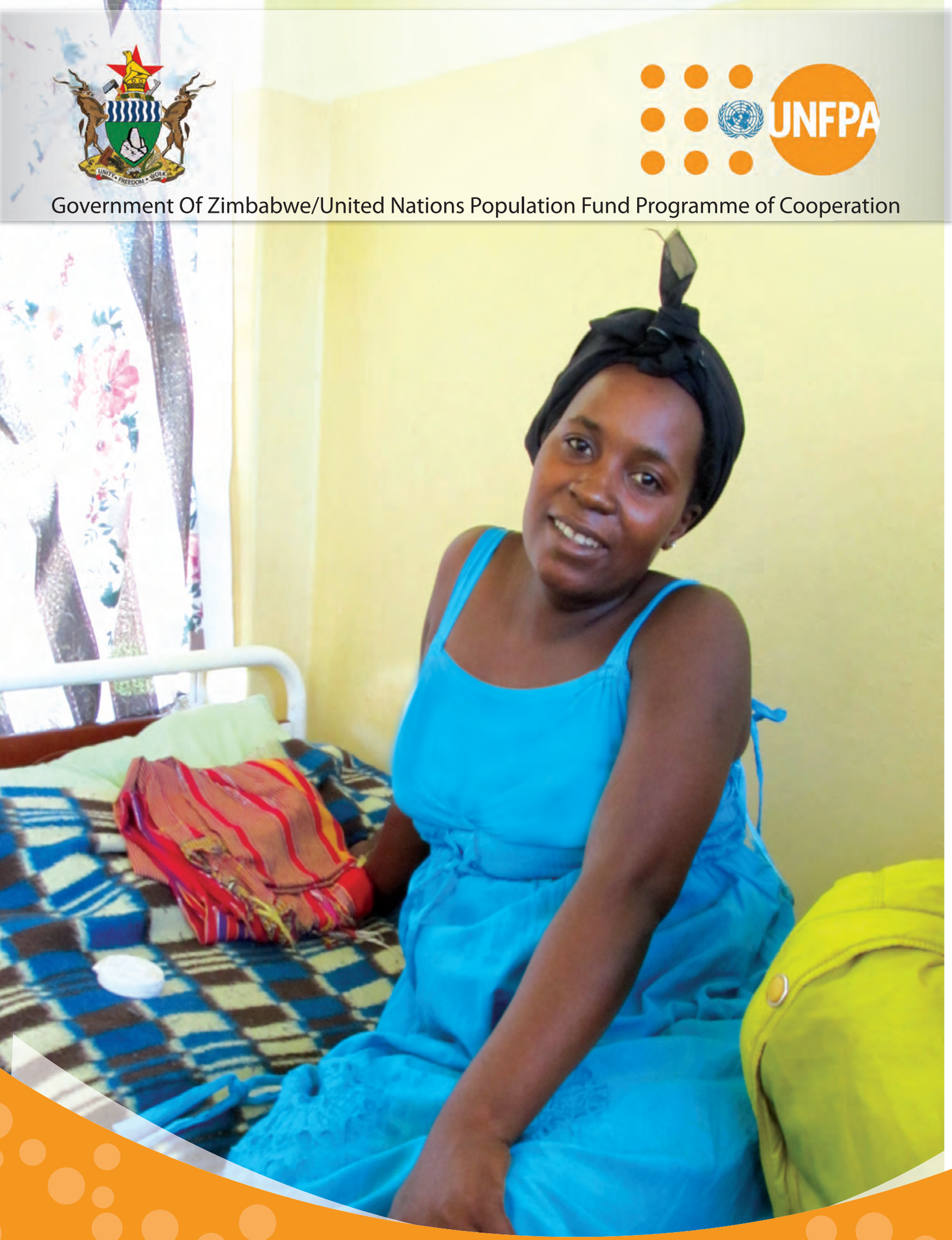
Government Of Zimbabwe/United Nations Population Fund Programme of Cooperation



Country Programme Action Plan (CPAP) 2012 - 2015

Country Programme Action Plan

(CPAP)

2012 – 2015

for the

Programme of Cooperation

Between

The Government of the Republic of Zimbabwe

and

The United Nations Population Fund

Government of the Republic of Zimbabwe

United Nations Population Fund

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ASRH	Adolescent Sexual and Reproductive Health
AWP	Annual Work Plan
CAP	Consolidated Appeal Process
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
CBO	Community Based Organization
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CERF	Central Emergency Response Fund
CP	Country Programme
CPD	Country Programme Document
COAR	Country Office Annual Report
CPAP	Country Programme Action Plan
CSO	Civil Society Organization
DHS	Demographic Health Survey
DFID	Department of International Development
EmONC	Emergency Obstetric and Neonatal Care
ERF	Emergency Response Fund
FACE	Fund Authorization and Certificate of Expenditures
FAO	Food and Agriculture Organization
FBO	Faith Based Organizations
FP	Family Planning
GBV	Gender Based Violence
GoZ	Government of Zimbabwe
HACT	Harmonised Cash Transfers
HIV	Human Immunodeficiency Virus
ICM	International Confederation of Midwives
ICPD (PoA)	International Conference on Population and Development (Plan of Action)
IMIS	Integrated Management Information System
IOM	International Organisation for Migration
IUCD	Intrauterine Contraceptive Device
MC	Male Circumcision
MDGs	Millennium Developmental Goals
MISP	Minimum Initial Service Package
MNH	Maternal and Neonatal Health
MoEPIP	Ministry of Economic Planning and Investment Promotion
MoESAC	Ministry of Education, Sports, Art and Culture
MoHCW	Ministry of Health and Child Welfare
MTP	Medium Term Plan
MWH	Maternity Waiting Home
NAC	National AIDS Council
NGO	Non-Governmental Organisation
PDU	Population and Development Unit
PMTCT	Prevention of Mother To Child Transmission
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
RMP	Resource Mobilization Plan
SBCC	Social and Behaviour Change Communication
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
UN	United Nations
UNAIDS	Joint United Nations Program on AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
UNWOMEN	United Nations Entity for Gender Equality and the Empowerment of Women
VIAC	Visual Inspection using Acetic acid and Cervicography
WHO	World Health Organisation
ZDHS	Zimbabwe Demographic Health Survey
ZIMSTAT	Zimbabwe National Statistics Agency
ZIMDAT	Zimbabwe Statistics Database
ZNASP	Zimbabwe National AIDS Strategic Plan
ZNFPC	Zimbabwe National Family Planning Council
(Z)UNDAF	(Zimbabwe) United Nations Development Framework
ZYC	Zimbabwe Youth Council

THE FRAMEWORK

The Government of Zimbabwe (GoZ), hereinafter referred to as the **"Government"**, and the United Nations Population Fund, hereinafter referred to as **"UNFPA"**;

- **Being** in mutual agreement on the content of this Country Programme Action Plan (CPAP), their respective roles and responsibilities in the implementation of the 6th Country Programme, and desirous of:

- **Furthering** their mutual agreement and cooperation for the fulfillment of the Programme of Action of the 1994 International Conference on Population and Development and its subsequent 5-year reviews, the Millennium Development Goals (MDGs), and other United Nations related conferences or summits to which the Government and UNFPA are committed, the Zimbabwe 2011-15 Medium-Term Plan (MTP) and related sectoral development plans germane to the UNFPA's comparative advantage;

- **Building** upon the experience gained and progress made during the implementation of the GoZ-UNFPA 5th Country Programme (2007-2011);

- **Entering** into a new period of cooperation as articulated in the 2012-2015 Country Programme Document (CPD) which was approved in September 2011 by the UNFPA Executive Board and operationalized in this CPAP;

- **Declaring** that these responsibilities shall be fulfilled in a spirit of friendly cooperation and mutual accountability;

Have agreed as follows:

PART I - BASIS OF RELATIONSHIP

1. The relationship between the Government of Zimbabwe and the United Nations Population Fund is governed by Resolution 2211 (XXI) of 17 December 1966, 34/104 of 14 December 1979 and 50/438 of 20 December 1995 of the General Assembly of the United Nations, and the Standard Basic Assistance Agreement (SBAA) signed by the Government and the United Nations Development Programme (UNDP) on 18 November 1993, which, mutatis mutandis, also holds true for UNFPA. This SBAA embodies the basic conditions under which UNFPA and its implementing partners shall assist the Government in carrying out its development projects, and under which UNFPA-assisted projects shall be executed.
2. This Country Programme Action Plan, covering the period 1st January 2012 to 31st December 2015, is to be interpreted and implemented in conformity with this agreement. It consists of ten parts wherein the general policies, priorities, objectives, strategies, management responsibilities and commitments of the Government and UNFPA are described, and three annexes (the CPAP Results and Resources Framework, the CPAP Planning and Tracking Tool and the Monitoring and Evaluation (M&E) Calendar).

PART II - SITUATION ANALYSIS

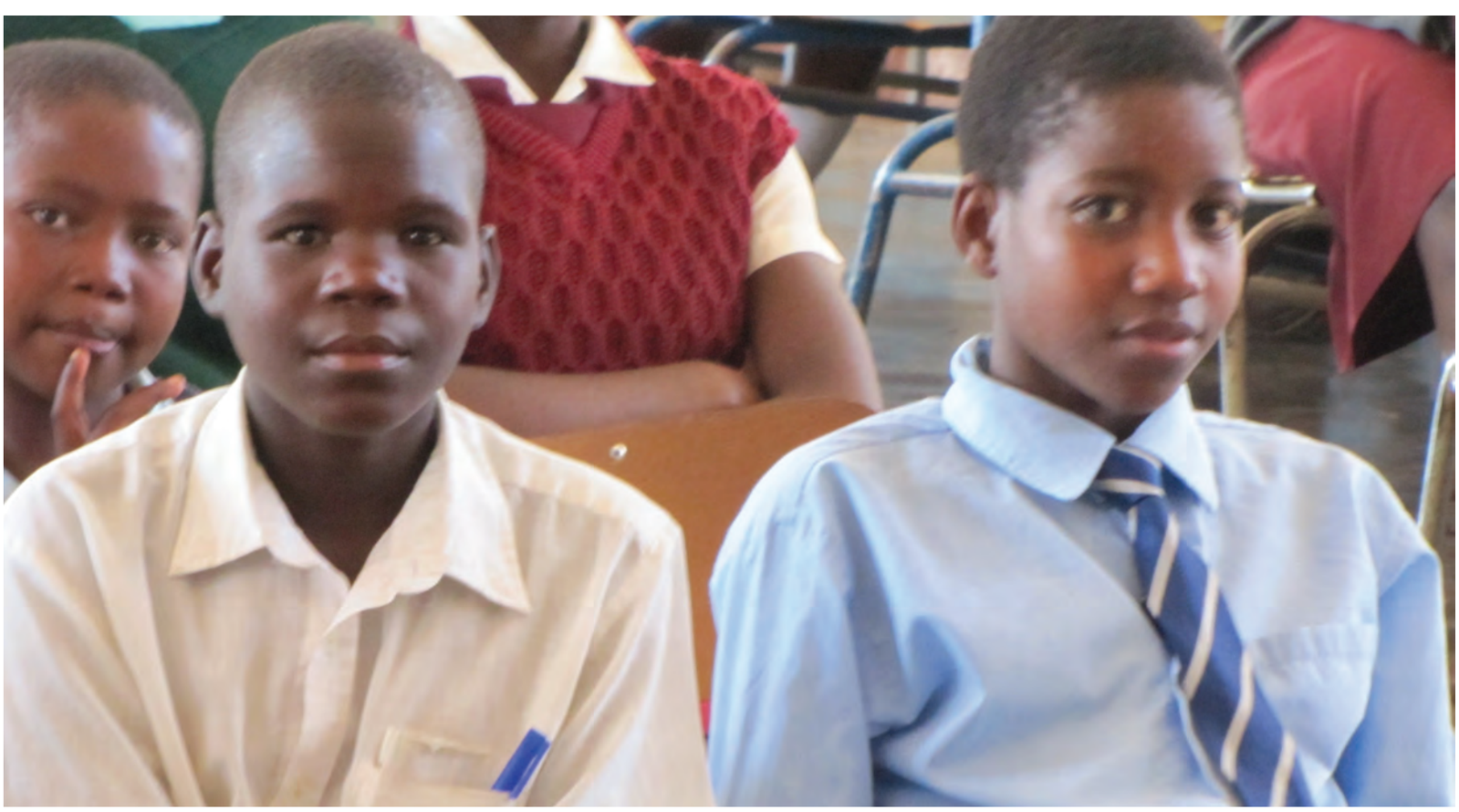
3. Zimbabwe faced major challenges from 2000 to 2008. This period was characterized by hyperinflation, a complex political and humanitarian situation, and a breakdown in the delivery of social services. The economy declined by 50.3%, and inflation reached the unprecedented level of 231 million per cent by July 2008. The percentage of the population living below the national poverty line rose from 55% in 1995 to 72% in 2003. This percentage is believed to have increased further due to the persisting adverse economic conditions which peaked in 2008. All these factors undermined the capacity of both public and private sectors to provide basic services.
4. The situation has stabilized since the signing of the Global Political Agreement in 2008, which saw the formation of an inclusive Government and the introduction of a multicurrency system in February 2009. The economy grew by 5.7% in 2009 and is estimated to have grown by 8.1% in 2010. Inflation declined to minus 7.7% by December 2009 before rising to an average of 3.1% in 2010. In the outlook, overall inflation is expected to be contained within single digit levels. Although humanitarian assistance is being scaled down and the country is moving into early recovery, the situation remains fragile.
5. Growing at an annual rate of 1.1% as from 2002, the population size of Zimbabwe was estimated at 12.3 million in 2008. About 70% of the population live in rural areas while young people aged 10-24 years comprise 34.6% of the population. Women constitute 52% of the population and the total fertility rate per woman dropped from 4.2 children in 2002 to 3.3 children in 2008. Due to the economic hardships and the effects of HIV, life expectancy decreased from 62 to 46 years for women and from 58 to 41 years for men between 1992 and 2008.

6. While population statistics have remained up-to-date, a number of statistical series, such as poverty and labour force statistics, have remained out-dated, hampering Government's ability to plan, monitor, evaluate and report on the millennium development goals and other overall and sectoral development goals. Lack of up-to-date data is mainly attributed to dwindling budgetary allocations for statistical development and a weak and uncoordinated national statistical system. The latter has resulted in duplication of effort, conflicting data and unnecessary waste of public resources.

7. The Zimbabwe Demographic and Health Survey recorded an increase in maternal mortality ratio from 283 maternal death per 100,000 live births in 1984 to 555 in 2005/6. The Zimbabwe maternal and perinatal mortality study (ZMPMS) of 2007 reported an equally high MMR of 725 per 100,000 live births and found HIV and AIDS-related conditions to be the leading indirect causes of maternal mortality, accounting for approximately 25% of all maternal deaths, while the direct causes such as haemorrhage, eclampsia and puerperal sepsis account for the remaining 75% of maternal deaths. According to the same study, successful prevention and treatment of the direct complications would contribute to reduce maternal mortality by 46%. Poor quality of care (partly related to high staff attrition and vacancy rates for essential health workers currently at 80% and 51% for midwives and doctors respectively), shortages of reproductive health (RH) commodities and a decline in institutional deliveries (from 72% in 1999 to 60% in 2009) have contributed to this picture.
8. Data on EmONC service coverage and quality of care is out-dated as it is based on the 2004 assessment of maternal and neonatal health (MNH) services. Commissioned by the Ministry of Health and Child Welfare (MoHCW), a national integrated health facility survey is currently underway to assess MNH services, including EmONC services and quality of care and will provide baseline data for monitoring EmONC and other MNH services under the 6th Country programme. The efforts of various players in MNH still require further coordination by the government.
9. According to preliminary results of the 2010/2011 ZDHS, contraceptive prevalence is estimated at 59% of women of reproductive age, up from 53.5% in 1999. However, unmet need for family planning has stalled at 13% for more than a decade. This means that about 211,000 married women who want to avoid or postpone childbearing are not using any method of contraception. Persuading half of these women to be family planning acceptors would increase the contraceptive prevalence to about 67%. Contraceptive use discontinuation contributes to the high level of unmet need. Results from the 2005/2006 ZDHS indicated that 22% of women who reported having discontinued use of contraception did so due to side effects, health concerns, need for a better method or inconvenience of the method. Preliminary results from the 2010-2011 ZDHS showed that short term methods (pill, 41.3 %; injectables, 8.3 %) were most commonly used while long term and permanent methods (female sterilization, 1.1%; implants, 2.7%; IUCD, 0.2%) were least used. Doubling the voluntary use of long-term and permanent methods would increase the number of all married women using these methods to 136,000.
10. The burden of cancers of the reproductive system is high. Cervical cancer accounts for 32.1% of cancers in women. With a rate among the highest in the world (47.4 cervical cancer cases per 100,000 women), it is estimated that every year 1,855 women are diagnosed with cervical cancer and 1,286 die from the disease in Zimbabwe. The disease burden for cervical neoplasia, both in terms of incidence and progression to cancer has been greatly influenced by the high prevalence of HIV. However, coverage of screening programs remains low, at 7.2% of eligible women on average, lower in rural areas (5.2%) and higher in urban areas (10.8%). The coverage is low despite the fact that screening and treatment services that are acceptable, safe, af-

fordable and sustainable can be implemented.

11. Young people, especially young women living with HIV, face a unique set of challenges in accessing SRH services. Consequently, young women are exposed to the risk of unintended pregnancies, unsafe abortions and sexually transmitted infections, including HIV. Lack of employment and gender-based violence worsen the situation. According to the 2009 national estimates, HIV prevalence is higher among women aged 15 to 24 (6.9%) than among men the same age (3.3%) and is fuelled by age-disparate sexual relationships. The adolescent fertility rate currently stands at 115 births per 1,000 women aged 15-19, up from 99 in 2005/6. This upward trend is driven by the sharp increase of adolescent fertility in rural areas, from 120 births per 1,000 women in 2005/6 to 144 in 2010/11 while remaining static at 71 births per 1,000 women in urban areas.
12. Youth-friendly service provision is very limited with only 4% of the 1,500 public health facilities offering such services. The public health system data collection tools inadequately capture age-disaggregated data for the youth population. As noted in the 5th CP final evaluation, this hinders the ability to monitor progress on adolescent reproductive health. The UN/GoZ Country Assessment found that the education sector's response to HIV is not comprehensive or effective; and that the basic and tertiary education curriculum is out-dated and overdue for reform. Although it is ministry of education policy that all schools should provide life skills based HIV and AIDS education to pupils, the basic education curriculum inadequately addresses relevant life skills to enable young people to exercise their SRH rights. Young people, in and out of school, lack access to RH information and services. This is further compounded by a weak framework for the protection of their SRHR and poor coordination of SRH and HIV prevention activities. Risk exposure of young people in tertiary institutions is substantial as they engage in transactional sex to afford tertiary education and this is worsened by the absence of focal persons for the implementation of HIV prevention activities in these institutions. There is need therefore to strengthen sexuality education and structures that target problems specific to the adolescents.
13. Zimbabwe is one of the few countries with a generalized HIV epidemic and high HIV prevalence to have recorded a sustained adult HIV prevalence decline, from 26.4% in 1997 to 14.3% in 2009. A significant HIV prevalence decline has also been recorded among pregnant women aged 15-49 (from 20.5% in 2004 to 16.1% in 2009) as well as among young pregnant women aged 15-24 (from 20.8% in 2002 to 11.6% in 2009). The decline in HIV sero-prevalence can be attributed to increased mortality as well as to changes in sexual behaviours, translated by a reduction in number of sexual partners and a sustained increase in consistent use of condoms with non-regular sexual partners.
14. However, with an estimated 48,000 new adult infections in 2009, Zimbabwe is still hard-hit by the HIV epidemic. New adult infections are concentrated among women aged 18-29 and men aged 20-44. About 95% of adult HIV infections are due to heterosexual transmissions driven by multiple, including concurrent, sexual partnerships, low levels of male circumcision, long-term sero-discordant relationships, sex work, and inconsistent condom use. Coverage of HIV prevention service delivery in Zimbabwe has increased substantially over the 2007-2011 period. Nevertheless, substantial gaps remain. Only 3% of the eligible men in Zimbabwe had accessed circumcision services by mid-2011 and the proportion of couples tested and counselled for HIV remains low. The prevalence of STIs among sex workers is high, reflecting continued involvement in high risk sexual activities with inconsistent condom use. There is growing recognition that linking SRH and HIV programmes is cost-effective in improving access to services. However, a rapid assessment on the status of SRH and HIV integration done in 2010 showed that



linkages at policy and systems levels were weak. Whilst there was some degree of integration at service delivery level, this was by default, not co-ordinated and occurred without the required guidance and policy support.

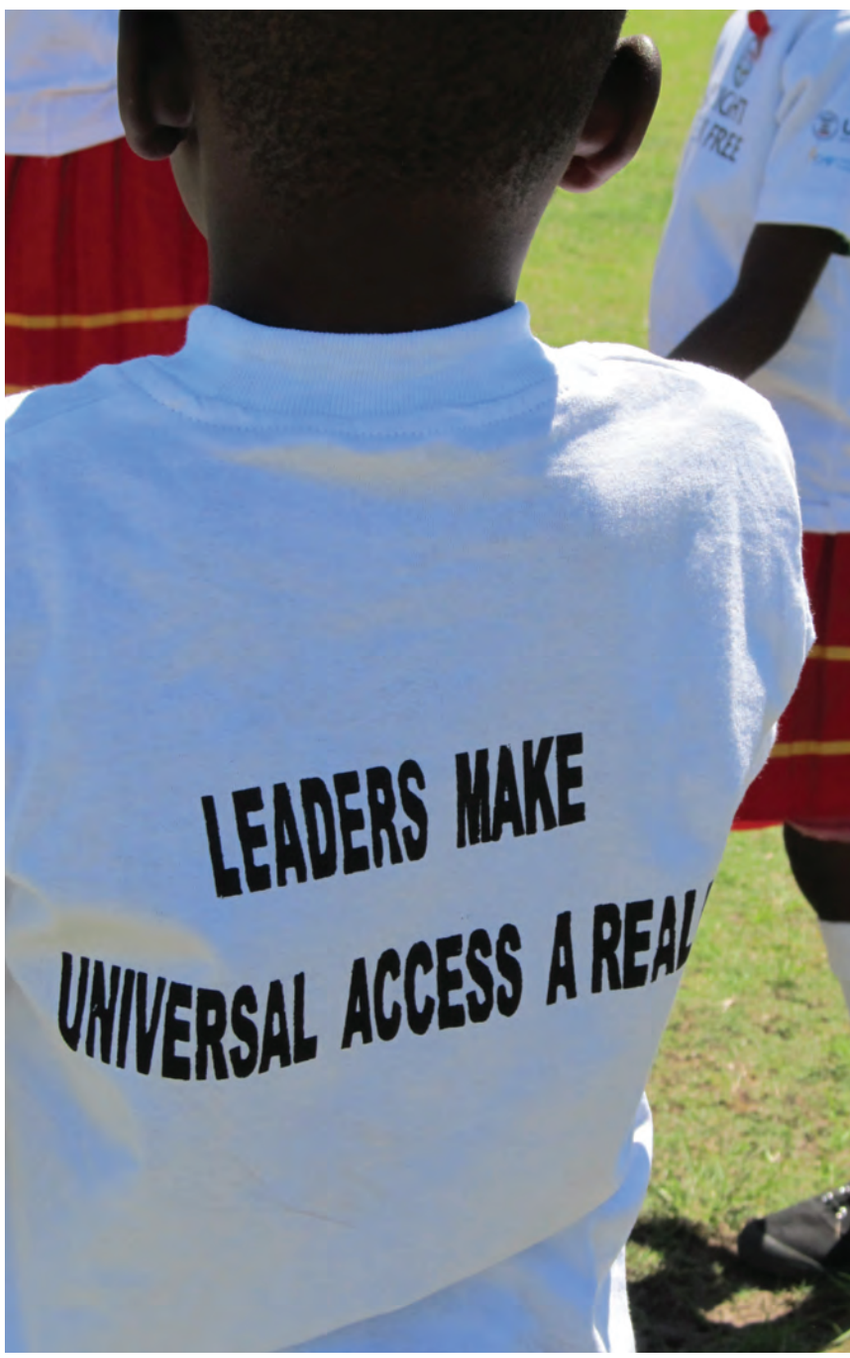
15. Despite several gender-responsive laws and policies, gender inequalities persist and more work is still required to reach the MDG target of 50-50 representation by 2015. Women are underrepresented in Parliament (14% and 33 % in the lower and upper houses, respectively). This shows the extent to which women have limited influence in decision making. Young women's participation in politics at all levels and across all sectors (including in tertiary institutions which are often the training ground for future political involvement) is also limited. The Constitution, which is currently under reform, still allows discrimination on matters of personal law and customary law, a duality that hinders women's full enjoyment of human rights. Furthermore, the right to health, including reproductive health rights are not included in the current Bill of Rights.
16. According to the 2005/6 ZDHS, 47% of women in Zimbabwe had ever experienced either physical or sexual violence (or both) since age 15, while 25% had ever been sexually abused. Further analysis shows that married women who have experienced physical and/or sexual violence are significantly more likely to be HIV-positive than those who had not experienced any physical or sexual violence. The Domestic Violence Act still faces resistance from some strongly traditional people of Zimbabwe who view it as an interference with their private lives and cause the break-up of marriages. This socio-cultural context has negated women's ability to use the protective measures of the law as they fear castigation by their families. This is compounded by women's economic dependence on men and limited access to legal aid, resulting in more than 50% of the cases reported to the police and courts being withdrawn. Like other progressive policy and legal provisions for women, awareness of the relief offered under the Domestic Violence Act is still not widespread.
17. A 2009 joint UNFPA, UNICEF, and IOM assessment indicated a general recognition of GBV as a protection priority but one with extremely limited resources for comprehensive response. Most communities lack access to basic services such as health care, psychosocial support and legal aid for survivors of GBV (both adult and child). In those communities where some minimal services do exist, they are limited in scope and capacity. While the majority of cases in rural areas are handled through the traditional justice system, leaders in these courts uphold patriarchal values and do not always apply human rights principles. Absence of a national system for coordination, monitoring and evaluation has affected effective implementation of the multi-sectoral approach.

PART III - PAST COOPERATION AND LESSONS LEARNED

18. The goal of the 5th CP was to contribute towards the improvement of the quality of life of the people of Zimbabwe through improving reproductive health, preventing HIV, promoting gender equality and women's empowerment, and improving the availability and utilization of data for development. To progress towards the achievement of this goal, the programme contributed to the development and implementation of a number of strategic policy and operational documents which include the Male Circumcision policy and strategy, the Domestic Violence Act, the National GBV strategy, Adolescents' Sexual and Reproductive Health (ASRH) strategy, the National Health Management Information Systems strategy, Waiting Mothers Shelter Guidelines, the Family Planning and STI guidelines as well as a Maternal and Neonatal Health roadmap.
19. The programme strengthened the capacity of the government and civil society organizations in the provision of integrated SRH/HIV and multi-sectoral GBV services. This focus resulted in the support of pilot projects such as the male circumcision project and its subsequent national rollout; a multi-sectoral and coordinated approach towards GBV service provision as well as the youth interact centers. The programme also saw the establishment of an adult rape clinic; the refurbishment of maternity waiting homes; the expansion of youth-friendly services to cover half of district hospitals; a national roll out of the HIV prevention behaviour change communication programme; and support to the Anti Domestic Violence Council. Partnership was expanded with the Ministry of Education, Sports, Art and Culture (MoESAC) and the Zimbabwe Youth Council (ZYC) towards promoting young people's sexual and reproductive health and rights.
20. To address emerging humanitarian issues, the CO mobilized over $2.5 million additional resources to strengthen EmONC services and GBV prevention and response. The CO also played a key role in the establishment and leadership of the GBV sub-cluster and the RH programme within the protection and health clusters, respectively. Furthermore, the CO ensured that RH and GBV were included prominently in national contingency plans, the consolidated appeal process and other strategic documents for humanitarian response.
21. The end of 5th Country Programme evaluation pointed to the progress in achieving the programme objectives. It also commended UNFPA's flexibility and creativity in meeting emerging national priorities due to the challenging social-economic, financial and political environment. The evaluation also identified critical areas for improvement which have been incorporated in the 6th Country Programme: (a) continue to strengthen all programme components evidence base; (b) expand national capacity strengthening at all levels, especially for the delivery of quality RH, HIV and GBV prevention services; (c) addressing the capacity of implementing partners to implement and fully operationalize existing policies and laws to realise programme results; (d) continuous need for flexibility to improve new strategies as the country's socio-economic and political situation stabilises; and (e) strengthening collaboration and/or joint programming with other UN agencies such as UNICEF on school-based advocacy initiatives, and WHO on Emergency Obstetric Care.
22. Key lessons learnt during the previous CP were (a) the realisation that joint programmes have the potential to create harmonisation and synergies but establishing common working ground and operational modalities needs tact, diplomacy and negotiation skills; and (b) the existence of policies and laws, though necessary, is not sufficient for program impact, there is also need for the programme to address implementation capacity issues.

PART IV - PROPOSED PROGRAMME

23. The GoZ/UNFPA Country Programme Action Plan, 2012-2015, builds on the CPD for Zimbabwe approved by the Executive Board of the United Nations Population Fund. The CPAP was developed in close consultation with the GoZ, United Nations sister agencies, donors and civil society organizations. The proposed programme contributes to national priorities through five of the eighteen 2012-2015 Zimbabwe United Nations Development Assistance Framework (ZUNDAF) outcomes: a) 2.1 Enhanced economic management and pro-poor development policies and strategies; (b) 2.3 Improved generation and utilisation of data for policy and programme development and implementation by Government and other partners; (c) 5.2Access to and utilization of quality basic health and nutrition services; (d) 6.1 Improved access to (and uptake of) HIV prevention services; and (e) 7.1Laws, policies and frameworks established and implemented to ensure gender equality and empowerment of women and girls. It also contributes to 4 of the 7 outcomes of the UNFPA global development results as articulated in the revised strategic plan 2008-2013.
24. The goal of the sixth country programme is to contribute to the improvement of the quality of life of the people of Zimbabwe, especially among women and young people, through promoting universal access to Sexual and Reproductive Health and Rights. In particular, the programme seeks to reduce maternal mortality, the unmet need for family planning, new HIV infections and gender based violence, informed by a better understanding of population dynamics, and using rights-based and gender-sensitive approaches.
25. Advocacy efforts will be scaled up to aim for an enabling policy and programming environment towards the achievement of MDG's in particular MDG 5 and the ICPD agenda. UNFPA will take the lead in the communication of reproductive health and rights, gender equality as well as population and development issues. Key strategies will include policy dialogue, social mobilisation, behaviour change communication, multi-media campaigns, utilization of social media, and strengthening of partnerships, whilst ensuring synergy between all programme components.
26. The protracted humanitarian crisis the country is experiencing will most likely continue to affect the population of Zimbabwe, although a transition into recovery is expected to take place gradually. Nevertheless, a continuous potential for acute emergencies such as disease outbreaks, natural disasters and other crises remains. As a result, the CO will continue to play an important role in emergency preparedness and response within the humanitarian country team. This includes playing a key role within protection and health clusters and other relevant humanitarian fora to ensure that the needs of pregnant women and girls and survivors of GBV are incorporated in all humanitarian strategies and plans, such as the consolidated appeal process and national contingency plans. Furthermore, the CO will ensure that the MISP is implemented and that GBV is mainstreamed across all sectors of humanitarian response, which includes the prevention of sexual exploitation and abuse by humanitarian actors.
27. Building on past achievements and on its comparative advantages, UNFPA will seek opportunities for joint programmes, develop and implement an advocacy and communication strategy to enhance country programme visibility, and a resource mobilization plan to raise additional funding to achieve the desired results of the country programme.
28. The programme will focus on three main areas, namely (a) Reproductive Health and Rights, (b) Gender equality (c) Population and Development



A. REPRODUCTIVE HEALTH AND RIGHTS COMPONENT

29. This component contributes to ZUNDAF outcomes 5.2 and 6.1 on increased access to and utilization of quality basic health and nutrition services and improved access to (and uptake of) HIV prevention services respectively and to UNFPA Global strategic outcome 2 on increased access to and utilization of quality maternal and new born health and Outcome 4 on Increased access to and utilization of quality HIV and STI prevention services especially for young people and other key populations at risk . It takes into account commitments made by the Government on the Global strategy on women's and children's health in October 2010, and the AU Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA). The areas of focus and interventions are in line with government priorities as articulated in key strategy documents, particularly the National Health Strategy (2009-2013), the MNH road map (2007-2015) and the ZNASP II.
30. Under this component, UNFPA will support the Ministry of Health and other key ministries in institutional and capacity strengthening. Evidence informed programming, continuous quality improvement approach and RH and HIV integration will be some of the broad strategies to be mainstreamed in the key outputs.
31. The first outcome is increased utilization of comprehensive gender-sensitive and youth-friendly RH services. Three outputs will contribute to this outcome.

Output 1: Strengthened capacity of government and civil society partners to coordinate and deliver reproductive health

32. Strategies for this output include (a) strengthening coordination mechanisms of MoHCW; (b) strengthening monitoring and evaluation mechanisms of MoHCW and other key organizations such as tertiary educational institutions; and (c) strengthening institutional and technical capacities of the MoHCW to deliver effective midwifery services.

Major Activities

- Support national coordination mechanisms. These include the following: SRH steering committee, MNH steering committee, ASRH coordination forum and RHCS steering committee. The ToRs of the various committees will be reviewed to assess relevance, avoid duplication and enhance efficiency. MoHCW will be supported to establish and operationalize RH partners' forum.
- Train provincial and district health teams. Training will be in planning, monitoring and evaluation of integrated SRH and HIV programmes, including continuous quality improvement of maternal health services.
- Train and provide institutional support to focal persons for SRH and HIV within tertiary educational institutions and youth serving organizations. This will enable them to effectively plan, implement, monitor and evaluate ASRH programme.
- Re-profile and raise the visibility of midwifery practice. This will be done through advocacy and supporting the midwives professional association and capacity building of training institutions to provide post-basic training in midwifery with midwifery tutors being capacitated with teaching skills. The midwifery curriculum will be reviewed to incorporate competency based training which meets the standards set by the ICM.

Output 2: Increased availability of reproductive health services and commodities

33. To achieve this output, the following strategies will be implemented: (a) capacity and system strengthening in reproductive health commodity security, including reproductive health commodities for STI control and HIV prevention, (b) support integrated EmONC and PMTCT within the context of continuous quality improvement, (c) scaling up of cervical cancer screening services using the VIAC "see and treat" approach, and (d) expand coverage of youth-friendly services.

Major Activities

- Support review of the RH policy, guidelines, protocols and standards. The RH policy is out-dated and will be reviewed and revised, if needed, in collaboration with key MNH partners. Review of guidelines, protocols and standards, in line with the revised policy and strategies, will also be supported.
- Support Reproductive Health Commodity Security (RHCS), including in humanitarian situations. This entails procurement and delivery of key selected commodities. These include commodities for FP, EmONC, MC, STI prevention, and MNH lifesaving and HIV drugs. Prepositioning and provision of dignity kits for women of reproductive age and RH kits for service delivery points in areas affected by emergencies will also be supported. Family planning method mix will be strengthened through capacity building of health workers to provide long-acting contraception (implants, IUCDs) at provincial, district, mission and selected rural hospitals.
- Support integrated EmONC and PMTCT. This includes strengthening of post abortion care, capacity building of health care providers and managers in continuous quality of care and MISP, development of clinical mentorship guidelines and supporting institutionalization of routine maternal and peri-natal death audits. Referral systems will also be strengthened through procurement and repair of ambulances.

- Support maternity waiting homes programme. This entails implementation of the MWHs guidelines including refurbishment with a focus on facilities providing comprehensive EmONC in rural districts.
- Support scaling up of cervical cancer programme. This entails the development and implementation of a cervical cancer control strategy, procurement and distribution of cervical cancer control equipment to ensure a national coverage of screening services.
- Support youth-friendly service delivery. This includes support for pre-service and in-service training of health workers and to facility-based youth-friendly corners using the minimum package as defined in the ASRH strategy.

Output 3: Increased demand for SRH services at the community level

34. This output will employ the following strategies: (a) strengthening communication for social and behavioural change (b) capacity-building of community health workers and advocates to mobilize community members to utilize RH services.

Major Activities

- Promote safe space within communities for young people. This will enable them to access information on SRHR, gender and development. This will be done through support to youth interact centres.
- Train community health workers to promote utilization of RH services. This entails promotion of choice in FP, supporting pregnant women to deliver in a health facility, and utilization by the communities of other RH services.

35. The 2nd outcome under this component is increased adoption of safer sexual behaviour and use of HIV prevention services. Several lower-level outcomes will be pursued to achieve this outcome: (a) Increased knowledge on HIV prevention including on male circumcision and sero-discordance; (b) Increased personalized risk perception; (c) Increased self-efficacy in use of HIV prevention methods; (d) Increased supportive community norms towards reducing multiple partnerships and stigma as well strengthening gender equality. Two outputs will contribute to these outcomes:

Output 4: Increased coverage of the social and behaviour change communication programme

36. To achieve this output, the programme will apply the following strategies (a) interpersonal communication at district and community-level; (b) capacity development of leaders as role models and advocates for HIV prevention; (c) technical assistance in the development and implementation of Social and Behaviour Change Communication (SBCC) interventions; (d) continued gathering of evidence for informing HIV prevention SBCC interventions;

Major Activities

- Provide technical assistance to the national HIV prevention behaviour change programme: Technical support will be provided to the National AIDS Council in using and adapting planning, monitoring and evaluation tools for the BC programme as well as in continuous review of evidence on epidemic trends and intervention effectiveness.
- Support capacity development of community behaviour change facilitators and community leaders: The programme will continue to provide support to updating and improving training curricula for BC facilitators and leaders as well as technically support training of trainers.
- Develop and update evidence-informed SBCC materials: The programme will support the development, updating and reprinting of brochures, leaflets, posters and home visit guides in support of the national programme. Information on SRHR, gender and combination HIV prevention will be integrated into these materials;
- Support decentralized interpersonal communication by behaviour change facilitators: Community facilitators in selected areas will be supported through low-cost incentives to deliver a range of communication activities. These activities will include community workshops, BC messaging at local events, and home visits. The community facilitators will use the Love & Respect approach to promote personalized risk perception, open communication about HIV, relationship skills and partner reduction. They will also work towards creating demand for condoms, PMTCT, male circumcision and other SRH/HIV services.
- Provide support to peer education on SRH/HIV issues among sex workers and young people: The programme will support capacity development and ongoing communication activities of peer educators. Sex worker peer educators will focus on promoting condom use, uptake of SRH/HIV services and collectivization of sex workers, in particular in relation to safer sex negotiation and GBV prevention. Youth peer educators will work towards promoting responsible sexual practices, increased risk perception of age-disparate sexual relationships and uptake of SRH/HIV services.
- Conduct operations research on effective communication approaches in support of universal access to combination HIV prevention. The programme will support operations research studies on comparing the effectiveness of different community mobilization strategies such as community meetings and home visits in demand creation for achieving universal access.
- Review and update basic life skills education curriculum to strengthen sexuality and HIV prevention education in schools. The MoESAC will be supported in the development of an updated curriculum that addresses the diverse needs of young people and increases young people's knowledge of HIV transmission risk and prevention methods.

Output 5: Increased availability of HIV prevention services

37. This will be achieved by using the following combination prevention approaches: (a) scaling up availability of safe and voluntary medical male circumcision services; (b) capacity and systems strengthening in condom programming; (c) expand coverage of services for sex workers; and (d) promoting SRH/HIV policy, system, and service integration.

Major Activities

- Provide technical assistance to development and roll out of the national combination HIV prevention strategy. In line with ZNASP II, support will be provided for the development, dissemination, implementation and subsequent reviews of the national combination prevention strategy.
- Support generation of evidence on cost-effective service delivery approaches. The programme will continue to support research on a new adult male circumcision (MC) device that does not require anaesthesia and has the potential to accelerate roll-out of services. Based on the results of the safety and comparability studies, further field studies may be supported. Based on emerging needs similar research may be supported for other MC approaches, roll-out of ART for prevention or any other new intervention areas.
- Strengthen capacity of health workers in integrated SRH/HIV service delivery. In order to scale up service delivery and expand the number of facilities providing quality integrated SRH/HIV services, the programme will support training of health workers on safe medical MC services, condom promotion, prongs 1 and 2 of PMTCT, targeted SRH/HIV services for sex workers and any other related emerging capacity gaps. Particular attention will be paid to using integrated curricula and minimizing time health workers spend away from their duty stations.
- Support delivery of safe and voluntary medical MC services in selected sites. Due to the large gap in MC coverage, the programme will also directly support low cost MC service delivery through providing financial support for MC outreach teams, MC service sites and MC days.
- Support effective management of health sector HIV prevention programmes. The programme will continue to support management of the public sector condom programme with a focus on analysis and addressing barriers towards improving access in underserved areas.
- Provide integrated SRH/HIV services to sex workers. In order to meet sex workers' health needs, services will be provided through specific referral clinics and outreach sites. The services provided to sex workers will include family planning, condom promotion, HIV testing, and STI treatment. In partnership with other agencies, the inclusion of ART services into the service package will be explored.

B. POPULATION AND DEVELOPMENT COMPONENT

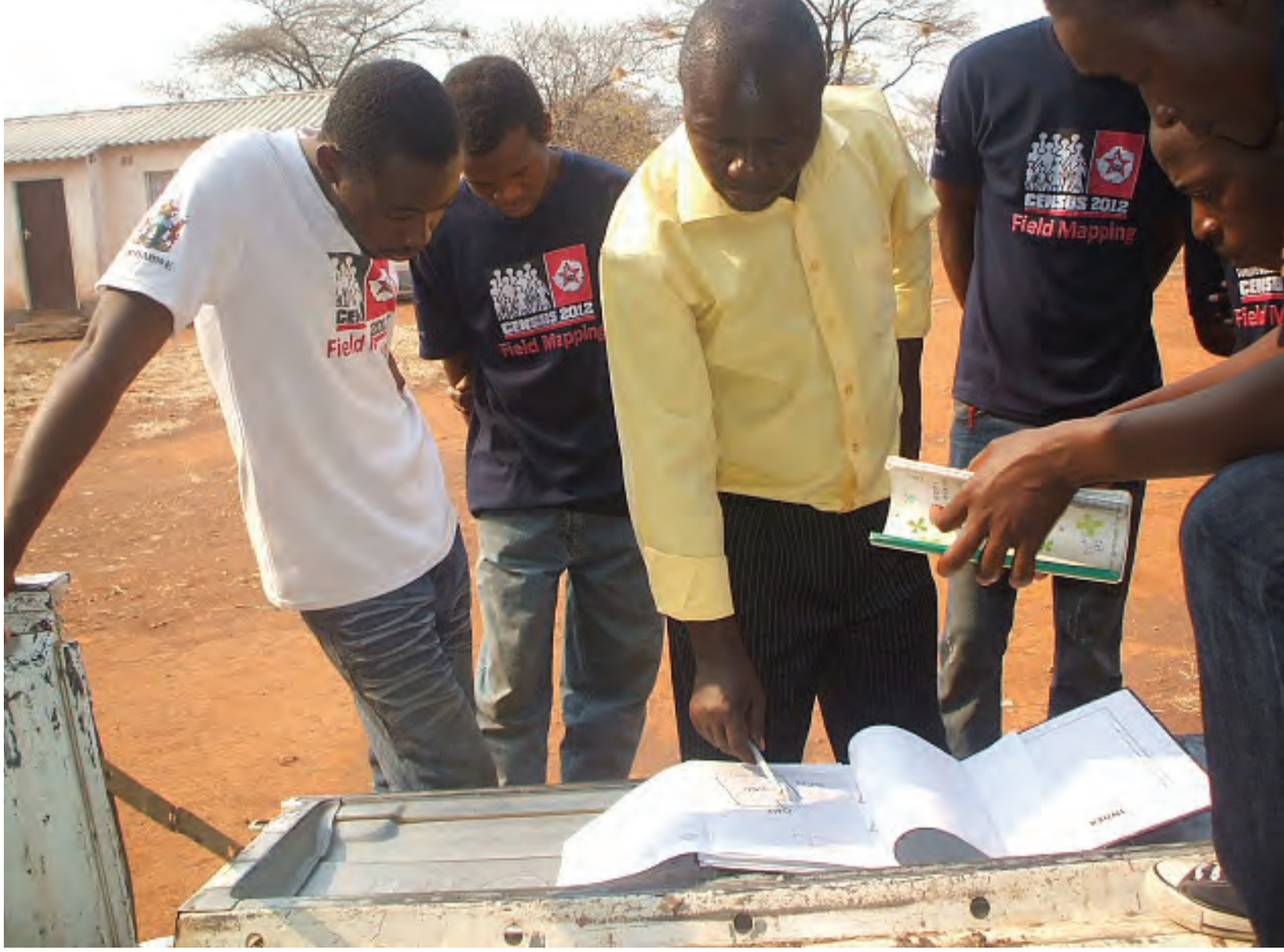
38. This component contributes to ZUNDAF outcome 2.1 and 2.3: enhanced economic management and pro-poor development policies and strategies; and improved generation and utilisation of data for policy and programme development and implementation by Government and other partners respectively; and to National Development priority 2 on pro-poor sustainable growth and economic development. It also contributes to the UNFPA strategic outcome 7 on Improved data availability and analysis resulting in evidence-based decision-making and policy formulation around population dynamics, SRH (including family planning), and gender equality. The outcome of this component is the increased availability and utilization of disaggregated data at national and subnational levels. Three outputs will contribute to this outcome.

Output 6: Strengthened capacity of relevant government departments responsible for planning to integrate population issues into development plans and monitor sectorial policies and plans

39. The strategy to achieve this output is capacity building.

Major Activities

- Support the PDU to monitor and report on implementation of the population programmes and projects elaborated in the Medium Term Plan. The projects include those aimed at reducing unmet need for contraception; increasing men's participation in reproductive health; and at ensuring gender responsive budgets and programmes in all the sectors and support the launch and dissemination of the revised NPP. Targets set for MDG 5, MDG 6 and national budget allocation to the health sector will be monitored, so will gender and youth development mainstreaming. A population monitoring and evaluation database will be set up to help with the monitoring process.
- Advocate for establishment of coordination mechanisms for the implementation and review of the ICPD PoA. An Inter-Ministerial Task Force will be established to coordinate the implementation of the National Population Policy and the country review of the ICPD POA. A country report on ICPD at 20 will be produced and shared at regional and global levels.



- Support research on inter-linkages between population, reproductive health, gender and sustainable development. Research institutions, universities and individual consultants will be engaged to identify and conduct research on population and development issues. PDU staff will be trained in integrating population issues in national development planning tools and in monitoring and evaluation. Research findings will be widely disseminated, using various media (fact sheets, flyers, workshops, etc.).

Output 7: Strengthened capacity of the Zimbabwe National Statistics Agency and line ministries to produce, analyse, disseminate and promote the utilization of population data

40. Strategies for this output include: (a) support for census and national household survey data collection exercises, (b) strengthening the routine information systems of line ministries; and (c) promoting utilization of data.

Major Activities

- Mobilize resources. This entails financial and material resources for the enumeration and analysis phases of the 2012 population census and conducting of the 2015 ZDHS. Advocacy efforts will be targeted at MoF to increase budgetary allocations to census operations while external assistance will be sought in line with the census resource mobilization strategy.
- Support analyses of the 2012 population census and 2010 ZDHS. This will focus on census thematic areas, including population projections. Support will be provided for secondary analyses of the ZDHS. Training in data analysis software packages and statistical report writing will be conducted.
- Support the implementation of the national health information strategy. This entails advocating for the review of the data collection instruments and statistical reports to ensure that key RH and GBV data is sufficiently disaggregated by sex and age.
- Support web-based databases to enhance data utilisation. This entails establishment and updating of web-based versions of the Zimbabwe Statistics Database (ZIMDAT) and Zimbabwe Integrated Management Information System (IMIS). ZIMSTAT and line ministry staff will be trained on use of the databases.

Output 8: Strengthened capacity of the ZIMSTAT to coordinate the national statistical system

41. The strategies to achieve this output include: (a) supporting the establishment and functioning of selected coordination mechanisms, (b) promoting interaction of NSS actors, and (c) advocating for the implementation of the National Strategy for the Development of Statistics (NSDS) and the sector plans derived from it.

Major Activities

- Review standards, concepts, definitions and methods used across the national statistical system. A publication will be produced and technical support and training provided to data producers on harmonized methods and standards.
- Review data needs of users. This will be done through statistical inquiries, consultative meetings and user-producer symposiums. Support will be given to identification and prioritization of data needs.
- Create a common platform for data management. Effort will be aimed at promoting use of compatible software systems to allow easy transfer of information across sectors (e.g. health, education, etc.)
- Raise awareness on the importance of quality statistics. Focus will be among various players in the national statistical system. This will be done through various advocacy initiatives including publications on why Zimbabwe needs good statistics.

C. GENDER EQUALITY COMPONENT

42. Gender equity, equality and women's empowerment has been identified as the 7th national priority, as articulated in the MTP and the National Gender Policy, and underpins the achievement of all MDGs. The Gender Equality component will contribute to the ZUNDAF Outcome 7.1: Laws and policies established, reviewed and implemented to ensure gender equality and empowerment of women and girls and UNFPA Global strategic outcome 5 on Gender equality and reproductive rights advanced particularly through advocacy and implementation of laws and policy. In the spirit of "One UN," UNFPA will coordinate with other agencies as needed and in line with the revised UNFPA strategic plan, the programme will maintain a special focus on protection and fulfilment of reproductive rights, and prevention and response to gender based violence.
43. The outcome of this component is an improved policy and legal environment for gender equality and increased utilization of gender-based violence services. Three outputs will contribute to this outcome.

Output 9: Increased capacity of leaders to address negative social norms and practices that perpetuate gender inequalities

44. This output seeks to address socio-cultural constraints which perpetuate values and practices prejudicial to women's empowerment, gender equity and equality. These constraints limit women's ability to use the protective measures of the law as they fear to be castigated by their families and communities. The threat of violence also limits women's ability to negotiate for safer sex and to seek reproductive health services.
45. Strategies to achieve this output include: (a) advocacy for social transformation; (b) capacity strengthening of parliamentarians, traditional and religious leaders and influential persons in key state and non-state organizations to develop and institute gender sensitive policies and approaches (c) building an evidence base.

Major activities

- Develop, translate and disseminate simplified operational guidelines on key gender equality laws, policies, services and procedures. These guidelines will seek to set minimum standards of practice among traditional and religious leaders in promoting gender equality. Participatory approaches will be used in development of these guidelines which will provide an opportunity to engage with these leaders and address misconceptions on human rights and negative social norms and practices on sexual and reproductive health and violence against women and girls.
- Support the development of gender responsive plans and budgets. This will be done at provincial and district level (including tertiary institutions), with particular focus on GBV and reproductive health rights of women and girls. This will involve sensitization of authorities at provincial and rural district level on gender mainstreaming and budgeting, followed by development of implementation plans that can be used to hold them acco9. untable for gender equality, with particular focus on GBV and reproductive health rights of women and girls. Leaders will be sensitised and encouraged to adopt the 4 P's campaign on promoting Prevention of GBV, Protecting survivors of GBV, promoting Participation of women in development and increasing Programmes on gender equality. Through the use of a gender marker at district level, leaders will be assessed on the extent to which they are promoting women's empowerment, reproductive rights and implementing initiatives to improve maternal health.
- Undertake sociocultural analysis of norms, values and practices perpetuating gender inequalities and GBV. This support will include commissioning gender related research that identifies equality gaps, monitors implementation of policies and guides programming, while building evidence for policy review and formulation.
- Support the National Gender machinery to coordinate, implement and monitor programmes on gender equality. This will involve provision of institutional and technical support to the ministry in charge of gender, Anti-domestic Violence Council, Women's Parliamentary Caucus and gender focal points in key sectors. Capacity assessments will be conducted jointly with other UN agencies and a capacity building plan will be developed and areas of support articulated in annual work plans.

Output 10: Increased availability of services to address gender-based violence

46. This output will address the current gaps in GBV service provision through institutional and technical capacity strengthening of health, police, judiciary, social workers and key community based cadres in provision of quality survivor-centred services. Efforts will be targeted at the major urban cities, mining and resettlement communities which have high reported incidence of domestic and gender-based violence. The second strategy will involve strengthening coordination of the multi-sectoral response to GBV.

Major activities

- Integrate gender and GBV modules in the pre-service curricula of the police, judiciary, and health service providers. This will involve a review of the current modules in use. Depending on the capacity of the training institutions, some support such as training of trainers may be provided to facilitate the effective adoption of the revised modules.
- Support GBV referral and coordination mechanisms at district and community level, including in humanitarian situations. Location specific referral pathways will be developed and disseminated. In line with the GBV strategy, coordination fora will be supported in selected communities to improve monitoring and reporting on GBV prevention and response efforts.
- Scale up survivor friendly GBV services. An evaluation of the efficiency and sustainability of the current GBV service delivery models will be conducted to identify the most cost effective and sustainable model. This will be followed by a capacity assessment of key service providers, based on which, support will be provided to achieve the minimum standards of care for survivors.
- Train traditional court officials at community level in victim friendly approaches. This training entails sensitization on the human rights and equality principles which need to be upheld in handling GBV cases.

Output 11: Increased community awareness of gender-responsive laws, mechanisms and services

47. This output will address lack of awareness of gender responsive laws, mechanisms and generate demand for services. Strategies to be used include (a) community mobilization, (b) mass media, and (c) capacity building of community based structures and networks.

Major activities

- Conduct multimedia campaigns on gender and reproductive rights, including on gender-based violence and its link to HIV and AIDS. A multimedia strategy will be developed in collaboration with government, civil society and other UN agencies, to harmonise key messages and approaches. A review of existing IEC materials and tools will be done to identify those whose use can be scaled up.
- Promote dialogue on gender issues among young people through forum discussions. Based on the key messages agreed in the multi-media strategy, young people will be engaged within youth interact centres.
- Train community based cadres in counselling and paralegal services. To ensure sustainability, cadres recruited from existing community based structures and networks will be trained. The counselling handbook developed for anti-domestic violence counsellors will be simplified and translated into vernacular languages, while the existing family law handbook will be upgraded and used for these trainings.

PART V - PARTNERSHIP STRATEGY

48. Despite significant investments over the years, UNFPA's contribution alone cannot achieve the impact level goals set out in the Country Programme in line with the UNDAF and national priorities. The achievement of these goals requires a comprehensive partnership involving the Government, UN agencies, donors and civil society.
49. UNFPA will sign letters of understanding with different implementing partners including government ministries and departments, and civil society. The government will be the main implementing partner through the relevant sector ministries. In the area of reproductive health (including HIV prevention), the Ministry of Health and Child Welfare will be the key implementing partner, while close collaboration with National AIDS Council and Zimbabwe National Family Planning Council will be sought in their areas of mandate. The ministry for gender will be the key implementing partners for Gender while ZIMSTAT and the Ministry of Economic Planning will be the key implementing partners for Population and Development. The ministry and parastatals responsible for youth development will be engaged as key partners to ensure youth mainstreaming. UNFPA will also work with civil society partners that have the capacity to expand coverage of its programmes, and partners with capacity to deliver on all of UNFPA's programme components. This is critical for ensuring an integrated approach. These programmes will be executed in line with the ICPD PoA and related international development goals.
50. The support offered by UNFPA to the GoZ in the areas of reproductive health (including HIV prevention), gender and population and development is based on national priorities and the availability of resources. This partnership is crucial to sustain policy commitment, but more importantly to ensure success and sustainability of programmes that make a meaningful difference in people's lives.
51. UNFPA is committed to utilizing the most effective joint programming modalities possible in the area of gender and more specifically on Gender Based Violence, which has been selected as a flagship programme UNFPA will work together with UN-WOMEN , UNDP, UNICEF, FAO, IOM and UNAIDS and others in this area to reduce transaction costs and build operational synergies. Within the Joint UN Team on AIDS, UNFPA will continue to intensify joint programming in the area of HIV prevention working together with the other UNAIDS co-sponsors. All activities of UN agencies and their partners in the area of HIV prevention will be consolidated in an annual Joint UN Action Plan on HIV and AIDS. In the area of reproductive health, UNFPA will utilize the most effective joint programming modalities possible.
52. Within the UN system, UNFPA was actively involved in the development of the ZUNDAF; drafting matrices for the following theme groups; HIV and AIDS, Gender, and Population and Basic Social Services (PBSS). UNFPA will work closely and develop joint programmes with UNICEF, UNDP and NGOs on MDG advocacy and data for development for monitoring purposes. This will be done through the ZIMDAT Joint Programme. UNFPA will aim to improve synergy and partnerships, with focus on its comparative advantage, as a thought-leader, advocate, and partnership-broker to advance the ICPD agenda and the MDGs.
53. Programme design and implementation will take into account other major initiatives supporting the same or related national priorities. The investments by UNFPA will complement the efforts by the government, the National AIDS Trust Fund, the Health Transition Fund, the United States Government Global Health Initiative, the Global Fund to fight AIDS, TB and Malaria, other UN agencies as well as various other partners. Coordination among these partners will be ensured through various mechanisms including the Reproductive Health Steering Committee, the HTF Steering Committee, and the National Partnership Forum on HIV and AIDS.
54. Over the recent years funding partners including Department for International Development (DFID), European Union (EU), and the Government of Japan have contributed significant financial resources towards implementation of UNFPA supported programmes. UNFPA will step up efforts towards identifying new funding partners as well as strengthening relationships with existing funding partners. UNFPA will play a major role among development partners in providing leadership in the areas of reproductive health, HIV prevention, gender, and integration of population dynamics in national development plans.

PART VI - PROGRAMME MANAGEMENT

55. UNFPA and the GoZ will implement the programme in collaboration with donors, civil society and United Nations organisations within the context of the UNDAF, 2012-2015, in line with the UNDAF joint implementation matrix, and in accordance with UNFPA rules and procedures. Civil society partners will also assist with programme implementation. UNFPA will make efforts to engage in formal joint programmes with United Nations and other development partners in the areas of capacity development, HIV prevention, maternal health, response to gender-based violence and data for development.
56. The Ministry of Finance is the Government Coordinating Authority and will have overall responsibility for the UNFPA Country Programme. A representative of the Ministry of Finance will sign the CPAP together with the UNFPA Representative. The programme will be implemented in collaboration with the ministries responsible for health, finance, economic planning, gender, and youth, United Nations agencies, CSOs, herein referred to as "implementing partners".
57. The various implementing partners are selected through a competitive capacity assessment process focusing on sound management systems including financial management, institutional and technical capacities, past experience in implementing related activities, and potential to contribute to the country programme outcomes and outputs.
58. The Ministry of Health and Child Welfare through the RH unit, AIDS and TB unit, ZNPFC and NAC will coordinate the implementation of the RH and HIV/AIDS programmes. The Ministry of Women's Affairs, Gender and Community Development will coordinate the implementation of the gender component of the programme, while the Ministry of Finance through the Central Statistical Office will coordinate and manage the Population and Development related activities.
59. To facilitate the implementation of all these activities, UNFPA will together with the respective implementing partners develop and sign annual work plans (AWPs) that outline activities to be executed during the year. UNFPA will use AWP monitoring tools to track progress towards implementation of planned activities and monitor expenditure patterns.
60. Review of the programme and financial capacity of implementing partners will assist in the UN to adopt a harmonized cash transfer (HACT) mechanism that will simplify the liquidation of the resources by partners. Based on the recommendations of the micro assessments, a harmonized training strategy will be developed and budgeted for as part of the implementation of the CPAP and appropriate cash transfer modalities will be determined.
61. Cash transfers for activities detailed in AWPs can be made by UNFPA using the following modalities:

    i) Cash transferred to Implementing Partners:
    - Prior to the start of activities (direct cash transfer), or
    - After activities have been completed (reimbursement)

    ii) Direct payment to vendors or third parties for obligations incurred by the Implementing Partners on the basis of requests signed by the designated official of the Implementing Partner.

    iii) Direct payments to vendors or third parties for obligations incurred by UNFPA in support of activities agreed with Implementing Partners.

62. Direct cash transfers shall be requested and released for programme implementation periods not exceeding three months. Reimbursements of previously authorized expenditures shall be requested and released quarterly or after the completion of activities. UNFPA shall not be obligated to reimburse expenditure made by the Implementing Partner over and above the authorized amounts.

    i) Implementing Partners with qualified National Execution (NEX) audit reports for two consecutive years will not be eligible for any direct cash transfers in the following year.
    ii) Implementing Partners with un-cleared, unsupported expenditure from any of the previous years as documented in the NEX audit reports, will not receive any additional direct cash transfers until these amounts have been cleared.
    iii) Implementing Partners with un-cleared advances, Operating Fund Account, from previous years will not receive any additional direct cash transfers until these amounts have been cleared.

63. Following the completion of any activity, any balance of funds shall be reprogrammed by mutual agreement between the Implementing Partner and UNFPA or refunded.
64. Cash transfer modalities, the size of disbursements, and the scope and frequency of assurance activities may depend on the findings of a review of the public financial management capacity in the case of a Government Implementing Partner, and of an assessment of the financial management capacity of the non-UN Implementing Partner. A qualified consultant, such as a public accounting firm, selected by UNFPA may conduct such an assessment, in which the Implementing Partner shall participate. The Implementing Partner may participate in the selection of the consultant.
65. Cash transfer modalities, the size of disbursements, and the scope and frequency of assurance activities may be revised in the course of programme implementation based on the findings of programme monitoring, expenditure monitoring and reporting, and audits.

Resource mobilization

66. In close collaboration with national partners and consultation with other United Nations agencies, UNFPA will develop and implement a resource mobilization plan (RMP) for the 6th Country Programme. In addition to lobbying the government for increased budgetary allocations for the country programme, UNFPA will continue to engage the donor community for additional resources.
67. The RMP outlines the CP funding requirements and the plans in place for the Country Office to mobilize resources. The proposed assistance from UNFPA, amounting to $39.6 million, will be obtained from regular resources ($13.2 million) and co-financing modalities and/or other resource ($26.4 million).
68. The contribution from the government may be cash or in-kind. At community level, contribution will be in-kind in the form of personnel and time to enhance community participation, ownership and sustainability of the programmes.

Human resources

69. The UNFPA country office consists of a representative, an assistant representative, an operations manager, ten national programme officers and a number of programme and administrative support staff, as per the approved country office typology. The CO wishes to strengthen its role in assisting various partners in meeting the challenges posed by high maternal mortality, the AIDS epidemic, and gender based violence, thus, the programme will earmark funds for additional national and international project staff to support country programme implementation as required. Fixed-term appointments will be prioritised. The UNFPA country office will seek technical expertise from national, regional, and international institutions, the UNFPA regional office in South Africa, and from South-South cooperation.
70. National Professional Project Personnel, Junior Professional Officers and United Nations Volunteers will also be employed as necessary. Technical assistance will be provided to the national institutions to support programme coordination and implementation. UNFPA Zimbabwe Country Office will implement all requirements of MOSS and MORSS to ensure required security and safety of staff and the organizations property is provided.

PART VII - PLANNING, MONITORING AND EVALUATION

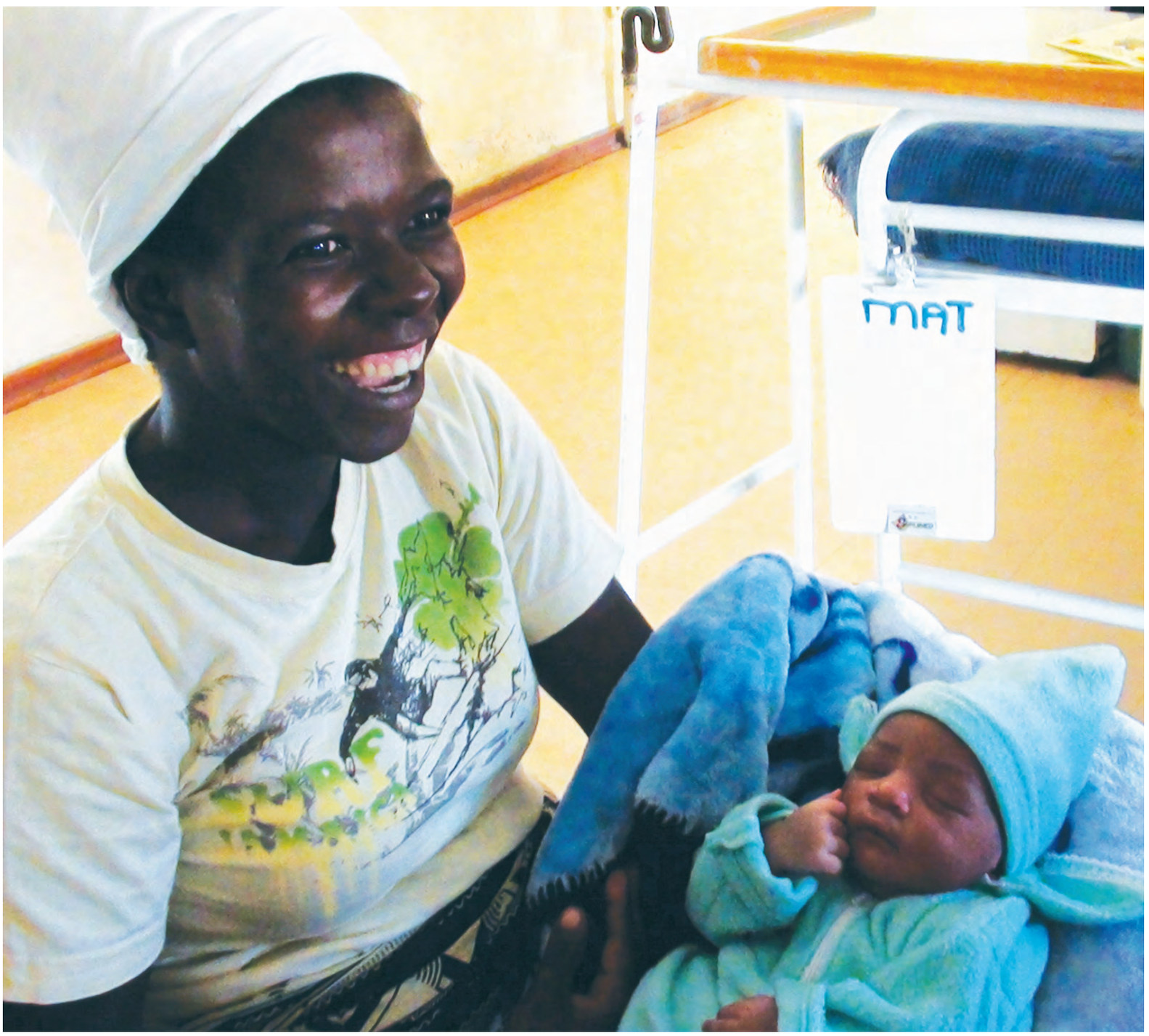
71. The CP will be monitored and evaluated jointly by UNFPA, the GoZ and implementing partners based on UNFPA procedures and guidelines. The CO will implement the various planning activities during the program cycle. The CPAP tracking tool and the monitoring and evaluation plan have been prepared as part of this document. Annually, AWPs with implementing partners; planning, monitoring and evaluation plans, and Office Management Plans (OMP) will be developed.
72. Monitoring of the CP program will be based on quarterly and annual review meetings with implementing partners. These will be linked to the ZUNDAF reviews. Field monitoring visits will be conducted to project sites at least once per year.
73. Implementing partners will be required to submit AWP monitoring tool and FACE forms every quarter. Reports to funding partners will also be submitted as required.
74. Midterm and end-of-programme evaluations will be undertaken to determine the efficiency, effectiveness, sustainability, relevance and impact of the programme. The mid-term review will be conducted in the second quarter of 2013 to allow adequate time for the results to be utilised to improve and re-design the programme for the rest of the cycle. The end of programme evaluation will be held in the first quarter of 2015 to allow the results to inform the development of the next country programme. Good practices and lessons learned will be documented and shared with all stakeholders during program implementation. In addition to carrying out mid-term and end of country programme evaluation, specific project evaluations will be carried out as required by funding partners.
75. To increase the capacity of implementing partners to monitor and evaluate their activities, training on UNFPA planning, monitoring and evaluation guidelines will be conducted.
76. Implementing partners agree to cooperate with UNFPA for monitoring all activities supported by cash transfers and will facilitate access to relevant financial records and personnel responsible for the administration of cash provided by UNFPA. To that effect, IPs agree to the following:

- Periodic on-site reviews and spot checks of their financial records by UNFPA or its representatives.
- Programmatic monitoring of activities following UNFPA's standards and guidance for site visits and field monitoring.
- Special or scheduled audits. UNFPA, in collaboration with other UN agencies (where desired) will establish an annual audit plan, giving priority to audits of Implementing Partners with large amounts of cash assistance provided by UNFPA, and those whose financial management capacity needs strengthening.

77. To facilitate assurance activities, IP and the UN agency may agree to use a programme monitoring and financial control tool allowing data sharing and analysis. The audits will be commissioned by UNFPA and undertaken by private audit services. Assessments and audits of non-government IPs will be conducted in accordance with the policies and procedures of UNFPA.

PART VIII - COMMITMENTS OF UNFPA

78. UNFPA commits a total of US$ 13.2 million from its regular resources over the period 2012-2015. Over the same period, UNFPA makes a commitment to mobilize resources amounting to US $26.4 million subject to donor interest. The regular resources are exclusive of funding that may be sourced in response to emergency appeals.
79. In case of direct cash transfer or reimbursement, UNFPA shall notify the Implementing Partner of the amount approved by UNFPA and shall disburse funds to the Implementing Partner in accordance with UNFPA guidelines and financial procedures. In case of direct payment to vendors or third parties for obligations incurred by the Implementing Partners on the basis of requests signed by the designated official of the Implementing Partner; or to vendors or third parties for obligations incurred by UNFPA in support of activities agreed with Implementing Partners, UNFPA shall proceed with the payment in accordance with UNFPA guidelines and financial procedures.
80. UNFPA shall not have any direct liability under the contractual arrangements concluded between the Implementing Partner and a third party vendor. Where more than one UN agency provides cash to the same Implementing Partner, programme monitoring, financial monitoring and auditing will be undertaken jointly or coordinated with those UN agencies.



PART IX - COMMITMENTS OF THE GOVERNMENT

81. The government of Zimbabwe will honour its commitments in accordance with the provisions of the Standard Basic Assistance Agreement signed by the Government of Zimbabwe and UNDP on 18 November 1993. In line with this agreement, the government will accord to UNFPA and its officials, and to other persons performing services on behalf of UNFPA, such facilities and services as accorded to officials and consultants of the various funds, programmes and specialized agencies of the United Nations.
82. The government shall apply the provisions of the Convention on the Privileges and Immunities of the United Nations agencies to UNFPA's property, funds, and assets and to its officials and consultants. In addition, the government will commit counterpart funding to the programme, and will also support UNFPA in its efforts to raise funds required to meet the additional financial needs of the country programme as may be identified in the course of project implementation.
83. Within the framework of this Country Programme Action Plan, the Government commits to support UNFPA in providing assistance to CSOs (registered Private Voluntary Organizations, Trust Funds, CBOs, and FBOs) to achieve the objectives of any project. Such organizations shall be accountable for the assistance directly to UNFPA.
84. The Government will facilitate periodic visits to programme sites for UNFPA officials and where necessary officials of donors supporting the programme for the purpose of monitoring the end use of programme assistance, assessing progress and collecting information for programme/project development and evaluation.
85. In case of supply assistance UNFPA will procure and the Government will clear, store and distribute and ensure access by UNFPA officials to do periodic end user monitoring. Equipment such as vehicles will be provided under loan agreements for the duration of the CP after which transfer may be effected on mutual agreement. UNFPA shall be exempted from Value Added Tax or any other forms of taxation in respect of procurement and services in support of this CP.
86. With respect to cash assistance from UNFPA, a standard Fund Authorization and Certificate of Expenditures (FACE) report, reflecting the activity lines of the Annual Work Plan (AWP), will be used by Government and other Implementing Partners to request the release of funds, or to secure the agreement that UNFPA will reimburse or directly pay for planned expenditure. The Implementing Partners will use the FACE to report on the utilization of cash received. The Implementing Partner shall identify the designated official(s) authorized to provide the account details, request and certify the use of cash. The FACE will be certified by the designated official(s) of the Implementing Partner. Cash transferred to Implementing Partners should be spent only for the purpose of activities as agreed in the AWPs.
87. Cash received by the Government and national NGO Implementing Partners shall be used in accordance with established national regulations, policies and procedures consistent with international standards, in particular ensuring that cash is expended for activities as agreed in the AWPs. Where any of the national regulations, policies and procedures are not consistent with international standards, the UNFPA regulations, policies and procedures will apply.
88. In the case of international NGO and IGO Implementing Partners cash received shall be used in accordance with international standards in particular ensuring that cash is expended for activities as agreed in the AWPs.
89. To facilitate scheduled and special audits, each Implementing Partner receiving cash from UNFPA will provide UNFPA or its representative with timely access to:

    i) all financial records which establish the transactional record of the cash transfers provided by UNFPA;
    ii) all relevant documentation and personnel associated with the functioning of the Implementing Partner's internal control structure through which the cash transfers have passed.
90. The findings of each audit will be reported to the Implementing Partner and UNFPA. Each Implementing Partner will furthermore:

    i) Receive and review the audit report issued by the auditors.
    ii) Provide a timely statement of the acceptance or rejection of any audit recommendation to UNFPA that provided cash.
    iii) Undertake timely actions to address the accepted audit recommendations.
    iv) Report on the actions taken to implement accepted recommendations to the UNFPA on a quarterly basis.

PART X - OTHER PROVISIONS

91. This Country Programme Action Plan shall supersede any previously signed Country Programme Action Plans between the government of Zimbabwe and UNFPA and become effective upon signature, but will be understood to cover programme activities to be implemented during the period from January 1st 2012 to December 31st 2015.
92. The Country Programme Action Plan may be modified by mutual consent of the Government and UNFPA, based on the outcome of the annual and mid-term reviews or compelling circumstances. Any new programme developed within the period covered by this Country Programme but not outlined in the Country Programme Action Plan will be developed jointly by UNFPA and the concerned Government Ministry or agency in consultation with the Ministry of Finance.
93. Nothing in this Country Programme Action Plan shall in any way be construed to waive the protection of UNFPA accorded by the contents and substance of the United Nations Convention on Privileges and Immunities of the United Nations adopted by the General Assembly of the United Nations on 13 February 1946, to which the Government is a signatory.

IN WITNESS THEREOF the undersigned, being duly authorized, have signed this Country Programme Action Plan on this 3th day of December 2011 in Harare, Zimbabwe.

For the Government of Zimbabwe (GoZ)

SECRETARY TO TREASURY
30 DEC 2011

Mr. Willard Manungo

Permanent Secretary
Ministry of Finance

For the United Nations Population Fund (UNFPA)

United Nations Population Fund
UNFPA
Zimbabwe

Dr. Basile O. Tambashe

Zimbabwe Country Representative

Annex 1 COUNTRY PROGRAM ACTION PLAN RESULTS AND RESOURCE FRAMEWORK

National priorities: (a) access to and utilization of high-quality basic social services for all; (b) universal access to HIV prevention, treatment, care and support; (c) pro-poor, sustainable growth and economic development; and (d) women's empowerment, gender equality and equity
UNDAF outcomes: (a) increased access to and utilization of high-quality basic health and nutrition services; (b) improved access to and use of HIV prevention services; (c) the Government and other partners generate and utilize data for policy and programme development and implementation; (d) enhanced national evidence-based economic management and pro-poor policy formulation and implementation; and (e) laws and policies established, reviewed and implemented to ensure gender equality and the empowerment of women and girls

Strategic Plan and UNDAF and CP Outcomes	CPD Outputs	Output Indicators, Baseline and Targets	Means of Verification	Risks and Assumptions (For all Outputs under the SP Outcome)	Role of Partners	Indicative Resources (Million US$)				
						2012	2013	2014	2015	Total
ZUNDAF Outcome 5.2: Increased access to and utilisation of quality basic health and nutrition services Indicators Percentage of births attended by skilled health personnel. Baseline; 60 % in 2009. Target: 80% in 2015										
SP Outcome 2: Increased access to and utilization of quality maternal and newborn health services										
CP Outcome 1: Increased utilization of comprehensive gender-sensitive and youth-friendly reproductive health services	CP Output 1: Strengthened capacity of government and civil society partners to coordinate and deliver reproductive health services	Percentage of district health teams supported in PME of RH programme. Baseline: 0 (2010); Target: 40% by 2015	Ministry of Health and Child Welfare Progress reports	Assumptions 1. Barriers to accessing services are addressed 2. The economic situation continues to improve	Ministry of Health and Child Welfare; Ministry of Youth Development, Indigenisation and Empowerment; Zimbabwe National Family Planning Council; Zimbabwe Youth Council	Regular resources				
						0.25	0.25	0.25	0.25	1.OO
						Other Resources				
						0.15	0.15	0.15	0.15	0.60

Strategic Plan and UNDAF and CP Outcomes	CPD Outputs	Output Indicators, Baseline and Targets	Means of Verification	Risks and Assumptions (For all Outputs under the SP Outcome)	Role of Partners	Indicative Resources (Million US$)				
						2012	2013	2014	2015	Total
<u>Outcome indicators:</u> Percentage of women aged 15-49 accessing cervical cancer screening services Baseline:7 % Target: 35% by 2015 Unmet need for family planning services Baseline: 13%; Target: 11%		Number of SRH and HIV focal persons in tertiary institutions and YSOs trained in PME of ASRH programs Baseline: 0 (2010); Target: TBD Number of midwifery training schools supported to provide post-basic midwifery Baseline: 0 (2010); Target 10 (2015)		3. Sustained political stability prevails 4. Adequate remuneration of health workers 5. Predictable financial arrangement Risks 1. Political instability 2. Decreased health partners' commitment 3. Recurring disasters/mergencies 4. Failure in multisectoral//multi-agency ccordination						
	<u>CP Output 2:</u> Increased availability of reproductive health services and commodities	Number of district, provincial and central hospitals supported to offer comprehensive EmONC services Baseline: TBD (2010); Target: TBD Number of hospitals supported to offer cervical cancer screening services using VIAC	Ministry of Health and Child Welfare Progress reports		Ministry of Health and Child Welfare	Regular Resources				
						0.5	0.5	0.5	0.5	2.00
						Other Resources				
						3.05	3.05	3.05	3.05	12.20

Strategic Plan and UNDAF and CP Outcomes	CPD Outputs	Output Indicators, Baseline and Targets	Means of Verification	Risks and Assumptions (For all Outputs under the SP Outcome)	Role of Partners	Indicative Resources (Million US$)				
						2012	2013	2014	2015	Total
		Baseline: 3 Target: 90 by 2015 Number of service delivery points supported to offer youth-friendly SRHR services. Baseline: 37 (2010); Target: 74 by 2015 Number of RH/HIV reference documents (policies, guidelines, protocols, clinical mentor-ship guidelines) developed, reviewed and/or revised with program support Baseline: 0 Target: 8 by 2015 Number of supported facilities in the public health sector with at least one health care worker trained in FP provision including implant insertions Baseline: TBD (2010); Target: TBD Number of supported district hospitals with functional maternity waiting homes, in line with the minimum require-ments are specified in the MWH operational guide-lines Baseline: TBD (2010); Target: TBD								

Strategic Plan and UNDAF and CP Outcomes	CPD Outputs	Output Indicators, Baseline and Targets	Means of Verification	Risks and Assumptions (For all Outputs under the SP Outcome)	Role of Partners	Indicative Resources (Million US$)				
						2012	2013	2014	2015	Total
	CP Output 3: Increased demand for sexual and reproductive health services at the community level	Number of young people reached through peer education on behaviour-change Baseline: 300,000 (2009); Target: 900,000 by 2015 Number of community health workers trained on promotion of family planning and supporting pregnant women Baseline: TBD; Target: TBD Number of young people utilizing youth interact centres supported by UNFPA Baseline: 0; Target: TBD			Ministry of Health and Child Welfare; National AIDS Council NGOs Zimbabwe Youth Council	Regular Resources				
						0.35	0.35	0.35	0.35	1.40
						Other resources				
						0.6	0.6	0.6	0.6	2.40
ZUNDAF Outcome 6.1: Improved access to (and uptake) of HIV prevention services Indicators Percentage of men 15-29 who are circumcised disaggre-gated by age, urban-rural Baseline: (2005/6): 9.9 % (DHS) Target:60 % by 2015 (to be projected based on uptake)										

Strategic Plan and UNDAF and CP Outcomes	CPD Outputs	Output Indicators, Baseline and Targets	Means of Verification	Risks and Assumptions (For all Outputs under the SP Outcome)	Role of Partners	Indicative Resources (Million US$)				
						2012	2013	2014	2015	Total
Percentage of men/women 15-49 (or 18-44) reporting use of a condom during last sex with a non-regular partner, disaggregated by sex, age, urban-rural Baseline: 71% (men) 47% (women) in 2005-6 Target: 85 % (men), 75 % (women) by 2015										
SP Outcome 4: Increased access to and utilization of quality HIV and STI prevention services especially for young people (including adolescents) and other key populations at risk.										
CP Outcome 2: Increased adoption of safer sexual behaviour and use of HIV prevention services Outcome indicators: Percentage of persons aged 18-44 reporting more than one sexual partner in the past 12 months	CP Output 4: Increased coverage of the social and behavior change communication. Programme	Number of person exposures during community meeting Baseline: 2,092,000 (2010 for 2000 BCFs); Target: 10.49 million by 2015 Number of people completing the home visits course Baseline: 0 (new program); Target : 840 000 by 2015 Updates on research evidence provided on an annual basis Baseline: 0; Target: 1	National AIDS Council and CBOs progress reports Research reports	Assumptions 1. Funding levels remain the same or increase mobilization of local and international resources 2. Acceptability expressed in surveys translate into actual demand	Ministry of Health and Child Welfare National AIDS Council NGOs	Regular resources				
						0.15	0.15	0.15	0.15	0.60
						Other Resources				
						0.65	0.65	0.65	0.65	2.60

Strategic Plan and UNDAF and CP Outcomes	CPD Outputs	Output Indicators, Baseline and Targets	Means of Verification	Risks and Assumptions (For all Outputs under the SP Outcome)	Role of Partners	Indicative Resources (Million US$)				
						2012	2013	2014	2015	Total
Baseline: 28.4% (men),9% (women) in 2010 Target: 18% (men), 7% (women) Percentage of persons aged 15-49 reporting condom use with a non-regular partner in the past 12 months Baseline: 71% (men), 47% (women) in 2010 Target: 80% (men), 70% (women) Number of men aged 13-49 accessing male circumcision services Baseline: 12,000 (2010); Target: 1.2 million Number of sex workers accessing SRH/HIV services Baseline 3,169 in 2010; Target: 8,169				3. Health system funding including retention scheme remains stable Risks 1. Reduction in resource availability 2. Lower uptake of MC services than anticipated 3. User fees, transport challenges or health system challenges could disrupt overall health delivery services						
	CP Output 5: Increased availability of HIV prevention services	Availability of a national combination HIV prevention strategy Baseline: 0 (2011) Target: 1 Availability of Service Guidelines and tools on provision of integrated SRH and HIV services Baseline: 0 Target: 2 Number of MC service delivery points strengthened with UNFPA support Baseline: 0 (2011); Target: 10 by 2013 Availability of evidence on the safety and effectivness of alternatives adult male circumcision device(s) Baseline: Safety Study done in 2011. First report to be available in 2012 Target: Evidence from Safety and comparative studies on at least 1 device available in 2012; Evidence on Cost Effectiveness of at least 1 MC device available in 2013	Program Reports		Ministry of Health and Child Welfare National AIDS Council	Regular resources	0.50	0.50	0.50	0.50	2.00
						Other Resources				
						1.25	1.25	1.25	1.25	5.00

Strategic Plan and UNDAF and CP Outcomes	CPD Outputs	Output Indicators, Baseline and Targets	Means of Verification	Risks and Assumptions (For all Outputs under the SP Outcome)	Role of Partners	Indicative Resources (Million US$)				
						2012	2013	2014	2015	Total
ZUNDAF Outcome 2.1 Enhanced economic management and pro-poor development policies and strategies Indicators Pro-poor macroeconomic policy framework in implemented Baseline: Macroeconomic policy developed and endorsed for implementation (2011) Target: Endorsement and implementation ZUNDAF Outcome 2.3: Improved generation and utilization of data for policy and programme development and implementation by Government and other partners Indicators Number of key survey and routine information system reports produced on schedule and made available in public domain. Baseline: 3 reports (cencus, ZDHS, and Education) produced out of 10 Key policies, strategies and action frameworks are based on or refer to up to date evidence										

Strategic Plan and UNDAF and CP Outcomes	CPD Outputs	Output Indicators, Baseline and Targets	Means of Verification	Risks and Assumptions (For all Outputs under the SP Outcome)	Role of Partners	Indicative Resources (Million US$)				
						2012	2013	2014	2015	Total
Baseline: Most policy and strategy documents refer to data which is 5 years or older(2010) Population policy in place Baseline: No population policy in place; Target: population policy in place										
SP Outcome 7: Improved data availability and analysis resulting in evidence-based decision-making and policy formulation around population dynamics, SRH (including family planning), and gender equality										
CP Outcome 3: Increased availability and utilization of disaggregated data at national and subnational levels Outcome indicators: Number of 2012 population census thematic reports produced and disseminated Baseline: 0 (2010); Target: at least 10 more Percentage of population and health indicators in the medium-term plan, UNDAF, and other development plans with up-to-date data Baseline: 40% (2010) Target: 100% by 2015	CP Output 6 Strengthened capacity of relevant Government departments responsible for planning to integrate population issues into development plans and monitor sectoral policies and plans	Number of publications on key population issues (research reports, ICPD at 20,) produced with UNFPA support Baseline 0. Target 5 by 2015. Number of progress reports on selected population programmes and projects articulated in the MTP Baseline 0: Target: 8 by 2015 Availability of a population monitoring and evaluation database Baseline: No database in place. Target: Functional database by 2013	ZIMSTAT progress reports MTP progress reports Population monitoring database	Assumptions 1. Adequate resources for statistical production 2. The provisions of the Census and Statistics act of 2007 are fully implemented and the new ZIMSTA organizational structure is fully operational 3. The NSDS is fully developed, costed and implemented 4. Conducive operating environment Risks 1. Insufficient financial resource allocation by the Government for statistical production 2. Continued skills flight among professional staff categories	Zimbabwe National Statistics Agency;	Regular resources				
						0.025	0.025	0.02	0.025	0.1
						Other resources				
						0	0	0	0	0

Strategic Plan and UNDAF and CP Outcomes	CPD Outputs	Output Indicators, Baseline and Targets	Means of Verification	Risks and Assumptions (For all Outputs under the SP Outcome)	Role of Partners	Indicative Resources (Million US$)				
						2012	2013	2014	2015	Total
	CP Output 7: Strengthened capacity of the Zimbabwe Statistical Agency and line ministries to produce, analyse, disseminate and promote the utilization of population data	Number of staff trained in latest data processing techniques (including web-based database systems) Baseline: 0;Target: 30 by 2015 Proportion of national cencus and ZDHS budgets mobilised/leveraged by UNFPA Baseline: 0; Target: 20% Number of Cencus and ZDHS thematic/in-depth reports produced with UNFPA support Baseline: 0 in 2011; Target: 10 reports produced by 2015	ZIMSTAT progress reports UNFPA standard progress reports		Zimbabwe National Statistics Agency; Ministry of Economic Planning and Investment Promotion; Ministry of Health and Child Welfare	Regular resources				
						2.05	0.30	0.15	0.20	2.70
						Other resources				
						1.30	0.10	0.10	0.30	1.80
	CP Output 8: Strengthened capacity of ZimSTAT to coordinate the national statistical system	Number of sectoral statistical committees supported by UNFPA. Baseline 0: Target: 15 by 2015 Availability of a publication on standardized concepts, definitions and methods used across the national statistical system produced and distributed Baseline: 0 (2011); Target:1 Number of statistical inquiries, consultative meetings and user-producer symposiums on statistics supported by UNFPA Baseline: 0, Target: 5 by 2015	UNFPA standard progress reports		Zimbabwe National Statistics Agency;	Regular resources				
						0.005	0.005	0.005	0.005	0.02
						Other resources				
						0	0	0	0	0

Strategic Plan and UNDAF and CP Outcomes	CPD Outputs	Output Indicators, Baseline and Targets	Means of Verification	Risks and Assumptions (For all Outputs under the SP Outcome)	Role of Partners	Indicative Resources (Million US$)				
						2012	2013	2014	2015	Total
ZUNDAF Outcome 7.1: Laws and policies established, reviewed and implemented to ensure gender equality for empowerment of women and girls Indicators Human rights instruments that promote women's and girls' rights integrated in the national legal framework Baseline 1: CRC, CEDAW and ACRWC and SADC Gender and Development Protocol ratified but only partially integrated in the national legal framework Target: Above fully intergrated by 2012 Proportion of national budget allocated to Ministry of Gender Baseline: 0.25% in 2011 Target: 11% in 2015 Proportion of women in desicion making positons(Parliament, Ministers,local Government,Public Service) Baseline: 18.55% in Parliament, 21% in Local Government, 20% in Ministerial positions Target: 50-50 representation										

Strategic Plan and UNDAF and CP Outcomes	CPD Outputs	Output Indicators, Baseline and Targets	Means of Verification	Risks and Assumptions (For all Outputs under the SP Outcome)	Role of Partners	Indicative Resources (Million US$)				
						2012	2013	2014	2015	Total
SP Outcome 5: Gender equality and reproductive rights advanced particularly through advocacy and implementation of laws and policy										
CP Outcome 4: An improved policy and legal environment for gender equality and increased utilization of gender-based violence services Outcome indicators: Percentage of gender-based violence survivors seeking assistance from the police Baseline: 10% (ZDHS 2005/6; Target: 40% by 2015 Number of policies and laws reviewed to incorporate GBV and RH rights Baseline: CEDAW, ACRWC and SADC Gender and Development Protocol ratified but only partially integrated in the national legal framework; ILO Convention 183 (maternity protection) not ratified (2008) Target: Reform of marriage laws, Review of DVA protection order forms, UN Security Council Resolutions (1325, 1820, 1889) integrated in national policies.	CP Output 9: Increased capacity of leaders to address negative social norms and practices that perpetuate gender inequalities	Number of leaders who have adopted and are reporting implementing the 4Ps campaign Baseline: 0 Target: 2,900 by 2015 Number of simplified operational guidelines for mainstreaming gender developed and disseminated Baseline: 0 Target: 1 by 2015 Availability of evidence on key determinants of gender inequalities. Baseline: 0 Target: 1	Program reports	Assumptions 1. Cooperation among Government, CSOs and donors 2. Mobilization of local and international resources is sustained 3. Availability of financial resources Risks 1. The new constitution is not gender sensitive	Ministry of Women's Affairs, Gender and Community Development Civil society organizations	Regular resources				
						0.30	0.30	0.10	0.10	0.8
						Other resources				
						0.05	0.05	0	0	0.1
	CP Output 10: Increased availability of services to address gender-based violence	Number of centres supported by UNFPA for quality gender-based violence service provision Baseline: 7(2011) Target: 30 by 2015 Number of service providers (legal, health, psychosocial and traditional court officials) trained through UNFPA support in survivor friendly approaches including in humanitarian settings Baseline 0: Target: 9,000 by 2015 Number of location specific referral pathways developed and printed Baseline 4: Target 20 by 2015	Program reports		Ministry of Women's Affairs, Gender and Community Development Civil society	Regular resources				
						0.20	0.20	0.15	0.10	0.65
						Other resources				
						0.30	0.30	0.15	0.05	0.80

Strategic Plan and UNDAF and CP Outcomes	CPD Outputs	Output Indicators, Baseline and Targets	Means of Verification	Risks and Assumptions (For all Outputs under the SP Outcome)	Role of Partners	Indicative Resources (Million US$)				
						2012	2013	2014	2015	Total
	CP Output 11: Increased community awareness of gender-responsive laws, mechanisms and services	Number of person-exposures to messages on gender responsive laws and mechanisms including through young people's forum discussions) Baseline: 0 Target: 5 million by 2015 Number of multimedia campaigns on gender and reproductive rights conducted Baseline: 0 Target: 1 per year Number of community based cadres trained in counselling and paralegal service provision. Baseline: 0 Target: 3,000 by 2015	Program reports		Ministry of Women's Affairs, Gender and Community Development Civil society organization	Regular resources				
						0.20	0.20	0.20	0.15	0.75
						Other Resources				
						0.30	0.30	0.20	0.10	0.90
Programme Coordination Assistance						Regular resources				
						0.375	0.375	0.375	0.375	1.50
						Other resources				
						0	0	0	0	0
TOTAL						Regular resources				
						4.95	3.20	2.80	2.75	13.70
						Other resources				
						7.65	6.45	6.15	6.15	26.4

Annex 2 The CPAP Planning and Tracking Tool

Country: ZIMBABWE
CP Cycle: SIXTH

RESULTS	Indicator	MoV	Responsible Party	Baseline	Targets (Cumulative unless stated)			
					2012	2013	2014	2015
ZUNDAF Outcome 5.2 Increased access to and utilisation of quality basic health and nutrition services	Percentage of births attended by skilled health personnel.	ZIMDAT, DHS, PASS, MIMS	GOZ, UNCT	60 % in 2009.	65%	Target: 70%	75%	Target: 80%
SP Outcome 2: Increased access to and utilization of quality maternal and newborn health services								
CP Outcome 1 Increased utilization of comprehensive gender-sensitive and youth-friendly reproductive health services.	Indicator 1. Percentage of women aged 15 – 49 accessing cervical cancer screening services Indicator 2 : Unmet need for family planning services	WHO estimates ZDHS/MIMS	MoHCW	Baseline Number 1: 7% Baseline Number 2: 13 %	Target Number 1: 9% Target Number 2: 12.5%	Target Number 1: 15% Target Number 2:12%	Target Number1: 25% Target Number 2:11.5%	Target Number 1: 35% Target Number 2:11%
CP Output 1 Strengthened capacity of Government and civil society partners to coordinate and deliver reproductive health services	Indicator 1: Percentage of district health teams supported in PME of RH program. Indicator 2: Number of SRH and HIV focal persons in tertiary institutions and YSOs trained in PME of ASRH programs Indicator 3: Number of midwifery training schools supported to provide post-basic midwifery training.		MoHCW MOHCW MoHCW	Baseline Number 1: 0 (2010) Baseline Number 2: 0 (2011) Baseline Number 3: 0	Target Number 1: 10% Target Number 2: TBD Target Number 3: 2	Target Number 1: 20% Target Number 2: TBD Target Number 3: 5	Target Number 1: 30% Target Number 2: TBD Target Number 3: 8	Target 1: 40% Target Number 2: TBD Target Number 3: 10

RESULTS	Indicator	MoV	Responsible Party	Baseline	Targets (Cumulative unless stated)			
					2012	2013	2014	2015
CP Output 2 Increased availability of reproductive health services and commodities	Indicator 1: Number of district, provincial and central hospitals supported to offer comprehensive EmONC services	Health Facility Assessment , NHIS	MoHCW	Baseline Number 1: TBD (NIHFA)	Target Number1: TBD	Target Number 1: TBD	Target Number 1: TBD	Target Number 1: TBD
	Indicator 2: Number of hospitals supported to offer cervical cancer screening services using VIAC	NHIS	MoHCW	Baseline Number 2: 3	Target Number 2: 25	Target Number 2: 50	Target Number 2: 75	Target Number 2: 90
	Indicator 3: Number of service delivery points supported to offer youth-friendly SRHR services. Baseline: 37 (2010); Target: 74	MoHCW/CSO; Quarterly Progress reports	MoHCW/ZIMSTAT	Baseline Number 3: 37	Target Number 3:45	Target Number 3: 55	Target Number 3: 65	Target Number 3: 74
	Indicator 4: Number of RH/HIV reference documents (policies, guidelines, protocols, developed) reviewed and/or revised with program support	Revised reference documents	MoHCW	Baseline Number 4 : 0	Target Number 4: 2	Target Number 4: 4	Target Number 4: 6	Target Number 4: 8
	Indicator 5: Number of supported facilities in the public health sector with at least one health care worker trained in FP provision including implant insertion	MoHCW/CSO; Quarterly Progress reports, MoH Training Reports	MoH; ZNFPC	Baseline Number 5: TBD	Target Number 5: TBD	Target Number 5: TBD	Target Number 5: TBD	Target Number 5: TBD
	Indicator 6: Number of supported district hospitals with functional maternity waiting homes, in line with the minimum requirements as specified in the MWH operational guidelines.	Assessment ; NHIS	MoHCW	Baseline Number 6: TBD	Target Number 6: TBD	Target Number 6: TBD	Target Number 6: TBD	Target Number 6: TBD

RESULTS	Indicator	MoV	Responsible Party	Baseline	Targets (Cumulative unless stated)			
					2012	2013	2014	2015
CP Output 3 Increased demand for sexual and reproductive health service at the community level.	Indicator 1: Number of young people reached through peer education on behaviour change in SRH and HIV prevention Indicator 2: Number of community health workers trained on promotion of family planning and supporting pregnant women Indicator 3: Number of young people utilizing youth interact centres supported by UNFPA	MoHCW/ ZNFPC/ CSO/ MYDIE quarterly progress reports MoHCW/ ZNFPC. quarterly progress reports MoHCW/ ZNFPC/ quarterly progress reports	MoHCW/ ZNFPC/ CSO/ MYDIE MoHCW/ ZNFPC MoHCW/ ZNFPC	Baseline Number 1: 300,000 (2009) Baseline Number 2: TBD Baseline Number 3: 0 (2011)	Target Number 1: 450,000 Target Number 2: TBD Target 3: TBD	Target Number 1: 600,000 Target Number 2: TBD Target Number 3: TBD	Target Number 1:: 750,000 Target Number 2: TBD Target Number 3: TBD	Target Number 1: 900,000 Target Number 2: TBD Target Number 3: TBD
ZUNDAF Outcome 6.1 Improved access to (and Uptake of) HIV prevention services	Indicator 1: Percentage of men 15-29 who are circumcised disaggregated by age, urban-rural Indicator 2: Percentage of men/women 15-49 (or 18-44) reporting use of a condom during last sex with a non-regular partner, disaggregated by sex, age, urban-rural	ZDHS, MoHCW routine programme reports. Special surveys	MoHCW, NAC	Baseline Number 1 (2005/6): 9.9 % (DHS) Baseline Number 2: 71% (men) 47% (women) in 2005-6	Target Number 1: 20 % (to be projected based on uptake)	Target Number 2: 35 % (to be projected based on uptake)	Target Number 3: 50 % (to be projected based on uptake)	Target Number 1 (2015): 60 % (DHS) Target Number 2: 85 % (men), 75 % (women)
SP Outcome 4: Increased access to and utilization of quality HIV and STI prevention services especially for young people (including adolescents) and other key populations at risk.								
CP Outcome 2 **Increased adoption of safer sexual behavior and use of HIV prevention services**	Indicator 1: % of persons aged 18-44 reporting more than one sexual partner in the past 12 months Indicator 2: % of persons aged 15-49 reporting condom use with	DHS, NBC survey, MoHCW and NAC progress reports DHS, NBC survey MoHCW and NAC progress reports	MoHCW. NAC, MoHCW, NAC	Baseline Number 1. 28.4 % (men), 9% (women) in 2007 Baseline Number 2: 71% (men) 47% (women) in 2005-6			Target Number 1:19.7% (men), 62% (women)	Target Number 1: 18 % % (men), 7 % (women Target Number 2: 85% (men), 75% (women)

RESULTS	Indicator	MoV	Responsible Party	Baseline	Targets (Cumulative unless stated)			
					2012	2013	2014	2015
	a non-regular partner in the past 12 months Indicator 3: Number of men aged 13-49 accessing male circumcision Indicator 4: Number of sex workers accessing SRH/HIV services.	MoHCW AND programme reports Programme reports	MoHCW ZAPP, NAC, MoHCW	Baseline Number 3: 12000 in 2010 Baseline Number 4: 3,169 in 2010	Target Number 3: 32000 Target Number 4: 4,419	Target Number 3: 72000 Target Number 4: 5,669	Target Number 3: 132,000 Target Number 4: 6,919	Target Number 3: 162000 Target Number 4: 8,169
CP Output 4 **Increased coverage of the social and behavior change communication programme**	Indicator 1: Number of person exposures during community meetings Indicator 2: Number of person exposures to home visits sessions (disaggregated by age and sex) Indicator 3: Updates on research evidence provided on an annual basis	BC program progress reports BC Programme Reports Research Reports All programme	NAC NAC MoHCW, NAC, UNAIDS	Baseline Number 1: 2,092,000 (for 2000 BCFs) in 2010 Baseline Number 2: 0 Baseline Number 3: 0 in 2011	Target Number 1: 4,192,000 Target Number 2: 710 000 Target Number 3: BC Final evaluation survey, Sex work size estimation.	Target Number 1: 6,292,000 Target Number 2: 760,000	Target Number 1: 8,392,000 Target Number 2:800 000	Target Number 1: 10,492,000 Target Number 2: 840 000
CP Output 5 **Increased availability of HIV prevention services**	Indicator 1: Availability of a national combination HIV prevention strategy Indicator 2: Availability of Service Guidelines and tools on provision of integrated SRH and HIV services Indicator 3: Number of MC service delivery points strengthened with UNFPA support Indicator 4: Availability of evidence on the safety and effectiveness of alternative adult male circumcision device(s)	Programme Reports Programme Reports Programme Reports Research Reports	MOHCW and NAC MOHCW MOHCW MOHCW	Baseline Number 1: 0 in 2011 Baseline Number 2: 0 in 2011 Baseline Number 3: 0 in 2011 Baseline Number 4: Safety Study done in 2011. First Report to be available in 2012	Target Number 1: National Combination HIV Prevention Strategy Finalised by 2012 Target Number 2: Draft SRH and HIV Integration Service Guidelines and tools available Target Number 3: 3 Target Number 4: Evidence from Safety and Comparative studies on at least 1 device available 2012	Target Number 2: Final SRH and HIV Integration and tools available Target Number 3: 10 Target Number 4: Evidence on Cost Effectiveness of at least 1 MC Device available 2013	Target Number 3: 10	Target 3: 10

RESULTS	Indicator	MoV	Responsible Party	Baseline	Targets (Cumulative unless stated)			
					2012	2013	2014	2015
ZUNDAF Outcome 2.1 **Enhanced economic management and pro-poor development policies and strategies**	Indicator 1: Pro-poor microeconomic policy frmework in implemented			Baseline: Microeconomic policy developed and endorsed for implementation (2011)	Target: Endorsement and implementation	Target: Endorsement and implementation		
ZUNDAF Outcome 2.3 **Improved generation and utilization of disaggregated data for policy and programme development and implementation by Government and other partners**	Indicator 1: Number of key survey and routine information system reports produced on schedule and made available in public domain Indicator 2: Key policies, strategies and action frameworks are based on or refer to up-to-date evidence Indicator 3: Population policy in place	ZIMSTA annual reports	ZIMSTA	Baseline Number 1: Three reports (Census, ZDHS, Education) produced out of 10 Baseline Number 2: Most policy and strategy documents refer to data which is five years or older (2010) Baseline Number 3: No population policy in place.	Preliminary Census Report Main ZDHS Report MTP Progress Review Report	Main Census Report MTP Progrtess Review Report	MTP Progress Review Report ICPD@20 country report	MTP Progress Review Report MDG Progress Report
CP Outcome 3 **Increased availability and utilization of disaggregated data at national and subnational levels**	Indicator 1: Number of 2012 population census thematic reports produced and disseminated Indicator 2: Percentage of population and health indicators in the medium-term plan, UNDAF and other development plans with up-to-date data	ZIMDAT, ZIMSTAT quarterly and annual reports	ZIMSTAT	Baseline Number 1: 0 in 2010 Baseline Number 2: 40%	60%	10 census thematic reports 80%	100%	100%
CP Output 6 **Strengthened capacity of relevant Government departments responsible for planning to intergrate population issues into development plans and monitor sectoral policies and plans**	Indicator 1: Number of publications on key population issues (research reports, ICPD at 20,) produced with UNFPA support Indicator 2: Number of progress reports on selected population	PDU progress reports PDU progress reports	MoEPIP MoEPIP	Baseline Number 1: 0 Baseline Number 2: 0	Target Number 1: 1 (annual target) Target Number 2: 2 (annual target)	Target Number 1: 1 (annual target) Target Number 2: 2 (annual target)	Target Number 1: 2 (annual target) Target Number 2: 2 (annual target)	Target Number 1: 1 (annual target) Target Number 2: 2 (annual target)

RESULTS	Indicator	MoV	Responsible Party	Baseline	Targets (Cumulative unless stated)			
					2012	2013	2014	2015
CP Output 7 Strengthened capacity of the Zimbabwe Statistical Agency and line ministries to produce, analyze, disseminate and promote the utilization of population data	Indicator 1: Number of staff trained in latest data processing techniques (including web-based database systems)	ZIMSTAT progress reports	ZIMSTAT	Baseline Number 1: 0 in 2011.	Target 1: 15	Target 1: 20	Target 1: 25	Target 1: 30
	Indicator 2: Proportion of national census and ZDHS budgets mobilized/leveraged by UNFPA	UNFPA standard progress reports	UNFPA	Baseline Number 2: 0 in 2011.	Target Number 2: 5% (annual target)	Target Number 2: 20% (annual target)	Target Number 2: 20% (annual target)	Target Number 2: 20% (annual target)
	Indicator 3: Number of census and ZDHS thematic/in-depth reports produced with UNFPA support	ZIMSTAT progress reports	ZIMSTAT	Baseline Number 3: 0 in 2011.	Target Number 3: 0 (annual target)	Target Number 3: 4 (annual target)	Target Number 3: 5 (annual target)	Target Number 3: 1 (annual target)
CP Output 8 Strengthened capacity of ZIMSTAT to coordinate the national statistical system	Indicator 1: Number of sectoral statistical committees supported by UNFPA.	IMASTAT progress reports	ZIMSTAT	Baseline Number 1: 0	Target Number 1: 15 (annual target)	Target Number 1: 15 (annual target)	Target Number 1: 15 (annual target)	Target Number 1: 15 (annual target)
	Indicator 2: Availability of a publication on standardized concepts, definitions and methods used across the national statistical system produced and distributed	ZIMASTAT progress reports	ZIMASTAT	Baseline Number 2: 0	Target Number 2: 1 (annual target) When	Target Number 1: 1 (annual target)	Target Number1: 1 (annual target)	Target Number 1: 1 (annual target)
	Indicator 3: Number of statistical inquiries, consultative meetings and user-producer symposiums on statistics supported by UNFPA	ZIMASTAT progress reports	ZIMASTAT	Baseline Number 3: 0	Target Number 3: 1 (annual target)	Target Number 2: 1 (annual target)	Target Number 2: 2 (annual target)	Target Number 2: 1 (annual target)

RESULTS	Indicator	MoV	Responsible Party	Baseline	Targets (Cumulative unless stated)			
					2012	2013	2014	2015
ZUNDAF Outcome 7.1 Laws, policies and frameworks established and implemented to ensure gender equality and empowerment of women and girls	Indicator 1: Human rights instruments that promote women's and girls' rights integrated in the national legal framework Indicator 2: Proportion of national budget allocated to Ministry of Gender Indicator 3: Number of women in decision making positions (Parliament, Ministers, Local Government and Public Service)	Legal framework documents, National Budgets.	Ministry of Women's Affairs, Gender and Community Development	Baseline 1: CRC, CEDAW and ACRWC and SADC Gender and Development Protocol ratified but only partially integrated in the national legal framework Baseline 2: 0.25% in 2011 Baseline 3: 18.55 % women's representation in Parliament; 21 % women's representation in local Government'20% women's representation in Ministerial positions; 9 % women's representation in deputy minister positions (2008); 74 % of Permanent Secretaries were male; At Director Level 67 % were male; 67 % female Public services commissioners				All these protocols fully intergrated in national legal frameworks 11% 50%
SP Outcome 5: Gender equality and reproductive rights advanced particularly through advocacy and implementation of laws and policy								
CP Outcome 4. An improved policy and legal environment for gender equality and increased utilization of gender-based violence services	Indicator 1: Percentage of gender based violence survivors seeking assistance from the police Indicator 2: Number of policies and laws reviewed to incorporate GBV and RH rights	ZDHS State party reports on CEDAW, AU Solemn Declaration on Gender Equality	Ministry of Women Affairs, Gender and Community Development Ministry of Women Affairs, Gender and Community Development	10% CEDAW, ACRWC and SADC Gender and Development Protocol ratified but only partially integrated in the national legal framework; ILO Convention 183 (maternity (protection) not ratified (2008)	15% Review of DVA protection order forms,	25% Reform of marriage laws	35% UN Security Council Resolutions (1325, 1820, 1889) integrated in national policies.	40%

RESULTS	Indicator	MoV	Responsible Party	Baseline	Targets (Cumulative unless stated)			
					2012	2013	2014	2015
CP Output 9 **Increased capacity of leaders to address negative social norms and practices that perpetuate gender inequalities**	Indicator 1: Number of leaders who have adopted and are reporting implementing the 4Ps campaign	GBV Database	Ministry of Women Affairs, Gender and Community Development	Baseline Number 1: 0	Target Number 1: 800	Target Number 1: 1800	Target Number 1: 2500	Target Number 1: 2900
	Indicator 2: Number of simplified operational guidelines on gender mainstreaming developed and disseminated	Partner reports	Ministry of Women's Affairs, Gender and Community Development	Baseline Number 2: 0	Target Number 2: 1 (annual target)	Target Number 2: 1 (annual target)	Target Number 2: 1 (annual target)	Target Number 2: 1 (annual target)
	Indicator 3: Availability of evidence on. determinants of gender inequalities	Research reports	UNFPA	Baseline Number 3: No comprehensive evidence available	Target Number 3: 1 research conducted (annual target)		Target Number 3: 1 research conducted (annual target)	
Output 10 **Increased availability of services to address gender-based violence**	Indicator 1: Number of centers supported by UNFPA for quality gender-based violence service provision	Program reports	Ministry of Women Affairs, Gender and Community Development , Civil society organizations	Baseline Number 1: 7 (2011) (Makoni one stop centre, Adult Rape clinic, Kotwa Hospital, Kotwa Police station, Mnene Hospital, Mberengwa Hospital, FST Mutare);	Target Number 1: 10	Target Number 1: 15	Target Number 1: 18	Target Number 1: 20
	Indicator 2: Number of service providers (legal, health, psychosocial and traditional court officials) trained through UNFPA support in survivor friendly approaches including in humanitarian settings	GBV Database	Ministry of Women Affairs, Gender and Community Development, Civil society organizations	Baseline Number 2: 0 (2011)	Target Number 2: 3,000	Target Number 2: 6,000	Target Number 2 :8,000	Target Number 2: 9,000
	Indicator 3: Number of location specific referral pathways developed and printed.	Program reports	Ministry of Women Affairs, Gender and Community Development , Civil society organizations	Baseline 3: 4 (Harare, Makoni, Mberengwa, Mudzi)	Target Number 3: 10	Target Number 3: 15	Target Number 3: 18	Target Number 3: 20
CP Output 11 **Increased community awareness of gender-responsive laws, mechanisms and services**	Indicator 1: Number of person exposures to messages on gender and reproductive rights (including through young people's forum discussions)	Program reports	Ministry of WAGCD and Civil society organizations	Baseline Number 1: 0	Target Number 1: 1 million	Target Number 1 3 million	Target Number 1: 4.5 million	Target Number 1: 5 million
	Indicator 2: Number of multimedia campaigns on gender and reproductive rights conducted	Campaign plans	Ministry of WAGCD and Civil society organizations	Baseline Number 2: 0	Target Number 2: 1 (annual target)	Target Number 2: 1 (annual target)	Target Number 2: 1 (annual target)	Target Number 2: 1 (annual target)
	Indicator 3: Number of community based cadres trained in counselling and paralegal services.	Program reports	Ministry of WAGCD and Civil society organizations	Baseline Number 3: 0	Target Number 3: 500	Target Number 3: 1,500	Target Number 3: 2,500	Target Number 3: 3,000

Annex 3 The CPAP Monitoring and Evaluation Calendar

Country: ZIMBABWE CP Cycle: Sixth

		2012	2013	2014	2015
M&E activities	Surveys/studies	Sociocultural analysis of norms, values and practices perpetuating gender inequalities and GBV survey.	ANC Survey	Study on the impact of key gender related policies and laws.	ZDHS, ANC Survey
	Monitoring systems	ZIMDAT, MDG Reporting, , NAC M&E system, NHIS , GBV database	ZIMDAT, MDG Reporting, NAC M&E system, NHIS , GBV database, ANC Surveillance	MDG Reporting, ZIMDAT, NHIS, NAC M&E system , GBV database	ZDHS, MDG Reporting, ZIMDAT, NHIS, NAC M&E system, GBV database
	Evaluations	Evaluation of male circumcision device, youth interact centres and one-stop centres for GBV	Mid-term Evaluation of the CP	Evaluation survey on national BC programme	End of CP Evaluation
	Reviews	UNDAF reviews, AWP mid - year and annual reviews	UNDAF reviews, AWP mid - year and annual reviews	UNDAF reviews, AWP mid - year and annual reviews	UNDAF reviews, AWP mid - year and annual reviews
	Support activiti es	Quarterly field visits	Quarterly field visits	Quarterly field visits	Quarterly field visits
	UNDAF final evaluation milestones			Mid-term evaluation (UNCT, GOZ IP, NGOs).	
	M&E capacity - building	Capacity build for staff from implementing partners on M&E	Capacity build for staff from implementing partners on M&E	Capacity build for staff from implementing partners on M&E	Technical and Financial Support for ZDHS in year 4,
	Use of information	UNDAF reviews, MDG reporting, UNFPA COAR	UNDAF reviews , MDG reporting, UNFPA COAR	UNDAF reviews, MDG reporting, UNFPA COAR	UNDAF reviews, MDG reporting, UNFPA COAR
	Partner activities	NHIS, NAC database, ZIMDAT, GBV data base, ZNFPC MIS, census.	NHIS, NAC database, ZIMDAT, GBV data base, ZNFPC MIS.	NHIS, NAC database, ZIMDAT, GBV data base, ZNFPC MIS.	NHIS, NAC database, ZIMDAT, GBV data base, ZNFPC MIS.

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