Zimbabwe National Family Planning Advocacy and Communications Strategy

2018 - 2020

PRIMARY HEALTH CARE • A HEALTHY NATION • MINISTRY OF HEALTH AND CHILD CARE ZIMBABWE

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Family Planning: It's Your Choice

Zimbabwe National Family Planning Advocacy and Communications Strategy

2018 - 2020

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Acronyms

A&C	Advocacy and Communication
ATB	AIDS and Tuberculosis
ASRH	Adolescent Sexual and Reproductive Health
BCCF	Behaviour Change Communication Facilitators
CBDs	Community Based Distributors
CBOs	Community Based Organisations
CIP	Costed Implementation Plan
CPR	Contraceptive Prevalence Rate
CSOs	Civil Society Organisations
DOI	Diffusion of Innovation
IEC	Information, Education and Communication
FBOs	Faith Based Organisations
FP	Family Planning
GoZ	Government of Zimbabwe
HCC	Health Centre Committee
IUCD	Intra-Uterine Contraceptive Device
LARCs	Long Acting Reversible Contraceptives
M&E	Monitoring and Evaluation
MNCH	Maternal, New-born and Child Health
MoHCC	Ministry of Health and Child Care
NAC	National AIDS Commission
OVC	Orphans and Vulnerable Children
PMTCT	Prevention of Mother to Child Transmission
PPP	Public Private Partnerships
PWD	Persons with Disability
SDGs	Sustainable Development Goals
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
VAACs	Village Action AIDS Committee
VHWs	Village Health Workers
WAAC	Ward AIDS Action Committee
ZDHS	Zimbabwe Demographic Health Survey
Zim Asset	Zimbabwe Agenda for Sustainable Socio-Economic Transformation
ZimVac	Zimbabwe Vulnerability Assessment Committee
ZNFPC	Zimbabwe National Family Planning Council

Foreword

The National Family Planning Advocacy and Communication Strategy aims to support and sustain achievements of the Zimbabwe National Family Planning Strategy (ZNFPS) and Costed Implementation Plan (2016 - 2020) goals of increasing Contraceptive Prevalence Rate (CPR) from 65.6% to 68% and reducing teenage pregnancy rate from 22% to 12% by 2020. As per this Strategy, actors will undertake advocacy and communication work through five strategic thematic areas focusing on; Creating an enabling environment, Strengthening the supply chain and commodity security, Improved quality integrated service delivery, Increased demand and comprehensive FP knowledge and Enhanced monitoring and evaluation and research.

Cutting across these strategy areas are six key strategic priorities that will drive the family planning agenda forward; reducing teenage pregnancies, providing family planning services in integrated setting, increasing utilisation of long-acting reversible contraception (LARC) and permanent methods, addressing child marriage, increased resource mobilisation for FP/RH, and reducing unmet need among excluded and hard to reach groups including young people, people with disability, those in religious sects and remote areas.

The implementation plan also defines measurable results that need to be achieved, an implementation timeline, and metrics to facilitate performance measurement. The strategy identifies the main targets for advocacy as follows, policy makers, health sector leaders and service providers, community leaders, NGO and private sector, community members, and the media.

The advocacy and communications strategy incorporates five interconnected dimensions of coordination, partnerships, innovations, multi-media engagement and edutainment. The approaches to be implemented include advocacy, social mobilisation and behaviour change communication. The advocacy and communications strategy was developed around a key strategic goal, mainly to increase investment and access to inclusive and quality integrated family planning and related sexual and reproductive health and rights services by 2020.

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

Acknowledgements

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Executive Summary

Background

Family Planning (FP) and Sexual and Reproductive Health and Rights (SRHR) are a critical contributing factor to ensuring improved health outcomes. FP is one of the most cost effective interventions to prevent maternal and child deaths. Condoms, one type of a contraceptive, prevents transmission of sexually transmitted infections (STI), including HIV. As part of Reproductive Maternal Neonatal Child and Adolescent Health (RMNCAH) programme, FP and SRHR are well articulated in country's current national development frameworks.

Though overall usage of contraceptives in the country is high yet the programme has its share of weaknesses, particularly limited choice, weak integration with other programmes and poor accessibility by certain sections of the population. The levels of knowledge, skills, attitude and behaviour (about contraceptives) among both providers and clients vary widely.

The political transition in the country has triggered some shifts in the Zimbabwe FP and Sexual and Reproductive Health Rights sector, which will also impact the implementation of the national advocacy and communications activities for the programme.

Conceptual Framework

This Strategy is based on the Ecological Model, which describes the social ecological approach to behaviour change. This approach recognises that individual behaviour change is determined by a complex socio-cultural environment in which the individual lives and grows. The Model helps in taking into account all determinants of behaviour at every stage.

Behaviour Change

Behaviour change (and development) is an individual attribute, which collectively leads to social change. It requires advocacy and communication for creating right conditions (enabling environment) and transmitting right information. Audience specific, channels of communication, packaging and delivery of messages are key in behaviour change. Advocacy, Social Mobilisation and Behaviour Change Communication are three main approaches in the long process of behaviour and social change. Each of these have a role on both provider and seeker side of the programme. Message being the main content of advocacy and communication, is at the center of behavior change. Their relevance, reach and frequency determine their effectiveness.

Rationale for the FP Advocacy and Communication Strategy

An all-encompassing National Advocacy & Communication Strategy is required to guide and drive the relevant response to the identified gaps and challenges. Advocacy and communication is at the centre of each stage of programme, such as mobilising political leadership, generating resources, implementing or creating demand. It is in this background that this Strategy was developed. Apart from other strategic goals of ZNFPS, the strategy will specifically, contribute to: 'Increasing investment and access to inclusive and quality integrated family planning and related sexual and reproductive health rights services by 2020'.

The Focus

The focus of the Strategy is the prevailing weak communications capacity within the health system to provide comprehensive FP information services. This perpetuates myths and misconception, harmful religious and cultural beliefs and social practices. Men's negative views, poor social status of women, lack of friendly services for young people and legal prohibitions for some groups to access contraceptive and FP services are other contributing factors. Addressing these require political commitment, focused plan, robust partnership and targeted implementation. The National FP Advocacy & Communication Strategy (FPACS) seeks to guide and address these.

The Strategic Results

This advocacy and communication strategy will support achievement of the National Family Planning Strategy (ZNFPS) goals of increasing Contraceptive Prevalence Rate (CPR) from 65.6 percent to 68 percent and reducing teenage pregnancy rate from 22 percent to 12 percent by 2020. Under the ZNFPC Strategy, actors will work through five strategic thematic areas focusing on:

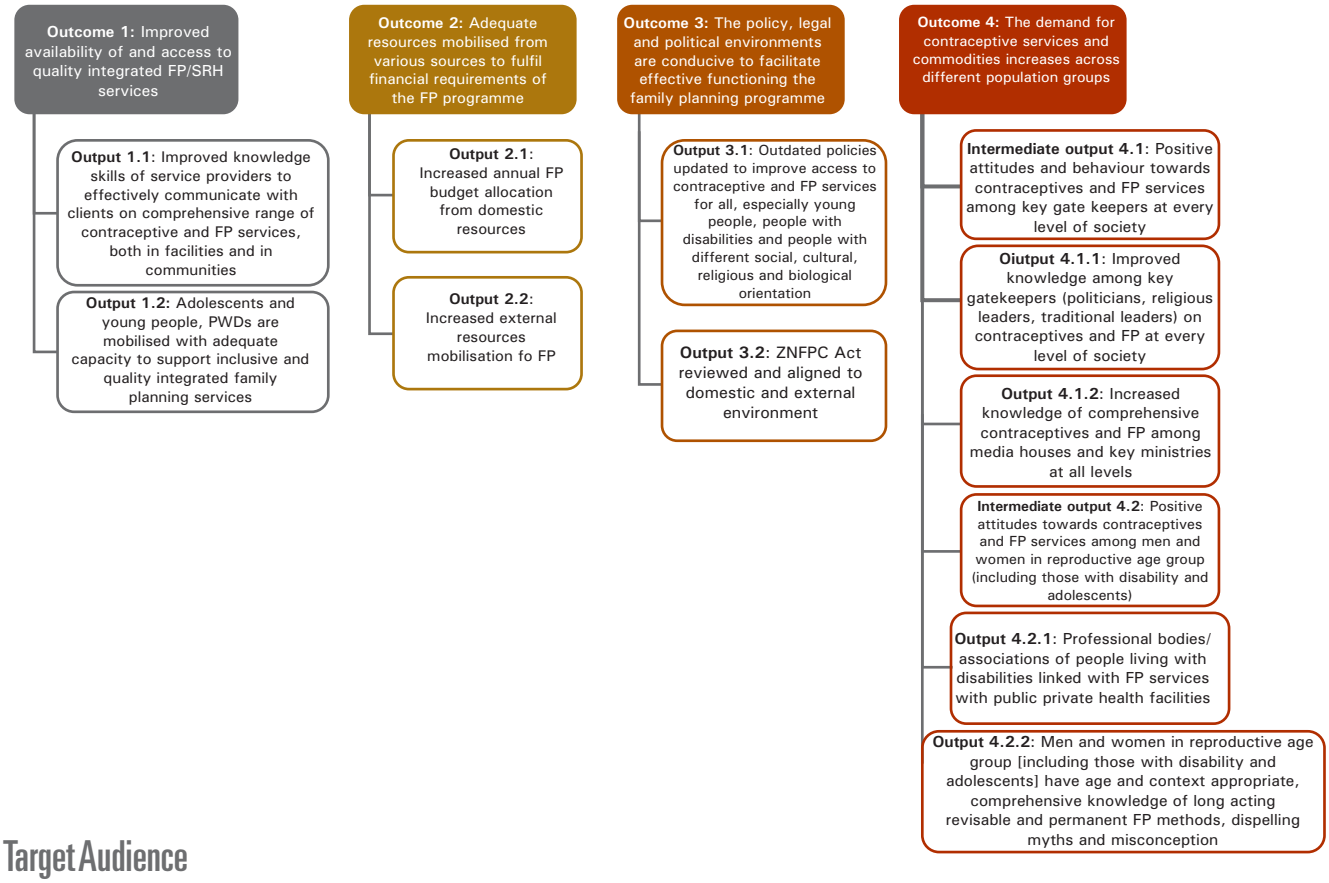
- Creating an enabling environment;
- Strengthening the supply chain and commodity security;
- Improved quality integrated service delivery;
- Increased demand and comprehensive FP knowledge; and
- Enhanced monitoring and evaluation and research.

The Advocacy and Communications Strategy will work in harmony with the national strategic goals, objectives and thematic areas. It will support achievement of the five outcomes of the Zimbabwe Family Planning Strategy 2016-2020 by delivering on four key results that include:

1. Adequate resources mobilised from various sources to fulfil financial requirements of the family planning programme
2. Conducive policy, legal and political environments to facilitate effective functioning of the family planning programme
3. Improved quality of integrated FP/SRH services by service providers in facilities and communities
4. Increased demand for contraceptive services and commodities across different population groups and geographic areas of Zimbabwe

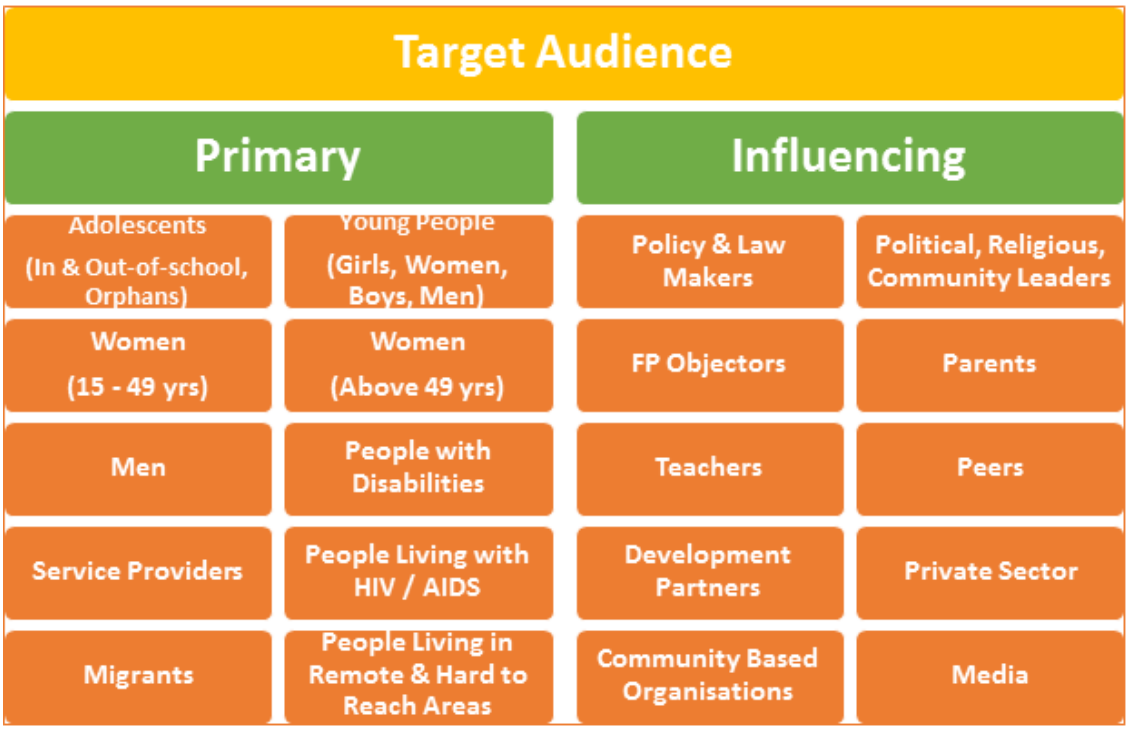
These key result areas are underpinned by specific outputs and intermediate outcomes as depicted in the results chain in Figure 1. These outputs and intermediate outcomes are aligned to those pursued by the National Family Planning Strategy. Therefore, the advocacy and communication strategy results chain maintains alignment to the intentions of the National Family Planning Strategy.

Figure 1: Advocacy and communication strategy results chain



Target Audience

The audiences are segmented to enable target specific messaging. The audiences are segmented based on their uniqueness in the population of Zimbabwe and with similar interests and needs related to family planning. They are segmented into Primary Audiences and Influencing Audiences as shown below:



Priority Behaviour Change

The strategy strives to affect following changes in behaviour as shown below.

Target group	Key behaviour Change
Adolescents and young people	• Abstinence, • Safer Sex, • Using Contraceptives, • Seeking advice and help from professionals
Service Providers	• Dealing with adolescents, young, women and men with sensitivity in providing comprehensive information and clinical contraceptive and FP services, both in facilities and in communities
Religious leaders	• Talk about, advice, guide and influence their communities/constituents on contraceptives and FP on the basis of evidence and from informed position
Teachers	• Guide, inform and counsel students in age appropriate and sensitive manner on sexual and reproductive health matters on the basis of evidence and informed position, they refer, support children in seeking professional help
Older Women	• Support their younger female and male relatives (daughters'-in-law, nieces, sons and nephews) in taking appropriate decisions in matters of sexual and reproductive health, including FP. • They proactively support their younger female relatives (daughters'-in-law, daughters, nieces etc) in practicing FP and taking care of their health
Women	• Make informed decision about contraceptives as per their need and choice and using them, asserting safer sex practice with partners, seeking help and advice from professionals
Political leadership	• Undertake evidence based lobbying for increased domestic resource allocation to FP programme. • Advocate for contraceptives & FP service uptake in their constituencies
Community Leaders	• Advice, guide and influence their communities/constituents on contraceptives and FP on the basis of evidence and from informed position, they actively participate in health affairs of their communities and liaise with local health facilities
Peers	• Abstain, practice safer sex, seek professional help and share / discuss these with their peers, they identify problems / issues with their peer on matters of Sexual & Reproductive health and proactively reach out to them for support/advice
Media	• Report correct information and stories about contraceptives and FP. • Dispel myths and misconceptions / negative views on FP by positive reporting
Men	• Support sex partners in use of contraceptives, discussing with partners & practicing safer sex, discussing with partner the family size, using condoms and adopting vasectomy, seeking help & advice from
Policy Implementers	• Draft and present evidenced based information & advice to their political authorities for increased domestic allocation to FP programme. Oversee & review FP programme implementation periodically at all levels
Parents	• Guide, handle, counsel, advice their children in a sensitive manner on sexual and reproductive health matters, they proactively support /accompany their children in seeking professional help/advice/services
Civil Society Organisations	• Work with their target groups to improve information, knowledge, skills and practice on sexual and reproductive health matters based on evidence and informed position. • Help in seeking/approaching professional help / support
Community Based Organisations	• Work with their target groups to improve information, knowledge, skills and practice on sexual and reproductive health matters based on evidence and informed position, they help in seeking approaching professional help / support

1 Definition of Key Terms and Concepts

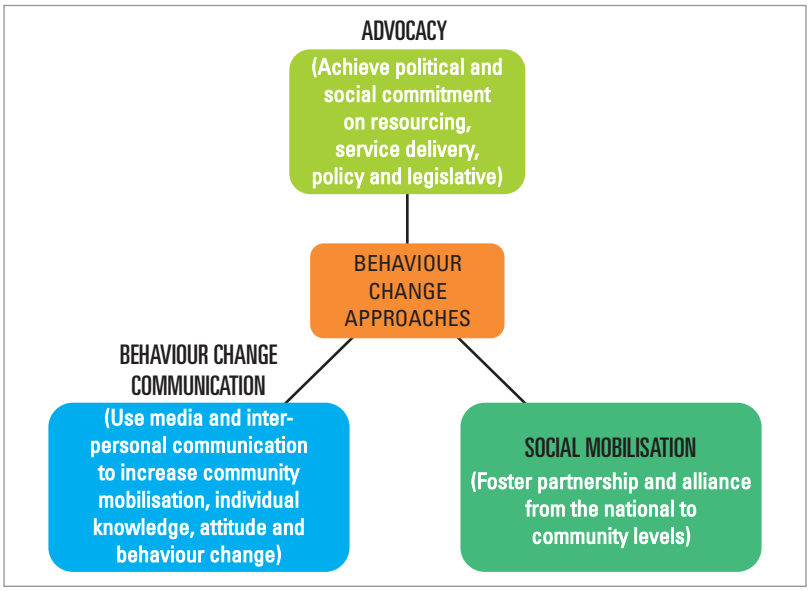
Behaviour Change

Behaviour change (and development) is an individual attribute, which collectively leads to social change. It requires advocacy and communication for creating right conditions (enabling environment) and transmitting right information. Audience specific communication through most appropriate channel/channels over a sustained period is key. Media and interpersonal communication (IPC) are two main channels for this. Role models, brand ambassadors and champions play important role in the effectiveness of these channels, receptivity of the messages and behaviour change. Packaging and delivery of messages (and services), in a culturally sensitive and acceptable manner is equally important. Proven concepts and approaches, like Positive Deviance[1] and Diffusion of Innovation (DOI)[2] theory can help in planning approaches for behaviour change.

Behaviour Change Approaches

Advocacy, Social Mobilisation and Behaviour Change Communication are three main approaches (Figure 3) in the long process of behaviour and social change. Each of these have a role on both provider and seeker (sides of the programme). Both need advocacy, mobilisation and behaviour change communication to strengthen programme and remove bottlenecks in service provision and demand for services.

Behaviour Change Approaches



Adapted from: The Kenya Malaria Communication Strategy 2016-2021

Advocacy ensures that the national government, policymakers, donors and media: i) remain engaged, ii) are strongly committed to improving laws and policies for enhancing coordination and improved access to the programme, iii) allocate adequate funding for the programme; and iv) the programme remains high on public agenda.

Social Mobilisation harnesses impact of the collective through bringing community members, service providers and other stakeholders together to strengthen service delivery, community participation and

[1]Positive Deviance: Positive behaviour by some individuals in the community, who act differently, can influence positive change in families, schools and communities
[2]Diffusion of Innovation (DOI) Theory: It explains how, over time, an idea or product gains momentum and spreads through a specific

utilisation of services toward improving sustainability and self-reliance. Social mobilization generates dialogue, facilitates negotiation and builds partnership and consensus among players.

Behaviour Change Communication is a set of organized communication interventions and processes aimed at influencing social and community norms and promoting positive behavioural change among individuals. It pertains to both service providers and seekers. Community mobilisation through media and Inter - Personal Communication (IPC) are at the heart of it.

Message and Delivery

Message is the main content of advocacy and communication and hence at the center of behavior change. Content, packaging and delivery of massages determine their acceptability and reach. Therefore, these need to be selected carefully. These are also in line with the key principles of communication and message delivery, viz., 1) Relevance 2) Reach, 3) Frequency. Box 1 briefly elaborates these principles.

Box 1: Key Communication & Message Delivery Principles

Message Relevance: The message must be contextual, gender sensitive, appropriate and directly linked to the intended audience. The audience should be able to relate with it. It should address the issues and concerns faced by them and packaged appropriately, for example issues of barriers, myths and misconception etc. It should therefore, lead to some thinking, discussion and hence action and change.

Reach: For message to have intended impact, it has to reach right audience at scale. Depending on the purpose, advocacy or information delivery, the audience could be many, having to be reached concurrently or in stages, starting from policy makers, to policy implementers to community gatekeepers to end users. Some common audience are public, men and women, adolescents, youth, vulnerable people (disabled etc.) legislators, civil servants, services providers, Civil Society Organisations (CSO), Community, Traditional and Religious leaders and Objectors etc.

Frequency: Consistent and sustained delivery of messages from varied sources is required for generating interest and influencing behavior change. However, its frequency varies from situation to situation and is context and need based. New messages, particularly, rooted in social context and meant for vulnerable segments take longer and require more frequent delivery than other messages.

Annexure 3 provides a detailed list of possible messages for the segmented audiences for priority behaviours.

Concept of Target Audience

Clear understanding of the audience is important for the effectiveness of messages. Segmenting audience is a way of achieving this. Based on common characteristics, segmentation enables targeted approaches and messaging. This helps in developing specific messages, appropriate packaging and unique delivery according to the audience. There are two broad categories of audience, viz., 1) Primary or 2) Influencing.

Primary Audience: Primary Audience is the key group to be reached with specific messages, e.g., FP. This is the direct beneficiary or the end user of the message or programme linked with the message. This also includes decision makers who are reached for making right policies, frameworks or take right decisions. Primary Audience can be segmented into sub groups like religious, political and community leaders; in-school and out-of-school adolescents; married and unmarried young women of child bearing age, men, women, boys etc.

Influencing Audience: The Influencing Audience is the one that directly or indirectly impacts on the knowledge and behaviours of the Primary Audience. For example, parents, teachers, husbands, peers, community leaders are Influencing Audience for FP service uptake in the community. For political, religious and community leaders, their highest authorities, churches, sects that influence them are their Influencing Audience. It is critical to identify and prioritise reaching Influencing Audience due to their power of influence on the Primary Audience to effect change in their knowledge, attitude and practice.

2 Background on Family Planning and Sexual Reproductive Health Rights

2.1 Situation Analysis

Family Planning (FP) and Sexual and Reproductive Health and Rights (SRHR) are a critical contributing factor to ensuring improved health outcomes. FP is one of the most cost effective interventions to prevent maternal and child deaths. Condoms, one type of a contraceptive, prevents transmission of sexually transmitted infections (STI), including HIV. As part of Reproductive Maternal Neonatal Child and Adolescent Health (RMNCAH) programme, FP and SRHR are well articulated in country's current national development frameworks, viz., Zimbabwe Agenda for Sustainable Socio-Economic Transformation blue print (Zim Asset: 2013-2018) and other key documents like National Health Strategy - NHS - (2016-2020), Zimbabwe National Family Planning Strategy - ZNFPS - (2016-2020) and its Costed Implementation Plan - CIP - (2016-2020) and the National Adolescent Sexual and Reproductive and Sexual and Health Strategy - ASRH - (2016 - 20).

As per Zimbabwe Demographic and Health Survey (ZDHS) of 2015, knowledge of any contraceptive method in Zimbabwe is almost universal. However, it is low for Emergency Contraceptives; long acting, reversible contraceptives (LARCs) and permanent methods, like Intrauterine Contraceptive Devices (IUCD) and Implants and male and female sterilisation. While overall usage of contraceptive is high in the country, it is heavily tilted to short acting methods (pills). In a context where 75 percent of women either do not want any more children or want to delay their next birth for at least two years, this seriously limits their choice. The usage is low in certain populations like young people, people in rural and hard to reach areas, people with disabilities and people with different sexual orientations. Unmet need for FP, particularly for adolescents (13%) and sexually active unmarried women (20%) is high. Majority of women use short-term contraceptive methods. LARCs use remains very low.

High levels of unintended pregnancy in the country, particularly for adolescent (48%) highlights the gap between knowledge and practice. This is the main cause of unsafe abortions, which are known to be associated with high rates of deaths. Over the years, HIV prevalence in the country has come down yet women (17%) and young girls (7%) continue to be at higher risk of HIV. This includes women with early sexual debut. The National Adolescent Sexual and Reproductive Health (ASRH) Strategy (2016-20) has identified poverty, lack of access to information on ASRH, poor service delivery and insufficient policy and regulatory framework as key drivers for ASRH challenges faced by adolescents and young people in Zimbabwe.

Poor integration with other RMNCAH and HIV / AIDS services, lack of domestic resources, unpredictability of contraceptive availability and weak capacity for long acting reversible and permanent methods and Youth Friendly Health Services (YFHS) are the main reasons for above. The government of Zimbabwe, in recognition of this, made them their FP2020 commitments in 2012 and reaffirmed again in 2017 London FP2020 Summit.

2.2 Political Context

The political transition has triggered some shifts in the Zimbabwe Family Planning and Sexual and Reproductive Health Rights sector. These shifts have set in motion the need for political leadership to speak publicly and act on developmental issues that affect people the most.

This will also impact on the implementation of the national advocacy and communications activities on FP led by the Ministry of Health and Child Care (MoHCC) working with various actors including the civil society organisations, Faith Based Organisations (FBO), development partners, private sector, and community-based organisations.

Importantly, understanding how the development sector will be affected by the political context and other dynamics, such as the funding of national FP and related activities will help build a new approach based on lessons learnt, missed opportunities, best practices and innovations.

2.3 Behaviour and Attitude Analysis

Most married women demand family planning services with seven out of every 10 women using either a contraceptive method or desire to do so. Zimbabwe has made significant progress in contraceptive use coverage, which currently stands at 67% but 10% of women, remain uncovered with their desire for contraceptive remaining unmet. Unmarried women and young women are particularly disadvantaged with 88% demanding a family planning service. There are also differences in unmet need among different population groups relating to age, location, education, and wealth. Majority of women use short-term contraceptive methods in a context where 76 percent of women either do not want any more children or want to delay their next birth for at least two years. LARCs use remains very low.

Common barriers for uptake of contraceptive methods include:

- Varying knowledge of the variety of contraceptive methods;
- Negative attitudes of communities and service providers on some contraceptive methods such as LARCs;
- Service provider knowledge, skills and attitude to offer the broad range of contraceptive methods;
- Availability of the broad range of contraceptive methods; and
- Declining funding and limited number of funders to sustain supply.

Varying knowledge of the broad range of contraceptive methods: Zimbabwe has near universal knowledge of contraceptives with short-term methods being known the most. These include pills, injectables and female and male condoms. Knowledge of LARCs varies with more women (90.3%) knowledgeable of the implants than IUCD (74.1%). Analysis of knowledge trends between 1999 and 2010 show an increase in the knowledge of female condoms, emergency contraceptives, implants, and injectables. Knowledge of male condoms and pill remained constant. However, IUCD, tubal ligation, vasectomy, and lactational amenorrhoea have been declining in popularity.

While the general knowledge of contraceptives is high, comprehensive knowledge of these methods remains low. For example, there are high discontinuation rates among women with 24% discontinuing use because of health concerns or side effects despite a desire not to fall pregnant. Further, although users in 2010 reported to have been provided with information on a range of methods (61%) and on side effects (53.2%), there was no improvement from the preceding five years on discontinuation of use. Misinformation on contraceptive methods such as LARCs is also prevalent[3]. A study in 2015[4] revealed high misinformation on IUCDs and implants' efficacy, side effects and reversibility leading to deep rooted negative perceptions about these methods which have caused limited use of LARCs. The CIP notes that efforts to impart accurate and adequate knowledge to facilitate contraceptive decision making face key challenges such as weak interpersonal communication for social mobilisation and awareness offered through community based cadres, unavailability of demand generation materials at service delivery points, between awareness raising tailored for young people. Limited availability of comprehensive information and contraceptive services for young people is another major barrier for comprehensive knowledge among this population group. Several factors that include religious beliefs and prohibitions, socio-cultural beliefs, and availability of youth friendly ready service providers hinder provision of comprehensive knowledge to adolescents.

[3]Factors Influencing the Uptake of Intra-Uterine Contraceptive Device (IUCD) in Selected Provinces in Zimbabwe: A 2016 Qualitative Study
[4]Factors Influencing the Uptake of Intra-Uterine Contraceptive Device (IUCD) in Selected Provinces in Zimbabwe: A 2016 Qualitative Study

Negative attitudes of communities and service providers on some contraceptive methods such as LARCs: Negative attitudes about contraceptives are influenced by religious beliefs and prohibitions, cultural beliefs, and misinformation on side effects and effectiveness. Young people are particularly affected. Provision of contraceptives to young people is prohibited by cultural and social norms that are premised on "sex only in marriage". Unmarried young women therefore face significant barriers in accessing contraceptives because of the negative attitudes among service providers, families and their community associated with this prohibition. Further misconceptions about the effect of hormonal contraceptives on ability to conceive in future for young women still to give birth, limits the variety of contraceptives that young women can use.

The uptake of LARCs is generally low with an inclination towards short-acting methods. This has an impact on women in the age group of 40 and above because their greater and unmet need is to limit future pregnancies while the greater and unmet need for women in the age group of below 40 years is contraceptives for child spacing. Other contributing factors include negative cultural and religious beliefs as well as myths on LARCs. For example, despite being effective, the uptake of Intra-Uterine Contraceptive device (IUCD) is low, although in recent times there has been a slight increase in the uptake among women 15-49 years from 0.2 percent to 1 percent (ZDHS 2015). A recent study identified several misconceptions about IUCDs, which fuel negative perceptions which included how it "affects sexual pleasure as it pricks the penis during sexual intercourse", "it is irreversible", "it causes cancer", "a baby can come out holding the "loop", and "the uterus will be removed and put back . Negative perceptions shown in the same study included women who use LARCs being viewed as women of loose morals, murderers and witches. Strong negative views on the use of LARCs among men are a major concern as they dominate decision making on use of family planning in 14.3 percent of households. The ZDHS 2016 shows that women that are empowered in decision-making about their health care, major household purchases and visits her family or relatives, are more likely to use temporary modern contraceptives (63.3%) compared to those whose husbands or partners control decision-making (42.7%). Shona and Ndebele culture and traditions shun the use of IUCDs as they are perceived to cause infertility, pregnancy complications and birth defects. It was also noted that the attitudes and limited knowledge on LARCs , discouraged women from opting for IUCDs and other LARCs.

Service provider knowledge, skills and attitude to offer the broad range of contraceptive methods: Service providers including community based cadres neither have the skills/knowledge and resources to support provision of LARCs. Confidence to provide information and offer particularly LARCs method is limited. This has contributed to skewed availability of short-acting methods. In 2016, health workers lacked practical experience to confidently insert IUCD even when they had received IUCD-related training, for example.

Availability of the broad range of contraceptive methods: The ZDHS 2015 established that the method mix is heavily skewed toward short-acting methods, particularly the pill. It was also established that there was low uptake of LARCs particularly in rural areas. This is attributed to the limited capacity of service providers to offer quality, integrated and comprehensive services; unavailability of wide range of options; and lack of access to information to enable making informed choices especially among the adolescents. The skewed demand of contraceptives has also tilted the supply of contraceptives leading to higher availability of short-acting methods compared to LARCs.

Declining funding and limited number of funders to sustain supply: The government allocates 1.7 percent of its annual health budget to fund the family planning programme, primarily the Zimbabwe National Family Planning Council (ZNFPC). However, this amount is not adequate to meet the demands of the family planning programme and let alone commodity supplies of the ZNFPC. The allocation also falls short of the 3 percent that the Government of Zimbabwe committed to FP2020 at the 2012 London Summit pledge. Economic challenges, competing development priorities and a shrinking fiscal space have combined to limit increase of the budget allocation of the family planning programme from the health

sector annual budget. At the same time, the family planning programme has a limited number of external funders, which threatens sustainability. Nonetheless, funding for commodities has steadily increased between 2012 and 2015, with no financial gaps. However, each main funder has tended to fund certain commodities, which, depending on the amount of funding of the external funder, skews the available method mix. Current external funding supports procurement of commodities leaving little for other components of the family planning programme. This has undermined effective support of quality service delivery and demand generation. However, latest data released in 2017 show that funding of family planning and sexual and reproductive health rights, declined in 2016, returning to 2013 low levels; and funding from several donors decreased in real terms. In this context, domestic resource mobilisation becomes critical to sustain the family planning programme.

2.4 Rationale for the FP Advocacy and Communication Strategy

Addressing these require political commitment, focussed plan, robust partnership and targeted implementation. Also required is an all-encompassing National Advocacy & Communication Strategy to guide and drive these. Advocacy and communication is at the centre of each stage of programme, be it mobilising political leadership, generating resources, implementing or creating demand. It is in this background that this Strategy is being developed. Apart from other strategic goals of ZNFPS, the Advocacy and Communication Strategy (ACS) will specifically, contribute to: 'Increasing investment and access to inclusive and quality integrated family planning and related sexual and reproductive health rights services by 2020'.

While this AC Strategy is immediately guided by the observed trends showing an increase in the number of married couples no longer interested in having more children but lacking knowledge on the long-acting reversible and permanent methods; HIV concerns; lack of information targeting marginalised people, including people with disabilities unsafe abortions; high discontinuation rates of the use of some contraceptives; teenage pregnancies and child marriage. It will also be futuristic, permitting adaptability to evolving situations in the SRHR arena.

The strategy elaborates how the MoHCC engages with partners in generating more interest in FP and related SRH, increasing demand and soliciting more investment. In addition, the AC strategy provides a framework and space for partners to actively participate in providing funding and technical resources as well as service delivery support to the national FP programme.

3 Strategy Development Process

Some of the Stakeholders who attended the Strategy Development meeting

The strategy was developed through a consultative two-stage process with stakeholders in the family planning programme. The first stage was a comprehensive situation analysis of family planning, advocacy and communication, which drew on stakeholder perspectives and literature review. The situation analysis identified the strengths and weaknesses of current advocacy and communication practices in the family planning programme. Opportunities to enhance or reform current efforts were identified and informed the development of this advocacy and communication strategy.

Pursuant to the situation analysis, stakeholders were engaged through key informant interviews, and workshops to contribute to the strategy content, guided by the findings of the situation analysis. This included a workshop with partners in the family planning programme, and young people. Input from these processes formed the building blocks for the advocacy and communication strategy, which was then validated by the stakeholders in September 2018

Activities, approaches and messages will focus mainly on supporting the Zimbabwe national family planning sector to meet its national goals and objectives.

The advocacy and communications strategy will take into account the five key strategies that actors will work towards to achieve the national goals, in addition to the valuable contributions by partners who want the re-organisation of the family planning and sexual and reproductive health and rights sector.

4 The Strategic Results

This advocacy and communication strategy will support achievement of the National Family Planning Strategy (ZNFPS) goals of increasing Contraceptive Prevalence Rate (CPR) from 65.6 percent to 68 percent and reducing teenage pregnancy rate from 22 percent to 12 percent by 2020. Under the ZNFPC Strategy, actors will work through five strategic thematic areas focusing on:

- Creating an enabling environment;
- Strengthening the supply chain and commodity security;
- Improved quality integrated service delivery;
- Increased demand and comprehensive FP knowledge; and
- Enhanced monitoring and evaluation and research.

Cutting across these strategy areas are six key strategic priorities that will drive the family planning agenda forward:

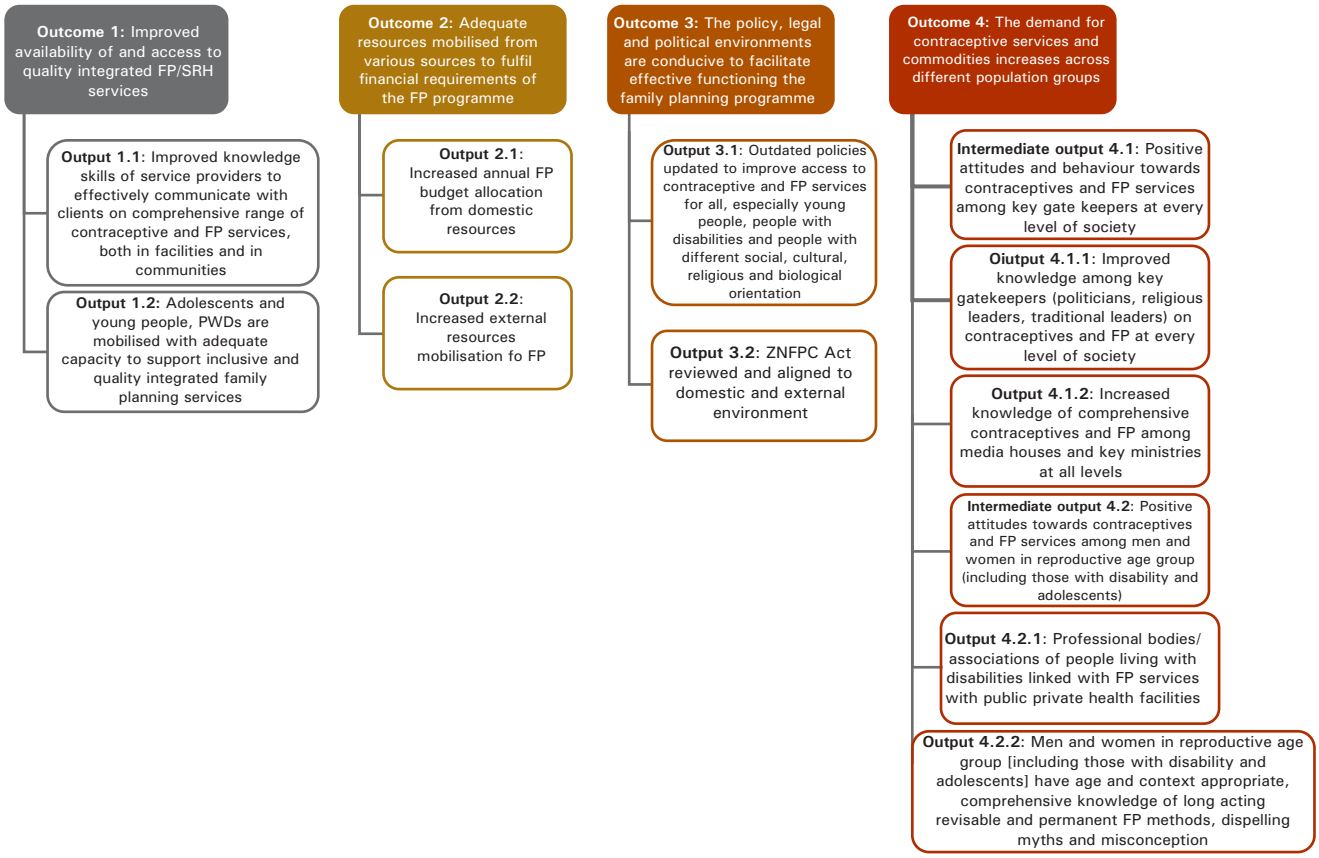
i) Reducing teenage pregnancies;
ii) Providing family planning services in integrated settings (e.g. HIV and SRH services, gender-based violence, nutrition, etc.);
iii) Increasing utilisation of long-acting reversible contraception (LARC) and permanent methods;
iv) Addressing child marriages;
v) Increased Resource Mobilisation for family planning and sexual and reproductive health; and
vi) Reducing unmet need among excluded and hard to reach groups including people living with disabilities, those in prohibitive religious sects and remote areas.

The Advocacy and Communications Strategy will work in harmony with the national strategic goals, objectives and thematic areas. It will support achievement of the five outcomes of the Zimbabwe Family Planning Strategy 2016-2020 by delivering on four key results that include:

i) Adequate resources mobilised from various sources to fulfil financial requirements of the family planning programme
ii) Conducive policy, legal and political environments to facilitate effective functioning of the family planning programme
iii) Improved quality of integrated FP/SRH services by service providers in facilities and communities
iv) Increased demand for contraceptive services and commodities across different population groups and geographic areas of Zimbabwe

These key result areas are underpinned by specific outputs and intermediate outcomes as depicted in the results chain in Figure 1. These outputs and intermediate outcomes are aligned to those pursued by the National Family Planning Strategy. Therefore, the advocacy and communication strategy results chain maintains alignment to the intentions of the National Family Planning Strategy.

Figure 1: Advocacy and communication strategy results chain



The outcomes, outputs and corresponding indicators are presented Table 1.

Table 1: Indicators and targets

Result	Indicator	Baseline	Target
Outcome 1: Improved availability of and access to quality integrated FP/SRH services	% of men and women accessing contraceptive and FP services from primary health care facilities and the community who received satisfactory service (disaggregated by level of health care)	0	80% (male and female)
	% of young people approaching pharmacies for emergency contraceptives and provided comprehensive contraceptive and FP information and referrals	0	80%
Output 1.1: Improved knowledge, skills of service providers to effectively communicate with clients on comprehensive range of contraceptive and FP services, both in facilities and in communities	% of health care staff at primary health care level with correct and comprehensive knowledge of contraceptives and FP services	0	80%

Result	Indicator	Baseline	Target
	% of health care staff at primary health care level who report improved skills for delivery of comprehensive FP services	0	80%
	% of Community Health Workers with correct and comprehensive knowledge of contraceptives and FP services (disaggregated by type of health worker)	0	100%
Output 1.2: Adolescents and young people (AYP) and people living with disabilities (PWDs) are mobilised with adequate capacity to support inclusive and quality integrated family planning services	Number of AYP and PWD groupings mobilised and equipped with tools and knowledge to demand quality contraceptive and FP service delivery	0	To be advised
Outcome 2: Adequate resources mobilised from domestic and external sources to fulfil financial requirements of the FP programme	% funding gap for the FP programme	0	To be advised
Output 2.1: Increased annual FP budget allocation from domestic resources	% of total Ministry of Health budget allocated to FP	1.7%	3.0%
	% of the HIV levy allocated for procurement of contraceptives	0.0%	5.0%
	% of the Health levy allocated for procurement of contraceptives	0.0%	5.0%
Output 2.2: Increased external resource mobilisation for FP	Amount committed by external funders	To be advised	To be advised
Outcome 3: The policy, legal and political environments are made increasingly conducive to facilitate effective functioning of the family planning	Number of laws enacted to facilitate functioning of the family planning programme	0	To be advised
	Number of revised policies to facilitate functioning of the family planning programme operational	0	To be advised
Output 3.1: Outdated policies updated to improve access to contraceptive and FP services for all, especially young people, people with disabilities and people with different social, cultural, religious and biological orientation	Number of policies revised to facilitate functioning of the family planning advocacy and communication programme operational	0	To be advised
Output 3.2: ZNFPC Act reviewed and aligned to domestic and external environments	ZNFPC Act reviewed	0	1
Outcome 4: The demand for contraceptive services and commodities increases across different population groups	% of eligible client receiving IUCDs	1%	3%

Result	Indicator	Baseline	Target
	% eligible clients receiving Implants	9.5%	15%
	% male eligible clients receiving male sterilisation	1%	5%
	% female eligible clients receiving female sterilisation	1%	5%
Intermediate outcome 4.2: Positive attitudes towards contraceptives and FP services among men and women in reproductive age group (including those with disability and adolescents)	% of people of reproductive age who dispel myths and misconceptions of long acting reversible and permanent FP methods	0	50%
Intermediate Outcome 4.1: Positive attitudes and behaviour towards contraceptives and FP services among key gate keepers, media houses, and ministry officials at every level of society	% media houses reporting regularly (one story per quarter) and positively on the FP programme	0	80%
	number of gatekeepers (by type) speaking positively about contraceptives and FP		
Output 4.1.1: Improved knowledge among key gatekeepers (politicians, religious leaders, traditional leaders) on contraceptives and FP at every level of society	% of key gatekeepers demonstrating correct and comprehensive knowledge of contraceptives and FP	0	100%
Output 4.1.2: Increased knowledge of comprehensive contraceptives and FP among media houses and key ministries at all levels	% media houses receiving knowledge on contraceptives and FP (disaggregated by geographical location)	0	100%
	% government ministries receiving knowledge on contraceptives (disaggregated by level)	0	100%
	% key politicians receiving knowledge on contraceptives and FP	0	100%
Output 4.2.1: professional bodies / associations of people living with disabilities linked with FP services with public private health facilities	% of existing professional bodies / associations of people living with disabilities engaged on comprehensive contraceptive and FP services	0	100%
	% of existing professional bodies / associations of people living with disabilities linked with FP services and with public health facilities	0	100%
Output 4.2.2: Men and women in reproductive age group (including those with disability and adolescents) have age and context appropriate, comprehensive knowledge of long acting reversible and permanent FP methods, dispelling myths and misconception	% of people of reproductive age with comprehensive knowledge of contraceptives	0	50%

5 The Strategic Approach

5.1 Conceptual Framework and Theoretical Underpinning

This strategy is based on the social ecological approach to behaviour change (see Figure 2). This approach recognises that individual behaviour change related to increased demand for family planning services and information takes place within a complex environment of socio-cultural influences. Individuals are embedded within a system of socio-cultural influences from family members, peers, community members and national institutions. Therefore, individual behaviour change concerning family planning is influenced by the individual's own characteristics and social, cultural and physical environment in which they live. This approach therefore recognises the following, that:

5.1.1. Stakeholders in the family planning programme will have a thorough understanding of their target audiences including their intra-personal characteristics (e.g. knowledge, attitude behaviour and self-concept and skills) and their daily lives and using this knowledge to design appropriate approaches for reaching them and the type and expression of messages to influence behaviour change.

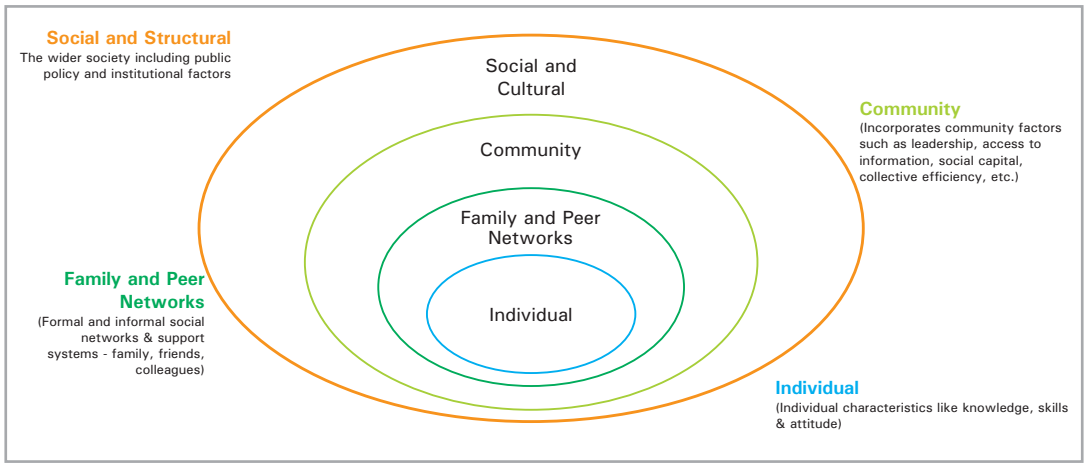
5.1.2. Complimentary roles of interpersonal processes such as interactions with husbands/ partners, other relatives within the family other social support networks in decision making on family planning are well understood and incorporated in the design of behaviour change activities e.g. support for inter-personal communication.

5.1.3. Community factors such as relationships among organisations, institutions and informal networks with defined boundaries, play a critical role in shaping family and interpersonal communication.

5.1.4. Wider society, including public policies and institutional factors (e.g. availability of commodities, knowledge and attitudes of service providers, conducive policies and legislation, formal and informal rules and regulations, etc.) all affect public perceptions/attitudes towards FP and ultimately contraceptive use behaviour. Communication and advocacy activities need to recognise this dimension in planning and implementation.

Therefore applying this model at each stage of the design and implementation of advocacy and communication activities helps to ensure that all determinants of behaviour are considered and addressed.

Figure 2: Ecological model (Levels of influence on human behaviour)

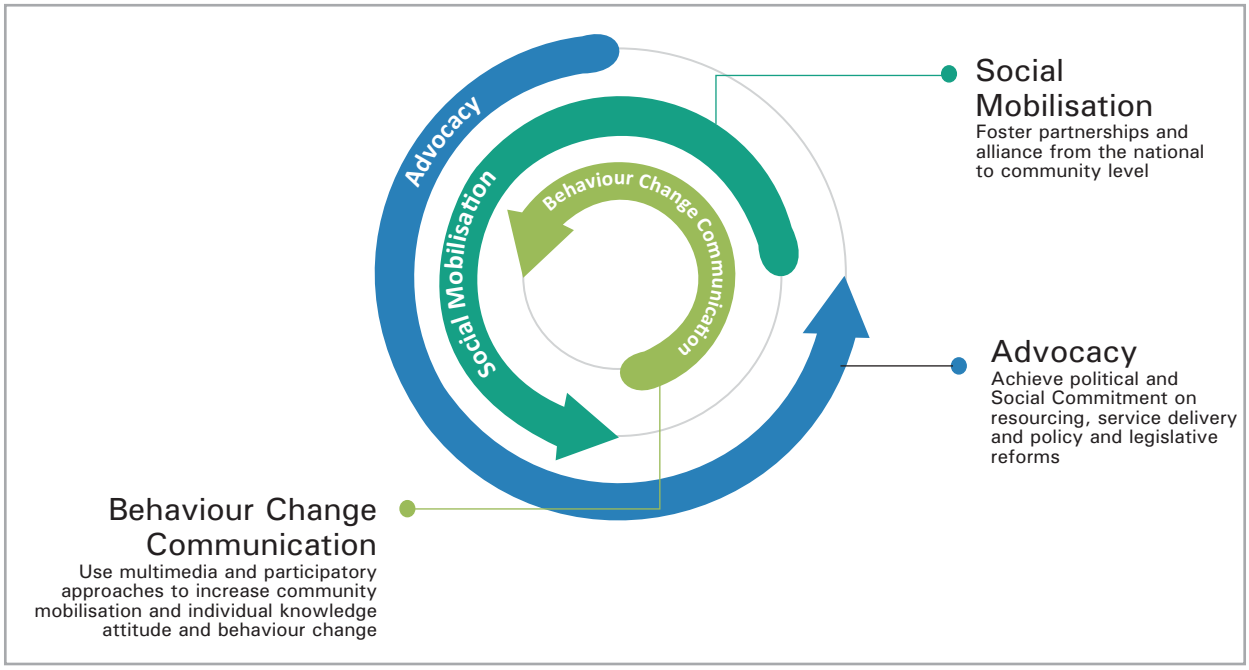


Source: Bronfenbrenner (1979). The ecology of human development: Experiments by nature and design. Cambridge, MA: Harvard University Press

5.2 Advocacy and Communication Approaches

This national advocacy and communication strategy promotes a range of advocacy and communication approaches to achieve the goal of the strategy, which aims to unlock supply side constraints through advocacy and social mobilisation and stimulate demand for services and information through behaviour change communication. Thus, the approaches can be summarised in three categories of advocacy, social mobilisation and behaviour change communication as presented in Figure 3. While the approaches are treated separately, in practice, there can be little distinction between advocacy and social mobilisation or social mobilisation and behaviour change communication depending on the distinct level required to address supply or demand of family planning services and information. Each sphere has to be planned for separately but implementation has to consider the overlap between the activities of the different spheres to ensure stakeholders respond appropriately and comprehensively to the broad specific needs of the wide range of audiences.

Figure 3: Advocacy and communication approaches



Adapted from: The Health Communication Capacity Collaborative HC3. (2014). An adaptable communication strategy for magnesium sulfate. Baltimore: Johns Hopkins Bloomberg School of Public Health Center for Communication Programs.

Advocacy will ensure that the national government, policymakers, donors and media: i) remain engaged, ii) are strongly committed to improving laws and policies for enhancing coordination of the family planning programme, and access to family planning, iii) allocate adequate funding for the family planning programme; and iv) family planning remains in the public agenda. In particular, advocacy will aim to increase investment in the family planning programme and related sexual and reproductive health and rights sector in Zimbabwe. It highlights understanding that, for the sector to attain inclusive and sustainable development, there is need to improve local funding to enable the re-organisation of the sector for the provision of quality integrated service delivery. Increased investment through the national budget, demonstrates political commitment driven by realisation of the cross-cutting nature of sexual and reproductive health and rights issues and how prioritisation can contribute to the country's achievement of its national health outcomes and other socio-economic objectives stipulated in the Zimbabwe Agenda for Sustainable Socio-Economic Transformation blueprint (Zim Asset: 2013-2018); and the global Sustainable Development Goals (SDGs)

Through advocacy, increased support from the government can help push for the reform and harmonisation of the legal and policy frameworks, which can significantly contribute to creating an environment that will strengthen the sector's capacity to deal with challenges including, teenage pregnancies, child marriages, HIV and AIDS and other Sexually Transmitted Infections (STIs), abortions, and gender-based violence.

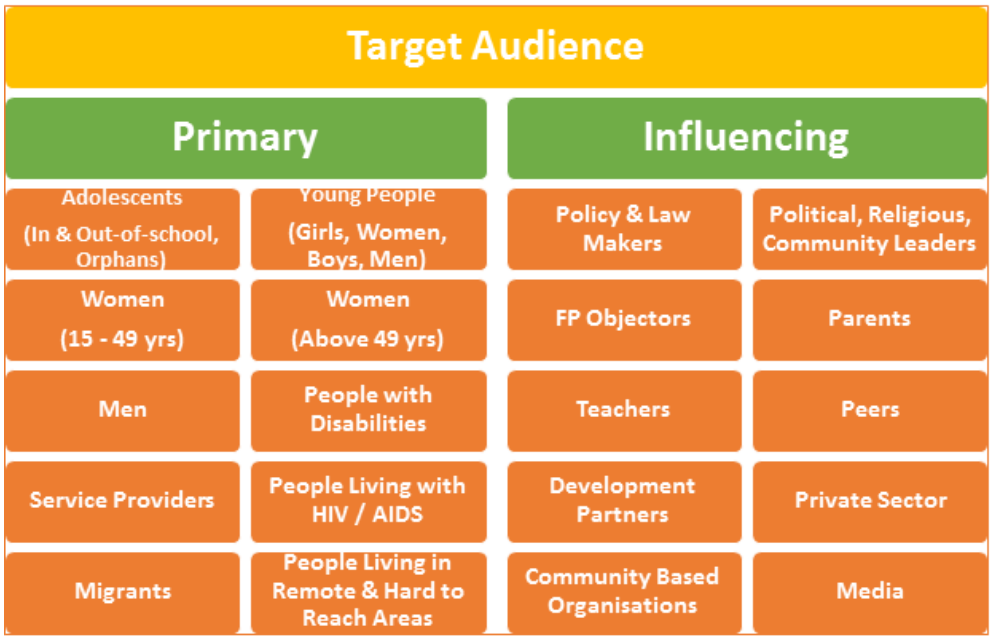
Social mobilisation will be used to harness impact of the collective through bringing together community members and other stakeholders to strengthen community participation for sustainability and self-reliance. Social mobilization generates dialogue, negotiation and consensus among players. At the heart of social mobilization is the need to involve people who are affected by family planning. The family planning programme will use partnerships for consensus-building initiatives, to increase capacity to tackle problem areas and support joint activities that can attract funding and help to accelerate the implementation of the Zimbabwe National Family Planning strategic goals and objectives.

Behaviour development and change communication is a set of organized communication interventions and processes aimed at influencing social and community norms and promote individual behavioural change or positive behaviour maintenance for a better quality of life. It is based on proven theories and models of behaviour change. In this strategy, behaviour change communication will promote and enhance **interpersonal communication,** and **community mobilisation**. This will be achieved through strengthening capacity of community based cadres, individual targeting with information packages. Multimedia platforms, used in a way to reach the target segmentation, and participatory approaches that include community dialogues, will comprise the channels for delivering messages.

5.3 Target Audience

The audiences are in segments to enable target specific messaging. The audiences are segmented based on their uniqueness in the population of Zimbabwe and with similar interests and needs related to family planning. The assumption is that demand generation is achieved if targeted communities or groups have common attributes. Segmenting audiences ensures that interventions developed and implemented are appropriate for specific audiences as well as messages and materials. They are segmented into Primary Audiences and Influencing Audiences as shown below:

Figure 4: Target Audience



5.4 Priority Behaviour Development

Table 1 presents the priority behaviour change expected from the various categories of audience of this strategy.

Table 2: Priority behaviour change

Target Group	Key Behaviour Change
Adolescents and young people	Abstinence, Safer Sex, Using Contraceptives, Seeking advice and help from professionals
Service Providers	Dealing with adolescents, young, women and men with sensitivity in providing comprehensive information and clinical contraceptive and FP services, both in facilities and in communities
Religious leaders	Talk about, advice, guide and influence their communities/constituents on contraceptives and FP on the basis of evidence and from informed position
Teachers	Guide, inform and counsel students in age appropriate and sensitive manner on sexual and reproductive health matters on the basis of evidence and informed position, they refer, support children in seeking professional help
Older Women	Support younger female and male relatives (daughters'-in-law, nieces, sons and nephews and other younger community members) in taking right / appropriate decisions in matters of sexual and reproductive health, including FP. They proactively support their younger female relatives (daughters'-in-law, daughters, nieces etc) in practicing FP and taking care of their health
Women	Making informed decision about contraceptives as per their need and choice and using them, asserting safer sex practice with partners, seeking help and advice from professionals
Political leadership	Undertake evidence based lobbying for increased domestic resource allocation to FP programme. Advocate for contraceptives & FP services in their constituencies
Community Leaders	Advise, guide and influence communities/constituents members on contraceptives and FP on the basis of evidence and from informed position, they actively participate in health affairs of their communities and liaise with local health facilities
Peers	Abstain, practice safer sex, seek professional help and share / discuss these with their peers, they identify problems / issues with their peer on matters of Sexual & Reproductive health and proactively reach out to them for support/advice
Media	Report correct information and stories about contraceptives and FP, they dispel myths and misconceptions / negative views on FP by positive reporting
Men	Supporting their partners in use of contraceptives, discussing with partners & practicing safer sex, discussing with partner the family size, using condoms and adopting vasectomy as a family planning method of choice, seeking help & advice from trained providers, serve as FP role models to other men.
Policy Implementers	Draft and present evidenced based information & advice to their political authorities for increased domestic funding allocation to FP programme. Oversee & review FP programme implementation periodically at all levels
Parents	Guide, handle, counsel, advice their children in a sensitive manner on sexual and reproductive health matters, they proactively support /accompany their children in seeking professional help/advice/services, serve as role models
Civil Society Organisations	Work with their target groups to improve information, knowledge, skills and practice on sexual and reproductive health matters based on evidence and informed position, they help in seeking/approaching professional help / support
Community Based Organisations	They work with target groups to improve information, knowledge, skills and practice on sexual and reproductive health matters based on evidence and informed position, they help in seeking approaching professional help / support

Annex 1 provides a detailed list of messages promoted for the segmented audiences for all priority behaviours.

6 The Implementation Plan

This section presents the Strategic Implementation Framework. It details the key strategies and activities promoted by this advocacy and communications strategy to deliver the key behaviour change in Table 2.

6.1 Key Result Area 1

Under Key Result Area 1 the following outcome will be achieved: Outcome 1: Improved availability of and access to quality integrated FP/SRH services. Achievement of this outcome shall occur if the following changes are realised by 2022:

6.1.1. Leadership and commitment of stakeholders at all levels to strengthen the multi-sectoral support to integrated FP, SRH, HIV and Maternal Newborn Child Health (MNCH) will be secured.

6.1.2. Health service providers in all settings will have adequate knowledge and skills of offering integrated FP and other health services including HIV/AIDS and MNCH services. They will have positive attitudes that support access to these services by all categories of the population, including adolescents, and persons with disabilities, and sex workers that require them.

6.1.3. Communities will prioritise all forms of FP. Through a sense of self - efficacy, in terms of their ability to take small actions to protect themselves from unintended pregnancy and reproductive health related diseases, communities will mobilise themselves to ensure quality FP and SRH service provision by all service providers at facility and community level.

6.1.4. Community based family planning services will be expanded and strengthened to increase availability and access to quality and youth friendly FP services in rural and underserved areas including tertiary institutions.

The strategies and activities to achieve these changes for the various audience are presented in Annex 2. Table 3 provides a summary of the strategies for each audience.

Table 3: Strategies for achieving outcome 1

Audience	Strategies
Government	Increase support through policy and guidelines reforms; and budgetary allocation for integrated FP and SRH service provision by lawmakers.
Community Based Structures/Networks such as CBDs, VHWs, BCC Facilitators, VAACs, WAACs, Health Centre Committees (HCCs)	Empower community based structures and institutions to support youth peer educators and to provide youth friendly integrated FP and SRH services in the community; Strengthen capacity of community led institutions for social accountability in health such as Health Centre Committees to monitor FP service provision; and Support social accountability structures to mobilise communities for FP information and service provision including community feedback mechanisms.

Audience	Strategies
Facility level Service Providers (Public and private)	Strengthen the communication skills of service providers and key stakeholders on integrated FP and SRH services and commodities through on-the-job trainings and provision of guidance notes and factsheets in wide languages, including the minority languages in areas where the language is dominantly spoken. These should focus on key FP issues for the health worker including dispelling myths and misconceptions about LARCs, utilisation of contraceptives by unmarried adolescents and young women, safe sex and side-effects interventions.
Women of child bearing age including those with disabilities	Enhance knowledge and awareness of integrated FP and SRH services at health service providers among women. Improve quality of service by meeting needs of persons with disabilities such as the visually impaired.
Adolescents, and young people	Strengthen interpersonal communication skills of peer educators; Strengthen use of ICT/multi-media innovations to reach a broader range of adolescents and young people; and Enhance primary and secondary school-based interventions; in addition to tertiary focused to strengthen behavior development and change.
CBOs/CSOs	Improve their capacity to disseminate information on integrated FP and SRH services; and provide support in community mobilisation.

6.2 Key Result Area 2

The outcome for this Key Result area is: Outcome 2: Adequate resources mobilised from various sources to fulfil financial requirements of the FP programme, which will be achieved through the following changes by 2022:

6.2.1. There will be local political commitment and support for the FP programme through increased budgetary allocation from 1.7 percent to 3 percent.

6.2.2. There will be an increase in the amount of funding and the number of development partners and donors contributing to the family planning programme.

Table 4: Strategies for achieving outcome 2

Audience	Strategies
Parliament, Ministry of Health and Ministry of Finance	Improve knowledge of current trends and needs; and Establish a special alliance to deal with pushing for creation of an enabling environment. Lobby for increased budget allocation towards family planning.
ZNFPC	Strengthen the ZNFPC's coordination role and brand on the FP market; Strengthen ZNFPC Advocacy and Communication department through capacity development and enhanced advocacy and communication planning and implementation.
Donors	Strengthen documentation and dissemination of results of the FP programme; Enhance capacity of ZNFPC to document the return on investment on FP programme in Zimbabwe.
Media	Improve visibility through mainstream media; Strengthen partnerships through joint activities with the media; Develop capacity and establish a Network of Journalists reporting Family Planning and Sexual Reproductive health and Rights; and map media focused activities to draw some benefits from the network.

6.3 Key Result Area 3

Outcome 3: "The policy, legal and political environments are conducive to facilitate effective functioning of the family planning programme" will form the key result which will be achieved through the following changes by 2022:

6.3.1. FP related Laws and Policies will be reformed , harmonised and implementation begun.
6.3.2. Political will and commitment towards family planning will remain strong.

Table 4 presents the strategies for achieving this outcome.

Table 5: Strategies for achieving outcome 3

Audience	Strategies
Parliament and other policy makers	Ensure parliamentarians and other high level stakeholders are kept informed on FP issues (funding, availability, access and norms/beliefs that affect use of contraceptives) and have in-depth knowledge of FP and other related issues that need legislative and policy reform; and Enhance high-level advocacy with key and relevant stakeholders.
Religious and traditional leaders	Lobby for support from community and religious leaders, and leaders of umbrella bodies such as National Association Of Societies For The Care Of The Handicapped (NASCOH)
CSOs	Strengthen capacity of CSOs to advocate for policy and legislative reforms that enable communication on FP and improve access to comprehensive FP services.

6.4 Key Result Area 4

The outcome of this Key Result Area is Outcome 4: The demand for contraceptive services and commodities increases across different population groups. This outcome will be achieved through the following changes:

6.4.1. Different population groups (in urban and rural areas), areas of low contraceptive prevalence rate, adolescent and young women, persons with disabilities demonstrate increased knowledge of FP, LARCs and integrated service provision.
6.4.2. Social and community norms and religious beliefs and prohibitions that undermine use of contraceptives including LARCs and undermine unmarried adolescent girls and young women's access to FP will increasingly be shifted in support these initiatives.
6.4.3. Communities will be mobilised to improve knowledge and demand for FP.
6.4.4. FP and in particular LARCs will be widely accepted and used by different population groups and geographic areas with low CPR coverage.

Table 6 presents the strategies to achieve the outcome.

Table 6: Strategies for achieving outcome 4

Audience	Strategies
Law and policy makers	Strengthen outreach by law and policy makers to ensure they implement and promote policies that support behavioural development and change, and social changes required to improve access to integrated family planning and access to a wide range of contraceptives.
ZNFPC, Ministry of Health	Improve the appeal of contraceptives through re-branding to attract groups such as adolescents and women above age 40.
Traditional and Religious Leaders	Mobilise and engage with the Traditional and Religious Leaders to promote social and community norms in support of FP; and Engage and strengthen the capacity and skills of Traditional and Religious leaders, community-based structures such as CBDs, VHWs BCCFs, HCCs, WAACs and VAACS to raise awareness on FP services and commodities and to promote behaviour development and change.
Community Based Structures	Engage and strengthen the capacity and skills of Traditional and Religious leaders, community-based structures such as CBDs, VHWs BCCFs, HCCs, WAACs and VAACS to strengthen awareness on FP services and commodities; and to promote behaviour development and change.
CSOs	Promote sharing of best practices and testimonials to influence positive practices and attitudes towards integrated FP/SRH/HIV/STIs services and commodities; Improve community mobilisation, participation, and uptake of integrated FP services at all levels and by all categories of communities that include PWDs and those in areas with low CPR coverage.
Women of child bearing age (Adolescents, young people, PWDs) Men and adolescent boys and young men	Promote the brand ambassadors', role models and champions approach to develop new positive behaviours; Empower all categories of the community including PWDs to be able to demand and access integrated FP services; and Support and strengthen scaling up of integrated FP and SRH service to all groups of people including key populations including , members of the Apostolic Sect, OVC, communities in the rural areas and geographically difficult to reach areas and places with low CPR coverage Strengthen awareness raising campaigns to increase knowledge on FP, Mobilise men to participate and take interest in issues to do with family planning and safe sex; and Promote use of men as brand ambassadors and champions to get the attention of other men and encourage their involvement in FP and SRHR issues.
Media	Develop capacity and frequently engage with the media to keep the FP momentum, raise awareness on FP issues/developments and heighten demand creation

6.5 Advocacy and Communication Products

Implementation of the advocacy and communication strategy will generate several products to facilitate behaviour change provided in Figure 6 informed by the intended objective of advocacy, social mobilisation, community mobilisation and information dissemination. The strategy products will be tailored to suit the intended audience with regards content preferences and channel.

Figure 5: Advocacy and communication products

7 Implementation Framework

This Strategy is critical for the achievement of the national FP goals as outlined in ZNFPS. The Strategy therefore, has a similar implementation framework as of ZNFPS. Adopting multi-sectoral approach, the implementation of the Strategy would require bringing different government ministries, parastatals, development partners, private sector, media and community together for effective advocacy and communication for the programme.

Greater awareness about the benefits of contraceptive services and FP programme, especially as an investment in the overall development of the country, require clear articulation of important aspects like leadership, coordination, partnership, resource mobilisation and performance monitoring.
With a focus on a multi-sectoral implementation of the FP Strategy, various government ministries will contribute to implementation of the Advocacy and Communication Strategy namely:

- **Ministry of Primary and Secondary Education** to intensify and scale up comprehensive sexuality education in schools
- **Ministry of Higher and Tertiary Education** to facilitate improved service delivery in tertiary institutions and enhanced contraceptive and SRH information dissemination in these institutions
- **Ministry of Youth, Sport, Arts and Recreation and Ministry of Women Affairs, Gender and Community Development** to support social mobilisation for youth and women's empowerment and increased access to contraceptive and FP and other SRH services, and
- **Ministry of Finance and Economic Development** to ensure adequate resourcing for FP programme to which this advocacy and communication strategy contributes

7.1 Strengthening Partnerships

MoHCC, together with ZNFPC will coordinate partnership on the FP programme in the country. It will bring together all stakeholders through various structures, mechanisms and initiatives. The existing Advocacy and Communications Technical Working Group will be the technical arm that feeds into the broader National Family Planning Partnership Forum. This will help strengthen collaboration and complementarity in programme design and implementation. New ideas, bringing accountability, building consensus, ownership and resource mobilisation will be boosted. Specifically, partnership will serve following purposes:

- Create platforms for sharing information, lessons learnt and new approaches (e.g., that promote use of long-acting, reversible and permanent contraceptive methods)
- Promote linkages and alliances with stakeholders addressing adolescent and youth sexual and reproductive health to address teenage pregnancies and child marriages and heighten prevention of HIV and other sexually transmitted infections
- Develop joint advocacy and communication tools and products and ensure media coverage of work reflecting the strength of partnerships including Public Private Partnerships (PPP);
- Develop partner and donor reporting templates to promote sharing of information and joint resource mobilisation
- Establish a network of Journalists specialising in FP and SRHR to strengthen advocacy in resource mobilisation and visibility of activities and needs, and
- Organise joint briefing meetings, workshops with donors

7.2 Leadership and Governance

MoHCC being the final custodian of public health in the country has the overall responsibility for the oversight and implementation of this Strategy at all levels - national, provincial, district and community

and by all players, government and non-government alike. ZNFPC, a parastatal of MoHCC, specifically mandated for the contraceptive services and FP programme of the country, will be the key arm of MoHCC in this role of oversight and implementation.

7.3 Coordination

The national and provincial FP coordination forums led by ZNFPC and their Advocacy and Communication Technical Working Groups (TWGs) will be the main national and provincial coordination structures for this Strategy. Based on specific activities, the existing government structures at provincial, district and facility levels will act as local coordination structures. These include Provincial and District Health Executives and Health Centre Committees at facility levels. Effective coordination at all levels will prevent duplication, enhance efficiency, track progress and results and facilitate knowledge sharing.

7.4 Resource Mobilisation

The success of the Strategy depends on the availability of resources that need to be mobilized through increased domestic allocation to FP programme and reaching out to traditional and non-traditional external sources, like donors, private sector, individual donations, philanthropies, foundations etc. This will require re-positioning the FP programme to global expectations of programming and accountability.

7.5 Capacity Development

Capacity is central to successful implementation of this advocacy and communication strategy. This includes capacity of ZNFPC the coordinating agency, CSOs and other structures tasked with implementation of tenets of this strategy.

Key actions to enhance capacity shall be as follows:

1. Enhance capacity of the advocacy and communications department and promote its integration in all ZNFPC programmes to improve its budget and increase advocacy and communication results.
2. Support and strengthen the coordination function of ZNFPC role in advocacy and communication within the sector.
3. Explore South-South and Triangular partnerships for information and lessons sharing to enhance capacity of local implementers including ZNFPC.

8 Performance Monitoring and Accountability

The Results Framework outlined in this Strategy (above) will be the basis of measuring the performance and fixing accountability. Each indicator is inherently associated with an individual or individuals and / or agency or agencies and therefore, clearly fixes the responsibility and hence the accountability. The existing source of information / data, namely, the service data (HMIS), surveys (MICS and ZDHS), global reports (Track20), RMNCAH and National Supply Chain system score cards etc. will be the source of information for this Strategy.

The M&E units of Department of Family Health (DFH) of MoHCC and ZNFPC will be the direct managers of the monitoring progress. Through various national annual and quarterly coordination and review mechanisms these units will be periodically sharing the progress information to take appropriate actions. In addition to the indicators outlined in the Result Framework above, additional indicators are presented in Annexure 2.

Annex 1: Design Messaging for All Audiences

Family Planning for a healthy nation, stronger economy and a brighter future

Or: You can tell the future through better family planning

Key Issue	Change Expected	Barrier	Messages
Adolescents and Young People			
Modern contraceptives are perceived to be only for married people	Empowered young people who can demand contraceptives of their choice.	Stigma among communities, negative attitude of service providers.	• Young people have the right to demand any contraceptive method of their choice (if eligible) to protect themselves from unintended pregnancies and sexually transmitted infections (STIs). • Your future is your responsibility, love yourself and protect yourself from STIs and unwanted pregnancy
Lack of youth-friendly health services	Youth-friendly attitude by service providers.	Unhelpful service providers with negative attitude	• Health Service Providers have a responsibility to educate young people to make informed decisions on how they can best protect themselves from STIs and prevent unintended pregnancy. Your care today can save a life! • Discriminatory attitudes toward young people seeking contraceptives and other sexual reproductive health services can adversely affect their willingness to seek services.
F/P messages not friendly to all categories of youth that include those with disabilities as well as those in rural and difficult to reach areas.	Development of holistic and integrated youth friendly advocacy products and labelling of contraceptives promoted for young people.	Conflicting messages, weak dissemination channels, poor packaging of information	• Regular use of condoms and contraceptives are an effective way to protect adolescents and young people against unintended pregnancies and STIs. • All teenagers have a right to access information on the advantages and disadvantages of all contraceptives. • Every woman in Zimbabwe has a right of access to commodities to achieve her reproductive intentions and protect herself from STIs, including HIV.
Negative peer pressure	Empowered young people making decisions that can save lives and ensure they reach their full potential in education and economically.	Uninformed young people, unsupportive families and communities.	• Health Service Providers and other relevant stakeholders are the best sources of information on sex, readiness and how young people can protect themselves against HIV and unintended pregnancy. • Your friends may sound smart, but they can mislead you. Visit your nearest health service provider today for all information you need on how to protect yourself against STIs and unintended pregnancy. • Young people who initiate sex at an early stage are at a higher risk of becoming pregnant and getting infected with STIs than those who initiate later at a time they have skills to negotiate for dual protection against unintended pregnancy and STIs.
Complexities in negotiating safer sex	Empowered adolescent girls and young women who can say NO! to unprotected sex.	Poverty increases vulnerability of girls, information deficits: ecological influences.	• Adolescent girls and young women who demand safe sex can achieve dual protection against unwanted pregnancies, HIV and other STIs. • Delaying having babies can ensure that young women attain good education and have a brighter future. • Unprotected sex can kill. • Unprotected sex can steal your dreams for a brighter future

Key Issue	Change Expected	Barrier	Messages
Poverty	Social support targeting vulnerable young people.	Competing government resources, weak social assistance programmes targeting adolescent and young women in tertiary institutions.	• · The Government of Zimbabwe should invest more in providing social assistance to students from poor households to prevent them from resorting to risky coping mechanisms that can disrupt their education and having unwanted pregnancies and STIs. • Invest in youth economic empowerment to reduce poverty and increase uptake of all family planning methods to reduce poverty and vulnerability to negative coping mechanisms. • Poverty may be temporarily painful but having transactional sex results in high negative impact and permanent problems
Pro-abstinence culture and religion	Tolerance and increased uptake of all modern FP methods; legal instruments promoting improved access by all and to be provided in all health facilities.	Rigid religious and cultural beliefs, Lack of effective legal instruments to enforce groupings to promote accessibility and use of contraceptives. FP Objectors of family planning can hinder achievement of intended outcomes	• A total 17 percent of teenagers in Zimbabwe across various religions and cultures become pregnant before they turn 19. Promoting all forms of protection against unwanted pregnancies and STIs can prevent teenagers from dropping out of school, engaging in unsafe abortions, baby dumping and can save their lives. (Media focused messaging)
Pro-abstinence families and communities	Empowered communities supportive of safe SRHR practices.	Rigid families and communities FP Objectors of family planning can hinder achievement of intended outcomes	• In Zimbabwe, teenage girls are among those that have unsafe abortions, which contribute to the high maternal deaths. A total 651 women per 100,000 live births, die of pregnancy-related conditions. • Failure by families and communities to promote sexual and reproductive health seeking behaviours among teenagers can increase child bearing at a very young age. • Teenage pregnancy is associated with increased risk of complications during child birth. • Unsafe sex puts adolescents at people age 15-24 are living with HIV and young women are most affected risk of HIV. Already, five percent of young
Early marriage	Girls are empowered to refuse early marriages and report such incidences to the police; Families shun marrying off their girl children before 18 years due to ncreased knowledge of its illegality and the dangers it poses to the girl child; and communities are empowered to report incidences to the police.	Religious beliefs hinder the reduction in early marriages Traditional leaders in support of child marriage	• Early marriage limits educational and other opportunities for girls, and often leads to early childbearing and increased health risks. • Teenage married girls are five times more likely to develop complications and even die in childbirth
		Men	
Lack of involvement in family planning Lack of interest to initiate use of male contraceptives such as vasectomy Ignorance on the benefits of some FP methods	Men actively participating in decision making and supporting their partners in uptake of preferred various contraceptives/FP method Men using the available methods of	Lack of male targeted FP information. Unfriendly attitude by service providers who view FP as a woman's responsibility. Negative attitude by men who view family planning as a	• Consistent use of condoms during sexual intercourse and having one and faithful partner can reduce chances of getting HIV and unintended pregnancy. • Men and women can realise their sexual and reproductive goals only when they plan together and consistently use reliable methods of family planning. • Prevention of HIV and unintended pregnancy is a responsibility of men and women. • A man who cares, protects his partner against HIV and unintended pregnancy. • Family Planning is everyone's business.

Key Issue	Change Expected	Barrier	Messages
Myths around LARCs in particular the IUCD	family planning Men become role models for FP use to other men	woman's issue. Myths and negative religious and cultural beliefs.	• Family Planning is my business (and put a pic of man holding a condom)
		Women	
Uninformed choices Limited knowledge of side effects of contraceptives Misconceptions and myths about LARCs	Women have correct comprehensive knowledge of the wide variety of contraceptives including LARCs and permanent methods (for those over 40 interested in child limiting) Knowledge on how to manage side-effects increased among all women of child bearing age	Limited services mainly in rural facilities. Lack of information on other contraceptive options leading to limited choices. Negative cultural and religious beliefs. Myths. Lack of support from partners.	• It is every woman's right to ask for more information about contraceptives that best suit their need for the effective prevention of unplanned pregnancy. Removing all barriers that stifle education on sexual and reproductive health is key to ensuring safe motherhood. • Health facilities can provide advice on how women and men can manage discomforts caused by some contraceptives. Don't act on rumours, visit the nearest clinic today and get help.
Lack of diverse contraceptives	Women are able to make decisions about the contraceptives they prefer to meet their needs of child spacing or child limiting Availability of full range of methods and the ability of women to choose a method that is appropriate for their own fertility goals and life circumstances.	Limited services mainly in rural facilities. Lack of information on other contraceptive options leading to limited choices. Negative cultural and religious beliefs. Myths. Lack of support from partners.	• The principle of Family Planning supports the rights of all people to accurate, unbiased information on contraceptive methods that can help them achieve their sexual reproductive preferences. • In Zimbabwe, high incidences of gender-based violence can affect women's capacity to negotiate safer sex, in addition to causing sexual and reproductive health complications. • Gender-based violence increases unintended pregnancies, stillbirths, miscarriages, infanticide and sexually transmitted infections.
Limited access to appropriate contraceptives by women of child bearing age Lack of diverse contraceptives	Despite age, marital status, economic background, religious or cultural beliefs, and location, women who need family planning are able to demand the type they require from health service providers.	Limited services mainly in rural facilities. Lack of information on other contraceptive options leading to limited choices. Negative cultural and religious beliefs. Myths. Lack of support from partners.	• Women have the right to equitable access to methods that can save their lives and protect them from STIs. • Contraceptive implants, female condoms, and emergency contraception should be widely available in all settings. • Expanding access to high quality, affordable contraceptive methods can lead to healthier timing and spacing of pregnancies and is essential to reducing maternal and newborn, deaths. • Every woman in Zimbabwe has a right of access to a contraceptive of her choice to achieve her reproductive intentions and protect herself from STIs, including HIV. • Women are encouraged to request from service providers, contraceptives that provide longer-term protection from unintended pregnancies. These methods are effective, convenient, reliable and may cost less in the long term. • To improve the wellbeing of women and girls in the rural and hard to reach areas, government should develop the capacity of service providers to administer long-acting and reversible contraceptive methods. • Expanding access to quality, accessible and affordable integrated family planning services can promote healthier timing and spacing of pregnancies and help to reduce mother and child deaths.

Key Issue	Change Expected	Barrier	Messages
Service Providers			
Limited information about contraceptives especially LARCs Lack of capacity to provide all FP commodities and services on demand Inaccessibility of services among people with disabilities	Service providers are well-informed about all contraceptive methods and related services. Capacity to administer LARCs strengthened.	Lack of information and required capacity and skills among service providers. Provision of capacity building trainings. FP not a priority area in some facilities. Incapacity, challenges to meet quality service requirements.	• Provision of quality integrated family planning services in the public health facilities is key to a majority of women seeking effective methods to plan their families and achieve their child-spacing goal. A total 75 percent of women in Zimbabwe depend on government health facilities to access contraceptives and related sexual and reproductive health services. (Media focused messaging). • Provision of correct family planning and related information in a friendly manner can help men and women to make informed decisions on contraceptives they prefer to use and how to protect themselves from STIs.
Poor communication skills Negative or discriminatory attitude	Improved client care and communication skills. Needs of people with disabilities satisfied. FP information packaged in formats that meet various needs.	Lack of information and required capacity and skills among service providers Provision of capacity building trainings, FP not a priority area in some facilities, Incapacity, challenges to meet quality service requirements	• Every service provider in Zimbabwe should respect the right of clients to information and services that can help them to make informed decisions on their family planning and sexual and reproductive health needs • Adhering to the Client Service Charter removes barriers for all groups of women (unmarried adolescent girls and young women, women with disabilities, and married women) to access family planning limiting unintended pregnancy • Unmarried adolescents and young women have a right to receive contraceptives of their choice from the service provider. This will prevent unintended pregnancy, reduce incidence of induced and unsafe abortions, promote healthy child spacing and build a brighter future for girls and boys in Zimbabwe. • Service providers should strive to provide all-inclusive contraceptive methods to meet needs of all eligible men and women. • All service providers should respect the rights of persons with disabilities and provide information in appropriate formats and language to support informed choices.
Limited availability of LARCs at health facilities Limited knowledge of integrated family planning and other sexual and reproductive health services Women who would like to have no more children do not have access to long-acting and permanent methods Those at risk of HIV or other STIs often lack access to the means for prevention of both infections and pregnancy	Full range of methods available and uptake of less popular long-acting contraceptive methods improved. Women of child bearing age having equitable access to integrated family planning services and contraceptive methods that save their lives and protect them from diseases.	Skewed supply of contraceptives at facility level	• Provision of integrated family planning and related sexual reproductive health services is an essential health care intervention for women in hard to reach areas. • Removing the barriers to men and women accessing contraceptive methods can help to prevent unintended pregnancy, fight maternal mortality and prevent HIV and other STIs. • Availability of reproductive health services and contraceptives is critical for an integrated package of low-cost, essential health care interventions for economically productive women and fostering healthy communities.
Legislators			
Creating an enabling environment Low FP budget	Parliamentarians demonstrate increased knowledge and attention to family planning through motions in parliament.	Lack of political will. Conflicting Laws and Policies. Lack of adequate resources	• Investing in family planning brings transformational benefits to women, families, communities, and the country. • nvesting in family planning is a development “best buy” that can accelerate achievement across Sustainable Development Goal themes on People, Planet, Prosperity, Peace, and Partnership.

Key Issue	Change Expected	Barrier	Messages
Creating an enabling environment Low FP budget Poor FP and SRHR service delivery Unsafe abortions Un updated legal instruments, and FP not a national priority area in practice	Increased parliamentary debates on family planning and other related issues. Increased support for family planning and use of LARCs by high-level individuals including the presidium and wives through public pronouncements and involvement in campaigns. Improved FP budget from the government. Improved service delivery in the hard to reach areas. New policy frameworks addressing unsafe abortion and other FP and SRHR challenges. Conflicting Policies and laws reformed and harmonised. Increased advocacy on the FP rights of persons with disabilities.		• Investing in family planning brings transformational benefits to women, families, communities, and the country. • nvesting in family planning is a development "best buy" that can accelerate achievement across Sustainable Development Goal themes on People, Planet, Prosperity, Peace, and Partnership. • The government can help to prevent high-risk pregnancies among adolescent girls. By investing in family planning, the number of unintended pregnancy, unsafe abortions and deaths related to childbirth can be reduced • Strengthening the quality of family planning and SRHR services can reduce maternal mortality rate of 651 per 100,000 in Zimbabwe; ensure early detection and treatment of all reproductive health related diseases that contribute to deaths of women and satisfying unmet need for contraception. • A weak family planning programme can create a population growth crisis that can fuel poverty and increase inequality in countries that fail to invest significantly in ensuring stronger sexual and reproductive health services. • Family planning and sexual and reproductive health services are a human rights issue that should be observed to ensure that women and men can access integrated services and be able to freely choose when and how many children they want to have. • Family planning supports the rights of the girl child to remain unmarried, childless and healthy until when she is physically, psychologically, and economically ready, and desires to bear children. In the rural Zimbabwe, 27 percent of teenage girls become pregnant before turning 19. • The government has a responsibility to support provision of comprehensive family planning and sexual and reproductive health services that can help women to avoid unplanned and closely spaced pregnancies linked with poor health and increased risk of induced abortion. • Legal instruments that respond to the FP and SRHR needs can strengthen protection of women and girls against negative behaviours, including sexual abuse, cultural and religious norms that promote child marriages and prevent women to bear children at the healthiest times of their lives.
CSOs			
Competition Working operating in silos Non-attendance of national FP forums Funding challenges to ensure commodity security and strong community mobilisation	Strengthened partnerships influenced by comparative advantages. Joint resource mobilisation activities Enhanced cooperation at various levels.		• Government and civil society partnerships can leverage the capacity to improve FP and SRHR services in the hard to reach areas. • Availability of a wide range of contraceptives and related sexual reproductive health services throughout the country can ensure that all women and men can have access to comprehensive health care and have their future in their hands. • Partners can tell the future through collective and better family planning decisions. • The civil society will continue to advocate for strengthened supply chain systems and an increased budget for commodity security and other family planning and related sexual and reproductive health services for a healthy generation and future generations. • The civil society in Zimbabwe is working with local communities to support creation of demand for integrated FP and SRHR services to contribute to improving the contraceptive prevalence rate. • Through cooperation with the government, the civil society in Zimbabwe aim to contribute to the creation of an environment that is responsive to the modern FP and related SRHR needs.

Key Issue	Change Expected	Barrier	Messages
Community Based Support Structures and Networks			
Lack of consistency in operations Funding challenges Limited information about other modern FP methods Poor communication skills Lack of trust of their capacity among other community members	Operations in rural communities sustained through longer-term funding by the Government and CSOs. Trainings on LARCs provided and communities are well informed about contraceptive options. Communication capacity enhanced. Support materials supplied to build trust between the networks and the communities.	Lack of funding for longer-term interventions. Lack of knowledge of all contraceptive methods, Unavailability some contraceptives even in the event of request by the communities, Poor coordination of activities, Negative attitude based on cultural and religious beliefs	• Healthy child spacing through consistent use of reliable modern contraceptives can promote good health and prevent deaths related to risky pregnancy and childbirth among women. • Communities can also support and advise partners having challenges to plan their pregnancies to seek correct information from community-based organisations working with the Ministry of Health and Child Care to provide contraceptives and information related to sexual and reproductive health services. • Community-based networks are supporting the Ministry of Health and Child Care to help women and men make informed choices about contraceptive methods that suit their desires to effectively plan their families and prevent HIV and other STIs. • Community-based networks encourage men to take equal responsibility towards deciding the method of contraceptive that can promote the good health of women and children. Of 100,000 live births, a total 651 women in Zimbabwe die of conditions related to pregnancy. • Women in need of information on contraceptives can inquire from community health workers trained on how various methods work and how to manage common side effects.
Religious and Traditional Leaders			
Some religious sects object the use of FP services and contraceptives Limited acceptability of LARCs by religious and cultural beliefs	Religious sects promoting FP services and use of all contraceptives. Traditional leaders support the use of all available types of contraceptives for all groups women (married and unmarried) to avoid unplanned pregnancies	Some religious Sects object the use of FP services and contraceptives	• Family planning saves lives. Although pregnancy and childbirth are natural, many pregnancies pose serious health risks for mothers and their children, specifically pregnancies characterised as: • **Too early**—girls under 18 face a higher than normal risk of death or disability from pregnancy, and their babies have more health risks. • **Too many**—women who have many births are more likely to have problems with their later pregnancies, and face increased risk of death or disability, as do their new-borns. • **Too late**—mothers over the age of 35 have a higher than normal risk of death or disability associated with pregnancy, and their babies have more problems than is normal. • **Too soon**—children spaced too closely have a higher risk of illness and death. Women should wait at least two years after giving birth before trying to become pregnant again. This birth interval increases infant and child survival and protects the health of the mother. • **Family planning/use of contraceptives reduces adolescent pregnancies and risk of sexually transmitted infections.** When adolescents have an unprotected sex they are exposed to sexually transmitted diseases and greater risk of falling pregnant. • Condoms as a method of family planning also helps prevent HIV infection and other STIs. • **Family planning improves children's health and development.** Households with poor child spacing are linked to poverty and overburden families, which in turn leads to poor performance in school, and poor parental guidance as parents or caregivers cannot give the individual attention required for each child.

Annex 2: Strategies, Activities and Enabling Channel Mix

Outcome 1: Improved availability of and access to quality integrated FP/SRH services
By 2022, the following will be achieved:

1. Leadership and commitment of stakeholders at all levels to strengthen the multi-sectoral support to integrated FP, SRH, HIV and MNCH will be secured.
2. Health service providers in all settings will have adequate knowledge and skills of offering integrated FP and other health services including HIV/AIDS and MNCH services. They will have positive attitudes that support access to these services by all categories of the population, including adolescents and persons with disabilities, who require them.
3. Communities will prioritise all forms of FP. Through a sense of self – efficacy, in terms of their ability to take small actions to protect themselves from unplanned pregnancies and reproductive health related diseases, communities will mobilise themselves to ensure quality FP and SRH service provision by all service providers at facility and community level.
4. Community based family planning services will be expanded and strengthened to increase availability and access to quality and youth friendly FP services in rural and underserved areas including tertiary institutions.

Audience	Enabling Channel Mix	Interventions
Government (MoHCC, MoFED)	Position papers, One-on-one meetings, Workshops and presentations,	**Strategies:** Increase support through policy, guidelines and budgetary allocation for integrated FP and SRH service provision by law makers: **Activities:** Increase advocacy initiatives with relevant policy makers for increased resources at health facilities to enable provisions of comprehensive and integrated FP/SRH services and commodities. Advocate for scaling up of integrated FP and SRH service to all groups of people including key populations such as PWDs, members of the Apostolic Sect, OVC, communities in the rural areas and geographically difficult to reach areas. Advocate for increased and accessible youth friendly FP services particularly in the rural areas and in tertiary institutions. Conduct campaigns for the improvement of the integrated FP and SRH services for all groups of population and in all geographic areas: **Activities:** develop position papers for submission and policy briefs targeting legislators and other influencers. Develop and distribute standardised guidelines on FP/SRH service provision for Institutions involved in FP related work
Community Based Structures/ Networks such as CBDs, VHWs, BCC Facilitators, VAACs, WAACs, Health Centre Committees (HCCs)	Community meetings, Print job aids briefs Information briefs/kit on quality integrated FP and SRH services.	**Strategies:** Empower community based structures and institutions to support youth peer educators and to provide youth friendly integrated FP and SRH services in the community. Strengthen capacity of community led institutions for social accountability in health such as Health Centre Committees to monitor FP service provision. Support social accountability structures to mobilise communities for FP information and service provision including community feedback mechanisms. **Activities:** Develop, print and disseminate tailor made 'job aids' that provide guidance for community-based structures and stakeholders to disseminate information of FP and SRH services and commodities. The job aids also strengthen and provide guidance on interventions such as outreach and counselling programmes. Provide guidance and support IPC at facility and community level. Support health accountability structures such as Health Centre Committees through information sheets and trainings to monitor delivery of quality of integrated FP and SRH services at local health facilities including provision of LARCs. Provide Health Centre Committees with the necessary information through IEC materials Train HCCs to implement simple social accountability tools such as community scorecards.

Audience	Enabling Channel Mix	Interventions
Facility level Service Providers (Public and private)	Workshops, On -job trainings through supervision visits, IEC materials for the health worker	**Strategies:** Strengthen the communication skills of service providers and key stakeholders on integrated FP and SRH services and commodities through on-the-job trainings and provision of guidance notes/sheets on key FP issues for the health worker including: dispelling myths and misconceptions about LARCs, utilisation of contraceptives by unmarried adolescent and young women. **Activities:** Review the training curriculum to incorporate integrated family planning and SRH services. Develop and disseminate job aids and flow charts for integrated FP/SRH/HIV/STIs service provision. Develop, print and disseminate standards for integrated FP/SRH service provision. Strengthen the capacity of service providers to provide youth friendly family planning services in rural areas, tertiary institutions and young people in difficult geographic areas to reach.
Women of child bearing age including those with disabilities	IEC materials, Community dialogues, Positive Deviance	**Strategies:** Enhance knowledge and awareness of integrated FP and SRH services at health service providers among women. **Activities:** Develop target specific and branded IEC materials on FP and SRH services and commodities available from different service providers. Facilitate community dialogues on the range of integrated FP and SRH services available at local health facilities.
Adolescents, and young people	Workshops IEC materials Multi-Media Innovations	**Strategy:** Strengthen interpersonal communication skills of peer educators. Strengthen use of ICT/Multi-Media platforms to reach a broad range of adolescents and young people. **Activities:** Support community based youth peer educators through information sheets, ICT and Mutli-Media platforms and training to: 1) provide correct and comprehensive information on contraceptive options to young people; prevention and management of HIV /AIDS and other STIs 2) provide appropriate referral for young people in need of services; and 3) support monitoring of quality youth friendly FP service provision at the local facilities.
CBOs/CSOs	Workshops Dialogues IPC, Media visibility mobile phone applications and short message, Multi-Media innovations Exhibitions, Mentorship	**Strategies**: Strengthen capacity of CSOs and CBOs to disseminate information on integrated FP and SRH services. Support CSOs and CBOs in community mobilisation and social accountability for service delivery. **Activities**: On-the -job trainings, reference materials, refresher courses Recreation activities like sports; drama and community theatre; information dissemination activities during commemoration days, market days, and exhibition days and other community and national events, link CBOs/CSOs with HCCs to facilitate implementation of community score card to measure and monitor FP service delivery at the facility and community.
Outcome 2: Adequate resources mobilised from various sources to fulfil financial requirements of the FP programme By 2022, the following will be achieved: 1. There will be local political commitment and support for the FP programme through increased budgetary allocation from 1.7 percent to 3 percent. 2. There will be an increase in the amount of funding and the number of partners contributing to the family planning programme		
Audience	**Enabling Channel Mix**	**Interventions**
Parliament, Ministry of Health and Ministry of finance	Hold meetings, Lobbying at events and	**Strategies:** Improve knowledge of current trends and needs. Establish a special alliance to deal with pushing for creation of an enabling environment. Facilitate joint financial resources mobilisation between NAC and ATB for family planning services as part of PMTCT and HIV prevention.

	events and organising side events at big events, Workshops, Petitions	Disseminate an investment case for family planning. **Activities**: Organise once a year advocacy workshop with parliamentarians. Identify, sensitise, and build capacity of select parliamentarians to be family planning champions (includes annual review meeting to discuss and track progress). Areas for advocacy include resource mobilisation and parliamentarians holding the national government accountable for international commitments. Develop petitions before budget presentation, before International Women's Day, Youth Day and in response to a matter of national interest. Develop and disseminate an investment case for FP. Convene annual meetings (1st quarter of year) with donors and partners to discuss national family planning budget to ascertain and coordinate funding commitments. Consult with the Ministry of Finance to defend annual funding requests for family planning, including presentation of "value for money" proposition of family planning investments.
ZNFPC	Website,Multi-Media platforms, One-on-one meetings, Workshops	**Strategies:** Strengthen the ZNFPC brand Strengthen ZNFPC Advocacy and Communication department through capacity development and enhanced advocacy and communication planning and implementation. **Activities:** Improved social media platforms, resource mobilisation App launched, new donor reporting and partnerships templates developed, and products in brail introduced. Rebrand website, engage App developer to develop resource mobilisation web/mobile App, develop new reporting templates Increase joint Capacity Building programmes. Develop South-South and Triangular partnerships proposals seeking cooperation in weak areas, Promote graphic designing internship to attract new skills/technological advancements to strengthen the brand.
Donors	One on one meetings Dialogues Documentation of change	**Strategy:** Strengthen documentation and dissemination of results of the FP programme. Identify and utilise Family Planning Champions among development partners. Enhance capacity of ZNFPC to document the return on investment on FP programme in Zimbabwe. **Activities**: document change as a result of the FP programme using documentaries, most significant change stories, images and testimonials that demonstrate the human impact of the FP programme. Document key successes on key groups such as religious leaders, adolescents and young people and those with living with disabilities; in addition to best practices and lessons learnt. Disseminate investment case among key actors and highly publicise through the media and other platforms.
Private Sector		
Media	Workshops Observations Interpersonal communication Change stories	**Strategies:** Improve visibility through mainstream media. Strengthen partnerships through joint activities. Establish Network of Journalists reporting Family Planning and Sexual Reproductive health and Rights. **Activities:** Media/News Conferences, Joint News Releases, Media interviews, Field Visits for marketing of LARCs and publicise and promotion of positive deviance in communities. Hold media/News conference quarterly, develop joint news releases quarterly and conduct on an on-going basis interviews for visibility. . Organise media field visits twice a year per province. Conduct joint workshop for the formation of network and hold an annual planning meeting thereafter. Undertake follow-up monitoring programmes twice a year.

Outcome 3: The policy, legal and political environments are conducive to facilitate effective functioning the family planning programme

By 2022, the following will be achieved:

1. FP related Laws and Policies will be reformed, harmonised and implementation begun.
2. Political will and commitment towards family planning will remain strong.

Audience	Enabling Channel Mix	Interventions
Parliament and other policy makers	Workshops, one-on-one meetings, dialogues, Newspaper articles, Radio and Television Programmes, media-print, electronic, radio and Multi-Media Innovations	**Strategy:** Ensure that Parliamentarians and other high level stakeholders are kept informed on FP issues (funding, availability, access and norms/beliefs that affect use of contraceptives) and have in-depth knowledge of FP and other related issues that need legislative and policy reform. Enhance high level advocacy through engagements with key and relevant strategically relevant actors. **Activities:** Develop orientation guides on key family planning issues. Identify champions for family planning (including the President, First Lady, and individual committee members). Conduct orientation for Parliamentary committees on family planning issues (1-day workshop or breakfast meeting), including education, health, agriculture, gender, and social development and finance. Establish a Parliamentary Sub-Committee on family planning, which engages multiple sectors. Organize the commemoration of family planning events by parliamentarians. Establish continuous review of their commitment, support and achievements.
Religious and Traditional leaders.	Workshops Dialogue meetings IEC materials Research reports	**Strategy:** Increase lobby for support from community and religious leaders, and leaders of umbrella bodies such as NASCOH. **Activities:** workshops with traditional and religious leaders on FP issues including LARCs and access and availability for unmarried young women. Workshops, dialogue and one-on-one meetings with religious sects umbrella bodies on FP including LARCs availability for unmarried young women. Identify FP champions among religious sects and in traditional sphere. Conduct studies to understand barriers to behaviour development and change, particularly in areas experiencing low uptake of contraceptives, including (LARCs).
CSOs	Meetings Workshops Policy briefs Research reports	**Strategy:** Strengthen capacity of CSOs to advocate for policy and legislative reforms. **Activities**: Establish a CSO coalition to bring consensus on issues for legislative and policy reform. Develop CSO position papers and policy briefs on reforms. Undertake studies to understand the political economy to influence FP policy and legislative reforms. Use findings and evidence to determine entry points for advocacy work.

Outcome 4: The demand for contraceptive services and commodities increases across different population groups

By 2022, the following will be achieved:

1. Different population groups (in urban and rural areas, areas of low CPR, adolescent and young women, those living with disabilities, and the Increased knowledge on FP, LARCs and integrated service provision among population groups and geographic areas.
2. Social and community norms and religious beliefs and prohibitions that undermine use of contraceptives including LARCs and undermine unmarried adolescent girls and young women's access to FP will increasingly be shifted in support of these initiatives.
3. Communities will be mobilised to improve knowledge and demand for FP.
4. FP, and in particular LARCs, will be widely accepted and used by different population groups and geographic areas with low CPR coverage.

Audience	Enabling Channel Mix	Interventions
Law and policy makers	IEC materials Meetings, presentations and demonstrations Workshops	**Strategy:** Strengthen outreach by law and policy makers to ensure they implement and promote policies that support behavioural and social changes required to improve access to integrated family planning and access to a wide range of contraceptives. **Activities:** Develop orientation guides on key family planning issues. Identify champions for family planning (The President and First Lady and other outspoken legislators). Organize the commemoration of family planning events by Parliamentarians. Provide key information kits for Parliamentarians and influencers for community outreach programmes.
ZNFPC, Ministry of Health	Meetings and position papers	**Strategy:** Improve appeal of contraceptives through re-branding. **Activities:** negotiate with development partners and suppliers for rebranding of contraceptives with appealing messages to improve utilisation particularly of the products promoted to reduce the unmet need for family planning (LARCs).
Traditional and Religious Leaders	Dialogue meetings Workshops IEC material	**Strategy:** Mobilise and engage with the Traditional and Religious Leaders to promote social and community norms in support of FP. Engage and strengthen the capacity and skills of Traditional and Religious leaders, Community based structures such as CBDs, VHWs BCCFs, HCCs, WAACs and VAACS to raise awareness on FP services and commodities; and promote behaviour development and change. **Activities:** hold training workshops targeting traditional and religious leaders. Conduct community dialogues for traditional and religious leaders and provide information kits that dispel myths, concerns, and misconceptions. Select outspoken traditional and religious leaders to be champions to be engaged in campaigns targeting FP constricting beliefs.
Community Based Structures	Dialogue meetings Workshops IEC material	**Strategy:** Engage and strengthen the capacity and skills of Traditional and Religious leaders, Community based structures such as CBDs, VHWs BCCFs, HCCs, WAACs and VAACS to raise awareness on FP services and commodities and promote behaviour development and change. **Activities**: Training meetings on interpersonal communication.
CSOs	Workshops Dialogue meetings IEC	**Strategies:** Promote sharing of best practices and testimonials to influence positive attitude behaviour development and change towards integrated FP/SRH/HIV/STIs services and commodities. Improve community mobilisation and participation and uptake of integrated FP services at all levels and by all categories of communities that include PWDs and those in areas with low CPR coverage. **Activities:** Joint awareness campaigns and supporting peer to peer activities for youth empowerment. Joint engagements with traditional and community leaders and appointing teenage champions/role models in primary and secondary schools, strengthen school-based educational innovations.

Audience	Enabling Channel Mix	Interventions
Women of child bearing age (Adolescents, young people, PWDs) Men and adolescent boys and young men	Community Dialogues IPC Newspaper Oped and other news articles Radio and Television Multi-Media Innovations (Podcasting, short on-line videos) IEC	**Strategies:** Promote the role models and champions approach for social behaviour development and change. Empower all categories of the community including PWDs to be able to demand and access integrated FP services. Support and strengthen scaling up of integrated FP and SRH service to all groups of people including key populations such as PWDs, members of the Apostolic Sect, OVCs, communities in the rural areas and geographically difficult to reach areas, in addition to areas with low CPR coverage. Strengthen awareness raising campaigns to increase knowledge on FP, LARCs and integrated service provision among population groups and in all areas. **Activities:** Home-based and social/community educational campaigns that include edutainment, community dialogues, faith-based mobilisation and group and network engagements. Other activities can be focused on multi-media interactive platforms, media campaigns through competitions and other programmes, social networks, school and tertiary focused campaigns. Annual commemorations, incorporation of FP issues in popular local television series/dramas, advertising radio programmes, peer to peer information sharing through youth peer educators and CBDs/VHWs also help to enhance empowerment of targeted groups.
Media		Strengthen the media as a vehicle for awareness raising, strengthening education on family planning and demand creation. Media can act as champions for change in behaviours and attitudes that are against family planning (Journalists who specialised in sexual and reproductive health right and Family Planning Reporting).

Annex 3: Monitoring Matrix for the Advocacy and Communication Strategy

Indicator	Unit of analysis	Analysis variables	Type of indicator	Definition	Source	Responsibility	Frequency of reporting
Average performance score for FP service delivery at health facilities	%	Location, level of facility	Output	This works the same as a teacher giving a mark at school for a pupil's test or exam. 50% is a pass, but anything below 50% is a fail and the lower the score goes down, the worse the service is. If however the work is such that it is more than just a pass, then the score will be above 50%: anything from 51% to 100%. The higher the mark given, the better the service is.	ZNFPC	ZNFPC	Annually
Motions to increase budgetary allocation for FP raised in parliament	Number	Total	Output	Motions made in the lower and upper house intended to increase the MOHCC budget	Hansard	ZNFPC	Annually
Initiatives undertaken by traditional leaders and religious leaders	Number	Type of initiative, location, denomination	Output	**Initiatives include:** joint statements, awareness campaigns among members,	Partners	ZNFPC	Annually
Number of motions on FP	Number	total	Output	Motions brought to the lower and upper house for debate	Hansard	ZNFPC	Annually
Proportion of trained MPs raising motions on FP by sex	Percent age	Sex	Output	Individual parliamentarians as a proportion of those trained who received training on FP and raising motions on FP in the lower and upper house of parliament	Hansard	ZNFPC	Annually
Number of trained MPs involved in public awareness on FP	Number	Sex, location	Output	Individual parliamentarians who are involved in FP awareness campaigns	ZNFPC	ZNFPC	Annually
Number of awareness campaigns undertaken on FP with parliamentarians	Number	Location	Output	Number of awareness campaigns led or involving parliamentarians	ZNFPC	ZNFPC	Annually
Actions taken by CBOs on social accountability	Number	Location	Output	Social accountability actions include: feedback reports on quality of service; meeting reports with health service providers/district MOHCC/ZNFPC on quality of FP;	Partner	ZNFPC	Annually
Actions taken by Health Centre Committees on social accountability	Number	Location	Output	Social accountability actions include: feedback reports on quality of service; meeting reports with health service providers/district MOHCC/ZNFPC on quality of FP;	Partner	ZNFPC	Annually
Proportion of HCCs trained using the community performance score card system to monitor quality of FP service delivery	%	Location	Output	These are HCCs that are provide Community score card information every quarter	Partner	ZNFPC	Annually

Indicator	Unit of analysis	Analysis variables	Type of indicator	Definition	Source	Responsibility	Frequency of reporting
People reached with private sector led FP campaigns	Total	location, sex, age,	Output	People reached in outreach campaigns	Private sector companies	ZNFPC	Annually
Proportion of population aware of at least one method of modern contraceptive	%	Age group, sex, marital status, location, wealth	Output	Total who mention at least one modern method of contraceptive as universally applied	ZDHS	ZIMSTAT	Five years
Proportion of population aware of at least one long acting and reversable contraceptives	%	Age group, sex, marital status, location, wealth	Output	Total who mention at least one LARC method available on the market	ZDHS	ZIMSTAT	Five years
Women receiving LARCs	Number	Type of LARC, Age group, sex, marital status, location, wealth	Output	Total women receiving a type of LARC at a health facility	DHIS	ZNFPC	Annually
Number of health facility staff trained on interpersonal skills for FP information; integrated FP service delivery; LARCs	Number	Location, type of facility, training	Process	Individual staff trained on the different training.	Partner	ZNFPC	Quarterly
Number of Health Centre Committees trained on quality integrated family planning services	Number	Location	Process	Health Centre committees that receive formal training from ZNFPC, Partners, of MoHCC	Partner	ZNFPC	Quarterly
Number of CBOs trained on quality integrated family planning services	Number	Location	Process	CBOs formally trained to support social accountability in the provision of FP services at local facilities	Partner	ZNFPC	Quarterly
Number of parliamentarians trained on critical integrated FP issues	Number	Sex	Process	Formal training of parliamentarians on integrated FP including issues needing their intervention	Partner	ZNFPC	Annually
Number of 1) traditional and 2) religious leaders trained on FP	Number	Location, sex, denomination (for religious leaders)	Process	Number of 1) traditional leaders 2) religious leaders trained on FP issues	ZNFPC	ZNFPC	Annually
Number of community health workers (1) VHWs and (2) CBDs trained on integrated and youth friendly FP service and interpersonal communication on FP	Number	Location, sex	Process	Number of 1) VHWs, and 2) CBDs trained in integrated FP service and interpersonal communication on FP	Partner	ZNFPC	Quarterly
Petitions developed to influence budget or emerging FP related issues targeting lawmakers and policy makers	Number	Type of petition (budget allocation, emerging issues)	Process	Number of petitions developed	Hansard	ZNFPC	Annually

Indicator	Unit of analysis	Analysis variables	Type of indicator	Definition	Source	Responsibility	Frequency of reporting
Visits on social media platforms dedicated to FP issues	Number	Type of social media platform	Process	Number of followed on ZNFPC managed social media platforms	Social media accounts	ZNFPC	Annually
Human Interest Stories shared with development partners	Number	Type (individual, institutional), location,	Process	Sharing means packaging in accessible format and delivered to development partners	Partners	ZNFPC	Annually
Number of donors participating in results sharing	Number	Type	Process	All platforms for sharing results of the FP programme	ZNFPC	ZNFPC	Annually
ZNFPC board members trained in resource mobilisation	Number	Total	Process	Total number of board members trained on resource mobilisation	ZNFPC	ZNFPC	Annually
Joint financing meetings with NAC and ATB for family planning services as part of PMTCT and HIV prevention	Number	Total	Process	Joint meetings whose agenda is resource mobilisation	ZNFPC	ZNFPC	Annually
Community dialogues on FP undertaken	Number	Location	Process	Community dialogue means a participatory meeting of a group community members to discuss FP issues	Partners	ZNFPC	Quarterly
Participants in community dialogues	Number	Location, sex, age group	Process	Participants are community members participating in the community dialogue	Partners	ZNFPC	Quarterly

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