Jordan

A. We Lead Programme Overview

CoA Member Organizations

The Community of Action (CoA) in Jordan was composed of 15 member organizations with [redacted] serving as the CoA host.[1] Three organisations withdrew during the course of the programme: [redacted] (due to the size of the grants) [redacted] (due to strategic reprioritisation) and [redacted] (due to legal issues related to the Ministry of Trade's registration and compliance procedures, which meant they could no longer receive a grant from [redacted] until they corrected their status.) . The majority of activities were undertaken in Amman, although some were undertaken in other towns and cities such as Jerash, Raseifah, Tafila and Zarqa.

Main Activities

- **Capacity building and training**: Conducting capacity assessments of CSOs, delivering tailored capacity-building programmes; developing SRHR manuals and guidelines, meaningful youth engagement (MYE) code of conduct; supporting coalition-building among diverse organisations; facilitating context analysis and advocacy planning.
- **Public awareness and community engagement on SRHR:** Mapping data sources and opinion leaders; designing engagement strategies for parents and influencers; facilitating community dialogues and learning forums; partnering with media to promote positive narratives; integrating SRHR into life-skills education.
- **Engagement with health services:** Mapping and identifying service providers and referral pathways; assessing and building capacity of providers on technical and social competencies; supporting design of inclusive, comprehensive SRHR services; creating safe hubs and spaces for youth–provider dialogue.
- **Policy and legislative advocacy:** Reviewing SRHR-related laws and policies; training youth on social accountability tools; collaboration with influential stakeholders, particularly within the governmental sector through active participation in committees; the development of policy papers; the amendment of regulations and instructions related to SRHR.

B. End Term Evaluation Fieldwork

Number of stakeholders interviewed	11 women; 1 man
Number of participants of CoA Sensemaking Workshop	6 women, 2 men
Number of participants of Rightsholder Sensemaking Workshops	16 women
Total number of participants	**36**

C. Country Context

[redacted]

Jordan is considered relatively stable in a volatile region but faces ongoing security challenges from regional spillovers, particularly the Syrian crisis. According to UNHCR, Jordan hosted almost half a million refugees as of October 2025, the vast majority from Syria,[2] however, estimates vary significantly and according to UNRWA "2.39 million registered Palestine refugees live in Jordan".[3] Ongoing regional conflicts, including genocide in Gaza, war, political instability, and humanitarian crises in neighbouring countries, have slowed the pace of the work in Jordan and hindered long-term planning due to uncertainty (and more recently associated budget cuts), despite initial expectations that these crises would be short-lived.

The most recent parliamentary elections were held on October 24, 2024, with Parliament consisting largely of independents, tribal blocs, and government-aligned members with no dominant political parties in a socially conservative environment. Women won nearly 20% of parliamentary seats in 2024, an increase from less than 14% previously.[4] This was supported by the Elections Law (2022) which raised the female quota and the Political Parties Law (2022) which mandates that women constitute at least 20% of founding members, while the Local Administration Law (2021) increased women's representation in local councils to 25%. The economy faces fiscal challenges with high national unemployment at approximately 16.2% and youth unemployment is over 40%,[5] alongside severe water scarcity threatening agriculture and urban water supply.[6]

Freedom of expression is limited with journalists facing censorship and legal constraints sometimes leading to self-censorship, and protracted funding reductions for international aid programmes have increased stress on vulnerable populations.[7] Civic space in Jordan has contracted sharply in recent years. Authorities have increasingly used the Cybercrime Law and the Associations Law to restrict freedom of expression and civil society activity, contributing to self-censorship. Protests are often met with heavy policing, and activists face detention or prosecution for online criticism of state policies. NGOs struggle under burdensome registration and funding requirements, while journalists operate in a climate of self-censorship.These dynamics have narrowed opportunities for citizen engagement and curtailed independent advocacy.

[redacted] is not explicitly criminalised in Jordan but [redacted] people do suffer discrimination and harassment under "morality" and "indecent acts" provisions contained in the Penal Code.[8] There are no legal protections or recognition for [redacted] partnerships or gender identity, and [redacted] marriage is illegal carrying severe social taboo.[9] Abortion is also criminalized under the Penal Code except only to protect the woman's physical or mental health, with no exceptions for cases of rape or incest, with performing or undergoing abortion for other reasons punishable by imprisonment. Access to abortion services can be very challenging.[10] Contraception is legal and widely available, often provided free or subsidized through public Primary Health Care centres, although widespread stigma exists for unmarried women seeking contraceptive access and access in rural areas is more limited.[11] There is no nationwide mandatory comprehensive sexuality education although some awareness and school-based programmes are implemented mainly by civil society and international partners. The Penal Code criminalizes rape and violence

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2 https://data.unhcr.org/en/country/jor

3 https://www.unrwa.org/where-we-work/jordan

4 https://www.unwomen.org/en/news-stories/feature-story/2025/08/jordan-sets-historic-record-for-women-in-politics-legal-reforms-and-leadership-training-drive-change

5 https://en.royanews.tv/news/65342/Unemployment-rate-in-Jordan-dips-to-16.2%25-in-Q3-2025

6 https://jordantimes.com/opinion/hazim-el-naser/jordans-economic-growth-drought-as-a-negative-externality

7 https://freedomhouse.org/country/jordan/freedom-world/2025

8 https://www.hrw.org/sithttps://en.royanews.tv/news/65342/Unemployment-rate-in-Jordan-dips-to-16.2%25-in-Q3-2025es/default/files/report_pdf/lgbt_mena0418_annex_0.pdf?utm

9 https://www.equaldex.com/region/jordan

10 https://newlinesmag.com/spotlight/jordan-abortion-conundrum/

11 https://bmjpublichealth.bmj.com/content/3/2/e002926

with the Family Protection Law addressing domestic violence, although marital rape is not recognised and social barriers and enforcement gaps leave victims vulnerable.[12]

The health system is fragmented including the Ministry of Health serving approximately 70% of the population, the Royal Medical Services, and a robust private sector,[13] with government health spending per capita at approximately $295.[14] Services such as family planning, prenatal regimens, and programmes addressing common childhood illnesses are implemented in practice but internal documentation of procedures in health establishments is limited. These services are inconsistently applied across facilities, with reports of IDPs and refugees being charged for tests such as mammograms depending on the centre visited.

National actors such as the Higher Population Council and various health directorates have adopted a Sexual and Reproductive Health and Rights (SRHR) strategy for 2020–2030. The strategy has a number of challenges, such as gaps between policy and practice, fragmentation in coordination/unification of a monitoring body for its work and progress, and resource shifts and constraints. Nevertheless, it remains a driver of change and a component within which programmes like We Lead can move their work forward.

Significant stigma surrounds talking about SRHR even at the generic level, let alone when trying to incorporate certain identity intersections into NGO agendas, government strategies, or advocacy campaigns, especially with added attention needed for identity intersections like refugee status, people living with disabilities, and others. The shame and stigma culture also affects those living with HIV, as documented firsthand by rightsholders who cited examples of mistreatment and even medical isolation in professional/hospital settings, emphasizing that this challenge transcends class, education levels, and profession.

Governmental health policies also avoid explicit references to sexuality or sexual health in the context of the Law on the Rights of Persons with Disabilities, even when their stated aim is to improve related services. The reference in this context is limited to reproductive health, which structurally marginalizes the sexuality and sexual health needs of persons with disabilities (PWD). There is also no comprehensive policy framework addressing the needs of people with different types of disabilities, including accessibility to health facilities and mobility to governmental institutions. That said in 2021, the National Reproductive and Sexual Health Strategy (2020-2030) was launched by the Higher Population Council and United Nations Population Fund. The strategy aims to coordinate national efforts on SRH across all sectors and all levels of government.[15]

D. Evaluation results

Relevance

According to the CoA organisations who completed the survey, the words that they most associate with the We Lead programme often indicated the active role the programme had with rights holders, in terms of it's empowerment or protection, which centred on marginalised communities. Members also indicated the programme was aligned with awareness raising, justice, advocacy and communication approaches:

[12] https://www.unescwa.org/sites/default/files/inline-files/jordan_country_summary_-_english.pdf

[13] https://applications.emro.who.int/docs/9789290226949-eng.pdf

[14] https://www.theglobaleconomy.com/Jordan/health_spending_per_capita/

[15] E1

The CoA organisations reported that they felt the programme's design for their country was well suited to respond to the needs of young women and girls generally, as well as women living with disabilities. The programme was considered by CoA members to be less well suited to the needs of women affected by displacement, and particularly the [redacted] community. It is important to note that the programme avoided explicit mention of the different rightsholder groups due to safety and security concerns. That is to say, the programme sought to adopt an inclusive approach, targeting young women from all rightsholder groups but without specification to avoid backlash from the Government and the community.[16]

Q: And now, thinking about the design of the We Lead programme for your country, how well or badly would you say the programme was designed to respond to the SRH-R needs of:

	Young women and girls generally?	Young women and girls with disabilities?	Young women and girls living with HIV?	Young women and girls who are affected by displacement?	Young women and girls who identify as belonging to the [redacted] community?
Very well	60%	67%	40%	30%	11%
Fairly well	40%	33%	20%	40%	11%
Neither well nor badly	0%	0%	0%	0%	11%
Fairly badly	0%	0%	10%	10%	11%
Very badly	0%	0%	0%	0%	0%
Don't know	0%	0%	30%	20%	56%

The localised Theory of Change (ToC) of the We Lead programme in Jordan was developed based on available evidence with the participation of all CoA organisations, and in alignment with national priorities. While the first ToC localisation workshop faced challenges as it was led by an external consultant, subsequent ToC reviews were considered highly successful, being facilitated by the host organisation together with the DMEL focal point.[17] Interviewees shared positive insights from participating in project ideation exercises like ToC localisation and reflection

[16] E1

[17] CoA survey

workshops, which tailored the programme to Jordan's context and framed their work effectively, as well as some challenges in the tone and level of exposure to certain topics that some felt were not as suitable to the status quo.

> *"The most effective aspects of the programme's design were its localisation, power-shifting and inclusion approach. By ensuring that grassroots organisations (youth-led and women-led organisations) were at the centre of decision-making, the programme not only built ownership but also ensured that interventions reflected national priorities and community realities. The flexible design of the programme also allowed us to adapt strategies as contexts changed, making it more responsive and impactful."*[18]

The first key adaptation was within the inception of the workplan itself and the beginning of the focus group and participatory research process/baseline study in the initial phase of the project. The first localisation exercise in 2021 was cited as "ambitious" and was accompanied by a coordinated process of visiting different organizations, gauging their interest, ability and willingness to engage in a participatory process. The context was and still is difficult and generally conservative, with terms like gender or mentions of the [redacted] community not easy, making the localisation exercise all the more necessary.[19]

There was significant effort put into working directly with committees and public stakeholders working on SRHR from a gendered perspective, although this was not so much the case with other committees working in mental health, for example, that could also have benefitted from the Programme. At the same time, engaging people with disabilities (PWD) from the planning stage contributed to shifting the scope of work of some CoA members to absorb both SRHR and disability rights and justice as part of their future work and vision as they seek to fundraise and strategize after We Lead.

Even though some of the organisations were well-established entities and youth groups already working in or adjacent to service delivery or awareness raising in the SRHR field, there was little knowledge of the legal framework of SRHR. This gradual process led to a more targeted revisiting of the ToC on an annual basis, that drew on more concrete information on national strategies around SRHR, and brought more actors on board to think about implementation together, namely those who became part of the advisory board.[20] Rightsholders were at the centre of this process, and feedback showed that the We Lead training topics were much needed. As a result, rightsholders who were initially the target of awareness-raising exercises then became more involved in policy-oriented work themselves. This proved that the sequencing of outcomes was sound, and that CoA organizations were asking the right questions during the inception phase[21]. In the same vein, midwives and health professionals and rightsholders who were guests on podcasts gave feedback on their content and reviewed them before they were published.[22]

On the other hand, CoA members and rightsholders alike shared that working on, posting about, and advocating for SRHR while remaining sensitive to context was difficult with the ongoing genocide in Palestine. This raised questions about the relevance of the programme's social media presence, but it also sparked important conversations about SRHR being a relevant issue to the wars, upheaval, and injustices happening in the area. CoA organisations were supported to address these issues through the provision of wellness stipends and through ongoing conversations among CoA members.

In developing materials under the programme, the consortium and host organisation sought to ensure the use of a contextualised and inclusive approach which avoided explicitly targeting specific rightsholder groups. For example, SOGIE training and Training of Trainers were

[18] CoA survey
[19] INT1, INT3
[20] INT2
[21] INT1, INT4
[22] INT10

considered relatively progressive for the Jordanian context. Hivos provided CoA members with detailed background information to help them decide whether they wished to participate. In addition, extensive safety and security measures were implemented throughout the process. The SOGIE training materials were translated and localized, and the sessions were facilitated by a Jordanian trainer, ensuring that contextual and cultural considerations were fully integrated. Additionally, a dedicated session focused on women living with disabilities, which was led by women with disabilities from the COAs, to promote sensitivity and inclusion within the learning space.[23] The programme also postponed the delivery of trainings to respond to the needs of the CoA. The Arabic content developed took into consideration the context and used the terminology that would not cause any harm if used in public.

Notwithstanding these efforts, some external governmental stakeholders and CoA members noted that, although training materials were generally appropriate, certain specific training sessions or elements therein were considered unsuitable to the Jordanian context.[24] For example, some felt that trainings were deemed too "advanced" for the specific context that We Lead network members were coming from, including materials that deal directly with [redacted] rights, sex workers' rights, or trans visibility. As noted by one participant: *"I've worked with other projects like Masarouna that brought in these headlines but did not centre them. We can talk of acceptance without going back into the theory of how* [redacted] *has started and create an environment where this mainstreaming is assumed."*[25]

A parallel example comes from the online awareness platform Mawadda. An interviewee from the Higher People's Council shared that she could not adopt the platform as an awareness-raising tool or bring it into the educational or governmental institutions she works with, because in her view. Although the information it presents is important, it did not sufficiently take the Jordanian social context into account. The platform was described as walking a thin line between sexual health awareness and sexual education or awareness around intimacy outside of marriage.[26] This was alarming to two governmental stakeholders who emphasized the taboo around this and stated that such an approach is *"too open-minded"*.[27]

This highlights the challenges and resistance that CoA members face from government authorities and the very restrictive environment they have to navigate. It also demonstrates the extent to which some CoA organisations are pushing boundaries and challenging social norms in their awareness-raising. According to one participant, the fact that the Mawadda receives a high volume of traffic and many questions, shows that the information it presents is in high demand and much needed[28]. The underlying monitoring data was not available to this evaluation team.

Effectiveness

Outcome 1: Strengthening the capacity of CoA members and rightsholders

Key capacity strengthening activities undertaken by the We Lead Programme in Jordan included organisational, financial, and management strengthening, support for developing internal policies and procedures vital for securing grants and funding, organizational strengthening covering strategic planning, policy development, procedures and internal systems including deployment of the Youth Power Pack for organizational resilience, and training of DMEL focal points on Theory of Change review, Outcome Harvesting, and Narrative Assessment.

As an advocacy programme operating in a dynamic context, the programme adopted the outcome harvesting methodology to capture both intended and unintended outcomes as part of a feminist MEAL and participatory approach, which focus on measuring outcomes rather than solely tracking

[23] INT2, E2
[24] INT8, INT10
[25] INT4
[26] INT8
[27] INT10
[28] CoA member feedback on draft country report

quantitative progress. This approach included reviewing reports and conducting quarterly meetings to assess and revise potential outcomes. Proposal writing workshops were conducted for the CoA organizations based on their needs and the M&E tools and plan were discussed. Each organization had their own proposal, logframe specific indicators and activity plan submitted at the beginning of each year in addition to a progress achievement table embedded within the quarterly report template to track progress. This approach was intended to enhance flexibility, empowerment, ownership and partnership and to provide guidance for enhancing proposals and interventions according to needs and capacities rather than creating power dynamics through evaluations driven by KPIs for the organizations each year.

The ToC localisation process and related proposal-writing trainings were identified as particularly impactful. These sessions were reported to clarify strategic alignments across organizations while also fostering collaboration and joint advocacy efforts. Participants noted that training materials used - particularly in sessions facilitated by consortium partners - were both useful and inspiring.[29]

On the other hand, some participants reported that the financial management training presented some challenges. Even those with relative experience within the CoA found the programme requirements difficult to navigate. While follow-up support was available, there remained a significant gap in access to MEAL tools. Some organizations expressed a desire for greater clarity around how their progress was being assessed - beyond the reports submitted to donors. There was a clear call for more standardized tools to ensure a shared understanding of evaluation criteria and metrics. Risk mitigation training, however, was cited as a particularly beneficial component of the capacity-building package.[30]

As noted above, the programme also provided technical skills for service provision via SOGIE (Sexual Orientation, Gender Identity, and Expression) training for 17 CoA members and partners, Training of Trainers sessions equipping six participants with advanced skills to lead SRHR advocacy and SOGIE workshops[31], as well as training on youth-led research tools, youth-led accountability, and meaningful youth engagement.Given the context of backlash and external risks, support was prioritised for organisational resilience and safety measures, including counselling and group therapy sessions, aimed at bolstering the emotional and mental health of CoA members. The continuation of the resilience fund was deemed crucial for the well-being of staff and CoA members. Safety and security content was effectively delivered in ways that allowed organizations to integrate learnings into their own systems. For rightsholders leading organisations - particularly those engaged in policy-level roles or national committees - these trainings were instrumental in enabling participation in SRHR discourse and leadership spaces. Skill-sharing and peer networking further amplified this impact, with participants citing opportunities to lead trainings both within the We Lead programme and outside it and apply newly acquired technical competencies in adjacent fields such as education and organisational management.[32]

Technical training, particularly in SRHR, was described by rightsholders as both essential and high quality. Despite being time-intensive, they were considered valuable and relevant. *"We had so many misconceptions and misinformation about birth control, its effects on our body, transferable infections…and we were so thankful that there was a medical professional giving us this information, both as a volunteer […], but also as a mother and a teacher."*[33]

Intersectionality as both an approach and an analytical lens was introduced to several participants through their engagement with the We Lead programme. This framework became foundational

[29] INT10
[30] INT4
[31] https://docs.google.com/document/d/1BB0G9NSxzNDC9ae8sBzNGM_01Ue2aaTg/edit#heading=h.z25ba8p24l6
[32] INT3
[33] FGD2

for understanding and addressing the layered and overlapping experiences of rightsholders, particularly those at the intersections of multiple forms of marginalization.[34]

According to the organisations who completed the survey, improvements in their credibility and sustainability, as well as their resilience and adaptivity tend to be most likely to be attributed to the role of the programme, with half of the organisation reporting a very substantial contribution made by the programme. They tend to attribute their capacities in inclusivity, supportive and led by women rights holders less to the programme, which may reflect that these organisations already felt they were inclusive.

Q: To what extent has the We Lead program contributed to strengthening your organisation's capabilities to be:

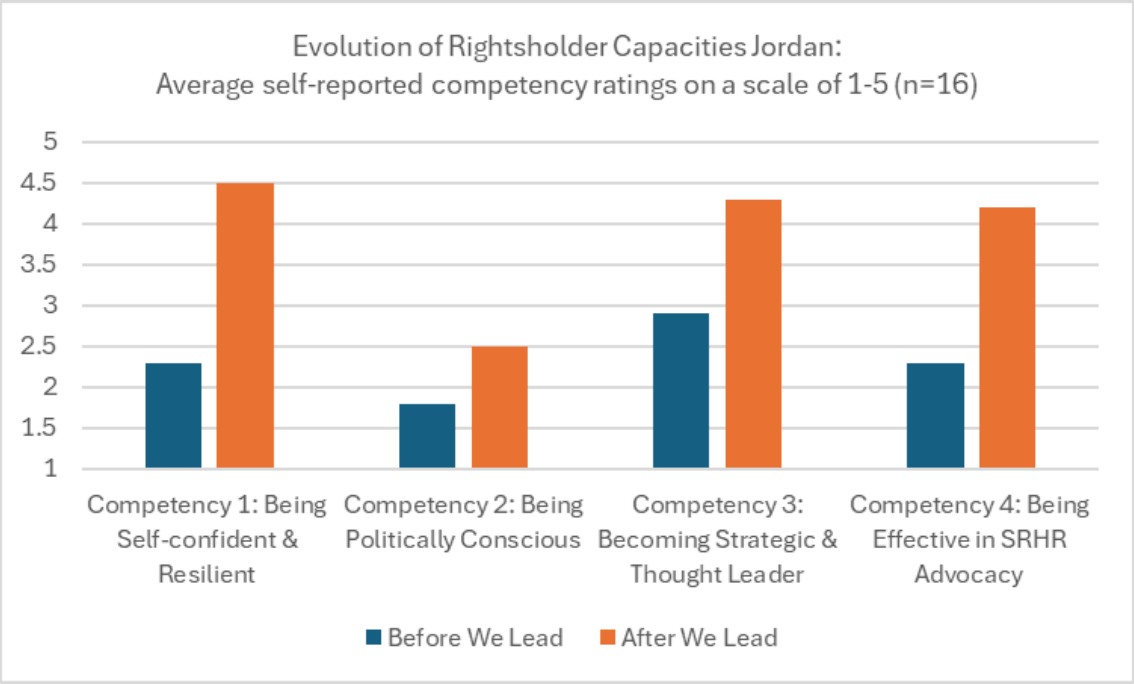
	Credible and sustainable?	Resilient and adaptive?	Inclusive, supportive, and led by young women rights-holders?	Active in promoting SRHR realization?	Safe, secure and practice collective care?	Act jointly?
A very substantial contribution	50%	50%	0%	25%	33%	33%
A substantial contribution	13%	13%	50%	38%	11%	11%
A moderate contribution	25%	25%	13%	38%	44%	44%
A limited contribution	13%	13%	25%	0%	11%	11%
No contribution at all	0%	0%	0%	0%	0%	0%
Don't know	0%	0%	13%	0%	0%	0%

While the overall budget of the initiative may have been modest, the capacity-building component was both wide in scope and deep in impact. The simultaneous process of localising the Theory of Change alongside country and context-specific analysis enabled a tailored approach that helped partners define their areas of focus. Initially, most emphasized the impact of Outcome 2: Awareness Raising, due to its relatively lower intensity. However, structured discussions and peer learning activities encouraged organizations to scale up their engagement. For instance, YPeer expanded its work from awareness campaigns to positioning youth as SRHR service providers (Outcome 3). Similarly, [redacted] evolved from research-focused activities to advocacy, developing legal and policy interventions. Other organisations transitioned from possessing only knowledge and lived experience to becoming key actors in the transfer of SRHR knowledge. Despite this growth, challenges such as developing unified SRHR materials emerged, indicating the need for clearer mechanisms for resource sharing and collaboration.[35]

In terms of capacity strengthening, the most notable trend was the positive effect the programme had on rightsholders' personal confidence and knowledge of SRHR topics, especially when it comes to being leaders on these subjects and incorporating them into both daily work and life. The capacity assessment results for the rightsholders confirm high levels of improvement in capacities across all 4 themes from before and after the programme, with the biggest improvement seen in terms of self-confidence and resilience. Some participants needed further clarification on being politically conscious, which allowed for an enriched conversation on SRHR

[34] INT1
[35] INT2

as a political subject, even if it is not intuitive for participants to name these topics as political, especially if they have not directly engaged in policy work.



Outcome 2: Awareness and support among the general public for the sexual and reproductive health rights of young women

The We Lead programme in Jordan implemented public awareness and campaign activities with the aim of shifting conservative narratives through strategic communication, media engagement, and peer-led outreach. Key public awareness activities include work with the SADA Podcast to enhance CoA members' capacity in media campaigning, video production, podcast creation and visual identity (chosen partly due to safety and security concerns), communication strategies. Marsa updated their online platform (www.marsa.me) intended as a sustainable reference for inclusive and evidence-based SRHR information, contextualized to the MENA region, including content on taboo subjects like sexuality and pleasure. Messaging was designed to revolve around changing hearts and minds, promoting acceptance and love, along the lines of "we are not fighting you, we are just like you".

Given that a national campaign might be challenging due to high economic and political pressure, the programme's strategy included focusing on the local level, working with families and immediate communities to raise awareness and shift attitudes about rightsholders. These sessions reached a broad and diverse audience, including men and women, youth and adults, parents of adolescents, and persons with disabilities (PWDs). Through interactive discussions and context-specific activities, these sessions created safe spaces for learning, dialogue, and reflection—helping to challenge misconceptions, promote positive attitudes toward SRHR, and strengthen community understanding and support for the rights of all individuals, regardless of gender, age, or ability.[36] Some activities focused on reaching youth in educational settings to facilitate peer-to-peer knowledge transfer, including student-led youth networks at universities, supported by the Royal Health Awareness Society (RHAS). Trained students covered topics such as early marriage, contraception, and mental health with their peers. RHAS also worked with the Faculty of Nursing at a university to integrate SRHR content into a university course, contributing to public support for SRHR. Meanwhile, a MENA webinar series was launched in collaboration

[36] E1

between the Jordan and Lebanon CoA Facilitators, focusing on reproductive politics. These sessions aimed to generate critical discussions and raise awareness on reproductive justice.

In the Jordanian context, outreach by CoA members and rightsholders can be considered an awareness-raising process in itself. Whether in more remote areas such as [redacted] or within cultural and social centers like the Prince Ali Foundation, targeted outreach to diverse communities was a central driver of awareness. Initial challenges included strong resistance rooted in misconceptions about SRHR, such as the conflation of sexual health with promoting intimacy outside marriage. In many cases, male heads of household (who were generally not targeted by the programme) discouraged women from attending trainings, citing fears of promiscuity or erosion of cultural norms. Over time, however, community participation increased, with rightsholders and service providers acknowledging greater openness to awareness sessions on SRHR. This success could be attributed to community keypersons like centre heads, teachers, and health service providers in the programme's operating areas, and those who attended Train-the-Trainer sessions at universities, libraries, mosques, as well as an in-person outreach strategy that went to rightsholders where they are.[37]

CoA members employed a wide range of methods to communicate SRHR information. [redacted] provided a diverse toolkit for young people between 12 and 25 ready for dissemination after final content review.[38] In Tafila, podcasts were complemented by community discussion sessions, which created informal spaces for dialogue on sensitive topics. Similarly, the [redacted] Foundation integrated sign language into podcast episodes, establishing them as accessible, long-term resources.[39] These approaches reflected the outcomes of earlier capacity-building efforts (such as podcast production and training-of-trainers workshops) which laid the groundwork for localized awareness initiatives. The use of multiple tools allowed collectives to work from their positionality and expand their reach, with rural participants first adopting in-person sessions and later incorporating podcasts, awareness materials on SRHR and GBV, and campaigns with tangible calls to action, including hotlines.[40]

CoA members advancing the rights of PWD also created innovative approaches to awareness, such as a drama performance featuring 15 actors with disabilities. The performance challenged misconceptions through lived narratives, demonstrating a replicable model of awareness and social change.[41] Over time, CoA members reported a visible shift in attitudes: early skepticism toward SRHR terminology gave way to greater acceptance, with SRHR topics entering mainstream discourse. Health professionals also confirmed that before 2021 there was little imagination for public or online discussions on SRHR, whereas now committees and national strategies are more actively engaging these issues.[42] Collaboration across government entities, CSOs, and medical professionals further legitimized these initiatives - for example, the Hikaya podcast, hosted by a medical professional, lent credibility to SRHR narratives. Members of [redacted] noted that the network created under We Lead provided protection and support for speaking out on these sensitive issues.[43]

While the progress achieved was significant, participants identified areas for further improvement. These included engaging men more intentionally (although men were involved in some CoA activities such as with Liwan, worker women in [redacted] in Zarqa), whether through podcast listening sessions, greater outreach to male health and education professionals, or further partnerships with religious leaders (FOCCECC has already collaborated with religious leaders to support in awareness raising efforts on HIV); as well as framing SRHR awareness as

[37] FGD1, INT7, FGD4
[38] FGD3
[39] INT3, FGD4
[40] INT2, FGD3, FGD1
[41] INT4
[42] INT2, INT9
[43] INT3, INT4

preparatory training for newlywed or engaged couples to foster household-level trust. Such strategies could help reduce the burden on women to disseminate SRHR knowledge within families in conservative contexts. This should be taken with the caveat that men tend to consider the subject matter of the programme taboo or are often too conservative to engage with it.[44]

Outcome 3: Awareness among health service providers and service delivery

The main activities undertaken in Jordan to improve health care services and strengthen the capacity of health service providers (HCPs) were focused on training, monitoring, institutional reform, and advocacy. Activities focused on influencing national health bodies and embedding inclusive practices, particularly concerning HIV and SRHR. The [redacted] utilized a National Task Force, which included representatives from the Ministry of Health (MOH), to develop Standard Operating Procedures (SOPs) for piloting the integration of HIV services into SRHR services within public health facilities. The task force led to measurable change: Three public health facilities in Amman began providing integrated HIV services within maternity and childhood departments. These services were previously available but not integrated which created stigmatization for patients.[45] [redacted] secured advocacy for the pilot phase by organizing a national consultation with 14 members of parliament.[46]

Meanwhile, [redacted] collaborated with 15 governmental and civil society entities to finalise and officially amend a comprehensive national SRHR toolkit, including content for PWDs, which was officially endorsed by the MoH as a national reference for youth-focused SRHR programming. The toolkit was disseminated informally through trainings and has improved day-to-day practices.[47] The MoH was also provided with a training package via the [redacted], for guidance for health personnel on treatment of people living with disabilities and later on training for the staff of the MOH. This helped ensure knowledge transfer to new staff, as part of its core induction programmes for newly recruited employees. As part of its efforts, [redacted] held a meeting with the Health Care Accreditation Council (HCAC), which expressed strong enthusiasm for disseminating the training through its e-learning platform that hosts thousands of healthcare professionals across the Kingdom. The training is expected to be officially accredited and certified by the MoH. Moreover, once uploaded on the HCAC platform, the training will become a mandatory requirement for staff working in any healthcare institution seeking any level of accreditation.

Following specialised training for 25 counsellors provided by [redacted], care providers in five of the Ministry of Social Development's (MoSD) care and shelter centres for girls began systematically integrating SRHR topics (like menstrual hygiene and bodily autonomy) into their activities. This marked the first time SRHR was included in the Ministry's protective care settings.

Marsa, meanwhile, implemented its annual Healthcare Providers' workshop in 2023 where seven participants from Jordan attended virtually. The workshop, attended by various health professionals (midwives, nurses, pharmacists, psychologists, and social workers), resulted in a 29% increase in awareness regarding resources to support young people with disability with their menstruation without medical intervention. Following a 2022 sexual health education workshop, Marsa also conducted on-site coaching visits to three CoA organizations in Jordan [redacted]) that provide sexual health services to share Marsa's experience in providing inclusive and engaging sexual health service delivery and exchange good practices to improve accessibility to the services provided.

For partners like [redacted], who have been operating since 2007, or other like JBCP, We Lead created an avenue for real expansion of scope and services because of the targeted nature of the activities and the intentional targeting of areas like Jarash which rarely receive such focused

[44] FGD4
[45] E1
[46] Jordan Outcome Harvesting Consolidation - Shared with Coralie.xlsx - Jordan.pdf
[47] FGD4

attention.[48] An intentional bottom-up approach expanded the definition of service providers to include pharmacists and informal counselors. In Zarqa municipality, trainings delivered in 2022 with the Directorate of Health became a steppingstone to a broader mechanism for training service providers and health personnel, which continued in collaboration with the Ministry of Health in 2023.[49]

Exposure to new practices encouraged health personnel to adopt less discriminatory approaches, fostering equitable treatment of patients from diverse identities.[50] The [redacted] manual (see outcome 4) equipped persons with disabilities with knowledge of their rights, enabling them to normalize stigmatized services such as gynecological visits and to challenge barriers to access.[51] Concurrently, service providers' treatment of persons with disabilities shifted from pity to accountability, bolstered by the use of hotlines to report accessibility challenges.[52] Participants noted the visible change in patients with disabilities relying less on parental guidance or guardians, asking more targeted questions to service providers that signalled service providers to review their own practices, which in turn signalled a new atmosphere for dealing with the pertinent needs of people with disabilities in healthcare settings.

The programme had a tangible impact on service provision and referral pathways. Health professionals noted that prior to the initiative, referrals were limited to intra-governmental channels. Participation in the project facilitated awareness of alternative service providers and created informal pathways to direct vulnerable populations, particularly young women, to appropriate support services.[53] However, it was observed that a formalised and inclusive referral system remains lacking. Existing systems do not fully incorporate identity-based needs or private sector participation, underscoring the need for a comprehensive national framework.[54]

Furthermore, despite progress, some commented that training distribution remained uneven. The Directorate of Disabilities and Mental Health reported limited access and exposure to larger referral processes compared to the Directorate of Maternal and Child Health, despite the former's closer alignment with SRHR-related target groups. Staff sought greater involvement in supervising and leading training initiatives to embed SRHR practices into everyday services for PWDs and recommended them as such to the evaluation team. Both bodies were part of consistent coordination with the We Lead cohort, but the programme did not purposefully prioritize one over the other [55]

Overall, the activities under Outcome 3 contributed to expanded SRHR service provision, improved inclusivity, and stronger institutional collaboration. Advisory committees and campaigns such as [redacted] played central roles in bridging gaps between policy and practice, although ongoing efforts are required to unify procedures, ensure equitable training access, and embed inclusive approaches across all directorates and health service providers.

Outcome 4: Influence policy change

With tangible awareness materials and ongoing campaigns, the We Lead CoA has influenced policy change in practical and measurable ways through a range of collaborative outputs, namely: (i) a policy paper on prevention of mandatory hysterectomies for persons with disabilities; (ii) a policy paper on creating a national sign language center; (iii) accompanying guidance for health personnel on treatment of people living with disabilities; (iv) updated Maternity and Childhood

[48] FGD3
[49] INT5
[50] INT10
[51] INT4
[52] INT4
[53] INT10
[54] INT9
[55] INT9

Department's Instructions for maternal, child, and family planning services; and (iv) the proposal for the creation of a national committee for the rights of those living with HIV/AIDS.

The programme created space for government collaboration, including engagement through the King Hussein Foundation Advisory Committee, a CoA member, around a dedicated HIV/AIDS committee. Other initiatives from partners such as [redacted] included the incorporation of STI testing and information. Meanwhile, work on updating outdated instructions for motherhood and family planning (which had not been revised for over two decades) was accelerated through the We Lead programme, which provided both advocacy tools and a clear path forward.[56] Although approved by the Ministry of Health, implementation is still pending due to bureaucratic processes. Nonetheless, evidence-based studies highlighted urgent needs such as the absence of sign language interpreters in health facilities and the lack of procedures tailored to people at specific identity intersections, especially in contexts of birthing and motherhood.[57]

The programme in Jordan included several examples of additional advocacy efforts by the CoA members to influence policy change. Policy changes on prevalence of hysterectomies for women with disabilities represented a critical achievement. Additionally there suggestions were made to revise the Mother and Child Regulations within the Ministry of Health to make them more inclusive, which were submitted to the minister and are currently under review. Other proposals also included establishing a center for sign language interpretation in health centers, signaling incremental but important institutional commitments.[58] The Ministry of Health approved the creation of the centre and has since expanded the scope and accessibility of services provided by the existing - but previously suspended - AIDS committee. The implementation and monitoring responsibilities which had also been requested are in progress in parallel with governmental approvals before these reach their stage of activation as policies.[59] These changes were partly in response to [redacted] policy brief (see above). These proposals reflect at least a formal recognition of systemic shortcomings, even if implementation timelines remain uncertain.

The engagement of stakeholders across government and healthcare providers was key to this progress because they gave their input on CoA member outputs, such as the health toolkit, and supported its dissemination. While it is difficult to measure the precise pace of implementation on the ground, the inclusion of recommendations in processes such as the shadow UPR report demonstrated impact, with several propositions advancing without rejection.[60] These efforts are also aligned with the ongoing national SRHR strategy, which runs until 2030.

Advocates emphasised that many health regulations, some dating back to 2004, remain outdated, underscoring the urgency of institutional reform. Identity intersections remain insufficiently addressed in existing frameworks, making concrete, rights-based recommendations essential. Within this context, the establishment of the National AIDS Coordinating Committee, revisions on mandatory hysterectomy protocols, and medical guidelines for health personnel working with PWDs were seen as pivotal achievements.[61] The preparatory studies underpinning these policies identified major gaps, highlighting that progress required immediate, targeted responses rather than general awareness raising. As such, the three policy papers represented focused interventions.[62]

In the case of mandatory hysterectomies, policy recommendations concretised practices that had previously been informal or overlooked, providing clear instructions to institutions. The paper underscored that such procedures often stemmed from social norms, discrimination, and a lack of recognition of bodily autonomy, with decisions frequently made by male relatives rather than

[56] INT5
[57] INT3
[58] INT1, INT8, INT7
[59] INT8
[60] INT1
[61] INT8
[62] FGD CoAs, INT8

women themselves. As one interviewee posited, *"Her brother or her father would take these decisions on their behalf. Now we are tightening the margin of mistreatment that can happen and defining legally that a hysterectomy comes from a social norm and happens because of a type of discrimination and lack of trust in the autonomy of certain bodies."*[63] The new recommendations narrow the margin of mistreatment and legally frame hysterectomies as an issue of rights violations and discriminatory practice.[64] Additionally, suggestions to alter the mother and child regulations within the MoH and make them more inclusive, were sent to the Minister and are under consideration.[65]

The programme also had significant influence on individual governmental stakeholders. Collaborations with initiatives like [redacted]'s research and needs assessment provided government health workers with critical insights into the experiences and needs of persons with disabilities - data that had previously been unavailable. The methodological approach to needs assessments was seen as both practical and replicable, offering a model for future collaboration, although there is no evidence to date of the update of these research findings by the Higher Council for Persons with Disabilities. Prior to the project, the last known large-scale campaign involving persons with disabilities dated back to 2017. By the project's close, rightsholders with disabilities were visibly leading advocacy efforts and working in partnership with NGOs focused on SRHR and disability inclusion.[66]

The [redacted] which conducted advocacy in coordination with CoA members, produced the first national guide for healthcare providers on effective communication with persons with disabilities. A training on the guide was conducted for MOH HCP supervisors across the Kingdom and there are efforts to include the training as part of the orientation trainings package for all HCP under the MOH. The guide bridged gaps in everyday practices and raised awareness among service providers within and outside government structures. One participant stated: "*Your definition of what disability and accessibility means to you needs to change*", as she named the overarching and basic challenge of misconceptions, which she would bring into conversations with stakeholders throughout the campaign, and would propagate outwards to talk about infrastructure and the physical surrounding of SRHR activities. The larger impact lies in embedding inclusivity into healthcare interactions, providing a model that can be replicated by other committees, and reinforcing the credibility of the We Lead approach.[67]

Advisory committees comprising 23 members were formally recognised within governmental SRHR structures, building trust between civil society and the public sector. Advisory committee guidance on treating PWDs and youth-focused service provision was praised for its innovation, practical relevance, and the passion behind its development, exceeding the impact of formal legislation.[68] The advisory committee mechanism emerged as a key driver for continuity, enabling stakeholders to conduct needs assessments, validate findings, and build a community of practice around SRHR in Jordan. Committees also increased the visibility of HIV services, reflected in a surge of visitors to government-funded HIV centres, signalling both improved service quality and the importance of continued monitoring. Health professionals engaged in the process noted that the committees created long-awaited opportunities to update outdated service delivery conditions and guidance. Moreover, the shaping of advisory committees as a vehicle for communication between different stakeholders and creating a platform for conversation and action was a key component not only in building the grounds for changes in SRHR policy, but also in creating sustainable networks between said actors.

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[63] INT9

[64] INT9

[65] INT1, INT8, INT7

[66] INT4

[67] INT3; INT10, INT11

[68] INT3; INT10

Taken together, these contributions highlight the significant role of We Lead in reinvigorating stagnant governmental processes. Before 2021, many policy areas - including maternal health insurance instructions, disability rights, and HIV/AIDS coordination, had been at a standstill. The introduction of dynamic committees, targeted information campaigns, and practical training for both CoAs and healthcare providers reactivated the policy space, created a pathway for institutional change, and placed SRHR firmly on the national agenda.

Support for greater empowerment of rights-holding groups, the creation of movements and an environment conducive to SRHR

Plan International, Oxfam, Humanity and Inclusion and other international organizations approached [redacted] after the We Lead closing conference. People heard about these coalitions and wanted to expand on this work and contribute to the movement at large, also contributing to the sustainability of the project. We Lead was the vehicle to start conversations about SRHR, create common goals and collaborate with the partnership with HPC being especially fruitful in this regard.[69]

The SRHR strategy 2030 serves as a larger roadmap to better understand which partners are working towards similar goals even if at different places, from different angles, and with less support especially after the USAID funding stop.[70]

CoA representative [redacted] attended the Summit for people with disabilities in Berlin, and although this happened beyond the programme timeframe, We Lead can be considered the launchpad for this engagement. Several members participated in places like Women Deliver, AWID, CPD, and others, all of which grew participants' networks and vision.

People who received training and became "ambassadors" of the SRHR information relayed the expansion of health services and the use of them by women in marginalized areas, which could otherwise be titled a "whisper to me" referral system. People would recognise these representatives as they remain in the community after the activities conclude and have formed networks of support with the help of the Train-the-Trainer curricula and associated activities.

The programme also fostered unexpected collaborations, with trust built through consistent engagement in activities. Several participants explained that skills sharing across the peer networks formed throughout the project served as hubs for incorporating ways of working into their organizations. NGOs began adopting We Lead's safety and accessibility practices when planning their own events, extending the programme's influence beyond its scope. SOGI training materials both introduced and expanded on basic concepts that fortified participating organizations' knowledge on these topics, making way for their incorporation into health service provision for programmes with related emphases like GBV.[71] Importantly, these were relayed through sessions with rightsholders after those who attended the first round (mostly CoA organization networks of participants) transferred information outwards in a way that is better tailored to their respective contexts.[72]

Ongoing exchanges with other initiatives enriched the collective work. For example, guidance manuals from [redacted] were integrated into a parallel peer support project, strengthening its approach.

> *"Talking to other initiatives throughout the lifetime of the project was very rewarding and we saw the integration of information and practices from other campaigns we were involved in like [redacted] into the activities of other organizations. For example, we*

[69] INT9
[70] INT8
[71] INT9, INT5
[72] FGD1, FGD2

incorporated the information from the guidance manuals as part of [redacted]i into peer support project happening in parallel.[73]"

Several CoA members also allocated budgets in their other projects to reach rightsholders with diverse disabilities, prompting a broader view of health services and community-based approaches that prioritize inclusivity and accessibility. This ranged from thinking about physical spaces where activities are held to how outreach is done for projects outside We Lead. While these gains were largely positive, there were expressed concerns that sustaining them will require continued coordination and commitment.

"Many moving parts of the project were able to set aside a budget to reach rightsholders that have certain disabilities of different kinds. The success was that the project allowed for a new lens in how people are viewing health services and what needs to be taken into account."[74]

Coherence

At the beginning of the programme, the roles and responsibilities among implementers, namely the host organisation, CoA Facilitator, and the consortium were not clearly defined, which created communication challenges. This challenge was later mitigated through stronger management by the host organisation and the CoA Facilitator, with the CoA Facilitator serving as the main focal point for communication with the COAs.[75] Choosing [redacted] as the host organization allowed for several moving parts of the project to be held by them even if the theme of We Lead was not directly related to their daily work. [redacted]'s deep knowledge of the existing civil society context in Jordan helped them have a role as an implementing partner. They did not accept to take simply the facilitating role and were careful and mindful to be at the forefront of the selection and recruitment of those participating in the CoAs.

The ToC localization process reappeared in conversations on coherence and partnership as interlocutors emphasized its value in discussing community-identified priorities with partners, keeping the approach collaborative and led from the ground. This inclusive approach supported the development of internal partnerships among participating organizations. Collaborations included coordinated content dissemination, such as radio broadcasts followed by listening sessions and facilitated discussions, which created opportunities for audience engagement across multiple platforms. External partnerships also played a role, with technical sessions delivered by specialized organizations over several years.[76] Meanwhile, the well-being fund which provided CoA staff with resources to proactively support their health and prevent burnout, represented an agile programming approach that was people-centered.

Despite these achievements, some partnerships between CoA members remained inactive and never progressed beyond preliminary agreements. Nevertheless, knowledge exchange among organizations was a key feature of the approach. Members with expertise in monitoring, evaluation, accountability, and learning (MEAL), as well as in outcome planning, regularly shared their knowledge with others. While the participatory model was described as highly effective, a lack of sustainability was observed when organizations, due to time or resource constraints, delegated responsibilities to volunteers without sufficient decision-making authority.[77]

The project also aimed to support the scale-up of ongoing initiatives by strengthening technical capacities in areas such as proposal writing, budgeting, and financial planning. These activities were framed as mutual exchanges, coordinated by community of action (CoA) facilitators who served as intermediaries between organizations and donors. Organizations that had built internal expertise began to share their knowledge externally, both within and beyond the CoA network.

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[73] INT4
[74] INT3
[75] CoA survey
[76] INT3
[77] INT3

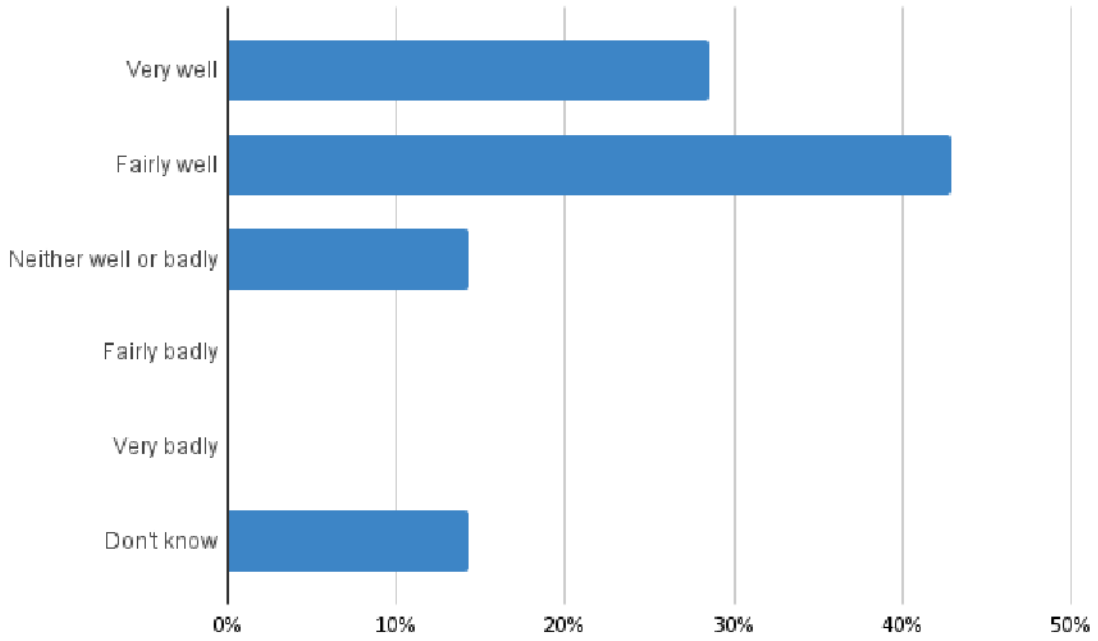
Collaborations with external institutions provided valuable third-party perspectives, allowing organizational needs to be framed for donors without placing additional burden on implementers. Support from donors was noted to be flexible and responsive, particularly in relation to capacity building and managing power dynamics.[78]

At the same time, contradictory expectations presented challenges. Organizations were encouraged to collaborate and expand their networks, yet doing so was occasionally perceived as a conflict of interest. This ambiguity generated confusion among participants.[79] Additionally, the design and implementation of the data, monitoring, evaluation, and learning (DMEL) process was described as unstructured and burdensome, with disproportionate responsibility falling on select organizations, especially the host, early in the process. Although participatory methodologies were intended, they were inconsistently applied. Monthly safety and security meetings and outcome harvesting were implemented intermittently. Despite these challenges, rightsholders had substantial visibility in global and regional forums such as Women Deliver, AWID, and CSW, representing a unique feature of the project's design that distinguished it from comparable initiatives.[80]

Engagements across a wide spectrum of stakeholders, ranging from royal-affiliated NGOs to grassroots and feminist groups, offered additional value. National-level committees expanded to include voices from underserved areas, enabling more inclusive representation. These actors also gained access to new service networks, referral systems, and data repositories through the project.[81] In parallel, the project was implemented alongside other regional initiatives, contributing to a broader understanding of the evolving SRHR ecosystem.[82] The Joint Annual Planning at the regional level proved to be highly effective. It brought together all implementers to collectively discuss and agree on the annual plan, ensuring alignment with each country's needs and capacity-strengthening priorities.[83] According to the organisations who completed the survey, just over a quarter felt the programme in Jordan did very well at coordinating with relevant international initiatives, with a further two in five reporting that the programme did this fairly well. The remained were ambivalent or not aware of these activities.

Q: How well or badly has the We Lead programme in your country coordinated with … other relevant international SRH-R initiatives?

[78] INT4
[79] INT4
[80] INT2
[81] INT2
[82] INT1, INT6, INT8
[83] CoA survey



Significant progress was also made in advancing inclusion. Organizations were held accountable for integrating persons with disabilities into their programming, which led to increased partnerships with specialized service providers and positioned rightsholders with disabilities as leaders in SRHR advocacy, including those who participated in awareness-raising efforts like the play by [redacted]. The CoA was characterized by a high degree of cohesion and shared purpose, often functioning without the need for formal coordination mechanisms. Nonetheless, opportunities for improvement in internal communication were identified. One CoA member recommended more structured engagement, such as regular coordination meetings or mentorship systems, to strengthen organizational processes.[84] On the other hand, others reported a high number of meetings which also posed a time burden.[85] Furthermore, feedback received through the validation process for this report noted that the design and refinement of activities—as well as any ongoing support needed—were handled through direct and continuous communication with the CoA Facilitator. It was also noted that annual proposals submitted at the beginning of each year were thoroughly reviewed by the host team and discussed in detail with the relevant organizations. This review process often took several months to ensure that the planned activities were realistic, suitable, and achievable. Any adjustments required throughout the year were discussed and incorporated as needed, in line with the programme's adaptive management approach[86].

Sustainability

Digital platforms and products established or supported under We Lead were highlighted as long-term resources for sustaining impact. Several podcasts were produced throughout the project by CoA members [redacted] a podcast for example, which included 17 episodes covering diverse SRHR topics, was considered durable given that its core content (e.g., puberty education) will remain relevant for years to come. Dissemination to governmental agencies was expected to expand its reach and potentially improve the capacities and quality of medical teams. Practices such as sign language interpretation introduced through these platforms

[84] INT4
[85] E1
[86] E1

are envisioned as sustainable norms that can be mainstreamed into organizational activities more broadly.[87]

The digital sustainability of materials is further reinforced by [redacted] commitment to hosting programme outputs online. Training resources - including those guiding changes in medical practices and etiquette when working with PwD - are currently being digitized and made publicly available, ensuring their use beyond the project timeline. [redacted] intention to continue developing We Lead Jo as an online platform strengthens this commitment by providing a reference space for new resources, peer learning, and continuous updates.[88]

Efforts to embed sustainable practices were also evident in the development of repeatable, low-cost interventions. The drama performance on disability and SRHR was identified as a resource that can be reproduced with minimal expense, while standardized conversations around SRHR are now incorporated across rightsholder engagements, referral mechanisms, and CoA activities.[89]

Institutionalization within the governmental sector was identified as a key driver of sustainability, with stakeholders noting that once practices are embedded in governmental procedures, their continuity is more assured.[90] This process was supported by the establishment of referral pathways that now include governmental entities, with identified focal points maintaining direct communication channels for coordination. The challenges and fears here are the slow pace of bureaucratic change, even when there is novelty in how institutions are growing in practice.[91]

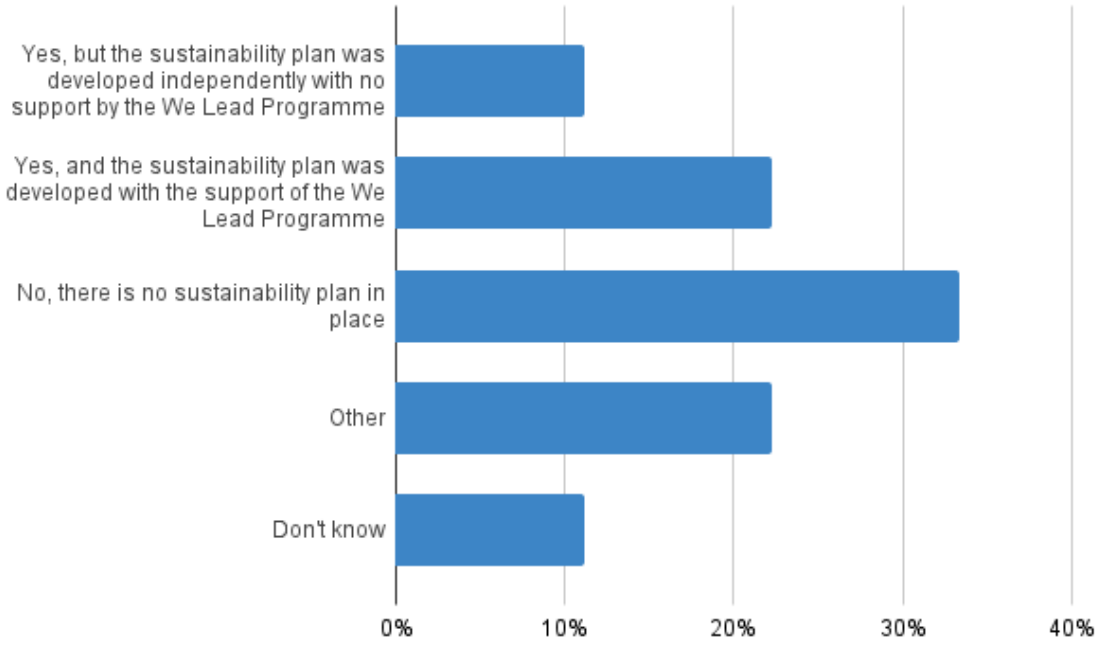
Sustainability was also linked to capacity-building outcomes and the formation of a community of practice. The programme strengthened women's empowerment by equipping them with practical skills, which participants emphasized as central to the relevance and effectiveness of the first outcome. Moreover, youth groups such as YPeer were able to register formally, document achievements, and strategize for long-term engagement, including developing new legal frameworks, recommendations, and outcome harvesting methods.[92] Also, some organizations are now contributing to the larger movement-building effort by incorporating SRHR into their long-term strategy. The digital presence of the [redacted] clearly shows this, for instance.

The community of practice approach fostered by [redacted] is set to continue beyond the project, enabling both formal and informal exchanges of knowledge. Email and WhatsApp groups emerged as practical tools to maintain communication, facilitate collaboration, and activate referral pathways across civil society and governmental actors, reflecting expanded opportunities for ongoing cooperation.[93]

A potential risk and hindrance to future continuation of activities is the lack of sustainability plan in place for a third of the CoA organisations who took the survey. The programme only supported the development of a sustainability plan for fewer than a quarter of the CoA organisations in Jordan. This suggests a relative weakness in the design of the programme for Jordan in that not a sufficient emphasis was placed on supporting the CoA organisations so that they adequately plan for once funding finishes.

Q: Does your organisation have a sustainability plan in place for when this programme ends?

[87] INT3
[88] INT2
[89] INT4
[90] INT9
[91] INT7, INT5, INT6
[92] INT2
[93] INT2



E. Recommendations

1. Incorporate the practices and accessibility considerations into the MEAL plans and results frameworks within the design of such programmes
2. Provide more standardised tools to ensure a shared understanding of evaluation criteria and metrics
3. Ensure follow-up for the establishment of the center for people with disabilities and the sign language interpretation.
4. Keep monitoring all reports from the Jordanian Higher Council to gauge what conversations within We Lead have been incorporated into governmental policies and documented practices for health workers.
5. Consider ways to continue the work of the CoA, including the space it provided for exchange between government and civil society stakeholders, both centering rightsholders and trying to widen the scope of services and geographic areas that they cover.
6. Consider working with schools as a means of engaging directly with full families to incorporate SRHR basics into curriculum while targeting parents as rightsholders.[94]
7. Continue building alliances by engaging community and religious leaders and professional associations to enhance credibility and break down cultural barriers.[95]
8. Consider increasing budget to (fewer) grantees to widen their scope of work and allow for more depth and breadth of activities, especially noting the impact some CoA partners were able to achieve even when beginning their partnerships and engagement two or three years into the programme.
9. Move beyond small, short-term grants toward more flexible, multi-year funding that gives grassroots and youth-led organisations the space to plan, innovate, and scale their

[94] INT8
[95] CoA survey

advocacy and interventions.[96]

10. Consider how governmental stakeholders might be involved in activities earlier to help strengthen accountability for implementing changes, national commitment, and sustainability
11. Consider how work can be done in the digital dimension to counter misinformation and misunderstanding around SRHR education.[97]
12. Widen the scope of the trainings and work to incorporate them into school curricula as an awareness raising tool, rather than confining them to the medical sphere.

[96] CoA survey
[97] INT10