|  |  |
| --- | --- |
| Danish organisation | Civil Connections Community Foundation (CCCF) |
| Title of the intervention | Girls Choose - Building a grassroots and gender sensitive Sexual and Reproductive health Rights and HIV and services strategy for periphery and marginalized communities in Masvingo, Zimbabwe. |
| Partner name(s) | My Age Zimbabwe, Zimbabwe |
| Amount applied for | 498,482 DKK |
| Country(ies) | Zimbabwe |
| Period (# of months) | 15 |

1. Objective and relevance (the world around us)

* *What is the main purpose with the intervention, including challenges that need to be addressed*?

This project’s overall objective is to create a conducive environment for adolescents and young people in their diversity – with specific emphasis to girls and young women in Zimbabwe, to access Sexual and Reproductive Health and Rights/services (SRHRs) and HIV related information freely and safely.

Through this project, we have the ambition to build/facilitate and naturalize/routinize a model for HIV and generally Sexual Reproductive Health Rights/services (SRHRs) provision/access to local grassroots communities starting with Masvingo, in a bid to close apparent gaps and secure the future of many young people, especially girls and young women, in a context that otherwise provides few alternatives. We refuse to believe that young people’s destinies are jeopardized by the lack of something so basic like the right to proper reproductive and sexual rights and services – we want to do something about this against all the odds.

The project has three specific objectives, namely:

1. To facilitate deepened knowledge about SRHR and HIV among project key stakeholders and further in the rest of the local communities through an extensive local community mobilization, information and engagement process suggested by the strategy of this project.
2. To facilitate easier access to SRHR services in Masvingo province through mobilizing and supporting the setting up of structures for SRHRs and HIV and Aids, to come closer to the communities that are commonly not sufficiently reached. The services will include knowledge hubs, Guidance, counseling, Contraceptives, HIV testing, PrEP (Pre exposure support), PEP (Post exposure support) and ARVs.
3. To facilitate a policy context that is aware, prioritizes and puts into place plans & resources for youth’s free and safe access to SRHR, HIV information and services at local community level through running an advocacy campaign and mobilization of key strategic stakeholders on this issue.

These are elaborated later in section 3.

* **Describe the context of the intervention:**

**Project location and geopolitical dynamics:**

Our project takes place in Masvingo district one of the seven districts in Masvingo province in south-eastern Zimbabwe. While Masvingo province has a population of 1.485 million as of the 2012 census, ranking fifth out of Zimbabwe's ten provinces, Masvingo district carries the bigger portion (299,101) of this population, and this probably because of its status as the provincial capital and city. Masvingo district is further sub-divided into seven administrative districts (sub districts), & bellow these lie 30 wards – the lowest of policy making units.

Our project will intentionally operate at the two lowest levels of policy – sub districts and wards, because this is where access to government services remains a challenge to devolve, let alone our ambition of bringing services closer to the most marginalized and alienated people. We will work with youth representatives/leaders from the 30 wards due to their power to mobilize locally, and tag these together with the policy leadership at the subdistrict level who have a say/real power over local policy. Doing this will also be familiarizing and naturalizing this interplay towards empowering young people and creating stages for advocacy, as well as getting the duty bearers to work first-hand with local challenges – here SRHR & HIV and Aids services as their own. Moreover, we will facilitate these to connect connections and actions with other CSOs, SRHR service providers, schools etc. for further grounding.

**SGBV, SRHR, HIV and AIDS Context for Masvingo Province**

**According to the Zimbabwe HIV Impact Assessment Report for 2018, Masvingo has an HIV prevalence of 14.5% and has the 4th highest HIV prevalence out of the 10 Provinces in Zimbabwe. This is coupled by the fact that** over twice the proportion of females aged 15 to 24 years were unaware of their status (53.0% for females aged 15-19 years; 51.1% for females aged 20-24 years) compared to all age groups of women over 30 years old for Masvingo Province.

The coverage for ART follows a similar pattern, ranging from 45.6% and 39.3%, respectively, among 15- to 19-yearolds and 20- to 24-year-olds, compared to over 75% among all age groups from 40 to 59 years. Only 61% of the total number of people living with HIV between 15-64 years had their viral load suppressed with adolescents and young people equally affected. Zimbabwe has introduced a comprehensive viral load monitoring program but based on this evidence adolescents and young people still lag in accessing HIV treatment and viral load monitoring services. 3.3% of girls and boys aged below 15 years had already had sex by the time the survey was commissioned which is a very high number of sexually active girls and boys of this age. Considering that more than 50% of adolescents and young people 15-24 years do not have comprehensive knowledge on HIV prevention methods it means this group of young people were more than likely not empowered to make informed decisions with regards to their sexual and reproductive health.

According to the Multiple Indicator Cluster Survey report for 2019, the fertility rate for girls 15-19 years of age in Masvingo is 126 per 1000 child births which is considerably high. The impact of this has been an increase in child marriages because culturally once a girl becomes pregnant, she is forced to live with the male responsible leading up to marriage. Masvingo has the 3rd highest child marriage prevalence of 43.4% which translates to 1 in 3 girls getting married off before the age of 18 years. Subsequently this has also resulted in a sharp increase of school dropouts with more than half of the school dropouts recorded by the Ministry of Primary and Secondary Education unaccounted for as the statistical report for 2019 as an example simply states absconded or others for more than half of the total school dropouts having already attributed some of the dropouts to pregnancy, marriage, death, illness, child labour, expulsion, and disability. Critical to the high prevalence of adolescents and young people getting pregnant is also the high number of unsafe abortions that is being recorded. According to the Guttmacher study over 75000 abortions occur every year in Zimbabwe.

Sexual and Gender Based violence is also an area of great concern. According to MICS 2019, 15% of the total maternal mortality is attributed to adolescents and young people which is a very big number. The percentage of girls and women currently in or out of union who have ever experienced physical or sexual violence since age 15 in Masvingo province is 42% which is the 5th highest in the country.

**On country level, Zimbabwe level is a contradictory context:**

Let us be clear from the start, Zimbabwe presents a very contradictory or call it interesting case for this kind of project because of two main factors. First, Zimbabwe has by far the most elaborate HIV/AIDS and SRHRs program and service delivery plan, system, and actions in sub-Saharan Africa, and this should also make them the best at handling HIV and related SRHR challenges. But as the second factor suggests, Zimbabwe has one of the highest HIV prevalence rates in the region – a real contradiction…! And there are many reasons to this as will be seen later. But this gives our project a supportive institutional space where the authorities are working towards the same objectives as we want – to increase SRHRs coverage and fight HIV. And our model of community mobilization, access, routinization, ‘detaboolizing’ of SRHR, and behavior impact is welcomed as a complimentary component. This will give us the space to build a usable and replicable model.

**HIV and SRHR in Zimbabwe:**

Again, Zimbabwe has one of the highest HIV prevalence in sub-Saharan Africa at 12.8%, with 1.4 million people living with HIV in 2019 (UNAIDS 'AIDSinfo', 2019). The HIV epidemic in Zimbabwe is generalized and is largely driven by unprotected heterosexual sex. Heterosexual people in stable unions account for around 55% of all new HIV infections (Zimbabwe National AIDS Council (2017). Women are disproportionately affected, particularly adolescent girls and young women. And there also continue to emerge revealing data (although scanty) on other groups such as people with disability, sex workers, homosexuals, transgender, incarcerated/prisoners etc., who due to their social status that limits their health services access, stand an even higher risk of HIV in the country.

For specifics, an estimated 730,000 women were living with HIV in Zimbabwe in 2018 (UNAIDS 'AIDSinfo', 2019). In the same year, 19,000 women became HIV positive, compared to 14,000 men (Ibid). In 2018, around a third of all new HIV infections in people above the age of 15 in Zimbabwe were among young people (under the age of 24). There were 9,000 new infections among young women, more than double the number of new infections among young men (4,200) ((UNAIDS 'AIDSinfo', 2019). Among young people living with HIV, 60% were aware of their status, much lower than the proportion of adults aware of their status overall. The proportion of young people on treatment and virally suppressed is also lower (Ministry of Health and Child Care Zimbabwe, 2019).

The explanations are that young people are more likely to engage in risky sexual behaviors than older adults, making them vulnerable to HIV, yet they have less frequent contact with the healthcare system in general, including HIV prevention and treatment services, let alone knowing their rights (SRHRs) in their sexual relations. In 2015, 17% of young women (aged 15-19) in Zimbabwe reported having had sex with a man 10 years older in the past 12 months. Intergenerational relationships (with older partners) are thought to be one of the main drivers of new HIV infections in young women. In these relationships, older partners are more likely to determine condom use, and are also more likely to have HIV than women’s younger peers (Zimbabwe National Statistics Agency, 2016). In Zimbabwe, only 42% of young women and 47% of young men have comprehensive knowledge about HIV and in general their SRHR, limiting their ability to take control of their sexual health (UNAIDS Data 2019).

On a general level, economically, the prolonged economic crisis facing Zimbabwe has resulted in many people being unemployed or working informally. Around 6 million are estimated to work in Zimbabwe’s informal sector, including roadside stallholders, miners, and sex workers. Their line of work means they are unable to claim social welfare or qualify for health insurance schemes, making treatment access difficult. Many are also unable to visit health clinics as they cannot afford time off work (Zimbabwe National Statistics Agency, 2016), or their homes are simply too far from access points, the case of periphery provinces and districts like Masvingo.

From a gender perspective, gender inequality is present within relationships and marriages, and drives HIV infections. For example, only 69% of men believe a woman has the right to refuse her husband sexual intercourse if she knows he has sex with other women. Although in the minority, 23% of females believe women do not have the right to ask their partner to use a condom if he has a sexually transmitted infection (STI) (Zimbabwe National Statistics Agency, 2015). This is also driven under the hood/fear of Gender-based violence (GBV) which has its toll on Zimbabwe. Survey results from 2015 found 39% of women and 33% of men thought a husband was justified in beating his wife for among others refusing sex with him (Ibid). GBV is intricately linked to inability to negotiate condom use or generally denial of SRHR, and greater vulnerability to HIV. In 2015, around one in five women who had ever been married or partnered (aged 15–49 years) had experienced physical or sexual violence from a male intimate partner in the past 12 months (UNAIDS Data 2019). Polygamous relationships are also common.

There still exists stigma and discrimination towards people living with HIV in Zimbabwe – with one study finding that 65% of people living with HIV had experienced some form of discrimination due to their HIV status (Ibid). Survey data from 2015 found 22% of women and 20% of men who were aware of HIV had discriminatory attitudes towards people living with HIV. Around 6% of women and 9% of men did not think children living with HIV should be allowed to attend school with children who are HIV negative. Additionally, 19% of women and 16% of men would not buy fresh vegetables from a shopkeeper with HIV (Ibid). The effects of stigma are far reaching. Around 40% of sex workers questioned said they avoid healthcare due to stigma and discrimination (UNAIDS Data 2019). Around 6% of people living with HIV report being denied some form of healthcare due to their positive status (Ibid).

Legally, there remains conflicts between formal and customary laws/practices, numbing SRHR access for many “illegal” or marginalized groups. The illegal nature of sex work and homosexuality presents huge barriers for these populations in accessing HIV services to take care of their health. It also means that the country is unaware of the demographics of people living with HIV among these groups, meaning targeted prevention, testing and treatment services are impossible. If people who are living with HIV cannot access treatment to prevent onwards transmission, this allows HIV to continue as a public health issue.

The Covid19 pandemic has also had its toll on Zimbabwe. This has led to that several aspects of social welfare, and here specifically the provision and access to Sexual and Reproductive Health services and Rights (SRHR) have been put aside in many low resourced communities in Zimbabwe. And it is again the most at risk and marginalized communities that have taken the hardest blow here including young people – especially girls and young women, People with Disabilities (PWDs), low-income homes, and ‘illegal’ sex groups. And we know that this is a recipe for disaster. Other factors include lack of youth-friendly access to healthcare services and gaps in Antiretroviral treatment (ART), poverty causing tread-offs, c**hild marriage, & unsupportive traditions.**

**Zimbabwe has a supportive environment, and this is good for our project:**

**As mentioned earlier**, knowing that the country faced a major challenge with HIV, Zimbabwe has been investing in strategies to roll back the statistics, making them one of the most robust at this in sub-Sahara Africa. For example, as of 2019, 90% of people living with HIV in the country were aware of their status, and 94% of those diagnosed were on treatment. Of the people diagnosed and on treatment, 86% are virally suppressed, meaning that they are likely to be in good health and will not pass HIV on to anyone else. Overall, this equates to 85% of all people living with HIV in Zimbabwe being on treatment and 73% of all HIV positive people being virally suppressed (UNAIDS 'AIDSinfo', 2019). Among the initiatives implemented by the government include:

1. HIV education and approach to sex education, rolling this also to young people in schools.
2. Condom availability and use, where there is per capital access to at least 30 condoms annually.
3. HIV testing and counseling (HTC), where progress was towards self-testing in the recent years.
4. Prevention of mother-to-child transmissions (PMTCT) as a standard measure in all able maternal units.
5. Antiretroviral treatment (ART) availability is high (85% with HIV are on treatment).
6. Voluntary medical male circumcision (VMMC) available in most heath centres.
7. Pre-exposure prophylaxis (PrEP) – or a tryout involving doses of ART to people without HIV.

The impact of the combination of the above is huge. According to UNAIDS, in 2019, there were 40,000 new HIV infections, down from 62,000 in 2010. While deaths from AIDS-related illnesses continue to fall – from 54,000 in 2010 to 20,000 in 2019. And, behavior change communication, high treatment coverage and prevention of mother-to-child transmission are all thought to be responsible for this decline.

**Our project compliments and extends this:**

Therefore, our project aims to be supportive of the already ongoing progress and contribute with closing a complimentary gap – that of increasing access/provision of the SRHR and HIV services and information to the lowest of the grassroots, by responsibly and carefully piloting and developing a model that enables this. Moreover, our model is heavily embedded on triggering behavioral change through information, mobilization, dialogues within communities about SRHR and HIV, and advocacy over a prolonged period of 15 months. We also believe our project will refocus attention to SRHR after the Covid19 adversities. Our project will focus on the following services among those offered by government:

* HIV education and *a rights* approach to sex education across all activities.
* Condom and other acceptable contraceptives availability at access points and other events.
* Possibilities of HIV testing/self-testing and counseling (HTC) at access points and popup events.
* Antiretroviral treatment (ART) availability at access points.
* Plus, information and referral regarding the rest.
* Describe how this intervention will strengthen civil society organising.

In a country where the HIV and SRHR programming is so elaborate and covered, yet the prevalence and services access levels remain low among high-risk and marginalized communities, we know from local observation and expert recommendations that deepen this access and working around issues of local perception towards behavioural change is one of the remaining bricks in a comprehensive model.

Key to deepening access and behavioural change is to mobilize unconventional stakeholders and access avenues, and this is where our project doubles as triggering a further strengthening of civil society organizing.

We will intentionally activate and capacitate 60 youth leaders/representatives that will then across the project work to reach out to other young people and the general community towards the project objectives and activities. We will connect these to local leaders, partnering schools, the local public health centres, mobilizing and setting into action local SRHR access points, but most importantly – we will mobilize 7 other CSOs to voluntarily work with us on the grassroots.

Groups like local access points are new to the entire SRHR response design, yet they will offer their places of work for the good of community. Getting public health workers to train, monitor, guide and be part of the project across the period is also a new way of activating the local public system. Having 7 NGOs to work with us is a new way of getting more voluntary actors activated around a public program. The young people being at the center of all this, while activating the local community is a concrete way to engender citizen participation and community voluntarism. Finally, we have a diverse set of activities all aimed at creating platforms for community activism, mobilization, collaboration, etc. These combined, will build a stronger community sense through this project.

* What climate and environmental conditions do the partnership and/or intervention need to respond to?

Although not directly linked to any environmental aspects – apart from for social sustainability, the project will involve environmentally friendly strategies in relation to materials used. We are for example intentionally eliminating things like producing T-shirts to reduce unnecessary resource consumption. Also, we will limit travel between the partner countries to the bare minimum for project success and do more of the monitoring virtually. Finally, we will also include deliberate messages around maintaining sustainable practices in our communication.

1. The partnership/collaborators (our starting point)

**Civil Connections Community Foundation – CCCF (Civil Connections):**

CCCF aims to increase value and achievement in international development initiatives with local grassroots communities, by building bridges for commonly unreached local grassroots actors (especially rural), through outfitting these with exposure, capacity, motivation, and mentorship for long-term sustainability.

**Our mission** is to facilitate grassroots development actors to achieve their aims for a fair and sustainable world. This is reached through four areas:

1. Identifying and make known/visible local community initiatives from the different locations we work in, that would otherwise find it difficult to gain such visibility for a great job they are doing.
2. Facilitating the strengthening of capacities of the identified local actors to be able to sustain as well as multiply their good achievements in their local communities as well as to the global level.
3. Supporting identified local grassroots development partners and activists in resource mobilization and joint fundraising as a way of closing resource needs that commonly hinder longer-term survival.
4. And, implementing a knowledge development hub - including an online journal of knowledge, working tools, methodologies, and other resources, aimed at building further knowledge and awareness.

This year we are/have implemented three CISU funded projects, two in Uganda and the newest in Georgia. In Uganda we have had the small-scale ICT in education in Yumbe district that piloted an immensely interesting telephone-based home teaching method with amazing results – ([see here](https://civilconnections.org/ict-for-rural-education-uganda/)). And in February 2021 launched the “Structures for youth policy and budget participation on Uganda’s decentralized system in Yumbe and Mayuge district ([see here](https://civilconnections.org/slogbaaproject/)). And, latest in September 2021 we started the “Youth Policy Participation in Samegrelo region in Georgia” that runs until mid-next year. Accompanied by other projects funded by among other the ERASMUS+ of the EU, NORDPLUS of the Nordic Council, and Oplysningspulje of CISU. More on “Vores CISU” or [here](https://civilconnections.org/).

**My Age Zimbabwe (MAZ):**

Formed in 2011 in Masvingo, MAZ is a youth led NGO focused on innovative youth-friendly communication strategies including Information Communication Technologies (ICT’s), edutainment and volunteerism. This is all meant to enhance advocacy for meaningful youth participation in developmental processes with a focus on Sexual Reproductive Health and Rights (SRHR), HIV and AIDS awareness, prevention, treatment care and support. Since inception, MAZ has also developed expertise in using performance arts and social media in communication and advocacy on SRHR & HIV and AIDS issues in schools and communities around Masvingo.

The organisation was founded and is led by a dynamic, passionate, and committed team of youths who believe in the power, potential, and the future of young people. MAZ’s advantage lies in the elaborate network of partners that are inclusive of media houses, government departments, and youth serving organisations and networks and key players in the field of SRHR and policy advocacy, as well as volunteers. Capacity wise, Onward Chironda the Director will oversee the overall implementation of this project, and the Programmes Manager Joseph Njowa will lead for day-to-day of this project. Onward Chironda is the founder of MAZ and has experience in community mobilisation, advocacy, and stakeholder engagements. Joseph Njowa has been the programmes manager at MAZ trust for the past 4 years and has vast experience in implementing related projects. Read more about MAZ [here](http://myage-zim.org/).

* Describe any previous acquaintance or cooperation between the partners, and how these experiences have fed into the development of the proposed intervention.

CCCF and MAZ will be cooperating on organizational level for the first time, however Andrew Julius Bende the Daily Leader and the person responsible for this partnership has worked with MAZ and Onward (their Director) for several years during his past employments. These two have found their organization’s objectives – especially regarding CCCF’s ambition to support marginalized communities towards changing their odds, an aspiration to do complimentary projects together. Both organizations are also keen on empowering young people, and building long-term, mutual respect-based partnerships, which will be central values across this project.

* **Describe the contributions, roles, and responsibilities of the partners and other actors**.

On a general level CCCF will facilitating the overall framework for the success of the project and keeping in contact with the funder for guidance. Specifically, CCCF will be lead on the following activities:

* Oversee project contract and coordination roles. Entailing facilitating that implementation frameworks, budgets and plans for ensuring success are in place & adhered to or adjusted if needed.
* Follow-up and remotely/virtually monitor the project in Zimbabwe. This will be through online meetings, two-time monitoring visits, quarterly reports, communication.
* Part of the training program in Zimbabwe, giving motivation talks online.
* Part of the mentoring program involving in online motivation sessions, discussion etc.

MAZ at the grassroots will oversee all implementations in Masvingo, dialoging with and always updating CCCF to ensure that the project keeps to its promises. As well as:

* Physically implement all the project activities. This will entail ensuring that logistics, participants, partners, trainers, experts, mentors, etc. are always in place on desired time.
* Responsibility for local monthly monitoring of the project and updating CCCF on this.
* Joint monitoring with CCCF including quarterly reporting and follow up virtual meetings.
* Oversee the local financial management and identifying an auditor that fits formal guidelines.
* Locally administer the project and fit it into their annual strategy/plan for smooth running.
* **Describe how the intervention will contribute to developing the relationship and collaboration between the partners.**

This project is the first formal collaboration between CCCF and MAZ, however, embarking on this journey sets off a commitment to joint growth & learning beyond the informal links.

And, in terms of the relationship to the target groups, this project will increase MAZ’s reach to both the young people, as well as the various new stakeholders we will work with in Masvingo. Secondly, the project gives space and skills development on different levels both social mobilization wise, as well as core competences around SRHR and HIV. We see the trainings as capacitating the stakeholders to reach out to young and old (their communities), while the mobilization provides the space for stakeholders – especially youths to work together and with other actors on a larger scale, and in a more organized way through referral pathways. The project will also contribute to positive health outcomes for both the participants and the community.

1. Target groups, objectives, and expected results (our intervention)

* Describe the composition of the target groups: specify approximate number of people in primary.

Our project has several primary target groups, both on the first tier – those directly forming the core group of mobilizers, ToTs, and service providers (termed **Tier 1** primary target group), and those that we are targeting and sure to reach though the different activities (termed **Tier 2** primary target group). Tier 1 primary targets = 121 people and Tier 2 target groups = 8000 people. In all 8121 people as follows:

1. At least 14 MAZ daily staff and volunteers that will be directly impacted through direct project participation. These are composed of a 40% to 60% male – female. Mostly young and local.
2. 60 youth leaders. In Tier 1, the 60 youth leaders are already politically elected by the local community to represent youth at ward level. They are a political/policy/local leadership structure that connects youth and their communities to the country’s policy and decision streams and bring vital policy and decision updates to the local communities and youth. Our project will take advantage of this to localize our activities. By taking part in the project – gaining information, systematizing outreaching, taking responsibility for activities, etc., these leaders will take up these roles as part of their work. In tier 2, these youth leaders will be part of implementing the outputs in 3.2, targeting at least 100 youth/sub district.
3. 15 patrons/teachers from 15 schools – In tier 1, MAZ already cooperates with 15 schools/15 contact teachers in Masvingo. These run the ‘Theatre for Development clubs’ in schools with information and activities around SRHR, HIV and AIDS. So, they are already predetermined as we will work through the same clubs, and our project will support them with further information and skills – action resources, updated guidelines, motivation, a supportive network, and renewed mandate. We will create more knowledge, empowerment, enthusiasm, as well as concrete frameworks to incorporate the project knowledge into the school routines for wider student reach and long-term presence. In tier 2, we envision engaging a minimum of 300 youth per school across the 15 schools, totaling 4500 in all.
4. 7 CSO representatives – In Zimbabwe and in this case – MAZ and Masvingo, no local organization stands alone, except for heavily resourced international ones. This said, MAZ already cooperates with several local CSOs with MOUs, but for proper coordination we will select the most SRHRs and or HIV related partners in the different sub-districts. The criteria are that they are rooted in the local community and have the mandate of the people. These organizations benefit from being part of a supportive network, gaining training and skills, being part of organizing events and legitimizing themselves in the local community. And the different coordinators will be local trainers, mobilizers across the various activities.
5. 4 government health center representatives - there are 4 government health centres in Masvingo district, and MAZ already cooperates with these. We will build on this to formally get 1 representative from each.
6. 7 access point providers drawn from the 7 sub districts in Masvingo. They will be nominated and reviewed by all other stakeholders i.e., the 60 youths, 15 schoolteachers, 7 CSOs. And afterwards be vetted by the 4 government health center representatives. The 7 together with the 4 health workers will form a SRHRs Access taskforce, that will work on an SRHRs bottleneck solution model, a process facilitated by MAZ.
7. 14 community leaders concerned with youth, gender, and health issues at sub district level. These are formal employees – 2 from each of the 7 sub districts. One (1) in charge of health and the other in charge of youth affairs. These bring legitimization, political backing, as well as policy/practice routinization.

**Secondary target groups:**

These will include wider populations in schools – at least an equal number to the primary target group (4500 people). Other youth segments that will be part of the public events in output 1.4 and 2.3 where estimate at least 500 youths per sub district = 3500 people. The project will also have an influence of parents, other teachers, and community leaders. At least the 1 million local radio listeners reached through output 1.7. At least 15000 people reached through information activities in output 1.8, and at least 700 in output 3.2

* Describe the objectives and expected results.

This project’s overall objective is to create a conducive environment for adolescents and young people in their diversity to access Sexual and Reproductive Health and Rights/services (SRHRs) and HIV related information and services freely and safely in Masvingo Urban and Rural Districts (Masvingo).

Specifically, the project will be run based on three objectives named earlier in section 1, reached through delivering the different outputs below. It should be noted that while we have set preliminary indicators for some, we will do a more rigorous indicator markup at the kick-off:

**For objective 1:**

* 1. Holding a kickoff project meeting for detailed planning and project information among the implementing partners and key stakeholders (including 2 from CCCF, 10 from MAZ, 4 from local health center = 16 people).
  2. Holding of two inception meetings/events at the start of the project aimed at popularizing the project, recruitment of stakeholders and setting up of agreements, permissions, processes and plans for engagement. Stakeholders here include 60 youth leaders, 15 school patrons, 7 CSOs representatives, 7 SRHRs access point providers, 14 local district leaders, 4 district local health center representatives = 107.
  3. Implement four (4) quarterly core training, reflections, & action planning for the 60 youth leaders in SRHR & HIV, to build their knowledge, common understanding and skills needed. See training modules [here](https://www.gfmer.ch/SRH-Course-2010/adolescent-sexual-reproductive-health/Adolescent-health-modules.htm).
  4. Implement four (4) quarterly core training, reflection, and action planning sessions for the rest of the primary stakeholders i.e., 15 school patrons, 7 CSOs representatives, 7 SRHRs access points providers, 14 local leaders concerned with youth & SRHR issues, and 4 local health center representatives = 47 in all).
  5. Implement four (4) quarterly sub district-based community mobilization & information events about SRHRs, where popup contraceptive distribution, testing and counseling is held, reaching 50 people per sub-district.
  6. Implement activities in school clubs championed by the school patrons to mobilize and give school youths the chance to learn about SRHRs & HIV and Aids and working with the schools to include this as an important part of their extra-curricular programming. These will entail information on SRHRs, peer-to-peer events facilitated by the school clubs, youths’ articles in local media, and being part of the radio programs in 1.7.
  7. Implement seven (7) bi-monthly radio talk shows about SRHRs and HIV and Aids, why it is important to pay attention to this, what the government & other stakeholders are doing about this, & where to find services.
  8. Implement other dialogue and information activities about communities’ reflections on SRHRs, personal experiences accessing the services, and what could be done to make this even more effective. These will include for example - bulk SMSs (about 5000 across the project), seven (7) bi-monthly Zoom (online) meetings, and production of seven (7) bi-monthly public information events reaching at least 10,000 people.

**For objective 2:**

* 1. Working with the local health center to set up a community SRHR services access system, rules for how the other access points will operate and monitored for efficiency, a capacitating program for the other access points, and a systems/process through which the 7 access points will attain supplies from the local community health center. This will be in form of bi-monthly calibration for key stakeholders.
  2. Facilitating of the 7 SRHR services points, contracts, access to SRHS supplies, system for managing and monitoring, and making the community aware of these and well as being part of evaluating the effectiveness with time. This will be in form of facilitating MAZ staff to do this work.
  3. Implement four (4) quarterly testing and outreach caravans into the communities where the public is invited to take the opportunity to test, get counseling, if they have an ARV pass get these, as well as time to ask clarifying questions and information sessions. We will target to reach 50 people for each.

**For objective 3:**

* 1. Implement four (4) quarterly review and dialogue meetings among the project key stakeholders and local policy makers (6 MAZ staff, 7 youth subdistrict representatives, 14 local leaders, 7 CSOs representatives, and 4 health center representatives = 38 in all). These review meetings should end up in recommendations for policy change/lobby on SRHRs service delivery both locally but also scalable.
  2. Facilitating of 7 mini subdistrict-based local awareness and policy advocacy actions in cooperation among the youth leaders/representatives and the 7 CSOs selected, as a way of building a grassroots advocacy movement for focus and delivery on SRHRs. These should also gather lessons learned from the grassroots.

Key indicators:

The following preliminary progress indicators will be tagged to all activities, while a more rigorous set of extra indicators (process and output) will be developed at the kick-off planning meeting.

* A plan & logistics in place at least a month before each implementation.
* All expected participants agree to attend at least a month before implementation.
* Rapid appraisals show a positive effect of the activity and that people find it relevant.
* Number of people attending each activity (at least 70%), and how many say would come to the next.
* All the relevant stakeholder clusters have been represented including marginalized.
* Majority of attendees feel they have learned more than they knew before the event.
* Level of distribution/access to the services we are delivering at the different events.
* Level of activation after each project judged by follow-up activities in communities by stakeholders.
* Describe how the target groups will participate in- and benefit from the intervention.

This question is answered under the answers to the question above.

* What is the strategy of the intervention? Describe the planned activities and how these will lead to the desired outputs and achievement of the objectives.

The strategy is in facilitating unconventional structures for SRHR & HIV related services access, where:

1. We focus on bringing the services closer to everyday people through mobilizing, capacitating, formalizing operation contracts and deploying of more SRHRs access points. Working across the 7 sub districts in Masvingo we want to mobilize at least one access point in each sub district to cooperate with the government health centres, MAZ and other civil societies, for easy, and safe space for young people and community at large to access SRHRs. This will solve to access/provision bottleneck.
2. We want to mobilize, create information, and deepen community knowledge about SRHRs – what they are, why they are important to observe, what the downsides of not having them are, and how each can play a part. The aim of this is not only to create awareness, but to create a foundation for demystifying and ‘de-taboolizing’ SRHRs and conversations around these. We want to break stigma both among the young people we focus on as well as their local communities. We want to create cohorts of ambassadors/advocates for SRHRs that will facilitate continued information and public dialogue about these.
3. We want to increase both government/public policy and local community focus and prioritization of SRHRs as an important aspect of young people’s everyday lives. So, following up from the normalizing the conversations about SRHRs, we want to show communities and policy makers that this is important to focus on for the health of our communities and the future of our young ones.
4. To facilitate all the above and more aspects not named, we want to utilize this project as a platform for normalization and routinization of the talk, the provision, the access, the advocacy, and policy inclusion. Therefore, we will run the project for a prolonged 15 months – giving ample time for repeating each of the activities several times, and ensuring progression across the 15 months, as well as all the activities being interconnected and complimentary to each other.
5. Another way to facilitate the normalization, localization, and routinization in setting a varied cross section of stakeholders in action and in constant conversation/planning processes about the SRHRs.
   * We focus on youths as a main target group and therefore working with 60 youth representatives/leaders formed of two representatives from each of the 30 wards in Masvingo districts. The two will be both male and female representatives at wards, thus bringing this issue/engagement to the local grassroots as opposed to working at a higher policy level. These youths will across the project/through all activities constantly mobilize other young people to the information, dialogue, access, and advocacy for SRHRs.
   * Working with the 15 schools in Masvingo district that MAZ already has cooperation arrangements with we want to reach young people (the prime target group) in arenas where majority of them spend most of their daytime. We will work with the 15 patrons from the schools to inform, dialogue, train/capacitate, put into supportive network of guest facilitators/resource people, as well as design activities that increase knowledge and participation of young people around SRHRs. The end game here is to get the schools to uptake SRHRs as a priority component of their co-curricular scheme.
   * To increase SRHRs coverage we want to mobilize, qualify, capacitate, and formalize 7 SRHRs access points – one for each of the 7 sub districts in Masvingo. While a country like Zimbabwe has universal access to SRHRs based at government health units’ level, some of these are far away from the local masses. Bringing these closer to where the local people are means breaking the access barriers by far. Setting this into practice and effectivizing it will give the local health centres, policy makers and government in general a first-hand model for further devolving health services.
   * We know that community issues are not solvable by one NGO, therefore we have as a strategy to mobilize 7 other NGOs (1 per sub district) to work with MAZ at the grassroots. These will be part of all the activities as volunteer hands, but this will also mean that they will be co-owners of the models being developed and thus can integrate the strategies in their working. They will increase our reach on the grassroots by far, they will strengthen the advocacy voice, as well as create a varied dialogue at the grassroots.
   * We will work with the local policy makers inviting and engaging 14 (2 from each of the 7 sub districts) in our project components. The two will be 1 in charge of health and the other in charge of youth affairs. These will be vital in not only legitimizing our project and political backing, but we want to capacitate them as well as get them used to making policy in this way, and its positive implications on the future of SRHRs.
   * Finally, we will actively work with the 4 government health centres in Masvingo district through 1 representative from each for their professional guidance, quality assurance in our project, monitoring of health services access points, setting required guidelines, and continuous mentoring/guidance where core health aspects are at play. The reverse is that like the policy makers, we will be able to build the confidence of the national health system to work in partnership with other actors in the process of future increasing SRHRs and other health aspects as the grassroots.

* What are the plans for systematising experiences along the way and at the end of the intervention?

We will setup a framework for systematizing experiences along the way as follows:

1. We have ensured that MAZ have a fully engaged project coordinator following the project from start to end. This also includes a project assistant and an accountant. The same modalities are present as CCCF.
2. Both CCCF & MAZ will meet up at the start of the project to jointly revisit the proposal and harmonize work plans and other aspects that are crucial to the realization of the project, including elaborated indicators.
3. MAZ will compile different reports on implementation that will be utilized by the partnership to follow the project. These will include short activity, which will then be compiled into a quarterly report that will be shared to CCCF and followed up by a Zoom meeting to engage on the results of the quarter.
4. The partnership will also implement joint physical monitoring visits, giving space to joint learn within the context and gather up on the specific exchanges of best practices and ideas.
5. Intervention-related information work in Denmark

* The purpose of the information work.
* Give Danish public access to what is happening in Zimbabwe & engaging them in our work.
* Utilize this information for lobby and advocacy towards policy support for development work.
* The target groups of the information work.
* Our members and followers through online channels and our Annual General Assembly
* To other Danish CSOs present/interested in Zimbabwe & the Danish public through public workshops
* The means of communication to be used (social media, printed matter, theatre, events, or the like).
* Public workshops & events, social media, World Wide Web (our website), and Printed content.

1. Supplementary financing - NA