuel	1.15	210	Per litre	1	2	483	2	493	2	503	2	513	2	523	2,514
Subtotal								**70,758**		**50,128**		**168,464**		**39,217**		**120,001**	**448,568**
Outcome 5.2. A national family planning research agenda developed and operationalised																	
Develop national family planning research agenda and keep current	Identify research needs from family planning forum members	Capitol hotel conference package	35	60	Per person	1	1	2,100	1	2,142	1	2,185	1	2,229	1	2,273	10,928
		Per diems and accommodations - national	100	5	Per person	2	1	1,000	1	1,020	1	1,040	1	1,061	1	1,082	5,204
		Transport - litre of fuel	1.15	100	Per litre	4	1	460	1	469	1	479	1	488	1	498	2,394
		Transport	60	60	Per	2	1	7,200	1	7,344	1	7,491	1	7,641	1	7,794	37,469

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total cost
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
		allowance - workshop			person												
	Prioritise research needs	Lunch	9	30	Per person	1	1	270	1	275	1	281	1	287	1	292	1,405
		Tea break	4.50	30	Per person	1	1	135	1	138	1	140	1	143	1	146	703
	Disseminate prioritised research needs through family planning Forum	Print - research needs through family planning forum	0.25	60	Per page	1	1	15	1	15	1	16	1	16	1	16	78
Conduct at least two family planning-related operations research studies	Generate research protocols in support of priority research needs as identified in the national family planning research agenda	No additional resources required	0					0		0		0		0		0	0
	Conduct family planning programmatic research	Institutional review board approval by Medical Research Council of Zimbabwe (MRCZ) (1% of budget) for programmatic research	6685.49	1	Per approval	1		0	2	13,638	2	13,911		0		0	27,550

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total cost
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
		Implementation cost per study (covers accommodations, per diems, etc.)	20000	1	Per study	1		0	1	20,400	1	20,808	1	21,224	1	21,649	84,081
	Present research findings to stakeholders	No additional resources required	0					0		0		0		0		0	0
		Conference Sponsorship (disseminate results)	2500	2	Per conference	1		0	1	5,100	1	5,202	1	5,306	1	5,412	21,020
Subtotal							**7**	**11,180**	**11**	**50,542**	**11**	**51,553**	**9**	**38,395**	**9**	**39,162**	**190,832**
5.3. A functional, active ZNFPCIP performance monitoring mechanism in place by 2017																	
Develop a performance monitoring dashboard	Conduct a workshop with M&E technical working group on development of ZNFPCIP dashboard. Finalise and operationalise the dashboard. Sensitise ZNFPCIP steering committee members on the use and interpretation of dashboard	Lunch	9	15	Per person	2	3	810		0		0		0		0	810
		Tea break	4.50	15	Per person	2	3	405		0		0		0		0	405

Activity	Sub-activity	Input	Item cost	Quantity	Metric	Frequency	2016		2017		2018		2019		2020		Total cost
							Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	Recurrence	Yearly cost	
Collect ZNFPCIP progress data for the dashboard and analyse results on a quarterly basis	M&E staff at ZNFPC/MOHCC collect data on a quarterly basis	No additional resources required	0					0		0		0		0		0	0
Conduct quarterly reviews of the implementation of ZNFPCIP activities through national family planning forum	Host one-day meetings each quarter	Lunch	9	40	Per person	1	4	1,440	4	1,469	4	1,498	4	1,528	4	1,559	7,494
		Tea break	4.50	40	Per person	1	4	720	4	734	4	749	4	764	4	779	3,747
Subtotal								**3,375**		**2,203**		**2,247**		**2,292**		**2,338**	**12,456**
TOTAL							**85,313**		**102,874**		**222,264**		**79,904**		**161,501**		**651,856**

APPENDIX 3: LIST OF PARTICIPANTS

Organization	Name
Ministry of Health and Child Care	Dr B. Madzima
	Dr Patron Mafaune
	Dr B. Maponga
	Ms M. Nyandoro
	Mrs Hove
	Mr B. Muzavazi
	Ms M. Mandara
	Mr. N.B. Madzikwa
Zimbabwe National Family Planning Council	Dr M. Murwira
	Dr N. Zwangobani
	Mr A. Vhoko
	Mr J. Chigweremba
	Mr B. Chikati
	Mr M. Mukaronda
	Mr L. Gamba
	Mr F. Machinga
	Mr K. Chanana
	Ms M. Marimirofa
	Mr O. Munamati
	Mr J. Chikozho
	Mr P. Sirewu
	Mrs l. Kanyimo
	Mrs S. Munangagwa
	Mr S. Tsarwe
	Mr C. Chitauro
	Mr S. Chikwizo
	Mr W. Makoni
	Ms W. Chitate
	Mrs M. Marange
	Ms R. Mazengeza
	Mrs D. Mawoko
	Ms M. Wadawareya
	Ms S. Shamu
National Aids Council	Mrs M. Maphosa-Mutsaka
	Ms L. Chifamba

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United Nations Population Fund	Cheikh C. Tidiane
	Mr Y. Yu
	Ms A. Msemburi
	Mrs A. Makoni
	Mrs B. Shoko
	Mrs D. Nyamukapa
	Mrs D. Hore
	Mr E. Mpeta
	Mr L. Muyambo
	Mrs N. Mavhiya
	Mrs P. Kasere
	Mr T. Chinhengo
	Ms R. Mhonde
	Mr S. Manyenya
	Mr T. Katsande
	Mr V.S. Raghuvanshi
	Ms P. Munyama
	Ms Mauye
	Ms Y. Chigangaidze
Department for International Development	Mr T. Daly
	Mrs W. Takundwa-Banda
U.S Agency for International Development	Mrs K. Webb
	Mrs L. Takundwa
	Mr M. Maruva
	Ms S. Bird
Crown Agents	Mr B. Chimunda
	Mr K. Munangarima
John Snow, inc. Zimbabwe	Mr T. Chitsike
	Mr Alson Tichatyei Mhazo
Pharmaceutical Society of Zimbabwe	Mr F. Dzumbunu
	Mrs H. Chinake
	Mr T. Sango
	Mr T. Gora
Maternal and Child Health Integrated Program Zimbabwe	Dr D. Makosa
	Mrs F. Chiyaka
Public Services International	Mr B. Zikhali
	Dr N. Muhonde
	Mrs N. Shoko

	Ms S. Madakadze
	Mr T. Mawoyo
	Ms V. Mabhunu
Young People Network	Ms N. Sithole
Ministry of Higher and Tertiary, Science and Technology Development	Ms E. Matipano
	Mr R. Gotora
Ministry of Women Affairs, Gender and Community Development	Mr T. Murwisi
Zimbabwe National Army	Mr M. Zingwangwa
Avenir Health	Mr P. Emmart
FHI360	Dr E. Munongo
	Mr S. Musungo
	Dr R. Homan
	Ms C. Lasway
	Ms T. Orr
	Dr M. Solomon
	Mr P. Olsen

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