PIP Annex 9

The *Simba Utano* Project

Gender Equality Strategy

A Katswe Sistahood and Youth Engage Project in Zimbabwe's Mazowe, Goromonzi, Seke and Umguza Districts

Project No. P-005993

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Part 1:

Gender Analysis of Targeted Districts

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List of Abbreviations

ABYM	Adolescent Boys and Young Men
AGYW	Adolescent Girls and Young Women
ASRHR	Adolescent Sexual and Reproductive Health and Rights
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
FGD	Focus Group Discussion
GBV	Gender-Based Violence
HIV	Human Immuno-Deficiency Virus
ICAD	Interagency Coalition on AIDS and Development
ICASO	International Council of AIDS Service Organisations
ICPD	International Conference on Population and Development
SADC	Southern Africa Development Community
SGBV	Sexual and Gender Based Violence
SRHR	Sexual and Reproductive Health and Rights
STIS	Sexually Transmitted Infections
LGBTQ	Lesbian, Gay, Bisexual, Transgender and Queer
MDGs	Millennium Development Goals
NGO	Non-governmental organization
SDGs	Sustainable Development Goals
UN	United Nations
UNFPA	United Nations Population Fund
ZDHS	Zimbabwe Demographic Health Survey

Executive Summary

Context

Women and girls constitute 52% of the total population in Zimbabwe. Despite constituting a majority of the population, women in Zimbabwe are disproportionately affected by poverty and disease. Furthermore, they remain largely underrepresented in decision making because of an array of socio-cultural and economic factors. Although indicators for the status of women and gender equality generally point to a state of disempowerment among women, the SRHR indicators are untenable. For example, women in Zimbabwe constitute nearly 61% of the total number of people living with HIV - and new infections among young women between the ages of 15-24 years are twice that of their male counterparts. Furthermore, knowledge levels of STIs and HIV prevention are low among adolescent girls and young women (AGYW), thereby resulting in high transmission and prevalence rates for this group. The *Simba Utano* project seeks to respond to this context by improving the health of AGYW at risk of HIV and other negative SRHR outcomes in four priority districts of Zimbabwe - Mazowe, Goromonzi, Seke and Umguza. A gender analysis was undertaken in February/March 2020 to better understand the situation in each of the targeted districts.

Findings

The gender analysis research confirmed what has been long known, while unravelling new insights, about factors hindering access to and utilization of SRHR, including HIV and SGBV services among adolescents and young people from a gender perspective in the *Simba Utano* targeted districts. The following represents key findings in each chapter of the report:

Roles, Responsibilities and Time

- Women and girls' time is largely consumed by household and reproductive activities while men dominate the economic and prestigious community leadership activities.
- Women and girls work longer hours per day compared to their male counterparts. Average time women and girls spend working per day is 16 hours across the districts while men generally work half that time. In all rural communities where farming is a source of livelihoods and income, women share responsibilities with men in the fields and still have to undertake household duties. This trend is the same for all other

situations where women are engaged in economic activities. Even with evolving times where traditional roles are being redefined to allow greater engagement of women in economic activities (e.g. in Umguza where women are engaged in artisanal mining activities), household duties remain predominantly their domain. Because men work less hours, they have plenty of leisure time while women have almost none. Women spend the little leisure time they have at church as they are not socially expected to patronise bars and other entertainment spots, except as sex workers.

- Women across all the 4 districts are responsible for caring for the sick. This increases their family responsibilities and absorbs much of the time that they might have spent on productive work. Their responsibilities grow exponentially in response to the high burden of SRH issues such as HIV and AIDS.

Access to and Control Of Resources

- Men have access to and control of the most important resources (resources that bring about wealth and status) across all communities in the study. The resources owned by men include land, houses, big livestock, finances and cash crops. Women, on the other hand, are restricted to commodities that are used in household activities in line with their responsibilities. They also own small livestock which is often for family subsistence and sometimes sold to meet daily family and children's financial needs.

- Through tradition and patriarchy, men are handed control over land, a very important resource and means of production for wealth creation. Land is the most important resource in farming, a common livelihood and income generating activity in all communities outside urban areas. It is also the ground upon which houses are constructed making it difficult for women to own homes.

- Since women do not own land, they cannot own important cash crops produced on the land even when they work hard on the land. This keeps women poor compared to their male counterparts.

- In one district (Umguza) where women were said to be increasingly involved in mining activities for economic sustenance, and in any other cases where women

were economically involved, the study indicated that women will have control of financial resources compared to communities where women stay at home. However, the study indicated that men are not comfortable with women who earn their own money because of its impact on changing power dynamics in a relationship. The study indicated that an elevated economic status for women can be a source of gender-based violence; women continue to be victimised by their insecure husbands.

- Men use their resources to pay for SRHR services as well as leisure activities such as drinking and paying for sex workers. Owing to their meagre resources, women are restricted from accessing SRHR services and were reported to use the little money they earn on meeting the financial needs of the family and the household. Women retain the primary (and often the only) responsibility for taking care of households and children.

Decision-making and Influence

- According to this study, women make less weighty decisions around the day to day running of households while the men decided on important issues at the family and community levels. Men take decisions around the use of finances in the home and tend to be leaders in the community.

- The majority of community leaders are men throughout the project's four districts. Owing to social norms, traditional leadership is often passed on from fathers to sons. Although on paper, political office and other public leadership positions are open to women, the lack of finances as well as discriminatory social attitudes limit the participation of women in leadership and decision-making.

- Men (partners and fathers) were said to have a significant influence on decisions taken by women on their SRHR in all the communities. Men and boys make decisions on behalf of their wives, girlfriends and daughters. This includes, according to the project communities, decisions around abortion, contraception use and family planning.

Gender and Health, including SRHR

Women and AGYW have more health needs compared to their male counterparts. Men and ABYM were said to have poor health-seeking behaviours compared to women and AGYW.

- Despite having a desire to access various health and SRHR services, including GBV services, women were limited by several factors such as: the high cost of services, long distances to health facilities, unfriendly attitudes of staff, the lack of services, male attitudes (parents and partners) as well as inequitable religious, cultural and social beliefs, practices and norms. For example, young, unmarried women were said to be stigmatised by health service providers and society for seeking contraception and other family planning services. This naturally influences their willingness to access such services.

- Lack of knowledge is also a key factor in accessing services. Despite national studies indicating that knowledge levels on SRHR are generally low among AGYW, males who took part in the study from all four districts feel that women and girls have 'too much information' on SRHR. AGYW knowledge on issues such as condom use is seen as being 'too forward' and a sign of unfaithfulness or promiscuity. In Goromonzi and Mazowe district, activities that strictly and exclusively target AGYW and women were openly resented because they were seen as disempowering men and boys while turning AGYW into 'prostitutes'.

- The study was also helpful in developing an understanding of the sources of SRHR information for adolescents and young people. AGYW get much of their SRHR information from NGO outreach programmes and workshops as well as schools. Due to cultural taboos that limit information on SRHR towards women and girls, AGYW rely less on family and friends. However, since societal norms and taboos are more accepting towards the sexuality of males, ABYM receive much of their information from friends and parents compared to AGYW.

- Poverty, especially among AGYW, is rampant and tends to be a huge factor in fuelling the various SRHR challenges such as child marriages, early pregnancy and HIV. AGYW are forced to sell sex for a living and, more prevalently, to engage in intergenerational sexual relationships with older men for money. Both in sex work and intergenerational sexual relationships, AGYW have less bargaining power for the use of contraception and are likely to be stigmatised when they seek to access services. Sex work was said to be common across all the districts but more prevalent in mining communities (Mazowe, Goromonzi and Umguza districts) where men had resources to buy sex and often abuse drugs and alcohol.

Culture, Religion and SRHR

- Study findings indicated that societal attitudes are informed by prevailing conservative cultural and religious beliefs which remain a factor in limiting access to SRHR services. This is especially true for women and girls who are viewed either as non-sexual beings or existing solely to satisfy the sexual needs of men.
- Such religious and cultural beliefs in the communities tend to sustain laws that limit women and girls' right to abortion. They also lead to violence and persecution of the LGBTQ community thereby driving sexual minorities underground and making it difficult for them to access services.
- Both culture and religion were reported as major drivers of child marriages, a key challenge in all four districts
- In the communities, female genital mutilation in the form of labia stretching has evolved from being a cultural practice to a social pressure on women to satisfy the sexual needs of men. Women who do not conform to this expectation may be beaten up by their partners. Furthermore, they may be exposed to HIV because their husband may feel justified to find other sexual partners who satisfy them. The practice of labia stretching was found to be prevalent in Mazowe, Goromonzi and Seke districts while virginity testing for AGYW was said to be common in Umguza district.
- The payment of the bride price *(lobola/roora*) was also viewed as a cultural practice that commodifies women and exposes them to intimate partner violence. By its very nature, the practice implies that men own women. The practise of lobola was widespread throughout all four districts.

Policy and Legal Environment for Gender Equality and Access to Services by AGYW

Despite Zimbabwe being a signatory to several international and regional instruments that seek to protect the rights of women and girls as well as promote gender equality and the SRHR of its citizens, the government actively negates such rights at worst and, in many cases, simply neglects these rights. The following were the areas in which legal and policy instruments were found to fall short of minimal standards for promoting gender equality as well as the SRHR of girls, women and sexual minorities:

- Same sex sexual relationships are criminalised and prohibited by the country's constitution.
- There are delays in adopting and signing into law the Marriage Bill which would criminalize child marriages which are common in the project communities. Despite a court ruling outlawing child marriages throughout the country, the practise is still socially acceptable. Criminalising people, including parents, who take part in these marriages will go a long way to enforcing the court's decision.
- There is uncertainty around the age of consent for accessing services. Many sexually active young people are unable to access contraceptives and other SRHR services without parental consent. Although government contends that no young person is ever turned away from health facilities because of their age, there is no legal definition of the age of consent around SRHR services. Consequently, access remains at the discretion of health service providers who may be quite biased in that regard. Furthermore, knowledge levels about laws and policies are low among the communities. This lack of knowledge has a bearing on gender equality, SGBV, SRHR and the rights of AGYW and women in general.

Institutional Structures and Capacity for Gender Equality in the Communities and Project

- Government structures and operations in support of gender equality, SRHR and SGBV are hampered by a lack of institutional capacity, understanding and funding.
- *Simba Utano's* project partners (Katswe Sistahood and Youth Engage) have varying capacities in gender mainstreaming in their organizations and programmes. Areas that need to be addressed include organizational policies, systems and practices in relation to promoting gender equality throughout the organization and its programmes.

Recommendations for the Project

1. Acknowledge current gender roles operating within the communities in the design of the project.
2. Work in a gender-transformative manner with sensitization activities that target all stakeholders including young people, parents, communities and community leaders to change social attitudes and norms around gender roles and gender equality.

3. Promote women's participation in decision-making throughout all aspects of the project..
4. Strengthen the knowledge and capacity of community health workers to provide services to women at the household level. It is also more cost effective for the AGYW community if services are brought to them rather than vice versa.
5. Collaborate with specialized organizations that help increase the income of women and AGYW.
6. Source some key services (i.e. contraceptives) and provide them free-of-charge thus increasing accessibility.
7. Target men and boys, to sensitise and transform their attitudes with regards to women's bodies. Such work is also needed to address harmful masculine stereotypes that limit access to services by men.
8. Implement the following strategies to overcome community-specific barriers to accessing services:
    i. Strengthen the capacity of health service providers to provide gender-sensitive and youth-friendly services
    ii. Undertake activities at the community levels that specifically challenge gender norms and societal attitudes that limit women's access to SRHR services.
    iii. Address the cost factor, by procuring and providing some SRHR services, especially those that can be provided outside the hospital setting.
9. Reconcile Church doctrines and beliefs with the need to promote the rights of AGYW to access SRHR services by targeting churches and church leaders as centres for AGYW service provision and information.
10. Improve access to information among AGYW through workshops and in-school interventions which are seen as the most effective way of reaching girls.
11. Initiate parenting skills sessions in order to improve communication on SRHR between parents and children.

- Organize mixed-sex activities to complement activities targeting females and males separately.
- Sensitize communities to understand, appreciate and integrate a rights-based approach to gender equality. Use the rights-based approach to advocate for reforms on those issues recognized by international declarations and conventions but not yet realised through laws and policies of Zimbabwe.

- Train service providers on existing guidelines on service provision for key populations (the LGBTQ community and sex workers, especially) and supplement this work with targeted sensitization activities for the relevant populations.
- Sensitise women on the harm caused by FGM practices (including labia stretching) in order to dispel myths and misconceptions that are held by men.
- Raise awareness in the communities on laws and policies around gender equality and access to SRHR services
- Advocate for a policy supporting a lower age of consent to ensure that young people, especially AGYW, can access services without parental accompaniment and consent.
- Advocate for stiffer penalties for adults who marry young girls – and the parents and community members who facilitate such marriages.
- Identify all existing government institutions with a mandate to pursue gender equality and to improve access to services; and then build their capacity through collaboration and support.
- Engage in advocacy around budgetary allocations to ensure that national and local public institutions that promote gender equality are adequately funded to allow them functionality and presence in the community.
- Develop the partner's capacity to mainstream gender by:
    i. Developing staff capacity to plan, implement as well as monitor, evaluate and report on the results of the project in a gender-sensitive manner.
    ii. Ensuring that activities and their implementation acknowledge the different needs of men, women, AGYW as well as ABYM - and seek to meet these needs.
    iii. Collecting data for project monitoring and evaluation in a manner that is gender-sensitive. This includes qualitative indicators that measure changes in gender and power relations.
    iv. Supporting the organizations involved in the project to develop and use policies, systems, work plans and tools for gender mainstreaming in the Simba Utano project and, overall, in their organizations.
    v. Develop a gender equality strategy for the project addressing all the aspects above.

1. Background and Introduction

1.1 Introduction

The Simba Utano project is a joint initiative of two Canadian organizations (ICASO and ICAD) and their two local Zimbabwean partner organizations (Katswe Sistahood and Youth Engage). The project seeks to improve the health of adolescent girls and young women (AGYW) at risk of HIV and other negative SRHR outcomes in four priority districts of Zimbabwe of Mazowe, Goromonzi, Seke and Umguza. The Simba Utano project is a four-year initiative whose aim is to meet the following key outcomes:

- Increased utilization of equitable Sexual and Reproductive Health and Rights (SRHR) and HIV services by vulnerable AGYW in 4 districts of Zimbabwe
- Improved delivery of quality, gender responsive, inclusive care and support to address priority SRHR needs of adolescents and young people particularly AGYW
- Improved effectiveness of young people particularly AGYW and community organizations to advocate for evidence-based, equitable, accountable and quality SRHR services and policies.

The partners to the *Simba Utano* project recognise that gender equality is a key factor in all development projects, especially a project that seeks to improve access to SRHR services. Societies in Zimbabwe, just like many other societies across the world have discriminatory gender norms and unconscious biases that often subordinate women to their male counterparts[1] as well as disadvantage minorities such as LGBTQ individuals. Sexual violence, lack of access to resources, unpaid labour as well as religious and cultural beliefs, among other factors militate against women, girls and sexual minorities' access to SRHR and HIV services[2]. In this regard, gender equality and the empowerment of women and girls is important to ensure that the same can have opportunities and capabilities to demand and utilise relevant services.

It is also important to note that interventions in the mould of the *Simba Utano* project are not gender-neutral – they may either do harm to already marginalised women and girls or leave

[1] National Gender Profile of Agriculture and Rural Livelihoods: Food and Agricultural Organization of the United Nations, Harare (2017)

[2] Gender Inequality and HIV: Avert (Accessed online on the 22 February 2020 - https://www.avert.org/professionals/social-issues/gender-inequality)

them out considering that they do not have the same opportunities to access such services as men and boys. To this end, a gender analysis is also needed to identify opportunities for improving access to SRHR and HIV services by women and girls as well as to reduce the negative impact of the project on the same[3]. It is against this background that the partners to the *Simba Utano* commissioned this research.

1.1 Goals and Objectives of the Study

A gender analysis for the *Simba Utano* is needed to understand the gendered power relations and inequalities that affect the four project districts across Zimbabwe. This gender analysis forms the basis upon which a gender equality strategy for the project is developed with the aim of responding to the foresaid need for a gender sensitive project in promoting access to SRHR services among AGYW.

The following were the specific objectives of the gender analysis:

- To explore gender inequality in terms of access to SRHR services in four project districts covered by the *Simba Utano* project.
- To establish programming gaps and opportunities as well as to provide recommendations for enhancing gender inequality and improving equitable access to SRHR services.

1.2 The Gender, SRHR and SGBV Context in Zimbabwe

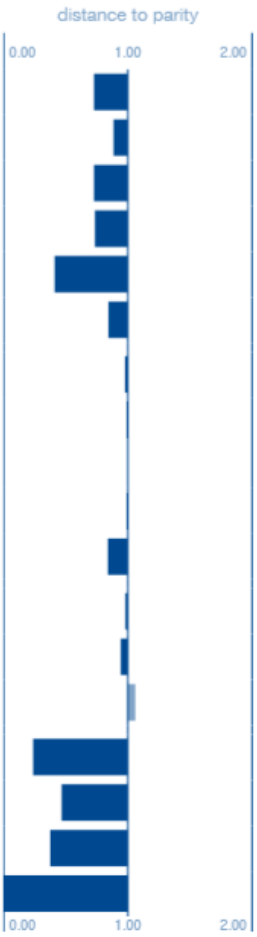
Women and girls make up 52% of the total population in Zimbabwe[4]. Despite constituting a majority of the population, women in Zimbabwe are disproportionately affected by poverty and disease while they, at the same time, remain largely underrepresented in decision making owing to several socio-cultural and economic factors, among others. As a result, Zimbabwe ranks lowly in the gender equality ranking.[5] Although Zimbabwe ranks sixth in sub-Saharan Africa, its score of 0.730[6] shows gender disparity compared to the ideal of zero.

[3] Grand Challenges Gender Equality Strategy Tool: Grand Challenges Canada, Toronto
[4] Inter-censal Demographic Survey: Zimstat and UNFPA, 2017
[5] The Zimbabwe National Gender Policy: Ministry of Women Affairs, Gender and Community Development
[6] The Global Gender Gap Report, 2020: World Economic Forum

Fig 1: Zimbabwe Gender Equality Ranking and Key Indicators on Gender Equality

COUNTRY SCORE CARD

	rank	score	avg	female	male	f/m
Economic participation and opportunity	**45**	**0.728**	**0.582**			
Labour force participation rate, %	50	0.885	0.661	79.5	89.8	0.89
Wage equality for similar work, 1-7 (best)	27	0.727	0.613	–	–	5.09
Estimated earned income, int'l $ 1,000	25	0.736	0.499	1.9	2.5	0.73
Legislators, senior officials and managers, %	90	0.411	0.356	29.1	70.9	0.41
Professional and technical workers, %	100	0.844	0.756	45.8	54.2	0.84
Educational attainment	**98**	**0.977**	**0.954**			
Literacy rate, %	71	0.990	0.899	88.3	89.2	0.99
Enrolment in primary education, %	1	1.000	0.757	89.4	88.5	1.01
Enrolment in secondary education, %	111	0.991	0.954	48.5	49.0	0.99
Enrolment in tertiary education, %	115	0.840	0.931	9.2	10.9	0.84
Health and survival	**1**	**0.980**	**0.958**			
Sex ratio at birth, %	1	0.944	0.925	–	–	0.98
Healthy life expectancy, years	1	1.060	1.034	55.9	52.7	1.06
Political empowerment	**54**	**0.238**	**0.239**			
Women in parliament , %	37	0.467	0.298	31.9	68.2	0.47
Women in ministerial positions, %	49	0.376	0.255	27.3	72.7	0.38
Years with female/male head of state (last 50)	73	0.000	0.190	0.0	50.0	0.00



Although indicators for the status of women and gender equality generally point to a state of disempowerment among women, the SRHR indicators are untenable. According to UNAIDS[7], women in Zimbabwe constitute nearly 61% of the total number of people living with HIV while, when compared to their male counterparts, new infections are more than double among young women aged 15-24 years.[8] Additionally, knowledge levels of STIs and HIV prevention are low among AGYW, probably, a cause of the high transmission and prevalence of the epidemic among this group. Studies indicate that only less than half (46.3%) of AGYW have comprehensive knowledge on HIV[9].

[7] https://www.unaids.org/en/regionscountries/countries/zimbabwe
[8] https://www.unaids.org/en/regionscountries/countries/zimbabwe
[9] The Zimbabwe Demographic Health Survey (2015)

Other SRHR indicators for this group are equally bad. Nationally, on average, a third of AGYW will marry before they turn 18[10], 22% of adolescents will fall pregnant as teenagers while only 47.5% of female adolescents 15-19 years report using some form of contraception in their last sexual encounters[11]. Sexual and Gender Based Violence also remains a huge problem affecting women and girls in Zimbabwe. According to the Spotlight Initiative [12]project documents, 1 in 3 women in Zimbabwe is affected by GBV, 35 percent of girls and women 15-49 years have experienced violence since the age of 15. Major factors sustaining such negative SRHR outcomes among young women include poverty, socio-cultural factors as well as the absence of gender-sensitive and youth friendly services[13]. The table below indicates the status of women with regards to SRHR and GBV at national level. Where possible, the statistics are provided at the provincial level for the four project districts.[14]

Table 1: Some Key Indicators for Women and AGYW's SRHR

Variable	Prevalence as a percentage								
	Mazowe District		Goromonzi		Seke		Umguza		Source
	F	M	F	M	F	M	F	M	
Adolescents aged 15-19 Years Ever been Pregnant (Teenage Pregnancy) (Provincial)	28.1	-	18.5	-	18.5	-	23.6	-	*National Fertility Study, 2016*
Percentage of Girls Not in School Due to Pregnancy (10-19 years) (National)	4.8	-	4.8	-	4.8	-	4.8	-	*ibid*
Percentage of Girls Not in School Due to Marriage (10-19 years) (National)	6.9	-	6.9	-	6.9	-	6.9	-	*ibid*

[10] Multiple Index Cluster Survey, 2019
[11] The National Fertility Study, 2016
[12] The Spotlight Initiative is an inter-agency initiative of UN organizations to pool efforts towards elimination of sexual and gender-based violence.
[13] The Girls' and Young Women's Empowerment Framework: Danida & the Ministry of Women Affairs, Gender and Community Development, 2014
[14] There is a challenge in accessing district level statistics in Zimbabwe hence many of the statistics are deducted from national level and, in some cases, at provincial level.

Marriage before age 18 prevalence (Provincial)	50		38		38		33		*Multiple Index Cluster Survey, 2019*
Percentage of people age 15-49 years who state that a husband/partner is justified in hitting or beating his wife for some reason (National)	37.4	23.7	37.4	23.7	37.4	23.7	37.4	23.7	*ibid*
Percentage of women (15-24 years) who have experienced violence since the age of 15 years (Provincial)	34.5		45.1		45.1		27.3		*Zimbabwe Demographic Health Survey (ZDHS), 2015*
Knowledge about HIV prevention among young people ages 15-24 years (%) (Provincial)	41.9	38.8	34.6	54.4	34.6	54.4	36.2	36.6	*ZDHS, 2015*

1.3 Key Study Questions

This study sought to answer the following questions:

1.3.1 Gender Equality in the Project Communities

2. What roles and responsibilities do women, men, girls and boys have pertaining to household, community, reproductive and other duties and how much time does each of them spend undertaking the same in Mazowe, Goromonzi, Seke and Umguza districts?
3. What resources (economic, financial, physical, natural and other assets) do women and men have access to and what is the impact of having or not having such control for women and men?

4. Who among men and women makes important decisions at the household and community levels and how do such decisions impact women, men, boys and girls differently?
5. What are the causes of gender inequality in terms of roles and responsibilities, access to and control of resources as well as participation in decision making?

1.3.2 Gender and SRHR

6. What hinders women, men, adolescent girls and young women and adolescent boys and young men from accessing health services, especially SRHR services?

1.3.3 Recommendations

7. What opportunities exist in the *Simba Utano* project to address the causes of gender inequality and the resultant disparities in the project districts?
8. How can the *Simba Utano* project promote equal access to SRHR services among women, men, adolescent girls and young women as well as adolescent boys and young men in the four project districts?

This report is structured and organized to answer these key questions of the study.

2. Methodology

2.1 Introduction

This report is based on a desktop and field research conducted in February 2020. The research was led by an independent consultant supported by the project implementation staff who were trained to become research assistants. Working with project staff who are familiar with the organizations, the communities and the project helped manage the sensitivities associated with some of the issues addressed in the study and project while at the same time helping build relations with the communities and other key stakeholders ahead of the project implementation.

2.2 Sampling

The research was carried out in two selected wards in each of the four project districts. The selection of the wards was done to balance the following key characteristics that are important to the project both within and across the districts:

- Within and across the districts, to diversify backgrounds of participants to include the urban, rural, farming and mining communities. Research has indicated that such backgrounds are a factor in the SRHR indicators of individuals.[15]
- Ensure, within each district, the representation of easily accessible and developed as well as the remotest and hard to reach communities.
- Considering the limited time for mobilization, in some cases, presence of structures for ease of mobilization within a short space of time was also a factor.

2.3 Theoretical Framework and Selection of Research Participants

The research used the ecological model for promoting access to SRHR services[16] as the basis upon which research participants were identified and selected. The model suggests that access to SRHR services among young people, including AGYW is determined by various individual and contextual factors within the surroundings of young people. As such, to understand these factors, there was a need to have the young people themselves, parents, community members and leaders as well as key institutions in health services

[15] ZDHS, 2015; MICS, 2014 etc
[16] Chandra-Mouli et al.

provision and policy makers taking part in the study. This is important because obstacles and opportunities for access to SRHR services may be found at each of these levels.

For young people, deliberate efforts were made to have at least 50% of participants being female as well as having a proportionate representation across the 15-24 years age range. In the FGDs with adults, there were deliberate efforts to include traditional and religious leaders since social and cultural beliefs and norms are known to shape access to health services, especially SRHR services.[17]

2.4 Data Collection

The methodology entailed both primary and secondary data collection:

- *Secondary data*: The consultant reviewed literature including *Simba Utano* project documents, national policies and strategies, UN Agencies country program reports, academic papers, statistical reports as well as reports and projects documents by other NGOs, among other literature.
- *Primary data*: Based on the literature review, the consultant in consultation with project partners developed tools for data collection in the field. Major tools included Focus Group Discussions (FGD) guides, interview guides, questionnaires as well secondary data extraction tools. FGDs were conducted separately in the communities with men, women, ABYM and AGYW while key informant interviews were done with service providers, government officials, representatives of other NGOs, policy makers and the Gender Commission. Staff of Katswe Sistahood and Youth Engage also provided important data on the organizational policies and capacity to implement gender-sensitive programmes.

Questions for the data collection tools were drawn and adapted from the Global Affairs Canada gender analysis tools. FGDs were conducted in Ndebele language in Umguza and in Shona in the three remaining districts.

A total of 32 FGDs were conducted as follows:

- 8 FGDs with AGYW (2 in each district in all the 4 districts)
- 8 FGDs with ABYW (2 in each district in all the 4 districts)

[17] Op. Cit., Danida & the Ministry of Women Affairs, Gender and Community Development, 2014

- 8 FGDs with women and community elders including community, traditional and religious leaders (2 in each district in all the 4 districts)
- 8 FGDs with men and community elders, including community, traditional and religious leaders (2 in each district in all the 4 districts)

2.5 Challenges and Limitations to the Study

The following challenges were faced during the study:

- Strict timelines for research as the study had to be conducted ahead of project implementation. In some cases, sampling of wards and participants was done conveniently to factor in time constraints.
- Most participants in the project were out-of-school youths. With both the FGDs and questionnaires done in the communities during the school term, many of the young people that could attend were out of school. However, attempting to conduct the study within schools was not possible considering the limited time and bureaucratic requirements of the education system in Zimbabwe, particularly when attempting to conduct research on issues of SRHR.
- Most of the AGYW participants in the study were married already. While this is an indicator of the early and child marriages challenges, it had an impact on some key findings of the study such as use of contraception which was found to be generally higher than what would have been expected among unmarried young women if other national studies are anything to go by.

3. Findings

3.1 Introduction

The gender analysis research confirmed what has been long known, while unravelling new insights, about factors hindering access to and utilization of SRHR, including HIV and SGBV, services among adolescents and young people from a gender perspective in the *Simba Utano* targeted districts of Mazowe, Goromonzi, Seke and Umguza. Such factors are complex and interlinked straddling the different facets of socio-cultural, economic, political and policy areas of the project communities and the country. In this chapter, the report highlights the major findings on gender dynamics and SRHR, particularly regarding access to services for AGYW. These findings are organised to reflect gender roles, responsibilities; access to and control over resources; decision making and influence; health and SRHR as well as institutional structures and frameworks for gender equality, especially with regards to the sexual and reproductive health and rights of adolescent girls, young women and women in general. The findings also revealed opportunities for enhancing gender equality in general and, specifically, in terms of improving access to SRHR and SGBV services through the project interventions.

3.2 Roles, Responsibilities and Time

The sharing of roles in the four districts almost invariably reflects the patriarchal nature of many communities in Zimbabwe[18]. At the household level, women, men, AGYW as well as ABYM share clearly defined yet complementary roles. Women and girls' time is largely consumed by household and reproductive activities while men dominate the economic and prestigious community leadership activities. Below, is an example drawn from an FGD done by ABYM in Goromonzi district. The only variations with other FGDs would be the nature of economic activities undertaken in the different districts with farming, vending and mining being the major activities for subsistence and income across the four districts.

[18] Chabaya O.. Rembe S. and Wadesango N.: The persistence of gender inequality in Zimbabwe: factors that impede the advancement of women into leadership positions in primary schools, 2009

Table 2: How Men, Women, AGYW and ABYM Share Roles Responsibilities and the Time Spent

Activities	Time in Hours	Women	Men	Girls	Boys
Household activities					
fetching water	2	✓		✓	
Cooking	4	✓		✓	
Cleaning the home	2	✓		✓	
Fetching firewood	2	✓	✓	✓	✓
Subsistence farming	3	✓		✓	✓
Doing laundry	2	✓		✓	
Economic activities					
Vending – selling small scale produce	5	✓		✓	✓
Farming	5	✓	✓	✓	✓
Large scale farm produce selling	5	✓	✓	✓	✓
Reproductive activities					
Taking care of children i.e. bath, lunchbox, sewing/mending uniforms	24	✓		✓	
Attending school meetings/ consultation days	1	✓			
Helping children with homework	1	✓		✓	
Other activities (including community activities)					
Fixing the roads	3		✓		✓
Community security	3				✓

Attending community meetings	2		✓		
Digging community boreholes/wells	3		✓		✓

Source: FGD with ABYM in Goromonzi District (Other FGDs showed a similar trend across the districts)

The findings indicate that, in a day, women work an average up to 16 hours[19] a day while men generally work only half that time. In farming communities, both males and females regardless of age, share economic responsibilities equally only for women and girls to get home and take care of the home and the whole family including their husbands and brothers. In addition to the usual household chores, women were said to be burdened by caring for sick relatives who needed home-based care. High prevalence of cancers, most of them related to SRHR and HIV, is increasing such responsibilities of caring for the sick.[20]

In mining communities and where formal employment exist (urban set-ups like Glendale and Concession in Mazowe), economic activities are dominated by men. In Umguza, however, women were observed to be highly involved in mining and vending – an exception created by the fact that most men and boys in the community migrate to South Africa in search of opportunities due to the proximity to the boarders. Most households in the community are therefore led by women who in the absence of men may end up taking what would have been seen as men's roles.

The study also indicated that the economic activities where most males are dominating are better paying. However, most women still have to shoulder the bulk of the responsibilities in the home i.e. school fees, clothing for the children, food, etc. '*Men usually spend their income on leisure activities, particularly alcohol and sex workers*,' suggested a participant in the FGD in Goromonzi. The study noted that the exclusion of women from economic activities is not helped by the national economic situation. Due to the harsh economic climate, economic opportunities were said to be limited. Most of the NGOs who come tend to address other issues and leave out the economic empowerment aspect with those

[19] Although the hours indicated in the table add up to 20 hours, not all tasks have to be undertaken within the same day. For example, laundry and fetching firewood are not daily activities.
[20] The global burden of women's cancers: an unmet grand challenge in global health: Lancet, 2017

organizations who support such work having stringent measures – for example, they would only want to support young people living with HIV.

3.2.1 Evolving Roles and Responsibilities Over Time?

The fact that men dominate economic activities is not to say that women and AGYW are not involved at all. In other districts, economic activities like vending and selling of horticultural products at the markets are largely done by women. This is a trend that developed in recent decades as the economy of the country deteriorated resulting in high unemployment. This has resulted in women becoming co-breadwinners, if not the ultimate breadwinners, in the families. One would have expected this change of time to alter gender roles. In an FGD with men in Arcturus, Goromonzi district, there was a debate on whether men should begin to share household responsibilities in response. The general sentiment among these men, however, indicated that household responsibilities were seen as a preserve for women. Communities like Umguza district where women are already significantly undertaking economic activities are a testimony that involvement of women in economic activities does not necessarily reduce their household responsibilities. Discussions on roles and responsibilities in Umguza district indicated that women who were earning income were still responsible for the typical women's tasks at home.

There are also seasonal differences in roles and responsibilities for farming communities. The only difference though is the reduction in hours women, girls, men and boys spend in economic activities. However, men and boys do not take over some of the household responsibilities when its off-season. Instead, they have more leisure time while the women allocate more time to the homes.

3.2.2 Leisure

The study also indicated that men and boys' responsibilities are not everyday activities and they are often at economic and community levels. This gives men and boys some time to rest. In all the four districts, the FGDs indicated that women and girls rarely have time to rest. Interestingly, in some FGDs[21] a discussion on how males and females in the community use their time and share responsibilities revealed that men and boys have leisure time of up to 6 hours a day to sit idly by or visit entertainment spots for drinking and leisure. As for women,

[21] FGD with ABYM in Glendale

going to church was the only time and space that would come close to leisure activities. In an FGD in Umguza district the trend of men having more leisure time was said to be a result of their responsibilities in generating incomes for the family, activities seen as laborious and more important. This, according to the study, implied that men deserved some leisure time even when they would have worked less hours per day compared to women. The following are some of the statements made by participants in the research pertaining to this issue:

> '*Of all the tasks, it is men who are overburdened because they do the most difficult and valuable tasks*' – participant in an adult women FGD, Muntu, Umguza District.

> '*It is the girls who have more time to rest because their tasks are less laborious even though they are time consuming*' – participant in an ABYM FGD, Goromonzi District.

These perspectives indicate that the gender inequality in the sharing of gender roles and responsibilities is accepted as normal by many in the project communities and changing such will require a change in attitudes as well. Women and girls' responsibilities (typically all non-income activities) are not considered as 'work' despite the amount of time spent undertaking such.[22]

3.3 Access to and Control Over Resources

Access to and ownership of resources as well as control of the same is critical in gender analysis to understand a society and, most importantly, to understand the health seeking behaviours of men and women, including AGYW as well as ABYM. The table below shows examples of resources owned by women and men as suggested in the FGDs conducted in the 4 districts:

Table 3: Resource Ownership between Men and Women

Resources Owned by Women	Resources Owned by Men
✓ Subsistence crop produce e.g. vegetables, tomatoes ✓ Household foodstuffs	✓ Land ✓ Houses ✓ Cash crops and farm produce e.g.

[22] ILO: Addressing gender gaps in Africa's labour market (https://www.ilo.org/africa/media-centre/pr/WCMS_458102/lang--en/index.htm)

✓ Small livestock e.g. chickens, goats, sheep, rabbits ✓ Kitchen wares ✓ Bedroom furniture	tobacco, cotton, maize grain, beans ✓ Cars ✓ Farming and other home equipment e.g. carts, hoes, spades, spanners, wheelbarrows etc. ✓ Livestock – cattle, sheep, goats ✓ Money/finances ✓ Household furniture except for the kitchen and bedroom furniture

The study indicated that men control most of the important resources and decide on how they are used. Men and society at large consider women as not being able to own fixed assets, for example, because they come from their parents' home to their marital home and, should they divorce, they will return to their parents. Therefore, as this study shows, women do not own land. These study findings confirm what has already been known through other studies about gender and control of resources.[23]

3.3.1 The Significance of Land

Despite having two distinct cultures in the four project districts – the *Ndebele* culture in Umguza and the *Shona* culture in the three remaining districts – beliefs and practices around ownership and control of resources favour men in all the communities. The land ownership structure in rural communities is passed, through patriarchy, from fathers to their sons. Women and daughters are expected to benefit through their husbands. All FGDs unanimously identified land as being owned and controlled by men. Land occupies a significant place in all these communities – it is a means of production and the ground upon which houses are built. It is not surprising, therefore, that women can neither own houses nor what grows on the same land. Concessions are made by all the cultures, however, for women to own subsistence crops because of their responsibilities to prepare food for families.

[23] Samuel Tarinda: Gender, Women's Economic Empowerment and Financial Inclusion, 2019/ Also see section on legal and policy instruments; discussion on inheritance laws

Even in communities where women are productively engaged in economic activities and leading households in the absence of men, ownership and control of critical resources such as land remains in the hands of men (see case story below).

Land is the most Critical Resource: The Case of Mazowe District

An officer in the Ministry of Women Affairs, Gender and Community Development from Mazowe District who accompanied the research team and participated in the men's FGD narrated a story that was reported to her office sometime. In the case, a woman whose husband was working in the city is said to have reported her husband for denying her proceeds from the sale of a tobacco crop she had planted, tended and harvested. Only after harvesting did the husband show up to sell the crop. The wife never got any money from her own labour.

When this story was narrated to the group to demonstrate the challenges that women face due to lack of control of productive resources, all men in the FGD found nothing amiss in this scenario. In justifying the actions of the man, the participants in the FGD argued that the man owned the land and, being the one who had bought the seed and implements used in the farming, the crop was his.

When pressed to explain why he did not share the money with the wife who invested time and labour, one of the participants said, '*I am the head of the house. I am the one who meets the expenses of the family anyway so why should I be questioned about this tobacco money. How about all the school fees I pay for the kids and the groceries I buy for the family? Does she know where I get that money from? I make money and use it the way I deem appropriate*.' All the male participants in the FGD agreed with this line of thought. However, most FGDs with women argued that women are the providers for all needs that need money in the families[24].

Since they do not own the important resources, women remain at the mercy of their husbands regardless of how hard they work. It appears, land is one of the most important resources for livelihoods in rural areas. Unfortunately, it is men who are privileged to own and control the same.'

[24] See section on Financial resources.

3.3.2 Society, Culture and Control of Resources

The report has already demonstrated the part played by culture in the control of resources by allowing men to inherit land. There is also another interesting socio-cultural dimension to property ownership. Men own big livestock like cattle while women own small livestock. Cattle are an important currency in bride price transactions that take place in both Shona and Ndebele cultures termed *roora* or *lobola* respectively. Part of the cattle owned by men, therefore, come from the bride price paid when their daughters are married off. Men are considered the 'owners' of their daughters or any of the children even though the role of raising children is squarely on the doorstep of women. So sacred is this cultural practice that even when the biological father of a bride is deceased, upon marriage, the cattle are given to his male relatives and not the mother. This is yet another example of how cultural norms and practices empower men and give them access to resources and control over the same.

3.3.3 Financial Resources Control and Societal Attitudes

Money is one of key resources identified in all districts and FGDs. In almost all of the FGDs in Mazowe, Goromonzi and Seke districts, money was said to be controlled by men except in one FGD[25] where suggestions were made to the contrary. This response is considered an outlier compared to other similar districts of Mazowe and Seke where economic activities are dominated by men. This may have been informed by the experiences of one of the participants or a few. Interestingly, this case was instructive. In such exceptions, women who owned resources that were typically classified as 'resources for men', particularly women who earn money, were considered a 'problem.' Participants suggested that when women control money, family stability is threatened. Such a scenario was even identified as a cause of gender-based violence (GBV).This view is revealing of the general sentiment in the project communities that women should not own important resources because that would make them want to 'rule over and control men.'[26] However, research indicates that economic empowerment of women is a potent strategy in addressing GBV. According to Sida (2015)[27], 'the empowerment of women through increased income opportunities … reduces the unequal power relationship between women and men and thus in a long-term perspective has a positive effect on GBV.'

[25] FGDs with men in Arcturus, Goromonzi district.
[26] FGD with men in Arcturus, Goromonzi district.
[27] Sida: Preventing and Responding to Gender-Based Violence: Expressions and Strategies, 2015

Men felt they were 'not men enough' if they were not working or earning. Notable by both observation and the feedback from study participants was the growing disorientation among men owing to the challenges they were facing in securing employment. With societal and men's attitudes associating being a man with having a job or income, some male participants confessed that 'their position is being taken by women who are earning.'[28] It is such feelings of inadequacy that resulted in men resorting to violence to try and reclaim 'their position of authority in the household.'

Notably, in Umguza, where women were found to be engaging in economic activities as they have head-of-the-house responsibilities, financial resources were prevalently but not universally classified as being under the control of women. The implication is that increasing women's participation in economic activities may increase their control to important resources but with possibilities of increasing their vulnerability to GBV at the hands of their intimate partners.

3.3.3.1 How Men and Women Use Money

Although men thought that they deserved respect for economic activities they engage in, women complained that households and families rarely benefit from the money earned by men. Many of the men were said to spend their money on extra-marital affairs, alcohol and other leisure activities while the money earned by women, even from the inferior activities they engage in and resources they had access to, was used to nourish families and pay school fees for the children.

> '*We are the mothers and the fathers as well. We are feeding our children, clothing them, paying school fees and doing everything for our children. The fathers cannot even buy a single pencil for school. One wonders where their money goes. If you ask, you are inviting trouble for yourself (physical violence).*' Participant in FGD with women, Goromonzi district.

3.3.4 Resources and Access to SRHR Services

The significance of women having less control over finances becomes magnified when one considers access to SRHR services. The cost of accessing services from local health facilities featured prominently as one of the prohibitive factors when it comes to accessing

[28] FGD with men in Goromonzi district.

the same. In Mazowe district[29], having access to and controlling financial resources also became important in beating stigma associated with accessing services. Men in the FGD indicated that being seen in health facility getting treatment for STIs was embarrassing. As a result, men preferred bribing health facility staff to see and provide with them with treatment outside the facility. Commenting on the friendliness of services in the local clinic, one participant in the men's FGD in Concession said:

> '*It is embarrassing to be seen in the hospital getting treatment for STIs. However, as men we have an advantage of having money. We just talk to the nurse and pay them (a bribe) to come and treat us in our homes or somewhere else, outside the facility*.'

Ultimately, the most important resource in all the communities is money or any other resource that can generate money. As the study shall indicate, money is not only a medium of exchange that allows individuals to access SRHR services, among other needs, it is also gives agency to those who have it. One such relationship that can be made between resources and agency is in leadership and decision making.

3.4 Decision-making and Influence

The enduring trend in all the communities is that the making of decisions at household level is shared between men and women albeit with men taking decisions on important matters or having the ultimate say on any decisions they have an interest in. Just as in the discussion above, men decide on all matters relating to important resources, including finances. While men decide on important issues as use of land, which assets to purchase or sell and budgeting, women are largely restricted to simple and inconsequential daily decisions such as what to cook or what the children should wear. At best, women may be made stewards of resources or may be consulted in household budgeting because of their 'discipline and shrewdness' but the final say is with the men. Even in Umguza district where women were said to be financial providers and controlling finances, the study did not show much variation in the decisions they were said to make. However, some participants felt that women with money do make important decisions:

[29] FGB with men in Concession

'Those women with money and resources tend to make important decisions such as to which schools the children should go.' - Participant in men's FGD, Goromonzi District.

In the scheme of things, it would appear, young women's opinions are the least valued in families as the study established that young men are sometimes consulted by their fathers on key family decisions as part of cultural apprenticeships that prepares them for the day they take over as 'heads of families'.

3.4.1 Decision Making and Women's Bodies

The reality of disempowerment of women is best demonstrated by the fact that women and girls do not even own their own bodies as men were said to be decision makers on matters relating to what should ideally be women's choices about their own bodies. The following are some of the decisions (by district) presented as taken by men regarding women's bodies and lives as well as other SRHR related decisions:

Mazowe District	Goromonzi District
Men: ✓ Decide when to marry off their daughters ✓ Initiate sex ✓ Decide or must endorse the type of contraceptive their wife should use	Men: ✓ Decide on the number of children their wife should have ✓ Determine the method of family planning to be used ✓ Decide on when to start or stop having kids ✓ Women are also forced to undergo (unsafe) abortions by men who would have impregnated them ✓ Force their daughters to marry older rich men or men from church ✓ Put pressure on women to pull their labia ✓ Decide when to have sex and the sex position
Seke District Men:	**Umguza District** Men:

✓ Decide on how much their daughters are worth in bride price ✓ Take decisions on how many children the family should have ✓ Determine they type of contraceptive to be used ✓ Decide on when their daughters should get married	✓ Run the lives of women and girls

The above decisions attributed to men about what should ideally be women's decisions or, at the very least, shared decisions between men and women indicate how pervasive male dominance is across all the project districts. Men control women's bodies judging by these views coming from the study. This control is often worse in cases where *lobola* has been paid. In Mazowe and Goromonzi, the older women felt that marriage (being the more formalised union whether *lobola* is fully paid for or not) made it more difficult for women to take charge of their lives and bodies', a view confirmed by other studies.[30]

To improve SRHR outcomes for women, there is need to work to include men and work on transforming gender norms in the communities. However, men's control of women's bodies is complex; it is sustained by the system of patriarchy in a way that it survives even in the absence of men. For example, paternal aunties who play the role of the father for girls in local cultures, were identified in one of Goromonzi's FGDs as actively policing the virginity of young women ensuring that it was preserved until marriage in order to make their families proud. This cultural dynamic may not easily show in a binary view of who takes decisions between men and women.

3.4.2 Leadership in the Community

Albeit on inconsequential matters, women were at least found to be making some decisions at the household level. When it comes to the community, the study rarely found decisions to

[30] Chiweshe, M. (2016): Wives at the Market Place: Commercialisation of Lobola and Commodification of Women's Bodies in Zimbabwe. See also: Ansell N (2001) ''Because it's our culture!' (Re)negotiating the meaning of lobola in Southern African secondary schools' Journal of Southern African Studies 27(4) 697-716

demonstrate any kind of influence that women may have on their societies. Traditional, political and religious institutions are dominated by men when it comes to leadership.

3.4.2.1 Traditional and Political Leadership

Socio-cultural beliefs and practices account for male dominance in traditional leadership positions. Just like land, traditional leadership positions are hereditary and often passed to the eldest male child (or household). If a Chief does not have any male children, the chieftaincy is often passed to a male relative. There are very few exceptions where traditional leaderships such as chieftainships have been passed to women. There are only 5 female (out of over 286) chiefs in the whole country.[31]

The study was revealing in terms of community attitudes towards women's political leadership. For example, 14 out of 32 FGDs identified voting and/or being voted into power as one of the important decisions that must be made by men and women at community level. Of those who identified this community responsibility, 78% exclusively identified it as a men's duty. The study findings are helpful in accounting for the low representation of women in political leadership positions. According to Gender Links[32], 14% of ward councillors are women while women constitute only 31% of all parliament and cabinet positions.

Interestingly, despite this, men in the study were generally of the view that women were occupying far more positions of leadership although they did not have statistics to back up their claims:

> '*With this 'thing' of women's rights, women have taken over everywhere. We do not have influence anywhere, its women all over now. I don't know if, as men, we have rights as well because we are being left out*.' – participant at a men's FGD in Concession, Mazowe District.

When pressed to give examples of women leaders in their community, however, the same participant could only mention one, the town manager. Regardless, his view was supported by many in the FGD. This sentiment may indicate that there is little support for women's rights, especially women leadership in the communities. This, again, calls for gender transformative programming approaches in such communities if project objectives are to be met.

[31] https://www.newsday.co.zw/2018/08/govts-urged-to-install-female-chiefs/
[32] Gender in the 2018 Zimbabwe Local Government Elections, 2018

However, although women are a far cry minority when it comes to occupying leadership positions in Zimbabwe, they constitute a majority of all registered voters (54%)[33]. Such a scenario raises questions as to why they are underrepresented in positions of influence.

3.5 Factors Limiting Women/Girls Participation in Decision Making

The lack of influence by women in the community is a product of many diverse factors among them economic, social, cultural as well as political factors, according to the study.

3.5.1 Economic Factors

The already explored idea that women lack access and control over economic resources was largely associated with their exclusion from decision making in the communities. While traditional leaderships are a hereditary privilege for men, political leaderships are, in theory, open to all. Campaigns for political leaderships require money which women neither have nor control. Even when such leadership is around local community development, ownership of resources plays a role in excluding women. The following examples were given to demonstrate this relationship between access to resources and leadership and how women are disadvantaged:

> *'For example, if there is a community bridge to be constructed, because women do not have the financial muscle, they are incapable of making any decision or taking leadership in the process of constructing.'* – a participant in the ABYM FGD, Seke District.

> *'Women do not own land or houses, so they cannot make decisions in the communities.'* – a participant in the men's FGD Umguza.

In all the communities, the denial of economic opportunities for girls and women is structural and systemic. It starts with limited opportunities for education for the girl child[34]. There is evidence[35] that points out to the fact that more girls drop out of school compared to boys for various reasons including financial constraints. Therefore, women are systematically denied the opportunity to lead earlier in life since being educated is regarded as capacity to lead in many instances. Men on the other hand can use their education to earn and use their

[33] Zimbabwe Electoral Support Network: Final Report of the 2018 Voters' Roll Audit
[34] View from FGDs e.g. Concession FGD with men
[35] British Council: Next Generation Report, 2020

earnings to access positions of leadership and influence. All the while, women and girls remain trapped in the cycle of poverty and exclusion from education as well as positions of leadership.

3.5.2 Social Attitudes and the Perceived Place of Women in the Community

Community attitudes are a huge factor in the women community leadership apathy. The study was helpful in unpacking such attitudes. The study perceptions pointed out to the fact that women have their own places where they were expected to be and not in leadership positions. There were suggestions, for example, that women should be 'vocal at church'[36], a sentiment that was used to indicate what is thought to be the place of women in society and justify why they would not take up political leadership. Interestingly, even in the churches, study participants indicated that leadership positions were in the hands of men with women expected to take up subordinate roles:

> '*Women have their own places to lead, they are very active in committees in faith institutions.*' – Men's FGD, Arcturus Mine, Goromonzi District.

Some of the church doctrines were even said to actively prohibit women leadership both in the church and community. In such churches, the study participants suggested, male leaders and fathers were found to be making decisions pertaining the SRHR of women, especially AGYW. In Mazowe, Goromonzi and Seke, there were narratives of church leaders in the 'apostolic sect' purporting to be under spiritual guidance to allocate husbands (often older men) to young girls and women. In some instances, women are denied access to health facility services because of their church leaderships and doctrines. (*See section on factors limiting access to services*)

In Umguza, there were also suggestions that the role of women was to form and lead women's community groups. This sentiment again buttresses the widely held position that women have their place in society and, in this case, to lead in exclusively women spaces.

[36] Men's FGDs at Chinyika (Goromonzi District) and Glendale (Mazowe District)

Statements Revealing Community Attitudes towards Women and Decision-making in the Community

'Women should just support decisions taken by men' Men's FGD, Goromonzi District

'We do not have decision making power at community level,' Women's FGD, Seke District

Women should not be involved in politics because it will make them look loose and uncultured. – Seke District, ABYM participant.

Among other reasons brought forward as limiting the influence or women and girls at community level are:

- Women are preoccupied with household tasks and shoulder the burden of taking care of families leaving them with limited time to participate in community activities – *Seke District*
- Women are perceived as weak leaders – *Goromonzi District*
- Socio-cultural attitudes that view women as perpetual minors, who in their parents' homes have to defer to their parents and when married are expected to answer to their husbands – *All districts.*

In a study titled, 'Factors influencing women political participation: The case of the SADC region', Mlambo C. and Kapingura F. (2019), noted patriarchy as well as social attitudes and norms that make it difficult for women to leave the home as among the critical factors limiting the participation of women in decision making. Several other studies confirm the findings of this study.[37]

3.6 Gender Equality and SRHR

3.6.1 Differentiated Needs for Women and Men

Both men and women suggested that they had a wide range of health needs covering a broad spectrum of services including information as well as prevention, testing and treatment services for various conditions, especially STIs and HIV/AIDS. There were no notable differences across all the districts in this regard. As the list below shows, women have far more health needs than men with men's needs only restricted to a limited range of SRHR

[37] Maphosa M., Tshuma N. & Ncube G. (2015): Participation of Women in Zimbabwean Politics and the Mirage of Gender Equity. *See also* Matswetu V., Kagaba M & Chikuvadze P. (2013): Zimbabwean women's participation and representation in politics: Lessons from Rwanda

aspects including condoms, STIs and HIV prevention as well as treatment. On the other hand, women's needs were diverse to reflect the various challenges that afflict their health. Notable needs for women, that men did not mention, included menstrual hygiene as well as maternal health needs. The women's list reflected their roles in taking care of children as well as caring for the family at large. While men never showed interest in the health of their partners or children, women on the other hand mentioned child health needs and the desire to have their partners join them in accessing health services, for example HIV testing.

The exercise also confirmed the poor health seeking behaviour of men. While women suggested that their needs included scans, x-rays and accessing medication for general health issues, men did not. Very few men see a reason to go to the clinic with ailments like headaches, for example. '*Men have negative health seeking behaviour*,' remarked one participant in the men's FGD in Muntu, Umguza District. Interesting as well is the observation by women that they had more health needs because, among other reasons, they '*cannot negotiate for safer sex hence vulnerable to infections*.'

The dynamics reflected in the list of different health needs of men and women, below, are worth considering in the project and some recommendations are proffered in the next chapter of this report.

List: The Key Health (including SRH) Needs for Men and Women

Health Needs of Women

- ✓ Knowledge on how to use the contraceptives
- ✓ Cancer screening, knowledge and treatment
- ✓ STI testing and screening
- ✓ HIV testing especially help on convincing their partners to get tested too
- ✓ Neonatal and postnatal maternal needs, including child health services
- ✓ Access to free sanitary wear
- ✓ Contraceptives: both short and long term as well as removal of long-term implants.
- ✓ All forms of medication
- ✓ Scans
- ✓ X-rays
- ✓ Education on Family planning methods to women they tend to be ignorant.

Health Needs of Men

- ✓ More information on SRHR
- ✓ Access to workshops that teach men on SGBV
- ✓ Contraception (especially condoms) and HIV knowledge
- ✓ STI testing, screening and treatment
- ✓ HIV testing and counselling

3.7 Factors Affecting access to Health Services, including SRHR

Across the 4 districts, women, men, AGYW and ABYM revealed that health services, particularly SRHR services, are not accessible for one reason or the other. Some of the reasons why access to services is limited are the same for men, women, AGYW and ABYM while other factors were unique to a specific group.

Table 4: Factors Limiting Access to SRHR Services for Men, Women, AGYW and ABYM

The following were the factors identified as limiting access to SRHR services by women, men, AGYW and ABYM according to the FGDs:

For Men	For Women
✓ The clinic closed and is no longer operational. (*Arcturus mine, one of the communities in Goromonzi has no clinic*) ✓ There is no public transport to get to the clinic. ✓ No ambulance for emergency situations. ✓ Service providers are not male friendly.	✓ Expensive user fees leading to more women not affording the cost of SRHR services ✓ Need for men's consent to access long term contraception ✓ Shortage of birth control pills. ✓ Lack of knowledge about SRHR ✓ Distance to the clinic is long ✓ Some religious beliefs do not permit women to access ante-natal care services e.g. some 'apostolic sects' are against visiting health facilities ✓ Shortage of health staff ✓ Village health workers are available in the communities, but they are not easy to reach, and they do not respect confidentiality ✓ Reliance on traditional medicine and religious beliefs for treatment ✓ Shortage of medications in clinics and hospitals ✓ Men not allowing women to have HIV testing
For Adolescent Boys and Young Men	**For Adolescent Girls and Young Women**
✓ Lack of privacy at health centres. ABYM are embarrassed to seek STIs treatment services for fear of being outed ✓ Lack of knowledge of the available SRH and SGBV services ✓ Lack of youth friendly services - services are not pro-young men and boys	✓ Unfriendly youth services ✓ Lack of confidence to approach service providers ✓ Services not available in the clinics ✓ Distance – the clinic is very far ✓ Stereotyping of unmarried girls who access services that indicate sexual activity ✓ Mistreatment by nurses during pregnancy and childbirth. '*Nurses beat us during delivery and say we are promiscuous for having sex at an early age*'[38] ✓ Expensive fees for treatment – cannot pay for prescribed medicines ✓ Need for men's (parents/partners) consent to access long term contraception. Sometimes they don't get

[38] FGD with AGYW in Goromonzi

✓ Long distances to travel for one to reach the nearest health service ✓ Fear of being judged at health centres ✓ Lack of disposable income to buy the flavoured condoms that the girls like	approval from boyfriends to access the services ✓ Shortage of birth control pills. ✓ Service providers do not respect confidentiality when one seeks treatment for HIV or STIs ✓ Health workers take too long to attend to patients ✓ Do not want to access HIV testing services from close by health facilities due to fear of being exposed ✓ Lack of knowledge about SRHR, services and where to get such ✓ Lack of support from parents and guardians ✓ The village health workers are not easy to reach, and they do not respect confidentiality ✓ Fear to be judged e.g. getting such services as condoms may present a girl as morally loose ✓ It is considered a cultural taboo for young unmarried girls to engage in sexual activities hence they can't be seen by their parents accessing SRHR services

Despite having more health needs, women and AGYW identified more obstacles when it comes to accessing services compared to their male counterparts. This trend represents both the gendered nature of accessing services which makes it hard for women and girls. Some of the women's challenges, although similar to those of men and ABYM, do not feature on the men's list suggesting that men just don't bother or have better coping mechanisms. The challenges that AGYW and young people in general face are systemic – they include individual, relationship and community as well as institutional challenges. At the same time, these challenges also cut through a wide range of economic, socio-cultural and physiological factors among others. Similar studies confirm the same challenges for AGYW and women who need SRHR services.[39]

[39] Girls; and Young Women's Empowerment Framework: Danida and the Ministry of Women Affairs, Gender and Community Development, 2014

3.7.1 The Ecological Model for accessing SRHR Services

As the *State of World Population* (UNFPA, 2013) report noted, “pressures from many directions” - friends, families, and communities - conspire to place obstacles between young people, especially AGYW, and the services they need to realize their SRHR. Young people live within communities and gatekeepers such as parents, teachers, health staff, religious and traditional leaders and others regulate their access to information and services.[40]

Joar Svanemyr et al.[41] developed a conceptual framework and helped point out key elements and target groups for creating an enabling environment for Adolescent Sexual and Reproductive Health and Rights (ASRHR). As Svanemyr et al. explain “the ASRHR are strongly influenced by a range of social, cultural, political, and economic factors and inequalities. These factors increase adolescents’ vulnerability to SRHR risks and also pose barriers to their access to SRHR information and services. This model is instructive as to the challenges that AGYW face in accessing services and what needs to be done to increase such access.

Figure 1: Ecological model for an enabling environment for accessing adolescent sexual and reproductive health services.[42]

[40].WHO, 2009
[41]Joar Svanemyr et. al., 2015
[42] Chandra-Mouli et al. adapted

3.7.1.1 Societal/Institutional Level Factors

This level represents the policies that must be in place to promote access to youth-friendly and gender-sensitive access by AGYW as well as ABYM. At the community level where this study took place, and where the project shall be implemented, this level is concerned about the friendliness of institutions that provide health services. Many of the obstacles cited in the lists above point to the unfriendliness of services hence a need to work at this level.

3.7.1.2 Health Facilities and SRHR Services

Communities in Mazowe, Goromonzi, Seke and Umguza district rely on public health facilities (clinics) to access SRHR services they need (*see the list of health needs*). In a survey conducted as part of this study 100% of young women and 75% of young men among the participants across the districts had visited the clinic in the past 12 months. This indicates that more young women than young men use clinic services, a trend that was confirmed through FGDs where men we said to have poor health seeking behaviour. Of those that visit the clinic, the bulk of the men (84% across the districts) sought HIV related services only. Although they put it as HIV counselling and testing, chances are they are being forced to visit the clinic to collect ARVs.[43] Otherwise, they would have not visited the clinic.

On the other hand, in all the districts, only a third of women visited clinics for HIV-related services, the remainder (67%) sought ante-natal and post-natal care, contraceptives as well as screening for STIs. This trend indicates that AGYW (most of them already married) rely on the clinics to access SRHR related services, including contraceptives. None of the young men reported ever visiting the clinic to access contraceptives yet, on average 25% of the AGYW visited the clinic because they needed contraceptive-related services. All female questionnaire respondents who claimed to know where to access services mentioned the clinic as a place where they can access such. ABYM, on the other hand, indicated that they have other sources for contraceptives (mostly condoms) among such sources were friends, bars and various entertainment spots that males frequent. Women in most of these communities cannot frequent such entertainment spots and some of the contraceptives that

[43] FGDs have already indicated that men generally do not want to be tested casting doubts on the fact that so many of them would visit clinics to get tested.

that they need can only be found and administered in the clinics hence the reliance on clinics for these services.

What is worrying, therefore, is the fact that AGYW identify clinic services as inaccessible due to various factors such as distance, cost, convenience, privacy and confidentiality as well as attitudes of service providers, among others[44]. There is a need to make clinic services accessible to AGYW if access to SRHR services is to increase. This is important considering the findings indicating that women need to get permission to use contraceptives. The clinic is a safe space to exercise their choices independently since husbands and parents would assume AGYW are visiting the clinics for the various services (other than contraceptives) that are offered there yet once they are at the clinic, they can access contraceptives without fear of being judged or questioned by their parents or communities.

One of the assumptions of this study was that AGYW found other services easy to access as compared to others. The survey revealed that once they reach the clinic, young people were generally comfortable to access all services that are offered in the clinic although AGYW in Goromonzi were less likely to access legal abortion, post-abortion care as well as services for SGBV services. However, they would feel comfortable to equally access all contraceptives on offer with an exception for condoms (see section on contraception). Suffice to say, making the clinic accessible (friendly and gender sensitive to the needs of AGYW) would increase uptake of the different forms of contraceptives[45].

3.7.1.3 Relationship and Community Level Factors

AGYW and women cited requiring permission from their partners and parents as an important obstacle for them in accessing SRHR services. In addition, they suggested they are likely to be judged as immoral by their communities for accessing certain services, especially contraceptives for unmarried girls. The following factors suggested by AGYW, for example, betray a lack of supportive relationships and the prevailing prohibitive social and cultural attitudes towards AGYW and women's access to SRHR services:

- ✓ Stereotyping of unmarried girls who access a certain type of service
- ✓ Lack of support from parents and guardians

[44] Refer to the table on factors limiting access to services
[45] According to the responses given in the questionnaires in all the districts

- ✓ Fear to be judged e.g. getting such services as condoms may present a girl as morally loose
- ✓ It is considered a cultural taboo for young unmarried girls to engage in sexual activities hence they can't be seen accessing SRHR services by their parents

These factors were mentioned by women and AGYW in all the four districts without exception. It is due to socio-cultural factors as well that abortion related services were not acceptable. Many of the respondents cited fear of religious backlash, for example, as the reason why they wouldn't be seen accessing such services. However, in practice abortion was said to be widespread and carried out by known old women in the community.[46] Such abortion is very likely to be unsafe and a hazard to the health of AGYW.

Studies have also shown that society places restrictions on the physical mobility of AGYW thereby limiting their opportunities to access services.[47] Various components of the study, including an inquiry into the roles, responsibilities and time use as well as societal attitudes indicated that in all the communities, AGYW did not have similar mobility freedoms as compared to their male counterparts, probably the reason they can only access services in the clinic because it's the only place they may get permission to visit besides the church and a few other places.

These insights of the role played by parents, partners and the community are therefore helpful in understanding, in part, why AGYW have limited access to SRHR services in comparison to their male counterparts.

3.7.1.4 Individual Level Factors

There were also some individual factors at the level of AGYW that prohibit access to services. A key factor in this regard is the economic status of AGYW. Already, the study has confirmed what is known about the economic vulnerability of women, especially AGYW by virtue of having less access to and control of resources. For example, the issue of cost as a prohibitive factor to accessing services was mentioned in at least 82% of all FGDs with women and AGYW as compared to only 38% of FGDs with men and ABYM. Even when

[46] In all the four districts, especially in men's FGDs illegal and unsafe abortion was said to be rampant. See also the legal and policy instruments section in this chapter.

[47] According the World Health Organization - https://www.who.int/life-course/news/women-and-girls-health-across-life-course-top-facts/en/

men experience the same prohibitive costs, their control of resources gives them coping mechanisms when it comes to accessing services (see section on *Access to and Control over Resources* in this report).

Self-efficacy also featured prominently as a factor for AGYW and not among their male counterparts. Societal pressure and expectations on the sexuality of AGYW takes away their confidence to access services as they are likely to be gender-discriminated[48] by both the community and the service providers. As a result, the girls in this study suggested that they 'lack confidence' to access and utilise services.[49] Plan international seems to agree when they suggest that, 'Due to their age, young people's (especially girls') ability to make decisions or express an opinion may (with regards to SRHR) not be respected[50].'

3.8 Use of Contraceptives

Promoting contraceptive uptake and use is a major intervention to address various SRHR challenges that AGYW and ABYM face such as unplanned early pregnancy, STIs and HIV. Just like the other SRHR indicators, use of contraception in the country and project districts reflects gender dynamics in the disfavour of AGYW. National studies[51] indicate that use of contraceptives is low among AGYW, a trend accounted for by several factors. The table 5, below, indicates the national situation with regards to use of contraceptives and gives an overview of which contraceptives are widely used.

[48] According the World Health Organization - https://www.who.int/life-course/news/women-and-girls-health-across-life-course-top-facts/en/
[49] Unguza FGD with AGYW
[50] https://plan-international.org/sexual-heath/access-srhr-services
[51] National Fertility Study, 2016

Table 5: Use of contraceptives among females ages 15-19 years by method of contraceptive

Current Sexual Activity	Age Group				Total 15-19	
	15-17		18-19			
	Number	%	Number	%	Number	%
Use of contraceptives in the last sexual encounter						
Used contraceptives	18,803	36.4	61,669	52.3	80,472	47.5
Did not use contraceptives	32,843	63.6	562,17	47.7	89,060	52.5
Total	**51,647**	**100.0**	**117,885**	**100.0**	**16,953**	**100.0**
Method of contraception used in the last sexual encounter						
Male condom	10,406	55.3	23,536	38.2	33,942	42.2
Pill	6,735	35.8	24,632	39.9	31,368	39.0
Injectable	773	4.1	5,710	9.3	6,483	8.1
Implant	387	2.1	4,345	7.0	4,732	5.9
Female condom	128	0.7	1,415	2.3	1,544	1.9
Withdrawal	0	0.0	622	1.0	622	0.8
Other	374	2.0	1,408	2.3	1,782	2.2
Total	**18,803**	**100.0**	**61,669**	**100.0**	**80,472**	**100.0**

Source: National Fertility Study, 2016

Average usage of contraceptives in this study (72%) was much higher than the national average of 47.5% from the National Fertility Study (2016). This disparity may be explained by the fact that only less that 10 percent of the questionnaire respondents who provided study data on usage of contraceptives were under the age of 19 while the majority of participants in this study were already married and likely to use contraceptives. Similar researches have indicated that age and marital status were factors in the usage of contraceptives with married people and older young people likely to use contraceptives compared to their younger sexually active unmarried counterparts[52]. The National Fertility Study is based on the age group 15-19 years who are likely to be unmarried. Further research in schools is needed to understand the trends among younger and unmarried girls. Among AGYW, long-term acting contraceptives, particularly injectables were more popular with 40% in Mazowe and 100 % of all respondents who reported using contraceptives using this method. This high use of long acting reversible contraceptives could be accounted for by the fact that most of the respondents were married and/or teen mothers already.

The study indicated that knowledge of emergency contraception is generally low among communities across all the districts, a trend that is worrying given the high levels of sexual violence and rape. Even where the communities had knowledge, availability of such emergency contraceptives was limited.

[52] ZDHS, 2015

3.8.1 Condom Use

Condoms (male) were found to be less used by females with only 17 percent of those who reported using contraceptives using this method whereas all the men (100%) who reported using a contraceptive used a male condom. This finding indicates that condom uptake among AGYW remains low. The popular sentiment (a trend in almost all of the FGDs with AGYW and ABYM) indicated that AGYW who use condoms are considered loose. A female participant in an FGD in Goromonzi said,

> *'To access as condom and use it as a woman, you need permission from your husband. Using a condom would give an impression that you are being unfaithful.'*

To demonstrate further the negative social attitudes, another participant suggested that unmarried girls who are on contraception such as depo-povera, the loop and the pill are viewed as 'loose' and 'prostitutes' while they would consider it taboo for a girl to be seen with a condom (male/female condom).

> *'A girl with condoms would be seen as a sex addict. "Hakuna huku inofamba ne Royco mubapiro" (There is no chicken that walks around with spices under its wing)' – Goromonzi FGD with ABYM.*

As a result of the fear of being labelled, girls shy away from accessing and using contraceptives, especially condoms. Discussions even suggested that being seen with condoms may cause mistrust in relationship, sometimes with consequences such as intimate partner violence. This was made worse by the fact that placement of condoms was not strategic so as to offer privacy to young people, especially AGYW who need them. A nurse at one of the health facilities in Goromonzi confirmed that they do not have a Youth Friendly Centre. As a result, condoms are placed in the open where they are mostly accessed by young men. "Young women's bodies and sexual activities are policed by society whereas the idea of boys experimenting with sex is more acceptable and celebrated. They say; '*bhuru rinoonekwa nemavanga*' (a strong bull will be seen by wounds from the fights),"she said during a key informant interview.

However, the general conclusion is that contraception and condom use in particular could increase among both AGYW and ABYM, especially if knowledge, attitudes and placement

improve. The following are some of the responses given by questionnaire respondents pertaining to why they did not use contraceptives in their last sexual encounters:

ABYM

- *I did not use a contraceptive because I was having sexual intercourse with my wife (Mazowe)*
- *She is someone I trust… (Mazowe)*
- *I am sexually active, have in information on contraceptives but cannot access them (Goromonzi)*
- *I was under pressure, so I did it anyway (Goromonzi)*

AGYW

- *We went for tests and he is someone well known in my family (Mazowe)*
- *I didn't use a condom because they are for unfaithful people. My partner would think that I am faithful. (Goromonzi and Umguza)*
- *I do not have access to contraceptives (Seke)*

These views are an indicator that there are myths and misconceptions in the project communities regarding the use of contraceptives.

3.9 Access to SRHR Information

Lack of knowledge, including especially lack of access to comprehensive sexuality education is acknowledged as one of the key barriers to accessing services globally and in Zimbabwe.[53] The study sought to understand the sources of information for young people and the results indicated that community awareness raising efforts of non-governmental organizations was the leading source of information accounting for 65% of the total young people who took the questionnaire and 75% of all male respondents. Interestingly, the views shared in the FGDs had suggested that NGOs favour AGYW when it comes to information dissemination.[54]

[53] Lost Without Knowledge: Barriers to Sexual and Reproductive Health Information in Zimbabwe, a Research by Amnesty International in Zimbabwe

[54] FGD with ABYM

'Women have more access to SRHR information. They are favoured by NGO meetings/workshops where they get information on SRH. Ndofunga ndokusaka mabhebhi acho akangwarisa, anozoziya zvatisingaziye even kuti condom rechirume ropfekwa sei' (I think that is why these girls are too forward, they know more than us even when it comes to how to put on a male condom!)' – FGD with ABYM in Goromonzi.

The perception that women and girls are favoured is a perception that is common, possibly due to the growing programming targeting women and girls based on the acknowledgement of their vulnerability and the fact that they have been left out for long. However, the claim that AGYW have more information is at variance with national studies demonstrating that ABYM have slightly better knowledge levels on SRHR issues compared to AGYW. The Zimbabwe Demographic Health Survey (2015) indicated that 46% of young women had comprehensive knowledge on HIV as compared to 47% of young men.

Overall, there is no outstandingly popular source of information among AGYW. However, 88% of ABYM identify friends as a source of SRHR information. Families, especially parents followed by relatives and siblings are the least popular source of information among young people. Although the number of young people who get information from parents is the lowest, it appears many young people, including especially girls, are talking to their parents about issues pertaining to sex and sexuality. It turned out from the FGDs that such talk with parents doesn't offer comprehensive knowledge but is rather warnings on the dangers of premarital sex. In imparting this information, parents were said to be liberating towards the sexuality of boys compared to girls. Considering parents are sharing information with their children to some extent, it is important to help develop their capacity to provide correct and comprehensive information that is empowering to young people.

Table 6: Sources of Information for AGYW and ABYM

Source	Total % by Sex		Total %
	F	M	
Parents/ Guardians	42	38	40
Relatives	33	63	45

Sibling	42	50	45
Friends/Peers	42	88	60
Teachers (School Curricular)	50	50	50
Traditional Media (Radio/Television/Newspaper)	42	63	50
Internet and New Media (including Facebook, Whatsapp, Instagram, YouTube etc.)	42	63	50
Workshops and Meetings by NGOs	58	75	65

3.10 Culture, SRHR and SGBV

There is a link between culture SRHR and SGBV. This study helped deepen an understanding of how culture is a factor in the access and utilization of SRHR services. Much of the findings pointed out to cultural beliefs that limit access to services such as contraception among women and AGYW as well as young people in general. The study was helpful in exploring the different cultural practices and how these relate to SRHR as well as SGBV. Some of the common practices mentioned and discussed as having an impact on SRHR and SGBV include the pulling of labia by girls, *lobola/roora*, *chiramu (*a practice of playing house between in-laws*)*, virginity testing and more prevalently, child marriages.

3.10.1 Child Marriages

Child marriages is a national problem. Mashonaland Central, the province to which one of the project districts (Mazowe)[55] belongs has the highest child marriage prevalence rate in the country at 48.9%.[56] Mashonaland province (Goromonzi and Seke districts are in this province) has the national third highest prevalence of 37.5 while Umguza in Matabeleland North is at 32.9, according to the Multiple Cluster Index Survey of 2014. Unsurprisingly, all the FGDs in this study identified child marriages as a big cultural problem relating to SRHR and SGBV. This view is shared by other studies. Kurebwa J. and Kurebwa N., in their study in Shamva, the district adjacent to Mazowe, suggested that child marriage was linked to the value placed on a girl when she is a virgin in many local cultures. Marrying off a girl while

[55] Mazowe district itself has a child marriage prevalence 33.7 % - the Dreams Research
[56] MCIS, 2014

she is young is a way, therefore, of guaranteeing that she is a virgin, suggests the Shamva study. This further tallies with the findings of this study in Umguza where virginity testing as a cultural practice was reported as rife. It may confirm that the two practices have the same basis at culture.

However, many other factors were linked to early and child marriages in this study. Among other key factors were poverty and religious beliefs. The following are some of the statements that were recorded in the FGDs across the districts to account for the imposing problem of child marriages:

- '*In the apostolic sect churches, young girls are forced to marry older men from church*' – FGD with women in Seke District.
- '*It is poverty that leads parents to pledging of child brides as the parents will be in need money'* – Concession FGD with ABYM
- *'There is a challenge of early marriages in this community. Young girls marry as early as 15 years. The reasons are mostly economic as poverty is a common in this community. Hope Fountain community has a mine so most of the times young girls fall prey to the resources that miners have*.' – FGD with young women in Umguza District.

Child marriages is a gendered problem affecting more girls than boys. While on average 32.8 % of women get married before turning 18 years only 3.7% of boys get married as children in Zimbabwe[57]. The problem of child marriages for girls has a complex alliance with its attendant ills of early/teen pregnancy, school dropouts, increased vulnerability to STIs and HIV as well as SGBV. These challenges have a symbiotic relationship and feed on each other to disempower AGYW. A participant in the men's FGD noted the relationship between child marriages and some of these challenges as follows:

> '*Child marriages and marital rape are common, and this affects young women and girls as they will be susceptible to diseases like HIV. It also propagates SGBV to an extent where it becomes normalised.'* - Umguza district FGD with Men.

Another participant in the same FGD added,

[57] MCIS

'Child marriages fuel SGBV and HIV since in most cases young girls do not have the negotiating power for safe sex considering the age difference.'

These views confirm what is already established through research that poverty is a driver of child marriages. UNICEF (2011), cited in Kurebwa J.& N., concluded that 'a poor girl is often the most vulnerable and exposed (to child marriages).' Child marriages perpetuate the cycle of poverty and keeps girls trapped in vulnerability. While girls get married early because they would have dropped out of school, getting married early also denies girls an opportunity to stay in school. Staying in school is known to improve SRH and future economic outcomes for AGYW.[58]

The study also indicated that early and child marriages were widely accepted in the communities. In a survey conducted among ABYM in Goromonzi to get their views on the ideal age of marriage, 63% suggested an age under 16 years with some even suggesting that girls as young as13 years are can get married.

3.10.2 Early and Teenage Pregnancy

According to the National Fertility Study, 'adolescent pregnancy is on the rise despite Zimbabwe having one of the highest contraceptive prevalence rates in sub-Saharan Africa.' This view was supported by an observation of key informants[59] who noted that successive demographic health surveys carried out in Zimbabwe have been consistent that teenage pregnancy is not going down in Zimbabwe. FGDs indicated that, owing to the social stigma that comes to families whose girls fall pregnant outside marriage, these girls are married off to their impregnators.

'When a girl falls pregnant, they drop out of school and are usually married off to the person responsible for the pregnancy.' – Umguza FGD with AGYW

In Goromonzi, in one of the FGDs with men it was encouraging to note that they realised that if the girl is impregnated by an adult person and such a girl is below the age of consent to sex, they should report the case to the police. However, practice is different as one of the

[58] World Health Organization (2017): The importance of sexual and reproductive health and rights to prevent HIV in adolescent girls and young women in eastern and southern Africa

[59] Interview with the Zimbabwe National Family Planning Council

participants was quick to suggest that '*in most cases we try to handle the case on our own as the men may end up being a son-in-law so maintaining good relations is important*.'

Pregnancy among teens does not only lead to marriage as the participants in the FGDs revealed. One other notable consequence was cited as dropping out of school. The girls drop out of school to carry out motherhood roles[60] and to look after their new husband[61] while the boy proceeds with school. All districts suggested that there were no serious effects on boys with an exception of one FGD in Mazowe district where a participant narrated a story of a classmate who had to transfer because he felt judged. The government has a re-entry police for girls who fall pregnant to be readmitted into school. However, this becomes impossible when the girls get married as most of them do.

Having children also impacts on their participation in economic and other social activities. Across the districts, girls who fall pregnant were also said to face the following challenges:

- They end up resorting to transactional sex out of desperation, as they try to fend for themselves and their children. (besides, once a girl falls pregnant, they are regarded as adults (emancipated minors) – FGD with AGYW, Mazowe district.
- They are no longer expected to date their own peers because, apparently, being a mother makes these girls adults at once. Such girls resort to having sexual relations with older men who can meet their financial needs (termed '*blessers*'). Neglect and sexual exploitation among young women who are out of school is generally rife across the country.

3.10.3 Pulling of Labia

Except for Umguza, which only reported the practice of virginity testing, pulling of labia was reported as rife in the three other districts. Although this started as a cultural practice, it is widely practiced now more under peer influence and social pressure. In Glendale, the women suggested that although it is not forced, they practice due to peer pressure as well as to please man and stay in marriages. Even boys were said to like girls with elongated labia and would boast to their friends about the sizes of their girlfriends' labia.[62] However, to say it is done because of peer pressure is not to say that there are no consequences for

[60] FGD with men in Umguza
[61] FGD with AGYW in Goromonzi
[62] Seke FGD with young men

women who do not pull their labia. SGBV and infidelity in marriage were some of the likely consequences of not pulling one's labia according to the study.

> '*The women who do not pull their labia are beaten by their husbands and the husbands will start cheating on them*.' – Mazowe District, FGD with women.

This expose indicates that besides the bodily harm that may come with this practice that falls in the category of female genital mutilation and as well as the objectification of women in the eyes of society and men, this practice exposes women to physical and emotional abuse at the hands of their partners. The infidelity that may arise, on the other hand, has potential to result in the spread of STIs, including HIV. Closely, linked to this practice was the use of herbs to tighten the vagina which was identified by women in Seke district. This practice has potential of causing cancers of the cervix by introducing foreign substances into the vagina.

3.10.4 Lobola/Roora and the Commodification of Girls and Women

The debate on the payment of the bride price as part of the Zimbabwean culture has been under spotlight for as long as the women's rights movement has been gathering momentum. Although it may have been a harmless cultural practice, payment of *lobola*/*roora* is seen by men as a licence to 'own' and oppress a woman.[63] Such attitudes were associated with gender-based violence in all the districts.

There were other practices like polygamy and its modern variations of '*small houses'* and '*Ben 10s'* where men have unofficial second marriages and older resourced women date younger men respectively. The obvious link with SRHR would be in the potential spread of STIs and HIV as is known among multiple concurrent sexual partnerships.

3.10.5 Taboos and SRHR

The communities shied away from discussing issues they considered taboos in their cultures and religion. Among these issues were sexual minorities, sex work and abortion. Despite the legal restrictions limiting access to SRHR services for these groups, evidence indicates that such key populations are at most risk to HIV. The National AIDS Council, a parastatal body coordinating the multi-sectoral response to HIV in Zimbabwe has developed a national strategy targeting such key populations but criminalization and societal norms and attitudes

[63] FGD with men in Mazowe

limits access to HIV prevention and treatment services among other SRHR services.[64] There was a challenge in soliciting for information around these issues as they were considered taboo.

3.10.5.1 Sexual Minorities

The Zimbabwean laws criminalise sex between men and is silent on such relationships among women. Organizations that promote the rights of sexual minorities across the spectrum do exist in Zimbabwe but under harsh conditions. Their offices are often raised by the police and they are routinely subjected to persecution by prosecution and violence. The situation is not helped by the cultural and religious conservatism that is prevalent in the communities. So strong is this conservatism that even accepting the existence of LTBTQ people in the communities is difficult. When asked if it was easy for the LGBTQ community to access services, one adult woman in an FGD in Mazowe said (in an uninterested and distance tone):

'We hear about 'them' but we don't have 'them' here. We hear they exist where you come from, in the city (Harare)'.

This short response and its tone is loaded in meaning and indicative of the taboos surrounding sexual minorities in Zimbabwe. It explains why many LGBTQ people leave rural areas to stay in the cities where cultures are getting diluted and views, though not permissive, are not as strong as in the rural communities. It is due to such criminalization and stigma that sexual minorities do not access the SRHR services they need. UNAIDS (2017)[65] estimates, for example, that only as little as 14.1 percent of men who have sex with men access HIV testing services and know their status.

3.10.5.2 Sex Work

Sex work is one of the taboos in the communities. During the study people were more free to talk about it compared to sexual minorities. However, the attitudes and tone were not accepting but rather stigmatising. Sex work is considered illegal in Zimbabwe and the police often arrest and harass sex workers, a situation that limits access to essential prevention and management services for HIV and other SRHR services. Prevalence of HIV among sex

[64] The Zimbabwe National Key Populations Strategy 2019-2020: NAC, 2019
[65] Cited in the National Key Populations Strategy: NAC, 2019

workers is extremely high with recent studies putting it at 56%.[66] The communities admitted that transactional sex was high and the following were some of the reasons given:

- It is due to high levels of poverty which hits AGYW the hardest. Therefore, girls engage in such transactional sex as a way of escaping poverty (also see section on teenage pregnancy) – FGD with ABYM in Goromonzi
- The girls have expensive tastes that they cannot cater for hence are drawn to men who can pay for sex – FGD with men in Mazowe
- There is a high influx of men with money from artisanal mining in the community. They use this money to attract young girls to have sex with them – FGD with women in Umguza

3.10.5.3 Abortion

Abortion in Zimbabwe is only permitted under limited circumstances of rape, incest, serious foetal impairment or when the pregnancy is a threat to the life of a mother. In practice this abortion is hard to get considering the bureaucratic legal and official requirements. In 2016, an estimated 65'300 induced abortions occurred in the country.[67] Because abortion is largely illegal, such abortions are carried out under unsafe conditions endangering the lives of women. Zimbabwe has one of the highest maternal mortality ratios in the world estimated at 651 deaths per 100'000 live births.[68] The study revealed that due to the legal restrictions and well as conservative religious and cultural beliefs and attitudes, the practice goes on underground. Across the districts, it was men who spoke more about it with women shying away from the discussion. Even in the survey held, only a few women were not courageous enough to access legal abortion or post-abortion care services from health facilities. Among reasons for unsafe abortions were poverty, being forced by men to abort (especially in cases where the man is already married and was having an extra-marital affair) as well the shame and fear of facing parents and communities with a pregnancy when one is unmarried. Considering the low usage of contraception and high rates of teenage pregnancy, it is unsurprisingly that a significant number of AGYW may end up requiring an abortion.

[66] ibid
[67] Induced Abotion and Postabortion Care in Zimbabwe: Guttmacher Institute, 2019
[68] ibid

3.11 Legal and Policy Frameworks

Public policy, including legal instruments, indicate a commitment on the part of state actors[69] in promoting and protecting the rights of women and AGYW with regards to their rights, especially when it comes to gender equality as well as improving access to sexual and reproductive health services and corresponding rights. These policy instruments, in a world that is collectively moving towards universal observation of key human rights including the rights of women, girls and young people, are promulgated at all levels from international, regional and national levels. Such instruments may not be binding on governments, yet they do reflect international consensus on key rights to gender equality. The following are some of the examples of key commitments to which Zimbabwe is a signatory:

3.11.1 International Commitments and Instruments

- ✓ **The Convention on the Elimination of all forms of Discrimination Against Women** has the clearest and most specific articulation of women's rights in all facets of development including women's participation in decision making, their access to resources as well as in matters relating to their SRHR. The CEDAW is considered the bill of women's rights (Machakanja P., 2016)[70]

- ✓ **The Beijing Platform for Action**

- ✓ **The Millennium Declaration:** The Millennium Development Goals (MDGs) were set at the 2000 Millennium Summit to accelerate global progress in development. Sexual and reproductive health is a prerequisite of all goals, particularly those related to gender and health. The Sustainable Development Goals have a goal on gender equality and promoting the rights of women, a theme that runs through the majority of the development goals.

- ✓ **The International Conference on Population and Development (ICPD) Programme of Action** marked the genesis of expanding SRHR packages beyond family planning and marked a departure from treating women's SRHR as a charity or a means for population control to acknowledging the same as fundamental human rights[71]. Prior

[69] Dye, T., 1972 defines 'public policy' as 'what government chooses to do or not to do.'
[70] https://zimlii.org/content/constitutional-and-legal-frameworks-protection-women-against-violence-zimbabwe
[71] Pizzarossa L. (2018): Here to Stay: The Evolution of Sexual and Reproductive Health and Rights in International Human Rights Law

to the convention, the approach and discourse to SRHR mainly focused on population control and saving lives of women during birth.

- ✓ **The Convention on the Rights of the Child** protects children's right to access sexual and reproductive health services and their rights to substantive equality and nondiscrimination based on age and gender.

3.11.2 Regional Treaties on Gender and SRHR

The following treaties apply at the continental and SADC regional level:

- ✓ **African Charter on Human and Peoples Rights Declaration on Gender Equality in Africa**: Addresses several women's rights and recognizes them as fundamental human rights, a major statement of policy intent for a continent known for cultures that subordinate women to men.
- ✓ **African Charter on the Rights and Welfare of the Child** gives a holistic view of children's' health and protection and the right to education and information. This holistic view states that every child, including especially the girl child, has the right to enjoy the best attainable state of physical, mental and spiritual health.
- ✓ **The Maputo Plan of Action**: Provides a framework to achieve universal access to comprehensive sexual and reproductive health rights (SRHR) and services in Africa.
- ✓ **The SADC Protocol on Gender and Development** recognizes the gendered nature of development including SRHR. Provides for equal participation in decision making for women and seeks to ensure that women have equal access to control over resources.
- ✓ **The African Union initiated Campaign on Accelerated Reduction of Maternal Mortality In Africa (CARMMA)**
- ✓ **The United Nations Commission on Life-Saving Commodities for Women and Children**
- ✓ **Global Strategy for Women's, Children's and Adolescents' Health (2016 – 30)**
- ✓ **SADC Model Law on Eradication of Child Marriages** seeks to outlaw child marriages in the region.

Zimbabwe has signed many of these instruments with most of them finding expression in the national constitution as well as the national laws and policies. Since the national constitution does not guarantee that these international instruments and commitments become national policy or law upon signature, the most important measures for the country are the national laws and policies. Table 7 shows some of the major legal and policy measures in place to promote gender equality and access to SRHR services among women as well as AGYW.

Table 7: Key National Legal and Policy Instruments on Gender Equality, SRHR and SGBV

Legal/Policy Instrument	Issues Addressed Relating to Gender Equality and Rights of Women and Girls, especially with regards to Access to SRHR Services
Legal Instruments	
The Constitution of Zimbabwe (2013)	-Section 17 addresses gender equality and seeks to promote the participation of women in all spheres, including in decision making while acknowledging their equality to men. Key provisions include: ✓ Access to resources, elimination of gender-based discrimination in policy, law and practice ✓ Protection of women and girls from gender-based violence ✓ Equal representation for women in key institutions of government and decision making, especially commissions -Section 80 voids all cultural practices, customs and traditions that infringe upon the rights of women and girls providing basis for challenging such practices as child marriages, female genital mutilation. The study established that women are being denied some of these constitutional rights in decision making, access to resources and are having their SRHR minimized through certain customs, traditions and cultural practices. This makes the provisions of the national constitution important.
Customary Marriages Act (Chapter 5:07) and Marriage Act (Chapter 5:11)	The Marriages Bill, 2017 is being debated to harmonize, repeal and replace the different marriage laws with a strong emphasis on outlawing child marriages, clearly stipulating 18 years as the minimum age at which girls can consent to marriage. Previously, girls would be allowed to marry as minors while boys were only allowed to marry at 18. Child marriages were found to be prevalent in all the study districts hence the importance of speedy policy reform to curb this disempowering practice for AGYW.

Domestic Violence Act (Chapter 5:16)	Many practices such as physical violence, virginity testing and female genital mutilation that were said to be existing in the project districts are outlawed through this legislation. This law was promulgated following wide consultations with the aim of protecting and providing services for survivors to cope.
Married Persons Property Act (Chapter 5:12)	This law states that all marriages contracted after January 1, 1929, are deemed to be out of community of property unless the parties have a separate agreement to the contrary. With this study indicating that men control key resources such as land and houses, husbands can prejudice wives through selling property without consulting or denying them right to property that they jointly worked for during the subsistence of marriages upon divorce.
Deceased Estates Succession Act (Chapter 6:02) and Administration of Estates Act (Chapter 6:01)	Surviving spouses are entitled to inherit the house and domestic premises in which they lived before the death of their spouse. Although this is progressive for many women who in the cultures of the project communities would have lost land and houses upon the death of their husbands, implications of the law are such that if the spouse (especially wife) was not living in that property at the time of death, they would be prejudiced, Polygamy, especially the unofficial 'small house' phenomena which was identified as an issue in the study poses some problems in this regard. Women in such unions may be prejudiced of property since most of them do not live with their spouses.
The Public Health Act (Act No. 19 of 1924)	Currently being repealed by the Public Health Bill of 2017 sets the age of consent to accessing services at 16 years, requiring anyone under the age of 16 to get parental consent to access SRH services and contraceptives. Access to HIV testing services is set at 16 years as well. Government however says that young people below the age of 16 are not turned away if they need services.[72] However, service provider attitudes will remain an impediment. This is a justification for having such age stipulated at an age that acknowledges the fact that young people are engaging in sexual activities early. The proposed Bill attempted to lower the age of consent to accessing services to 12 years. A higher age of consent to services affect girls more than boys as AGYW access contraceptives and services through the heath facilities mainly. The study revealed that ABYM have alternative means for accessing services outside the public health facilities without the restrictions of age of consent to services.
Termination of Pregnancy Act	The law denies AGYW abortion rights except under limited circumstances of fetal impairment, improper sexual relations and when the mother's life is

[72] Key informant interview with the Director of Family Planning in the Ministry of Health and Child Care

	threatened. The procedures set in the law also make it cumbersome for women and girls to access the same even under they are entitled to such at law. Many resort to illegal and unsafe abortions, a trend that was identified in this study as common in all the four districts.
Other Laws with Implications on Access to SRHR and SGBV Services	The Zimbabwean constitution and laws criminalize same sex marriages and man-to-man sex, a move that limits access to services for the LGBTQ community. The stigma in the community and among service providers does not help the situation. Similarly, laws that prohibit soliciting for sex prevent sex workers from accessing services while leaving AGYW engaging in sex work open to abuse and rape without recourse they will fear coming out to report.
Policies and Strategies	
The National Gender Policy (2004)	Comprehensively seeks to address issues affecting women across gender, Constitutional and Legal Rights; Gender and Economic Empowerment; Gender, Politics and Decision Making; Gender and Health; Gender, Education and Training; Gender Based Violence; Gender and Environment; and Gender, Media and ICTs underpinned by principles of gender justice, equality, integration and inclusiveness. However, the policy lacks identifying and addressing the specific SRHE needs of AGYW leaving out key concerns raised by the study such as access to contraception and other services by young unmarried women.
The Zimbabwe National Maternal and Neonatal Health Road Map (2007)	Seeks to invest in reducing the high burden of maternal and neonatal mortality and morbidity. Due to such practices as early marriages, early pregnancy and poor access to services for several reasons, efforts to reduce maternal mortality are needed for women. On the same level, considering the burden of caring for children and families, interventions that address neonatal mortality and morbidity are equally important.
Zimbabwe National Family Planning Strategy	Identifies and seeks to address structural barriers to access to SRHR across the ecological environment of young people at individual, relationship, community and institutional/policy level.
National Population Policy	Recognizes SRHR as a key component of development, the need for population data to inform planning, mainstream gender and address harmful social & gender norms. The study has established that access to services for young people, especially AGYW, is a result of creating a conducive environment at these different levels.
National Youth	As the principal policy for empowering young people, the policy makes gender

Policy	equity and equality one of its principles. The policy recognizes young women's vulnerability and the need for targeted strategies as their needs are different from those of young men. Issues identified in the study as affecting young women such as teenage and unwanted pregnancies as well as unsafe abortions are addressed in the policy. However, the policy maintains a moralistic view to the sexuality of young people, an approach that is likely to undo the positives identified already.
National HIV/AIDS Policy in Zimbabwe	Provides for a multisectoral response to HIV and acknowledges the gendered nature of HIV and AIDS as a public health and national development issue.
Zimbabwe School Health Policy	Recognizes the challenges of young people, especially AGYW, such as HIV, STIs, teenage pregnancy as well as illegal abortion. Despite having principles such as 'best interest of the learner' the policy is shaped by parenting attitudes and social norms around what is expected of a school-going young person hence emphasizes abstinence and maintains the long-standing position denying access to condoms in schools. As a positive, the policy recognizes that girls and women have different needs from boys and men. It allows education on SRHR with limits of what is deemed to be 'age appropriate.' This denies young people who are sexually active the services they need since the MoPSE would rather not acknowledge that young learners are engaging in sexual activities.
National Health Strategy for Zimbabwe 2016-2020	The policy addresses the key issues affecting AGYW but would have benefited from an elaborate gender analysis and strategy that explicitly address the differentiated needs of men and women identified in this gender analysis of the project districts.
Reproductive, Maternal, Newborn, Child, Adolescent Health, and Nutrition Strategy (2017 – 2021)	Builds upon the Maternal and Newborn Health Road Map: 2010 – 2015 to go beyond SRHR and promote integration of nutrition and child survival. With women predominantly responsible for household roles in this study, such a policy helps alleviate the burden that comes with such responsibilities in poor and food insecure settings.
National Adolescent and Youth Sexual and Reproductive	Addresses key issues affecting young people particularly in response the major obstacles they face in accessing information and SRHR services. Among these is the provision of youth-friendly services as well as delivery of comprehensive sexuality education. The study identified the lack of confidential, affordable and

Health (ASRH) Strategy II: 2016 – 2020	conveniently located services as one of the reasons why they don't access contraceptives, among other SRHR services.
National Family Planning Strategy: 2016 – 2020	The strategy seeks to re-position family planning in all development processes and reduce the unmet need for contraception, with a special focus on adolescents and long-term methods.
The School's Re-entry Policy	With pregnancy-related school dropouts rampant in the four districts, this policy allows girls who fall pregnant while in school to be allowed to get back to school after delivery. However, with the study indicating that most of the girls are forced to marry the fathers of their children and the roles[73] they are expected to play afterwards, such return to school is unlikely. The policy also does not allow the girls to go back to the same school leaving them with the burden of going to a far-away school. Social attitudes and stigmatization of teen pregnancy and motherhood are a factor in limited success of the policy.
Ministry of Primary and Secondary Education Life Skills, Sexuality, HIV and AIDS Strategic Plan 2012-2015	The objective of the strategic plan is to ensure that the education sector supports all learners with access to correct information and skills related to SRH, HIV prevention, care, treatment and support by end of 2015. Information and life skills such as confidence featured prominently as key obstacles for youth access to services in this study making such an intervention critical. The downside of the policy is that it promotes abstinence, in line with the Ministry of Primary and Secondary Education's 'abstinence only' policy yet children are engaging in sex. 'SRH education is not comprehensive, the programme has largely ignored issues of gender and sexuality.'[74]

3.12 Knowledge about Policies in the Project Districts

The study showed that knowledge of policies, and by extrapolation rights, was low among communities with only 30% of questionnaire respondents and 40% of the FGDs being able to identify and/or discuss policy aspects in respect of gender equality, SRHR as well as SGBV. However, this average masks high disparities among districts with knowledge levels as high as 60% among respondents in Goromonzi district and as low as 10% in Seke district (see table 8 for district knowledge levels of policies). Knowledge levels were high among AGYW (50%) compared to ABYM (19%). There were indications that boys and men were

[73] See section on teenage pregnancy.
[74] National Fertility Study

excluded in programming around women's rights[75]. While high knowledge of policies and rights among women is important to ensure that they demand and claim such rights, it is equally important to include men as the study shows that they are main violators and enablers of such access to rights. Among policies and laws identified in the study relate to curbing child marriages, women's rights, criminalization of sex work, access to services and GBV.

Table 8: Knowledge of Policies across the Districts

District	Percentage of participants who know a policy/law relating to SRHR, SGBV and gender equality %
Goromonzi	60
Mazowe	30
Umguza	20
Seke	10

The huge difference between Goromonzi and the other three districts was not accounted for in the study. Considering the general knowledge trends, it is possible that the selection of participants was biased towards individuals who may have been previously active in awareness raising programmes. All the same, with the project aiming to undertake advocacy as one of its key objectives, there is a need to ensure that knowledge on rights is increased in order to enable an advocacy process driven by the needs of the communities.

As for the need for advocacy, the analysis of the legal and policy environment in Zimbabwe indicates the following key gaps:

- ✓ There are several international and regional conventions that are neither recognized nor implemented in the country. These pertain to universally accepted human rights that are not being recognized in the country. Issues relating to LGBTI, sex work, abortion rights come to mind.
- ✓ National policies in place are not being implemented. Despite expressions in the national constitution and various policies, gender equality rights and women empowerment indicators are underperforming. Areas for advocacy represent equal

[75] For example, FGD with men in Mazowe and FGD with ABYM in Goromonzi.

participation in decision making positions, economic empowerment and access to health services among others.

It is important to note in this regard that societal attitudes are a factor in the non-adoption or implementation of these legal and policy measures. In some cases, such attitudes were so pervasive that women and girls were under pressure to be complicit in the violation of their own rights. The case of pulling labia to meet partners and societal expectations is an example of how girls violated themselves to fit societal attitude narrative based on a cultural practice that has since been rejected. As a result, advocacy is only a complementary pillar to other programming approaches such as sensitization on the health of AGYW health.

3.13 Institutional Structures and Frameworks

3.13.1 National Level Structures

The ratification of several regional and international instruments for gender equality and the promotion of the SRHR of women and girls has resulted in the setting up of a number of institutions and structures. Section 245 of the Constitution sets up a Gender Commission, which is mandated to ensure gender equality, investigate violations and act on the same. However, though in place, the commission remains under resourced and is yet to comprehensively fulfil its mandate. The government also has a Ministry of Women Affairs, Gender and Community Development whose mission is 'to spearhead women empowerment, gender equality and equity for community development.'[76] This ministry is decentralised to the district level which was visible in the community during the study. Considering the economic challenges that the country is facing the ministry's programmes and interventions are limited. However, in collaboration with NGOs, the ministry has some visibility and has been linking women with opportunities for economic empowerment.

3.13.1.1 The Women's Bank

This study confirmed what is already known about lack of economic opportunities for women, especially at household level. Several studies[77] have explored such exclusion in the

[76] https://socialprotection.org/connect/stakeholders/zimbabwe-ministry-women-affairs-gender-and-community-development

[77] World Bank. 1994. *Enhancing women's participation in economic development*. A World Bank policy paper. Washington DC ; World Bank. *See also* Lechman E. & Okonowicz A. (2014): Are Women Important for Economic Development? An Evidence on Women's Participation in Labor Market and Their Contribution to Economic Growth In 83 World Countries

mainstream national economic activities and concluded that the trend is sustained by a number of factors. For example, this study indicated that women are not seen as leaders in business and politics, a social attitude likely to affect them when they want to borrow to fund their businesses. Additionally, since they do not own immovable assets, women do not have collateral security to offer in exchange for loans in the mainstream banking sector[78]. As a result, in June 2018, government launched the Zimbabwe Women Microfinance Bank as a measure to ensure the participation of women in the mainstream economy. The idea behind the bank is to give the previously unbanked rural women an opportunity to save and get loans to fund their entrepreneurial ventures. If success is realised in economic empowerment, it is likely that other indicators such as health and participation in decision making may change. The study associated exclusion of women and domination of men, mainly to the fact that men control important resources such as money.

3.13.1.2 Other Structures and Interventions

As for SRHR, the Ministry of Health has set up an Adolescent Sexual and Reproductive Health Forum, which is a multi-stakeholder steering committee for government entities, parastatals and non-governmental organizations to coordinate players and share experiences on the SRHR of adolescents.[79] A review of the National Adolescent Sexual and Reproductive Health Strategy, indicated that there was need for inclusion of the Ministry of Primary and Secondary Education in this committee for the purposes of delivering CSE in school with a view to broaden the message beyond abstinence only. During a key informant interview with the Ministry of Health and Child Care, it was indicated that contradictions in views on such matters are under ongoing discussions in this forum[80].

There is also a lot of work happening with CSOs as government remains constrained by resources. For example, several NGOs together with the UNFPA and the National AIDS Council are running national girl empowerment programmes such as the Sista2Sista girls-only clubs for 10-19-year-olds. According to MoHCC, '*The clubs offer a safe place to vulnerable adolescent girls where they share their experiences with mentors and each other. The girls are taught about sexual and reproductive health and rights, financial literacy and how to address difficult social situations. The programme's objective is to give girls the*

[78] https://www.weforum.org/agenda/2019/06/women-finance-least-developed-countries-collateral/
[79] Key informant interview with Director of Family Health in the Ministry of Health and Child Care.
[80] ibid

confidence and self-esteem to stand up for themselves. They are taught that early marriage is wrong and to report cases of sexual abuse. Evidence has shown that girls-only clubs are effective as fewer pregnancies and marriages are found among girls who are in these clubs.'[81] Further inquiry is needed in the districts and among the project participants if they have benefited from such programmes. Feedback from study participants indicated that they have heard of or, at least, participated in some activities of this nature in their community.

3.13.2 Project Implementation and Institutional Capacity

The implementing partners are at various stages of gender mainstreaming in their organizations and programmes. They have, to varying extents, policies, systems and practices for gender-responsive programming and gender-sensitive organizational operations. The *Simba Utano* project and this gender analysis are part of the measures taken by the project partners as a step towards strengthening gender equality and addressing the vulnerability of women in the project communities. Below, each organization is assessed in terms of its institutional capacity to address the gender needs of the Simba Utano project.

3.13.2.1 Katswe Sistahood

The organization's mission is to promote gender equality using feminist approaches to empower women in all facets of their lives. The organization has a Gender and Safeguarding policy that addresses and provides for gender equality in the organization and programmes. Overall, practices in the organization indicate a fairly high level of understanding of gender issues and systems when it comes to programming. The organization's staff, although they would do with additional training in some areas, demonstrate high levels of knowledge and expertise on gender equality issues especially in the context of their work.

While the domination of their staff complement by women is understandable considering the nature of their interventions, the organization however may need to consider having males among its officers, especially for interventions targeting men. The cultural norms in the communities they work may make it difficult for women to facilitate such activities as dialogues with men. An effective approach may be to work with male peer leaders or role models to effect behaviour change as opposed to attempting to get women to lead male

[81] National Fertility Study Report, op. cit.

activities, an approach that may find resistance and hostility. Once gender norms are challenged, working with women to target men will not be a big challenge. The staff identified the following as areas for further capacity building:

- Gender mainstreaming in development programmes
- Knowledge on international and national policies/instruments and strategies on gender equality and empowerment of women
- Development and implementation of organizational gender policies and strategies

3.13.2.2 Youth Engage

The organization has gender provisions and strategies embedded in the overall organizational policies and procedures. While in practice, the organization includes gender assessments in designing, implementation as well as monitoring and evaluation of all their projects, Youth Engage does not undertake staff capacity assessments and trainings on gender. As a result, although knowledge and expertise were high among senior staff, among junior staff many areas of capacity development were identified. The following areas for capacity building were identified by staff:

- Basics and an introduction to gender
- Gender mainstreaming in development programmes
- Knowledge of international and national policies/instruments and strategies on gender equality and empowerment of women
- Development and implementation of gender policies and strategies
- Gender-responsive monitoring and evaluation, including collection and analysis of sex-disaggregated project data

Noticeably, perceptions and attitudes which reflect gender biases were an issue among some of the staff members even those with training and high levels of knowledge on gender. During staff assessments about 30% of all respondents felt that AGYW had equal opportunities and access to resources in comparison to their male counterparts. The responses of some of the staff of the two organizations also indicated that they put blame on girls for falling pregnant in certain circumstances. Despite progress in promoting gender equality, gender bias and attitudes that unfairly blame women remain a problem in the

Zimbabwean society and the world at large. According to a recent UN study[82], Zimbabwe has the highest percentage of people who exhibit a gender bias in one way or another (96%).

Knowledge on international, regional and national policy instruments was also low among staff with only a few policies being mentioned. Considering that advocacy is a major objective of the project, such knowledge of policies is foundational in analysing gaps and undertaking advocacy.

4 Recommendations

4.1 Introduction

The foregoing chapter has made some key conclusions pertaining to gender equality and the position of women and girls in the project communities, including in relation to access to SRHR services. This chapter addresses some key recommendations that help in designing a gender-sensitive and gender-responsive intervention that broadly promotes the rights of girls and women while at the same time promoting gender equality in the broader society as well as in terms of accessing SRHR services. Therefore, some of the recommendations are specific to improving access to SRHR services among AGYW while others relate to gender equality in all aspects in the programming communities.

Project and Organizational Recommendations for the Simba Utano Project

Summary of Key Findings	Recommendations for Gender Equality and Improved Access to SRHR Services by AGYW
Roles, Responsibilities and Time	
• Women and girls' time is largely consumed by household and reproductive activities while men dominate the economic and prestigious community	• *Design of project activities to consider that the most vulnerable women and AGYW will have limited time to attend activities. Since they will need permission from their parents and partners, women and girls are made answerable, sometimes with grave*

[82] The Gender Social Norms Index: UNDP, 2020

leadership activities. • Women and girls work longer hours per day compared to their male counterparts. Average time women and girls spend working per day is 16 hours across the districts while men generally work half that time. Because men work less hours, they have plenty of leisure time while women almost have almost none considering the nature of their responsibilities. Women spend the little leisure time they have at church. • Women across all the 4 districts are responsible for caring for the sick, a responsibility that grows with many SRHR-related sicknesses.	*consequences such as domestic violence for missing household chores during the time they attend project activities. Men on the other hand may be away at work during weekdays but could still be available considering high unemployment rates. While working in a gender transformative manner to change such gender roles, it is important for the project to acknowledge the current state and ensure that activities are timed conveniently for AGYW, women, ABYM and men. Activities with AGYW should neither taking too long nor be done too early or too late.* • *In addition, the project must work in a gender-transformative manner with sensitization activities that target young people, parents, communities and community leaders to change social attitudes and norms on gender roles. This is important because study illustrated that the existing skewed gendered distribution of roles is accepted by both men and women as normal. Women would be disadvantaged in many respects as long as their responsibilities and time use are not changed. It is also important in this respect that in the course of implementing the project, roles and responsibilities given to AGYW and ABYM do not entrench the current trend. Project officers must give AGYW equal and important tasks in the project.* • *How men and women spend their leisure time in the project communities is instructive for the*

	purposes of increasing access to services. Men have multiple entry points for providing services, including the various entertainment spots they patronise during leisure time while women have little leisure time. They are left to rely on the clinics which they deem as unfriendly. Considering the fact that women consider going to church as part of their leisure, it is important that churches become service points targeting women in this project. However, churches have their own limitations (see recommendations on culture, religion and SRHR). • *Additionally, working with community health workers and developing their capacities is essential in reaching out to women with services in the homes where they spend the bulk of their time.*
Access to and Control Over Resources	
• Men have access to and control the most important resources (resources that bring about wealth and status) across all communities in the study. • In one district (Umguza) where women were said to be increasingly involved in mining activities for economic sustenance, and in any other cases where	• *With women and girls having little access to and control over financial resources, the project needs to be layered with other interventions that seek to increase incomes of women and AGYW. The study findings have demonstrated that cost of services is a prohibitive factor in accessing services. Women and girls are the worst affected in this regard.* • *However, income generation support is a specialised area and a difficult one to explore under the current economic conditions. The*

women were economically involved, the study indicated that women will have control of financial resources compared to communities where women stay at home. However, the study indicated that women who earn money tend to be victimised by their insecure husbands. • Men were said to use their resources to afford SRHR services as well as on leisure activities such as drinking and paying for the services of sex workers. Owing to their meagre resources, women are restricted from accessing SRHR services and were reported to use the little financial resources they earn on meeting the financial needs of the family and the household since they are responsible for taking care of households and children.	*project partners may identify suitable organizations to come and support such initiatives among the same target groups.* • *Alternatively, the project should source some key services such as contraceptives and provide them free-of-charge through the project. This cuts on the costs of accessing the same.* • *The already made suggestion to provide services through community-based health workers who visit women in the communities and their homes also helps reduce the cost of travelling for women and girls who are not able to pay for transport to far-away health facilities.* • *Supporting women to generate own income should still be accompanied by sensitisation activities as well as community dialogues that seek to transform gender norms and social attitudes towards women who work and earn. This is an important Do-No-Harm principle which can help curb retribution violence that follows women who become financially independent - a situation that upsets power dynamics in their relationships with men who are often insecure.*
Decision-making and Influence	
• Women were found to take less weighty decisions around the day to day running of households while	• *The project must give AGYW and women positions that have weighty decision making and influence as much as possible.*

the men decided on important issues at family and community level. Men take decisions on use of finances in the home and tend to be leaders in the community hence the majority of community leaders are men in the project districts. • Women's participation in leadership is limited mainly by social norms and lack of finances. • Men (partners and fathers) were said to have a significant influence on the decisions taken by women on their SRHR in all the communities.	• *Leadership and decision making is yet another area that requires transformation in gender norms and societal attitudes. Programming in the project must implement activities that seek broader changes in gender relations beyond the realm of SRHR. This can be achieved through linking up and working with other organizations or layering with other projects the organizations already implement e.g. Katswe Sistahood already has projects that seek broad gender transformation and increase the participation of women in leadership and decision making. These interventions need to be implemented simultaneously with the 'Simba Utano' project in the districts.* • *It is important to have some activities in the project that are targeting men and boys, particularly to sensitise them and to work with them in other ways that seek to transform their attitudes with regards to women's bodies. Men and boys must be taught and engaged on disregarding traditions that deny women autonomy on their bodies. One such tradition and attitude is the thinking that paying the bride price gives men a licence to 'own' their wives and control their bodies. Such control is being extended to denying women and AGYW vital SRHR services.*
Gender and Health, including SRHR	
• Men and ABYM were said to	• *The project must have activities that target*

have poor health-seeking behaviours compared to women and AGYW. • Despite having a desire to access various health and SRHR services, including GBV services, women were limited by several factors such as the high cost of services, long distances to health facilities, unfriendly attitudes of staff, unavailability of services, attitudes of men (parents and partners) as well as prohibitive religious, cultural and social beliefs, practices and norms. Unmarried young women were said to be stigmatised by health service providers and society for seeking services such as contraception. This tends to limit their access to such services. • Lack of knowledge is also a key factor in accessing services. Despite national studies indicating that knowledge levels on SRHR are generally low among AGYW and in comparison to	*men and ABYM to address harmful masculinity that is rife in the project communities where men shy away from accessing services. With poor health seeking behaviours men are exposing women and girls to STIs, including HIV because of the prevalent practice of polygamy as well as multiple and concurrent sexual relations reported in the study.* • *Strategies for overcoming barriers to accessing services established in the study include:* *i. Strengthen capacity of health service providers to guarantee confidentiality. Also important to ensure that staff in the health facilities are friendly and respect the rights of AGYW and women who seek services.* *ii. As already suggested, the programme must be active at the community levels to challenge gender norms and societal attitudes that limit women's access to SRHR services. Sensitization of traditional and community leaders, the community in general, boys and men, teachers (for in-school youths) among other community gatekeepers is essential in creating an enabling environment for AGYW to access services.* *iii. To address the cost factor, the Simba*

ABYM, males who took part in the study across the districts feel that women and girls in the project districts have 'too much information' on SRHR. Knowledge on such issues as condom use among AGYW is seen as being 'too forward' and a sign of promiscuity hence it is frowned upon by society. In Goromonzi and Mazowe district, activities that strictly and exclusively target AGYW and women were openly resented because they were seen as disempowering men and boys while turning AGYW into 'prostitutes' (in line with the view that having knowledge on contraception use for women and girls is a sign of unfaithfulness). • AGYW get much of their SRHR information mainly from outreach programmes and workshops of NGOs as well as schools. Due to cultural taboos that limit information on SRHR towards women and girls, AGYW rely less on family	*Utano project may consider procuring and providing some of the services, especially those that can be provided outside the hospital setting. Project partners may identify partners that use the voucher system for accessing services and linking up with such organizations to provide free or affordable services. Working with community-based health cadres is also crucial in reducing the cost of transport to clinics for AGYW who need services. Such an approach also allows women and girls who spend most of their times in the home an opportunity to access SRHR services.* *iv. Church doctrines and beliefs need to be reconciled with the need to promote the rights of AGYW to access SRHR services and sensitization activities targeting churches and church leaders are important in this regard. Additionally, churches can be an entry point to services and information provision considering it is a regularly frequented place by women; going to church is the most common way of spending time for women outside the daily routine of household responsibilities.* • *Awareness raising and information dissemination activities must take into*

and friends for SRHR information. However, with societal norms and taboos being more permitting towards the sexuality of males, ABYM receive much of their information from friends and tend to get information from parents compared to AGYW. • Poverty, especially among AGYW, is rampant and tends to be a huge factor in fuelling the various SRHR challenges such as child marriages, early pregnancy, sex work and HIV.	*consideration existing gender dynamics. While peer education activities are likely to succeed with ABYM whose majority rely on friends on SRHR, for AGYW it is important to strengthen workshops and curriculum-based or in-school interventions as these were found to be the most effective for girls in the study.* • *In all the districts parents are key gatekeepers in the lives of AGYW. As a result, it is important that parenting skills activities be held with them, including parent-youth dialogues to help resolve taboos regarding communication on SRHR between parents and their children. This would also help improve communication between AGYW and their parents hence increase access to SRHR information and services.* • *There is resentment towards activities targeting women and girls alone in the project communities. Men have a negative attitude towards such activities as they feel such activities empower women more and threaten the power of men. While this is true and necessary, engaging boys and men to sensitize them on why such power relations need to be challenged is an important intervention. There is a need for mixed-sex activities to complement activities targeting females and males separately.*
Culture, Religion and SRHR	
• Study findings indicated that	• *Working with communities and churches as*

societal attitudes are informed by conservative cultural and religious beliefs which are rife in the project communities. Such societal attitudes were said to be are a factor in limiting access to SRHR services, especially for women and girls who are viewed as non-sexual beings but existing solely to satisfy the sexual needs of men. • Such religious and cultural beliefs in the communities tend to sustain laws that limit women and girls' right to abortion as well as persecute the LGBTQ community thereby driving sexual minorities underground and making it difficult for them to access services. • Both culture and religion were reported as major drivers of child marriages which are a key challenge in all the four districts • In the communities, female genital mutilation in the form of pulling of labia, has evolved from being a cultural practice to a societal pressure on women to satisfy the sexual needs of	*already suggested in the section above is critical in changing harmful beliefs and norms.* • *Sensitization of communities also needs to take a rights-based approach, emphasising that the culture of human rights is fair to all. However, it will take long to change social attitudes of communities towards the sexual minorities, abortion and sex work, among other issues considered taboo. In the meantime, Zimbabwe has guidelines and strategies in place for addressing these issues and reaching key populations, despite legal and social obstacles. The project must train service providers on these guidelines and supplement this work with targeted sensitization activities for the relevant populations. This may work on both ends to increase the demand and supply of services.* • *Sensitise women on the harm caused by FGM practices and communicate to dispel myths and misconceptions that are held by men regarding sex with women who have elongated labia. This will reduce social pressure for women to pursue what used to be cultural practice that has since been overtaken by time.*

men. Women who do not conform to this expectation may be beaten up by their partners and are exposed to HIV through sexual networks as their husbands were thought to be justified to find other sexual partners who satisfy them. The practice of pulling labia was found to be prevalent in Mazowe, Goromonzi and Seke districts while virginity testing for AGYW was said to be common in Umguza district. • The payment of the bride price *(lobola/roora*) was also viewed as a cultural practice that commodifies women and expose them to intimate partner violence since the practice is viewed as implying that men own women. All the project communities and cultures subscribe to the paying of the bride price.	
Policy and Legal Environment for Gender Equality and Access to Services by AGYW	
The following are some of the major legal and policy gaps in the country: • Same sex sexual	• *Use the human rights-based approach in advocacy to secure reforms on issues that are provided for in regional and international*

relationships are criminalised and prohibited by the country's constitution. • There are delays in adopting and signing into law the Marriage Bill as a means for criminalizing child marriages which were found to be rife in the project communities. The study found out that child marriages were common in the communities but were being swept under the carpet since such practices were still socially acceptable despite a court ruling outlawing child marriages in the country. Criminalising people, including parents, who take part in these marriages will go a long way in curbing the same. • There is uncertainty on age of consent to accessing services with many sexually active young people deemed unable to consent to accessing contraceptives and other SRHR services without parental consent	*instruments but not yet realised through laws and policies in the country. Arguments for policy advocacy must point out to the need to fulfil human rights.* • *Raise awareness in the communities on laws and policies on gender equality and access to SRHR that are in place in the country. This will help with community participation in advocacy aimed at demanding the implementation of such policies because national policies that are in place are not being implemented. As such, despite expressions in the national constitution and various policies, gender equality rights and women empowerment indicators are underperforming. Areas for advocacy represent equal participation in decision making positions, economic empowerment and access to health services among others.* • *Advocate for a policy-provided lower age of consent to accessing services to ensure that young people, especially AGYW can access services without parental accompaniment and consent. This may imply that the project moves quickly to input into the ongoing discussions on the Public Health Bill.* • *There is a need to advocate for a provision that provides for stiffer penalties for adults who participate in child marriages as grooms or parents and community members who facilitate such. The window of opportunity for*

• There are low knowledge levels in the communities in terms of laws and policies that have a bearing on gender equality, SGBV, SRHR and the rights of AGYW and women in general.	*such advocacy is in the Marriages Bill currently before parliament.*
Institutional Structures and Capacity for Gender Equality in the Communities and Project	
National and Community Level • The community has various government, private and non-governmental structures in pursuit of gender equality in its various dimensions, including in the area of SRHR and SGBV. While private and non-governmental structures present in the community are often project-based, government structures are permanent although their operations and effectiveness is hampered by lack of institutional capacity as well as underfunding.	• *In all the districts, the project should identify all existing government institutions with a mandate to pursue gender equality and to improve access to services and then build capacity through collaboration. This is key in gaining legitimacy for the project but also to sustain results of the project after the four-year prescribed period of the Simba Utano project.* • *Engage in advocacy around budgetary allocations to ensure that national and local public institutions that promote gender equality are adequately funded to allow them functionality and presence in the community.*
Organizational Level • The *Simba Utano* project	• *Develop the capacity of the project partners in the following areas:*

implementing partners (Katswe Sistahood and Youth Engage) have varying capacities in gender mainstreaming in their organizations and programmes. Areas that need to be addressed include organizational policies, systems and practices in relation to promoting gender equality in the organization and the programmes.	i. Developing staff capacity to plan, implement as well as monitor, evaluate and report on the results of the project in gender-sensitive manner. ii. Ensuring that activities and their implementation acknowledge differentiated needs of men, women, AGYW as well as ABYM and seek to meet these needs. Activities must exploit opportunities to strengthen gender equality while at the same time limiting any impact the project may have in sustaining equality or furthering the marginalization of women and girls. iii. Collecting data for project monitoring and evaluation in a manner that is gender-sensitive including qualitative indicators that measure changes in gender and power relations. *iv.* Supporting the organizations involved in the project to develop and use policies, systems, work plans and tools for gender mainstreaming in the Simba Utano project and, overall, in their organizations.

Part 2:

GES Implementation

Foreword

In February and March 2020, the Simba Utano project commissioned a Baseline Report and a Gender Analysis as part of the Project Implementation Plan (PIP). The purpose was to better understand the situation of adolescent girls, young women and vulnerable populations on the issues of human rights and health - and more specifically Sexual and Reproductive Health and Rights (SRHR), including HIV. To keep costs down and to provide in-house research experience, the field work for both consultancies was undertaken by teams from the implementing organizations, Katswe Sistahood and Youth Engage. Under the guidance of the consultants, the partners participated in both the data collection and data analysis phase, an experience that has strengthened their capacity for ongoing analysis and reporting throughout the project. That represented part 1 on the GES. The purpose of this document (Part 2) is to draw on the findings of the Gender Analysis, and to some degree the Baseline and operationalize the mainstreaming of gender into the project. A secondary objective is to activate and strengthen a youth led SRHR/HIV movement in Zimbabwe. How we will do this is explained in greater detail in subsequent sections of this report.

The ultimate outcome of the project is to improve the health of adolescent girls and young women (AGYW) at risk of HIV in four priority districts of Zimbabwe. Simba Utano is a four-year project that will seek to achieve the following key objectives (outcomes):

- Increased utilization of equitable SRHR and HIV services by vulnerable AGYW in 4 districts of Zimbabwe;
- Improved delivery of quality, gender responsive, inclusive care and support to address priority SRHR needs of adolescents and young people particularly AGYW;
- Improved effectiveness of young people particularly AGYW and community organizations to advocate for evidence-based, equitable, accountable and quality SRHR services and policies.

Zimbabwe is signatory to the Sustainable Development Goals and this project will contribute to the attainment of SDGs 3 and 5 on Health and Gender respectively. The project objectives are also linked to GAC's Feminist International Assistance Policy, specifically, the three gender equality objectives which underpin GAC's Feminist International Assistance Policy:

- to enhance the protection and promotion of the human rights of women and girls;
- to increase the participation of women and girls in equal decision-making, particularly when it comes to sustainable development and peace; and
- to give women and girls more equitable access to and control over the resources they need to secure ongoing economic and social equality.

1. Background and Rationale

In recent decades, at international and national levels, gender equality has gained recognition, not only as a human right but as a development goal in its own right and a pre-requisite for the attainment of other social, economic and human development aspirations. International and regional instruments have paved way for governments to put in place policies and programmes for promoting gender equality. Notable among these instruments, at the international level, are the the Convention on the Elimination of all forms of Discrimination Against Women and the Beijing Platform.

Many provisions of these instruments have found expression in regional and Zimbabwean laws, policies and programmes. However, implementation of these laws and policies has proved difficult in large part due to widespread socio-cultural norms and beliefs. This is particularly true when it comes to the sexual and reproductive health and related rights of young women and adolescent girls. The International Conference on Population and Development (ICPD) Programme of Action of 1994 established the groundwork for the recognition of such rights, especially for women, adolescents and young people. Subsequently, the Sustainable Development Goals (SDGs) a development framework upon which all nations plan to attain sustainable development is unequivocal when it comes to the centrality of gender equality in attaining the desired progress. SDG 5 is a goal in its own right while target 5.6 pursues universal access to SRH. This is to complement the SRH target expressly included in SDG 3 to ensure health and well-being for all as well as a commitment to end the AIDS pandemic.

Regardless of these efforts, women and Adolescent Girls and Young Women (AGYW) remain excluded and disadvantaged in many facets of development in Zimbabwe. This was amplified in the Part 1 (Gender Analysis) of the Gender Equality Strategy (GES) undertaken recently by Katswe Sistahood and Youth Engage in the four districts, Goromonzi, Seke, Mazowe and Umguza, where the Simba Utano project is being implemented. According to the Gender Analysis (GA) findings, social norms, beliefs and attitudes are the major causes of gender inequality in the four districts. Decisions about the health of women and AGYW are often taken by men on behalf of their wives, partners, daughters or sisters while access to SRH services is determined through a patriarchal system of beliefs and attitudes that dominate the cultures and religions of the project communities. Needless to say, these social norms, attitudes and beliefs increase the vulnerability of women to negative SRH outcomes such as unplanned pregnancy, HIV, early marriage, sexual and gender-based violence as well as child marriages. In the culture and religious belief systems, abortion and same sex relationships are considered taboo. Even men are not spared as the very notion of exploring health-seeking behavior options is deemed 'unmanly.'

The findings of the gender analysis also confirmed the universal reality that gender equality is reinforced by co-attendant factors such as poverty, age, social and economic class and sexual orientation.. Successful interventions in promoting gender equality and protecting the rights of women and AGYW must operate at the intersection of these various factors that feed marginalization and exclusion - and consequently, the GES for Simba Utano must emphasizes a holistic gender transformative approach.

As reported in the Forward, the Gender Analysis was the first stage of the Gender Equality Strategy (GES) process. The purpose of this document is to operationalize the findings of the Gender Analysis (GA). The Analysis provided a number of recommendations that are clearly reflected in the project activities (i.e. engagement of men and boys) and some which are equally as relevant and practical (home visits by community health workers) but are not addressed in the PIP. The implementation strategy identifies where the conclusions and recommendations of the GA can be integrated into the

project activities. It must be noted that the GA provided an exhaustive list of the economic, social, cultural, familial, educational, geographical and political constraints AGYW face in accessing SRHR services and protecting their own health. This document will endeavour to outline the tactics that should/could be used to address those constraints which are particularly applicable to this project. By GAC standards, this is a small intervention; thus we need to carefully prioritize where we can best target our resources.

Theoretical Framework

This strategy is underpinned by the following values and conceptual basis:

1. **The ecological approach** recognises that barriers to accessing SRH services for AGYW are systemic and structural, existing at the various levels of the environment in which women and AGYW live. The approach considers the fact that besides responding to the individual level constraints, community and societal/institutional levels must also be aligned to create an enabling environment for women and AGYW to access SRH services. Hence the key outcomes of this strategy seek to comprehensively address the challenges at these four levels.

2. **Layering of the interventions for a comprehensive response.** In addition to ensuring that SRHR services are available and empowering AGYW with information and life skills, there is need to advocate for greater AGYW participation in decision making. Furthermore, we must recognise the reality that the marginalization of AGYW feeds on other social determinants of health such as sexual orientation, age and socio-economic status. All these must be addressed simultaneously to attain gender equality.

3. **A human rights-based approach** is the basis of advocacy and sensitization of communities and key institutions. The key message is that the rights of AGYW individuals are inalienable and supersede cultural norms. At the national advocacy level, such rights must be fulfilled and protected by putting in place the necessary laws and policies and implementing them.

2. Strategic Pillars

In order to deliver the proposed gender equality vision and intermediate outcomes, the Zimbabwe implementing partners will deploy the following four key pillars based on the acronym **ICAN**:

- **I**nformation Dissemination: Information is a foundational input for behaviour change and action in development interventions. In order to increase access to SRH services among AGYW, there is need to ensure that the different target groups have the information they need to take relevant actions. AGYW, their parents and communities need information to challenge social norms and beliefs that limit access to services and to build systems of support for the primary target groups. Simultaneously, service providers need to be sensitised to the different SRH needs of AGYW, and by extension, adolescent boys and young men (ABYM) in order to be better prepare to meet these needs. The communication strategy of the project recognises the inherent capacity in all individuals to play a part in promoting gender equality. Hence, the ICAN strategy acronym comes to life with the moniker '*I Can* ' which recognises our individual responsibility in contributing to a gender equal and gender just society.

Box 1: Summary of Gender Analysis Findings for the Simba Utano Project Districts

- There is glaring gender inequality in the distribution of roles and responsibilities as well as in decision making and access to and control of resources across the four districts. The inequality disadvantages women in many ways when it comes to accessing SRH services especially when it comes to taking decisions on accessing services, getting time to access such services and having the financial resources to afford the same.
- Men dominate positions of leadership in the communities, a situation attributed to lack of finances as well as discriminatory social attitudes that limit the participation of women in leadership and decision-making.
- Social norms, beliefs and attitudes are the major causes of gender inequality and define the major obstacles for women and AGYW in accessing SRH services. The social norms and beliefs are informed by cultures and religions of the communities. At worst harmful cultural and religious practices fuel SRH challenges such as child marriage, female genital mutilation and many other forms of GBV.
- Men (partners and fathers) have a significant influence on decisions taken by women on their SRHR in all the communities including decisions around abortion, contraception use and family planning.
- Men have poor health-seeking behaviour as a result of harmful gender norms.
- Access to SRHR services, for women is limited by several factors such as the high cost of services, long distances to health facilities, unfriendly attitudes of staff, the lack of services, male attitudes (parents and partners) as well as inequitable religious, cultural and social beliefs, practices and norms.
- Lack of information, misinformation and myths on SRH are also a key factor in accessing services for women. Women access information through formal institutions such as schools, clinics and NGOs yet prevalent social attitudes would label them as 'loose' for seeking such information or services. Men on the other hand have multiple sources of information and services because societal attitudes are liberating towards male sexuality.
- Poverty is a key factor in fuelling the various SRHR challenges such as child marriages, sex work, early pregnancy and HIV.
- Despite Zimbabwe being a signatory to several international and regional instruments that seek to protect the rights of women and girls as well as promote gender equality and the SRHR of its citizens, the government actively negates such rights at worst and, in many cases, simply neglects these rights. For example, same sex sexual relationships are criminalised, while child marriages are not.

- **C**apacity Development: In order to meet the minimal expectations for a gender-transformative project, this strategy recognises the need to develop the capacity of stakeholders and target groups as well as the capacity of the partner organizations themselves. Early in the project, each organization must insure that they have appropriate policies, systems and procedures in place including a Code of Conduct around sexual harassment and sexual exploitation. In addition, staff must have the capacity to support gender equality programming in the project communities. Additionally, the project needs to strengthen parent capacity to better communicate with their children on SRHR issues and health service providers need support in providing gender-sensitive and youth friendly services.

- **A**dvocacy: Access to SRH services for AGYW, among other marginalised sectors of communities is a human right that is expressed in many declarations, laws, policies and strategies globally, regionally and nationally. Social norms often prevent the adoption and/or implementation of progressive policies/laws that promote access to SRHR services or the rights of AGYW. This strategy will work through participatory and evidence-based advocacy to seek reform in this regard.

- **N**etworking and building partnerships: Increasing access to SRH services among AGYW is a function of various development outcomes that impact gender equality. These outcomes require the participation of AGYW in leadership positions. However, the implementing partners may not have the necessary skills, experience and resources to address these issues at once. As a result, this strategy emphasises the need to work with relevant partners who may already be working in the communities and/or on the specific thematic focus areas to be layered with the Simba Utano project.

3. Strategic Objectives

Drawing from the GES (Part 1) and the Baseline Report, six key objectives have been developed for the project. Except for the last, each is linked to a specific intermediate Simba Utano outcome.

1. Empower individual AGYW to exercise agency;
2. Influence societal attitudes and norms in the project districts to promote gender equality;
3. Support Service Providers to deliver non-discriminatory gender-sensitive and youth friendly SRH services;
4. Support health system to deliver non-discriminatory gender-sensitive and youth friendly SRH services;
5. Support stakeholder advocacy to promote gender equality and protect women and AGYW's sexual and reproductive rights; and
6. Strengthen Partner organizational transformation

GES Objective 1: Empower individual AGYW to exercise agency

The vision of a gender just and equal society will only be attainable if AGYW have the necessary assets, including information and confidence to seek and utilise SRH services. SHRH knowledge – and where to access relevant services – is central to empowering individuals to exercise agency.

Linked to Outcome 1100: Increased knowledge and awareness of SRHR and HIV among vulnerable AGYW

Outcome 1100: Increased knowledgeand awareness of SRHR and HIV among vulnerable AGYW	
Simba Utano Project Outputs	**Relevant Recommendations from the Gender Analysis and/or Propose Action Points**
1111: Assessments conducted to understand the unique needs of AGYW in selected wards from hotspots in the four districts.	AGYW's needs are broad There is need to prioritise pregnant and married AGYW, sexual minorities and sex workers as having unique vulnerabilities.
1112: Youth Champions, Community Facilitators and Pachoto Groups established and trained to engage vulnerable AGYW.	Because of their experience with AGYW, implementing groups (Youth Champions etc.) already have substantial experience in terms of sensitizing AGYW. The Gender Analysis also recommends that the partners make use of school-based opportunities. These were said to be most effective in reaching out to AGYW with information on SRHR. Sensitization and other project activities must be convened at times convenient for AGYW to attend. Activities for men and women can be organized both as mixed or same sex groups. Key messages should include: • Important services for AGYW - and where to access them • Harmful social norms and cultural practices such as harmful masculinities and the pulling of labia must be address • Key policies and laws relating to the SRHR and rights of AGYW
1113: Sensitization of vulnerable AGYW on SRHR and HIV	
Additional Project Interventions **Leadership capacity development for AGYW**	

GES Objective 2: Influence societal attitudes and norms in the project districts to promote gender equality

Women, AGYW, LGBTQ people and sex workers are particularly vulnerable because of social norms and practices that are shaped by culture and religion. Harmful practices such as early marriages, pulling of labia, paying of the bride price, and virginity testing were found to be rampant among the project communities making women and AGYW vulnerable to negative SRH outcomes. Addressing these norms and practices will improve access to SRHR services and reduce GBV.

This objective is closely associated with ultimate outcome indicator : # and % of AGYW and ABYM, demonstrating positive attitudes towards ending SGBV through the project (disaggregated by age and sex). Both the Gender Analysis **and** the Baseline Report investigated the links between harmful social and masculine norms and attitudes towards ending GBV. The baseline survey of 220 AGYW and 134 young men and boys examined the following statements:

- Is it normal for men to physically abuse their wives and boys beat their girlfriends;
- Do women and girls have the same rights as men and boys;
- Do you believe that rape/sexual abuse is justified if girls/women wear provocative clothing
- Are women and girls to blame for sexual abuse against them if they wear revealing clothes

Measuring attitudinal change over the duration of the project will be an important indicator of how successful our interventions have been.

The Gender Assessment emphasized the need to sensitize multiple groups within communities (church leaders, community leaders, health workers, man and boys) on how beliefs and attitudes

shape norms and practices which limit AGYW access to SRHR knowledge and services. In addition to sensitizing men on how societal and cultural norms harm them, it is imperative to ensure that they also understand how they can become enablers in support of AGYW fighting for their rights. This is particularly important considering the gender analysis finding that men and boys make decisions around the access to SRHR services on behalf of women.

Parent-child relationships are also important in encouraging access to services among adolescents and young people, especially AGYW. However, many parents in the communities are unwilling to talk to their children about issues relating to sex and sexuality. Furthermore, children do not have the skills or confidence to communicate with their parents about SRH. The project must assist parents in learning how to communicate with their children and support their decisions to access SRHR services.

Linked to Outcome 1120: Increased awareness of parents, caregivers, traditional and religious leaders, young men and adolescent boys of harmful social norms and inequalities that hinder access of AGYW to SRHR and HIV information and services

Intermediate Outcome 1120: Increased awareness of parents, caregivers, traditional and religious leaders, young men and adolescent boys of harmful social norms and inequalities that hinder access of AGYW to SRHR and HIV information and services:	
Simba Utano Project Outputs	**Recommendations from the Gender Analysis and ProposedAction Points**
1121: Youth Champions, Community Facilitators and Pachoto Groups trained on effective communication skills to increase awareness of SRHR and HIV at the community level	Project staff already has substantial experience in providing gender sensitive training to marginalized groups, particularly AGYW. The partners will be supported by a curriculum and resource kit aimed at addressing the needs of young men and boys as well as AGYW. The training should promote dialogue and self-reflection with the end result of motivating young people to adopt healthy behaviour and practices
1212 Parents and caregivers engaged to better understand impact of harmful social norms	Content of the engagement with parents through the planned workshops must include: • parenting and communication skills to facilitate communication between parents and their children. • SRHR needs of AGYW and ABYM and the importance of allowing them to access services • Evidence that despite conservative attitudes of parents, their children are engaging in sex before marriage and need protection from diseases and unplanned pregnancies • Harmful social norms and practices should be examined and questioned
1123: Traditional and community leaders engaged to better understand impact of harmful social norms	Traditional and community leaders are key gatekeepers in terms of providing access to the community. They must be brought on board and see themselves as part of the solution. Church doctrines and beliefs need to be reconciled with the need to promote the rights of AGYW to access SRHR services. The project should encourage progressive churches and ministers to serve as entry points for services and information. Messaging must address the following harmful beliefs, attitudes, social norms and practices that need revisiting or abolishment: • Child marriages • Bride price (roora/lobola) • Pulling of labia • Virginity testing for girls • Inheritance of wives/husbands • Attitudes towards women as a 'weaker sex' who cannot lead and make decisions about their own lives and their societies

	• Beliefs and attitudes towards LGBTQ and sex workers as taboo
1124: Young men and adolescent boys engaged to better understand impact of harmful social norms	Men and boys are part of the solution; however they do respond differently. In addition to mixed groups, there is also a need to undertake separate activities for men. Peer education activities are particularly important for ABYM and must take into consideration existing gender dynamics Messaging for young men and boys must aim to: • Dispel harmful masculine or social attitudes that expose ABYM to negative SRHR outcomes or stand in the way of their accessing services • Sensitize ABYM on the equal rights of women and AGYW, as well as the harmful social norms that militate against these rights • Dispel macho myths around virginity and pulled labia.

GES Objective 3: Support Service Providers to deliver non-discriminatory gender-sensitive and youth friendly SRH services

According to the gender analysis, there is need to sensitize health service providers at all levels on the rights of adolescents and young people to access SRH services in line with existing standards and policy guidelines as well as universally accepted human rights. The gender analysis in all project communities identified the attitudes of service providers as well as their inability to respect client confidentiality as major limiting factors to accessing SRH services.

One of the obstacles for women and AGYW in accessing SRH services is the limited channels through which such services can be accessed. While clinics can be unfriendly and, in some cases inaccessible, there is need to diversify channels of service provision to include non-judgemental sources accessible to AGYW.

The gender-unfriendliness of services is due in part to the inability of service providers to collect, analyse and utilise data that provides insights into gender- and age-specific needs of clients. There is need to sensitize health professionals on the importance of evidence to improved their health service delivery.

Linked to Intermediate Outcome 1210: Increased knowledge and skills of service providers at the facility and community level to deliver gender-equitable and adolescent-responsive SRHR services to vulnerable AGYW

Intermediate Outcome 1210: Increased knowledge and skills of service providers at the facility and community level to deliver gender-equitable and adolescent-responsive SRHR services to vulnerable AGYW	
Simba Utano Project Outputs	**Recommendations from the Gender Analysis and/or Action Points**
1211: Facility-based Health Service Providers trained on gender equitable and adolescent-responsive SRHR and HIV service delivery and referrals	Sensitization and training must also include: • SRH rights of AGYW, including policies and laws which protect their rights to access services. This includes existing guidelines for servicing key populations. • Siting of health facilities and positioning of services e.g. condoms must be convenient for AGYW to access • Need for privacy and confidentiality in offering services. A confidentiality code of conduct needs to be developed and approved by MOH • Promote the importance of data collection and analysis

	(disaggregated by age and sex) as an important measure of success at individual clinics. • Health service providers and respective leaderships must have a proportional representation of males and females • Services must be offered at times that are convenient for AGYW and do not conflict with their child rearing and other responsibilities.
1212: Community Health Workers (i.e. Village Health Workers, Community Adolescent Treatment Supporters) trained on gender-equitable and adolescent-responsive SRHR and HIV service delivery and referrals.	Community health workers (CHW) are essential in increasing access to services for AGYW by reducing both the travelling time and the cost of the services. However, the gender analysis revealed that these CHW do not respect the privacy and confidentiality of their clients. This needs to be an important aspect of their training. A code of conduct around confidentiality needs to be developed, approved and distributed. It also needs to be an important component of the CHW training.
1213: District dialogues conducted with Health Providers to facilitate access by vulnerable AGYW to gender equitable and adolescent responsive SRHR and HIV services and referrals	Health service providers must have a proportional representation of males and females. Ensure that vulnerable AGYW participate in the dialogues Improving AGYW confidence in advocating for improved services is an important part of the AGYW training..
Additional Project Interventions **Implementing partners must encourage facilities to provide free contraceptives;** **Churches should be used as entry points for SRH sensitization**	

GES Objective 4: Support health system to deliver non-discriminatory gender-sensitive and youth friendly SRH services

The GA reported that AGYW and ABYM indicated that health services, particularly SRHR services, are not accessible for one reason or the other. Some of the reasons why access to services is limited are the same for all groups, but there are specific factors which are unique to AGYW and ABYM that demonstrate the need for changes to the health system. These include:

- ✓ Unfriendly youth services
- ✓ Services not available in the clinics
- ✓ Stereotyping of unmarried girls who access services that indicate sexual activity
- ✓ Mistreatment by nurses during pregnancy and childbirth. '*Nurses beat us during delivery and say we are promiscuous for having sex at an early age*'[83]
- ✓ Expensive fees for treatment – cannot pay for prescribed medicines
- ✓ Need for men's (parents/partners) consent to access long term contraception. Sometimes they don't get approval from boyfriends to access the services
- ✓ Shortage of birth control pills.
- ✓ Service providers do not respect confidentiality when one seeks treatment for HIV or STIs
- ✓ Health workers take too long to attend to patients
- ✓ The village health workers are not easy to reach, and they do not respect confidentiality

[83] FGD with AGYW in Goromonzi

Linked to Intermediate Outcome 1220: Strengthened integrated response to support the delivery of gender-equitable and adolescent-responsive SRHR services to vulnerable AGYW

Intermediate Outcome 1220: Strengthened integrated response to support the delivery of gender-equitable and adolescent-responsive SRHR services to vulnerable AGYW	
Simba Utano Project Outputs	**Recommendations from the Gender Analysis and/or Action Points**
1221: Coordinating committees established to link SRHR services for vulnerable AGYW at various levels of the health system	Advocate for women to make up 50% of participants and committee leadership. Network with other feminist organizations and projects (including KS's own stable of interventions) that seek broader gender transformation and which support women's' leadership opportunities
1222: Health facility managers and administrators sensitized to facilitate the delivery and referral of gender equitable and adolescent-responsive SRHR and HIV services to vulnerable AGYW	In addition to professional health workers, community health workers need to be a primary focus of the project. Not only do they serve as providers of SRHR information to AGYW, but they refer AGYW to clinics and hospitals for services. The referral system is weak and HF managers and administrators must lead and strengthen this aspect of the health system. HF managers and administrators must insist that HS providers work more closely and respect the roles played by the community health workers. HF managers must be exposed to data collection and analysis (disaggregated by sex and age) as an important tool for measuring the clinic success in delivering appropriate services to AGYW and ABYM. The project must identify age and sex of HF managers – and encourage the appointment of younger women into the positions. A mentoring system should be established to support and encourage this cadre
1223 Twinning facilitated with international and/or domestic CBOs to enhance project capacity to deliver quality, gender equitable and adolescent responsive SRHR and HIV services.	Encouraging reciprocal visits between KS/YE and other national and regional networks, partners and projects involved in promoting gender transformation is the key objective of the twinning component. The exchanges must include a minimum of 50% AGYW participation.
Additional Project Interventions	

GES Objective 5: Support stakeholder advocacy to promote gender equality and protect women and AGYW's sexual and reproductive rights based

Enacting and implementing laws and policies that promote gender equality as well as protect the AGYW and ABYM is crucial in improving access to SRH services from both the demand and the supply side. This objective will advocate for and support the following priorities:

- Laws and policies that support gender equality and protect the SRHR of AGYW;
- Public institutions with a mandate to pursue gender equality and improve access to SRH services in the project areas (through capacity building)
- Budgetary allocations at national and local authority levels that are sufficient to support gender equality programmes and institutions

Linked to Intermediate Outcome 1220: Strengthened integrated response to support the delivery of gender-equitable and adolescent-responsive SRHR services to vulnerable AGYW;

Intermediate Outcome 1310: Increased knowledge and skill of AGYW, health workers and community organizations to advocate for SRHR	
Relevant Simba Utano Project Activities	**Recommendations from the Gender Analysis and/or Action Points**
1311: Community Youth and Health Champions trained and supported to produce and use data related to delivery of SRHR services for vulnerable AGYW	Youth Champions, Community Facilitators and Pachoto Groups must be informed and oriented to the findings and recommendations of the gender assessment and supported to integrated the learnings into their engagement with AGYW
1312: Health Center Committees strengthened to advocate for the needs of vulnerable populations including AGYW and PLHIV	The project should adopt a rights based approach when working with the HCCs. The Committees can be very influential in advocating for and strengthening AGYW/ABYM access to SRHR services. The possibility of establishing a network of effective HCCs should be examined A strengthened HCC can raise community awareness about laws and policies already in place that support gender equality, access to SRHR services and women's empowerment. The HCCs should be encouraged to advocate for the implementation of the laws that affect AGYW. For example child marriages are still relatively common despite court rulings outlawing the practice. HCCs should be encouraged to support the Marriages Bill presently before Parliament which will criminalize the activity. Similarly, advocacy work might focus on the Public Health Bill which could eliminate the confusion over age of consent which limits AGYW access to contraceptives.
1313: Participatory community-based assessment tools adapted to assess SRHR/HIV service acceptability, availability and access	Ensure that the tools developed by the project are widely available to support a gender transformative and adolescent responsive SRHR approach
1314: Public awareness and promotional materials developed and distributed	Use women-owned companies as much as possible to procure goods and services
Additional Project Interventions **Sensitization, training and strengthening the resources and skills of public institutions mandated with pursuing gender equality and protecting the rights of women and AGYW (Ministry of Women Affairs, Gender and Community Development, the Gender Commission etc.)**	

GES Objective 6: Support project implementing partners to strengthen their gender-transformative programming capacity.

Delivering a gender-sensitive and gender-responsive project also requires an assessment of organizational capacity followed by an attempt to upgrade skills and capacity to meet the identified needs. To implement the project, the partners should ensure that:

- Staff is knowledgeable and skilled in terms of project planning, implementing, monitoring, evaluating and reporting on the results of gender transformative programmes;
- Organizational gender-transformative policies and systems are in place;
- Gender sensitive data is collected and analysed on a consistent basis;
- Networking and collaboration with other civil society organizations working on promoting gender equality is strengthened.

GES Objective 6: Support project implementing partners to strengthen their gender-transformative programming capacity.	
Simba Utano Project Activities	**Relevant Recommendations from the Gender Analysis**

1. Partner staff are knowledgeable and skilled in planning, implementing, monitoring, evaluating and reporting on the results of gender transformative programming	Train all staff on data collection and analysis. The staff who participated in the collection/analysis of field data during the gender assessment and baseline report will already have substantial experience. They could serve as mentors to other staff. Any training must include the collection and analysis of gender-disaggregated data
2. Partner organizations have gender transformative policies and systems in place	Update or develop the following policies to ensure that gender has been mainstreamed into all organizational policies: • Human Resources Policies • Organizational Programme Strategies • Sexual Harassment Policies • M&E Systems and Procedures • Communication Strategy • Advocacy Strategy
3. Partner staff routinely collect and analyse data in a gender-sensitive manner, including qualitative indicators that measure changes in gender and power relations	Partners should develop a common understanding and agreement around how to collect and analyse qualitative data.
4. Partners network and collaborate with other civil society organizations to promote a gender equity agenda	This tends to be a Director-level activity. Directors must insure participation by all levels of the organization, including volunteers.
Additional Project Interventions	