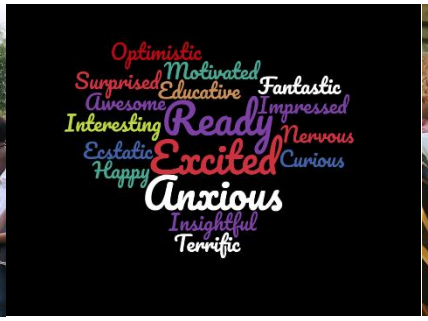
SIMBA UTANO

Project Implementation Plan



Project: P005993

Submitted by: Interagency Coalition on AIDS and Development (ICAD) and International Council of AIDS Service Organizations (ICASO)

Date: 28 February 2020 (Revised: 10 June 2020)

LIST OF ACRONYMS

AGYW	Adolescent Girls and Young Women
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
DAC	District AIDS Council
KS	Katswe Sistahood
HCC	Health Center Committee
ICAD	Interagency Coalition on AIDS and Development
ICASO	International Council of AIDS Service Organizations
MOH	Ministry of Health
MOWGACD	Ministry of Women Gender and Community Development
MSP	multiple sexual partnerships
NAC	National AIDS Council
PLHIV	Person Living with Human Immuno-deficiency Virus
SGBV	Sexual and Gender Based Violence
SRHR	Sexual Reproductive Health and Rights
STIs	Sexually Transmitted Infections
VHW	Village Health Worker
YE	Youth Engage
ZDHS	Zimbabwe Demographic Health Survey

TABLE OF CONTENTS

A. Introduction

This Project Implementation Plan was developed over a period of four months. A four-day validation and planning workshop was organized in Zimbabwe to bring both local partners together to review, validate and plan the project. This workshop took place in Harare Zimbabwe on November 19-22, 2019 and was attended key staff and stakeholders from Youth Engage and Katswe Sistahood as well as local stakeholders including adolescent girls and young women (AGYW) from the 4 selected districts and District AIDS Coordinators. The workshop was attended by 25 people (20 female) participants and had the following objectives:

- To provide an overview of the entire project
- To review contextual and background information
- To understand the work of different partners and share experiences
- To review the geographic reach and beneficiaries
- To validate the design and approaches to the context/policy of the country
- To review and revise the logic model
- To discuss the governance, management, timelines and roles and responsibilities
- To review/revise the outputs and activities based on updated logic model
- To plan for activities and timing
- To review budgets
- To discuss monitoring and evaluation and the performance measurement framework

During the workshop, key design elements of the logic model were reviewed, and the bulk of the workshop was spent discussing the changes and planning the project. One decision implemented during the PIP was to finalize the target districts. Post workshop, various components of the PIP were developed including the annual and project workplan, and a revised budget. In addition, the PMF and Logic Model were both revised in collaboration with GAC. Both the gender assessment and baseline are in process and will be forwarded to GAC before the 20 March 2020. The following is a summary of the updated project implementation plan that has been developed in close collaboration with our implementing partners. This PIP has been written to meet the requirements outlined in the contribution agreement and provides some additional information in the annexes.

A. Project Summary

HIV continues to bare significant impact in parts of sub-Saharan Africa where there is a generalized epidemic. Zimbabwe has the sixth highest HIV prevalence in sub-Saharan Africa at 12.7% with 1.3 million people living with HIV in 2018 (UNAIDS,2018). With a frail health system, a struggling economy, and pervasive socio-cultural stigma and discrimination, access to information and services related to sexual reproductive health and rights (SRHR) including HIV is particularly difficult for populations vulnerable to and at greater risk of HIV and other sexually transmitted infections (STIs), such as adolescent girls and young women (AGYW). In Zimbabwe, high HIV incidence among adolescent girls and young women (AGYW) is driven by age-disparate and transactional sex, lack of economic empowerment, gender-based violence including intimate partner violence, child-marriage and/or through transmission within young key populations, especially young sex workers and sexually exploited adolescents. This project will seek to address some of these challenges around social norms, behaviours and barriers that limit access to SRHR information and services.

The project will be implemented through a collaboration involving two Canadian organizations (ICASO and ICAD) and two local Zimbabwean organizations (Youth Engage and Katswe Sistahood). The staff of both Zimbabwean organizations have extensive experience working with young and vulnerable populations on the issues of human rights and health and more specifically sexual reproductive health and rights (SRHR) (including HIV). ICASO and ICAD bring technical expertise, resources and tools to enhance and support the work of the local partners.

The project will address the demand side of health service delivery. This will be done by working in priority districts to address the systemic barriers to accessing health which includes the socio-cultural norms and traditional community beliefs that impede access and utilization of services especially for AGYW and other vulnerable populations. From the supply side, the project will address the structural barriers to equitable access to SRHR services. From a structural perspective, the project will strengthen health and governance systems to support the delivery of quality and responsive SRHR and HIV services for AGYW.

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. The project will utilize proven effective strategies and evidence-based best practices to increase the utilization and access to SRHR information and services and ultimately curb new HIV infections. 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

The project will be implemented in 24 selected wards in four districts of Zimbawe: Seke, Mazowe, Umguza and Goromonzi. It will reach over 31,000 adolescent girls and young women (AGYW) and 12,000 adolescent boys and young men (ABYM). It will also support the work of youth volunteers, health workers and religious and community leaders. See Reach section for a detailed breakdown.

B. Theory of Change

Zimbabwe has the sixth highest HIV prevalence in sub-Saharan Africa, at 12.7% with 1.3 million people living with HIV in 2018 (Avert, 2016). Within a generalized epidemic that is largely transmitted through unprotected sex, there are key populations who are at higher risk of poor sexual and reproductive health, and HIV more specifically. Women, especially young women, continue to bear a disproportionate burden of HIV infection in Zimbabwe. Adjusting for age, the ratio of HIV prevalence in women to men is an average of 1.7 times. This disparity is highest for women ages 20-24 years who are three times more likely to be HIV infected than young men of the same age group (NAC, 2017). Among young women, HIV prevalence increases with age, with 2.7% of women aged 15-17 living with HIV, increasing to 13.9% of women aged 23-24; meanwhile among young men HIV prevalence holds steady at around 2.5% until the age of 23-24 when it increases to 6% (ZDHS, 2016). In addition, HIV prevalence among young people (15-24) could be significantly higher as only 64% of young women (and 47.5% of young men have ever tested for HIV (ZDHS, 2016). There are several underlying causes that increase the risk, vulnerability and susceptibility of women and adolescent girls to higher HIV infections. These include poverty, gender inequality and disparities in economic benefits and social capital, cultural social and religious norms, policy inconsistences and male domination in decision making.

This Theory of Change is developed based on a detailed review of over 30 documents related to HIV and SRHR in Zimbabwe including epidemiological studies, research, national standards, policies and several recommended strategies. Through a Project Implementation Planning workshop the TOC was validated with representatives from the District AIDS Commissions and local staff and partners from Youth Engage and Katswe Sistahood who were able to validate the logic model but also share their proven approaches and on the ground experience, responding directly to the needs of vulnerable populations. To achieve the ultimate outcome of improved health of adolescent girls and young women (AGYW), one must understand the underlying situation and HIV risk factors mainly attributed to gender inequality that will shape the approaches (the intermediate outcomes) to this project.

HIV is pervasive due to a combination of drivers that include key behavioral (proximate) determinants including early sexual debut, multiple sexual partnerships (MSP), transactional sex and low condom use which significantly contribute to the high rates of infection particularly among young women (NAC, 2017). The age of sexual debut among women is about 40% before age 18 (twice as high as men) and is sometimes as early as 12 years (DHS, 2016). The levels of MSP in men and women in Zimbabwe has been on the increase and is higher in younger age groups. In addition, age-disparate partnerships may be the main behavioural determinant of the more rapid rise in HIV prevalence in young women than in men in Zimbabwe. In 2015, one in five (20%) young women age 15-24 reported having sexual intercourse with a partner who was 10 or more years older and older men not only have a higher HIV prevalence but also have higher levels of sexual risk behaviour. In 2015, only 30% of men and 18% of women reported using a condom at their last sexual interaction. (DHS, 2016). With low levels of using protective measures, such as condoms, the prevalence of sexually transmitted infections (STIs) and HIV among sexually active youth is quite high. Young women are more susceptible to HIV/STIs as they often lack the power to avoid sexual coercion or to negotiate safer sex with their partners. Many of these proximate determinants will be addressed through engaging young people and increasing their awareness on the associated risks through intermediate outcome 1100.

These behavioural drivers are heavily influenced by several socio-cultural and socio-economic determinants. Due to economic hardships, young women often turn to un-protected transactional sex which puts them at higher risks of HIV. More than half of all sex workers in Zimbabwe are living with HIV with a last recorded prevalence of 57.1% in 2016. Sex workers are amongst the vulnerable groups that have one of the highest HIV incidence rates as well (NAC, 2017). Young women's vulnerability is further compounded by child marriage (34% of women aged 20-24 years old were married or in union before they were 18 years old), which has consequences for teenage pregnancies (24% within the age range of 15-19 years), which further limits their educational and economic advancement (MOWGACD, 2014). Gender based violence, including intimate partner violence is another factor that fuels the epidemic. Approximately 17% of women believe their husband has a right to beat them if they refuse sex, suggesting that they therefore would be unlikely to refuse sex. With such gender and power imbalances, condom negotiation is difficult for women (Avert, 2016). Some of the cultural practices that put adolescents at risk include: child / early marriage, traditional personal hygiene and cleansing practices, wife pledging (kuzvarirwa) and HIV cleansing (NAFS, 2017). Socio-cultural and religious norms also suppress discussion and acceptability of comprehensive sexuality education in school settings, prohibits condom promotion and criminalises same-sex behaviors with severe negative impacts on HIV incidence.

To curtail the epidemic, it is critical that responses should be designed to target sub-groups of the general population and priority areas where investments would have the greatest impact. This project will focus on some of the hotspot areas (high prevalence and risk factors and highest likelihood of new infections, where there are high STIs) identified in Smart Investment to End HIV/AIDS in Zimbabwe based on Hotspot Analysis (WFP, 2015) and recommendations from the District AIDS Coordinators which includes Goromonzi, Seke, Mazowe, Umguza. While urban trends have shown a slight improvement in HIV rates, there are pockets of vulnerability within urban areas particularly in highly populated urban informal settlements and mining communities where economic disparities have increased vulnerability in the low economic-strata and to younger women in these communities who engage in sex work. Other vulnerable areas include: i) mining areas which are densely populated and present high-risk factors for STI and HIV transmission; ii) peri-urban and border areas which have overflow from urban areas and/or mobile populations, and; iii) farming communities with low HIV/STI awareness and limited access to information and services.

The four selected geographies exhibit a range of socio-economic characteristics that warrant special attention amidst the STI hotspots. The context of each of these districts is further detailed to provide a basis for the necessary project interventions to support this TOC.

Goromonzi is a peri-urban district comprised of mines, farms and several highway corridors (Nuamapanda and Mutare) with close proximity to the capital Harare. The high levels of poverty, the mobile population and the proximal locations to urban centres along highway corridors contributes to high levels of transactional sex. Goromonzi has a high number of STI cases compared to other districts in the province and a HIV prevalence rate is at 15.5 % among age group of 15-49 for both men and women (2018 HIV Estimates). Populations most affected include young sex workers, AGYW and farm workers. Pervasive cultural practices such as early child marriage, age-mixing and economic power relations further contribute to increase in teenage pregnancies. There is a continued increase in school dropouts due to teenage pregnancy or early marriage. AGYW are also vulnerable to sexual and gender-

based violence (SGBV) including intergenerational sex in farms , mines and schools surrounding the hotspots areas. Within AGYW and young men, there levels of knowledge of STIs and HIV prevention is low. Currently there are few interventions targeting this vulnerable population. Furthermore, health services are scattered and accessibility is often a challenge for AGYW. Key strategies to address the above will include HIV combination prevention and service provision for sex workers through moonlight testing and mobile clinic services.

Seke is a peri urban district with agriculture being the main economic activity through horticulture, dry land farming and selling of farm products. Seke has a very high rate of teenage pregnancies and there is limited knowledge on adolescent sexual and reproductive health and rights (ASRHR) among adolescents and young people in general. Furthermore, there is a low uptake of HIV Testing by adolescents (15% tested) and the HIV prevalence rate is at 16.5% (NAC, 2018 estimates). There is an increase in some sex work around Ziko and Guzha which are considered the hot spots. Alcohol and drug abuse is common and contributing to SGBV. There is limited access to health information and services including family planning as well and adolescent and youth friendly services.

Mazowe district has the highest rate of child marriage in the country attributed to high levels of poverty and leading to high levels of school dropouts. Mazowe has one of the oldest mines and has high levels of artisanal gold mining which supports and attracts high levels of transactional sex work. The National Aids Council (NAC) reported that HIV prevalence rate in the district is at 18.6% which is higher than the national at 14%. Key drivers of the epidemic include having multiple concurrent sexual partners and this includes sex work, incorrect and inconsistent use of condoms, unequal gender relations resulting in SGBV and child marriages. AGYW are vulnerable to STIs, HIV and high levels of SGBV and intergenerational sexual relations. Some key strategies necessary to address these challenges include more comprehensive information on SRHR, SGBV and HIV; access to support for victims of SGBV; improved access to SRHR prevention and treatment services.

Umguza district is primarily a rich agricultural district with some manufacturing industries and small-scale artisanal mining facilities dotted around the district. Umguza has the highest incidence of STIs in the country and has the second highest HIV prevalence (19%). The mining activities, farming compounds and the presence of uniformed forces has led to sex work among AGWY making them vulnerable to STIs including HIV. There is a low level of comprehensive knowledge of sexual and reproductive health (SRH) and HIV prevention among young people. Access to HIV testing and SRH and HIV services are limited. Furthermore, there is inadequate youth friendly SRH services for tertiary institutions and for out of school youths. In addition, early marriage and teenage pregnancies are common. Simba Utano will partially model its Umguza program on the Global Fund's Sista2Sista project which focuses on empowering AGYW with SRH and HIV information through mentorship programs. It will also work with the Young People's Network on Sexual Reproductive Health, HIV and AIDS. Some key strategies include the provision of information about reusable sanitary pads and condom demonstrations.

In Zimbabwe, gender inequality significantly impacts the spread of HIV particularly among AGYW. This will be detailed in the forthcoming Gender Equality (GE) Strategy. Women are disproportionally affectedly particularly due to their position within patriarchal societies. Entrenched socio-cultural

beliefs and practices and unequal gender power relations prevent sex negotiation and protected sex in relationships including marriage, further fuelling the epidemic. The high prevalence of STIs, including HIV in women and girls as well as key population groups is attributed to low utilisation and inconsistent use of condoms due to the inability to negotiate condom use, violence against women, and failure to disclose HIV status. Household poverty reduces disposal income in the home and the girl child often becomes the victim of choice as compared to the boy child to drop out school when the family faces socio-economic challenges. School drop-out in most cases result in adolescent pregnancies and child marriages. Adolescent pregnancies are more than twice higher among girls with primary education than among those who attended secondary school. Childbearing at an early age greatly reduces women's educational and employment opportunities, contributes to the perpetuation of household poverty, and often leads to young girls engaging in transactional sex. Adolescent pregnancy has massive psycho-social, economic and health consequences including emotional stress, low self-esteem, dropping out of school, expulsion from school, stigmatization of single mothers, forced marriage and/or promiscuity, abandonment, unsafe abortions, suicide, poverty, and negative health outcomes for both the mother and child (Zimabwe's National Adolescent Fertility Study conducted by UNFPA in 2017). Gender inequality is present within relationships and marriages, with only 68% of men believing a woman has the right to refuse sexual intercourse if she knows he has sex with other women. Gender-based and intimate sexual violence is pervasive, with more than a quarter of women with a married or stable partner having experienced physical or sexual violence from their partner preventing women from negotiating use of condoms and further increasing risk of HIV; 22% of women report their first sexual intercourse was forced and this rises to almost 28% for those reporting that their first sexual experience was under the age of 15. These factors buttress the need to empower adolescent and young women to make informed sexual and reproductive health decisions, and also, the need for interventions to address the underlying inequalities that place girls in these positions. Furthermore, harmful gender norms on masculinity also serve as a barrier to men's uptake of sexual health and HIV prevention and treatment services which subsequently increases their risk to HIV exposure. The Zimbabwe Gender Assessment report (2013) and the Zimbabwe National Gender Policy (2013 – 2017) was reviewed and the project will draw from the Girl and Young Women's Empowerment Framework (2014) produced by Ministry of Women Affairs, Gender and Community Development, and the draft national HIV and Gender strategy (2017).

One of the key assumptions is the recognition that power imbalances and unequal access to resources and services is grounded in patriarchal and unequal power relations that limit and control women's choices over their health. This project seeks to address gender inequality and support Canada's GE policy by: i) advancing women's equal participation with men as decision-makers in shaping decisions particularly around their own health and well-being; ii) supporting women and girls in realizing their full human rights and most importantly their right to health; and iii) reducing gender inequalities in access to and control over health services through engaging women and girls in the delivery and monitoring of services and advocating for improved implementation and legislation. Proposed interventions outlined below such as awareness raising, shifting community attitudes and social norms will help transform gender relations and address gender inequality.

The Project's theory of change is grounded in the following assumptions that:

- women and girls' sexual and reproductive choices are a fundamental human rights (right-based approach) that are essential in advancing gender equality, autonomy and empowerment;
- collaboration, participation, learning and addressing both the 'demand' and 'supply' sides of SRHR is key to project success, and;
- local organizations and communities are at the frontlines of SRHR work and key drivers of change and therefore must be supported through strengthened capacity, improved relationships with key decision makers, and enhanced ability to influence change.

These assumptions are integrated in the program's three components (intermediate outcomes), which together will contribute to achieving the ultimate outcome of improved health of adolescent girls and young women (AGYW) at risk of HIV in four priority districts in Zimbabwe. A comprehensive approach that summarizes this project would be one that draws from the Sexual and Reproductive Health Rights Programmes for Young People, Essential Packages Manual (Rutgers, 2016). This model has three main components: SRHR education (demand); SRHR services (supply); and a supportive environment (advocacy). Adapting from this approach, component one (Outcome 1100) aims to increase utilization of SRH and HIV services addressing the demand side through increasing self-awareness, community awareness and acceptance. Component two (Outcome 1200) focuses on the supply side through improving delivery of services through building capacity within the health system and in communities and ensuring enabling environments to support integrated SRH and HIV service delivery. Component three (outcome 1300) focuses on the rights aspects and ensures effectiveness of AGYW, health workers and community organizations to advocate for SRHR. These components complement each other: the programming informs advocacy, and the policy context supports the programming. This project also adapts strategies from the *Country Assessment to Strengthen Adolescent Component of National HIV Program in Zimbabwe*: and the *Roadmap to Revitalise HIV Prevention in Zimbabwe 2016.* The comprehensive national response to the HIV epidemic in Zimbabwe currently indicates that sustained behavior change (promotion of safe sex practice) will be central to ending HIV and AIDS by 2030. One of the key recommendations for programming requested by the Women's Coalition of Zimbabwe to the Global Fund (2017-2019) is to ensure community engagement and social behaviour change communication that promotes gender transformative models.

The following is an updated Logic Model for Simba Utano followed by a comprehensive description of the results.

Logic Model for Simba Utano

ULTIMATE OUTCOME:	1000 Improved health of adolescent girls and young women (AGYW) at risk of HIV in four priority districts in Zimbabwe				
INTERMEDIATE OUTCOMES:	1100 Increased utilization of gender–equitable and adolescent-responsive[1] SRHR[2] and HIV services by vulnerable AGYW in 4 districts of Zimbabwe		1200 Improved delivery of gender equitable and adolescent responsive SRHR and HIV services to address needs of most vulnerable AGYW		1300 Improved effectiveness of AGYW, health workers and community organizations to advocate for SRHR.
IMMEDIATE OUTCOMES:	1100 Increased knowledge and awareness of SRHR and HIV among vulnerable AGYW.	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.	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.	1220 Strengthened integrated response to support the delivery of gender-equitable and adolescent responsive SRHR services to vulnerable AGYW	1310 Increased knowledge and skill of AGYW, health workers and community organizations to advocate for SRHR.
OUTPUTS:	1111 Assessments conducted to understand the unique needs of vulnerable AGYW in selected wards from hotspots in the four districts.	1121 Youth Champions, Community Facilitators and Pachoto groups trained on effective communication skills to increase awareness of SRHR and HIV at the community level	1211 Facility-based Health Service Providers trained on gender-equitable and adolescent responsive SRHR and HIV service delivery and referrals	1221 Coordinating committees established to link SRHR services for vulnerable AGYW at various levels of the health system.	1311 Community Youth and Health Champions trained and supported to produce and use data related to delivery of SHRH services for vulnerable AGYW.
	1112 Youth Champions, Community Facilitators and Pachoto Groups established and trained to engage vulnerable AGYW on SRHR and HIV.	1122 Parents and caregivers engaged to better understand impact of harmful social norms.	1212 Community Health Workers trained on gender-equitable and adolescent-responsive SRHR and HIV service provision and referral.	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.	1312 Health Center Committees strengthened to advocate for the needs of vulnerable populations including AGYW and PLHIV.
	1113 Sensitization conducted of vulnerable AGYW, on SRHR and HIV.	1123 Traditional and community leaders engaged to better understand impact of harmful social norms.	1213 District dialogues conducted with health service providers to facilitate access by vulnerable AGYW to gender -equitable and adolescent responsive SRHR and HIV services and referrals.	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 [3]	1313 Participatory community-based assessment tools adapted to assess SRHR/HIV service acceptability, availability and access.
		1124 Young men and adolescent boys engaged to better understand impact of harmful social norms.			1314 Public awareness and promotional materials developed and distributed

[1] Gender-equitable and adolescent-responsive is defined as care and support to address priority needs of AGYW.
[2] The project will include a strong focus on SGBV in response to the local context.
[3] Twinning with domestic and/or international CBOs might also be arranged under intermediate outcomes 1100 and 1300.

Intermediate Outcome 1100 seeks to address some of the socio-cultural barriers that impede access and utilization of services by engaging and working with individuals and communities to inform, affect attitude change and/or challenge social norms. This outcome draws heavily from the "ecological model for an enabling environment for shaping adolescents sexual and reproductive health" (Svanemyr, et. al, 2015) which considers the four spheres of influence (individual, relationship, community and societal) for creating enabling environments for adolescent SRH.

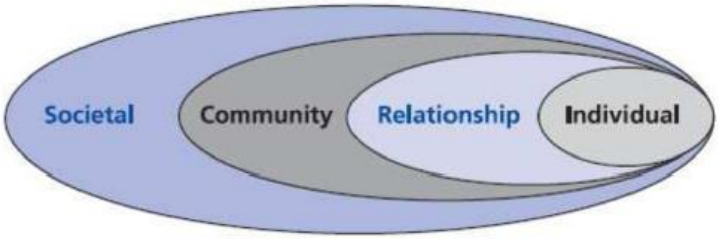


Figure 1. Ecological model for an enabling environment for shaping adolescent sexual and reproductive health [5].

https://www.sciencedirect.com/science/article/pii/S1054139X14004236

Outcome 1110 starts at the **individual level**, focusing on increasing AGYW knowledge and awareness. Social norms and taboos related to gender, sexuality and SRH issues create a culture of silence particularly for adolescent girls who become reluctant to ask for information or to express their worries about SRH. Many girls have limited agency to express themselves without judgment and know few people and places to seek correct information and support. Providing information empowers one to make informed choices but also promotes self-efficacy. Output 1111 focuses on understanding the unique needs of AGYW which will be accomplished through the baseline, gender assessment and innovative means such as storytelling and journaling. Output 1112 will work with existing structures such as Youth Champions, Community Facilitators, Pachoto Groups, Youth Theater and Arts Groups (comprised of AGYW and peers) and provides them with the training and resources to effectively engage with AGYW and the community. Output 1113 focuses on the sensitization of the wider community to the needs of the AGYW through: monthly Pachoto safe space meetings; outreach to hotspots for vulnerable key populations, and through theater and arts festivals. This mobilization will be organized by young people for young people. It will also focus on improving AGYW accessibility to SRHR and HIV information.

Outcome 1120 expands to include **relationship, community** and **societal** spheres which focuses on influencing and reducing behaviours that heighten risk for STI/HIV transmission. Output 1121 focuses on improving the communication skills of the Youth Champions, Community Facilitators and Pachoto groups to increase awareness of parents, caregivers, traditional and religious leaders, young men and adolescent boys. Ongoing mentorship and job aides will be developed for these groups to support their outreach activities. Output 1222 focuses specifically on reaching parents and caregivers through dialogues and mass media on key issues affecting young people and their SRH. Output 1123 will work with the community gate-keepers such as traditional and community leaders to engage them to better understand the impact of harmful social norms on AGYW. Output 1124 will work with young men and

adolescent boys through effective forums (i.e. Men Engage) to promote community support and will foster open communication within intimate relationships.

Intermediate Outcome 1200 focuses on the delivery of gender equitable and adolescent responsive SRHR and HIV services by improving the knowledge and skills of facility and community health services providers (1210) and strengthening the integrated response in service delivery (1220). The absence of confidential and judgment-free environments can be a barrier to girls obtaining SRH information.

Outcome 1210 focuses on improving the quality of services by building the knowledge and skills of facility-based service providers and community health workers and ensuring availability of services through district dialogues. Through output 1211, health services providers at facilities will be sensitized and trained on gender-equitable and adolescent responsive SRHR and HIV service delivery including referrals for issues such as SGBV. Output 1212 wll increase the capacity of community health workers. Community health workers include Village Health Workers (VHWs) and the Behaviour Change Communicators (BCCs) The VHWs and BCCs will be trained in ethics, human rights and GBV prevention and management. Output 1213 will create an opportunity for young people to dialogue with health workers around adolescent and youth friendly services. Note that the advocacy activities will be conducted under Outcome 1300.

Beyond direct health service delivery, outcome 1220 focuses on integrated response mechanisms within and external to the health system. Output 1221 coordinates outreach to vulnerable populations in hotspots, holding multi-sectoral cluster meetings and ensuring referral protocols are followed. Output 1222 addresses bottlenecks within the health system by sensitizing non-medical staff, administrators and community advisory groups to support gender-equitable and adolescent responsive SRHR and HIV services. This would ensure support for quality services delivery and ensure stocks and supplies are maintained. Output 1223 focusing on twinning with other CBOs and organizations working in similar work to enhance learning and promote quality programming.

An important part of health systems is to ensure there are accountability mechanisms exist for quality services and stakeholders such as AGYW are meaningfully engaged in program design, implementation and monitoring. Outcome 1300 builds the effectiveness of AGYW, health workers and community organizations to advocate for SRHR. Outcome 1310 will engage key stakeholders, including AGYW, to develop skills to be effective policy influencers. Output 1311 introduces a novel way of engaging young people to become “data reporters”. Youth Champions will be identified and trained as data collectors and will develop an accountability framework for young people on key issues such as teen pregnancy, SGBV, the impact of early marriage and HIV & STIs among AGYW. These groups will be trained to collect and analyze data and will conduct stakeholder engagement and advocacy activities with key government ministries on gender-responsive, inclusive and accountable SRHR and HIV services and policies. Quarterly joint reflection meetings, participation in committees and policy dialogues are some of the proposed engagement activities. Output 1312 focuses on the need for Health Center Committees (HCCs) to be more inclusive of SGBV survivors, teen mothers, sex workers and PLHIV. *Community Scorecards* have been used in other programs in Zimbabwe and have been shown to be effective tools for holding duty-bearers accountable. Katswe Sistahood has already used them to track a set of health targets and indicators over a period of two years and they have contributed to improving

health centre staff attitudes towards adolescents' access to SRHR services and information. Output 1313 supports the development of advocacy tools focussing on assessing SRHR/HIV service acceptability, availability and access.Output 1314 supports the production and development of SRHR materials and also includes the promotion of key campaigns such as the Day of the African Child. This project will employ innovative approaches such as story-telling and digital filming documentation, *PhotoVoice;-* where AGYW themselves will lead the process of documentation and reporting.

Environmental Sustainability

This project was assessed through GAC's environmental screening tool (EIP) and was categorized as a Category C project with negligible environmental risks as the activities are focus predominantly on capacity building. The primary mandate for this project is to build the technical capacity and governance of community-based organizations, their partners and the community level response to HIV and SRHR. Wherever feasible, the project will strive to minimize environmental impacts e.g. through reducing its carbon footprint by minimizing travel. Most activities in the project involve training of community volunteers and health workers and they will be sensitized on appropriate disposal of medical waste including condoms.

Human Rights

Sexual and reproductive health and HIV is related to multiple human rights, including the right to life, the right to health, the right to be free from violence and torture, the right to privacy, and the prohibition of discrimination as highlighted in the International Covenant on Economic, Social and Cultural Rights; and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). The key population data shows continued high risk of HIV and STIs and the incarceration, harassment from police and punitive laws make it difficult to promote safer behaviors. For instance, the possession of condoms is used as proof of sex work leading to arrest. This is also true for men who have sex with men (MSM), lesbian, bisexual and transgender groups who continue to experience complex legal persecution and multi-faceted discrimination and marginalization that contribute to heightened HIV risk and vulnerability. Social isolation, stigma and discrimination, and repressive policies and legislation create hostile environments where very few social or legal protections exist. These results in barriers to accessing SRHR services including HIV testing (knowing one's HIV status), counselling, prevention, treatment and support.

AGYW and women in target communities cannot make decisions on their own reproductive health and are denied access to information or quality services. The right to health includes access to timely, acceptable and affordable health care of appropriate quality. This project will seek to transform negative attitudes, norms and behaviors pervasive in patriarchal communities through sensitization and engagement of duty-bearers including men, health administrators and policy makers. Young people, AGYW and PLHIV will be engaged in gathering information, data collection and utilizing data for advocacy and social change. The key human rights issues will be discussed as part of the the Gender Equality Strategy as they are reflective of the situation in the four districts.

Project Risks

There are several key risks that would hinder that attainment of the project outcomes and it is important to consider these and their relevant mitigation measures.

i. Fiscal Considerations

Usually fiscal matters are considered a manageable risk, but in the case of Zimbabwe, this is a unique risk. An unstable economy, unprecedented inflation and a lack of financial stability makes project implementation more complex. To avoid the possibility of the Central Bank freezing funds in Zimbabwe, one of the mitigation measures presently under discussion with GAC is to transfer and hold project funds in US dollars in a secure stable account in Botswana. Funds would then be transferred across on an "as needed" basis.

ii. Community Sensitivity around Gender Norms and Sexual Rights

Since the program tackles sensitive topics around sexuality and sexual rights, there could be a backlash from gate keepers, leaders, parents and norm-setters in the community, particularly around issues of power and gender dynamics. The project will utilize local community volunteers/community agents to work with community structures. The project will also use culturally-sensitive and appropriate messages and strategies in its sensitization, mobilization and advocacy efforts. The project will sensitize key stakeholders on gender equality and will utilize proven mechanisms for tackling some of these barriers e.g. Pachoto groups.

iii. Health Worker Bias

There is a risk that project implementation may be resisted by health workers, health administrators and policy makers based on their own beliefs and perceptions. To mitigate this risk , the project will complement facility based interventions and and utilize community mechanisms such as VHWs to support the outreach and services to reach AGYW. The project will carry out gender sensitization among health workers to be more gender responsive and work with vulnerable populations including adolescent girls and sex workers. Working through partners and with key beneficiaries especially young people, the project will influence and advocate for SRHR and lobby to influence policies. It will use innovative ways to hold duty-bearers to account. The project will continue to advocate for rights and investments in SRHR, including comprehensive HIV services for adolescents and young women.

iv. Retention of Community Volunteers and Facilitators

There is risk of retention of community volunteers and facilitators. However, these have been carefully selected from the existing communities and they have an inherent and vested interest to support the development of their own communities. In addition, volunteers will be linked to economic opportunities to support their daily sustenance. The project also takes a unique approach in engaging young people in data collection and monitoring which not only builds capacity but ensures ownership and sustainability of the interventions.

v. Security Risks

Civil unrest and insecurity will be an ongoing challenge for te project especially in light of the deteriorating economic situation. The lack of commodities such as electricity and fuel will obviously have an operational impacts. The development of a security protocol for staff and volunteers will be a priority.

vi. Natural Disasters and Climate Change

Lastly, climate change has had some impact particularly around food production and growing cycles with intermittent rains, flooding (Idai), droughts, pestilence making it difficult for communities to plan and ensure household food security. There is a risk that these natural disasters may affect project implementation. While the project has little control over these, it will monitor the situation through the existing warning systems and adjust planning according to the situation to ensure that SRHR and HIV support services are still maintained.

Sustainability Planning

The proposed activities have been developed in close communication and collaboration with local partner organizations to identify core needs at a grass-roots level and who are already working within the priority districts. The project will use evidence-based approaches that are already proven within these communities and will support and strengthen the scale-up and roll-out of these through providing training and support.

The project will tackle the barriers to participation by engaging and sensitizing local leadership, men and boys in SRHR issues including gender equality. One of the unique strategies of this project is to utilize existing community resources including young people and PLHIV as agents of change. In addition, the project will build on existing structures such as Pachoto Groups and Community Facilitators. Furthermore, the project will engage young people to conduct project monitoring which in turn will support their advocacy efforts and ensure their meaningful participation in decision making. Reducing HIV-related and gender-based stigma and discrimination and empowering AGYW as active agents of change will contribute to resilient and sustainable systems for health and improved health of AGYW at risk of HIV in four priority districts in Zimbabwe.

The long-term sustainability of each local partner organizations will be strengthened in terms of capacity and performance, particularly in the area of governance and community engagement, empowerment and advocacy. The partners will improve their technical capacity and project management skills which will enable them to scale-up and attract more resources in the future. The community sector continues to have a vital role to play in advocacy, especially in holding key stakeholders accountable for delivery of adolescent and youth friendly SRHR and HIV services.

Working with health authorities, facilities and staff, the project will improve the long-term quality of SRHR and HIV services. The project will have a lasting impact by building the capacity of local institutions, strengthening the health system and empowering young people in their own development.

C. Reach

As we noted in the theory of change, to curtail the epidemic it is critical that the responses are designed to target sub-groups of the general population and priority areas where the investments have the greatest impact. Consequently, the project will focus on some of the hotspot areas defined in *Smart Investment to End HIV/AIDS in Zimbabwe based on Hotspot Analysis* (WFP, 2015) as those with high HIV prevalence, high risk factors (such as STIs) and where there is the highest likelihood of new infection. The selection of hotspots was done with the advice and recommendations from the District AIDS Coordinators (DACs).

When the initial proposal was submitted, four districts had been selected: Bubi, Mazowe, Marondera and Chipinge. The estimated number of direct beneficiaries was 85,000 AGYW (ages 10-24), 25,000 young men (ages 10-24) and would include (young and adult) key populations including men who have sex with men (MSM) and sex workers. The project originally planned to work with over 480 (280F, 200M) Village Health Workers, Peer Educators, Behaviour Change Communicators, Community Leaders, Health Workers and Administrators and would indirectly benefit a population of over 300,000 (51% F) in the four districts.

More than two years later, much has changed. Most importantly, other donors (particularly the Global Fund to Fight AIDS, Tuberculosis and Malaria) have risen to the challenge and started to work in some of the districts identified in the original proposal. At the PIP workshop in Harare in November 2019, it was recommended, in consultation with the DACs, that the project would target those districts and wards in which no other donor was operating. Consequently, along with the continuation of Mazowe, three new districts were selected: Umguza, Seke and Goromonzi. Because of geography, distance and cost, it was agree that it would not be feasible or even necessary to focus on all regions within each district and consequently specific hotspot wards were identified

The estimated **direct** beneficiaries from this project will be 31,100 AGYW (ages 10-24) and 12,728 young men (ages 10-24). The project will also train and engage youth champions (98F, 50M), community facilitators (100F, 50M) and men engage facilitators (26F, 48M) who will influence religious leaders (240F, 480M), community leaders (120F, 600M) and other intermediaries (4235 F, 4945M) including policy makers, parents and care givers, health service providers, community health workers as well as sex workers and men who have sex with men. The project will **indirectly** benefit a population of 170,000 in the four districts (52% F) and will include 26,700 women of reproductive age (25-49 years). It will also influence policies at the district and national level, with lessons learned and best practices.

List of Districts and Wards

District Name	*Wards*
Umguza	Hopefountain, Kensington, Fairbridge, Muntu, Stanhope
Mazowe	Ceaser Mine, Nzvimbo, Amatol, Mzowe Mine, Tsvungubvi, Somerset, Concession, Glendale
Seke	Nemasanga, Mandedza, Beatrice, Matiti, Nyatsime

Goromonzi	Murape, Mwanza, Mawanga, Acturus, Ivordale, Chinyika

A table providing additional information on the wards and population/target groups is included as Annex 1.

D. Outcome-Based Schedule

i. Workplan for Year 1

The activities and sub-activities are attached as Annex 1

ii. Workplan for Project Duration

Activity		Year 1 (Jan – Dec)					Year 2 (Jan – Dec)				Year 3(Jan – Dec)				Year 4
		PIP	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
1110	**Increased knowledge and awareness of SRHR and HIV among vulnerable AGYW**														
1111	**Assessments conducted to understand the unique needs of vulnerable AGYW in selected wards from hotspots in the four districts**														
1111.1	Organize a meeting with 30 AGYW representatives/30 stakeholders from selected wards														
1111.2	Document their experiences through story-telling and journaling														
1111.3	Analyse the findings to incorporate into programming														
1112	**Youth Champions, Community Facilitators and Pachoto Groups established and trained to engage vulnerable AGYW on SRHR and HIV**														
1112.1	Identify adolescents and young people for Youth Champions, Community Facilitators and Pachoto Groups														
1112.2	Formation of Youth Champions														
1112.3	Formation of Community Facilitators														
1112.4	Setting up of ward level Pachoto groups														
1112.5	Establish youth theatre and arts groups for outreach														
1113	**Sensitizing Stakeholders and Partners on the SRHR Challenges faced by AGYW**														
1113.1	Conduct monthly Pachoto safe spaces for AGYW														
1113.2	Organize outreach for hotspots and to reach vulnerable key populations														
1113.3	Conduct Pachoto outreach meetings; theatre and arts for demand creation														
1113.4	Organize Nzwika (Arts Festival) at district and national levels to create awareness for AGYW														
1113.5	Community sensitization with key stakeholder at district and ward levels														
1113.6	Organize and participate in the quartely provincial Adolescent Sexual Reproductive Health(ASRH) Forum to share project experiencies and lessons learnt for input into the national ASRH forum														
1113.7	Organize and participate in the HIV & AIDS Multi-Sectorial District taskforce to influence the agenda and input into the National AIDS Council Reporting Mechanism.														
1113.8	Bi-Annual MPs & Youth Indaba at the National level														
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.**														
1121	**Youth Champions, Community Facilitators and Pachoto groups trained on effective communication skills to increase awareness of SRHR and HIV at the community level.**														
1121.1	Review and revise Simba Utano (Pachoto and Youth Data Reporters Program)Training Manual														

Activity		Year 1 (Jan – Dec)					Year 2 (Jan – Dec)				Year 3(Jan – Dec)				Year 4
		PIP	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
1121.2	National level Training of Trainers of Community Facilitators (30 facilitators from the 4 districts trained) on Pachoto the methodology														
1121.3	Training of community facilitators(120 pple across all districts) on youth friendly service provision movement building and effective communication														
1121.4	Training of 120 Youth Champions (30pple x 4 districts)														
1121.5	Training of 120 Community Facilitators(30 pple x 4 dist = 120) at ward level for running Pachoto groups														
1121.6	Ongoing mentorship and support for community facilitators														
1121.7	Job aides for Youth Champions and Community Facilitators														
1122	**Parents and caregivers engaged to better understand impact of harmful social norms**														
1122.1	Adapt materials for awareness-raising with community stakeholders including parents and leaders														
1122.2	Community dialogues on SRHR and HIV with parents, caregivers - quarterly														
1122.3	Diseminate key messages through mass media e.g. radio														
1123	**Traditional and community leaders engaged to better understand impact of harmful social norms**														
1123.1	Organize bi-annual meetings for traditional leaders engagements through meeting														
1123.2	Organize bi-annual meetings for religious leaders engagements through meeting														
1124	**Young men and adolescent boys engaged to better understand impact of harmful social norms**														
1124.1	Organize Men Engage forums bi-anualy														
1124.2	Participate in SGBV prevention awareness days/events e.g. 16 days of activism														
1124.3	Launch of Annual Advocacy Campaign on a selected theme: Teen Pregnancy, SGBV, Early Marriage, HIV & STIs among AGYW in Hotspots														
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**														
1211	**Facility-based Health Service Providers trained on gender-equitable and adolescent responsive SRHR and HIV service delivery and referrals**														
1211.1	Develop Training Toolkit for Health Service Providers														
1211.2	Provide training on gender equitable and youth friendly services for Health Service Providers														
1211.3	Provide training on gender equitable and youth friendly services for CBOs and Youth Networks														
1211.4	Organize reflection meetings with Health Service Providers on available data and emerging issues collected by project trained youth champions														
1212	**Community Health Care Workers (i.e. Village Health Workers, Community Adolescent Treatment Supporters) trained on community centered gender-transformative and adolescent-responsive SRHR and HIV approaches including human rights, SGBV**														

Activity		Year 1 (Jan – Dec)					Year 2 (Jan – Dec)				Year 3(Jan – Dec)				Year 4
		PIP	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
1212.1	Develop the toolkit														
1212.2	Organize workshop for Community Health Care Workers														
1213	**District dialogues conducted with health service providers to facilitate access by vulnerable AGYW to gender -equitable and adolescent responsive SRHR and HIV services and referrals.**														
1213.1	Capacity Training of 30 Youth Champions on conducting advocacy dialogues on Teen Pregnancy, SGBV, STIs/HIV														
1213.2	Selected Pachoto Champions/Data Collectors attend quarterely key meetings to push agreed Advocacy positions														
1213.3	Advocacy dialogues conducted quartely with health service providers														
1213.4	Production of Advocacy IEC material on emerging themes targeted at different Stakeholders														
1213.5	Reproduce the Patients Charter adapted to AGYW needs & realities along with Referral Pathway														
1213.6	Support Youth Champions, Advocates run Social media advocacy campaigns, SIMBA UTANO bloggers - and podcasters club production sessions														
1213.7	Website maintenance														
1220	**Strengthened integrated response to support the delivery of gender-equitable and adolescent responsive SRHR services to vulnerable AGYW**														
1221	**Coordinating committees established to link SRHR services for vulnerable AGYW at various levels of the health system**														
1221.1	Map the districts and identify clusters of wards within and around HIV and STIs hot spots .														
1221.2	Facilitate adolescent and youth friendly outreach on SRHR and HIV information and services for indentified hotspots														
1221.3	Map Community Health Care Worker and health service providers for each of the 3 clusters at district level														
1221.4	Organize 3 multi-sectorial cluster meetings per district to strengthen referral systems/ pathways for adolescents and youth health (clusters around hotspots)														
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**														
1222.1	Identify key health facility managers and health administrators for sensitation meetings in collaboration with NAC														
1222.2	Organise sensitization meetings with the Health facility managers/ health admins/ MOH department heads														

Activity		Year 1 (Jan – Dec)					Year 2 (Jan – Dec)				Year 3(Jan – Dec)				Year 4
		PIP	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
1222.3	Convene feedback meetings with Health facility managers/ health admins/ MOH department heads on provision of YFS at district level.														
1223	**Twinning facilitated with international or domestic CBOs to enhance their capacity to deliver quality gender transformative and adolescent responsive SRHR and HIV services**														
1223.1	Identify needs, gaps and possible international CBOs/NGOs which could address needs/gaps														
1223.2	Arrange partnerships														
1223.3	Organize travel and other logistics between the partnerships														
1223.4	Incorporate lessons learned through mixed-media from the parternership into the service provision cascade														
1223.5	International volunteer placments in Zimbabwe (2 vols/placment)														
1223.6	Volunteers placed in Canada (5)														
1310	**Increased knowledge and skill of AGYW, health workers and community organizations to advocate for SRHR.**														
1311	**Community Youth and Health Champions trained and supported to produce and use data related to delivery of SHRH services for vulnerable AGYW.**														
1311.1	30 Youth Champions- Data Collectors engage in consultative meetings & develop a 10 point demands- Teen Pregnancy, SGBV, Early Marriage, HIV & STIs among AGYW advocacy paper														
1311.2	Training of Youth Champions on the Accountability Framework, Action Research, Data Collection & Advocacy														
1311.3	Monthly Data Collection meetings within Pachoto Groups														
1311.4	Conduct Stakeholder engagement-sensitization meetings with key Government Ministries on Gender Responsive, Inclusive & Accountable SRHR/HIV Services & Policies														
1311.5	Quarterly Joint reflection meetings i.e. preparation for Advocacy at District level														
1321.6	Quarterly Nzwika District level Festival Policy dialogues with Parliamentary Portfolio Committees (in the community), Duty Bearers & Policy Makers														
1321.7	Parliament Visits; Submission of Petitions, Position Papers & Follow up														
1312	**Health Center Committees strengthened to advocate for the needs of vulnerable populations including AGYW and PLHIV.**														
1312.1	Reconstitution of Health Centre Committees (advocate for inclusion of AGYW in the HCCs including SGBV survivors, Teen Mothers, Sex Workers)														
1312.2	Conduct 2 day capacity building workshops with Health Centre Committees														

	Activity	Year 1 (Jan – Dec)					Year 2 (Jan – Dec)				Year 3(Jan – Dec)				Year 4
		PIP	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
1312.3	Quarterly HCC - AGYW meetings ScoreCard review, data analysis meetings														
1313	**Participatory community-based assessment tools adapted to assess SRHR/HIV service acceptability, availability and access.**														
1313.1	Workshop- Review existing Accountability Framework, & develop Simba Utano Score Card														
1313.2	Design, Printing of Accountability Framework														
1313.3	Development of Promotional materials i.e. tshirts , banners														
1313.4	Health Center Committees, AGYW and PLHIV trained to gather, interpret and use data to advocate for gender equitable and responsive HIV and SRHR services and polices														
1314	**Public awareness and promotional materials developed and distributed.**														
1314.1	Production, printing and distribution of IEC material (flyers, posters, pamphlets, banners)														
1314.2	Production of media materials for sensitizations (short documentaries, photo voice)														
1314.3	Run social media mobilization monthly														
1314.4	Participate in 3 radio interviews annually														
1314.5	Production and distribution of annual newsletter/magazine														
1314.6	Documentation and packaging of advocacy material such as policy briefs														
1314.7	Information dissemination & Advocacy meetings with the Media (traditional, new) TV, Radio, Print, Social Media														
1314.8	Commemmoration of the Day of the African Child														
1314.9	Monitoring, Evaluation & Learning														
	Other Activities														
	Conduct Baseline Evaluation														
	Train KS and YE staff on Collection of Data for Gender Analysis														
	Conduct Gender Assessment														
	Purchase 2 vehicles (if approved)														
	Conduct Quarterly Partnership Meetings														
	Conduct Annual Workplan Meeting														
	Conduct Annual Project Steering Committee Meetings														
	Update Partner Websites														
	Conduct Endline Evaluation														
	Conduct Dissemination of Results Workshop														

E. Results-Based Management and Evaluation Plan

i. Performance Measurement Framework

The PMF is attached as Annex 2. The PMF outlines the plans for gathering information in order to monitor and report on progress under the Simba Utano project. Regular monitoring of performance will also allow for periodic revision of the logic model and the identification of adjustments to be made to interventions in order to ensure that these remain as responsive as possible to the expected outcomes of the project.

Indicators for the Simba Utano project have been carefully selected and reviewed during the PIP process to align with the Feminist International Assistance Gender Equality Toolkit for managing gender equality outcomes. It ensures that:

- All results have sex-age disaggregated and gender-sensitive indicators
- Baseline data and targets are sex-age disaggregated.
- Targets are set high enough to reduce gender inequalities within the scope and influence of the project

In addition, the project indicators have been influenced by the data collected by a number of other sources, including:

- The Zimbabwe Demographic Health Survey (ZDHS, 2016);
- National HIV and Gender Strategy (2017, draft);
- Roadmap to Revitalize HIV Prevention in Zimbabwe (2016);
- Girls and Young Women's Empowerment Framework (2014) produced by the Ministry of Women, Gender and Community Development (MOWGACD); and
- Smart Investment to End HIV/AIDS in Zimbabwe based on Hotspot Analysis (WFP, 2015).

The project relies on various data collection methods and tools. At ultimate outcome level, information will be obtained through existing reputable data sources notably the ZDHS. At intermediate outcome level, progress will be measured through various means. These include measures collected through the offices of the District AIDS Coordinators as well as survey tools implemented by Simba Utano for Parents, Care Givers and Young People. Survey tools will include a client satisfaction survey as well as one for health facility personnel. Survey tools will be used to establish baseline and endline measures over the four year period while existing tools will be used on an annual basis to measure performance.

At immediate outcome and output levels, a range of tools will be employed for more frequent data collection.. These will include monitoring tools such as the community score card and focus groups. Community-based tracking through bimonthly reports generated by KS's Pachoto Groups and YE's Young Champions will also be monitored. The community score card process will also serve to establish accountability between services and communities and features as an important measurement tool in the PMF. Survey tools will also be used at these levels to track more behavioural and qualitative outcomes such as perceived access to and control over resources. PMF targets have already been updated based on the data obtained from the Baseline Report and the Gender Equality Strategy (attached).

ii. Performance Reporting Framework

The table below outlines the performance reporting framework including report type, content, who is responsible for its preparation, report recipient(s) and schedule.

Project Reporting Table

Report	Content Areas	Responsible	Schedule
PIP	Project context, rationale, cross cussing issues, results, reach, LM, RBM, PMF, Revised Budget, roles and responsibilities., Gantt chart, Year 1 Workplan and Budget	ICAD	29 February 2020; The Gender Assessment will be submitted around the 10 Maarch and Baseline by the 20 March 2020
Annual Work Plans	Analysis of project context, performance, risks and mitigation strategies, updated planned activities, schedule and budget for the year	ICAD	Within 45 days following the end of the project year* February 15 2021 February 15, 2021 February 15, 2022 February 15, 2023
Annual Report	Project context, risk analysis, planned to actual results, explanation of variances	ICAD and ICASO	15 February 2021 15 February 2022 15 February 2023
Cost Share Tracking Form	To be submitted semi annually	ICAD	30 September and 31 March of each year
Financial Report and Request for Advance	Submitted quarterly	ICAD	Within 45 days after the end of each quarter
Audited Financial Statments	To be submitted annually (see CA for frau-uert link) with a copy to Department Representative identified in Agreement	ICAD	30 June 2020, 30 June 2021, 30 June 2022,

			30 June 2023, 30 June 2024.
Semi-annual narrative progress reports	Planned to actual results achieved and explanation of variances, management issues, lessons learned, qualitative information, accumulated results, progress on cross cutting issues	ICAD	August 15 2020 August 15 2021 August 15 2022 August 15 2023
Technical and other ad hoc reports	Reports on the use of consultants and other ad hoc reports when required	ICAD	As required
Project Steering Committee	Minutes of PSC meetings	ICAD	Within 14 days of each meeting
Asset Disposal Plan	Disposal of Assets Plan for approval	ICAD	30 June 2023
Final Narrative Report	All narrative considerations plus description and analysis of progress made towards handover to local partners. This report will include an assets disposal plan	ICAD	April 15 2024
Final Financial Report	Overall financial progress and closeout report	ICAD and ICASO	April 15 2024

F. Project Management and Governance

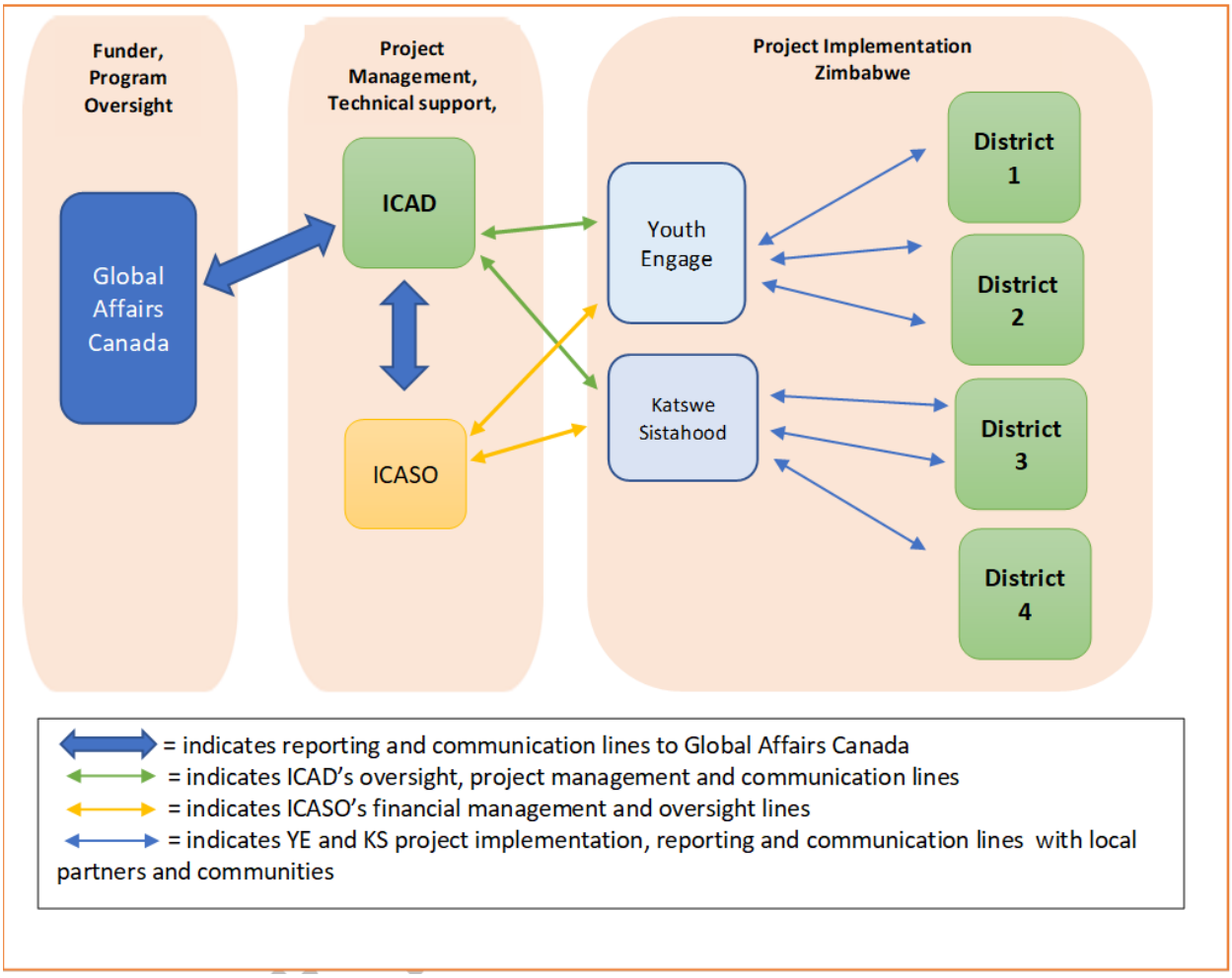
The Interagency Coalition on AIDS and Development (ICAD) is the Canadian Executing Agency for the Simba Utano project in partnership with the International Council of AIDS Service Organizations (ICASO). Once the PIP has been approved, the Contribution Agreement will be revised to include both organizations as co-signatories. During the PIP phase, hower, ICAD is the principle signatory with GAC and will bear the overall legal responsibility for the project management, administration, implementation and quality assurance- but will do so in close coordination with ICASO. The division of labour between ICAD and ICASO means that ICASO will take the lead on financial management and reporting aspects of the project while ICAD will lead on all program related aspects and direct communication with GAC.

Notwithstanding the agreed division of responsibilities, the Canadian implementing partners will have equal roles in project implementation and quality assurance. ICAD and ICASO will manage the project in collaboration with Zimbabwean project partners and will provide timely and appropriate Canadian financial resources and technical support as required.

The relationship between and across these four partners will be managed so that partners will share a common approach to project implementation, monitoring and evaluation, and narrative and financial reporting. The Senior Program Officer, based in ICAD, is responsible for the day to day communications and coordination with partners, including the final sign-off of reports and disbursements.

Finally, it is important to note that both organizations already have Sexual Exploitation and Abuse Policies in place.

Figure 1: **Simba Utano Project Management Structure**



A more detailed portrayal of theProject Management Structure and the Flow of Funds/Wiring Diagram is attached as Annex 5 and Annex 6

i. Partnerships

The project will be implemented through a collaboration involving two Canadian organizations (ICASO and ICAD) and two local Zimbabwean organizations (Youth Engage and Katswe Sistahood). Both Zimbabwean partners and their staff have extensive experience working with young and vulnerable populations on the issues of human rights and health and more specifically sexual reproductive health and rights (SRHR) (including HIV) over the past 10 years. ICASO and ICAD bring technical expertise, resources and tools to enhance and support the work of the local partners. It should be noted that our Zimbabwe partners will also seek to engage with like minded local partners in order to achieve the project goals. These relationships will be developed over the life of the project.

A. Katswe Sistahood

Founded in 2007, Katswe Sistahood is a feminist organisation fighting for the full attainment of Sexual and Reproductive Health and Rights (SRHR) by women in Zimbabwe. Katswe is a platform that enables young women to mobilise, organise and articulate their needs with regard to SRH education, SRH services and legal protection and helps them to better develop their capacity to understand and pursue their rights. “Rooted in a feminist analysis and women´s lived realities, Katswe creates safe spaces for learning, sharing and consciousness-raising that catalyse women´s collective power to act”. (2019 Annual Report).

Approach and Methodology
Katswe’s programming is centered on 5 main areas: Information, dissemination and awareness raising; Advocacy; Capacity building and training; Provision of referrals to key services and commodities; and Developing partnerships and networking.

The organization has two main modes of service delivery – through Pachoto groups and the 4As approach. **Pachoto** is a Shona word meaning fireplace and represents the coming together of women to share stories and skills. Katswe has adopted the concept and uses it as a space for discussion and self-awareness with the aim of creating a vibrant feminist movement that has the capacity to analyse and respond to local, national and regional issues that affect women and girls. Each community-based Pachoto group is made up of 20-25 young women, aged between 15-18 and 18-35. The approach has the following goals:

- Girls and young women are informed, are confident and have a critical consciousness.
- Girls and young women can identify and propose tangible solutions to community problems.
- Girls and young women who are talented in the Arts locate opportunities for growth.
- Girls and young women should achieve emotional, physical, political and economic wellbeing.
- More girls and young women get into leadership positions.

For implementing projects, Katswe uses the **4As approach**, which can also be seen as a cycle: Assessment, Awareness, Advocacy and Action. The approach is anchored on the ecological model which seeks to transform the individual, the broader community and the national legal and policy framework. . Some examples of its 2019/2020 program include Access to SRH Services; Training for Transformation; the Legal Help Desk and Feminists on Campus. Katswe is heavily involved in various campaigns such as Ending Child Marriages; Ending Economic Violence and a church-based Ending SGBV Campaign

Katswe has also embraced Art not only as a core medium of communication but as a tool for economic empowerment for young women. In 2018, Katswe launched the Pachoto Arts Academy and by the end

of 2019, 100 young women had been trained in music, dance, poetry and handicrafts. The graduates have been quite successful. For example, the Pachoto Band has composed and recorded 3 Albums and one band member has already started a solo career under a local record label. Katswe's "Feminist Poetry and Arts Slam" held every last Friday of the month is fast becoming popular especially with university students. It also provides an opportunity for them to enroll in the organization's *Feminist on Campus Initiative*. The Highlight of 2019 was the *"YAKA! Baka- Get turned on for Social Justice"*, a Feminist Arts Festival that was held in Lusaka under the theme "The Political Economy of Women's Liberation. The Festival brought together about 200 feminist activists from Zambia, Namibia, Malawi, and Zimbabwe and explored the use of art, media, theatre and tech as entry points for feminist expression and advocacy.

As noted above, the organization engages in rigorous policy advocacy activities. A 2019 example is the Campaign on the unconditional retention of pregnant girls in school. This was adopted as a policy position for inclusion in the Education Act that is currently under review. Another key achievement is the #HappyFlow Campaign which, after a 4 year campaign, has resulted in the availability of free sanitary products in schools

Funders and Partners
2019 donors included: Ford Foundation; Amplify Change; UN Women; Trocaire; Open Society for Southern Africa; Global Fund for Women; HIVOS; Mama Cash; Urgent Action Fund for Africa; and Sex Rights Activity Network.

B. Youth Engage

Youth Engage (YE) is a grassroots youth organization that advocates for the health, well-being and human rights of all young people, regardless of faith, race, religion, gender, sex or tribe. It believes in youth-led, data-driven accountability and focusses on utilizing the collection and analysis of qualitative and quantitative data to measure the success and impact of Zimbabwe health targets, health policies and health interventions.

Youth Engage Accountability Advocacy Model
What is most relevant to the Simba Utano project is YE's Youth Data Reporters program which focusses on using scorecards to collect and analyze SRHR qualitative and quantitative data at the district health facility level.The Youth Data Reporters represent a diversity of young people and ensures that the health response is driven by young people, including young key affected populations. Youth Data Reporters are selected from a pool of applicants currently working in the community and national levels on SRHR, the provision of youth friendly services and comprehensive sexuality education. Selected applicants are invited to a rotational one year program. At the start of each program Youth Data Reporters undergo a rigorous training of the curriculum and each is expected to collect data and gather evidence from their community. The data collected is then synthesized by an overseer at the national level and processed for use in innovative communication tools and evidence-based advocacy.

Youth Engage with technical support from IPPF and UNAIDS also piloted the Age of Consent toolkit in Zimbabwe https://www.unaids.org/en/resources/presscentre/featurestories/2016/december/20161205_zimbabwe

Funders and Partners in 2019
Youth Engage is a member of the National Technical Working Group on HIV and AIDS which is coordinated by the National AIDS Council and a member of the SRHR National forum which is

coordinated by the Ministry of Health and Child Care. In addition, the organization is a member of *Right Here Right Now*, a coalition of 11 organizations in Zimbabwe working on the Termination of Pregnancy Act as well as other SRHR issues. Youth Engage is also a member of the The Partnership for Maternal, Newborn and Child Health Adolescent and Youth constituency. Other partnerships include Zimbabwe AIDS Network, Zimbabwe National Network of People Living with HIV, MIPA, National AIDS Council, SAT, UNAIDS, Ministry of Health and Child Care, Zimbabwe Youth Council, Umguza AIDS Network, WASN, WAG, UNFPA, UNESCO

Youth Engage is currently funded by Right Here Right Now (RHRN Consortium) and the ICAD/ICASO SIMBA UTANO Project. It has recently submitted an application to the "Y+ for the Her Voice" and is expecting a response shortly. Youth Engage is also a member of COMPASS Platform and has been invited to submit a campaign idea which will be supported through the platform

C. Twinning Partnerships

Twinning is defined as a formal, substantive collaboration between two or more organizations seeking to build capacity, improve program effectiveness and learn from one another to achieve a common goal. The twinning component of the project will provide technical support and skills and an opportunity for the partner organizations to learn from and share experiences with other gender transformative and adolescent responsive SRHR organizations in the southern African region. It consists of two components:

a. The technical support component will be housed at ICAD. It will provide an opportunity for three university or community college graduates to respond to a clearly identified partner need. Examples might include: website design and development (YE); organizational sustainability and proposal writing (YE); and strengthening Katswe's advocacy campaigns through research on international policy/instruments and institutional linkages. The support will be virtual and each attachment/internship is expected to last 3-4 months. ICAD first began operating an in-house internship program over 15 years ago and consequently has substantial experience in matching and mentoring the ideal candidates with clearly defined job descriptions formulated by the partners. This is a no cost activity – but contributes to the cash/in kind contribution made by the Canadian partners which is calculated at the rate of CDN $100/full day of work.

b. Whilst the internship component is very specific and highly defined, the organizational twinning component allows for more flexibility, creativity and vision. It provides an opportunity for the partner organizations and their networks to engage directly with one another in order to learn and share experiences. It can involve visits or a series of visits around a specific issue, common resource development or support for advocacy initiatives. The project has allocated funds for 4 interventions at a maximum cost of US$2,000 each. Decisions around selection will be left to the discretion of the partners. However, they will be required to complete an activity form which details how the activity contributes to the progress of the project.

ii. Roles and Responsibilities of Project Stakeholders

The roles and responsibilities of all partners are detailed in Annex 3.

- The project organogram with names and positions is attached as Annex 6
- The wiring/funds flow diagram is attached as Annex 7.

iii. Project Committees

Project Steering Committee (PSC)

PSC meetings are opportunities to assess and discuss the progress made by a project on gender equality outcomes, to determine whether it is in accordance with the approved work plan and to take any decisions needed to improve performance. PSC meetings present opportunities to raise awareness on gender equality among steering committee members. The Simba Utano PSC will take place annually in the third quarter of each year. Participants will include representatives of the four partners, Global Affairs Canada and Zimbabwe Government national and district officials. Zimbabwe representation will be drawn from the Ministry of Health, the National AIDS Council, the Gender Policy Unit as well as AIDS coordinators for each of the districts and AGYW stakeholders.

Partner Management Committee

In addition to the regular daily communication between partners, a formal skype meeting will be held on a quarterly basis between all four partners to discuss project progress and the plans for the upcoming activities. More specifically, it will:

- Review project activities against the workplan;
- Review project achievements against set targets;
- Identify lessons learnt and best practices emerging from project execution;
- Identify challenges in project execution and propose solutions; and
- Review Semi Annual Report (SAR) and approve for presentation.

Canadian Partner Meeting

ICAD and ICASO will meet annually in either Toronto or Ottawa. The agenda will focus on both financial and programmatic issues and challenges.

G. Gender Equality Strategy

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 UNGA Convention on the Elimination of all forms of Discrimination Against Women (1979), the Beijing Platform for Action (1995)and the Sustainable Development Goals, specifically SDG5 (2016)

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 who remain excluded

and disadvantaged in many facets of development in Zimbabwe. This was amplified in Part 1 (Gender Analysis) of the Gender Equality Strategy (GES) undertaken in the four districts where the Simba Utano project is being implemented. According to its 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 AGYW to negative SRH outcomes such as unplanned pregnancy, HIV, early marriage, sexual and gender-based violence. 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 (GA) 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 AGYW must operate at the intersection of these various factors that feed marginalization and exclusion. Consequently, the GES for Simba Utano must emphasizes a holistic gender transformative approach.

Part 2 (Implementation) of the GES focusses specifically on operationalizing the findings of the Gender Analysis. Drawing from GA and the Baseline Report, the Implementation component has developed six key GE objectives for the project. Except for the last, each is linked to a specific intermediate Simba Utano outcome. The GE objectives are:

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

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

The GES (Parts 1 and 2) is attached as Annex 9.

H. Communications Strategy

ICAD and ICASO are long-standing organizations that have extensive and multi-sectoral networks and partnerships in Canada and globally with well-established channels to support awareness raising, knowledge sharing and the exchange of programmatic lessons learned.

Throughout the project lifecycle, communication and public engagement activities will be implemented in Canada and international forums. Project-based learnings and methodologies will be shared with Canadian organizations to build knowledge, capacities and enhance HIV/SRHR service delivery here at home for African, Caribbean and Black (ACB) populations, and their health and community service providers. As a coalition-based organization, ICAD coordinates Canada's national ACB network of service providers and community advocates. It is also a co-founder and Governing Council member to the African, Black Diaspora Global Network (ABDGN), a global network advocating for issues affecting Black and African diaspora populations and the importance of neglected intersectional issues related to health and HIV/SRHR in the global policy arena. Community forums, speaker series and online webinars will provide regular platforms for knowledge exchange and policy dialogue and will support efforts to bridge Canada's domestic response and its international development programming. Regular project updates/results will be brought to the broader Canadian academic, public health and global health sectors through presentations and sessions at Universities, conferences and symposia, through participation in working groups, and other national networks active on issues of adolescent health, SRHR and global health and development. Knowledge sharing will also include broader engagement with Canada's public through opinion pieces and blog spots in Canadian media outlets, on ICAD and ICASO websites and social media platforms and through partner networks such as the Canadian Council for International Cooperation (CCIC) and the Canadian Network for Women and Child Health (CanWaCH).

Project learnings will similarly contribute to policy development in Canada and within leading global multilateral agencies. In Canada, communications and public engagement efforts will involve work with government officials and Parliamentarians. Briefings and meetings will be held in Ottawa with Parliamentary caucuses such as, the All-Parliamentary Global Health Caucus on HIV, TB and Malaria, the Canadian Association of Parliamentarians for Population and Development, the Africa Caucus, and others.

At global levels, on-the-ground program experience, project stories and results will contribute to civil society advocacy efforts for advanced policy, programming and accountability. Activities will include visibility at leading international AIDS and SRHR conferences and will feed into policy and programming debates at the boards of UNAIDS, UNITAID, the Global Financing Facility and the GlobalThe Project will adhere to the Government of Canada's "Public Visibility and Recognition" policy as well as GAC's own "Recognizing results: Public recognition guidelines for Global Affairs Canada's development partners".

The project will also support the development or updating of KS and YE's social media platforms. These platforms will acknowledge the Government of Canada's contribution to the prpject, unless it is felt that such recognition could pose security or operational challenges to KS and YE. All four partner websites will promote the project's successes, share lessons learned and serve as a fundraising tool

Annexes

Annex 1: Project Reach Table

District	Ward Name	Total Population of the Disrict/Ward		Adolescents and Youth (10-24)		Youth Champions		Commun. Facilitators		Men Engage Facilitator		Religious Leaders		Community Leaders		Other Key populations		Total
		Female	*Male*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F/M*
Umguza																		
Ward 1	Hopefountain	3,242	2,451	900	450	2	1	4	2	1	2	10	20	5	25	50	50	
Ward 2	Kensington	2,533	2,211	800	350	2	1	4	2	1	2	10	20	5	25	50	50	
Ward 7	Fairbridge	2,431	2,106	800	350	4	2	4	2	1	2	10	20	5	25	75	75	
Ward 14	Muntu	2,176	1,996	800	350	4	2	4	2	1	2	10	20	5	25	75	75	
Ward 16	Stanhope	2,206	2,407	800	350	4	2	4	2	1	2	10	20	5	25	75	75	
Subtotal		***12,588***	***11,171***	***4,100***	***1,850***	***16***	***8***	***20***	***10***	***5***	***10***	***50***	***100***	***25***	***125***	***325***	***325***	**6,969**
Mazowe																		
ward 24	Ceaser Mine	5,170	4,706	1,200	800	6	3	4	2	1	2	10	20	5	25	220	250	
Ward 8	Nzvimbo	3,650	3,597	1,000	650	4	3	4	2	1	2	10	20	5	25	220	250	
Ward 34	Amatola	4,151	4,640	1,700	750	4	2	4	2	1	2	10	20	5	25	220	250	
Ward 22	Mzowe Mine	2,529	2,689	800	230	4	2	4	2	1	2	10	20	5	25	220	250	
Ward 17	Tsvungubvi	2,748	2,547	800	230	4	2	4	2	1	2	10	20	5	25	220	250	
Ward 16	Somerset	3,993	4,033	1,500	665	5	2	5	2	1	2	10	20	5	25	220	250	
Ward 15	Concession	2,487	2,260	800	500	5	2	5	2	1	2	10	20	5	25	220	250	
Ward 33	Glendale	4,299	4,046	1,100	650	4	2	4	2	1	2	10	20	5	25	220	250	
Subtotal		***29,027***	***28,518***	***8,900***	***4,475***	***36***	***18***	***34***	***16***	***8***	***16***	***80***	***160***	***40***	***200***	***1,760***	***2,000***	**17,743**

Seke																		
Ward 1	Nemasanga	3,422	2,234	1,000	350	4	2	4	2	1	2	10	20	5	25	190	250	
Ward 2	Mandedza	4,292	4,067	1,500	650	4	2	4	2	1	2	10	20	5	25	190	250	
Ward 13	Beatrice	4,107	3,782	1,500	500	4	2	4	2	1	2	10	20	5	25	190	250	
Ward 8	Matiti	4,225	4,739	1,500	700	4	2	4	2	1	2	10	20	5	25	190	250	
Ward 9	Nyatsime	1,357	3,273	500	450	4	2	4	2	1	2	10	20	5	25	100	120	
Subtotal		***17,403***	***18,095***	***6,000***	***2,650***	***20***	***10***	***20***	***10***	***5***	***10***	***50***	***100***	***25***	***125***	***860***	***1,120***	**11,005**
Goromonzi																		
Ward 4	Murape	4,501	3,850	1,900	700	4	2	4	2	1	2	10	20	5	25	215	250	
Ward 12	Mwanza	5,002	3,421	2,100	600	5	3	5	3	1	2	10	20	5	25	215	250	
Ward 2	Mawanga	4,781	3,408	2,100	600	5	3	5	3	1	2	10	20	5	25	215	250	
Ward14	Acturus	5,619	4,501	2,100	750	4	2	4	2	1	2	10	20	5	25	215	250	
Ward 9	Ivordale	5,671	3,788	2,100	600	4	2	4	2	2	2	10	20	5	25	215	250	
Ward 16	Chinyika	4,502	3,522	1,800	500	4	2	4	2	2	2	10	20	5	25	215	250	
Subtotal		**30,076**	**22,490**	**12,100**	**3,750**	**26**	**14**	**26**	**14**	**8**	**12**	**60**	**120**	**30**	**150**	**1,290**	**1,500**	**19,100**
Total	24	89,094	80,274	31,100	12,725	98	50	100	50	26	48	240	480	120	600	4,235	4,945	54,817

Annex 2: Work Plan for Year 1

	Activities for the period January to December 2020	PIP	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec
1110	**Increased knowledge and awareness of SRHR and HIV among vulnerable AGYW**													
1111	**Assessments conducted to understand the unique needs of vulnerable AGYW in selected wards from hotspots in 4 districts**													
1111.1	Organize a meeting with 30 AGYW representatives/30 stakeholders from selected wards													
1111.1.1	Determine selection proceedure													
1111.1.2	Select representatives from each ward													
1111.2	Document their experiences through story-telling and journaling													
1111.2.1	Review notes and identify relevant stories													
1111.2.2	Identify uses for stories (specific project activities or internal media)													
1111.2.3	Draft stories with individual AGYW													
1111.3	Analyse the findings to incorporate into programming													
1111.3.1	Analyse findings within small group discussion													
1111.3.2	Organize stakeholder (staff, AGYW) meeting to share findings													
1112	**Youth Champions, Community Facilitators and Pachoto Groups established and trained to engage vulnerable AGYW on SRHR and HIV**													
1112.1	Identify adolescents and young people for Youth Champions, Community Facilitators and Pachoto Groups													
1112.1.1	Identify mechanisms for advertising the positions													
1112.1.2	Develop job descriptions													
1112.1.3	Advertise positions													
1112.1.4	Select representatives from each ward for the positions													
1112.2	Formation of Youth Champions													
1112.2.1	Develop TORS for facilitator													
1112.2.2	Select facilitator													
1112.2.3	Develop curriculum													

	Activities for the period January to December 2020	PIP	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec
1112.2.4	Organize workshop logistics													
1112.2.5	Conduct worshop/training													
1112.2.6	Develop mentoring/monitoring plan for Youth Champions													
1112.3	Formation of Community Facilitators													
1112.3.1	Develop TORS for trainer													
1112.3.2	Select facilitator													
1112.3.3	Develop curriculum													
1112.3.4	Organize workshop logistics													
1112.3.5	Conduct worshop/training													
1112.3.6	Develop mentoring/monitoring plan for Community Facilitators													
1112.4.1	Setting up of ward level Pachoto groups (24)													
1112.4.2	Identify suitable candidates													
1112.4.3	Organize logistics to bring together each of the groups													
1112.4.4	Provide orientation and training to each groups													
1112.5.	Establish youth theatre and arts groups for outreach													
1112.5.1	Advertise theartre and arts groups throughout the wards													
1112.5.2	Bring interested individuals together to form theatre and arts groups													
1113	**Sensitizing stakeholders and partners on the SRHR challenges facing by AGYW**													
1113.1	Conduct bi-monthly Pachoto safe spaces for AGYW by staff													
1113.1.1	Arrange meetings (including refreshments)													
1113.1.2	Conduct Pachoto meetings in all 4 districts													
1113.1.3	Organize outreach for hotspots and to reach vulnerable key populations													
1113.1.4	Conduct 16 outreach meetings (4/district) around hotspots in order to reach key vulnerable populations													
1113.3	Conduct Pachoto outreach meetings; theatre and arts for demand creation													
1113.3.1	Organise pachoto outreach meetings; theatre and art for demand													
1113.3.2	Organise logistics for outreach meetings													
1113.3.3	Conduct outreach meetings													

	Activities for the period January to December 2020	PIP	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec
1113.4	Organize annual Nzwika (Arts Festival) at district and national levels to create awareness for AGYW													
1113.4.1	Develop program schedule													
1113.4.2	Book performers													
1113.4.3	Book location, refreshments etc.													
1113.4.4	Advertise festival													
1113.4.5	Develop/collect relevant AGYW material for distribution at festival													
1113.4.6	Hold festival													
1113.5	Community sensitization with key stakeholder at district and ward levels													
1113.5.1	Identify and invite key community stakeholders at district and ward levels													
1113.5.2	Conduct 4 community sensitization meetings (one/district)													
1113.6	Organize and participate in the quartely provincial Adolescent Sexual Reproductive Health(ASRH) Forum to share project experiencies and lessons learnt for input into the national ASRH forum													
1113.6.1	Develop agenda for each quarterly meeting in consultation with Forum executive													
1113.6.2	Invite participants and circulate agenda													
1113.6.3	Pepare policy or programming documentation to share with participants													
1113.6.4	Facilitate meeting													
1113.6.5	Undertake any required followup from the meeting													
1113.7	Organize and participate in the HIV & AIDS Multi-Sectorial District taskforce to influence the agenda and input into the National AIDS Council Reporting Mechanism													
1113.7.1	Contribute to the agenda for each quarterly meeting in consultation with taskforce													
1113.7.2	Prepare background documents and position papers													
1113.7.3	Participate in meeting													
1113.7.4	Undertake any required followup from the meeting													
1113.8	Bi-Annual MPs & Youth Indaba at the National level													
1113.8.1	Prepare background documents and position papers													
1113.8.2	Participate in meeting													
1113.8.3	Undertake any required followup													

	Activities for the period January to December 2020	PIP	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec
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**													
1121	**Youth Champions, Community Facilitators and Pachoto groups trained on effective communication skills to increase awareness of SRHR and HIV at the community level**													
1121.1.	Review and revise Simba Utano (Pachoto and Youth Data Reporters Program) Training Manual													
1121.1.1	Identify staff or engage consultant to take on the review													
1121.1.2	Identify advisory group to support the activity													
1121.1.3	Review and revise Simba Utano Training Manual													
1121.1.4	Finalize and distribute manual													
1121.2	National level Training of Trainers of Community Facilitators (30 facilitators from the 4 districts trained) on Pachoto the methodology													
1121.2.1	Identify and select Trainers													
1121.2.2	Organize logistcs for meeting of 30 TOTs													
1121.2.3	Conduct training session for the 30 TOTs													
1121.3	Training of community facilitators(120 pple across all districts) on youth friendly service provision movement building and effective communication													
1121.3.1	Map and identify 120 community facilitators													
1121.3.2	Identify and book workshop/training location													
1121.3.3	Organize meeting (invitations, particpant travel, food and refreshments etc)													
1121.3.4	Conduct training for 120 community facilitators on building a youth friendly service provision movement													
1121.4	Training of 120 Youth Champions (30pple x 4 districts)													
1121.4.1	Map, Identify and select Trainers													
1121.4.2	Organize meeting (invitations, location, participant travel etc)													
1121.4.3	Conduct training for 120 Youth Champions													

	Activities for the period January to December 2020	PIP	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec
1121.5	Training of 120 Community Facilitators(30 pple x 4 dist = 120) at ward level for running Pachoto groups													
1121.5.1	Identify and select 120 Facilitators representing all 24 wards													
1121.5.2	Organize one meeting in each of the 4 districts (invitations, location, participant travel etc)													
1121.5.3	Conduct 4 trainingof community facilitators on implementing Pachoto program in each ward													
1121.6	Ongoing mentorship and support for community facilitators													
1121.6.1	Provide district level mentoring meetings (one/quarter) for community facilitators													
1121.7	Job aides for Youth Champions and Community Facilitators													
1121.7.1	Review existing aids and make relevant upgrades													
1121.7.2	Produce (or procure) and disseminate 130 kits to community facilitator prior to their training													
1122	**Parents and caregivers engaged to better understand impact of harmful social norms**													
1122.1	Adapt materials for awareness-raising with community stakeholders including parents and leaders													
1122.1.1	Adapt materials													
1122.1.2	Print resources													
1122.2	Community dialogues on SRHR and HIV with parents, caregivers - quarterly													
1122.2.1	Map districts and identify concerned or engaged parents and caregivers													
1122.2.2	Adapt and print relevant resources													
1122.2.3	Conduct quarterly meeting with target group													
1122.3.4	Diseminate key messages through mass media e.g. radio													
1123	**Traditional and community leaders engaged to better understand impact of harmful social norms.**													
1123.1	Organize bi-annual meetings for traditional leaders engagements through meeting													
1123.1.1	Conduct planning meeting for program staff													
1123.1.2	Identify community leaders to participate in sessions focussing on improving their understanding of social norms													

	Activities for the period January to December 2020	PIP	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec
1123.1.3	Conduct semi annual meeting with community leaders													
1123.2	Organize bi-annual meetings for religious leaders engagements through meeting													
1123.2.1	Conduct planning meeting for program staff													
1123.2.2	Identify traditional leaders to participate in sessions focussing on improving their understanding of social norms													
1123.2.3	Conduct semi annual meeting with traditional leaders													
1124	**Young men and adolescent boys engaged to better understand impact of harmful social norms. (Year 2 activity)**													
1124.1	Organize semi annual Men Engage forums													
1124.2	Participate in SGBV prevention awareness days/events e.g. 16 days of activism													
1124.3	Launch of Annual Advocacy Campaign on a selected theme: Teen Pregnancy, SGBV, Early Marriage, HIV & STIs among AGYW in Hotspots													
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**													
1211	**Facility-based Health Service Providers trained on gender-equitable and adolescent responsive SRHR and HIV service delivery and referrals**													
1211.1	Develop Training Toolkit for Health Service Providers													
1211.1.1	Develop TORS for consultant													
1211.1.2	Establish advisory group of health service providers													
1211.1.3	Develop and test materials													
1211.1.4	Print training tool kit													
1211.2	Provide training on gender equitable and youth friendly services for Health Service Providers													
1211.2.1	Identify health faciliteis which do not offer youth friendly services and seek approval from MOH to train them													
1211.2.2	Conduct 5 trainings of 20 health workers each on the provision of youth friendly services at their facilities													

	Activities for the period January to December 2020	PIP	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec
1211.2.3	Conduct 1 post training mentorship and coaching for the 100 health workers													
1211.3	Provide training on gender equitable and youth friendly services for CBOs and Youth Networks													
1211.3.1	Identify CBOs and Youth Networks operating in the 4 districts													
1211.3.2	Revise and print resources													
1211.3.3	Organize (TBD) trainings for approximately 20 participants													
1211.3.4	Conduct training to CBOs and networks (one in year 1)													
1211.4	Train health workers in primary data collection, reporting and utilization 0f data for analysis and planning)													
1211.4.1	Provide training to Health Service providers on data collection, analysis and utilization													
1211.4.2	Analyse and utilize data collected by Youth Champions on a quarterly basis													
1211.4.3	Organize reflection meetings with Health Service Providers on available data and emerging issues collected by project trained youth champions													
1211.4.4	Present data analysis to relevant for a such as the National AIDS Council Reporting Mechanism													
1212	**Community Health Care Workers (i.e. Village Health Workers, Community Adolescent Treatment Supporters) trained on community centered gender-transformative and adolescent-responsive SRHR and HIV approaches including human rights, SGBV**													
1212.1	Develop the toolkit													
1212.2	Organize workshop for Community Health Care Workers													
1212.2.1	Identify and select with MOH 15 CHWs from each of the 4 districts													
1212.2.2	Print tool kit													
1212.2.3	Conduct 2 trainings of 30 CHWs in each on SRHR including HIV, SGBV and human rights													
1212.2.4	Provide ongoing support to CHWs through semi annual staff visits													
1213	**District dialogues conducted with health service providers to facilitate access by vulnerable AGYW to gender -equitable and adolescent responsive SRHR and HIV services and referrals.**													

	Activities for the period January to December 2020	PIP	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec
1213.1.1	Capacity Training of 30 Youth Champions on conducting advocacy dialogues on Teen Pregnancy, SGBV, STIs/HIV													
1213.1.2	Selected Pachoto Champions/Data Collectors attend quarterely key meetings to push agreed Advocacy positions													
1213.1.3	Advocacy dialogues conducted quartely with health service providers													
1213.1.4	Production of Advocacy IEC material on emerging themes targeted at different Stakeholders													
1213.1.5	Reproduce the Patients Charter adapted to AGYW needs & realities along with Referral Pathway													
1213.1.6	Support Youth Champions, Advocates run Social media advocacy campaigns, SIMBA UTANO bloggers - and podcasters club production sessions													
1213.1.7	Website maintenance													
1213.1.8	Engage consultant to help YE in developing website													
1213.1.9	Maintain and update all 4 websites (internally and thorugh consultant)													
1220	**Strengthened integrated response to support the delivery of gender-equitable and adolescent responsive SRHR services to vulnerable AGYW**													
1221	**Coordinating committees established to link SRHR services for vulnerable AGYW at various levels of the health system**													
1221.1.1	Map the districts and identify clusters of wards within and around HIV and STIs hot spots .													
1221.1.2	Using District AIDS Coordinator maps, identify ward clusters in and around HIV and STI hotspots													
1221.2	Facilitate adolescent and youth friendly outreach on SRHR and HIV information and services for indentified hotspot clusters													
1221.2.1	Determine content for info sessions													
1221.2.2	Identify 120 community facilitators from each of the clusters who can provide info on services													
1221.2.3	Conduct semi annual info and awareness raising sessions in each of the clusters													
1221.2.4	Provide ongoing support to facilitators on an as needed basis													

	Activities for the period January to December 2020	PIP	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec
1221.3	Map Community Health Care Worker and health service providers for each of the 3 clusters at district level													
1221.3.1	In collaboration with MOH, map and identify CHWs and Health Service Providers working in the different clusters													
1221.3.2	Identify health facilities that are providing/can provide adolescent friendly services													
1221.4	Organize 3 multi-sectorial cluster meetings per district to strengthen referral systems/ pathways for adolescents and youth health (clusters around hotspots)													
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**													
1222.1	Identify key health facility managers and health administrators for sensitation meetings in collaboration with NAC													
1222.2	Organise sensitization meetings with the Health facility managers/ health admins/ MOH department heads													
1222.3	Convene feedback meetings with Health facility managers/ health admins/ MOH department heads on provision of YFS at district level													
1223	**Twinning facilitated with international or domestic CBOs to enhance their capacity to deliver quality gender transformative and adolescent responsive SRHR and HIV services**													
1223.1	Identify needs, gaps and possible international CBOs/NGOs which could address needs/gaps. Prioritize the needs for year 1													
1223.2	Develop relationship and formally contract partner (one/year)													
1223.3	Organize travel and other logistics between the partnerships													
1223.4	Incorporate lessons learned through mixed-media from the parternership into the service provision cascade													
1310	**Increased knowledge and skill of AGYW, health workers and community organizations to advocate for SRHR**													
1311	**Community Youth and Health Champions trained and supported to produce and use data related to delivery of SHRH services for vulnerable AGYW**													

	Activities for the period January to December 2020	PIP	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec
1311.1	30 Youth Champions- Data Collectors engage in consultative meetings & develop a 10 point demands-Teen Pregnancy, SGBV, Early Marriage, HIV & STIs among AGYW advocacy paper													
1311.2	Training of Youth Champions on the Accountability Framework, Action Research, Data Collection & Advocacy													
1311.3	Monthly Data Collection meetings within Pachoto Groups													
1311.3.1	Determin what data is to be collected and how (refer to PMF)													
1311.3.2	Train Youth Champions in action reseach, data collection and analysis													
1311.3.3	Organize data collection meetings by district													
1311.3.4	Invite participants and arrange refreshments													
1311.3	Conduct 4 meetings (by district) of Youth Champions on a quarterly basis													
1311.4	Conduct Stakeholder engagement-sensitization meetings with key Government Ministries on Gender Responsive, Inclusive & Accountable SRHR/HIV Services & Policies													
1311.5	Quarterly Joint reflection meetings i.e. preparation for Advocacy at District level attended by representatives from community champions and facilitators, AGYW ward representatives and staff,													
1311.6	Quarterly Nzwika District level Festival Policy dialogues with Parliamentary Portfolio Committees (in the community), Duty Bearers & Policy Makers													
1311.7	Parliament Visits; Submission of Petitions, Position Papers & Follow up													
1311.7.1	Establish policy priorities for the year													
1311.7.2	Determine if the writing will require a consultant or be written in house													
1311.7.3	Develop at least one policy paper addressing vulnerability of AGYW													
1312	**Health Center Committees strengthened to advocate for the needs of vulnerable populations including AGYW and PLHIV**													
1312.1	Reconstitution of Health Centre Committees (advocate for inclusion of AGYW in the HCCs including SGBV survivors, Teen Mothers, Sex Workers)													
1312.1.1	Collaborate with MOH in identifying particpants													

	Activities for the period January to December 2020	PIP	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec
1312.1.2	Collaborate with MOH in determining the key issues to be addressed at Committee meetings													
1312.1.3	Develop a set of updated Committee rules and regulations (if none exist)													
1312.2.4	Conduct 2 day capacity building workshops with Health Centre Committees													
1312.2.5	Map and identify facilities in each ward/district													
1312.2.6	Work with MOH and HC staff in developing a suitable agenda and workshop content													
1312.2.7	Organize workshop (invitations, release forms, printing of resource materials, location, refreshments, participant travel,													
1312.2.8	Conduct 2 day workshop training for 30 participants													
1312.3	Quarterly HCC - AGYW meetings ScoreCard review, data analysis meetings													
1313	**Participatory community-based assessment tools adapted to assess SRHR/HIV service acceptability, availability and access**													
1313.1	Workshop- Review existing Accountability Framework, & develop Simba Utano Score Card													
1313.2	Design, Printing of Accountability Framework													
1313.3	Development of Promotional materials i.e. tshirts , banners													
1313.4	Health Center Committees, AGYW and PLHIV trained to gather, interpret and use data to advocate for gender equitable and responsive HIV and SRHR services and polices													
1314	**Public awareness and promotional materials developed and distributed.**													
1314.1	Production, printing and distribution of IEC material (flyers, posters, pamphlets, banners)													
1314.1.1	Determine which promotional materials already developed can be distributed in support of the project													
1314.1.2	Make simple revisions where necessary (i.e. t-shirt design, revised flyers or pamphlets				`									
1314.1.3	Copy/print older/revised resources and distribute at workshops and similar events. (Newly developed resources will be developed and distributed in Year 2			`										
1314.2	Production of media materials for sensitizations (short documentaries, photo voice)													

	Activities for the period January to December 2020	PIP	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec
1314.3	Run social media mobilization monthly (ongoing organizational activity)													
1314.4	Participate in 3 radio interviews annually (by invitation)													
1314.4.1	Plan radio spots and radio programs, with the participation of professionals involved in implementation and the beneficiaries													
1314.4.2	Participate in a radio program at least once annually													
1314.5	Production and distribution of annual newsletter/magazine (already a regular organizational activity)													
1314.6	Documentation and packaging of advocacy material such as policy briefs													
1314.7	Information dissemination & Advocacy meetings with the Media (traditional, new) TV, Radio, Print, Social Media													
1314.7.1	Develop key messages for public awareness on SRHR issues affecting AGYW													
1314.7.2	Monitor the disemination of the ongoing public awareness SRHR issues by the project													
1314.8	Commemmoration of the Day of the African Child													
1314.9	Monitoring, Evaluation & Learning													
	Other Activities													
	Conduct Baseline Evaluation													
	Train KS and YE staff on Collection of Data for Gender Analysis													
	Conduct Gender Assessment													
	Purchase2 vehicles (if approved)													
	Conduct Quarterly Partnership Meetings													
	Conduct Annual Workplan Meeting													
	Conduct Annual Project Steering Committee Meetings													
	Update Partner Websites													
	Conduct Endline Evaluation													
	Conduct Dissemination of Results Workshop													

Note: Not all activities will be conducted in Year 1 – see Detailed Workplan

Annex 3: Performance Measurement Framework

Expected Results	Indicators	Baseline Data	End of Project Targets	Data Sources	Data Collection Methods	Frequency	Responsibility
ULTIMATE OUTCOME							
1000 Improved health of adolescent girls and young women (AGYW) at risk of HIV in four priority districts in Zimbabwe[4] .	# of new cases of HIV per year among AGYW in selected priority districts [5].	**Goromonzi** 15-19: 408 (f); 92 (m) 20-24: 895 (f) 275 (m) **Seke** 15-19: 34(f); 7(m) 20-24: 73(f); 31(m) **Mazowe/ Umgaza**[6] 15-19: xx(f); xx(m) 20-24: xx(f); xx(m)	3 % decrease in number of new cases (positive second tests) in selected districts from 2017 baseline:	District HIV reports	Review reports	May be collected annually but reported at end of project	Project Manager in coordination with YE/KS
	# and % of AGYW and ABYM, demonstrating positive attitudes towards ending SGBV through the project (disaggregated by age and sex)[7]	Women/girls Agree: 51.4 Disagree 45.0 Don't know: 3.6% Men/boys Agree 48.5% Disagree 46.3%) Don't know 5.2%)	At least 30% change by end of project	Baseline and End line survey plus focus groups with women, girls, men and boys;	Review results of Surveys plus FGDs	Baseline and Endline Survey and FDGs	Project Manager in coordination with YE/KS

[4] AGYW defined by Zimbabwe Government as adolescent girls and young women between the ages of 10 and 24. The Project's principal focus is the15-24 cohort
[5] The GoZ does not report new HIV cases by district, age and sex. However data available at district level provides the following proxy data which will be reported HTS4: # of clients who tested positive, annually, during (HIV) re-test (excluding for ART initiation) disaggregated by age and sex. It is best practice for two tests to be conducted for an HIV diagnosis.
[6] Data for Mazowe and Umguza only available once the ICAD/District MOU is signed (to be issued after approval of PIP and revised CA)
[7] "Women are to blame for sexual abuse by wearing revealing clothes" is the proxy for determining changes in attitudes (disaggregated by age and sex) towards ending SGBV

INTERMEDIATE OUTCOME							
1100 Increased utilization of gender-equitable and adolescent-responsive SRHR and HIV services by vulnerable AGYW in 4 districts of Zimbabwe	% of AGYW reporting that they have ever accessed SRHR services (disaggregated by age)	Ages 20-24: 22% (78/354) Ages 15-19: 13% (47/354) Ages 10-14: 5% (17/354)	At least 20% increase per age group by the end of the project	Adolescents and youth at facilities	A and Y Survey	End line	YE and KS Project Managers
	% of AGYW who use contraception report practicing safer sex through condom use.	17%	At least a 30% change by the end of the project	GES	A and Y Survey	Endline	YE and KS Project Managers
1200 Improved delivery of gender equitable and adolescent responsive SRHR services to vulnerable AGYW	# of health facilities providing AYF SRH services as per MOH tiered guidelines	100% (4/4 clinics) Sample size is too small to be relevant. . Consequently, it will be updated during the initial facility visits by project staff. Recommend number of facilities is 4/district =24	TBD as soon as project teams are permitted to travel and gather the info. (deadline is the end of the calendar year)	Facility assessments	Review of facility assessments	Semi-annually	Project Manager in coordination with YE/KS
	# and % of AGYW reporting satisfaction with AYF-SRH services received at facilities in project communities.	97% of AGYW (97 of the 100 AGYW in the Survey who had ever accessed SRHR services) [8]	Maintaining a 90% average throughout the project	AGYW exit survey at facility	AGYW Survey	Semi annual and endline	Project Manager in coordination with YE/KS
	Add New Indicator % of AGYW reporting satisfaction with confidentiality by HF staff	89.4 (185/207)	Maintaining 90%* average throughout project	AGYW exit survey at facility	AGYW Survey	Semi-annual and Endline	Project Manage incoordination with YE/KS

[8] Initial decline anticipated as AGYW gain knowledge and awareness of what good service delivery entails.

	# of AGYW provided with access to sexual and reproductive health services (including HIV testing, modern methods of contraception), through this project	46% of AGYW (100/217) in targeted districts	15% yearly increase beginning in Y2	DHIS or clinic records	Review of MOH registers/records and project data	Annually	Project Manager in coordination with YE/KS
1300 Improved effectiveness of AGYW, health workers and community organizations to advocate for SRHR	# of national laws, policies and strategies relating to SRHR implemented or strengthened, through this project at the district level	None	At least one by end of project	District or national policies	Review of policies	Annually	Project Manager in coordination with YE/KS
	# of advocacy activities completed by GAC-funded partners which are focused on SRHR	None	At least 3 events annually	District event calendar and project records	Review records	Annually	Project Manager in coordination with YE/KS
IMMEDIATE OUTCOME							
1110 Increased knowledge and awareness of SRHR and HIV among vulnerable AGYW	# and % of AGYW aware of protective health related skills i.e. condom use.	70% (154/220) aware of the importance of condom use	At least 80% of AGYW indicate knowledge of protected health related skills	Knowledge Attitude and Practice (KAP) survey	Review of KAP survey results	Baseline, endline	Project Manager with Survey Consultant
	# of AGYW knowing where and how to access SRHR services	80.9% (161/199) AGYW;	At least 95% of AGYW indicate knowledge regarding access to services.	KAP survey	Review of KAP survey results	Baseline, endline	Project Manager with Survey Consultant

1120 Increased awareness of parents, caregivers, religious and traditional leaders, young men and adolescent boys of harmful social norms and inequalities that hinder access of AGYW to SRHR and HIV information and services	% of community members (F/M) who can identify consequences of harmful social norms and inequalities including: • Early sexual debut • Transactional sex • Age disparity partnerships • Normalization of GBV	Baseline data inconclusive. Field staff to survey different community groups (M/F) in each district to identify consequences of harmful social norms. Baseline surveys to be collected before Dec. 2020.	TBD once data has been collected and analyzed.	Sample of community members including leaders (need to disaggregate between type of community member)	Initial 2020 surveys followed by pre and post workshops surveys	Annually (cumulative responses from community workshops)	Project Team
	% of community members (M/F) engaged in activities that improve AGYW access to SRHR/HIV information and services	None	40% of participants engaged in improving AGYW access to SRHR by end of project (i.e. include parental communication with AGYW on SRHR; advocacy through Coordinating Committees)	Sample of community members including leaders (need to disaggregate between type of community member);	Focus Group discussions Pre and post workshop surveys	Annually	Project Team
1210 Increased knowledge and skill of service providers at the facility and community level to deliver gender-equitable and adolescent-responsive SRHR services to vulnerable AGYW.	# and % (M/F) of trained health care service providers who can identify key elements of gender-equitable and adolescent responsive services and how to provide them.	25% (5/20) women 25% (1/4) men;	At least 80% of those trained	Post training questionnaire	Review of survey results	Annually from Y2	Project manager in coordination with YE/KS
1310 Increased knowledge and skill of AGYW to advocate for SRHR.	# and % of AGYW expressing confidence (on a likert scale of 5) in their ability to advocate for SRHR 1- Very uncomfortable 2- Somewhat uncomfortable	#,% of AGYW Cat 1-2: 32% (71/220): Cat 3: 14% (30/220)	At least 60% comfortable and 40% very comfortable/ confident by end of the project	Survey of AGYW	Review survey results	Year 3 Annual Report and endline	Project Manager in coordination with YE/KS

	3- Neutral 4- Comfortable 5- Very comfortable or confident	Cat 4: 30% (66/220) Cat 5: 24% (53/220)					
OUTPUTS							
1111 Assessments conducted to understand the unique needs of AGYW in selected wards from hotspots in the four districts	# Assessments conducted in all wards	None	all assessments conducted during Baseline	Project Records	Review of records	At project start	YE and KS
1112 Youth Champions, Community Facilitators and Pachoto Groups trained to engage vulnerable AGYW on SRHR and HIV.	# (f/m) of Youth Champions, Community Facilitators and Pachoto members trained to engage vulnerable AGYW on SRHR and HIV	None	40 in Y1; 100 in Y2 and 100 in Y3.)	Project records – training registrars	Attendance record review	Semi annually	YE and KS
1113 Sensitization of vulnerable AGYW on SRHR and HIV conducted	# of sensitization trainings organized for vulnerable AGYW	None	TBD in Y1	Project records	Review of training lists	Semi annually	YE and KS
	# of AGYW attending sensitization exercises	None	TBD in Y1	Project records	Review of training lists	Semi annually	YE and KS
1121 Youth Champions, Community Facilitators and Pachoto Groups trained on effective communication skills to increase awareness of SRHR and HIV at the community level.	# (f/m) of Youth Champions, Community Facilitators and Pachoto members trained on effective communication skills	None	40 in Y1; 100 in Y2 and 100 in Y3 . of whom 75% are AGYW	Project records – training registrars	Attendance record review	Semi annually	YE and KS
1122 Parents and caregivers engaged to better understand impact of harmful social norms	# of community awareness activities that include gender sensitivity analysis conducted for parents and care givers.	None	At least 2 events annually	Project records – training registers	Attendance record review	Semi annually	YE and Ks
1123 Traditional and community leaders engaged to better understand impact of harmful social norms	# of events targeted at traditional and community leaders in gender-sensitive community awareness activities	None	3 events by end of project	Project records – training registers	Attendance record review	Semi annually	YE and Ks

1124 Young men and adolescent boys engaged to better understand impact of harmful social norms	# of events targeted at young men and adolescent boys in gender-sensitive community awareness activities	None	At least 3 events in in Y2, 2 in Y3 and 1 in Y4	Project records – training registers	Attendance record review	Semi annually	YE and Ks
1211 Facility-based Health Service Providers trained on gender equitable and adolescent-responsive SRHR and HIV service delivery and referrals	# of facility-based health service providers (f/m) trained	. 25% (5/20) women 25% (1/4) men;	Estimated number of health providers to be trained=80. Training to take place during Y2 and Y3 (50%/year)	Post training questionnaire	Review of survey results	Semi annually	Project Manager and JE and KS
1212 Community Health Workers (i.e. Village Health Workers, Community Adolescent Treatment Supporters) trained on gender-equitable and adolescent-responsive SRHR and HIV service provision and referrals.	# of VHWs/CATSs (f/m) trained on gender transformative and adolescent responsive SRHR and HIV approaches	None	Estimate number =100 of whom 75% are female.. Training to take place during Y2, Y3 and Y4 (approx. 30%/year)	Training records	Review of attendance records	Semi annually	YE and KS
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	# district dialogues conducted	None	At least 1 process undertaken per district	Project records from mobilization activities	Review of project records	Semi annually	YE and KS in coordination with the Project Manager
1221 Referral Protocols developed and disseminated to stakeholders.	# of health staff (f/m) trained on referral protocols	None	80% of health facility staff in selected wards trained by the end of the project (est.# of health facility staff = 80 of which 75% are female)	Project records	Review of project information	Semi annually	Project Manager

1222 Coordinating committees established to link SRHR services for vulnerable AGYW at various levels of the health system	#/level of coordinating committees established	None	At least 1 Health Committee/ward	Project records	Review of attendance records	Semi annually	KS/YE
	#/%/ of Coordinating Committee members are female.	None	50% female membership on committees	Project records	Review of attendance records	Semi annually	KS/YE
1223 Health facility managers and administrators sensitized to facilitate the delivery of gender equitable and , adolescent-responsive SRHR and HIV services to vulnerable AGYW	#/% (F/M) of health facility managers, administrators, and health officials trained to facilitate gender equitable, adolescent-friendly integrated SRHR and HIV services.	None (F/M breakdown unknown. Numbers will be determined during initial visits to all facilities on/before 31Dec. 2020.)	#/% (F/M level) of health facility managers/administrators/health officials by end of project (est. # of managers/administrators = 24.	Project records –training registers	Review of attendance records	Semi annually	YE/KS
1224 Twinning facilitated with regional and/or domestic CBOs to enhance project capacity to deliver quality gender transformative and adolescent responsive SRHR and HIV services	# of twinnings facilitated between partners and other CBOs	None	4 south/south twinnings by end of project	Project records	Review project information	Semi-annually	Project Manager
1311 Community Youth and Health Champions identified, trained and supported to collect, analyze and use data related to delivery of SRHR services for vulnerable AGYW	# of youth and health champions (f/m))trained on data collection and analysis	None	At least 20 people (75% female) per district by end of project	Project records – training registers	Review attendance records	Semi-annually	YE and KS
1312 Health Center Committees revitalized and strengthened to advocate for the needs of vulnerable populations including AGYW and PLHIV	# of HCC revitalized and strengthened	None	One functioning HCC per health facility per ward by end of project	Project records	Review records	6/year	YE and KS project managers

1313 Participatory community-based assessment tools (e.g. community scorecards) adapted to assess SRHR/HIV service acceptability, availability, access	# community-based tools adapted /or # of scorecard activities conducted	None	At least 2 community assessment conducted per ward (initial and follow-up)	Project records	Review records	In 2021 and 2023	YE and KS project managers
1314 Public awareness and promotional materials developed and distributed.	# and types of materials produced to highlight key results and support advocacy	None	1000 t-shirts and caps designed and distributed; 12 large banners fabricated; 5000 SRHR-related pamphlets produced	Project information and materials	Review material developed	Semi annually	Project manager in consultation with YE and KS

RF/6 June 2020

Annex 4: Roles and Responsibilities

ICAD Roles and Responsibilities:

As the principal signatory with GAC, ICAD bears the overall legal responsibility for the project. It's primary responsibilities include:

- Plan and manage the process to complete the PIP, in collaboration with all project partners;
- Prepare the project documents, including annual work plans, progress reports, annual reports, and end of project reports;
- Review and submit financial reports prepared by ICASO as per the reporting schedule outlined in the project Contribution Agreement;
- In cooperation with ICASO, develop and sign contracts with Canadian project partners;
- Develop in partnership with ICASO, project financial management systems and train all project partners in their application;
- Recruit, administer and manage technical assistance (Canadian and international partners) in partnership with ICASO;
- Provide project oversight and technical assistance in the development and implementation of monitoring and evaluation and gender strategies, in partnership with ICASO;
- Coordinate and facilitate project support provided through internships and twinning initiatives;
- Develop and produce project related communications and resource materials;
- Coordinate project-related internal and external communications, including regular project meetings, website updates, and project-specific public engagement activities in Canada and globally;
- Support ICASO and project partners to ensure compliance with financial reporting and procurement policies and procedures as outlined in the contribution agreement with GAC;
- Monitor the risks associated with the delivery of the project and their impact(s) on project activities
- Ensure the project is well coordinated with other SRHR and HIV initiatives in Zimbabwe, including those funded through GAC, international initiatives and other ICAD and ICASO programming;
- Liaise with GAC as required.

ICASO's Roles and Responsibilities

ICASO will take the lead on financial management and reporting. It's primary responsibilities include:

- Support the planning and development of the PIP, in collaboration with all project partners;
- Support the preparation of all project documentation, including annual work plans, progress reports, annual reports, and end of project reports;
- Lead on the preparation of all financial reports according to the schedule outlined in the Contribution Agreement with GAC and partnership agreement with ICAD
- Develop and maintain project financial management systems and train all project partners in their application
- Collaborate with the Senior Program Officer in the preparation and verification of all project budgets;

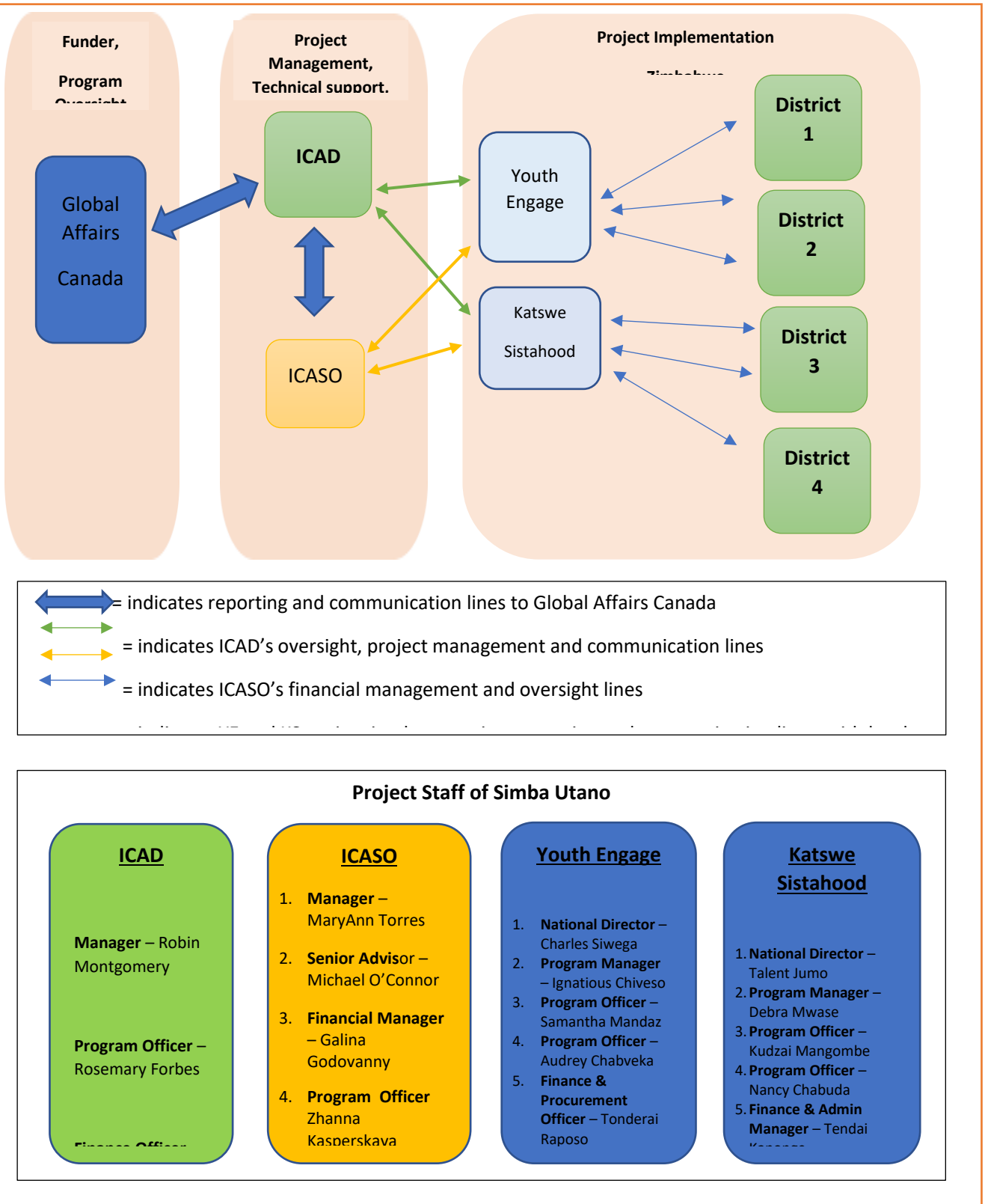
- Ensure that accounting and financial systems and supporting documentation are in place and maintained and bills are paid in a timely fashion;
- Ensure project partners (ICAD, ICASO, Katswe Sistahood and Youth Engage) comply with financial reporting requirements mandated by the contribution agreement with GAC and other reporting requirements such as reporting to Revenue Canada and filing for GST/HST;
- Manage any project related audits including preparing working papers, closing project books for the financial audit, making entries, etc.;
- Provide technical support to local partners in Zimbabwe as required to ensure they comply with the financial reporting and accounting requirements as mandated in the contribution agreement with GAC and partnership agreement with ICAD;
- Disburse funds to project partners and ensure that they account for spending in an accurate and timely manner;
- Manage and oversee the completion and filing of project timesheets and in-kind/cash in-kind contributions as mandated in the contribution agreement with GAC and partnership agreement with ICAD;
- Manage and oversee project-related procurement of good and services in collaboration with ICAD;
- Maintain ongoing communication channels with ICAD on all issues related to the project.

Youth Engage and Katswe Sisterhood Roles and Responsibilities:

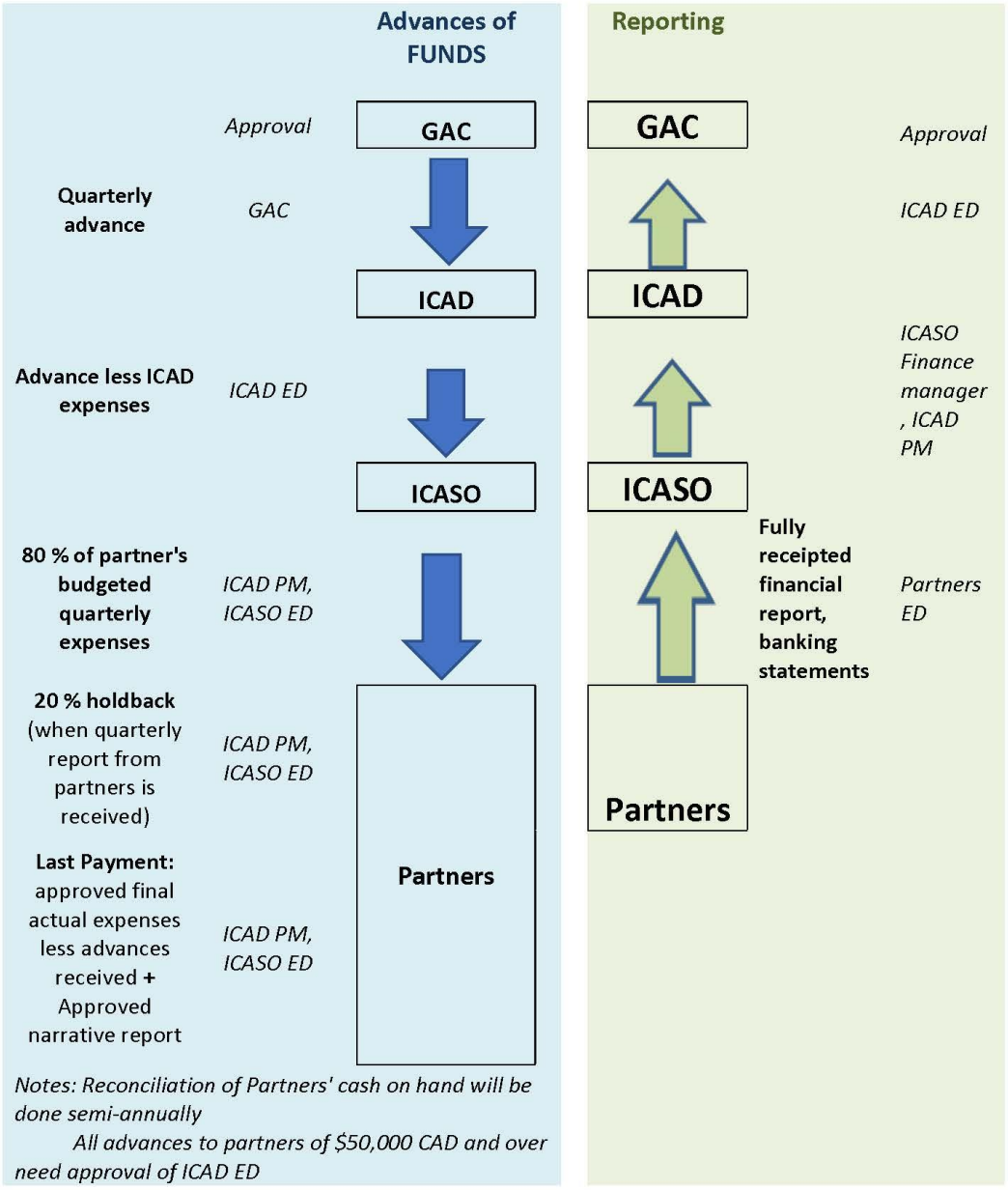
- Primary responsibility for the implementation of project activities in Zimbabwe through their headquarters, staff and partners in the project districts;
- Provide training and technical support to local project partners, beneficiaries and community groups as detailed in the Project Implementation Plan (PIP);
- Develop annual work plans and annual budgets based on the PIP for approval by ICAD and ICASO;
- Coordinate, implement and monitor project work plans and budgets to execute activities in the four project districts as per the PIP;
- Implement monitoring and evaluation activities of the project;
- Collaborate with ICAD and ICASO in the preparation and verification of all project budgets;
- Ensure compliance with financial reporting and procurement policies and procedures as outlined in the contribution agreement with GAC;
- Prepare narrative and financial reporting for approval by ICAD and ICASO as mandated in the contribution agreement with GAC and in the partnership agreements with ICAD-ICASO;
- Ensure that accounting and financial systems and supporting documentation are in place and maintained and that bills are paid in a timely fashion;
- Support the development and production of project related communications and resource materials;
- Participate in project-related internal and external communications, including regular project meetings, website updates, and project-specific public engagement activities in Canada and globally;
- Support any project related audit processes including: preparing and providing supporting documentation, closing project books for the financial audit, etc.;
- Liaise with relevant Government and health authorities, including staff in government health facilities involved in project activities;

- Coordinate project activities with district authorities and other local and international initiatives;
- Ensure project activities remain in line with government strategies and priorities;
- Monitor the risks associated with the delivery of the project and their impact(s) on project activities;
- Manage and oversee the completion and filing of project timesheets and in-kind/cash in-kind contributions as mandated in the contribution agreement with GAC and partnership agreement with ICAD-ICASO;
- Manage and oversee project-related procurement of good and services in collaboration with ICAD-ICASO;

Annex 5: Project Management Structure



Annex 6: Wiring Diagram



Annex 7: Procurement Plan and and Summary of Assets

PROCUREMENT PLAN
for the
SIMBA UTANO PROJECT

The purpose of this document is to specify the procurement processes and procedures to be followed during the implementation the Simba Utano project.

a. NATIONAL CONTEXT

In developing the procurement plan for the Simba Utano project, the challenges of working in Zimbabwe need to be acknowledged. For the past several years, the economy has been deteriorating and as a result some practices which would be possible in other countries are not practical in Zimbabwe. For example, it is possible to hire a consultant by circulating a request for expressions of interest through social media sites and then selecting the best qualified person at the most advantageous price. However, it would not be cost effective to advertise through the print media since the price of advertising in local papers ranges from US $500 to $1,000. NGOs in Zimbabwe have long been in the habit of purchasing large ticket items in South Africa and importing them to Zimbabwe. For example, vehicles and electronic goods purchased in South Africa are generally less expensive and of better value than those procured locally.

Secondly, the Simba Utano project has budgeted for annual monitoring visits to Zimbabwe, commencing in May 2020, where on-site financial support and guidance will be provided. This may not be feasible in the short to medium term. As an alternative, financial monitoring and capacity building will be enhanced through regular conference calls between ICASO, ICAD and the financial directors from YE and KS. These routine calls with finance teams will review financial reports, discuss challenges and determine what training or additional support may be required.

Thirdly, as indicated in the signing authorizations (Section 2), ICAD and ICASO will review and approve purchases of goods or service over USD 3,000. ICAD/ICASO involvement in sign off at levels below that will be too cumbersome to implement. ICASO requires Partners to submit copies of all receipts and will request clarification and additional information when necessary. Non-budgeted expenditures will be disallowed.

Finally, the Zimbabwe Partners are at different stages of development. Kitswe Sistahood (KS) has been implementing projects for several years and is managing a budget in excess of $US 750,000. Youth Engage (YE) is a relatively newer NGO with a smaller annual budget. Naturally, management procedures are more developed in KS. For this reason,the Partners have agreed that all purchases over USD 10,000 will be handled by KS through their existing financial

management and oversight systems. This would apply specifically to the vehicles since all other planned expenditures are well below this threshold. KS policies require a Board signature on all cheques and a Board discussion and authorization for purchases over $10,000. Funds for vehicles will be deposited into the KS bank account in Botswana to avoid difficulties in transferring funds to South Africa. YE will be fully engaged in the procurement of both vehicles and ownership will be transferred to the organization once the vehicle arrives in Harare. In the event that a suitable and competitively priced vehicle can be located in Zimbabwe, the funds will still be transferred to Botswana to mitigate a potential "hold on large trasnfers" by the Zimbabwe banking authorities.

It's worth noting that KS has purchased vehicles in the past and that the KS finance manual outlines stringent procurement and disposal procedures.

b. SIGNING AUTHORIZATIONS REQUIRED

It is understood that the Partners will endeavour to avoid cash payments given its inherent risk. However, when no other option exists, Partners will ensure that the proper segregation of duties and controls exist[9]. The first step in the procurement process is that the relevant Finance Officer must confirm that the purchase request is authorised and included in the project budget. The Partner's governance boards also play an oversight role and authorize transaction. In the case of KS at least one Board member is required to co-sign all cheques.

Simba Utano procurement signing authorizations required for project expenses in Zimbabwe are as follows. All limits are specified in US Dollars (USD):

- All purchases of goods and services worth less than $500 are at the recommendation of the relevant Program Officer (PO) with approval of the National Director (ND) of the relevant Partner organization;
- All purchases of goods and services of $500 and less than $3,000 are at the approval of the ND. Partners can seek advice from the Program Manager ICAD (PM/ICAD) and Financial Manager ICASO (FM/ICASO) if helpful;
- All purchases of goods and services of $3,000 and less than $10,000 are at the approved by the ND after prior consultation with both the PM/ICAD, the FM/ICASO
- All purchases of goods and services of $10,000 and over are at the recommendation of the ND, the approval of the organization's Board of Directors, the recommendation of the PM/ICAD and the FM/ICASO and the approval of both Executive Directors of ICAD and ICASO.

[9] Segregation of duties and controls is defined in organizational financial policy manual and general specifies that all cheques, fund transfers and wire payments require the signature of two authorized signing officers. No signing authority can sign for their own expense reimbursements, nor, where possible, for expenses they have approved themselves.

c. METHODS FOR PROCUREMENT

Procurements shall be made using one of the following methods: (a) small purchase procedures, (b) competitive sealed bids, (c) competitive negotiations and (d) non-competitive negotiation. The approval process for each purchase must conform to the authorization schedule set out in Section 2 above.

Small Purchases of Goods and Services (under $500) Examples include: venues, bus tickets, community/staff per diems, conferencing fees, equipment hiring (P.A systems) design and/or translation of IEC materials and tent hire.

Purchases of less than $500 will require three over-the-telephone quotations of rate, price, etc. A memorandum will be prepared setting forth the date calls were made, parties contacted, and prices obtained. Efforts will be made to get the lowest and best price.

Larger Purchases of Goods and Services $500 to $3,000 Examples include airfares and venue rentals for meetings/small conferences

Purchases of supplies, equipment and services which cost between $500 and $3,000 will require written estimates but no legal advertisement is required. The relevant Partner will solicit written responses from at least three vendors, and if three responses are not available, a statement describing and justifying the procurement process will be prepared and kept on hand for audit purposes.

Goods and Services $$3,000 to $5,000 Examples include consulting fees, mid-size conference and regional travel

Bidding will be employed when detailed specifications for the goods or services to be procured can be prepared and the primary basis for award is cost. A Request for Proposals (RFP) or an Invitation for Bids (IFB) notice will be prepared. No legal advertisements are required, and the relevant Partner may solicit written responses via widespread circulation of the notice on social media and/or by directly contacting prospective suppliers by sending them a copy of the notice.

The RFP/ IFB will include a complete, accurate and realistic specification and description of the goods or services to be procured, the deadline and whether the bid award will be made on the basis of the lowest price or the lowest evaluated price. If the lowest evaluated price is used, the measurable criteria to be used must be stated in the IFB.

Proposals will be initially reviewed by the ND and measured against the stipulated criteria. A short list of 3 candidates/bids will be forwarded to ICAD as part of the final collaborative review process. At each stage, a record (minutes) will be compiled as to how the decisions are reached. Once the final decision is made, a draft contract will be prepared by the relevant Partner. The draft contract must be reviewed by the PM/ICAD and FO/ICASO before it is finalized and sent to the successful bidder.

When soliciting an IFB is not realistic, such as the purchase of accommodations or international travel, the Partners will gather at least three quotes and choose the product with the best value for money. The decision will be documented and justification and records kept on hand for audit purposes.

Goods and Services $5,000 to $10,000 Examples include large conferences and consultancies

When the cost of a contract, lease or other agreement for materials, supplies, equipment or contractual services, exceeds $5,000, an RFP or IFB notice will be prepared. This notice will be published through online platforms such as websites, listservs, and newsletters. This notice will appear no less than seven (7) days and no more than twenty-one (21) days before the due date for bid proposals. The relevant Partner may also solicit sealed bids from responsible prospective suppliers by sending them a copy of such notice.

Only in exceptional circumstances will expedited procurement processes for goods and services be considered based on approved written rationale and appropriate approvals as outlined in sections 3.c and 3.d. If an expedited procurement is implemented, the process will maintain the principles of openness, fairness and transparency outlined in this document and the procedures and rational will be agreed to by the project Partners in advance.

Similar to c) above, an RFP/ IFB will include a complete, accurate and realistic specification and description of the goods or services to be procured, the deadline for the bid and whether the bid award will be made on the basis of the lowest price or the lowest evaluated price. If the lowest evaluated price is used, the measurable criteria to be used must be stated in the IFB.

The bids will be tabulated and the results of the tabulation and the bid procurements will be examined for accuracy and completeness by the appropriate National Director. The ND shall determine that all firms are responsive and responsible. A short list of 3 candidates/bids will be forwarded to ICAD as part of the final collaborative review process. At each stage, a record (minutes) will be compiled as to how the decisions are reached. Once the final decision is made, a draft contract will be prepared by the relevant Partner. The draft MUST be reviewed by the PM/ICAD and FO/ICASO before it is finalized and sent to the successful bidder.

The award must be made to the offeror whose proposal is determined to be the most advantageous to the Simba Utano Project. Evaluations must be based on the factors set forth in the IFB and a written evaluation of each response prepared. The review committee (consisting of both National Directors and a representative from ICAD and from ICASO) may contact the firms regarding their proposals for the purpose of clarification and record in writing the nature of the clarification. If it is determined that no acceptable proposal has been submitted, all proposals may be rejected. New proposals may be solicited on the same or revised terms or the procurement may be abandoned

Partners may cancel an Invitation for bid or reject all bids if it is determined that such is in the best interests of the Simba Utano project. Bidders will be notified in writing of such cancellation or rejection. Partners may allow a vendor to withdraw a bid if requested at any time prior to the

bid opening. Bids received after the time set for bid opening shall be returned to the vendor unopened.

Purchases above $10,000 Example: Vehicles

The Partners will use competitive negotiations upon a written determination that: specifications cannot be made specific enough to permit the award of a bid on the basis of either the lowest bid or the lowest evaluated bid price (in other words, bidding is not feasible). This process may be required for vehicle purchase. If reasonably priced, project appropriate, second-hand vehicle are not available in Zimbabwe, they may be purchased from a neighboring country (i.e. South Africa). In this instance competitive negotiations will proceed as follows:

Proposals can be solicited through regional newspaper advertisements; additionally, an IFB may be prepared and mailed to qualified vendors or service providers. The notice must be published at least seven (7) days and not more than twenty-one (21) days before the date for receipt of the bids. The IFB will describe the goods needed and identify the factors to be considered in the evaluation of the IFB and the relative weights assigned to each selection factor. Requests for bids will always include cost as a selection factor.

The award must be made to the offeror whose proposal is determined by the Partners to be the most advantageous to the Simba Utano Project. Evaluations must be based on the factors set forth in the IFB and a written evaluation of each response prepared. In the case of a vehicle purchase the evaluation will include independent reports by an impartial car mechanic and reports on test drives by NDs or their surrogates. The review committee (consisting of both National Directors, a representative from ICAD and from ICASO) will consider the options and determine which is most advantageous to the Simba Utano Project. If it is determined that no acceptable proposal has been submitted, all proposals may be rejected. New proposals may be solicited on the same or revised terms or the procurement may be abandoned.

d. CONSULTING SERVICE CONTRACTS

Generally, all procurement in excess of $200 will be memorialized and supported by a written contract. Where it is not feasible or is impractical to prepare a contract, a written finding to this effect will be prepared and some form of documentation regarding the transaction will be prepared. All contracts will contain language which allows Partners the opportunity to cancel any contract for cause. The cause shall include (but not be limited to) demonstrated lack of ability to perform the work specified, unwillingness to complete the work in a timely fashion, failure to keep accurate and timely records of the job, or failure to make those records available to the Partners (on request) or any other documented matter which could cause a hardship for the Simba Utano Project if a claim should arise or the work not be completed on schedule at the specified cost.

e. DOCUMENTATION

All source documents supporting any given transaction (receipts, purchase orders, invoices, RFP/RFQ data and bid materials) will be retained and filed in an appropriate manner according to Global Affairs Canada (GAC) audit requirements. Where feasible, source documents pertinent to each individual procurement shall be separately filed and maintained. Where it is not feasible to maintain individual procurement files, source documents will be filed and maintained in a reasonable manner (examples include chronologically, by vendor, by type of procurement, etc.). Whatever form of documentation and filing is employed, the purpose of this section is to ensure that a clear and consistent audit trail is established. At a minimum, source document data must be sufficient to establish the basis for selection, basis for cost, (including the issue of reasonableness of cost), rationale for method of procurement and selection of contract type, and basis for payment.

Global Affairs Canada has the right to audit the Simba Utano at any time during the implementation of the project and for 3 years following expiry of the project or early termination of the agreement. The Partners shall maintain and retain, for such period of time, separate accounting, financial records and original supporting documentation to account for all expenses related to the implementation.

f. GENDER DIVERSE AND FEMALE-OWNED BUSINESSES

All necessary affirmative steps will be taken and documented to solicit the participation of gender diverse and female-owned businesses. The Partners will solicit proposals from gender diverse/women-owned businesses that provide the goods or services that are being sought. Where possible and feasible, delivery schedules will be established, and work will be subdivided to maximize participation by gender diverse/women- owned businesses. Subdivided components will be bid as a separate contract. Where feasible, evaluation criteria will include a factor with an appropriate weight for these firms. A list of gender diverse and female-owned businesses located within the Project's geographical areas of operation shall be maintained and used when issuing IFBs, RFPs and RFQs. This list shall also be consulted when making small purchases.

g. CODE OF CONDUCT

Conflict Of Interest

No Partner Board member, employee, consultant, elected or appointed official or designated agent of the project will take part or have an interest in the award of any procurement transaction if a conflict of interest, real or apparent, exists. A conflict of interest occurs when the official, employee or designated agent, partners of such individuals, immediate family members, or an organization which employs or intends to employ any of the above has a financial or other interest in any of the competing firms.

No Partner Board member, employee or designated agent of the project may acquire a financial interest in or benefit in any way from any activity which uses any portion of the project funding, nor shall they have any interest in any contract, subcontract or agreement for themselves or any family members.

NOTE: These rules apply to all named parties and shall be effective for the period of service and for one year after leaving said position (or office, in the case of elected officials).

Acceptance of Gratuities

No Partner Board member, employee or designated agent of the Partners shall solicit or accept gratuities, favors or anything of monetary value from contractors, potential contractors, subcontractors or potential subcontractors.

h. PENALTIES

Any Board member, employee or designated agent of the Partner organizations who knowingly and deliberately violates the provisions of this code will be open to civil suit without the legal protection of other members of the Partnership. Furthermore, such a violation of these procurement standards is grounds for dismissal (if an employee or Board member) or such sanctions as available under the law (if an elected official).

Any contractor or potential contractor who knowingly and deliberately violates the provisions of these procurement standards will be barred from future transactions under the Simba Utano Project.

Summary of Assets

	Item Description	Price US	Approx Price Canadian	Method of Procure.	Delivery Location/ Date	Destination
1	PIP Workshop accommodation and food Manna Pools	11,840	15,392	Competit. bid	Harare/Nov 2019	Harare/KS
2	HP ProBook 640 G5 14" Notebook Computer (Best Buy)		1,541	Competit. bid	Ottawa/Nov 2019	Harare/YE
3	HP ProBook 640 G5 14" Laptop Computer (newegg)		1,532	Competit. bid	Ottawa/Nov 2019	Harare/KS
4	Baseline (consultancy fees of $7,000 and field research $7,500)	7,000	9,380	Competit. bid	Harare/Jan 2020	Harare/YE
5	Gender Assessment (fee of $7000 and field research $7,500	7,500	10,050	Competit. bid	Harare/Jan 2020	Harare/KS
6	Promotional Materials (hats and t-shirts for outreach)		10,000	Competit. bid	Year 1	Harare
7	SRHR Movement Toolkit (consultancy)		5,000	Competit.bid	Year 1	Harare/KS
8	IEC Materials (consultancy)		3,000	Competit. bid	Year 1	Harare/YE
9	Design and Printing of Score Cards		2,000	Competit. bid	Year 2	TBD
10	Videography and editing costs for 3 videos		9,000	Competit. bid	Year 2 and 3	TBD
11	Production, printing and distribution of IEC materials (flyers, posters, pamphlets etc)		20,000	Competit. bid	Year 1, 2, 3	TBD
12	20 podcasts ($500/each)		10,000	Competit. bid	Years 2,3 and 4	TBD
13	Endline		20,000	Competit. bid	Sept 2023	Harare
14	Vehicles (2)	35,000	47,000 each	Competitive Negotiation	Johannesburg/ Sept. 2020	Harare

Disposal Plan: It will be assumed that everything will have been consumed during the life of the project. Should anything remain (i.e. computers), then ownership will revert to the Zimbabwe project partners. Asset disposal will follow the procedures outlined in Katswe Sistahood's Financial Management Manual

Annex 8: Baseline Report

(Separate attachment)

Annex 9: Gender Equality Strategy (Part 1 and Part 2)

(Separate attachment)

Annex 10: Budget by Line Item

(Separate attachment)

Annex 11: Activity Based Budget

(Separate attachment)

Annex 12: Budget by Year

(Separate attachment)