National Adolescent and Youth Sexual and Reproductive Health (ASRH) Strategy II: 2016-2020

Stepping up for good Sexual and Reproductive Health Outcomes for Adolescents and Youth in Zimbabwe
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Stepping up for good Sexual and Reproductive Health Outcomes for Adolescents and Youth in Zimbabwe
Foreword

Zimbabwe has a young population with a third being between the ages of 10-24 years. These young people face a myriad of challenges related to their development. These include unemployment, gender based violence, child marriage, HIV infection and other negative reproductive health outcomes. Young women in particular are exposed to the risk of unintended pregnancies, unsafe abortions and sexually transmitted infections.

The first National Adolescent Sexual Reproductive Health (ASRH) Strategy: 2010-2015 provided for age appropriate interventions centered on behaviour change communication, life skills and livelihoods, youth-friendly service delivery, policy and advocacy, and coordination. It defined the minimum or essential package for ASRH service provision for the health facility, school or community based approaches. A mid-term review of the strategy was conducted in 2013 and there were no major changes except breaking down of the school based approach into two: Primary & Secondary and Higher and Tertiary and the review, inclusion of HIV as a cross cutting and integral component and alignment of the minimum package of services and activities in line with the four approaches. Implementation of the National ASRH strategy was coordinated by a multi-sectoral coordination forum which is chaired by the Ministry of Health and Child Care (MoHCC). In Zimbabwe, significant efforts have been made by different organisations to implement programmes that seek to positively impact on the sexual and reproductive health status of young people. Some of these programmes have been evaluated individually. In line with the National ASRH Strategy: 2010-2015, a review of ASRHR interventions implemented during the five year period was conducted by the John Hopkins Bloomberg School of Public Health in order to foster evidence based programming and in particular the development of the Strategy II.

This new strategy is therefore based on evidence from the recent 2015/6 Zimbabwe Demographic Health Survey (ZDHS) regarding adolescent’s related issues and on recommendations of the review of interventions which was conducted by the John Hopkins Bloomberg School of Public Health, the 2015 national adolescent fertility study, programme evaluation reports and also considers other documented national, regional and global best practices and the country context.

The participatory and evidence based approach utilised during the process of developing this strategy signifies the multisectoral approach that is required and strengthened as we Step up for good Sexual and Reproductive Health Outcomes for Adolescents and Youth in Zimbabwe. I would like to express my gratitude to all our partners for their complementary and continued support towards ASRHR and indeed welcome new partners for a common cause.

Hon. Dr. D. P. Parirenyatwa
Minister of Health and Child Care
2016
Acknowledgements

The Government of Zimbabwe (GoZ), through the Ministry of Health and Child Care (MOHCC) would like to extend its gratitude to all stakeholders who contributed to the development of the National Adolescent and Youth Sexual and Reproductive Health Strategy (ASRH) II: 2016-2020. Special thanks go to adolescents’ representatives, the National ASRH Coordination Forum members, other line ministries, young people serving organisations, religious organisations and individuals who contributed to this strategy.

Under the overall and direct supervision of Dr. Gibson Mhlanga, Dr. Bernard Madzima and Ms. Margaret Nyandoro (MOHCC), the ASRH Strategy II Development Committee, is highly commended for facilitating the development process. The leadership and technical support received from the following line ministries and parastatals also deserves acknowledgement: Ministry of Primary and Secondary Education, Ministry of Higher and Tertiary Education, Science and Technology Development, Ministry of Youth, Indigenisation and Economic Empowerment, Ministry of Women’s Affairs, Gender and Community Development, Ministry of Public Service, Labour and Social Welfare, Zimbabwe National Family Planning Council, Zimbabwe Youth Council and National AIDS Council.

Very high recognition also goes specifically to the Department for International Development (DFID) of the United Kingdom, Irish Aid, and the Swedish International Development Agency (SIDA); as well as the Swiss Agency for Development and Cooperation (SDC) and the United States Agency for International Development (USAID) for their contribution towards the development of the strategy.

Sincere gratitude also goes to United Nations Family, mainly comprising UNFPA, UNICEF, UNESCO, UN Women, UNAIDS and WHO for their extensive technical support, towards the development of this strategy. The financial support from UNFPA and Southern Africa AIDS Information Dissemination Services (SAF AIDS) towards the development processes is also appreciated.

Brigadier General (Dr.) G. Gwinji
Secretary for Health and Child Care
2016
## List of Stakeholders Consulted:

<table>
<thead>
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<th>Name of Stakeholder</th>
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</table>
# Table of Contents

1. **FOREWORD**
2. **ACKNOWLEDGEMENTS**
3. **LIST OF FIGURES**
4. **LIST OF TABLES**
5. **ACRONYMS**
6. **DEFINITIONS OF TERMS**
7. **EXECUTIVE SUMMARY**

## 1. INTRODUCTION

1.1 **CONTEXT OF ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN ZIMBABWE**

1.1.1 **CURRENT SRH CHALLENGES AMONG ADOLESCENTS AND YOUNG PEOPLE IN ZIMBABWE**

1.1.2 **Adolescent Pregnancies**

1.1.3 **Maternal Mortality**

1.1.4 **Child Marriages**

1.1.5 **STDs and HIV**

1.1.6 **Gender Based Violence**

1.2 **ACHIEVEMENTS OF THE ASRH STRATEGY 2010-2015**

1.3 **LESSONS LEARNED AND RECOMMENDATIONS FROM THE ASRH STRATEGY 2010-2015**

## 2. RATIONALE FOR THE STRATEGY 2016-2020

3. **THEORY OF CHANGE FOR THE ASRH STRATEGY**

4. **SOLUTIONS PATHWAYS**

5. **ASSUMPTIONS UNDERPINNING THE THEORY OF CHANGE**

## 3. RESULTS FRAMEWORK

6. **IMPACT, OUTCOMES AND OUTPUTS OF THE STRATEGY**

6.1 **GUIDING PRINCIPLES FOR THE ASRH STRATEGY 2016-2020**

7. **STRATEGIES OF THE ASRH STRATEGY 2016-2020**

7.1 **OUTCOME 1: INCREASED SAFE SEXUAL HEALTH PRACTICES AMONG ADOLESCENTS AND YOUNG PEOPLE**

7.2 **OUTCOME 2: INCREASED UPTAKE OF QUALITY YOUTH FRIENDLY INTEGRATED SRH AND HIV SERVICES**

7.3 **OUTCOME 3: STRENGTHENED PROTECTIVE ENVIRONMENT FOR ADOLESCENTS AND YOUNG PEOPLE**

## 8. IMPLEMENTATION APPROACHES

8.1 **MULTIPLE INTERVENTIONS**

8.2 **INTEGRATION AND LINKAGES**

8.3 **TARGETING**

8.3.1 **Targeting the most vulnerable**

8.4 **YOUTH PARTICIPATION**

8.5 **GENDER MAINSTREAMING**

8.6 **COMMUNITY AND PARENT ENGAGEMENT**

8.7 **AGE APPROPRIATE SRH INFORMATION AND SERVICES**

## 9. SUPPORTIVE PILLARS FOR THE STRATEGY STAKEHOLDER ANALYSIS

9.1 **COORDINATION**

9.1.1 **Strategy Steering Committee**

9.1.2 **National Coordination Forum**

9.1.3 **Provincial level coordination**

9.1.4 **District level ASRH Coordination**

9.1.5 **Ward and community level coordination**

9.2 **INNOVATIONS OPERATIONS RESEARCH AND KNOWLEDGE MANAGEMENT**

9.3 **POLICY AND ADVOCACY**

9.4 **CAPACITY DEVELOPMENT**

## 10. STRATEGY IMPLEMENTATION

11. **ROLES AND RESPONSIBILITIES OF KEY STAKEHOLDERS**
# Table of Contents

12 **BACKGROUND**

12.1 **OBJECTIVES OF THE M&E FRAMEWORK**

12.2 **GUIDING PRINCIPLES FOR THE M&E FRAMEWORK**

12.3 **THE FORMULATION PROCESS**

13 **CORE INDICATORS FOR THE ASRH M&E FRAMEWORK**

13.1 **INTRODUCTION**

13.2 **BASELINES AND TARGET SETTING**

13.2.1 Impact plan

13.2.2 Outcome Plan

13.2.3 Outputs Plan

14 **MONITORING AND EVALUATION FRAMEWORK, OUTPUTS, USERS AND USES**

14.1 **MONITORING FRAMEWORK**

14.1.1 Data sources

14.1.2 Monitoring outputs

14.1.2.1 Monitoring data flow

14.2 **EVALUATION FRAMEWORK**

14.2.1 Mid Term Evaluation of the ASRH strategy

14.2.2 End of Strategy Evaluation Report

14.2.3 Special evaluative studies

14.3 **USERS AND USES OF THE M&E FRAMEWORK**

2 **KNOWLEDGE MANAGEMENT SYSTEMS**

14.4 **DATA CAPTURING**

14.5 **DATA STORAGE**

14.6 **DATA RETRIEVAL**

14.7 **DATA ANALYSIS**

14.8 **DISSEMINATION AND SHARING**

14.9 **DECISION-MAKING**

14.10 **DATA QUALITY ASSURANCE**

15 **MONITORING AND EVALUATION CALENDAR**

15.1 **M&E IMPLEMENTATION PLAN**

16 **PERIODIC REVIEW OF FUNCTIONALITY OF ASRH M&E FRAMEWORK**

SECTION 2: OPERATIONS RESEARCH FRAMEWORK

17 **INTRODUCTION**

17.1 RATIONALE AND OBJECTIVES FOR OPERATIONS RESEARCH

18 **THE OPERATIONS RESEARCH FRAMEWORK**

18.1 TYPES OF OPERATIONS RESEARCH

18.1.1 Exploratory/Diagnostic Studies: Problem Not Known

18.1.2 Field Intervention Studies

18.1.3 Evaluative Studies

18.1.4 Cost-effectiveness Studies

18.2 MANAGEMENT ARRANGEMENTS FOR OPERATIONS RESEARCH

19 **BIBLIOGRAPHY:**

ANNEXES

ANNEX 1: POLICIES AND LEGAL INSTRUMENTS

ANNEX 2: DATA QUALITY ASSURANCE GUIDELINES

ANNEX 3: PROCESS INDICATORS

ANNEX 4: PROBLEM TREE FOR THE ASRH IN ZIMBABWE

39

39

39

39

40

40

40

40

40

41

41

44

46

46

46

48

50

50

50

50

50

51

54

54

55

55

55

55

55

56

57

57

57

57

57

58

58

58

58

60

60

60

60

61

62

64

65

67

69
List of Figures

FIGURE 1: THEORY OF CHANGE FOR THE ASRH STRATEGY 2016-2020 15
FIGURE 2: RESULTS FRAMEWORK FOR THE ASRH STRATEGY 19
FIGURE 3: SUMMARY OF IMPLEMENTATION APPROACH 28
FIGURE 4: COORDINATION STRUCTURE FOR ASRH 33
FIGURE 5: DATA FLOW FOR THE ASRH STRATEGY 2016-2020 49
FIGURE 6: INSTITUTIONAL ARRANGEMENTS FOR DATA UTILISATION 49
FIGURE 7: KNOWLEDGE MANAGEMENT SYSTEM FOR ASRH M&E FRAMEWORK 54

List of Tables

TABLE 1: SRH STATUS OF ADOLESCENTS AND YOUNG PEOPLE 2
TABLE 2: KEY ACHIEVEMENTS AND DELIVERABLES FOR THE ASRH STRATEGY (2010-2015) 7
TABLE 3: APPROACHES AND STRATEGIES USED IN 2010-2015 ASRH STRATEGY IMPLEMENTATION 10
TABLE 4: OUTPUTS OF THE STRATEGY 20
TABLE 5: TARGETING APPROACH FOR THE ASRH STRATEGY 30
TABLE 6: SERVICES BY OBJECTIVE AND AGE CATEGORY 32
TABLE 7: COMPOSITION OF THE STRATEGY STEERING COMMITTEE 34
TABLE 8: RESPONSIBILITIES IN THE SSC 34
TABLE 9: IMPACT PLAN 41
TABLE 10: OUTCOME PLAN 42
TABLE 11: OUTPUT PLAN 44
TABLE 12: DATA SOURCES FOR THE ASRH STRATEGY (2016-2020) 46
TABLE 13: TARGETING APPROACH FOR THE ASRH STRATEGY 47
TABLE 14: PURPOSE OF SPECIAL EVALUATIVE STUDIES 51
TABLE 15: USERS AND USES OF THE M&E FRAMEWORK 52
TABLE 16: ASRH MONITORING CALENDAR, OUTPUTS AND RESPONSIBLE ENTITIES 56
TABLE 17: ASRH EVALUATION CALENDAR, OUTPUTS AND RESPONSIBLE ENTITIES 57
TABLE 18: EXPLORATORY STUDIES 59
TABLE 19: FIELD INTERVENTION STUDIES 60
TABLE 20: EVALUATIVE STUDIES 60
TABLE 21: COST EFFECTIVENESS STUDIES 60
# Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
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<tr>
<td>ASRH</td>
<td>Adolescent Sexual and Reproductive Health</td>
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<td>HBC</td>
<td>Home Base Caregiver</td>
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<td>MEL</td>
<td>Monitoring, Evaluation and Learning</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>MoHCC</td>
<td>Ministry of Health and Child Care</td>
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<td>Young People's Network on Sexual Reproductive Health, HIV and AIDS</td>
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<td>SBCC</td>
<td>Social Behaviour Change Communication</td>
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<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<td>HTC</td>
<td>HIV Testing and Counselling</td>
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<td>VHW</td>
<td>Village Health Worker</td>
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<td>Voluntary Medical Male Circumcision</td>
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Definitions of Terms

**Adolescence** is defined by the World Health Organisation (WHO) as the period between the ages of 10 – 19 years and young people as the period between the ages of 10 – 24 years. Therefore, for the purposes of this strategy, the terms *adolescents* and *young people* are used interchangeably. The adolescence period is broken down into the following three phases:

**Early adolescence:** 10 - 13 years (marks the beginning of sexual maturation).

**Mid adolescence:** 14 - 15 years (the main physical changes are completed, while the individual develops a stronger sense of identity and relates more strongly to peers).

**Late adolescence:** 16 - 19 years (the body fills out and takes its adult form, while the individual develops a stronger sense of identity and relates more strongly to his or her peers).

- **Young adult** refers to anyone aged 15 – 24 years
- **Youth** refers to anyone between 20 – 24 years
- **Young person** refers to anyone between 10 – 24 years
- **Teenager** refers to anyone aged 13 – 19 years
- **Child** refers to anyone less than 18 years

**Puberty:** the physical process of sexual maturation that includes the development of secondary sexual characteristics.

**Sexuality:** the total expression of who we are as human beings. It encompasses one's whole psychological development, that is, values, mental attitudes, physical appearances, beliefs, emotions, likes and dislikes, one's spiritual self and all the ways in which one has been socialized (ZNFPC; 1995).

**Gender:** refers to socially constructed women and men's roles and responsibilities. It also refers to how people are perceived and expected to think and act as women and men because of the way in which is organized, and not because of biological differences (MOHCC; 2001).

**Reproductive health:** the state of complete physical, mental and social well-being of an individual in all matters relating to the reproductive system and its processes and functions but not merely the absence of disease or infirmity. It includes sexual health, the purpose of which is the enhancement of life and personal relations and not merely counselling and care related to reproduction and sexually transmitted diseases (ICPD Program of Action, para 7.2).

**Outreach services:** refer to extending health services beyond facilities to community youth centres, youth clubs, schools and churches through community outreach workers like teachers, peer educators/counsellors, village health workers and community based distributor

**Indicators:** markers of health status, service provision or resource availability, designed to enable the monitoring of service performance or programme goals. They provide the quantitative and qualitative detail to a set of goals, objectives and targets of a policy or program. An indicator is a specific measure of program performance or impact that is tracked over time by the M&E system.

**Monitoring:** the routine tracking of key elements of a programme or project and its intended outcomes. It usually includes information from records and surveys and can be both population and client-based.

**Evaluation** is a process of assessing the effectiveness and sometimes efficiency of the project. It is a time-bound exercise done to measure the extent to which the organization achieves its desired results. This is done at outcome and also impact level.
**Indicators:** markers of health status, service provision or resource availability, designed to enable the monitoring of service performance or programme goals. They provide the quantitative and qualitative detail to a set of goals, objectives and targets of a policy or program. An indicator is a specific measure of program performance or impact that is tracked over time by the M&E system. Indicators should meet the CREAM criteria (Clear: indicators should be precise; Relevant: appropriate to the subject and evaluation; Economic: can be obtained at a reasonable cost; Adequate: the ability to provide sufficient information on performance; and Monitorable: easily monitored, and amenable to independent validation). They should be SPICED:

- **Subjective:** key informants (beneficiaries/stakeholders) have a special position or experience that gives them unique insights which may yield high return time-wise. What may be seen by some as ‘anecdotal evidence’ becomes critical data because of the source’s value

- **Participatory:** indicators should be developed together with those best placed to assess them, i.e. with the project’s ultimate beneficiaries, local staff and other stakeholders

- **Interpreted and communicable:** locally defined indicators may not mean much to others, which means they need to be explained or interpreted to different stakeholders

- **Cross-checked and compared:** the validity of indicators needs to be cross-checked by comparing different indicators and progress, and by using different stakeholders and methods to ensure validity

- **Empowering:** the process of developing and assessing indicators should be empowering in itself and should allow stakeholders to reflect critically on their changing situation

**Diverse and disaggregated:** there should be a deliberate effort to seek out different indicators from a range of groups and across gender. The data needs to be recorded in a way that these differences can be assessed over time.

**Peer education:** the approach whereby educational activities are offered by trained people to members of the same age, education or social group. Activities are aimed at developing knowledge, attitudes and skills, which will enable them to be responsible for and protect their own health and prevent HIV.

**Sexual Violence:** any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work. Sexual activity without consent; physically forced sex or pressured sex which includes threats, harassment, luring, or tricking. It includes rape within marriage or dating relationships; rape by strangers; sexual abuse of mentally or physically disabled people; sexual abuse of children; — forced marriage or cohabitation, including the marriage of children; — denial of the right to use contraception or to adopt other measures to protect against sexually transmitted diseases; — forced abortion;

**Adolescent Agency:** Personal agency refers to one’s capability to originate and direct actions for given purposes. It is influenced by the belief in one’s effectiveness in performing specific tasks, which is termed self-efficacy, as well as by one’s actual skill i.e. Cognitive tools, including insights, precepts, knowledge, and action schemas that youth might employ to help them achieve goals."

**Self-efficacy:** Self-efficacy refers to subjective judgments of one’s capabilities to organize and execute courses of action to attain designated goals (Bandura, 1977, 1997)\(^1\)

\(^1\) (1977). Self-efficacy: Toward a unifying theory of behavioral change
Abortion: The deliberate termination of a pregnancy, usually before the embryo or fetus is capable of independent life. In medical contexts, this procedure is called an induced abortion and is distinguished from a spontaneous abortion (miscarriage) or stillbirth.

Youth Friendly Services: Sexual and Reproductive Health services delivered in ways that are responsive to specific needs, vulnerabilities and desires of adolescents and youth. The services are offered in a nonjudgmental and confidential manner with respect and dignity.

Age Appropriate: This is suitability of information and services for people of a particular age group.

Age Appropriate Comprehensive Sexuality Education (AACSE): This is an age-appropriate, culturally relevant approach to teaching about sexuality and relationships by providing scientifically accurate, realistic and non-judgmental information. Sexuality education provides opportunities to explore one’s own values and attitudes as well as build decision-making communication and risk reduction skills about many aspects of sexuality.

Child Abuse: Child maltreatment, sometimes referred to as child abuse and neglect, includes all forms of physical and emotional ill-treatment, sexual abuse, neglect and exploitation that results in actual or potential harm to the child’s health, development or dignity. Within this broad definition, five sub-types can be distinguished — physical abuse, sexual abuse, neglect and negligent treatment, emotional abuse and exploitation.

Child Marriage: This is a situation where marriage, cohabitation or any arrangement is made for such marriage or cohabitation with someone below the age of 18 years.

Health: A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Life Skills Education: This is a structured program of needs and outcomes based participatory learning that aims to increase positive and adaptive behavior by assisting individuals to develop and practice psycho-social skills that minimize risk factors and maximize protective factors. Life skills education programs are theory and evidence based, learner-focused, delivered by competent facilitators and are appropriately evaluated to ensure continuous improvement of documented results.

Under saved and vulnerable adolescents and young people: high risk lacking adequate care and protection. Includes orphans and street children, adolescents with disabilities; adolescents living with HIV and AIDS; adolescents living informal settlements; adolescents with disability, in the labor market; sexually exploited; adolescents living below poverty line.

Non-State Actors: A non-state actor is as an entity that is not part of any state or a public institution. Non-state actors range from grassroots community organizations to non-governmental organizations, philanthropic foundations and academic institutions.

Persons With Disability: Any person with physical, sensory, mental, psychological or any other impairment, condition or illness that has, or is perceived by significant sectors of the community to have a substantial or long term effect on their ability to carry out ordinary day-to-day activities.

Sexual, Reproductive Health and Rights: The exercise of control over one's sexual and reproductive health linked to human rights and includes the right to:
• Reproductive health as a component of overall health, throughout life cycle, for both men and women;
• Reproductive health decision-making, including voluntary choice in marriage, family formation, determination of the number, timing and spacing of one’s children, right to access information and means needed to exercise voluntary choice;
• Equality and equity for men and women, to enable individuals to make free and informed choices in all spheres of life, free from discrimination based on gender; and
• Sexual and reproductive health security, including freedom from sexual violence and coercion, and the right to privacy.

**Sexual Health:** A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

**Sexuality:** It is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors.

**Unsafe Abortion:** A procedure for terminating pregnancy performed by persons lacking the necessary skills or in an environment that is not in conformity with minimal medical standards or both.
Executive Summary

Background

Zimbabwe’s first ASRH strategy covered the period 2010 to 2015. This was in the backdrop of both national and international recognition of the plight of adolescents and young people between the ages of 10 to 24 in relation to the sexual and reproductive health challenges. The 1994 International Conference on Population and Development (ICPD) marked the first converted global recognition of the SRH challenges for this group. It also heralded the turning point for the need to develop comprehensive, multi-sectoral programmes to address the SRH needs of adolescents and young people. The ICPD’s Programme of Action acknowledged the previous lack of attention paid to adolescent reproductive health and urged governments to respond to the gap in information and services targeting the adolescent and young people.

The past 5 years have seen, significant efforts by the Zimbabwean government to identify the major problems facing youth in Adolescent Sexual and Reproductive Health (ASRH) and identifying underlying factors, direct causes and determinants of the outcomes of ASRH interventions. There is therefore a body of evidence being generated nationally as well as globally on the important determinants of early sexual initiation, safer sexual behaviours, and other important ASRH issues.

ASRH is therefore a key priority area of work for the MOHCC and central to any efforts aimed to improve the overall health and development of adolescents and young people.

Rationale for the ASRH Strategy 2016-2020

The goal is to reduce morbidity and mortality associated with sexual and reproductive activity among adolescents and young people.

ASRH Strategy II development process

The ASRH Strategy 2016-2020 was developed using a participatory approach that encompassed stakeholder participation in the development of the content. A stakeholder consultation workshop and a validation meeting were carried out to confirm the content of the draft strategy. Young people representatives actively participated
in the development process and provided useful insight that enriched the document.

Technically, the ASRH Strategy development process included a review of a combination of local and international standards and experiences from a wide range of countries and organisations including relevant UN agencies development partners, government ministries and departments, etc. The process therefore relied primarily on the stakeholder consultations (workshops), research findings and recommendations, programme reports and literature. An Excel tool was developed and used to collate and analyse the findings of the literature review, particularly, the challenges, causal factors and the strength of the evidence available on intervention approaches articulating “what works and does not work” focusing on target populations, programming effectiveness and structural issues.

A sample of ASRH projects being implemented across the country by NGOs and development partners were also reviewed and evidence on promising interventions analyzed. A problem tree analysis tool was utilised to identify key ASRH problems causality factors and impacts on the adolescents and young people. This process resulted in the development of the Theory of Change and Results Framework.

Operational, governance, coordination issues were analysed using a SWOT analysis (strengths, weaknesses, opportunities and threats).

The ASRH Strategy II
The 2016-2020 ASRH Strategy II represents the second generation results-based strategy that aims to address Sexual and Reproductive Health (SRH) challenges among adolescents and young people between ages of 10-24 years in Zimbabwe. The strategy incorporates lessons learned in implementing the first generation ASRH strategy for Zimbabwe (2010-2015) and changes in the national and global context with regards to ASRH. It is the result of an in-depth analysis of the challenges facing adolescents and young people in the country. The strategy derives content from reviews of SRH related operational research and literature, ongoing ASRH programmes reports, consultations with multiple stakeholders including policy makers and implementers and the active involvement of the adolescents and young people themselves.

The strategy identifies the key challenges facing adolescents and young people as high rates of unplanned pregnancies, early childbearing, adolescent marriages, and gender based violence, maternal mortality and HIV and STDs. These challenges were prioritised through a problem tree analysis and an assessment of recent evident of the magnitude of the problems, causal factors, underlying causes including policy environment to tackle the challenges.

This process resulted in the development of the Theory of Change and Results Framework.

The theory of change identifies: (1) poverty, (2) lack of access to information on ASRH, (3) inadequate and relevant service delivery and (4) inadequate policy, and regulatory framework, as the major drivers for ASRH challenges facing adolescents and young people in Zimbabwe. The strategy identifies solution pathways that can address these challenges and lead to a more supportive environment conducive to change in behaviours and inclusive of safer sexual and reproductive practices. Ensuring a safer supportive environment can lead to reduction in adolescent pregnancies and their complications, and HIV and STI infections. Four pathways through which the strategy will achieve its desired changes were identified as follows:

- **Solution pathway 1**: Economic empowerment of families, adolescents and young people will lead to reduced school drop outs and harmful behaviours that increase vulnerability to ASRH risks among young people and adolescents.
- **Solution pathway 2**: Increased knowledge dissemination on ASRH and HIV to adolescents, young people and adults will lead to higher risk perception among adolescent and young people (AYP) and reduced religious, cultural and social norms among adults that increase vulnerability of adolescents to ASRH risks.
- **Solution Pathway 3**: Improved availability of integrated HIV and ASRH services in adolescent localities
will lead to increased utilization of HIV and ASRH.

- **Solution Pathway 4:** Strengthened ASRH policy and legislative environment leads to better safeguards for adolescent and young people’s sexual and reproductive health rights.

The interconnectedness of the challenges and solution pathways clearly demonstrates the multi-sectoral and integrated nature of this strategy and the inadequacies of implementing the proposed strategy in silos. No one single pathway will lead to the envisaged outcomes as all pathways are interlinked.

**Results Framework**
The results framework is summarised as below.

**Strategy Impact**
The impact statement for the strategy as highlighted above is “improved sexual and reproductive health of adolescent and young people in Zimbabwe”. Achievement of this impact is measured through reduced pregnancies and their complications, and reduction in new HIV and STDs infections.

**Strategy Outcomes**
Three outcomes will contribute to this impact as follows:

- **Outcome 1:** Increased safe sexual and reproductive health and HIV practices among adolescents and young people;
- **Outcome 2:** Increased uptake of quality youth friendly integrated SRH and HIV services; and
- **Outcome 3:** Strengthened protective environment for adolescents and young people.

The corresponding outputs are presented below.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Output</th>
</tr>
</thead>
</table>
| **Outcome 1: Increased safe sexual health and HIV practices among adolescents and young people.** | Output 1.1: Increased correct and comprehensive knowledge of HIV, STDs, and pregnancies among adolescents and young people.  
Output 1.2: Improved life skills among adolescents and young people. |
| **Outcome 2: Increased uptake of quality youth friendly integrated SRH and HIV services – Factor in accessibility not just affordability and availability.** | Output 2.1: Increased availability of quality youth friendly integrated SRH and HIV services.  
Output 2.2: Increased affordability to quality youth friendly integrated SRH and HIV services. |
| **Outcome 3: Strengthened protective environment for adolescents and young people.** | Output 3.1: A policy, legal and institutional framework that protects the SRHR of adolescents and young people is in place and enforced.  
Output 3.2: Increased community support for ASRH and adolescent HIV programmes.  
Output 3.3: Improved Parent to child communication on SRH and HIV issues. |
Implementation strategies
The ASRH Strategy 2016-2020 is primarily a prevention strategy. Within this context, special groups such as those already infected with HIV and STDs will be supported to realise their SRH rights through empowerment and treatment in a way that enables them to make better life choices and avoid new infections. Adolescent girls already in marriage or pregnant will be supported to avoid repeat pregnancy and pregnancy complications.

The ASRH Strategy will achieve the impact results by implementing key strategies/interventions linked to the outputs within the context of the results framework. The aim is not only to find what works but also to expand the scale and reach of the interventions to ensure that adolescent and young people in need of the service have equitable access and services are available. The strategy recognises the diversity of adolescent and young people populations and the need to segment their intervention programmes accordingly. It also highlights the fundamental element of the relationships between adolescent and young people, the adults and peers and emphasises the need for innovations and evidence based approaches that work.

Implementation Approaches
The framework for implementation of the ASRH strategy II is presented below.

Adolescents and young people are placed at the centre of the response allowing them to access services and embrace safe sexual and reproductive health practices. The three levels of interventions are anchored on three environments: 1) policy and legal environment; 2) service delivery environment; and 3) the programme management environment. These approaches are anchored on: 1) delivering age appropriate information and services but with considerations for what is in the best interest of child given the presenting situation; 2) ensuring boys, young men, girls and young women access services and are reached with interventions that support behaviour change; 3) community and parent engagement; and 4) youth participation.

The ASRH Strategy Pillars
The strategy is underpinned by four key pillars.
1) Coordination
2) Innovations, Operations Research and Knowledge management
3) Policy and Advocacy
4) Capacity development
5) Monitoring and Evaluation

These pillars are supported by coordination structures that allow for national coordination and accountability, dynamic stakeholders participation, policy alignment and oversight, resource mobilisation, monitoring and evaluation. The sub national levels mirror the national structures and are supported by the National Coordination Forum.

Terms of reference for the coordination structure have been developed to facilitate implementation. Overall, the strategy strategy is aimed to provide sector wide guidance to government ministries and all non-state actors including civil society and development partners in the provision of reproductive health services.
1. Introduction

The Government of Zimbabwe through the Ministry of Health and Child Care designed and implemented an Adolescent Sexual and Reproductive Health (ASRH) Strategy that was during the period 2010 and 2015. This document therefore presents the Government of Zimbabwe’s second generation results-based strategy to address SRH challenges among adolescents and young people. It is a five year strategy, from 2016 to 2020, and incorporates lessons learned in implementing the first generation strategy.

The new ASRH strategy covers adolescent and young people between ages of 10-24 years in Zimbabwe and takes into account new developments and changes in the national and global context with regards ASRH.

The strategy is aimed to provide sector wide guidance to government ministries and all non-state actors including civil society and development partners in the provision of sexual and reproductive health services for adolescents and young people in the 10 to 24 years age group.
2. Context of Adolescent Sexual and Reproductive Health in Zimbabwe

2.1 Current SRH Challenges among Adolescents and Young People in Zimbabwe

Adolescent and young people face many sexual and reproductive health challenges\(^2\) such as high rates of unplanned pregnancies, early childbearing and the transmission of sexually transmitted infections, including HIV. While often viewed as one homogeneous group, in reality adolescents and young people are an enormously diverse group, not only in terms of age and gender, but also in terms of ability, beliefs and the nature of circumstances and vulnerabilities they experience. Furthermore, many approaches that address the vulnerabilities and challenges of adolescent and young people often fail to contextualize sexual reproductive health within a wider framework of young people’s lives or involve them in identifying solutions to their challenges.

The key SRH related challenges facing adolescents and young people can be categorised into the following categories:

1) Adolescent pregnancies
2) Child marriages
3) STI and HIV
4) Gender Based Violence
5) Maternal Mortality

These challenges have been identified and prioritised on the basis of incidence and the impact on the lives of the adolescents and young people as presented in Table 1

Table 1: SRH Status of adolescents and young people

<table>
<thead>
<tr>
<th>ASRH Issue</th>
<th>Prevalence 15-24</th>
<th>Total</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Boys</td>
<td>Girls</td>
<td></td>
</tr>
<tr>
<td>HIV prevalence</td>
<td>15-19 age group</td>
<td>15-19 age group</td>
<td>HIV prevalence</td>
</tr>
<tr>
<td></td>
<td>(3.7%) young</td>
<td>(4.6%)</td>
<td>(2.8%) for 10-14</td>
</tr>
<tr>
<td></td>
<td>male (20-24) (8%)</td>
<td>Young females</td>
<td>girls (4.6%) and boys</td>
</tr>
<tr>
<td></td>
<td>(HIV test 24%</td>
<td>(10.8%)</td>
<td>(3.7%) aged 15-19</td>
</tr>
<tr>
<td></td>
<td>boys 15-19 last</td>
<td>(HIV testing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12 months )</td>
<td>coverage 35%</td>
<td></td>
</tr>
<tr>
<td>Knowledge of HIV</td>
<td>49% boys aged</td>
<td>51% girls aged</td>
<td>HIV 1.3%: age group 15-24: 8%</td>
</tr>
<tr>
<td></td>
<td>15-19 have</td>
<td>15-19 have</td>
<td>in 15-19 had multiple</td>
</tr>
<tr>
<td></td>
<td>comprehensive,</td>
<td>comprehensive,</td>
<td>sexual partners.</td>
</tr>
<tr>
<td></td>
<td>correct knowledge</td>
<td>correct knowledge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>of HIV</td>
<td>of HIV</td>
<td></td>
</tr>
<tr>
<td>Condom Use</td>
<td>62% at last</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>intercourse</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>79.9% 15-24 age</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>and 71.9% 15-19</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>years groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>using a condom</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV Testing</td>
<td>15-19 years age</td>
<td>15-19 years age</td>
<td></td>
</tr>
<tr>
<td></td>
<td>group 37.6%</td>
<td>group 47.9%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>15-24 years age</td>
<td>15-19 years age</td>
<td></td>
</tr>
<tr>
<td></td>
<td>group 47.5%</td>
<td>group 47.9%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>20-24 years age</td>
<td>15-24 years age</td>
<td></td>
</tr>
<tr>
<td></td>
<td>group 63%</td>
<td>group 63.9%</td>
<td></td>
</tr>
<tr>
<td>ART Coverage</td>
<td></td>
<td>PLHIV 10-14 age</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>group, (48%);</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>51% among 10-19,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>54% for aged 15-19</td>
<td></td>
</tr>
<tr>
<td>STI prevalence</td>
<td>STI Prevalence</td>
<td>STI prevalence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>boys aged 15-19</td>
<td>among girls 15-19</td>
<td></td>
</tr>
<tr>
<td></td>
<td>years 8%</td>
<td>years 9%</td>
<td></td>
</tr>
</tbody>
</table>

\(^2\)Adolescent sexual and reproductive health: the challenge for society. Senanayake P1, Noll JH, Faulkner KM
<table>
<thead>
<tr>
<th>ASRH Issue</th>
<th>Prevalence 15-24</th>
<th>Total</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Teen Fertility</strong></td>
<td>17% 15-19 have given birth; 22% have begun child bearing; 17% pregnant with first child</td>
<td>Total fertility rate (15-19) Urban 63/1000 Rural 138/1000 20-24 urban 153 rural 243/1000 Rural 27% Urban and 10% rural</td>
<td>ZDHS 2015</td>
</tr>
<tr>
<td><strong>Contraceptive</strong></td>
<td>Low adolescent CPR of 10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>FP unmet need</strong></td>
<td>15-19 age group: 12.6%; 20-24 age group: 10.1%</td>
<td>Urban 11.7% Rural 14.5%</td>
<td>ZDHS 2015</td>
</tr>
<tr>
<td><strong>FP Knowledge</strong></td>
<td>Knowledge decreases by age group 41.4% for 15-19 years and 37.1% in age</td>
<td></td>
<td>ZDHS 2010</td>
</tr>
<tr>
<td><strong>Maternal Mortality</strong></td>
<td>24% of maternal deaths were in adolescents aged 15-19</td>
<td></td>
<td>HMIS 2011</td>
</tr>
<tr>
<td><strong>ANC coverage</strong></td>
<td>66% of pregnant adolescent girls (aged 15-19) with a live birth in the last two years attended at least four antenatal care (ANC) visits by any provider</td>
<td></td>
<td>MICS 2014</td>
</tr>
<tr>
<td><strong>Gender Based Violence</strong></td>
<td>2% of Adolescent boys 13-17 experienced sexual violence</td>
<td>Physical violence: Physical violence: 34.8% among 20-24 year olds; 27.9% among 15-19 years</td>
<td>All In 2015; NBSLEA 2011 (for boys data)</td>
</tr>
<tr>
<td><strong>Sexual Violence</strong></td>
<td>37.5% of males aged 18-24 years and 15.7 % of males aged 13-17 years  experienced emotional violence before reaching 18 years according to NBSLEA</td>
<td>Ever experienced sexual violence: girls 13-17yrs 41%; 32.5% of girls aged 18-24 experienced sexual violence prior to 18 years, 47.8% physical violence and 29% emotional 15-19 years age group 27.9% 20-24 years 34.8%</td>
<td>NBSLEA 2011 ZDHS 2015</td>
</tr>
</tbody>
</table>
### 2.1.1 Adolescent Pregnancies

The ZDHS 2015 report\(^3\) shows that Adolescent Fertility Rate remains high among young girls 15-19 years old though slightly decreased since 2010 (from 115 to 110). 10.3% of urban and 27.2% of rural women 15-19 year old have started child bearing. The 2016 adolescent fertility study revealed that 9% of the adolescents aged 10-19 years had ever been pregnant. When broken down by age group, 17% of the adolescents aged 15-19 years and 0.2% among the 10-14 year-olds had experienced pregnancy. Adolescent pregnancies are more than twice higher among girls with primary education than among those who attended secondary school. Childbearing at an early age greatly reduces women’s educational and employment opportunities and is associated with higher levels of fertility. Adolescents with no comprehensive knowledge on pregnancy and those who were supporting adolescents getting pregnant were at higher risk of pregnancy.

A teenage girl in the rural areas is more likely to be exposed to the risk of pregnancy compared to their urban counterparts. The proportion of teenagers who have begun childbearing decreases as wealth increases: five times more teenagers in the lowest wealth quintile (34 percent) have begun childbearing compared with teenagers in the highest wealth quintile (6 percent). Delays sexual debut has positive impacts on adolescent development. AIR (2014)\(^5\) identifies delaying marriage and sexual debut, as decreasing the likelihood of early pregnancy. Knowledge level for Family Planning methods is universal but FP use declines with age.

### 2.1.2 Maternal Mortality

The 2014 MICS confirmed the 2012 census results of a high Maternal Mortality Rate (MMR) (525 per 100,000 live births). When compared to the 2002 census results the MMR has more than halved in the ten-year period (the 2002 Census reported a MMR of 1068). The decrease is due to the reduction in HIV and AIDS related deaths. For example, the underlying MMR (excluding HIV and AIDS) shows a steady pattern at around 400 per 100,000 live births. About 24% of these are adolescent girls 15-19 years. Underlying causes include poverty leading to lack of information, poor health seeking behaviour and poor affordability and access to maternal health services.

### 2.1.3 Child Marriages

Available data shows that one in every four adolescent girls (25%) aged 15-19 were married or in union by age 18 (MICS 2014). A quarter (25%) of adolescent girls entering into marriage or union, bear the negative consequences of child / early marriage which include teen pregnancies and higher experiences of Gender Based Violence (GBV) and high risk for HIV infection. There is urban rural difference in female child marriage with 27.4% married in rural as compared to 16.9% in urban areas (MICS 2014). Child marriages lead to school dropouts, low socioeconomic opportunities and health risks associated with adolescent pregnancy, childbearing and gender-based violence. Adolescent girls who marry older men also risk HIV infection (UNICEF 2012).


The Constitution of Zimbabwe 2013 provides the marriageable age as 18 years for both boys and girls. It also states that no person may be compelled to enter into marriage against their will. The Constitution supersedes all legislative and customary principles prevailing in the country. However, the current Marriage Act [Chapter 5:11] provides for marriage of a girl between the ages of 16 and 18 with consent of a guardian or a judge of the High Court in the absence of a guardian and ministerial consent for a girl below the age of 16 requires. The Customary Marriages Act [Chapter 5:07], does not specify the minimum age of marriage thus allowing the practice for early marriages to continue.

Interpretation of the inconsistency in the law, in defining a child, the age of consent to sex and the age of consent to marriage as provided in the various pieces of legislation such as the Children’s Act [Chapter 5:06] and the ratified international Convention on the Rights of the Child (CRC); 2012 and the African Charter on the Rights and Welfare of the Child continues to pose problems to both the young people and service providers. The Ministry of Justice and Legal Affairs has however conducted a marriage law review that will provide opportunities to address early marriage and the different treatments for boys and girls in the Marriage Act [Chapter 5:11]. Evidence suggests that the age gap between married adolescents and their partners tends to be large, while marriage to peers is often a coping mechanism usually in the context of an unintended pregnancy. The former is associated with higher risk of HIV infection. There is also evidence that girls who marry at young ages are more likely to marry older men which puts them at increased risk of HIV infection.

Reducing child marriages require strategies and intervention that target the underlying causes of child marriages. Interventions that empower young girls through mentoring and economic empowerment livelihoods and skills development and maternal empowerment related to ANC, family planning and reproductive health, PMTCT and interventions that prevent sexual debut among adolescent girls, promote educational opportunities beyond secondary education, and strengthen the enabling environment for girls to thrive in.

### 2.1.4 STDs and HIV

**HIV**

HIV continues to be major health problem for adolescents and young people in Zimbabwe. HIV prevalence in age group 15 – 19 years is 3.7% and 4.6% for boys and girls respectively. Almost 40% girls and 30% boys have sex before age 18 (ZDHS 2010/11). While a significant proportion of adolescent girls and boys is indulging in sex, only 62% of males aged 15-24 were found to have used a condom in their last sexual encounter. However, the statistics show that the majority of young men are HIV negative and therefore efforts should focus on ensuring they remain HIV negative. The gender- and age- disparity in HIV prevalence among adolescents aged 15-19 and young people aged 20-24, is a major concern (See Table 1). Such an increase clearly indicates fundamental gaps in HIV prevention, treatment and care interventions and further increases adolescent vulnerability to new HIV infection and HIV-related morbidity and mortality.

The “**All IN: Country Assessment to Strengthen Adolescent Component of National HIV Program in Zimbabwe (2015)**” report shows that half of adolescents in need of ART are not on treatment, increasing the likelihood of mortality. There is need for focused multifaceted programme responses that target adolescents and young people in adolescent localities: in school, community and facility based to mobilise for treatment literacy and adherence to lifelong ART among adolescents.

Adolescents and young people are not homogenous. They face different challenges. The dearth of data on key populations is also a fundamental gap which undermines initiatives to enhance access to HIV prevention, treatment and care services for adolescents and young people. There is need to increase access to and uptake of HIV prevention, treatment and care services among the vulnerable and underserved including adolescents with disabilities, adolescents living with HIV in conflict with the law etc.

The Adolescents and young people living with HIV in particular, face unique challenges as they transition to adulthood because they are less likely to be in school, likely to be orphaned, often lack access and affordability to appropriate services and are often unable to negotiate contraceptive use or even access contraceptive methods.

**STIs**

Evidence shows that adolescent girls are at risk of STIs, pregnancy, early marriage, and early child bearing in the developing countries. These factors heighten exposure to HIV infection and indicate unprotected sex among adolescents. STI prevalence among adolescent girls is 9% compared to 8% among adolescent boys aged 15-19 (ZDHS 2010/11, p.203). Essentially, almost one in ten adolescent boys and girls aged 15-19 have reported having an STI which increases vulnerability to HIV among adolescents and young people. Correct and
consistent use of condoms provides one of the most effective means of reducing sexual transmission of HIV and STDs. Condom use during last higher-risk sex, primarily among adolescents aged 15-19 who reported multiple sexual partners in the last 12 months and used a condom at last sex was 62%.

2.1.5 Gender Based Violence

Gender based violence is a major problem in Zimbabwe. The National Baseline Survey on Life Experiences of Adolescents (NBSLEA 2011) highlighted the scale of violence against adolescents and the various forms of violence - sexual, physical and emotional abuse - experienced by adolescents. 2.2% of males and 13.9% of females aged 18-24 years have experienced physical and sexual violence. About 33% females aged 18-24 years indicated that they had experienced some form of sexual violence before reaching the age of 18 years, while 9% of the males reported the same.

The underlying causes are multiple. According to UNICEF (2012), “child marriage, gender-based power relations, women’s low economic status and traditional practices or social norms” perpetuate the incidence of domestic violence while societal attitudes convey acceptance and justification of domestic violence. A WHO study shows that HIV and VAW are rooted in poverty, and low education levels among women (WHO, 2010). Sexual violence however remains a hidden problem as less than half of the survivors report or tell anyone. While a policy framework exists to curb gender based violence of any form, the situation remains escalated due to weak implementation and as highlighted, negative norms and traditional practices that perpetuate violence.

Zimbabwe has developed a National Gender Based Violence Strategy, based on the key pillars of GBV programming, namely leadership, prevention, service provision, coordination, research and documentation and Standard Operating Procedures for Safe Shelters (2012). This is in line with the provisions of the Beijing Platform for Action to assist survivors of gender based violence. Several other policies including a Multi Stakeholder Approach to the Management of Child Sexual Abuse and Victim Friendly Courts have been constituted. An Inter-Ministerial Cabinet Committee on Rape and GBV and a National Action Plan on Rape are also in place. Although the policy framework has been strengthened by the enactment of the new Constitution, the harmonization of laws with the Constitution is still to be realized. GBV remains a serious concern and impediment to girls’ and women’s active participation in development with GBV levels remaining unacceptably high.

Recent studies reveal a higher tendency by the survivors to conceal abuse when violence is executed by family members or intimate partners. Concealment stifles the justice system as it prevents existing laws and platforms designed to tackle acts of violence against women from being implemented effectively. As a result, perpetrators are often not prosecuted or punished for their actions and may continue to offend.

2.1.6 Policy and legal environment for ASRH

The United Nations Committee on the Rights of the Child states that adolescents have a right to health services that meet their particular needs, including the right to information on sexual and reproductive health, family planning, contraception, risks associated with early pregnancy and the prevention and treatment of sexually transmitted infections. In this context, Zimbabwe has made great strides in efforts to promote sexual reproductive health for adolescents and young people. The country is signatory to key regional and international commitments and conventions that promote sexual reproductive health (Annex 1).

2.2 Achievements of the ASRH Strategy 2010-2015

The approach to the implementation of the ASRH strategy 2010-2015 was multi sectoral. This was achieved through establishing multi-sectoral coordination structures. The structures included the National ASRH Forum and its National ASRH Steering Committee constituted to enhance coordination in the implementation of the strategy. The two structures have a multi sectoral representation and were designed to provide a platform for carrying out the multi sectoral function, provide leadership and coordination oversight and share experiences in ASRH programming.

The ASRH strategy 2010-2015 had national and subnational focus. At the national level, the strategy focused on ensuring a conducive policy and legal environment and standardizing implementation of ASRH activities through developing guidelines and training manuals for use by different implementers at all levels. The initiatives

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\textsuperscript{11} WHO, 2010, Statistics of Linkages between HIV and AIDS Violence against Women and Girls

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aimed to ensure that the national policies and legislation were aligned to the government of Zimbabwe’s international commitments regarding ASRH and that all ASRH rights were firmly protected in policy and law. At sub national level, the strategy was multi-dimensional addressing Social Behaviour Change Communication (SBCC), livelihoods, and service delivery. Under service delivery, the strategy worked in three environments: the health facility, community and the school. The strategy was anchored on the national peer education approach.

The strategy implementation made significant strides in setting up an appropriate framework for supporting ASRH initiatives. Table 2 highlights the achievements of the ASRH strategy (2010-2015).

Table 2: Key achievements and Deliverables for the ASRH Strategy (2010-2015)

<table>
<thead>
<tr>
<th>Area</th>
<th>Achievements</th>
</tr>
</thead>
</table>
| Framework documents and guidelines | - A Life Skills and Sexuality Education Strategy for the Ministry of Education, Sport, Arts and Culture;  
- Standard National ASRH Training Manual for Service Providers (2012);  
- Standard Operating Procedures for Community Youth Interact Centres;  
- National Youth Policy and development of an Implementation Plan  
- a National Integrated ASRH Advocacy Package  
- Standard National ASRH Monitoring, Evaluation and Reporting Framework |
| ASRH Strategy reviews, operational research | - Established, launched and decentralised the National Young People’s Network on SRH and HIV  
- Conducted the Mid Term Review of the National ASRH Strategy (2013)  
- Carried out a mapping exercise for ASRH Serving Organizations  
- Reviewed the ASRH Interventions implemented between 2010-2015 (2015)  
- Piloted the ASRH and VMMC Linkages project  
- Carried out an assessment of approaches towards reaching out to young people with SRH and HIV services |
| Capacity building, advocacy and instructional strengthening | - Capacity built service providers in youth friendly service provisions; oriented HIV and AIDS Focal persons in tertiary colleges on ASRH  
- Conducted Policy dialogues and advocacy around ASRH  
- Strengthened programming for adolescents living in difficult circumstances; e.g. living in the streets, living with HIV and living with disabilities  
- Conducted pre and in service training for ASRH service providers: college focal persons, peer educators, nurses and teachers  
- Launched the National ASRH Coordination Forum and piloted the decentralisation in Masvingo and Mashonaland West  
- Disseminated the National ASRH Strategy: over 15000 copies distributed;  
- Contributing towards the development of the ZNASP III  
- Supported and strengthened 76 health facilities to provide Youth Friendly services  
- Developed and printed IEC materials (largely print)  
- Established and equipped Youth Friendly Centres in 63 districts  
- Established and launched a national ASRH Coordination Forum |

*Multiple sources: ASRH Strategy 2010-2015, MTE, ASRH evaluation report and programme reports*

The ASRH strategy midterm review (MTE) (2013) was an important milestone in the implementation of the strategy as it heralded a transition period for the ASRH strategy. The MTE report included an Addendum, a framework for carrying forward key findings/recommendations. The overall purpose of the Addendum was to improve efficiency and effectiveness in the implementation of ASRH interventions during the second Phase of the National ASRH Strategy (2010-2015) implementation. Several key actions were articulated in the MTE Addendum to the ASRH Strategy including:

- the need to shift geographic coverage and moving toward district wide responses rather than focus on specific facilities;  
- embracing social media as a vehicle for communicating ASRH messages and reaching out to the adolescents and young people; and  
- targeting those left behind (vulnerable and underserved groups) and strengthening youth participation.
The ASRH response had also evolved over the plan period. While gaps in implementation existed, the response to ASRH nationally had expanded in reach and some innovative initiatives were yielding results. The National ASRH Coordination Forum though deemed relatively weak, provided an opportunity to share experiences on the various projects being implemented by the multiple stakeholders, operational research on effectiveness of their programme approaches and avoiding duplication of efforts.

The MTE, through the Addendum framework recommended specific areas for action or shift in some interventions and approaches as follows:

- Separate school based approach into Primary & Secondary (basic) and Higher & Tertiary and develop a framework for age appropriate SRH information and services;
- Improve integration and broaden the participation of adolescents and young people in HIV and SRH in ASRH programming;
- Consider development of an M and E strategy in the next generation ASRH strategy;
- Consider discontinuing or review functionality and opportunity for combination interventions to strengthen their effectiveness. Serious consideration should be given to whether to continue ineffective intervention approaches in the backdrop of limited resources. For example the review identified only 78 youth friendly corners out of 1560 health facilities and 27 youth centres in a country with over 60 districts. Evidence also showed that only those adolescents in proximity of walking distance tended to access the services;
- Prioritise vulnerable and underserved target groups not included in the strategy (disabled, HIV positive, street kids; and
- Strengthen community participation. This was found weak for most facilities with parents and community members remaining skeptical about services rendered by the youth centres and peer educators.

Further recommendations were made by an assessment of ASRH interventions in Zimbabwe conducted in 2015. These recommendations included the need to:

- Reduce systemic barriers to service utilization in order to increase adolescent use of services;
- Ensuring strong community support and parent to child communication;
- Consider focusing on the most vulnerable and underserved adolescents and young people with limited access to information and services;
- Invest in provider capacity throughout the health system and outreach strategies to meet family planning needs of adolescent girls of all ages rather than youth centers and youth corners;
- Utilize evidence base to prioritise implementation approaches and interventions that work. For example, while peer education is a useful adjunct to other services and providers, they should not be invested as an alone strategy. Combination strategies are more beneficial; and
- Continue to explore behavior change programs, but to remember that it is often cheaper and more sustainable to invest in structural changes.

2.3 Lessons Learned and Recommendations from the ASH Strategy 2010-2015

Several studies were conducted to assess progress and provide evidence on relevance and cost-effectiveness of different approaches used to implement the strategy. These assessments included the findings of the Mid Term review (2013) and an assessment of the ASRH strategies in Zimbabwe (JHU 2015). These findings were corroborated by findings from other regional and global multi country studies that provide evidence base for ‘what works and does not work’ as well as highlight the importance of combination interventions and approaches to improve the efficiency and effectiveness. Evidence also showed that some commonly popular programme interventions were not being effective. The studies also provided evidence of some promising initiatives in the ASRH programme.

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13 ASRH Midterm review (MTE) report 2014
15 JHU: A review of the 5-year National ASRH Strategy (2010-15) in Zimbabwe
Table 3 provides a summary of findings from the mid-term review and final assessment of the ASRH interventions in Zimbabwe. It is organized according to the key areas of interventions for the ASRH Strategy 2010-2015:

a) Social and behaviour change communication;
b) Service Delivery;
c) Policy and advocacy;
d) Coordination and networking; and
e) Cross-cutting strategies.
Table 3: Approaches and Strategies Used in 2010-2015 ASRH Strategy Implementation

<table>
<thead>
<tr>
<th>Approach</th>
<th>Issues from the ASRH evaluations: (ASRH MTE; Evaluation of ASRH in Zimbabwe etc.)</th>
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</table>
| Social and behaviour change communication (SBCC) | SBCC were peer led prevention approaches that emphasized abstinence, faithfulness and engaging parents. The approach assumed effective health systems for increased access and utilisation and livelihoods and life skills training. Review showed that:  
  - Peer education approach was undermined by limited resources. Community awareness had excluded parents. The PCC strategy was developed but not implemented. Duty bearers and rights holders often lacked information and effectively support ASRH programmes.  
  - There was no standardized approach to BCC, while IEC materials had been developed, this often lacked target segmentation. Media effectiveness and reach was not assessed.  
  - Other target groups were left out of the strategy development e.g. young people with disabilities, living on the streets, young people in correctional facilities and adolescent parents further compromising reach of the more vulnerable and underserved populations.  
  - **Life skills and livelihoods**: This aimed to build capacity and mobilise demand and required teachers to have up to date information on SRH to be able to serve young people particularly in difficult circumstances. Integration of livelihood skills has lagged behind. However, the development of the Life Skills, Sexuality and HIV/AIDS Strategic Plan: 2010-2015 was hoped to strengthen delivery  
  - **ICT platforms like WhatsApp, Facebook** were seen as promising innovations in programming for adolescent and young people. Access was limited by limited resources. |
| Service Delivery | |
| a. Health Facility Based Approach | **Youth friendly corners**: Aimed to improve access to ASRH information, Clinical and counseling services.  
  - The assessments revealed weak referral system from lower level facilities. Affordability was a major challenge as young people lacked means to access the centres resulting in low service utilisation. Services were also utilised more b those geographically close to the service facilities. Availability was compromised by inadequate staffing, staff attitudes not youth friendly and shortage of FP commodities and STI supplies.  
  - The assessments showed that for YFCs to be effective, the whole health facility has to be youth friendly. capacity building needs to be facility wide: Current YFCs were found to be ineffective and costly. |
| b. Community based approach | **Community Youth Centres**: The approach had linkages to private pharmacies, ASRH drop in clubs and was aimed to inculcate knowledge and skills on ASRH-R issues and enhanced leadership within culturally diverse communities. Youth centres offered clinical services and use peer educators.  
  - Despite being a popular strategy evidence shows that youth centres were not cost effective for increasing uptake of SRH services among adolescents.  
  - Services were mostly used by a relatively small proportion of young people who lived nearby, mostly male. Youth centres were mainly frequented for recreation purposes. The cost per beneficiary was very high. The centres were used more for recreational purposes, limits girls seeking sensitive health information or services. |

17 JHU: Evaluation of ASRH services in Zimbabwe  
18 ASRH MTE 2014  
19 Providing ASRH services: what we know: Donna Denno et al. Searching journal content for Venkatraman Chandra-Mouli in author.  
20 Johns Hopkins School of Public (JHU): Review of ASRH Interventions in Zimbabwe  
21 Providing ASRH services: what we know: Donna Denno et al., “Effective strategies to providing ASRH services to increasing demand and community support,” Journal of Adolescent Health, Jan 2015  
23 Mid Term Review of the National Adolescent Sexual and Reproductive Health (ASRH) Strategy: 2010 - 2015  
24 What Does Not Work in ASRH: Review of Evidence on Interventions Commonly Accepted as Best PracticesVenkatraman Chandra-Mouli,a* Catherine Lane,b* Sylvia Wongs
<table>
<thead>
<tr>
<th>Approach</th>
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</tr>
</thead>
<tbody>
<tr>
<td>c. Peer education:</td>
<td>Popular strategy but effectiveness was undermined by limited resources, poor support, weak linkages between peer educators and other community cadres and limited access by young people including those living in special circumstances, disabled, living in the streets and PLHIV. Approach was ineffective at improving sexual and reproductive health outcomes ((Data on the effectiveness of such services is limited). Cost per beneficiary very high.</td>
</tr>
<tr>
<td>d. School based approach</td>
<td><strong>Life skills education:</strong> carried out in schools where the youth create HIV clubs, guidance and counselling clubs and implemented peer education. ZNFPC’s equipped YFC and supplied clubs with resources. The Life Skills, Sexuality and HIV and AIDS Education Strategic Plan; 2012 – 2015 was launched. It was viewed as a promising strategy but there was limited evidence of effectiveness as the approach was not fully implemented. School based approaches also carried out innovative approaches with ITC.</td>
</tr>
</tbody>
</table>
| Policy and advocacy | • The Life Skills, Sexuality, HIV and AIDS Education Strategic Plan 2012 - 2015 was a policy initiative for the Ministry of Primary and Secondary Education; The strategy was used as resource material for the development of (ZNASP II) allowing incorporation of SRH issues for adolescents and young people; It was used to support the review of the National Youth Policy development.  
• Stakeholders highlighted the lack of policy to enforce registration and accreditation of ASRH serving organisations; this was said to be important in ensuring harmonization of the programme strategies and messages to adolescents and young people.  
• There was inadequate dissemination of national policies and strategies leading to stakeholders not being aware of the policy issues and resulting in poor application; Concerns were raised on the guidelines on age of consent in situations when the adolescent was already engaged in sex and personnel were said to often use discretion and required approvals at the local level.  
• The strategy was not inclusive of all the underserved and marginalized adolescent and young population groups. |
| Networking and Coordination | • **The review found weak coordination as a major challenge** for the national ASRH forum. Forum members had corroborated this weakness sighting lack of clarity on coordination at the sub national level and unclear terms of reference for the steering committee and the ASRH forum.  
• There was limited participation of young people in ASRH programming (including programme and policy designing) though the formation and inclusion of the youth network had resulted in stronger communication and involvement of the young people.  
• Harmonisation and coordination between the Ministry of Health and Child Welfare and other line ministries, policy makers, ASRH serving organisations, research institutions, young people, parents, teachers and communities was till limited particularly at the sub national level.  
• Thematic coordination not working, at sub national level. There were no clear lines of communication. |

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26 Providing ASRH services: what we know: Donna Denno et al; Venkatraman Chandra-Mouli et al.

<table>
<thead>
<tr>
<th>Approach</th>
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</tr>
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<tbody>
<tr>
<td></td>
<td>• Some critical stakeholders were left out of executive committee resulting in poor communication and participation in planning and resource leveraging of ASRH issues.</td>
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<td></td>
<td>• Referral system within ASRH at service delivery level was not used though more supportive to curative services. Implementation depended on strength of organisation and strategy lacked clear decentralization plan.</td>
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<td></td>
<td>• The review recommended the revision of the TORS for the ASRH forum to strengthen accountability of thematic leads and to maintain stronger linkages between the ASRH Coordination forum and the Reproductive Health Steering Committee and other ASRH related committees and fora at the different levels.</td>
</tr>
<tr>
<td>Cross-cutting strategies</td>
<td><strong>Parent to child communication</strong> was undermined by inadequate scale of awareness. The development of a Parent-Child Communication Package and the National ASRH Advocacy Package will unpack the roles and responsibilities of parents, guardians and communities in promoting the SRH Rights and needs of young people. These two materials had not yet been operationalized at the time of this process and hence cannot draw any lessons.</td>
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<td></td>
<td><strong>Meaningful participation of young people</strong></td>
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<td></td>
<td>• While the young people’s network is one way of ensuring youth participation within the strategy, it was not very effective in reaching out to young people at grassroots level who are not affiliated to any institution.</td>
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<td></td>
<td>• There was a need for an assessment of the Young People’s Network, other Youth Associations as strategic opportunities and structures for promoting meaningful participation of young people in SRH Programming.</td>
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<td></td>
<td><strong>Gender mainstreaming</strong></td>
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<td></td>
<td>• Efforts to mainstream gender issues in programming and training of peer educators were noted though the assessment noted that the community approach was negatively skewed towards the girl child. This leaves the boys behind weakening the strategy.</td>
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<tr>
<td></td>
<td>• Access to peer based ASRH in the community youth centres for girls was limited by parental restrictions. Facilities were therefore more utilised by boys for sports such as soccer, further discouraging girl participation. Girls also spent limited time to attend center activities.</td>
</tr>
<tr>
<td></td>
<td>• There was limited orientation and guidance on gender mainstreaming in ASRH for stakeholders</td>
</tr>
<tr>
<td></td>
<td><strong>Monitoring and Evaluation:</strong> The evaluation also found that there was no standard M&amp;E system. NIH was not sensitive to conventional adolescent age group 10-24 further weakening documentation and dissemination of information within the forum and for the different stakeholders.</td>
</tr>
<tr>
<td></td>
<td>• There was need for evidence based programming and standard mandatory guidelines for reporting for all ASRH partners.</td>
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</tbody>
</table>
3. Rationale for the Strategy 2016-2020

The 2016 – 2020 ASRH strategy is a follow-up to the 2010-2015 strategy. During the five years strategy implementation period, new developments have occurred both nationally within the dynamic environment adolescents and young people live and globally influencing trends in the challenges the adolescents and young people face.

Furthermore, given the multi sectoral nature of the response strategies and diversity of the target population and their needs, this framework provides the multi stakeholders a guide within which to effectively respond to the ASRH challenges. Empirical evidence also shows that the situation of young people requires significant innovations. The new strategy will implement such innovations ensuring effective engagement of the adolescent and young people and challenging the status quo in policy alignment, the gender dimension, and the socio cultural impacts of ASRH. While the previous strategy had achieved some significant results, more effort is required to impact on the challenges facing adolescents and young people. Furthermore, not all planned activities for the 2010-2015 were completed. This second generation strategy will aim to achieve some of the pending targets and outstanding issues. There are also changes in the body of evidence from research on what works as well as expanding the scale and reach of interventions.

4. ASRH Strategy 2016-2020 Strategy Development Process

The ASRH Strategy 2016-2020 was developed using a participatory approach that encompassed two stakeholder consultation workshops for content development and one validation workshop. Young people representatives actively participated in the development process and provided useful insight that have enriched the document.

Technically, the ASRH Strategy development process included a review of a combination of local and
international approaches and experiences from a wide range of countries and organisations including relevant UN agencies, development partners, government ministries and departments and civil society. The process also included a review of research findings and recommendations, programme reports and literature. An Excel tool was developed and used to collate and analyse the findings of the literature review, particularly, the challenges, causal factors and the strength of the evidence available on intervention approaches articulating “what works and does not work” focusing on target populations, programming effectiveness and structural issues.

A sample of ASRH projects being implemented across the country by NGOs and development partners) were also reviewed and evidence on promising interventions analyzed. A problem tree analysis tool was utilised to identify key ASRH problems causality factors and impacts on the adolescents and young people. This resulted in the development of the Theory of Change and Results Framework.

Operational, governance, coordination issues were analysed using a SWOT analysis (strengths, weaknesses, opportunities and threats).

5. Theory of Change for the ASRH Strategy

The Theory of Change for the ASRH strategy 2016-2020 is summarized in Figure 3. It was developed after articulation of the problem tree presented in Annex 4. The strategy’s overarching theory of change is that, 

“if 1) knowledge of ASRH and associated risks is increased among adolescents, young people; 2) adult and family and youth economic security is promoted; 3) an adequate, accessible, youth friendly and quality supply of ASRH services is maintained; and 4) an enabling policy and regulatory environment is achieved then adolescents and young people will experience less adolescent pregnancies, pregnancy complications, HIV and STD infections.”

The theory of change therefore identifies: (1) poverty, (2) lack of access to information on ASRH, (3) inadequate and relevant service delivery and (4) inadequate policy, and regulatory framework, as the major drivers for ASRH challenges facing adolescents and young people in Zimbabwe. Addressing these challenges will provide a solution pathway that leads to an environment that is more supportive and cares for ASRH at the family, community and institutional levels. It is this supportive framework that provides an enabling environment for adolescents and young people to change behaviours and begin to seek ASRH services, engage in safer sexual and reproductive practices leading to reduced number of adolescent pregnancies and their complications, and reduction in new HIV and STI infections. Child marriages and sexual abuse of boys and girls are recognised as immediate causes of adolescent pregnancies and HIV and STI transmission in localities where such incidences are high.

The interconnectedness of the challenges and solution pathways clearly demonstrates the multi-sectoral and integrated nature of this strategy and the inadequacies of implementing the proposed strategy in silos. For example, literature shows that household poverty predisposes adolescent girls to child marriage as the boy child is prioritised for education from the little resources available in the household. When the girl child drops out of school, the chances of being married off increases. In this instance, addressing social drivers for child marriages alone will not be adequate. Inversely, research from CAMFED shows that when girls return to school well-dressed their visibility increases and this attracts the attention of older men. If the girl child is not empowered with life skills and SRH knowledge to build their self-efficacy and worth, this support can actually have the negative effect of increasing the girls’ SRH risks.

29 The 2012 census shows that teen marriages are closely linked with the school drop-out. xx
Figure 1: Theory of Change for the ASRH Strategy 2016-2020

Reduced Teen Pregnancies:
- Delayed sexual debut
- Reduced child marriages
- Reduced School drop-outs especially among girls
- Reduced household poverty
- Improved economic empowerment

Reduced new STD and HIV infection:
- Decreased sexual violence among girls and boys
- Increased self efficacy and self-worth among girls and boys
- Increased access to justice for sexual violence cases against adolescents and young people
- Increased awareness and knowledge among adolescents, young people and adults of HIV, STI, pregnancies, and other life skills
- Increased knowledge dissemination on ASRH and HIV to young people, adolescents, young people and adults

Reduced pregnancy complications:
- Increased consistent and correct use of STD and HIV prevention services, and FP methods
- Increased availability of quality youth-friendly integrated ASRH and HIV services
- Increased affordability of quality youth-friendly integrated ASRH and HIV services
- Increased utilisation of ANC, delivery and PNC services
- Strengthened ASRH policy and legislative environment
- Strengthened protective systems for securing ASRH rights
- Strengthened plans, programmes and budgets for delivery of youth friendly ASRH services
5.1 Solutions pathways

This section presents the rationale for the selected solutions pathways of the programme as presented in the Theory of Change. No one single pathway will lead to the envisaged outcomes as all pathways are interlinked.

Solution pathway 1: Economic empowerment of families, adolescents and young people will lead to reduced school drop outs and harmful behaviours that increase vulnerability to ASRH risks among young people and adolescents.

Household and youth poverty leads to a variety of challenges that tend themselves to increasing the vulnerability of adolescents to sexual and reproductive health risks. For example, the MICS (2014), DHS (2010) and Census (2012) show that girls in poorer families are likely to drop out of school which increases their risk of either getting married or falling pregnant. The Zimbabwe Youth Investment Case of 2015, found that high unemployment among youths and subsequent idleness was contributing to increasing cases of drug, substance and alcohol abuse among adolescents and young people. Such practices increase the risk of young people participating in unsafe sexual practices which exposes them to STDs, HIV and unwanted pregnancies. The same report also finds that due to youth poverty, an increasing number of adolescent girls and young women were getting enrolled in commercial sex work especially in poor urban locations. This again increases their vulnerability to sexual and reproductive health infections and adolescent pregnancies. Addressing both youth and family poverty will contribute to keeping more adolescents in school and thus avoid risky behaviour such as drug and substance abuse which increase vulnerability of adolescents and young people. Youth poverty also undermines access of adolescents and young to ASRH services such as treatment for STDs, HIV testing, contraceptives and condoms to prevent STI prevention.

Thus reducing household and youth poverty directly contributes to addressing SRH challenges for AYP. Less poor AYP are less vulnerable to the risks of SRH.

Solution pathway 2: Increased knowledge dissemination on ASRH and HIV to adolescents, young people and adults will lead to higher risk perception among AYP and reduced religious, cultural and social norms among adults that increase vulnerability of adolescents to ASRH risks.

Young people often do not seek information or care, because they believe that they are at little or no risk of health problems. Misinformation among adolescents and young people leads to misconceptions about health care and use of contraceptives and their side effects. Therefore, availability of correct and comprehensive information is important to aid adolescents and young people make the right life choices. If the messaging is focused on facilitating behaviour change and social mobilization studies have shown that such initiatives can greatly reduce vulnerability of AYP to ASRH risks. A review of 21 high quality interventions aimed at reducing teenage pregnancy in low and middle income countries found that those that had a visible impact incorporated strong information dissemination and social mobilisation. Similarly in Kenya, interventions with intensive knowledge dissemination and strong peer to peer support also had a visible impact on increasing knowledge and contributing to safer sexual and reproductive health practices among adolescents and young people. Evidence from Kenya shows that knowledge dissemination can be effective in this regard if: (1) multiple channels of information are used that reach in-school and out of school adolescents and young people (including the most at risk); and (2) age appropriate information dissemination approaches are adopted. Findings of the Zimbabwe Youth Investment case also show that appropriate knowledge dissemination using channels, especially those that are peer based, has potential to improve safer sexual practice among University students.

Increasing knowledge, especially life skills has been shown to increase self-efficacy, self-worth and confidence among adolescents and young people. For boys this knowledge can empower them to avoid sexual objectification of their female counterparts which can contribute to reducing sexual violence. For example, anecdotal evidence from the evaluation of the SYP funded by UNFPA in Zimbabwe revealed that girls were often abused by cattle herders who are often adolescents and boys and young men. This abuse mainly stems from the objectification of females. On the other hand increasing self-efficacy and worth of adolescent girls and young women has the potential to increase their capacity to avoid and also report cases of sexual abuse which both contribute to reduction of sexual abuse of girls. While there is an evident link between increasing knowledge and

30 Solutions pathways are the broad means of achieving the intended outcomes.
31 (e.g. increasing youth participation in ASRH programmes)
34 M Chiwco (2016) Zimbabwe Youth Investment Case Study: Key Findings. A research report prepared for the Zimbabwe Youth Council.
life skills and reduction in sexual violence, there is limited evidence that supports this link. It is important to reduce sexual violence of girls and boys because it directly contributes to STDs, HIV infections and adolescent pregnancies in addition to other reproductive health ills.

Negative religious, cultural and social norms and beliefs premised on ignorance of and misinformation on ASRH are also a significant factor. It is well known that these norms and beliefs lead to social conditions that drive adolescents’ and young people’s continued SRH challenges. These include:

1) Adolescent girls being married off with disregard to the SRH challenges they will face in such arrangements;
2) an environment that regards discussing or accepting adolescents sexual and reproductive as taboo and where adolescents and young people who seek ASRH services are stigmatized;
3) social conditions where some adolescents and young people, particularly girls, must seek permission from a parent or spouse before they can access reproductive health services; and
4) An environment where parents are ill prepared to discuss SRH issues with their children.

A global study conducted by the WHO to understand drivers of adolescent pregnancies as part of the process of developing global guidelines on prevention of adolescent pregnancies finds that negative norms and beliefs are major drivers of child marriages which in turn increase adolescent pregnancies. The equity atlas of Zimbabwe, drawn from the 2012 census data, shows that adolescent pregnancies are highly prevalent in areas where teen marriages are high. Thus reducing child marriages directly contributes to reduction in adolescent pregnancies and associated health risks. The WHO guidelines for prevention of early pregnancy, through a systematic research of evidence of various interventions, identified increasing knowledge on ASRH among adults and leaders, coupled with community mobilisation as a relevant strategy to address child marriages and raise community support for ASRH. In Nepal for example, using participatory behaviour change messaging, CARE International was able to reduce child marriages by between 10-20% over a three year period.

In Zimbabwe, the impact assessment of ASRH interventions funded by UNFPA and implemented by MoHCC and ZNFP, showed that increasing awareness of ASRH among communities and their leaders combined with community mobilisation can lead to increased community support for ASRH. This support buoyed by increased knowledge of ASRH, also contributes to improved parent-child communication on issues of SRH. However, the evidence on the links between knowledge dissemination and community behaviour change and community support for ASRH is not yet conclusive. More research on understanding the links is still required.

Solution Pathway 3: Improved availability of integrated HIV and ASRH services in adolescent localities will lead to increased utilization of HIV and ASRH services

Availability of health services that provide appropriate care for adolescents and young people is a major contributor to limited use of SRH and HIV services in the Zimbabwean context. The mid-term review (conducted by JIMAT Development Consultants) and end line evaluation (conducted by John Hopkins) of the previous ASRH strategy (2010-2015) all show that availability of appropriate SRH services for adolescents and young people still remain a challenge and is contributing to adolescents and young people’s lack of access to these services. Young people reported that they did not use the facilities as the nursing staff would deny them some services because of their age as they would shout at them. The Zimbabwe Youth Investment Case also supports these assertions as it found that “availability of youth friendly Health Services is generally poor”. The same study also noted that “Stigmatisation of adolescents and young people with HIV or STDs by health personnel was reported

35 WHO (2011) WHO Guidelines on Preventing Early Pregnancy and Poor Reproductive Outcomes Among Adolescents in Developing Countries.
to be widespread in rural clinics”. All these factors were limiting adolescents’ and young people’s access to ASRH services. Therefore increasing availability of quality youth friendly ASRH services will likely contribute to increasing adolescents’ and young people’s access to ASRH and HIV services. Research shows that implementing interventions such as the following will increase adolescents’ and young people’s access to ASRH services:

1) Identifying and integrating young people’s preferences and needs regarding clinic hours, location, types of services, and costs;
2) Involving youth, families, and community members in designing, implementing, and evaluating programs;
3) Establishing protocols, guidelines, and standards to help providers better serve youth; and
4) Providing a low-cost approach to increasing adolescent use of existing clinical services.

For example, introducing youth friendly service in Zambia led to an increase in the number of adolescents and young people using reproductive health services. In two pilot clinics in Lusaka, adolescents and young people who used family planning tripled over one year.

Supporting availability of youth friendly health care services, while having the potential to increase uptake of services, it might have a disproportional effect on girls and young women if other supportive measures are not included that create an environment for girls to access services.

**Solution Pathway 4: Strengthened ASRH policy and legislative environment leads to better safeguards for adolescent and young people’s sexual and reproductive health rights.**

Policies and legislation that support adolescent sexual and reproductive health are important to support achievement of SRH goals for this group. There is still weak evidence on what policies and legislation work. For example the WHO global review of research on policies and legislation that address adolescent pregnancies found no conclusive evidence on the right policy and legal mix that can facilitate reductions of adolescent pregnancies. However, it was clear that policies and legislation do contribute to improvements in the sexual and reproductive rights of adolescents and young people which are in turn important to: galvanise community support for ASRH (including community by-laws); increase access to and provision of quality youth friendly health service delivery; and foster better protection of adolescents from abuses that expose them to sexual and reproductive ills such as adolescent child marriages, and sexual abuse.

### 5.2 Assumptions underpinning the Theory of Change

Achievement of the solution pathways is underpinned by several assumptions which include:

- Availability of adequate resources to support implementation of a comprehensive approach to addressing ASRH and HIV;
- Ownership of the strategy by implementing partners (donors, young people, NGOs, and development partners);
- Ownership of the interventions at provincial and district levels leading to availability of adequate supportive supervision of health workers, enhanced coordination and linkages for comprehensive support at the community level; and
- Community environment is supportive of ASRH, giving opportunities for adolescents and young people to make personal choices (underpinned by free participation in learning platforms for both boys and girls).

### 6 Results Framework

This section presents the results framework for the strategy. It lays out the envisaged impact, outcomes and outputs. Strategies to achieve this results framework are also presented.

#### 6.1 Impact, Outcomes and Outputs of the Strategy

The results framework is summarized in Figure 2.

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37 Creel L. C., Perry R. J. (2002) Improving the Quality of Reproductive Health Care for Young People
38 Creel L. C., Perry R. J. (2002) Improving the Quality of Reproductive Health Care for Young People
39 WHO (2011) WHO Guidelines on Preventing Early Pregnancy and Poor Reproductive Outcomes Among Adolescents in Developing Countries
Figure 2: Results framework for the ASRH strategy

Impact: Improved sexual and reproductive health of adolescent and young people

Outcome 1: Increased safe sexual and reproductive health among adolescents and young people
  - Output 1.1: Increased correct and comprehensive knowledge of HIV, STIs, Family planning, ANC, delivery and PNC among adolescents and young people
  - Output 1.2: Improved life skills among adolescents and young people

Outcome 2: Increased uptake of quality youth friendly integrated SRH and HIV prevention services
  - Output 2.1: Increased availability of quality youth friendly integrated SRH and HIV services
  - Output 2.2: Increased affordability of quality youth friendly integrated SRH and HIV services

Outcome 3: Strengthened protective environment for adolescents and young people
  - Output 3.1: A policy, legal and institutional framework that protects the SRHR of adolescents and young people is in place and enforced
  - Output 3.2: Increased community and youth participation in ARH and HIV programmes
  - Output 3.3: Increased parent to child communication
The impact statement for the strategy is “**improved sexual and reproductive health of adolescent and young people in Zimbabwe**”. Achievement of this impact is measured through reduced pregnancies and their complications, and reduction in new HIV and STDs infections. Three outcomes have been identified to contribute to this impact as follows:

- **Outcome 1**: Increased safe sexual and reproductive health and HIV practices among adolescents and young people;
- **Outcome 2**: Increased uptake of quality youth friendly integrated SRH and HIV services; and
- **Outcome 3**: Strengthened protective environment for adolescents and young people.

Seven outputs will contribute to the identified three outcomes presented in Table 4.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Output</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome 1</strong>: Increased safe sexual health and HIV practices among adolescents and young people</td>
<td><strong>Output 1.1</strong>: Increased correct and comprehensive knowledge of HIV, STDs, and pregnancies among adolescents and young people</td>
</tr>
<tr>
<td></td>
<td><strong>Output 1.2</strong>: Improved life skills among adolescents and young people</td>
</tr>
<tr>
<td><strong>Outcome 2</strong>: Increased uptake of quality youth friendly integrated SRH and HIV services – Factor in accessibility not just affordability and availability</td>
<td><strong>Output 2.1</strong>: Increased <em>availability</em> of quality youth friendly integrated SRH and HIV services</td>
</tr>
<tr>
<td></td>
<td><strong>Output 2.2</strong>: Increased <em>affordability</em> to quality youth friendly integrated SRH and HIV services</td>
</tr>
<tr>
<td><strong>Outcome 3</strong>: Strengthened protective environment for adolescents and young people</td>
<td><strong>Output 3.1</strong>: A policy, legal and institutional framework that protects the SRHR of adolescents and young people is in place and enforced</td>
</tr>
<tr>
<td></td>
<td><strong>Output 3.2</strong>: Increased community support for ASRH and adolescent HIV programmes</td>
</tr>
<tr>
<td></td>
<td><strong>Output 3.3</strong>: Improved Parent to child communication on SRH and HIV issues</td>
</tr>
</tbody>
</table>

The results framework can be summarised into four result areas which in turn frame the ASRH aspects addressed in the M&E Framework:

a. **Enabling Environment**: describes the needed resources and environments for ASRH programming. Strengthened commitment, partnerships and accountability to plan, budget, finance and monitor the scale-up of low-cost evidence-based ASRH and HIV interventions targeting adolescents and young people.

b. **Supply**: National, provincial, district, community and households are able to provide high quality youth-friendly SRH and HIV (addresses accessibility issues: availability, affordability, adaptability, adoptability, etc. of services)

c. **Demand**: Adolescents and youth are able to seek and utilize high quality and equitable youth-friendly SRH and HIV services.

d. **Quality**: High quality of SRH and HIV services for adolescents and youth is maintained and improved (Quality issues are cross-cutting and can be incorporated in enabling environment, demand and supply issues)
6.2 Guiding Principles for the ASRH Strategy 2016-2020

The ASRH strategy is intended to guide MOHCC, other government departments and ministries, policy makers, civil society and development partners in the provision sexual reproductive health services to adolescents and young people aged 10 and 24 years in Zimbabwe. It aims to provide age appropriate quality, affordable and appropriate sexual and reproductive health services to young people of Zimbabwe. It also provides guidelines to relevant parastatals, policy makers, various line ministries, non-governmental organisations and communities for the period 2016-2020. The strategy seeks to adopt a preventive, promotive, curative and counselling service approach for young people.

The Guiding Principles include:

i. Respect for human rights: Provision of SRH services to young people from a human rights and developmental approach.

ii. Integration of life skills and livelihood programmes into SRH programmes is vital for sustainable SRH behaviour change.

iii. Gender and cultural sensitivity is fundamental in ASRH programmes, to ensure equal access and acceptability of social services and opportunities by adolescents and young people.

iv. Adopt evidence-based, participatory and multi-sectoral approaches to ASRH programming that are effective and efficient.

v. Ensuring meaningful and active participation of young people at all levels. Responsiveness to varying Sexual and Reproductive Health needs of adolescents and young in provision of ASRH services.

vi. Recognition of the critical role parents, guardians and communities play in the promotion of SRH for adolescents and young people.

vii. Effective engagement of adolescents and young people in results oriented planning, implementation, monitoring and evaluation of ASRH programs and fostering partnerships for achievement of mutual goals.

viii. Foster accountability and transparency at all levels.

7. Strategies of the ASRH Strategy 2016-2020

The ASRH Strategy 2016-2020 is primarily a prevention strategy. Within this context, special groups such as those already infected with HIV and STDs will be supported to realise their SRH rights through empowerment and treatment in a way that enables them to make better life choices and avoid new infections. Teenage girls already in marriage or pregnant will be supported to avoid repeat pregnancy and pregnancy complications.

The ASRH Strategy will achieve the impact results by implementing the following key strategies/interventions.

7.1 Outcome 1: Increased safe sexual health practices among adolescents and young people

**Under output 1** the main objective is to increase risk perception and risk averse behavior among adolescents and young people. The strategy aims to increase intensity, quality and availability of information and knowledge on ASRH to influence behaviour change with regards sexual practice and SRH service utilisation. It recognises that for this change to happen information is required through multiple channels that are able to reach the generality of and those most at risk among adolescents and young people. Ensuring adolescents and young are reached in different localities and that ASRH is integrated in the health delivery system at the community level thus expanding opportunities for reaching adolescents and young people are some of the strategies proposed to achieve reach. Strengthening the capacity of Civil Society Organisations (CSOs), Youth Serving Organisations and Faith Based Institutions to provide integrated ASRHR and HIV services is a critical strategy to ensure extended reach. Integration of ASRH knowledge and information dissemination in non-health youth focused programmes will also enable the expansion of reach of adolescents and young people.

All these strategies are underpinned by the development of standardised information packages that provide comprehensive and age appropriate knowledge that are delivered using appropriate approaches for reaching adolescents and young people.

Special groups such as adolescents living with HIV and those that are pregnant require specific information to help them in their circumstances. The strategy promotes a combination of peer based approaches (e.g. support
groups) and other channels of information supplied through different service providers. These approaches will also serve as referral platforms for other special services e.g. Anti-Retroviral Therapy (ART) for adolescents and young people, access to justice and health services for survivors of sexual abuse, and Antenatal Care (ANC) and Post-natal Care (PNC) for pregnant adolescents and young people.

**Under output 2**, the strategy aims to empower the adolescents and young people with life skills that help to build their self-efficacy, confidence and other skills important to avoid risky behaviour and influences of peer pressure. The specific strategies include ensuring that the training materials are comprehensive and standardised and that they are evaluated with lessons being used to improve their content and delivery. The strategy promotes innovative methods for reaching separate groups of boys and girls with life skills and other ASRH information. These innovations need to be rigorously evaluated for effectiveness and value for money. Those that present the best value for money and can be easily scaled at reasonable cost will be supported for scale up.

<table>
<thead>
<tr>
<th>Output</th>
<th>Strategies/Interventions</th>
</tr>
</thead>
</table>
| **Output 1.1: Increased correct and comprehensive knowledge of HIV, STDs, Family planning, ANC, delivery and PNC among adolescents and young people** | S1.1.1: Support implementation, monitoring and evaluation of the Comprehensive Sexuality Education (including drug and substance abuse among adolescents) programme and in and out of school youths.  
S1.1.2: Strengthen ASRH (including family planning) and HIV education in higher and tertiary institutions’ curricula.  
S1.1.3: Explore the use of mass media to raise awareness of key ASRHR issues (TV, radio, mass advertisements, etc.).  
S1.1.4: Strengthen formal and informal peer based approaches and mentorship programmes that integrate ASRH and HIV in schools, tertiary institutions and in the community that increase participation of boys and girls, vulnerable adolescents and spousal communication. Implementers will be supported by a redesign of the current peer education model to make it result oriented especially at the local level with regards to setting targets for reach of adolescents and young people with SRH information and services. In this regard the strategy will facilitate development of: 1) a comprehensive peer educator’ training, replacement and monitoring policy that guides recruitment, training and supervision of peer educators; and 2) a results based performance measurement system for peer educators.  
S1.1.5: Strengthen capacity of CSOs, Youth Organisations, Youth Serving Organisations and Faith Based Institutions to provide integrated ASRHR and HIV services.  
S1.1.6: Implement innovative messaging approaches such as social media, edutainment, Edu-sports U – report etc. that remove stigma and increase demand for ASRH and HIV service utilisation.  
S1.1.8: Pilot supporting existing community health workers to provide information to pregnant adolescent girls and young women to empower them with knowledge about the pregnancy and avoiding repeat pregnancy. Initiatives such as support groups can be considered. |
| **Output 1.2: Improved life skills among adolescents and young people** | S1.2.1: Pilot and review innovative approaches for enhancing boys’ and girls’ life skills and self-efficacy and ‘adolescents agency’ i.e. “cognitive tools, including insights, precepts, knowledge, and action schemas that youth might employ to help them achieve goals.”  
S1.2.2: Implement and evaluate efficacy of the ASRHR training manual for adolescent (Health service providers)  
S1.2.3: Strengthen linkages with sustainable livelihoods programmes according to their needs in a bid to reduce vulnerability of female adolescents and young women as well as their male counterparts.  
S1.2.4: Strengthen programming on adolescent at risk populations and drug and substance abuse among adolescents such as drug users, children sexually exploited and in conflict with the law etc. |
7.2 Outcome 2: Increased uptake of quality youth friendly integrated SRH and HIV services

Under output 2.1 the aim is to increase the availability of quality youth friendly integrated SRH services. For effective service provision there is need to train personnel and improve their capacity to manage the logistics and supplies for the services. The guidelines and training manual exist to facilitate the process. Resources are needed to ensure the supply chain is not broken. Facilities that are accredited for ART provision need well trained personnel to screen and initiate ART. Advocacy for treatment adherence is an integral component of the interventions. Contraceptive commodity distribution needs to be linked to strengthened social mobilization and improvement in quality of services if youth are to access them.

Output 2.2 aims to increase affordability of quality youth friendly services. The strategy identifies through mapping exercises adolescent localities and the target groups particularly those in underserved and hard to reach areas. The at risk populations (living with disability, HIV positive, living on the street sex workers, young prison inmates, etc. are particularly targeted) Using evidence base, appropriate and cost effective methods and approaches are prioritised to ensure maximum access (e.g. establishing secondary delivery points using existing infrastructure, mobile outreach and decentralized services such as HIV testing). This is aimed to reduce service utilisation costs for the youth the majority of whom are unemployed with no other livelihood options. Training of staff in monitoring ad evaluation (M&E) will be an important intervention to ensure data generation and utilisation for local decision making and dissemination. Through efficient monitoring, at risk population groups are identified and particular effort made to improve their access to service. This includes counselling and care for adolescent indulging in drug and substance abuse.

ANC, MTCT, PNC

Strong SBCC on the importance of maternal care for pregnant adolescent and young people will be a critical component for them to use these services and increase the chances of reducing pregnancy complications as well as repeat pregnancy.

An innovative initiative is to pilot supporting existing community health workers to provide information to pregnant adolescent girls and young women to empower them with knowledge about the pregnancy and avoiding repeat pregnancy. Support groups will be considered for this initiative. The strategy advocates for strengthened Emergency Obstetric Care (EmoC) services to increase access and improve management of pregnancy complications.

Adolescent access to ART and STIs treatment

Almost half of the adolescent and young people in need of ART are not accessing the services. The strategy advocates for decentralized HIV and TB service and increasing the service points as well as leveraging public private sector partnerships and resources to reach more youths. For cost effectiveness the services are comprehensive and integrated. Advocacy for strengthened 1) HIV integration in school, community and the health facility; 2) ASRH and HIV awareness to facilitate HIV testing (consent for under 16 years) and counselling; 3) identification of adolescents in need of ART; 4) support for adherence to ART; 5) STD screening; and 6) other psycho-social support service will be intensified to increase service uptake.
## Capacity of adolescents to demand services

The strategy aims to build capacity of adolescents and young people to demand ASRH and HIV services through strengthening abilities of youth serving organisations to outreach, build evidence and advocate for better service delivery.

<table>
<thead>
<tr>
<th>Output</th>
<th>Strategies/Interventions</th>
</tr>
</thead>
</table>
| Output 2.1: Increased availability of quality youth friendly integrated SRH and HIV services | S2.1.1: Support capacity building of health service providers to provide facility wide youth friendly integrated SRH and HIV services according to the Guidelines on Youth Friendly Service Provision (including alignment of services to the Multi-Sectoral Protocol on the Management of Sexual Abuse in Zimbabwe).  
  
S2.1.2: Advocate for no stock outs for ASRH commodities (Contraceptives and condoms, STD treatment drugs, age appropriate ART).  
  
S2.1.3: Advocate for increased distribution of contraceptive and STI commodities and products in adolescent localities by existing programmes taking cognisant of the best interest of the child. |
| Output 2.2: Increased affordability of quality youth friendly integrated SRH and HIV services | S2.2.1: Expand youth friendly integrated ASRH and HIV services to the hard to reach areas and underserved at risk populations (living with disability, HIV positive, living on the street, etc.) using appropriate and cost effective methods (e.g. establishing secondary delivery points using existing infrastructure, mobile outreach and decentralising services such as HIV testing).  
  
S2.2.2: Strengthen enrolment of adolescents (including those HIV positive) in current national ART, PMTCT, Counselling and VMMC programmes by creating treatment.  
  
S2.2.3: Advocate for decentralised adolescent ART and STD treatment services in private and public sectors.  
  
S2.2.4: Advocate for adolescent access to HIV TB services.  
  
S2.2.5: Improve data generation and dissemination on adolescent at risk populations and drug and substance abuse among adolescents.  
  
S2.2.6: Lobby policy makers to create an environment which allows for adolescents and young people use ASRH services |

### ANC, MTCT, PNC

S2.2.7: Create awareness among adolescent girls and young women and their communities on the importance for ANC (especially early registration), MTCT, facility-based delivery and PNC.  
  
S2.2.8: Pilot supporting existing community health workers to provide information to pregnant adolescent girls and young women to empower with knowledge about the pregnancy and avoiding repeat pregnancy. Initiatives such as support groups can be considered.  
  
S2.2.9: Advocate for decentralised Emergency Obstetric Care (EmoC).

### Adolescent access to ART STDs treatment

S2.2.10: Strengthen HIV integration in school, community and facility based ASRH and HIV awareness to facilitate HIV testing (consent for under 16 years), counselling, identification of adolescents in need of ART, adherence to ART, STD screening and other psycho-social support service.
7.3 Outcome 3: Strengthened protective environment for adolescents and young people

Output 3.1 calls for a strengthened protective environment through implementing policies and ensuring a legal and institutional framework that protects the ASRH rights and prevent stigma and discrimination of adolescents and young people infected or affected by HIV. Community leadership, parents and duty bearers are targeted for awareness on ASRH rights and responsibilities and ensuring rights violations are sanctioned. Community leadership are also targeted to champion the underlying causes of ASRH problems that affect youth and protection of ASRH rights. Communities are also mobilised to create awareness about the statutory instruments and laws that deal with issues of child marriages, gender based violence, children’s charter etc. and duty bearers engages in the advocacy and communication to create a protective environment for adolescents and young people.

Output 3.2: Community dialogue structures will be established and utilised to dialogue/communicate on ASRH and HIV challenges (including child marriages and sexual violence) in target communities. Traditional and religious leaders, ordinary community members are empowered to advocate for support adolescent use of ASRH and HIV services. Dialogue sessions and community engagement is also used to strengthen linkages between broader health programmes and ASRH and HIV in the community (e.g. involving community based health workers in ASRH programming and linking community health workers with peer educators on ASRH). Community dialogue structures are also designed to engage communities on ways address drivers for child marriage and galvanise support for harmonisation of legal and policy harmonisation on legal age of marriage.

The strategy identifies existing and or establishes community based support systems for adolescents with special needs including HIV positive, sexually abused, living with disabilities etc. Such systems and structures are strengthened and linked with relevant youth serving and youth led organisations to facilitate reaching the constituents of young people and to mobilise for improvement of youth participation in ASRH programmes.

Empowering youth and ensuring that parent child communication is effective and knowledge is widespread on dispelling myths and misconceptions helps to create a conducive environment.

Output 3.3 focuses on building effective parent to child communication. The strategy implements awareness and behaviour change programmes targeted at parents and other significant family members to understand ASRH problems and their underlying causes as well as the positive impacts of effective parent child communication. The awareness aims to dispel negative attitudes and cultural practices that fuel negative ASRH problems. Parental engagement is a crucial component of sexual and reproductive knowledge and development of young people. Parents will therefore be motivated through education programmes that link with the wider community to identify and remove barriers of communication around sexuality due to lack awareness on sexuality.
<table>
<thead>
<tr>
<th>Output</th>
<th>Strategies/Interventions</th>
</tr>
</thead>
</table>
| Output 3.1: A policy, legal and institutional framework that protects the SRHR of adolescents and young people is in place and enforced | S3.1.1: Review/align and harmonise policy and legal framework to facilitate implementation of ASRH programmes. 
S3.1.2: Advocate for conducive environment to enhance equitable access to quality affordable ASRH services. 
S3.1.3: Advocate for resourcing and implementation the Multi-Sectoral Protocol on the Management of Sexual Abuse in Zimbabwe. |
| Output 3.2: Increased community and youth participation in ARH and HIV programmes | S3.2.1: Implement community sensitisation and mobilisation interventions for ASRH and HIV. 
S3.2.2: Implement and evaluate promising practices such as ASRH committees to facilitate community mobilisation for ASRH and HIV. Strengthen linkages between community and health facilities. 
S3.3.3: Facilitate establishment of community dialogues focusing on ASRH and HIV challenges in target communities with traditional and religious leaders, and ordinary community members to empower them support adolescent use of ASRH and HIV services. 
S3.3.4: Strengthen linkages between broader health programmes and ASRH and HIV in the community (e.g. involving community based health workers in ASRH programming and linking community health workers with peer educators on ASRH). 
S3.3.5: Facilitate community dialogues that address drivers for child marriage and galvanise support for harmonisation of legal and policy harmonisation on legal age of marriage 
S3.3.6: Facilitate development of community based support systems for adolescents with special needs including HIV positive, sexually abused, living with disabilities etc. 
S3.3.7: Support youth serving and youth led organisations to reach their constituents of young people to improve youth participation in ASRH programmes. 
S3.3.8: Raise awareness and empower adolescents, young people to demand for ASRH and HIV service delivery |
| Output 3.3: Improved Parent to child communication on SRH issues | S3.3.1: Align the existing PCC package 
S3.3.2. Implement and review the revised PCC package 
S3.3.3 Support linking implementation of the PCC package with interventions that strengthen parental care of children e.g. Family clubs |
8. Implementation Approaches

The implementation approaches supported by the strategy can be summarized in Figure 3. Adolescents and young people are placed at the center of the response allowing them to access services and embrace safe sexual and reproductive health practices. Immediate support should be provided by the family through better communication on SRH issues and care and support for adolescents and young people (e.g. condoning of all forms of abuse and child marriages). The community is an important environment for adolescents as it facilitates their behaviour change in terms of use of SRH services and sexual practices.

These three levels of interventions are anchored on three environments: 1) policy and legal environment; 2) service delivery environment; and 3) the programme management environment. The right policy and legal environment will enable adolescents and young people secure their SRH rights and communities and families to advocate for better protection of adolescent and resourcing for adolescent and young people SRH services. An appropriate service delivery environment will support uptake by increasing availability and affordability of quality, youth friendly ASRH and HIV services. Programme management is the third anchor.
Figure 3: Summary of implementation approach

1) Policies that increase quality YFHS e.g. guidelines for care
2) Legislation and policies that protect adolescents from abuse e.g. child marriage, sexual abuse, commercial sex work
3) Policies that enhance availability and affordability of services

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1) Strengthen Coordination and Linkages
2) Monitoring, evaluation and learning
3) Innovations that address girls’ and boys’ vulnerability
4) Youth participation

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1. District wide and facility wide. Capacity to provide integrated youth friendly HIV and ASRH service
8.1 Multiple interventions

To deliver comprehensive quality ASRH services, the strategy acknowledges that no one intervention can address the challenges adolescents and young people face. Multiple interventions will therefore be employed to respond to the multidimensional ASRH challenges faced by adolescents and young people. These interventions support message segmentation to reach the vulnerable and underserved populations of adolescent and young people. They incorporate an empowerment approach to ensure gender and rights are realized which are particularly effective in improving reproductive health outcomes. Box 1 presents a model framework for implementing multiple interventions in a community. This is based on lessons learned in the implementation of the previous strategy, ASRH Strategy 2010-2015.

**Box 1: Model multiple interventions at the community level**

1. Strong community mobilization (traditional and religious leaders and ordinary community members) supported by a locally based CBO including establishing community level structures to support ASRH outcomes e.g. ASRH committees;
2. Build ownership of interventions among community members;
3. Ensure vibrancy of local level community structures and strong community based planning;
4. Establish and closely support peer educators through CBOs, community health workers and the ASRH committee;
5. Support in-school learning on Comprehensive Sexuality Education through training teachers and complimentary peer based approaches;
6. Facilitate coordination and networking among key stakeholders – district level ZNFPC, MoHCC structures and at the local level: local peer educators, community health workers, health facility staff, community members and CBOs (including possibilities of joint planning);
7. Focus on reaching the most vulnerable girls and boys with information, referral for service and follow up through alternative peer to peer methods and working with community health workers;
8. Ensure availability of facility wide quality youth friendly HIV and SRH services and that SRH commodities are available as well as availability of condoms in public spaces easily accessible to adolescent and young people; and
9. Consider district wide support for availability of quality youth friendly HIV and SRH services.

8.2 Integration and linkages

The strategy promotes integration of SRH and HIV services. It recognizes that not all SRH and HIV services can be integrated as they depend on various factors such as type of facility, capacity of personnel and the type of service and resources required e.g. ART initiation. Therefore, this approach will be supported by a strong element of referral service.

To achieve significant changes in the SRH status of young people, a multi-sectoral response is required. The strategy embraces this approach by recognizing that there are other critical services and interventions that need to be delivered by other stakeholders. These key services include:

- Comprehensive Sexuality Education (CSE) in schools;
- Addressing youth poverty;
- Eradicating child marriages;
- Reducing sexual violence among adolescent girls and young women; and
- Increased distribution of contraceptive and STI prevention methods in adolescent localities.

The strategy therefore promotes close linkages to ensure ASRH interventions are integrated in existing and new programmes or projects. It promotes awareness and utilization of guidelines on SRH and HIV and AIDS linkages. Strengthening linkages between the ASRH service provision and other critical HIV related services including VMMC and HT. The ASRH strategy will facilitate identification of programmes that provide opportunities for closer linkages with interventions espoused in this strategy.

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40 What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practices
Veena Venkatarangan, Chandrakanta Moulis, Catherine Lane, and Sylvia Wong

8.3 Targeting

Implementation of the strategy will target all adolescent and young people and geographical areas but at varying degree depending on the severity of the ASRH challenges (STDs, HIV and adolescent pregnancies), access and availability of services. Age appropriate service provision will be critical in this regard as target segmentation will ensure the right messages reach the appropriate target groups. Adolescent localities, where many adolescent and young people can be found at growth point, recreational facilities, club sites considering rural and urban variations and access to media channels and ICT will be considered as various studies reflect the need to have target segmentation.

Depending on the severity of SRH challenges the depth and basket of interventions will be varied as described in Table 5. The targeting approach is based on categorizing districts according to priorities with Priority one being the worst affected districts, while Priority two and three are those moderately affected and least affected. Census data shows that SRH challenges (e.g. teenage pregnancies) among adolescents and young people decrease with increasing wealth and decreasing remoteness of the districts. Thus the package of interventions has been devised in this regard. Furthermore, as HIV is transboundary, addressing a few wards in a district will be inadequate to have a sustained impact. Therefore, in areas of high prevalence of HIV, STDs and adolescent pregnancies district wide approaches are recommended.

Table 5: Targeting approach for the ASRH strategy

<table>
<thead>
<tr>
<th>Priority #</th>
<th>Description</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Districts with highest HIV prevalence, STI incidence, adolescent pregnancies and child marriages</td>
<td>Implementation of activities in the model of interventions presented in Box 1. Ensure district wide approach.</td>
</tr>
<tr>
<td>2</td>
<td>Areas of moderate prevalence of HIV prevalence, STI incidence, adolescent pregnancies and child marriages</td>
<td>Target specific vulnerable groups and hot spots (e.g. vulnerable groups: adolescents and young girls engaged in commercial sex work, in marriage, out of school girls and boys, teen girls in marriage and those pregnant or with children, adolescents boys and girls living on the street and those living with disabilities, hot spots: Tertiary institutions, resettlement areas, urban camps, transit corridors etc.). Compliment with mass media and social media approaches. Strengthen in-school Comprehensive Sexuality Education. Support quality youth friendly health service delivery (private and public).</td>
</tr>
<tr>
<td>3</td>
<td>Areas of lowest HIV prevalence, STI incidence, adolescent pregnancies and child marriages</td>
<td>Target specific vulnerable groups and hot spots (e.g. vulnerable groups: adolescents and young girls engaged in commercial sex work, in marriage, out of school girls and boys, teen girls in marriage and those pregnant or with children, adolescents boys and girls living on the street and those living with disabilities, hot spots: Tertiary institutions, resettlement areas, urban camps, transit corridors etc.). Support mass media communication targeted at families and adolescents. Support health service delivery (private and public). Support in-school comprehensive Sexuality Education.</td>
</tr>
</tbody>
</table>


8.3.1 Targeting the most vulnerable

Within the context of the overall response to the adolescents and young people SRH problems, programmes will identify and focus on more vulnerable and underserved groups. Many adolescents, especially those who are most marginalized or vulnerable, are not being reached by adolescent health programmes. These include: orphans, adolescents living with disability, adolescents living positively with HIV, adolescents living in the streets, teen mothers, adolescent inmates, and adolescents in sex work.

While the strategy promotes specific targeting of vulnerable groups it is also cognizant of the negative externalities this could present. For example, literature has shown that interventions that target specific groups e.g. boys only or girls only, have a negative effect on the excluded group. Based on such evidence the ASRH strategy does not promote interventions that only target one group of adolescents hence the motivation for comprehensive and integrated interventions that reach all relevant vulnerable groups.

8.4 Youth participation

The participation of young people is key to addressing their SRH problems. In this strategy, youth participation is recognised as a right as it is enshrined in the Convention on the Rights of Children, article 12. Through this strategy young people will be supported to advocate for and implement programmes that address their SRH challenges. To achieve this, youth led organisations will be capacity built to enhance their skills and knowledge in the delivery of youth focused and rights based interventions. Youth participation will also be achieved through strengthening peer to peer approaches, mentorship and Girls and Boys Empowerment clubs. Specifically, to strengthen the peer education approaches, the strategy will commission a possible redesign of the current peer education model. While a popular model, current evidence base suggest possible reasons for failure of this approach, requiring more research into the conditions under which this approach can be effective.

8.5 Gender mainstreaming

There are clear differential impacts of the SRH challenges on adolescent boys and girls and young people. They face unique challenges based on their gender and reproductive roles. The imbalance in power relations influenced by socially constructed gender roles disempowers girls to negotiate and make decisions concerning their SRH rights free of discrimination and violence. Therefore in this strategy gender considerations are central and mainstreamed as cross cutting in all interventions proposed. In the context of this strategy, gender mainstreaming addresses the power imbalances between males and females. This, therefore, requires targeting of both sexes with messages that breakdown the underpinning social constructs. The strategy will build capacity of service providers to address gender issues in ASRH programming. To support gender mainstreaming by service providers, the strategy will develop standard gender mainstreaming guidelines for ASRH.

8.6 Community and parent engagement

Community support and parent to child communication are critical enablers for adolescents and young people to access services and information that enhance safe sexual practice and late sexual debut. However, community support and parent to child communication are undermined by negative attitudes towards ASRH for adolescents and young people. These negative attitudes are fueled by cultural and religious beliefs and practices as well as

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42 ASRH Midterm review 2014
misconceptions about ASRH. Therefore to facilitate community support and parent to child communication on ASRH, the strategy promotes interventions that address these underlying causes of negative attitudes and practices towards ASRH among parents, and community leaders. The current PCC strategy will be reviewed for alignment with the ASRH strategy and operationalisation.

8.7 Age appropriate SRH information and services

The strategy provides guidelines on provision of age appropriate ASRH and HIV services. For HIV services, the strategy is guided by existing policies and guidelines such as those on HTC, ART and BCC for Zimbabwe. The underlying principle is in providing services that are in the best interest of the child given their presenting circumstances. This principle is enshrined in Section 81 (2): ‘A child’s best interests are paramount in every matter concerning the child’. The age disaggregation will be flexible as it is cognizant of the fact that people are not homogenous. The adolescents and youth people in particular present a diversity and issues that need to be considered within the framework implementation. Their exposure to the challenges will determine, within the context of the guidelines, the specific services to be provided. For example, an adolescent who is sexually exploited or living in the street etc. may need a more open approach to care depending on the condition presented.

Table 6: Services by Objective and Age Category

<table>
<thead>
<tr>
<th>Age</th>
<th>Objective</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-14 years old</td>
<td>Delay Sexual Debut&lt;br&gt;Avoid early marriages&lt;br&gt;Avoid new HIV infections</td>
<td>Comprehensive Sexuality Education (in and out of school)&lt;br&gt;Provision of Life Skills Education (in and out of school)&lt;br&gt;Support girls to stay in school&lt;br&gt;HTC and ART (HTC guidelines best interest of the child)&lt;br&gt;Community support for ASRH</td>
</tr>
<tr>
<td>15-19 years old</td>
<td>Delay Sexual Debut&lt;br&gt;Avoid adolescent pregnancies&lt;br&gt;Avoid early marriages&lt;br&gt;Avoid new STI and HIV infection</td>
<td>Comprehensive Sexuality Education (in and out of school)&lt;br&gt;Provision of Life Skills Education (in and out of school)&lt;br&gt;Support girls to stay in school&lt;br&gt;HTC and ART (HTC guidelines best interest of the child)&lt;br&gt;STI screening and treatment&lt;br&gt;Access to SRH commodities&lt;br&gt;Community support for ASRH</td>
</tr>
<tr>
<td>20-24</td>
<td>Avoid new STI and HIV infection</td>
<td>Comprehensive Sexuality Education&lt;br&gt;Provision of Life Skills Education and livelihoods to address youth unemployment and poverty&lt;br&gt;HTC and ART&lt;br&gt;STI screening and treatment&lt;br&gt;Access to SRH commodities&lt;br&gt;Community support for ASRH</td>
</tr>
</tbody>
</table>

In addition to segmenting information and service provision, interventions targeted at reducing ASRH challenges should consider specific age specific implementation approaches.

9. Supportive Pillars for the Strategy Stakeholder Analysis

The strategy is underpinned by four key supportive pillars that ensure effective implementation. The pillars are.

1. Coordination
2. Innovations Operations Research and Knowledge management – incentivise innovative projects
3. Policy and Advocacy
4. Capacity Development
5. Monitoring and Evaluation
9.1 Coordination

A robust national coordination and accountability structure that strives for dynamic public sector, civil society, and private sector and target groups representation and participation at national and decentralized levels will coordinate the four pillars under which this strategy is organized. The structure is presented in Figure 4. At the national, the apex is the Strategy Steering Committee. This is followed by the National Coordination Forum. At provincial and district levels, ASRH coordination will be done through the National ASRH Coordination Committees.

Figure 4: Coordination structure for ASRH
9.1.1 Strategy Steering Committee

The SSC shall be responsible for:

a) Resource mobilisation;
b) Policy and strategy guidance;
c) Oversight and evaluation
d) Guidance

Table 7 summarises the responsibilities and composition of the SSC

<table>
<thead>
<tr>
<th>Responsibilities of the SSC</th>
<th>Composition of the SSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Resource mobilisation</td>
<td>Category</td>
</tr>
<tr>
<td>• Oversight and evaluation</td>
<td>Ministries</td>
</tr>
<tr>
<td>• Policy advocacy</td>
<td>MoPSE, MoHCC, MWAGCD,</td>
</tr>
<tr>
<td>• Strategic direction</td>
<td>MoY, MoHE, MoPSLSW, VFU -</td>
</tr>
<tr>
<td></td>
<td>Min of Home Affairs, Min of</td>
</tr>
<tr>
<td></td>
<td>Justice</td>
</tr>
<tr>
<td></td>
<td>Parastatals</td>
</tr>
<tr>
<td></td>
<td>NAC, ZNFPC and ZYC</td>
</tr>
<tr>
<td></td>
<td>Development partners</td>
</tr>
<tr>
<td></td>
<td>UNFPA, UNICEF, UN Women,</td>
</tr>
<tr>
<td></td>
<td>WHO</td>
</tr>
<tr>
<td></td>
<td>Donors</td>
</tr>
<tr>
<td></td>
<td>SIDA, DFID USAID, EU, GIZ,</td>
</tr>
<tr>
<td></td>
<td>SDC</td>
</tr>
<tr>
<td></td>
<td>CSO and international</td>
</tr>
<tr>
<td></td>
<td>CSO representative</td>
</tr>
<tr>
<td></td>
<td>Organisations</td>
</tr>
<tr>
<td></td>
<td>One organisation</td>
</tr>
<tr>
<td></td>
<td>representing</td>
</tr>
<tr>
<td></td>
<td>young people</td>
</tr>
</tbody>
</table>

The SSC is chaired by the MoHCC Reproductive Health directorate. ZNFPC, NAC and ZYC have specific responsibilities in the coordination structure as presented in Table 8. The SSC will meet once a year.

Table 8: Responsibilities in the SSC

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>MoHCC</td>
<td>Chair the SSC</td>
</tr>
<tr>
<td></td>
<td>Provide secretarial services to the SSC</td>
</tr>
<tr>
<td></td>
<td>Facilitate coordination of implementation of the strategy</td>
</tr>
<tr>
<td>NAC</td>
<td>Support youth participation</td>
</tr>
<tr>
<td>ZNFPC</td>
<td>Provide secretarial support to the decentralized ASRH coordination</td>
</tr>
<tr>
<td></td>
<td>Coordinating Monitoring and Evaluation of the ASRH Strategy</td>
</tr>
<tr>
<td>ZYC</td>
<td>Mapping youth serving organisations and supporting youth participation</td>
</tr>
</tbody>
</table>
9.1.2 National Coordination Forum

The NCF ensures that interventions and approaches espoused by the strategy are adopted by the multi-sectoral stakeholders in their programmes. Through the coordination forum, key programmatic information, research findings and promising practices - evidence of what works and in what context, geographic mapping of ASRH programmes, joint planning, monitoring and targeting and lessons learned will be shared. The forum will also provide opportunities to enhance collaborations between organisations implementing ASRH interventions in similar localities.

The forum representation includes implementers of ASRH related interventions including organisations that support youth economic empowerment, academia and research institutions.

The MOHCC will be the Chair of the NCF. The NCF will meet quarterly with the thematic working groups meeting more frequently at least once a quarter to feedback on to the quarterly Forum meeting. Because of the expected large numbers of the forum, it will be divided into Thematic Working Groups each led by a selected thematic lead.

9.1.3 Provincial level coordination

At provincial level the existing provincial ASRH coordination forums will be utilised. These coordination structures have been piloted in two provinces Mash West and Masvingo and will be scaled up during phase two taking into account what works for strengthened ASRH coordination.

The purpose of the provincial coordination structures is to:

- strengthen linkages and coordination between organizations working on ASRH at provincial level;
- undertake policy advocacy and strengthen resource mobilisation and optimising the use of available resources for ASRH at provincial level;
- contribute towards sharing of good practices, human interest stories and lessons learnt in ASRH Programming at both provincial and national levels;
- facilitate evidence-based ASRH programming through providing strategic guidance and information sharing among ASRH serving organizations within the province.

Use of the existing ZNFP structures will allow for decentralization of ASRH coordination to be rolled quicker, more cost effectively and improve efficiency in planning at this level. The Provincial ASRH Coordination Forum will ensure representation at other provincial coordination structures such as the PACS agenda of the Provincial AIDS Committees (PAC and DAC) meetings to facilitate strengthened linkages between the HIV and ASRH.

ZNFP is also delegated focal point for the ASRH information system further allowing the organisation to strengthen its role in the ASRH delivery.

The decentralisation to the district will follow a phased approach linked to the capacity building of the key stakeholders and the strengthening of the ASRH response nationally.

9.1.4 District level ASRH Coordination

At district level, the decentralized coordination structures of the ZNFP currently being considered in its restructuring exercise will be used to facilitate ASRH coordination. This will also allow for a quicker, more cost effectively and improve efficiency in planning at that level as it also avoids creating new structures. The reporting channel for the Provincial ASRH coordination forum and the decentralized ZNFC structures at district will be guided by the recommendations of the institutional review currently underway.

9.1.5 Ward and community level coordination

At the ward level coordination will be through ASRH committees which are sub-committees of the Health Facility Committees. Through the strategy ASRH committees will be scaled up to all districts and continuously monitored to sustain performance.

Capacity building of the MOHCC, other key ministries and parastatals will be critical to enable to institutions to deliver on their roles.
9.2 Innovations Operations Research and Knowledge management

Innovations that promote reach and improve effectiveness ASRH programmes will be supported through the strategy. This will be supported by a strong operations research, learning and documentation component. Operations research priorities for the new strategy shall include:

a) Impact assessment of the proposed intervention approach – integrated, district wide targeting families, communities, the adolescent and service delivery.

b) Impact and cost effectiveness assessment of Innovative approaches to determine their feasibility for scale up;

c) Cost effectiveness of interventions to be implemented from this strategy to allow for scale of cost effective solutions;

d) Process reviews of interventions will be conducted to identify bottlenecks undermining effectiveness.

An operations research framework will be developed to support implementation of the AYSRH strategy II.

9.3 Policy and Advocacy

There are still gaps in the legislative environment for adolescent and young people in a number of areas including policy constraints on consent issues, primarily for adolescents aged 10-14. The strategy advocates for review and harmonizing of policy and legislation as well as broadening the framework for adolescent and youth participation in planning and decision-making. It also advocates for active engagement and access of adolescent key populations to ASRH and HIV services, and promoting adolescent-responsive services and ASRH and rights for all.

9.4 Capacity development

Capacity development is central to the success of the implementation of the ASRH Strategy. Capacity building runs through all aspects of the strategy implementation processes targeting service providers to ensure availability of comprehensive, equitable (rights based) ASRH services and commodity support. This is also aimed to ensure maximum reach to the underserved and difficult to reach target populations. The personnel are trained and receive mentorship to improve inter personal skills critical for effective communication with adolescents and youth in creating demand for service. Through capacity building, personnel also equipped to enhance the quality of integrated SRH/HIV services.

The key stakeholders will be capacity built to improve coordination and enhance their capacity to efficiently carry out the assigned roles through the coordination forum. The key communication resource materials including the PCC strategy, the social behaviour change strategy will be utilised as part of the capacity development initiatives for the target populations including the parents and community leadership.

10. Strategy Implementation

Implementation of the ASRH Strategy will require well though through planning by the key stakeholders in collaboration

The strategy will be implemented in two phases. Phase one will run through to December 2016 while phase two will run through to December 2020. There are several activities that will run concurrent and or will be continues once they have started. This is mainly because a number of activities were already a carryover from the last strategy (2010-2015) and need to continue. Table 8 highlights the phased implementation approach for the strategy.

Phase One: up to December 2016: Focuses on creating an enabling environment through of policies’ and legislation, development and or finalization of Standard Guidelines and Manuals a number of which had already been initiated towards the end of ASRH strategy including the Standard National ASRH Training Manual for Service Providers (2012); Standard Operating Procedures for Community Youth Interact Centres and the National Integrated ASRH Advocacy Package. Phase one also advocates for issues availability of supplies and commodities and affordability by the adolescent and young people. It aims to create demand though knowledge enhancement and creating as sense of urgency for the target group’s to participate and also for the services provider to provide equitable user friendly services.
Phase Two builds on phase one and focuses more on creating demand and providing SRH services to adolescents and young people in a standardized approach. This will be achieved through social & behavior change communication and strengthening integration of ASRH services with other services. A midterm review will be carried out during year three to determine progress in implementation and effort in addressing effectiveness in addressing the SRH needs of adolescents and young people.

### Planned phased implementation

<table>
<thead>
<tr>
<th></th>
<th>Phase 1 (6 months (Jun-Dec 2016))</th>
<th>Phase 2 (Year 2017-2020)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enabling environment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polices and legislation</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Standard Guidelines and Manuals</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Quantity and Quality Supply</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Availability and affordability of adequate quality services</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Supply of adequate commodities</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Demand</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge building (Capacity of knowledge service providers)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Knowledge building target groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community acceptance</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Parent to child communication</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

Through the results framework outputs and interventions, this ASRH strategy provides a framework to guide the development of annual implementation plans. It is critical that such plans clearly define the annual priority activities, resource requirements and specific roles and responsibilities of stakeholders, in line with the phased approach.

The implementation of the ASRH Strategy will be multisectoral. The MOHCC will provide the overall guidance and coordination. Other line ministries, parastatals and nongovernmental organizations will be responsible for implementing specific interventions that fall within their respective mandates. The ASRH Coordination forum will ensure that the proposed interventions are well integrated and coordinated.
11. Roles and Responsibilities of Key Stakeholders

Below is an outline of the general roles and responsibilities of key ASRH stakeholders in rolling out the strategy.

<table>
<thead>
<tr>
<th>Roles and responsibilities of key stakeholders</th>
<th></th>
</tr>
</thead>
</table>
| **Ministry of Health and Child Welfare (all levels)** | • Create and maintain a consolidated database of ASRH stakeholders at all levels,  
• Disseminate and facilitate operationalisation of the ASRH strategy, including resource mobilisation and decentralisation of the ASRH Coordination forum,  
• Accrediting and certifying all ASRH serving organisations,  
• Facilitate development and operationalisation of annual plans and standardised ASRH training manuals for service providers,  
• Facilitate development and operationalisation of the national and standardised ASRH monitoring and evaluation plans, tools and indicators  
• Address ASRH advocacy issues,  
• Organise ASRH review meetings with stakeholders periodically. |
| **Line ministries, parastatals, local authorities, NGOs and other stakeholders** | • Facilitate dissemination and operationalisation of the ASRH strategy, including resource mobilisation,  
• Support the strengthening of the ASRH Coordination forum and thematic groups,  
• Adopt and operationalize the different stakeholders respective mandates and approaches to providing ASRH services as highlighted in this strategy,  
• Participate in the ASRH Coordination forum and other ASRH related committees that might be established during the implementation of this strategy,  
• Utilize the standard operational standards and ASRH training manual for service providers  
• Monitor (collect, analyse and utilise data) the implementation of the ASRH strategy and facilitate sharing with other stakeholders,  
• Participate in progress review meetings with stakeholders at all levels. |
| **Key UN Partners and Other Donor agencies** | • Provide technical support for the implementation of this strategy,  
• Mobilize and avail financial resources for the implementation of this strategy,  
• Participate in the ASRH Coordination forum and other ASRH related committees that might be established during the implementation of this strategy. |
Monitoring and Evaluation Framework

12. Background


12.1 Objectives of the M&E Framework

The overall purpose of the national ASRH M&E framework is to guide the development and implementation of the national ASRH M&E system and improve its performance. At a minimum the ASRH M&E system performance includes the production of timely and quality data on the ASRH programmes and the use of data for evidence informed decisions-making in programme planning, programme improvement and resource allocation. The specific objectives of the national ASRH M&E Framework are:

- To provide the basis for the development of the M&E approach which includes data and information flow mechanism, indicators of progress and tools for data collection.
- To guide all stakeholders to measure the progress in the implementation of the National Adolescent Sexual and Reproductive Health Strategy 2016-2020.
- To ensure greater transparency, effective coordination and communication among different groups involved in ASRH Programmes.
- To guide the continuous tracking ASRH programmes in terms of inputs, outputs, outcomes and impact.
- To advocate the key role of M&E and related technical assistance for realizing the goals and objectives of the ASRH Strategy 2010-2015.

12.2 Guiding Principles for the M&E Framework

The following principles will guide achievement of the M&E framework objectives. They have been drawn from the Guiding Principles of the Government of Zimbabwe National M&E Policy.

1. **Managing for Results**: Monitoring and Evaluation rides on the Integrated Results Based Management (IRBM) principles that focus on results (outputs, outcomes and impacts). The results are targeted at improving the quality of life of the citizenry.

2. **Value for money**: Monitoring and Evaluation shall ensure that resources allocated achieve the intended results in the most economic, efficient and effective manner.

3. **Ownership and Inclusivity**: Monitoring and Evaluation shall ensure that the public identifies with Government programmes and projects and that these programmes and projects benefits all Zimbabweans.

4. **Utility**: Monitoring and Evaluation shall provide information which is readily usable by all stakeholders.

5. **Integrity and Credibility**: Monitoring and Evaluation shall be based on reliable evidence based data. At project and programme levels, Monitoring and Evaluation shall use realistic and practical techniques and indicators for measurement of results and progress.

6. **Transparency**: Information pertaining to monitoring and evaluation shall be easily accessible to the general public and clear communication on the availability and use of resources shall be provided.

7. **Accountability**: Individuals and institutions shall be required to explain how allocated resources are used for implementing agreed outputs and outcomes.

8. **Ethical considerations**: Monitoring and evaluation shall provide due regard for the welfare, beliefs and customs of those involved or affected, upholding a strict moral code.
9. **Confidentiality**: Institutions and individuals shall be assured of their right to provide information to monitors and evaluators without their identity being publicised.

10. **Equality and equity in ASRH**: Monitoring and Evaluation shall ensure the use of ASRH disaggregated data in decision making

12.3 **The formulation process**

The M&E framework was developed in a participatory process with members of the ASRH Coordination Forum. A one day workshop was held in Harare that included all relevant sector ministries, UN agencies and NGOs. The workshop sought stakeholder input in the design of the M&E framework and priorities for operations research.

The M&E framework was validated by stakeholders before finalisation

13. **Core Indicators for the ASRH M&E Framework**

13.1 **Introduction**

The ASRH M&E Framework was primarily developed using internationally recognised PEPFAR, UNAIDS, and UNGASS indicators. Indicators were selected based on their relevance to the ASRH strategy results and the Zimbabwe context. The process also included a participatory review of the indicators involving M&E professional from ASRH serving organisations NGOs), government ministries (health, education, youth, ASRH, higher and tertiary education), UN agencies and government agencies (ZNFPC and NAC).

Tables 2 to 4 present the impact, outcome and output plan for the ASRH Strategy 2016-2020. A complete description of the indicators is presented in the M&E plan, a separate volume from this M&E framework.

13.2 **Baselines and Target setting**

Baseline values and targets for the impact, outcome and output monitoring plans will be set. Targets will be based on:
1. historical performance of the indicator;
2. measures that need to be put in place for the performance of the indicator and how these measures can take; and
3. the target needs to be ambitious and yet realistic basing it on the points 1 and 2.

The baseline study will draw data to inform the selected indicators from the following sources:

1. the Zimbabwe Demographic Health Survey (2015);
2. The Multiple-Indicator Cluster Survey (2014);
3. District Health Information System 2 (DHIS2);
4. National Activity Report Form (NARF) database (NAC);
5. Zimbabwe Demand Generation Database for community level (NAC); and
6. Education Inform Management System.

Other data sources for outputs will include: 1) National Adolescents Sexual and Reproductive Health Activity Report Form, (NASRHA); 2) Zimbabwe Demand Generation Database for community level; and the National Adolescents Sexual and Reproductive Health Activity Report Form, (NASRHA).

While these sources will provide the ASRH strategy with national and provincial level baselines, specific baseline surveys will be conducted in hot spot districts, especially Priority 1 districts (see Table 6), to obtain district level baseline data for indicators of interest. Specific tools will be developed to capture the required indicators at impact, outcome and output level. ASRH serving organisations will be encouraged to use these tools for their projects in the process providing additional information for district level baselines.
13.2.1 Impact plan

Table 9 provides the impact plan for the ASRH Strategy 2016-2020. The main indicators to be tracked shall be obtained from the Zimbabwe Demographic Health Survey.

13.2.2 Outcome Plan

Table 10 presents the outcome plan. All Outcome 1 and 2 indicators will be obtained from the DHS. One indicator under outcome 2 will be obtained from the DHIS2. Outcome 3 indicators will require a new source. There is potential to include this in on-going surveys such as DHS or MICS.

<table>
<thead>
<tr>
<th>Impact Indicator</th>
<th>Measurement Unit/Criterion (% no. rate, etc.)</th>
<th>Source</th>
<th>Ratio</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent fertility rate</td>
<td>DHS</td>
<td>TBA</td>
<td>TBA</td>
<td>TBA</td>
<td>DHS</td>
<td>DHS</td>
<td>DHS</td>
<td>DHS</td>
</tr>
<tr>
<td>STI prevalence rate among adolescents and young people</td>
<td>DHS</td>
<td>TBA</td>
<td>TBA</td>
<td>TBA</td>
<td>DHS</td>
<td>DHS</td>
<td>DHS</td>
<td>DHS</td>
</tr>
<tr>
<td>HIV prevalence rate among adolescents and young people</td>
<td>DHS</td>
<td>TBA</td>
<td>TBA</td>
<td>TBA</td>
<td>DHS</td>
<td>DHS</td>
<td>DHS</td>
<td>DHS</td>
</tr>
<tr>
<td>Maternal mortality rate (MMR)</td>
<td>DHS</td>
<td>TBA</td>
<td>TBA</td>
<td>TBA</td>
<td>DHS</td>
<td>DHS</td>
<td>DHS</td>
<td>DHS</td>
</tr>
</tbody>
</table>

Table 9: Impact plan
<table>
<thead>
<tr>
<th>Impact Reference</th>
<th>Outcome Description</th>
<th>Ref Number, Outcome Indicator</th>
<th>Measurement Unit/Criterion (%, no. rate, etc.)</th>
<th>Target</th>
<th>Source</th>
<th>Baseline</th>
<th>2017</th>
<th>2016</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMP1 2</td>
<td>Increased uptake of quality youth friendly integrated SRH and HIV services</td>
<td>OTM203: Percentage of young women with live births in the past 24 months that received PNC services. Scheduled PNC visits include: 48 hours, 3 days, 7 days and six weeks (Mothernew-born receiving PNC within three days) and subsequent</td>
<td>%</td>
<td>DHS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IMP1 2</td>
<td>Increased uptake of quality youth friendly integrated SRH and HIV services</td>
<td>OTM202: Proportion of 15-24 year old females having live birth outcome in the past 24 months attending at least 3 ANC visits during the last live birth.</td>
<td>%</td>
<td>DHS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IMP1 2</td>
<td>Increased uptake of quality youth friendly integrated SRH and HIV services</td>
<td>OTM201: Proportion of sexually active adolescents and young people who had an HIV test in the preceding 12 months and know the result</td>
<td>%</td>
<td>DHS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IMP1 2</td>
<td>Increased uptake of quality youth friendly integrated SRH and HIV services</td>
<td>OTM200: Proportion of currently sexually active young women (15-24) using FP methods</td>
<td>%</td>
<td>DHS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IMP1 2</td>
<td>Increased uptake of quality youth friendly integrated SRH and HIV services</td>
<td>OTM103: CPR (15-24 years)</td>
<td>%</td>
<td>DHS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IMP1 2</td>
<td>Increased uptake of quality youth friendly integrated SRH and HIV services</td>
<td>OTM102: Primary abstinence</td>
<td>%</td>
<td>DHS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IMP1 2</td>
<td>Increased uptake of quality youth friendly integrated SRH and HIV services</td>
<td>OTM101: Proportion of young women 15-24 who have had sex in the preceding 12 months with a partner who is 10 or more years older than themselves.</td>
<td>%</td>
<td>DHS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IMP1 2</td>
<td>Increased uptake of quality youth friendly integrated SRH and HIV services</td>
<td>OTM100: Proportion of adolescents and young people (15-24) having premarital sex using a condom at last intercourse</td>
<td>%</td>
<td>DHS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IMP1 2</td>
<td>Increased uptake of quality youth friendly integrated SRH and HIV services</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impact Reference</td>
<td>Outcome Description</td>
<td>Ref Number: Outcome Indicator</td>
<td>Measurement Unit/Criterion (%, no. rate, etc.)</td>
<td>Target</td>
<td>Allowable Variance</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>IMP2 2</td>
<td>Outcome 3: Strengthened protective environment for adolescents and young people</td>
<td>OTM300: Number of legislation that support ASRH passed by parliament</td>
<td>No</td>
<td>TBA</td>
<td>5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>OTM301: Number of policies passed by cabinet that support ASRH</td>
<td>%</td>
<td>TBA</td>
<td>5%</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>OTM302: Percentage of adults who are in favour of young people (10-24) being educated about the use of condoms in order to prevent HIV/AIDS.</td>
<td>%</td>
<td>TBA</td>
<td>5%</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>OTM303: Proportion of adults who are in favour of adolescents and young people using: 1) condoms; and 2) family planning methods.</td>
<td>%</td>
<td>TBA</td>
<td>5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vills)</td>
<td></td>
<td>OTM204: Proportion of sexually active adolescents undergoing STI screening in the past twelve months</td>
<td>%</td>
<td>DHS</td>
<td>5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>OTM205: Percentage of eligible young people aged 10 – 24 years initiated on ART in the past 12 months</td>
<td></td>
<td>%</td>
<td>DHS2</td>
<td>5%</td>
<td></td>
<td></td>
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</tbody>
</table>
### 13.2.3 Outputs Plan

The output plan is presented in Table 11.

<table>
<thead>
<tr>
<th>Outcome ref</th>
<th>Output ref</th>
<th>Ref Number: Indicator</th>
<th>Unit</th>
<th>Source</th>
<th>Target Baseline</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>Allowable variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1.1</td>
<td>OUT1101: Percentage of respondents who correctly identify all three major ways of preventing the sexual transmission of HIV and who reject three major misconceptions about HIV transmission or prevention</td>
<td>%</td>
<td>DHS</td>
<td>TBA</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>1</td>
<td>1.1</td>
<td>OUT1102: Percentage of young people who know of at least one formal source of male or female condoms.</td>
<td>%</td>
<td>DHS</td>
<td>TBA</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>1</td>
<td>1.1</td>
<td>OUT1103: Percent of all respondents (10-24) who, in response to prompted questions, say that a person can reduce their risk of contracting HIV by using condoms or having sex only with one faithful, uninfected partner</td>
<td>%</td>
<td>DHS</td>
<td>TBA</td>
<td></td>
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<tr>
<td>1</td>
<td>1.1</td>
<td>OUT1104: Percentage of adolescents and young people (15-24) who know at least three danger signs during pregnancy</td>
<td>%</td>
<td>MICS</td>
<td>TBA</td>
<td></td>
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</tr>
<tr>
<td>1</td>
<td>1.1</td>
<td>OUT1105: Percentage of adolescents and young people (15-24) who know precautions for preventing mother to child HIV transmission</td>
<td>%</td>
<td>MICS</td>
<td>TBA</td>
<td></td>
<td></td>
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<tr>
<td>1</td>
<td>1.1</td>
<td>OUT1106: Percentage of adolescents and young people (15-24) who know at least three danger signs during delivery</td>
<td>%</td>
<td>MICS</td>
<td>TBA</td>
<td></td>
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</tr>
<tr>
<td>1</td>
<td>1.1</td>
<td>OUT1107: Percentage of adolescents and young people (15-24) who know at least three post-delivery danger signs for the mother</td>
<td>%</td>
<td>MICS</td>
<td>TBA</td>
<td></td>
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</tr>
<tr>
<td>1</td>
<td>1.1</td>
<td>OUT1108: Percentage of adolescents and young people (15-24) who know at least three danger signs for the new-born</td>
<td>%</td>
<td>MICS</td>
<td>TBA</td>
<td></td>
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<tr>
<td>1</td>
<td>1.1</td>
<td>OUT1109: Percentage of adolescents and young people who know at least three symptoms of STIs</td>
<td>%</td>
<td>TBA</td>
<td>TBA</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>1</td>
<td>1.2</td>
<td>OUT1201: Percentage of young people who believe they have the ability to refuse unwanted sex.</td>
<td>%</td>
<td>TBA</td>
<td>TBA</td>
<td></td>
<td></td>
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<tr>
<td>1</td>
<td>1.2</td>
<td>OUT1202: Percentage of young women and men aged 15-24 who report they could get condoms on their own if they wanted, disaggregated by sex (female, male), and age (15-19, 20-24).</td>
<td>%</td>
<td>TBA</td>
<td>TBA</td>
<td></td>
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<tr>
<td>2</td>
<td>2.1</td>
<td>OUT2101: Percentage of randomly selected retail outlets and service delivery points typically accessed by young people which have condoms in stock at the time of the survey.</td>
<td>%</td>
<td>TBA</td>
<td>TBA</td>
<td></td>
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<tr>
<td>2</td>
<td>2.1</td>
<td>OUT2102: Proportion of service outlets (public and private) offering a minimum package SRH and HIV services to adolescents and young people according to the Service Guidelines for Youth Friendly health service provision</td>
<td>%</td>
<td>TBA</td>
<td>TBA</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2.1</td>
<td>OUT2103: Stock out rate of FP commodities</td>
<td>Rate</td>
<td>TBA</td>
<td>TBA</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2</td>
<td>2.1</td>
<td>OUT2104: Number of Service outlets offering SRH, HIV and cervical</td>
<td>No</td>
<td>TBA</td>
<td>TBA</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Outcome ref</td>
<td>Outcome</td>
<td>Ref Number: Indicator</td>
<td>Unit</td>
<td>Source</td>
<td>Target Baseline</td>
<td>2015</td>
<td>2016</td>
<td>2017</td>
<td>2018</td>
<td>2019</td>
<td>2020</td>
<td>Allowable variance</td>
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</tr>
<tr>
<td>2</td>
<td>2.2</td>
<td>cancer screening services to adolescent whose facilities are designed to have a youth friendly environment and are offering youth friendly services</td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td>2.2</td>
<td>OUT2105: Average cost of SRH and HIV services in public and private health providers: a. HIV testing and counselling b. STI screening c. STI testing d. Condoms (female and male) e. FP products f. ANC visit g. PNC visit h. Delivery</td>
<td>$</td>
<td></td>
<td>TBA</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2</td>
<td>2.2</td>
<td>OUT2106: Average out of pocket expenditure incurred by adolescents and young people to reach an SRH or HIV service.</td>
<td>$</td>
<td></td>
<td>TBA</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>2</td>
<td>2.2</td>
<td>OUT2107: Proportion of adolescents and young people who have the opinion that SRH and HIV services are affordable</td>
<td>%</td>
<td></td>
<td>TBA</td>
<td></td>
<td></td>
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<tr>
<td>3</td>
<td>3.1</td>
<td>OUT3101: Number of policies and legislation reviewed</td>
<td>No.</td>
<td></td>
<td>TBA</td>
<td></td>
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<tr>
<td>3</td>
<td>3.2</td>
<td>OUT3201: Number of district reporting at least 50% of wards having action plans to address ASRH issues.</td>
<td>No.</td>
<td></td>
<td>TBA</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>3</td>
<td>3.3</td>
<td>OUT3301: Percentage of young people who report regulation of their behaviours by their parent or primary caregiver(low, medium or high level)</td>
<td>%</td>
<td></td>
<td>TBA</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3</td>
<td>3.3</td>
<td>OUT3302: Percentage of young people who feel connected with their parents and/or primary caregivers.</td>
<td>%</td>
<td></td>
<td>TBA</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>3</td>
<td>3.3</td>
<td>OUT3303: Number of young people who report to have had at least one discussion about ASRH with a parent/guardian/primary caregiver in the past 12months</td>
<td>No.</td>
<td></td>
<td>TBA</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>3</td>
<td>3.3</td>
<td>OUT3304: Percentage of adults who are in favour of young people being educated about the use of condoms in order to prevent HIV/AIDS.</td>
<td>%</td>
<td></td>
<td>TBA</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3</td>
<td>3.3</td>
<td>OUT3305: Number of SRH and HIV/AIDS prevention programmes with at least 15% participation of young people</td>
<td>No.</td>
<td></td>
<td>TBA</td>
<td></td>
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</tbody>
</table>
14. Monitoring and Evaluation Framework, Outputs, Users and Uses

14.1 Monitoring framework

The monitoring framework comprises clear data sources; outputs; and institutional arrangements for data collection, processing, reporting and decision making. It relies heavily on already existing SRH and HIV data collection systems.

14.1.1 Data sources

The main data sources for the monitoring system and the information collected is presented in Table 12. Also refer to Annex 2 for more details on specific indicators to be collected from these data sources.

<table>
<thead>
<tr>
<th>System</th>
<th>Organization Hosting</th>
<th>Level</th>
<th>What it collects</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHIS2</td>
<td>MOHCC</td>
<td>All Levels</td>
<td>Utilisation of services</td>
</tr>
<tr>
<td>EMIS</td>
<td>MOPSE</td>
<td>All levels</td>
<td>HIV and ASRH education in school</td>
</tr>
<tr>
<td>National Activity Reporting Form (NARF)</td>
<td>NAC</td>
<td>All Levels</td>
<td>HIV services, activities, target population and reach</td>
</tr>
<tr>
<td>MHTE</td>
<td>MHTE</td>
<td>All levels</td>
<td>HIV and SRH Service utilisation in tertiary</td>
</tr>
<tr>
<td>ZNFPC (Family Planning)</td>
<td>ZNFPC</td>
<td>All Levels</td>
<td>ASRH</td>
</tr>
<tr>
<td>Zimbabwe Demand Generation Database (ZDGD) for community level</td>
<td>NAC</td>
<td>All Levels</td>
<td>Population reached with demand services, service satisfaction</td>
</tr>
<tr>
<td>National Adolescents Sexual and Reproductive Health Activity Report Form, (NASRHAf)</td>
<td>ZNFPC</td>
<td>All levels</td>
<td>For NGOs: ASRH activities being conducted and geographic coverage, financial allocations, target population and mile stones. For donors and UN agencies (Partners being funded, amount of funding for ASRH related activities, geographical coverage, planned financial flows)</td>
</tr>
<tr>
<td>Community and facility level ASRH service score card</td>
<td>ZNFPC</td>
<td>All levels</td>
<td>Data on satisfaction of adolescents and young people on service quality.</td>
</tr>
</tbody>
</table>

One additional tool proposed for the ASRH strategy is the score card on ASRH service delivery. Youth friendliness and quality of service are important conditions for utilisation of services. The community score card administered to adolescents and young people by Peer educators and selected community based health workers will be an important tool in the monitoring framework “tools box”.

All tools will need to be revised to ensure all indicators at output level are measured in the routine quarterly strategy progress reporting. Furthermore, all tools will need to be revised to ensure collection of data for the age groups of this strategy (10-24 years) and the different sexes.

1.1.1 Monitoring outputs

The following monitoring outputs will be produced using the monitoring framework:
• Quarterly National ASRH Update Report
• Quarterly Provincial ASRH Update Report
• Quarterly National Service Map
• Annual ASRH Progress Report
• Annual Service Map
• Regional and international commitments reports

**Quarterly National ASRH Update Report**

The Quarterly National ASRH Update Report shall be used to monitor progress on ASRH output level results in the country using data collected from administrative records of stakeholders represented in the M&E framework. The report, detailing a summary of quarterly ASRH activities and milestones will report on the following:
• Activities and reach of projects
• Funding levels for ASRH outcome areas
• New partners in ASRH and initiatives
• Major achievements, challenges, lessons learned, good practices and recommendations.

**Quarterly Provincial ASRH Update Report**

This report consolidates ASRH indicators in a province to be used by the Provincial ASRH Coordination Committee to make decision on programmes that supports or implements ASRH activities in the province. It demonstrates progress in the various sectors on ASRH within the province and details the following:
• Activities and reach of projects
• Funding levels for ASRH outcome areas
• New partners in ASRH and initiatives
• Major achievements, challenges, lessons learned, good practices and recommendations.

**Quarterly Service Maps**

Objective: to assist the coordinating agency to ensure right spread and intensity of response to achieve the desired outcomes. The service maps will provide information on activities, funding and partners in priority I and 2 districts as classified by the ASRH strategy (see Table 13):

Table 13: Targeting approach for the ASRH strategy

<table>
<thead>
<tr>
<th>Priority #</th>
<th>Description</th>
<th>Activities</th>
</tr>
</thead>
</table>
| 1          | Districts with highest HIV prevalence, STI incidence, adolescent pregnancies and child marriages | Implementation of activities in the model of interventions presented in Box 1  
Ensure district wide approach |
| 2          | Areas of moderate prevalence of HIV prevalence, STI incidence, adolescent pregnancies and child marriages | Target specific vulnerable groups and hot spots (e.g. vulnerable groups: adolescents and young girls engaged in commercial sex work, in marriage, out of school girls and boys, teen girls in marriage and those pregnant or with children, adolescents boys and girls living on the street and those living with disabilities, hot spots: Tertiary institutions, resettlement areas, urban camps, transit corridors etc.).  
Compliment with mass media and social media approaches  
Strengthen in-school Comprehensive Sexuality Education  
Support quality youth friendly health service delivery (private and public) |
| 3          | Areas of lowest HIV prevalence, STI incidence, adolescent pregnancies and child marriages | Target specific vulnerable groups and hot spots (e.g. vulnerable groups: adolescents and young girls engaged in commercial sex work, in marriage, out of school girls and boys, teen girls in marriage and those pregnant or with children, adolescents boys and girls living on the street and those living with disabilities, hot spots: Tertiary institutions, resettlement areas, urban camps, transit corridors etc.).  
Support mass media communication targeted at families and adolescents.  
Support health service delivery (private and public).  
Support in-school comprehensive Sexuality Education. |
Annual ASRH Progress Report

The Annual ASRH progress report shall provide information on progress on all ASRH indicators presented in the ASRH M&E Framework and key guidance for informed policy decision making and subsequent programmes. This report shall be informed by data collected from provincial ASRH progress reports and any other surveys/studies conducted within the year that demonstrate the outcome level results on ASRH. It shall contain a quantitative and qualitative description of the status of reproductive health among the adolescents and the young people in Zimbabwe for a particular year.

The annual progress report consolidates the following quarterly progress:

- Data on service uptake and milestones against targets
- Annual programme activities, reach and achievements of programmes
- Funding activities and levels for ASRH outcome areas
- New partners in ASRH and yearly initiatives
- Major achievements, challenges, lessons learned, good practices and recommendations.

Annual Service Map

The annual service maps consolidate quarterly information and assist the coordinating agency to ensure right spread and intensity of response to achieve the desired outcomes. The Annual service maps will provide summarized strategic information on activities, funding and partners in priority 1 and 2 districts as classified by the ASRH strategy.

Regional and International Commitments

The ASRH M&E framework will guide the reporting at the Regional and International ASRH committees. Some of the indicators captured in the framework feed data into the regional and international committees and it is important to ensure that this data contributes to ASRH decision-making at the upper levels.

14.1.2 Monitoring data flow

Figure 5 presents the institutional arrangements for data flow. Data will be consolidated at the province level. ZNFPC is the coordinator of the monitoring system. NAC already collects data from the EMIS, ZDG and NARF. Thus this system will be maintained with ASRH related data from these sources moving from NAC to ZNFPC at the provincial level. ZNFPC already has access to the DHIS2 and the NASHIRA and its own ASRH data collection systems for administrative data from youth centres. Data from all these sources will be consolidated by ZNFPC at the provincial level. Once consolidated, analysis of the data will lead to the production of the Quarterly Provincial ASRH Update Report. This report is shared with the Provincial ASRH Coordination Forum for planning.

Data from the provincial level is consolidated at the ZNFPC national office. The data is used to prepare the Quarterly National ASRH Update, ASRH Service Map and the ASRH National Status Report. These reports are shared with the National ASRH Coordination Forum (NCF) chaired by the MOHCC. MOHCC presents the reports to the NCF and the Strategy Steering Committee (SSC). Once shared and approved by the NCF secretariat the reports produced by the monitoring system can be shared with a larger audience beyond that participates in the NCF.
14.1.3 Institutional arrangements for data utilisation

Institutional arrangements for data utilisation are presented in Figure 6. The institutional arrangement follows the ASRH strategy Coordination structures. Decision making using the monitoring system will be undertaken first at the provincial level, through the Provincial ASRH Coordination Committees. At the national level outputs of the monitoring system will be shared in the:

1. Technical Working Groups of the NCF;
2. NCF Secretariat; and
3. SSC.

Figure 6: Institutional arrangements for data utilisation
14.2 Evaluation framework

The evaluation framework consists of the type of evaluations to be conducted. Three types of evaluations will be undertaken:

1. Mid-term evaluation of the ASRH Strategy 2016-2020
2. Final Evaluation of the ASRH Strategy 2016-2020
3. Special evaluative studies of the ASRH Strategy 2016-2020

All evaluative studies will be conducted by external (to the ASRH implementation) and independent agencies. The process will be free from bias ensuring the results are credible and objective. The objectives of the evaluation studies will focus on: accountability, learning and taking stock of results achieved. The Strategy Steering Committee will have overall charge of the commissioning of evaluative studies.

14.2.1 Mid Term Evaluation of the ASRH strategy

The primary purpose of Mid-term evaluation (MTE) is to assess the progress of the strategy implementation halfway through the term against the goal and objectives, recommend recourse and/or revisions, where needed, on the direction the implementation should take in order to meet the set goal and objectives.

The following questions will guide the MTR. These can be adjusted based on the need.

- Are there signs of advances towards the outcomes?
- What progress does the midterm ASRH Tracking Tool show?
- What challenges are causing delays?
- What has changed in the context?
- Is the project still relevant?
- Are there new opportunities?
- How can the challenges be overcome?
- Is it feasible to complete with the remaining resources and the existing context?

14.2.2 End of Strategy Evaluation Report

Evaluations promote accountability and learning. Accountability in the implementation of the ASRH strategy will be enhanced through; 1) measuring the effectiveness, relevance, efficiency, and sustainability of the ASRH programmes; 2) disseminating information to stakeholders and holding discussions; and 3) using the findings to inform resource allocation and decision making. In addition, evaluation generates knowledge about the magnitude and determinants of programme performances; provides information about what worked well and what did not, and why. It also provides information on whether underlying programming theories and approaches used are valid. Evaluation findings guide decision makers and program managers to replicate successful strategies, and improve or develop others.

14.2.3 Special evaluative studies

Special evaluative studies will include:

1. Impact assessment studies
2. Process evaluations
3. Value for money evaluations

The decision of the special evaluative study to undertake will be determined by the presenting need and unanswered questions among implementers. Table 14 summarises the purpose of the special evaluative studies.
Table 14: Purpose of special evaluative studies

<table>
<thead>
<tr>
<th>Type of evaluation</th>
<th>Purpose</th>
</tr>
</thead>
</table>
| Process evaluation                                                                 | □ To assess quality of implementation
  Measures what is done by the programme, and for whom these services are provided and how well the services are being provided. |
| □ To assess appropriateness of activities
  □ To check whether planned beneficiaries are reached
  □ To know if funds are being used correctly
  □ To find out performance of implementers
  □ To confirm if results are likely to be achieved
  □ To identify main obstacles, and real-time solutions |
| Value for Money evaluation                                                          | □ To establish whether an investment is worthwhile
  Comparison of costs and benefits occurring at different times in the lifespan of a project |
  □ a. Is there value for money?
  □ b. Should we do nothing? |
  □ To inform the design of interventions
  □ a. Optimal mix of interventions (low and high return)
  □ b. Reach (how many HHs by type to reach by each activity)
  □ c. Where to intervene (regions, districts)
  □ d. Targeting approaches (some are more expensive than others) |
  □ To facilitate the objective acceptance / rejection of a project |
| Impact Assessment                                                                   | □ Supporting evidence-based policy making;
  The systematic identification of the effects – positive or negative, intended or not – on the beneficiaries (individuals, households, institutions), and the environment caused by a given development intervention such as a policy, plan, program or project. |
  □ Improving design and implementation of policies, plans, programs and projects;
  □ Promoting accountability and transparency; and
  □ Stimulating individual and organizational lesson learning; |
  □ A well-designed impact evaluations can help policymakers, planners and managers to learn about ‘what works and what doesn’t and why’. |

14.3 Users and uses of the M&E framework

The ASRH M&E Framework responds to various user needs. These users include government, development partners, Civil Society Organizations, Private Sector, ASRH Committees, Parliament, Independent Commissions and regional and continental organizations. Researchers will also need data from the monitoring and evaluation system. To support the need for information, several reports will be produced by the M&E framework. These will include an Annual ASRH Status Report and specific reports of the Government of Zimbabwe to report on progress on international and regional adolescent sexual reproduction status and issues. Table 15 presents the users and uses of M&E framework.
<table>
<thead>
<tr>
<th>User</th>
<th>Type of information</th>
<th>Uses of the information</th>
</tr>
</thead>
<tbody>
<tr>
<td>MoHCC</td>
<td>✔ Progress in implementation of ASRH programming plans</td>
<td>✔ Policy making</td>
</tr>
<tr>
<td></td>
<td>✔ Progress on targets for ASRH programming</td>
<td>✔ Budgeting development (ASRH responsive budgeting)</td>
</tr>
<tr>
<td></td>
<td>✔ Progress on achieving targets on international, regional and continental commitments</td>
<td>✔ Resource Mobilisation</td>
</tr>
<tr>
<td></td>
<td>✔ Major achievements in implementing ASRH</td>
<td>✔ Programme formulation and development</td>
</tr>
<tr>
<td></td>
<td>✔ Impact of ASRH programming on ASRH on citizens in Zimbabwe</td>
<td>✔ Measuring progress on ASRH equality and women’s empowerment</td>
</tr>
<tr>
<td></td>
<td>✔ Implementation challenges for ASRH programming</td>
<td>✔ Reporting on progress on regional and international commitments</td>
</tr>
<tr>
<td></td>
<td>✔ Lessons Learnt in ASRH programming</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✔ Emerging good practices in ASRH programming</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✔ Functionality of M&amp;E System</td>
<td></td>
</tr>
<tr>
<td>Other Government ministries</td>
<td>✔ Sector level progress in implementation of ASRH programming plans</td>
<td>✔ Policy making</td>
</tr>
<tr>
<td></td>
<td>✔ Sector level progress on targets for ASRH programming</td>
<td>✔ Budgeting development (ASRH responsive budgeting)</td>
</tr>
<tr>
<td></td>
<td>✔ Sector major achievements in implementing ASRH</td>
<td>✔ Programme formulation and development</td>
</tr>
<tr>
<td></td>
<td>✔ Sector implementation challenges for ASRH programming</td>
<td>✔ Measuring progress on ASRH equality and women’s empowerment</td>
</tr>
<tr>
<td></td>
<td>✔ Sector lessons Learnt in ASRH programming</td>
<td>✔ Reporting on progress on regional and international commitments</td>
</tr>
<tr>
<td></td>
<td>✔ Sector emerging good practices in ASRH programming</td>
<td></td>
</tr>
<tr>
<td>Parastatals</td>
<td>✔ Progress on targets for ASRH programming</td>
<td>✔ Company policy making</td>
</tr>
<tr>
<td></td>
<td>✔ Major achievements in implementing ASRH</td>
<td>✔ Budget for work place and corporate social responsibility programmes</td>
</tr>
<tr>
<td></td>
<td>✔ Impact of ASRH programming on ASRH in Zimbabwe</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✔ Implementation challenges for ASRH programming</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✔ Lessons Learnt in ASRH programming</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✔ Emerging good practices in ASRH programming</td>
<td></td>
</tr>
<tr>
<td>Parliament</td>
<td>✔ Sector level progress in implementation of ASRH programming plans</td>
<td>✔ Policy making</td>
</tr>
<tr>
<td></td>
<td>✔ Sector level progress on targets for ASRH programming</td>
<td>✔ Budgeting review (ASRH responsive budgeting)</td>
</tr>
<tr>
<td></td>
<td>✔ Sector major achievements in implementing ASRH</td>
<td>✔ Monitor achievement of ASRH results</td>
</tr>
<tr>
<td></td>
<td>✔ Progress on achieving targets on international, regional and continental commitments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✔ Impact of ASRH programming on ASRH on citizens in Zimbabwe</td>
<td></td>
</tr>
<tr>
<td>Development partners (donors)</td>
<td>✔ Major achievements in implementing ASRH</td>
<td>✔ Programme formulation</td>
</tr>
<tr>
<td></td>
<td>✔ Progress on targets for ASRH programming</td>
<td>✔ Measuring progress on ASRH equality and women’s empowerment</td>
</tr>
<tr>
<td>User</td>
<td>Type of information</td>
<td>Uses of the information</td>
</tr>
<tr>
<td>------</td>
<td>---------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Civil Society Organisations (CSOs) /Non-Governmental Organisations (NGOs)</td>
<td>□ Progress on achieving targets on international, regional and continental commitments □ Impact of ASRH programming on ASRH on citizens in Zimbabwe</td>
<td>□ Policy advocacy □ Monitor progress on ASRH results in Zimbabwe □ Resource mobilisation □ Programme formulation</td>
</tr>
<tr>
<td>Media Houses</td>
<td>□ Impact of ASRH programming on the nation □ ASRH programming actions</td>
<td>□ Packaging of relevant news for various target groups</td>
</tr>
<tr>
<td>Private sector</td>
<td>□ Progress on targets for ASRH programming □ Major achievements in implementing ASRH □ Impact of ASRH programming on ASRH in Zimbabwe □ Implementation challenges for ASRH programming □ Lessons Learnt in ASRH programming □ Emerging good practices in ASRH programming</td>
<td>□ Company policy making □ Budget for work place and corporate social responsibility programmes</td>
</tr>
<tr>
<td>Citizens in Zimbabwe</td>
<td>□ ASRH programming activities □ Impact of ASRH programming on the nation</td>
<td>□ Policy advocacy □ Decisions at an individual level to participate and benefit from opportunities presented by ASRH programming initiatives □ Decision to safeguard their interests from harm</td>
</tr>
</tbody>
</table>
2. Knowledge Management Systems

A knowledge management system shall be developed to support implementation of the National ASRH M&E Framework. It will enable a systematic way of capturing as well as storing, retrieving, analysing and disseminating M&E data (see Figure 7).

Figure 7: Knowledge Management System for ASRH M&E Framework

14.4 Data capturing

All ASRH data capturing tools will be revised to incorporate all indicators to be tracked with this M&E framework. ZNFPC shall be supported to establish an online database. This database shall be linked NAC CRIS database, MOHCC HIV database, DHIS2 and the NDGD at the provincial level. District level data will be captured within current systems for capturing DHIS2, NARF, NDGD and EMIS.

CSOs implementing ASRH projects and programmes will also submit data to the ZNFPC through the online data capturing forms linked to the ZNFPC ASRH M&E framework database. The data to be submitted by CSOs will be in the format of the NASRHAF tool.

With the advent of GSM availability in many rural localities, the ZNPC should be supported to pilot mobile based data collection systems for community based data collection by implementers - peer educators and other community health cadres).

To improve data compilation the following will be required:

- Register all implementing partners in all districts including renewal of organizational registration annually
- Review and revise existing data collection tools, clarify cutoff dates and reporting timeframes (refer to the Monitoring and Evaluation Calendar for more information).
- Formal linkages between ZNFPC, NAC and MoHCC put in place to establish clear roles and responsibilities and strengthen role of NHIS in data collection.
- Develop a data dictionary to harmonize AIDS and TB, NHIS, and NAC indicators.
- Develop appropriate curricula for initial and refresher trainings for all staff involved in data collection.
- Develop and revise mentoring tools and checklists for continuous support and supervision of staff responsible for data collection.
14.5 Data storage

Data shall be stored in hard copy and electronic formats. Hard copy data shall be that contained in tools completed at the primary level (service delivery point, and in the community). While partners use a variety of data storage facilities (either paper or electronic) the establishment of an online database which development partners can enter their NASRHA data will enhance efficiency in data capture.

However, the establishment of the database also takes into cognizant that some partners at the lower levels district and community may have challenges accessing internet. For those that are unable to access the database paper based completion of the NASRHA data can be done. These forms will be collected by the MOHCC district offices for submission to the ZNFPC provincial office via the provincial Medical Director’s office. Data capturing will be undertaken by the provincial ZNFPC office. While paper based on the NASRHA may be accepted the ZNFPC and MoHCC (at district level) should be supported to fully operationalize paperless storage at the district level.

The M&E guidelines and tools to be developed will provide guidance for data storage but the following measures will improve data storage and transmission:

a. Assist ZNFPC develop an online database;
b. Develop capacity of ZNFPC to capture data on the NASRHA tools; and
c. Develop formal protocol for collaboration on data collection and data sharing between ZNFPC, MoHCC and NAC.

A back up system for electronic data at district and provincial level will be developed as part of the M&E history files.

14.6 Data retrieval

Data shall be managed by an appointed database administrator at each level (provincial and national level) and organization. Access to data on the database shall depend on the user requesting and its intended use.

14.7 Data analysis

Data analysis shall be conducted at two levels – provincial and national – by ZNFPC using standardized reporting templates. The database will also provide dashboards and reports on progress including the geographical maps showing programming areas, coverage and progress.

14.8 Dissemination and sharing

Various methods shall be used to disseminate M&E data. The dissemination will have a feedback loop (user feedback) on the quality and adequacy of data leading to revisions of reporting templates. Data will be disseminated through the ASRH Coordination Forums at provincial and national level. The MOHCC will be responsible for targeted data and information dissemination. Social platforms such as Facebook and Twitter shall be used to generate conversations around specific ASRH issues emanating from monitoring data.

14.9 Decision-making

Decision-making on the ASRH M&E information will be based on the planning and decision making guidelines and tools for the ASRH M&E System coordinated by the MoHCC – the main coordinator of the M&E system. The NCF Secretariat led by MOHCC, will steer decision making based on monitoring data with stakeholders.

14.10 Data Quality Assurance

Data quality assurance is a critical component of the monitoring and evaluation system. The ASRH M&E framework data quality assurance will answer the question, “How well does data meet the needs and expectations of the data users especially decision makers?”

Ensuring data quality enhances integrity of the monitoring outputs and stakeholder trust. This in turn increases
utilisation of the outputs in decision making. The M&E system will address the following data quality challenges through routine integrity checks of the system: omissions, duplications, inconsistencies, and miscalculations that may occur when data is collected, analyzed and finally reported. The need for data quality assurance is further necessitated by the volume of data and complexity of data flow within the ASRH M&E framework. To support data quality the following measures are necessary:

a. Establish a data quality audit procedure
b. Establish formal relationships for data quality assessments between ZNFPC, NAC, and MOHCC.

Data quality audits will be conducted by the NCF secretariat while implementation of the data quality assurance will be the prerogative of ZNFPC, the implementer of the ASRH M&E system.

Annex 1 provides more details on data quality assurance guidelines.

15. Monitoring and Evaluation Calendar

The ASRH Strategy M&E Calendar shows the activities and key dates during which they will be carried out. It is split into two parts, namely monitoring calendar (Table 16) and evaluation calendar (Table 17). The calendars provide information on the outputs from the anticipated activities. The agencies responsible for executing the activities and delivering the outputs are also provided. The ZNFPC will carry primary responsibility for leading and coordinating the generation, packaging and analysis of the ASRH M&E information.

**Table 16: ASRH Monitoring Calendar, Outputs and Responsible Entities**

<table>
<thead>
<tr>
<th>Date (Month, day)</th>
<th>Task / Activity</th>
<th>Description</th>
<th>Output</th>
<th>Responsible Entity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly</td>
<td>Provincial ASRH Coordination Forum meeting</td>
<td>Meeting of ASRH stakeholders at provincial level to monitor activities.</td>
<td>Minutes of the Provincial ASRH Coordination Forum meeting</td>
<td>ZNFPC</td>
</tr>
<tr>
<td>End of March, June, Sept &amp; Dec</td>
<td>Quarterly TWGs meetings at national level NCF Secretariat quarterly meeting</td>
<td>National ASRH Status update Provincial ASRH Status Update National ASRH service map Discussion on</td>
<td>Minutes of TWGs meeting ASRH Update Quarterly Report Minutes of ASRH Secretariat meeting</td>
<td>MoHCC (meetings) ZNFPC (quarterly Report)</td>
</tr>
<tr>
<td>Feb and Nov</td>
<td>Biannual joint monitoring by NCF Secretariat</td>
<td>Monitoring visit to service sites to determine</td>
<td>Joint Monitoring Report</td>
<td>MoHCC</td>
</tr>
<tr>
<td>November</td>
<td>Annual National ASRH status report</td>
<td>ASRH status Annual Report Report</td>
<td>Annual ASRH Service Map Discuss annual report Minutes</td>
<td>ZNFPC MoHCC</td>
</tr>
<tr>
<td>December</td>
<td>Annual SSC meeting</td>
<td>Spot checks Verifying figures, and registers among others, at ward level</td>
<td>Data quality Audit committee (from NCF Secretariat) - MoHCC Community ASRH committee</td>
<td>Audit committee</td>
</tr>
<tr>
<td>Twice a year (June and Nov)</td>
<td>Every programme</td>
<td>Physical inspection of beneficiaries Verification of beneficiaries</td>
<td>Quality and progress report Community ASRH committee</td>
<td>Audit committee</td>
</tr>
<tr>
<td>Last quarter of the year</td>
<td>Database audit</td>
<td>Verifying database information</td>
<td>Quality report</td>
<td>Audit committee</td>
</tr>
</tbody>
</table>
Table 17: ASRH Evaluation Calendar, Outputs and Responsible Entities

<table>
<thead>
<tr>
<th>Task / Activity</th>
<th>Timing</th>
<th>Output</th>
<th>Responsible Entity</th>
</tr>
</thead>
<tbody>
<tr>
<td>End of Strategy/Outcome and Impact Evaluation</td>
<td>Every 5 years</td>
<td>Evaluation Report</td>
<td>ZNFPC</td>
</tr>
<tr>
<td>Mid-Term Review</td>
<td>Mid-Point</td>
<td>Mid-Term Review Report</td>
<td>ZNFPC</td>
</tr>
<tr>
<td>Baseline</td>
<td>At start</td>
<td>Baseline Report</td>
<td>ZNFPC</td>
</tr>
</tbody>
</table>

Notes: "^" Initiative might be tax waiver, input subsidy, special purpose fund, or such the like. "^" Evaluations will be gender-responsive in their design, execution and outputs.

15.1 M&E Implementation Plan

In the first year of implementation, the MoHCC will facilitate the launch of M&E framework. Provincial and district dissemination meetings will be held to provide orientation to both state and non-state institutions and agencies that will be involved in generation of information, updating the indicators, and reporting on them. Financial resource mobilization will also be promoted targeting potential funding source within and outside Zimbabwe. Procurement of hardware (laptops, printing and stationery) and software items (technical assistance for the design of the web-based tool) for the setting up of the M&E System will be done also in the first year and continue into subsequent years.

Capacity development will be started in year 1 starting with ZNFPC head office and formalisation of data sharing, and gathering between ZNFPC, MoHCC and other stakeholders at all levels. The capacity building will be cascaded down to the provincial and district levels. The ASRH M&E System will be periodically reviewed for functionality and quality and timeliness of outputs.

16. Periodic Review of Functionality of ASRH M&E Framework

The ASRH M&E Framework is a living document which is open to a periodic review and refinement guided by lessons from implementation. A participatory review is foreseen starting with one in the first year of implementation in order to quickly resolve any bottlenecks encountered by stakeholders before they discourage them from effectively performing their roles.

The review will be led by the ZNFPC and the NCF Secretariat.

The NCF Secretariat will organize platforms at national, provincial, district and ward level to check on the functionality of the system, quality of its outputs, relevance to decision-making, data gaps, performance of stakeholders in information generation, collation, analysis, reporting, quality assurance, decision-making, and communicating feedback to the information providers and users.

Section 2: Operations Research Framework

17. Introduction

This section presents the Operations research framework for the ASRH Strategy.

The working definition for operations research in the context of this framework is “the search for knowledge on interventions, strategies or tools that can enhance the quality, effectiveness or coverage of programmes in which the research is being conducted”. Operations research is essentially a process for identifying and solving programme problems. Operations research should increase the efficiency, effectiveness, and quality of services delivered by providers, and the availability, accessibility, and acceptability of services desired by users. It also compares one service delivery approach against another in terms of impact, cost effectiveness, quality, and acceptability to among intended beneficiaries.
Thus the success of an operations research conducted for the ASRH strategy will be judged by whether it helped to improve programme performance or influenced policy change by offering robust evidence on key questions being asked.

17.1 Rationale and objectives for Operations Research

Adolescents and young people are a moving target both in terms of mobility, interests, motivations and influencers of behaviour. To remain relevant programmes need to continuously adapt interventions to remain relevant to changing contexts and behaviours of adolescents and young people that have an influence on their sexual and reproductive health. Identifying and agreeing strategies, approaches and interventions that requires evidence of what works and does not work. Furthermore, implementers need to pay attention to the effectiveness and impact of interventions in order change course early on and ultimately achieve cost effectiveness. Without operations research it is difficult for programmes to achieve these critical aspects of ASRH programming.

Thus strong operations framework will support effective implementation of the ASRH strategy ensuring results are achieved in the most cost effective manner.

Objectives of the operations framework are:

1. Improved program outcomes in relation to ASRH;
2. To assess the feasibility of new strategies or interventions;
3. To use evidence for resource mobilisation; and
4. To advocate for policy change.

18. The Operations Research Framework

18.1 Types of operations research

Operations research for the ASRH strategy is divided into four types:

1. Exploratory/diagnostic studies;
2. Field Intervention Studies
3. Evaluative Studies
4. Cost-effectiveness Studies

There are four type of Operations Research which includes the following:

18.1.1 Exploratory/Diagnostic Studies: Problem Not Known

These studies help programme planners and managers understand the underlying factors for an identified problem. They examine the basic factors influencing a problem situation that need to be addressed later through planned programmes. Table 18 presents possible issues to be addressed under this type of operations research.
<table>
<thead>
<tr>
<th>Topic</th>
<th>Issues</th>
</tr>
</thead>
</table>
| Child marriages                            | 1. Explore key drivers of child marriages (Among different sub groups and By geographic coverage)  
2. Who is marrying these children and why?  
3. Why are they resorting to marriage?  
4. What cultural and religious practices are perpetrating child marriage? |
| Adolescent pregnancies                     | 1. Explore key drivers of adolescent pregnancies  
2. Explore why there is lack of utilization of contraception among adolescents especially those who have reached the age of consent  
3. Determine availability of contraceptive services and post abortal care? Identify service barriers.                                      |
| Sexual violence                             | 1. Prevalence of forced sexual encounters among adolescents and young people  
2. Myths and misconceptions of sexual violence  
3. Drivers of sexual violence                                                                                             |
| Emerging social behaviours of young people | 1. Explore current social and sexual behaviour (e.g. vuzu parties, sex races blood covenants etc.) of adolescents and young people that expose them sexual and reproductive ill health.  
2. Explore the drivers of such behaviour                                                                                       |
| Safe cities and safe spaces                 | 1. Exploring behaviour of young people that undermines SRH security in the cities                                                                                                                     |
18.1.2 Field Intervention Studies

Field interventions studies help determine the most effective and efficient solution to an identified causal factor. These studies test, on an experimental basis, new approaches or solutions to overcoming a programme problem. Field intervention studies test new ASRH and HIV/AIDS service delivery approaches. These studies are always prospective and longitudinal and usually employ either an experimental or quasi-experimental research design. Table 19 provides a list of issues to be considered for field intervention studies.

**Table 19: Field intervention studies**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Issues</th>
</tr>
</thead>
</table>
| Community based approaches   | 1. Compare the effectiveness of peer education approaches  
2. Determine effectiveness of media and mobile phone based outreach and other traditional outreach methods                                      |
| Demand creation              | 1. Does the PCC package, as a model for increasing parental knowledge and skills, effective?  
2. How does it compare with other models e.g. Family clubs?                                                                                   |
| Male involvement             | 1. What are the interventions and approaches that work for increasing male involvement in ASRH and HIV activities?                        |
| Emerging intervention        | 1. Determine effectiveness of emerging approaches for reaching adolescents and young people e.g.  
a. Social media  
b. Entertainment  
c. Awareness  
Comprehensive Sexuality Education | 2. How effective is the CSE approach in the school and community setting?  
3. What has been the contribution of CSE to behaviour change?                                                  |
| STI and HIV                  | 1. What are the common syndromes  
2. Where are they getting treated?                                                                                                           |

**Table 20: Evaluative studies**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Issues</th>
</tr>
</thead>
</table>
| Impacts of ASRH approaches   | Impact assessment of ASRH interventions (service utilisation and safe sexual and reproductive health practice)  
Measure sustainability of results of the ASRH strategy                                                                                       |

18.1.3 Evaluative Studies

Very often, SRH and HIV/AIDS activities are implemented for years but never assessed. In such cases, evaluative studies can be a valuable operations research approach for examining retrospectively or cross-sectional the effect of program activities. Evaluation is an ongoing process that should occur continually over the life of a programme. Table 20 presents evaluative studies to be considered in the operations research.

18.1.4 Cost-effectiveness Studies

In many cases, the overall impact of a programme in terms of increasing knowledge about HIV, changing unsafe sex practices, or reducing HIV transmission may be known, but the cost and particularly the cost-effectiveness of the programme are unknown. For programme managers who have to make difficult decisions about allocating scarce resources, cost effectiveness studies can be a valuable management tool, and cost-effectiveness analyses are frequently part of intervention and evaluation studies. Table 21 summarises the cost effectiveness studies to be undertaken in this Operations research framework.

**Table 21: Cost effectiveness studies**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost effectiveness of the intervention</td>
<td>Assess cost effectiveness of selected successful new interventions for scale up?</td>
</tr>
</tbody>
</table>
18.2 Management arrangements for Operations Research

Operations research shall be coordinated by ZNFPC with technical support from the NCF Secretariat. TWGs through the NCF will develop operations research topics that the NCF secretariat will deliberate and approve. ZNFPC will be in charge of coordinating such research as operations research falls within the confines of the monitoring and evaluation framework.
19. Bibliography:

3. Adolescent and Sexual Reproductive Health, Strategy Advocacy Package (Draft), Ministry of Health and Child Care, 2015
5. Adolescent and Sexual Reproductive Health, Strategy: Mid-term Review: Assessment of Approaches to Reaching Young People in the Community with SRHR Information and Services, P. Chiororo et al., UNFPA, 2012
6. All In End Adolescent/AIDS Country Assessment to Strengthen Adolescent Component of National HIV Program in Zimbabwe: Phase 1 – Rapid Assessment Findings, Ministry of Health and Child Care, 2015
7. Anti-Domestic Council Strategic Plan, Ministry of Women’s Affairs Gender and Community Development, 2012-2015
8. Assessment of approaches to reaching young people in the community with SRHR information and services, P. Chiororo et al., UNFPA, 2012
10. Effective Adolescent Sexual and Reproductive Health Education Programs in Sub-Saharan Africa, Kalemba F. W. University of California project, 2013
13. Emerging Infectious Diseases • www.cdc.gov/eid • Vol. 12, No. 11, November 2006
14. Factors associated with utilization of ASRH services offered at Harare Youth Friendly Corner by the youths in Harare Urban District, Mapfurira J, Dissertation MA programme, UZ, 2013
15. Factors contributing to Teenage Pregnancies in a Rural Community of Zimbabwe, Journal of Biology, Agriculture and Health Care. Volume5. No 14. 2015:
22. HIV Estimates Zimbabwe, Ministry of Health and Child Care Spectrum, 2014
23. Improving the Quality of Reproductive Health Care for Young People, Creel L. C., Perry R. J, 2002
36. Scaling up HIV/AIDS prevention programmes in selected rural areas, Restless Development, 2012
37. Sexual and productive Health (SRH) services with HIV interventions in practice Background, Paper 26th Meeting of the UNAIDS Programme Coordinating Board Geneva, Switzerland 22-24 June 2010
42. What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practices Venkatraman Chandra-Mouila,*, Catherine Laneb,*†, Sylvia Wongc
43. What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practice, Global Health, Science and Practice 2015 | Volume 3 | Number 3:
44. WHO Guidelines on Preventing Early Pregnancy and Poor Reproductive Outcomes Among Adolescents in Developing Countries, WHO, 2011
45. Zimbabwe Demographic and Health Survey, Key Indicators ZDHS 2015
48. Zimbabwe Policy Guidelines on Voluntary Medical Male Circumcision. MOHCC
ANNEXES
Annex 1: Policies and Legal Instruments

Key regional and international commitments and Conventions that promote SRH
- International Conference on Population and Development (ICPD), 1994,
- Sexual and Reproductive Health Strategy for the SADC Region: 2006 – 2015,
- Universal Declaration of Human Rights, Economic, Social and Cultural Rights Covenant,
- United Nations General Assembly Special Session on HIV and AIDS (UNGASS)
- WHO Standards

Policies and Laws that guide implementation of ASRH Strategy:

- **National reproductive health policy**: Defines reproductive health explicitly and emphasizes user friendly reproductive health services for young people, including young people’s and parent’s involvement;
- **National population policy (1999)**: Defines individual rights to choose freely the number and spacing of children;
- **National gender policy and strategy**: Includes campaigning against early marriage and also prevention of sexual violence;
- **Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) 2006-2010 & 2011-2015**: Define national response to HIV including prevention, treatment and care among young people. This replaced the National HIV policy (1999). The National HIV Policy was the first Zimbabwe policy guideline on prevention and management of HIV.
- **Zimbabwe maternal and neonatal health road map**: Defines the country’s strategy to address reproductive health;
- **National health strategy, 2008-2013**: Defines the overall health strategy and encompassed reproductive health;
- ‘**Life skills, Sexuality and HIV and AIDS Education Strategic Plan 2012-2015**’ Allows minors who have fallen pregnant to be readmitted in school after delivery; availing Comprehensive Sexuality Education (CSE)

Existing Laws that guided ASRH Strategy Development:

- **Termination of Pregnancy Act (Chapter 15:30)**: Permits abortion only if the pregnancy endangers the life of a pregnant woman, or constitutes a serious threat of impairment of physical health, where there is high risk of serious deformity for child being born, and in cases of unlawful intercourse;
- **Sexual Offences Act (Chapter 09.21)**: Protects children from sexual abuse. Criminalizes sex with a minor under 16 years for girls and wilful transmission of HIV;
- **Domestic Violence Act (Chapter 05:16)**: Offers remedies for acts of violence and criminalizes harmful cultural practices such as virginity testing, forced child marriage, forced wife inheritance;
- **The Child Protection and Adoption Act (Chapter 05:06)**: Protects the rights and safety of children, prevention of neglect, ill-treatment and exploitation of children and young persons. Guidelines on adoption of children;
- **The Marriage Act (Chapter 05:11)**: Precludes marriage for boys under 18 and girls under 16. Under customary marriage act no age specification for marriage is pronounced. The girl’s guardian approves the marriage.
Annex 2: Data Quality Assurance Guidelines
The six ASRH data quality dimensions:

Good data quality must be consistent with the following six data quality dimensions:

- **Availability**: This describes the availability of required data using the approved ASRH data collection tools. Source documents (data collection forms and databases) for the reported data and information should be readily available to prove that services were indeed provided to beneficiaries.

- **Accuracy**: The closeness of measured values or observations to the true value without bias, manipulation or duplications/double counting. It is a measure of the extent to which data reflect reality. Accuracy will be determined by a rigorous data collection process and competency of data collectors.

- **Completeness**: This refers to non-existence of errors of omission such as omitted records in a dataset or variables with no data in a form. It addresses the question of whether all eligible data are included in a data collection form.

- **Consistency**: Describes the non-existence of data contradictions across all data sources which include data collection forms, electronic registers and the final reports. Consistency in turn determines the reliability of data; when data is inconsistent, it is regarded less reliable.

- **Timeliness**: Data is timely when it can be availed as per schedule or requirements without delay.

- **Integrity**: Data has integrity when the system used to generate them is protected from deliberate bias and manipulation by individuals. It also means the data is appropriately secured in both hard copy and electronic files.

<table>
<thead>
<tr>
<th>Element</th>
<th>ASRH Measures</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability</td>
<td>Capacity building (training, mentoring)</td>
<td>Train data collectors and analysts on the tools to be used, indicators and how to complete tools including the reporting protocol and timelines</td>
</tr>
<tr>
<td></td>
<td>Data storages</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Budget for tool printing</td>
<td></td>
</tr>
<tr>
<td>Accuracy</td>
<td>Capacity building (training, mentoring)</td>
<td>Make data verification routine</td>
</tr>
<tr>
<td></td>
<td>Data verification (spot checks, triangulation – email) ad hoc</td>
<td>Mentor stakeholders on data quality (quarterly physical meetings)</td>
</tr>
<tr>
<td></td>
<td>Database with checks and balances</td>
<td>Database query to capture unique count (registers)</td>
</tr>
<tr>
<td></td>
<td>Division of areas of operation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Translated tools for understanding</td>
<td></td>
</tr>
<tr>
<td>Consistency</td>
<td>Capacity building (training, mentoring)</td>
<td>Maintain consistent use of tools, carry out checks and compare tools, use other data sources to compare information</td>
</tr>
<tr>
<td></td>
<td>Data verification (spot checks, triangulation – email) ad hoc</td>
<td></td>
</tr>
<tr>
<td>Timeliness</td>
<td>Capacity building (training, mentoring)</td>
<td>Design reporting protocol with clear timelines and responsible people/organization</td>
</tr>
<tr>
<td></td>
<td>Calendar and reminders for data submission</td>
<td>Ensure resources available for data movement from one sources to another</td>
</tr>
<tr>
<td></td>
<td>Transport available to assist in reporting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Budget for tool printing</td>
<td></td>
</tr>
<tr>
<td>Integrity</td>
<td>Capacity building (training, mentoring)</td>
<td>Train data collection cadres and ensure clearly defined data handling and management system to reduce leakages</td>
</tr>
<tr>
<td></td>
<td>Data storages</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Database with checks and balances</td>
<td></td>
</tr>
<tr>
<td>Completeness</td>
<td>Capacity building (training, mentoring)</td>
<td>Train data collectors on indicators collected and why they are important. Triangulate data and provide feedback on received data Allow enough data for data capture and cleaning.</td>
</tr>
<tr>
<td></td>
<td>Data verification (spot checks, triangulation – email) ad hoc</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Translated tools for understanding</td>
<td></td>
</tr>
</tbody>
</table>
- **Raising awareness on the importance of data quality:** In order to ensure that data quality agenda is understood and adhered to DQA issues will be discussed in different level where data collection and aggregation occurs from the community to national level so that all cadres handling data are committed and adhere to set data management and reporting standards. This exercise is done to all new stakeholders and also continuously depending on gaps identified during the implementation of project activities.

- **Monitoring and Evaluation Framework:** a comprehensive Monitoring and Evaluation Framework detailing monitoring, reporting, evaluation and data management standards, tools and procedures for each has been developed.

- **Monitoring, reporting and evaluation capacity strengthening:** The ASRH programme promotes increased data collection, entry, consolidation, analysis and reporting knowledge and skills of all stakeholders and their staff through formal trainings, coaching, and mentoring support. Through capacity strengthening, it is hoped that all the six data quality dimensions are achieved by stakeholders.

- **Data collection and reporting tools:** to ensure accuracy and reliability, ASRH stakeholders will develop or adapt simple and standard data collection and reporting tools and these tools are continuously reviewed and updated so that they remain relevant to the context. Appropriate utilization of these tools by building the capacity building of users is necessary.

- **Data reporting guidelines:** to enable timeliness and accuracy, reporting guidelines that are consistently communicated to all stakeholders to ensure adherence will be developed. Reporting is also done regularly on monthly and quarterly basis.

- **Data verification visits:** data verification is one of the most effective measures that will be adopted to ensure that data of good quality is reported to key stakeholders:- in simple terms, data generated by at each level of programming/reporting will be tested if it is consistent with the six data quality dimensions. Records that are not consistent with these dimensions are discarded. A data verification checklist tool will be developed and utilized to assess data quality. ASRH team will conduct data verification visits to relevant stakeholders on monthly and quarterly basis. The process involves the random selection of list of records from the Monthly reports to be checked against the source documents which are kept at lower echelons.
### Annex 3: Process Indicators

<table>
<thead>
<tr>
<th>Outcome ref</th>
<th>Output</th>
<th>Ref Number: Indicator</th>
<th>Unit</th>
<th>Target</th>
<th>Allowable variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1.1, 1.2</td>
<td>PROC1101: Number of young people reached with CSE (disaggregated by sex, age, community, new &amp; old and training provider (peer educator, NGO staff, teacher in school, tertiary institution))</td>
<td>number</td>
<td>TBA</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2.1</td>
<td>OUT2101: Percentage of randomly selected retail outlets and service delivery points typically accessed by young people that received condoms supplies in the last month</td>
<td>%</td>
<td>TBA</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2.1</td>
<td>OUT2102a: Proportion of service outlets (public and private) whose staff received training in offering a minimum package SRH and HIV services to adolescents and young people according to the Service Guidelines for Youth Friendly health service provision</td>
<td>%</td>
<td>TBA</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2.1</td>
<td>OUT2102: Proportion of service outlets (public and private) that were supported with supplies to offer a minimum package SRH and HIV services to adolescents and young people according to the Service Guidelines for Youth Friendly health service provision</td>
<td>%</td>
<td>TBA</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2.1</td>
<td>OUT2103: Percentage of Service Delivery Points (SDPs) meeting all standards on Youth Friendly Service Provision (YFSP) (Disaggregated by setting)</td>
<td>%</td>
<td>TBA</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2.1</td>
<td>OUT2104: Percentage of SDPs meeting all standards on (YFSP) (Disaggregated by setting)</td>
<td>%</td>
<td>TBA</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2.1</td>
<td>OUT2105: Percentage of adolescents and young people interviewed that highly satisfied with SRH and HIV service delivery at the local service provider (disaggregate by service provider sex and geography)</td>
<td>%</td>
<td>TBA</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2.2</td>
<td>OUT2201: Proportion of adolescents and young people who are aware of SRH and HIV services costs.</td>
<td>%</td>
<td>TBA</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>3.1</td>
<td>OUT3101: Number of policies reviewed addressing barriers identified in the problem statement</td>
<td>number</td>
<td>TBA</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>3.2</td>
<td>OUT3201: Number of functional ASRH Committees (Disaggregated by community)</td>
<td>number</td>
<td>TBA</td>
<td></td>
</tr>
<tr>
<td>Outcome ref</td>
<td>Output</td>
<td>Ref Number: Indicator</td>
<td>Unit</td>
<td>Target</td>
<td>Allowable variance</td>
</tr>
<tr>
<td>------------</td>
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<td>--------------------------------------------------------------------------------------</td>
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<td>--------------------</td>
</tr>
<tr>
<td>3</td>
<td>3.3</td>
<td><strong>OUT3301:</strong> Number of young people who got reprimanded of their behaviours by their parent or primary caregiver (low, medium or high level)</td>
<td>number</td>
<td>Baseline</td>
<td>2015</td>
</tr>
<tr>
<td>3</td>
<td>3.3</td>
<td><strong>OUT3302:</strong> Number of parents/caregivers in parental care dialogues</td>
<td>number</td>
<td>2015</td>
<td>2016</td>
</tr>
<tr>
<td>3</td>
<td>3.3</td>
<td><strong>OUT3303:</strong> Number of households reached with PCC</td>
<td>number</td>
<td>2015</td>
<td>2016</td>
</tr>
</tbody>
</table>
Annex 4: Problem Tree for the ASRH in Zimbabwe

Immediate effects:
- High Teen Pregnancies
- High new STD and HIV infection
- High pregnancy complications among adolescents

Immediate causes:
- Early sexual debut
- Increased child marriages
- High incidence of sexual violence
- Low consistent and correct use of STD and HIV prevention services, and FP methods
- Low in utilisation of ANC, delivery and PNC services

Primary causes:
- Increased school drop-outs
- Weak community care and support services for ASRH
- Weak parent to child communication, care and support
- Low access to justice for sexual violence cases against adolescents and young people
- Low availability of quality youth-friendly integrated ASRH and HIV services
- Unaffordability of quality youth-friendly integrated ASRH and HIV services

Secondary causes:
- High household poverty
- Presence of harmful cultural, social and religious beliefs and norms
- Low awareness and knowledge among adolescents, young people and adults
- Weak protective systems for securing ASRH rights
- Weak plans, programmes and budgets for delivery of youth friendly ASRH services
- Lack of economic opportunities
- Low access to correct knowledge on ASRH and HIV among young people, adolescents, and adults
- Weak ASRH policy and legislative environment
Health Development Fund

Supporting the National Health Strategy to improve access to quality health care in Zimbabwe