Kenya

A. We Lead Programme Overview

CoA Member Organizations

By 2024, the Community of Action (CoA) in Kenya consisted of eleven member organisations, in addition to the Centre for the Study of Adolescence (CSA) as the host. Together, they represented young women with disabilities, young women living with HIV, young women identifying as [redacted], [redacted] and young women affected by displacement. Each organisation brought distinct expertise while working collectively to influence service delivery, social norms, and policy frameworks.[1] One of the members [redacted] left the programme at the end of 2023. The We Lead Programme in Kenya was implemented across Nairobi, Mombasa, Kilifi, Kisii, Garissa (Dadaab), Turkana (Kakuma), and Siaya,

Main Activities

- **Capacity building and training**: Training on advocacy, leadership, SRH-R knowledge, policy engagement, and research skills; training on outcome harvesting, organisational Gender, Equality and Social Inclusion (GESI) policies, psychosocial support, wellness initiatives
- **Public awareness and community engagement on SRH-R**: Convening advocacy dialogues with county officials, producing radio dramas and social media campaigns, facilitating community listening sessions.
- **Engagement with healthcare providers**: Inclusive SRH-R training for health professionals; institutional advocacy; dialogue platforms linking providers with civil society; community-led monitoring by rightsholders
- **Policy and legislative advocacy**: County-level advocacy; rights-based legal engagement; international advocacy.

B. End Term Evaluation Fieldwork

Number of stakeholders interviewed	3 women; 6 men
Number of participants of CoA Sensemaking Workshop	9 women; 1 man
Number of participants of Rightsholder Sensemaking Workshops	23 women; 1 man
Total number of participants	**43**

C. Country Context

Kenya's social, political, and economic environment both enabled and constrained the programme's progress. The last general election was held in August 2022, resulting in the election of William Ruto of the Kenya Kwanza Alliance as president, with his center-right government focused on economic empowerment but generally socially conservative. Women currently hold approximately 23% of National Assembly seats supported by constitutional gender quotas,[2] although they face persistent challenges including political violence, adverse societal attitudes,

[redacted]

[2] World Bank Proportion of seats held by women in national parliaments (%)

and resource constraints. Political stability in 2025 has faced stress due to socio-economic grievances and youth-led protests (the Gen Z movement) concerning cost of living increases and governance issues.[3] Civic space is under pressure with the government maintaining oversight over demonstrations and media and increasing security operations and arrests against activists.[4]

The political environment in 2024 was also shaped by the #RejectFinanceBill demonstrations, a wave of youth-led protests that successfully forced the withdrawal of the Bill, including proposed Eco Levy on hygiene products.[5] While this represented a major public victory and highlighted the growing influence of young people in shaping policy debates, the unrest also created significant risks for advocacy groups. Violent crackdowns and civil disruption heightened safety concerns for rightsholders, particularly young women and [redacted] individuals, and forced CoA organisations to postpone, reschedule, or adapt activities, often shifting to residential or virtual formats to safeguard participation. These events illustrated both the potential and the precarity of youth-driven advocacy within Kenya's contested civic space.

Homosexuality remains criminalized under Section 162 of the Penal Code with [redacted] individuals facing legal risks, harassment, and high levels of social stigma.[6] Advocacy for decriminalization is active but faces strong opposition from conservative societal and political actors, and same-sex marriage is illegal. However, in February 2023, Kenya's Supreme Court reaffirmed that [redacted] people have the constitutional right to form associations, including formal NGOs. The Court held that the NGO Coordination Board's refusal to register the National [redacted] was discriminatory solely on the basis of sexual orientation. In its judgment, the Court emphasized that the right to freedom of association is "inherent in everyone," regardless of how unpopular their cause may be. Importantly, the Court also interpreted the word "sex" under Article 27(4) of the Constitution to include sexual orientation, establishing that discrimination on this basis is unconstitutional.[7]

Abortion is permitted under the Constitution if there is need for emergency treatment, or the life or health of the mother is in danger.[8] Contraception is legal and widely available supported by the National Reproductive Health Policy (2022-2032) aiming for universal coverage, with contraceptive prevalence among married women at approximately 64% by 2030, while the public sector provides minimal support for infertility care with services mainly available privately. The Sexual Offences Act (2006) and Protection Against Domestic Violence Act (2015) provide legal frameworks against GBV.[9] The country has also recently seen progressive jurisprudence, including legal recognition of intersex persons and the Supreme Court's 2023 ruling on freedom of association for queer persons. These developments created opportunities for advocacy and broadened the space for marginalised groups to claim their rights.

However, proposed laws such as the Family Protection Bill[10] threatened to undermine gains. Restrictive laws on abortion, consent for adolescents, and sterilisation of young women with disabilities further limited the scope of SRH-R protections, underscoring the entrenched legal barriers that advocacy efforts had to confront. At the same time, the Ministry of Health's withdrawal from the Eastern and Southern Africa (ESA) ministerial commitment to comprehensive sexuality education reduced momentum for youth-focused SRH-R initiatives. Meanwhile, Comprehensive Sexuality Education is not comprehensive or nationally mandated although civil society and the UN have urged for adoption of inclusive age-appropriate sexuality education.

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[3] Amnesty International (2025) Kenya: Authorities weaponized social media and digital tools to suppress Gen Z protests.

[4] Freedom House (2025) Kenya

[5] Amnesty International (2025) Kenya: Authorities weaponized social media and digital tools to suppress Gen Z protests.

[6] Equaldex (2025) Kenya

[7] E9, Reuters (2023) Ruling by Kenya's Supreme Court buoys LGBTQ+ community

[8] Center for Reproductive Rights (2025) Kenya

[9] UNWomen (2025) Kenya

[10] CIVICUS (2025) The Family Protection Bill threatens to escalate violence against LGBTQI+ people

A further limitation was that adequate financial allocations did not accompany many policy commitments. For example, while Kilifi's Persons with Disability Act and Mombasa's planning documents integrated menstrual health and youth-friendly services, rightsholders noted that these gains were only partially implemented because budget lines were either delayed or insufficient, limiting translation into consistent service improvements. Communities also exhibited resistance rooted in patriarchal norms, stigma, and cultural taboos, particularly concerning the rights of young women with disabilities and those identifying as [redacted]

The healthcare system is devolved to 47 county governments with the national Ministry of Health setting policy and a large faith-based sector complementing public provision particularly in rural areas, and according to World Bank data total health expenditure at approximately 4.33% of GDP and out-of-pocket spending accounting for approximately 24%. The Maternal Mortality Ratio is 149 per 100,000 live births (World Bank), the Under-5 mortality rate is 39.4 per 1,000 live births (World Bank), and skilled birth attendance is high at 89% supported by the free maternity policy (Linda Mama programme). It should be noted that as of 2025, the government has transitioned from the National Health Insurance Fund (NHIF)-based Linda Mama to the Social Health Authority (SHA) Linda Jamii to provide maternal care. The transition has raised several concerns, particularly around access and affordability. While Linda Mama offered widely understood, free maternal services, Linda Jamii now requires enrollment under the Social Health Authority (SHA), which means that many women especially those in informal or low-income settings must pay annual premiums upfront before accessing care.[11] The fertility rate averages 3.2 children per woman (World Bank) with an adolescent birth rate of 56.3 per 1,000 girls aged 15-19 (World Bank). Severe regional disparities exist with North Eastern counties having the lowest facility density, lowest contraceptive uptake, and highest maternal/child mortality while Nairobi and Mombasa show highest access.

Kenya's healthcare system faces numerous challenges, with recurrent stockouts of essential SRH-R commodities, inadequate infrastructure for disability inclusion, and frequent staff transfers disrupting service delivery. Economic instability, high costs of living, and the lingering effects of the COVID-19 pandemic limited rightsholders' ability to participate fully in advocacy or access services. In refugee-hosting regions such as Dadaab and Kakuma, displacement and intercommunal tensions heightened vulnerabilities, while droughts and floods intensified inequalities by restricting access to health services, education, and livelihoods. These challenges are compounded by dramatic cuts in donor funding: USAID, a key backer of Kenya's HIV, maternal health, and family planning programs, suspended much of its support in 2025, leading to life-saving commodity shortages, health worker layoffs, and a severe financing gap of billions of Kenyan shillings in reproductive, maternal, newborn, child, and adolescent health.[12]

D. Evaluation results

Relevance

The words that CoA member organisations would most use to describe the programme in Kenya, according to the survey, emphasise the visionary, empowerment, impactful aspects of the programme's design and activities. Respondents particularly highlight inclusivity, inclusion, equality, diversity and intersectionality as the principles which underpinned the nature of the work in Kenya.

[11] E9
[12] E9

The We Lead programme in Kenya was widely regarded as relevant to the realities of young women from marginalised groups. Its emphasis on inclusivity and intersectionality aligned with the complexity of young women's identities, spanning disability, HIV status, displacement, and sexual orientation. By engaging across these intersecting factors, the programme directly confronted barriers that other initiatives often left unaddressed, such as the double stigma experienced by young women with HIV who also identified as [redacted], or the social exclusion of young women with disabilities in refugee settings.[13] Its rightsholder-led design allowed participants to conceptualise their own workplans, grounding interventions in their lived realities and ensuring relevance.[14] This contrasted with earlier SRH-R interventions, which had often applied a "one-size-fits-all" model without creating safe, tailored spaces for groups such as young women with disabilities or those identifying as [redacted].

According to the survey results, in Kenya, the programme was perceived by a majority of the CoA to have been well designed (either very or fairly well) to meet the needs of the different rightsholder groups, although the findings suggest that there were some limitations with the design which prevented the activities from very well suited to meet the varying needs of the different marginalised communities. The [redacted] community and women affected by displacement were perceived to have been less well served by the programme's design with just 10% saying that they had been very well served.

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	50%	40%	30%	10%	10%
Fairly well	50%	50%	70%	70%	50%
Neither well nor badly	0%	0%	0%	10%	40%

[13] FG3
[14] E1, E2

Fairly badly	0%	10%	0%	0%	0%
Very badly	0%	0%	0%	10%	0%
Don't know	0%	0%	0%	0%	0%

Rightsholders consistently highlighted the programme's relevance, describing it as "*transformative"* in meeting their needs for SRH-R information, safe spaces, and stigma reduction.[15] One participant observed that *"what comes to my mind when I hear about We Lead is feminist advocacy. It was the first time I heard people talk about inclusivity in this camp"*.[16] Others emphasised that the programme allowed them to shift from passive participation to active leadership, noting that "*it gave me a platform to grow personally. I found a voice inside me… I came out strong, speaking even where women were never supposed to*".[17] Such testimonies illustrated that the programme did not simply provide services but actively responded to the structural and social barriers faced by young women.

The programme also reflected national SRH-R priorities and was described as *"one of the SRH-R programmes aligned with government priorities. Kenya prioritises SRH-R for young people and women"*.[18] This alignment was operationalised through collaboration with government stakeholders and integration of programme activities into county-level frameworks, such as the Kilifi County Disability Act and the Siaya Reproductive Maternal, Neonatal, Child, Adolescent and Health Act (RMNCAH).[19] Health providers confirmed that programme activities were embedded in county health workplans, meaning that *"their activities became part of our routine operations"*.[20]

By situating advocacy within government systems, the programme increased both legitimacy and prospects for sustainability. Many of these relationships were not pre-existing but were built through the programme's intentional strategy of embedding rightsholders and CSOs into formal decision-making spaces. For instance, CoA organisations and rightsholders participated in county technical working groups, contributed to annual county health plans, and co-developed youth-friendly service guidelines with health departments.[21] National-level linkages also grew through collaboration with the Ministry of Health and the National Council for Population and Development, which hosted programme teams and facilitated their entry into refugee camps.[22] This demonstrated that while the programme aligned itself with existing priorities, it also actively created new collaborative spaces that had not previously existed.

Nevertheless, the programme faced several challenges related to its relevance. The policy engagement objective was reported as less relevant in refugee camp settings, where policymaking authority primarily lay with UNHCR and county governments, who were not included, creating complexity and frustration for CoA members.[23]. Participants also reflected that advocacy examples and trainings often relied on national or county-level processes, which did not resonate with refugee rightsholders operating under different legal and structural realities. As a result, some felt that while they could confidently lead conversations at the community level, they lacked the tools and readiness to influence policies in these multi-layered governance environments. Calls were therefore made for more contextualised advocacy strategies that directly addressed refugee law, camp governance, and SRH-R in displacement settings. Similarly, while community-level advocacy proved effective, restrictive national frameworks, such

[15] FG1, FG2
[16] FG3
[17] FG3
[18] E2
[19] E1
[20] E4
[21] E4, E7
[22] E8
[23] FG3

as the criminalisation of abortion[24] and age-of-consent laws, limited the applicability of local learning at the national level.[25]

Inclusivity was another area where gaps remained. While the programme centred on rightsholders, some groups felt less emphasis was placed on their needs. For example, several participants explicitly observed that young women with disabilities were left behind compared to other groups, with some perceiving more focus on [redacted] groups. Beyond perceptions of unequal emphasis, structural barriers reinforced this gap. Disability-focused organisations reported receiving very small budgets, despite being expected to deliver across all four outcome areas, which limited their ability to engage with rightsholders fully. For instance, high caregiver support costs meant that only a small number of young women with disabilities could participate. Accessibility upgrades such as ramps, signage, Braille formats or interpreters were frequently flagged during advocacy but were not funded, and government partners noted that infrastructure lagged behind rising demand. In addition, caregiver engagement, critical for reducing stigma and enabling access at home, was only introduced in the fourth year, which participants themselves later described as a "missed opportunity" that should have been planned from the start. These layered challenges meant that although the programme was unique in deliberately targeting young women with disabilities and their caregivers, and achieved policy influence (e.g., contributing to disability legislation and budget allocations), its reach within the disability community remained narrower than intended and did not always cover diverse or invisible disabilities.

To address these concerns, the programme supported disability-inclusive measures such as the co-creation of disability-friendly service checklists to identify and fix barriers in health facilities, and the strengthening of the Kilifi County Disability Network at its inception.[26] It also introduced caregiver engagement in later years, recognising their critical role in reducing stigma and supporting access, and provided opportunities for young women with disabilities to participate directly in technical working groups and parliamentary consultations on the Disability Act. While these steps demonstrated an effort to rebalance inclusion, they were often implemented late in the programme cycle and constrained by limited resources, leaving a perception among some that inclusivity across rightsholder groups remained uneven.

Male engagement was similarly weak, with communities questioning why men and boys were left out of the design despite their influence on SRH-R outcomes. Participants stressed that their involvement as allies should have been planned deliberately from the outset.[27] Some even recommended dedicated programming for boys, noting that their own SRH-R vulnerabilities, including exposure to violence, were largely unaddressed.

Finally, the reporting tools sometimes limited the visibility of small but meaningful changes. The outcome harvesting template prioritised "big fruits" such as policy shifts, which meant smaller outcomes, like young women affected by displacement sitting at decision-making tables, were not adequately captured.[28] As one participant explained, *"just having young women affected by displacement sit at the decision-making table was a big outcome. But the template didn't recognise it as such."* Nevertheless, these smaller outcomes were often recognised informally in other ways, for instance, during routine reflection sessions and after-action reviews, which provided space to record incremental but significant progress.[29] They were also incorporated into the annual Theory of Change contextualisation, where new themes such as caregiver engagement or wellness were introduced based on the lived experiences of rightsholders.[30] This disconnect between lived experience and reporting frameworks risked underplaying the programme's relevance to

[24] In Kenya, this comes from the Penal Code, which criminalizes attempts to procure an abortion, assisting in abortion, and self-induced abortion, with penalties including imprisonment

[25] FG1, FG2

[26] E1; E7

[27] FG4

[28] FG4

[29] E1

[30] E1

rightsholders and meant that some of the programme's most meaningful shifts for rightsholders were underrepresented in official documentation.

While many activities reflected continuity across the programme's life cycle, others evolved in response to emerging needs, such as increased psychosocial support, wellness initiatives, and safety measures during periods of political unrest.

Each year, the Theory of Change (ToC) was reviewed and adapted to reflect the Kenyan context, which enabled the programme to remain responsive to emerging issues. The process was evidence-informed and consultative, drawing on outcome harvesting, activity implementation reviews, and annual linking and learning events to identify shifts in context and gaps in programming. CoA organisations, rightsholders, CSA as host, Hivos, and consortium partners all took part, while duty bearers and healthcare providers were engaged in later years to bring in service delivery and policy perspectives. This reflects the programme sequential logic, beginning with a strong capacity-building component and later moving on to community-led advocacy. The annual review allowed the CoA to validate assumptions, identify emerging risks (especially around safety, security, and psychosocial wellbeing), and adapt strategies to the evolving SRH-R context.[31] This inclusivity ensured that adaptations such as the integration of wellness, safety, security, and caregiver engagement were directly grounded in lived realities and responsive to Kenya's evolving SRH-R landscape.[32] Stakeholders described this iterative design process as *"very effective"*[33], particularly because it created space for new priorities identified by rightsholders themselves. That said, while engagement was strong at partner level, challenges such as limited time and competing priorities affected deeper community participation.[34]

Alongside these programmatic adjustments, the membership and functioning of the CoAs also shifted over time, in response to contextual risks and opportunities. For instance, the participation of one [redacted] feminist forum was terminated in 2023 following serious concerns about the mishandling of a rightsholder's safety incident. Other organisations adapted their focus or structures in response to contextual challenges and opportunities. [redacted] for example, permanently closed its Kisii offices in 2023 after community threats, while [redacted] International replaced a planned monitoring tool with a comprehensive risk framework to address safety concerns. Inuka Success redirected its efforts from tracking the Refugee Act to supporting the development of the Garissa County Anti-FGM Policy and later secured recognition as an operating partner in Dadaab Sub-County by UNHCR, the Garissa County Government, and the Department of Refugee Services. These examples demonstrated that while the CoA were responsive to emerging risks and policy windows, their operating environment remained precarious and required constant adaptation.

Effectiveness

Outcome 1: Strengthening the capacity of CoA members and rightsholders

The programme focused on strengthening CSOs led by, or inclusive of, young women from rightsholder groups. Reports highlighted extensive capacity building in advocacy, communication, social accountability, and finance and compliance. They also received training on SHRH, which clarified myths and misconceptions and strengthened participants' understanding of constitutional provisions and gender-based violence frameworks. In addition, outcome harvesting and strategic planning support equipped organisations with practical tools to track results, set priorities, and align their strategies with wider policy processes.

As shown in the table below, the majority of the CoA organisations attribute their improvements in capacities to the programme, for all the capacity strengthening topics. Particularly for SRH-R realisation, and safe, secure, and collective care, for which 70% report a very substantial

[31] CoA survey
[32] E1
[33] E1
[34] CoA survey

contribution by the programme. Credibility and sustainability is an area where fewer organisations report a very substantial contribution by the programme.

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 SRH-R realization?	Safe, secure and practice collective care?	Act jointly?
A very substantial contribution	20%	30%	50%	70%	70%	44%
A substantial contribution	70%	70%	40%	30%	30%	56%
A moderate contribution	10%	0%	10%	0%	0%	0%
A limited contribution	0%	0%	0%	0%	0%	0%
No contribution at all	0%	0%	0%	0%	0%	0%
Don't know	0%	0%	0%	0%	0%	0%

Organisational resilience initiatives included financial independence and resilience training for five organisations in 2023 expanding to 10 in 2024, with [redacted] resource mobilisation training in December 2023 directly contributing to securing a large three-year European Union grant in 2025. [redacted] Board received capacity strengthening enabling them to draft their first Gender Equality, Social Inclusion, and Diversity Policy in July 2022. [redacted] was guided to establish an M&E system in 2022, and [redacted] strengthened operational capacity addressing risk and M&E framework gaps.

Meanwhile, advocacy, policy, and research skills training equipped CSOs with evidence-based advocacy tools including Restless Development's Meaningful Youth Engagement and Youth-led Accountability training for 38 CoA members from Kenya, Uganda, and Nigeria, with further YLA training for 14 Kenya CoA members in 2024 resulting in 52% increased understanding of critical concepts. FEMNET's Evidence for Impact Advocacy and Opposition Monitoring training for 13 participants from 10 CoAs in September 2023 led to a Kenyan representative joining Kisumu County's Monitoring and Evaluation Technical Working Group. Leadership development saw nine young women assume leadership roles in 2024, including one rightsholder as a national reproductive health conference panelist. Peer education and community mobilisation used "training of trainers" models, with SRH-R champions emerging. FEMNET also conducted training on Gender Responsive Budgeting in 2024 and on sustainability and men-to-men engagement in 2025.[35]

Research and monitoring initiatives included Youth-Led Research training enabling RAI to transition to Kobo Collect offline data collection in Kakuma Refugee camp, M&E refresher training on Outcome Harvesting for 22 people, and Health Systems Monitoring and Accountability planning and data analysis training by Positive Vibes. Communication and safety training included [redacted]

[35] E10

July 2022 media engagement workshop for journalists and CSO representatives on positive messaging for young women with disabilities SRH-R, M&C Saatchi's communication campaign planning, safety and security training for focal points, and Training of Trainers workshops in Mombasa, among others. Safety and well-being initiatives included the LILO methodology training (6 workshops for both LILO Women and Lilo Inclusion), well-being processes, and security awareness.

Outcome one was widely considered to be the most effective of the four programme outcomes.[36] Rightsholders described how they moved from passive engagement to active leadership, with some joining decision-making bodies and others registering new organizations during the programme's life cycle. For instance, following training by [redacted] a CoA organisation, a young woman rightsholder was appointed to the Nairobi KEMRI Community Advisory Group, placing her at the forefront of influencing national SRH-R policies. In Mombasa, rightsholders affiliated with [redacted] formally registered Women Space for Empowerment in April 2024, a new community-based organisation dedicated to advancing the rights and empowerment of young women living with HIV. Participants viewed these opportunities as transformative, with one interviewee noting that they *"shifted from just being present in spaces to actually influencing decisions"*.[37] This demonstrated that the programme's emphasis on capacity building translated into visible leadership outcomes at individual and institutional levels.

The programme also provided platforms for young women to practice their leadership through direct engagement in advocacy, budget monitoring, and service accountability. These experiences not only enhanced personal confidence but also embedded rightsholders' voices in formal structures. As one participant observed, *"before, we would only listen. Now we present our issues and demand answers"* [38]. This reflected a substantive shift in power dynamics, where marginalised young women were no longer treated merely as beneficiaries but increasingly as agents shaping their own SRH-R agenda. Importantly, the wider enabling environment also began to adjust in response. Programme stakeholders, including healthcare providers, county officials, and partner organisations, became more willing to share decision-making spaces with rightsholders. Healthcare providers and county officials, for example, acknowledged that rightsholders' lived experiences "*carried more weight when they spoke about their own challenges*," leading to invitations to county forums and technical working groups. In some cases, partner organisations institutionalised this shift by appointing rightsholders to staff positions or involving them directly in planning and budgeting processes. These developments suggested that changes in leadership and influence were not only attributable to individual empowerment but also reflected broader systemic shifts catalysed by the programme, changes that would have been unlikely to occur without its deliberate design and advocacy focus.

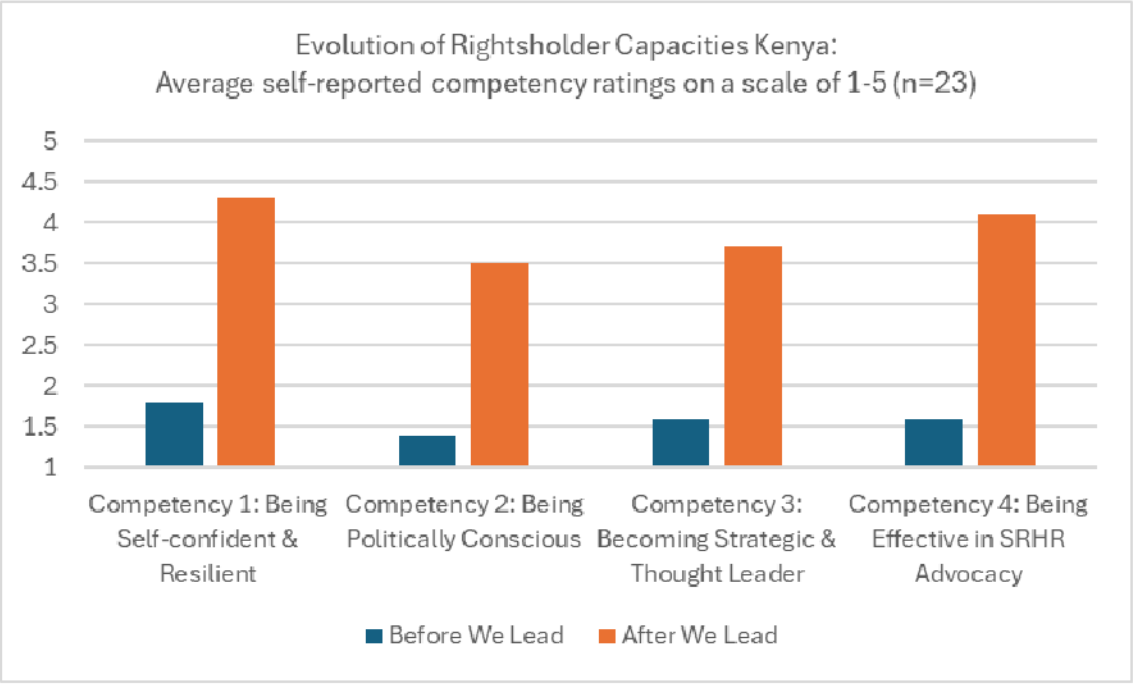
External contextual shifts also shaped outcomes. The Supreme Court's 2023 ruling on freedom of association for queer persons created new opportunities for [redacted] organisations to register formally. While this legal development was external to the programme, We Lead played a pivotal role in equipping groups to seize the opportunity by providing the organisational and advocacy skills necessary to navigate registration processes and engage with authorities.

At the same time, challenges were noted. Not all CSOs equally benefited from the programme's investments; smaller organisations, particularly those in refugee-hosting areas, continued to struggle with resource mobilisation and security risks. The 2023 Mid-term Review also found gaps where some CoA organisations working with young women with disabilities did not employ staff with lived disability experience, limiting the authenticity of representation. Such limitations underscored that while significant progress was achieved in strengthening CSOs, inclusivity within organisations themselves remained uneven.

The capacity assessment results for the rightsholders show high levels of improvement in capacities across all 4 themes from before and after the programme, with the biggest

[36] CoA survey
[37] E1; FG4
[38] FG4

improvement seen in terms of self-confidence and resilience and effectiveness in SRH-R advocacy.



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

The programme placed strong emphasis on shifting public discourse to acknowledge and support the SRH-R of young women from marginalised groups. It invested heavily in campaigns, media engagement, and commemorative events that aimed not only to raise awareness but also to reshape attitudes and narratives among diverse audiences.

Radio dramas, community theatre, and social media campaigns became central tools. For example, four PYWV rightsholders produced advocacy videos in August 2022 calling for SRH-R protection. Mass media engagement included [redacted] Aurelia Origi hosting live SRH-R conversations on Radio Maisha reaching an estimated 350,000 people, building on five SRH-R-focused TV talk shows in 2022. The "Art Healing" publication developed with Positive Vibes featured artwork and narratives by young women with disabilities officially endorsed by Kilifi County Government as a lasting advocacy tool. These platforms allowed rightsholders to tell their own stories and reach large audiences in local languages. Campaigns focused on issues such as gender-based violence, harmful practices including FGM, stigma towards people living with HIV, and broader SRH-R access challenges faced by young women with disabilities and [redacted] communities. Social media and online campaigns were designed to target youth audiences on platforms like TikTok and Twitter, while radio dramas and community theatre were tailored to reach wider community members, including parents, local leaders, and health providers, in both urban and rural settings. Workshop reflections highlighted that audiences responded positively when they heard directly from young women, with one participant remarking that *"it carried more weight when rightsholders themselves spoke about their challenges"*.[39] By amplifying lived experiences, the programme humanised abstract policy debates and challenged stigmatising stereotypes. Social media was also used to mobilise support around global campaigns such as the 16 Days of Activism, linking local advocacy to international movements.

The programme also worked strategically with journalists and community radio stations, training them to report sensitively on SRH-R. [redacted] convened a media engagement workshop in Kilifi County in July 2022 bringing together journalists, social media influencers, and CSO representatives to develop positive messaging on young women with

[39] FG4

disabilities' SRH-R. [redacted] Initiative conducted capacity-building training for community journalists from Nairobi-based radio stations in June 2023. FEMNET provided media training focusing on social media advocacy and campaign creation. These efforts resulted in significant media coverage including five journalists publishing progressive stories after the DAYO workshop such as Harrison Kivisu's "The Unsung Champions" feature in People Daily, collaboration agreements from Ruben FM, Pamoja FM, The Voice of Kenya, and Mtaani Radio following AFOSI training, Maryagatha Gichana's Thomson Reuters Foundation-supported investigative article "Sterilised Without My Consent - Tales of HIV Positive Women" in Daily Nation that won international recognition, and Association of Grassroot Journalists Kenya producing two radio dramas broadcast across five community stations. This resulted in greater visibility of issues affecting young women with disabilities, those living with HIV, and [redacted] persons. MC Saatchi also led the Safisha Rada social media campaign in collaboration with CoA members calling for men to confront and change harmful behaviors. Across platforms, Safisha Rada reached 48.8 million people. Media coverage engaged 87% of the Kenyan population. Nearly 90% of active social media users in Kenya saw the campaign. The campaign also registered a tangible impact on men's intention to act, with a 34% increase in willingness to challenge abusive attitudes among peers, a 46% increase in belief that peers would call out gender-based violence, and a 50% increase in belief that peers should call out gender-based violence, according to a post campaign survey.[40]

Despite these achievements, progress was uneven. Conservative cultural and religious norms remained strong, and in some areas, for instance, in Kakuma, communities resisted the programme's messaging. KIIs noted that some audiences perceived discussions of contraception or sexuality as encouraging promiscuity, generating backlash.[41] Similarly, content addressing the rights of [redacted] persons attracted hostility both online and offline. For example, participants reported being accused of "encouraging teenagers to go have sex" when raising issues of contraception, while some peers continued to promote FGM during sessions, undermining advocacy efforts.[42] Rightsholders remained highly visible in these efforts, which made their advocacy more powerful but also placed them at risk of stigma, harassment, and even physical threats. To mitigate this, safety protocols, psychosocial support, and mentorship were introduced. At the same time, Values Clarification and Attitude Transformation (VCAT) training for healthcare providers and community health volunteers sought to reduce backlash from service providers and local leaders.[43] These reactions demonstrated that while communication efforts achieved reach and visibility, shifts in attitudes required longer-term engagement.

The programme's approach contrasted with earlier SRH-R projects that relied mainly on top-down messaging. By deliberately positioning young women as communicators and campaign leaders, We Lead helped shift the public narrative from one of pity or moral judgement to one of agency and rights. This transformation was partial and contested, but it laid the groundwork for future advocacy by ensuring that rightsholders were no longer invisible in public discourse.

Outcome 3: Awareness among health service providers and service delivery

The programme sought to make SRH-R services more inclusive, respectful, and accessible for young women from marginalised groups. It invested in a series of training and sensitisation workshops with healthcare providers to address entrenched stigma, discrimination, and gaps in service provision. These sessions targeted a wide range of cadres, including nurses, clinical officers, counsellors, reception staff, and community health volunteers (CHVs), with participation extending to county reproductive health coordinators and hospital managers. By engaging actors across different levels of the health system, the programme ensured that improvements were not

[40] https://hivos.org/story/safisha-rada-a-national-movement-led-by-men-for-men/

[41] FG3

[42] FG3

[43] E1, FG4, E4

limited to frontline providers but also reached those shaping policy and oversight within facilities.[44]

VCAT workshops, facilitated by CoAs together with county health departments and technically supported by CSA and consortium partners such as FEMNET and Restless Development, were particularly transformative. Healthcare workers reported improved understanding of the lived realities of young women with disabilities, those living with HIV, and [redacted] persons. One provider explained that the training helped them "*receive clients in a humane way*".[45] In parallel, Continuing Medical Education (CME) sessions run through county health offices and hospital management teams provided practical updates on adolescent-friendly care and non-discrimination, while structured dialogues with rightsholders created space for direct feedback on provider behaviour. These combined efforts led to small but meaningful changes, such as ensuring privacy through curtains in maternity wards, improving signage, and hiring youth-friendly receptionists at Kambajo Dispensary in Siaya County, entrance ramp repairs at Ruben Center facility enhancing disability accessibility, and a County Governor directing Kisii Teaching and Referral Hospital to provide free washroom access.[46] These adjustments signalled a shift from abstract awareness to tangible improvements in service environments. FEMNET also conducted a VCAT training for healthcare providers in 2023.[47]

The programme also piloted community-led monitoring tools, such as Positive Vibes' "Ma'Box" feedback platform, which [redacted] used to capture real-time user experiences. Piloted in facilities such as Kapiyo Health Center, the tool enabled young women and other community members to submit feedback anonymously through both digital and physical entry points, making it easier to raise sensitive concerns. Common issues flagged included disrespectful provider attitudes, long waiting times, lack of privacy, stockouts of commodities, and discrimination towards young women with disabilities and [redacted] persons. Facility managers used this feedback to correct staff behaviour, install privacy curtains, and adjust staff schedules, demonstrating a concrete response to rightsholder input. This allowed young women to hold facilities accountable for service gaps and discriminatory practices, in Nairobi.

Positive Vibes also piloted two different workshop processes that utilised art as an advocacy tool in Kenya. The first was the Art for Healing in April 2023 through which 15 young women with disabilities shared their stories through the creation of art and portraits which were published in a book in 2024. At the launch of the book in Kilifi this group of women shared their lived experience and held dutybearers to account for better services and support. The second was the piloting of the Seen&Heard methodology in June 2024, a trauma-informed, people-centred methodology which uses a story building process to create space for witnessing, envisioning a new future and the creation of products that can be used to inform and influence.[48]

Community scorecards further reinforced dialogue between rightsholders and providers, operating as facilitated workshops where community members and health facility staff jointly identified service gaps, scored performance across agreed indicators (such as youth-friendliness, accessibility, confidentiality, and commodity availability), and developed action plans. This process is known as "Data Analysis" and "A better place"and arre steps in Positive Vibes' iMAQI cycle. These sessions were reported to build mutual trust: young women felt their voices were heard, while providers appreciated having structured data to guide improvements. In some instances, this led to commitments such as introducing sign language interpretation for key SRH-R services.

Other examples of service delivery improvements resulting from CoA member advocacy included Dandora 1 Health Care Facility organizing its first free reproductive health medical camp targeting [redacted] and young women living with HIV serving 118 individuals, Dandora II Health Facility

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[44] E5, E6

[45] FG1

[46] Kenya Outcome Harvesting Consolidation - Shared with Coralie.xlsx - Kenya.pdf

[47] E10

[48] E11

independently organizing Continuous Medical Education on [redacted] women's SRH needs, two young women living with HIV becoming community health promoters in Mombasa County after [redacted] training, and [redacted] joining Kisumu County's Monitoring and Evaluation Technical Working Group providing access to Kenya Health Information System data for evidence-based advocacy.[49]

At the systemic level, progress was evident but uneven. Some facilities institutionalised youth-friendly spaces and nominated young women as community health promoters, embedding inclusion into everyday operations. However, frequent staff transfers undermined continuity: newly posted providers often lacked training, raising concerns that gains might erode without consistent follow-up. Persistent barriers, including stockouts of essential commodities, inaccessible infrastructure, and insensitive treatment by unsensitized staff, persisted. However, these were increasingly addressed through advocacy efforts, such as feedback tools and facility dialogues, which prompted incremental responses from county authorities and health management teams.[50]

Rightsholders also pointed out a growing mismatch between increased demand, driven by improved provider attitudes and confidence from awareness efforts, and the health system's limited capacity to respond. This gap was particularly evident where respectful treatment was offered but structural needs, such as ramps or adapted couches, remained unmet, creating frustration and highlighting that sustainable change requires coupling attitudinal shifts with service delivery investments.

Outcome 4: Influence policy change

We Lead contributed to advancing policies and institutional frameworks that respected and protected the SRH-R of young women. Its advocacy initiatives targeted county and national decision-makers, emphasising locally defined priorities while linking them to regional and international frameworks.

At county level, notable achievements included the accelerated development of the Kilifi County Persons with Disability Act, which moved forward in a shorter timeframe than expected after sustained advocacy by rightsholders and CoA member, [redacted] in 2023. They organised consultative forums, co-created disability-friendly service checklists, and presented memoranda that directly informed the draft, ensuring lived experiences shaped the final provisions, under the We Lead Programme.[51] Movement building and collaboration with the Kilifi County Disability network also played a key role in the advocacy.[52] In Mombasa, menstrual health and youth-friendly services were integrated into county planning documents, with dedicated budget lines, following community dialogues led by [redacted] and the participation of young women in public forums that influenced allocations. In Siaya County, [redacted] with support from FEMNET, advocated for the adoption and enactment of RHMCAH, a comprehensive adolescent and HIV/SRH-R plan, by providing technical input and mobilising youth voices during policy consultations, embedding rights-based approaches into local governance. Inuka Success was actively involved in the creation of the Garissa County Anti-FGM Policy, ensuring that the needs and perspectives of young women affected by displacement were incorporated. These examples illustrated how We Lead's facilitation of rightsholders' participation in policy spaces and its investment in capacity building translated into institutional commitments with potential for long-term impact.

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[49] Kenya Outcome Harvesting Consolidation - Shared with Coralie.xlsx - Kenya.pdf; WE LEAD CONSOLIDATED ANNUAL REPORT 2023 FINAL.pdf

[50] For example, the Ma'Box online feedback platform highlighted discrimination against LBTQI+ clients and poor time management by staff, triggering direct interventions to improve service delivery. VCAT and CME sessions were systematically used to re-orient newly posted providers and address persistent provider bias. Facility dialogues and community scorecards were employed to escalate recurring stockouts to County Health Management Teams, while advocacy on disability inclusion contributed to the Kilifi County Disability Act and informed budgetary allocations for accessibility improvements

[51] E7

[52] E12

At national level, rightsholders contributed to policy dialogues on the Reproductive Health Policy, Persons with Disability Act, and Intersex Persons Bill, and presented testimonies to the Presidential Taskforce on Femicide.[53] Through participation in the Universal Periodic Review (UPR) process and Beijing +30 consultations, they influenced Kenya's positioning in international human rights forums. Legal advocacy also achieved breakthroughs: litigation efforts supported by We Lead partners such as [redacted], Jinsiangu, and Kenya Human Rights Commission (KHRC) secured recognition of transgender rights in 2024, including a precedent-setting court ruling that protected a transgender woman from incarceration in a male prison and affirmed the need for legal gender recognition. These actions, complemented by training and paralegal support for rightsholders, created a foundation for broader inclusion while highlighting both the catalytic role of We Lead and the persistent risks of backlash.

Despite these advances, structural barriers persisted. Restrictive laws on abortion, consent for adolescents, and sterilisation of young women with disabilities limited the scope of SRH-R protections.[54] As a result, even progressive county policies or judicial precedents could not fully dismantle systemic barriers. Inadequate government budgeting for SRH-R further constrained implementation, raising doubts about whether progressive policies could be fully realised without donor support.[55] Additionally, some CoAs acknowledged weak policy literacy and difficulties in tracking commitments, which undermined accountability.

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

The programme went beyond short-term training by embedding empowerment in durable participation pathways and leadership pipelines that extended beyond individual activities or grant cycles. Rightsholders moved from occasional participation to sustained roles in advisory groups, community structures, and peer-led initiatives, embedding their voices in routine decision-making rather than ad hoc spaces.[5657] In several counties, young women were nominated as community health promoters or supported to present memoranda to national and county assemblies and budget hearings, ensuring their priorities were anchored in formal governance processes.[58] Mentoring and wellness were deliberately integrated as enablers of participation rather than stand-alone add-ons, ensuring that survivors of trauma and highly stigmatised groups could continue engaging in advocacy and public fora. Participants also developed transferable competencies in agenda setting, facilitation, documentation, and safe referral, which they applied in community dialogues and facility meetings beyond programme-organised events. These shifts demonstrated empowerment not only as knowledge acquisition but as sustained practice over time.[59]

While external opportunities, such as favourable court rulings, opened participation space, it was programme inputs like structured roles, mentoring, and accompaniment that converted these openings into sustained agency, particularly for young women with disabilities, those living with HIV, [redacted] participants, and displaced young women who often started from lower levels of access.[60]

Coalitional reach expanded through issue-linking, where disability, HIV, displacement, and [redacted] rights were framed together under SRH-R. This broadened alliances and gave county officials a clearer entry point for commitments.[61] Partnerships with statutory bodies not only

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[53] E3

[54] FG1, FG2

[55] FG2

[56] For example, following Meaningful Youth Engagement training by [redacted] a rightsholder was appointed to the Nairobi KEMRI Community Advisory Group, the first time a young woman had held such a position, giving her a direct voice in shaping national SRH-R research priorities.

[57] FG4

[58] Rightsholders affiliated with [redacted] in Mombasa registered Women Space for Empowerment, a new CBO advancing the rights of young women living with HIV.

[59] FG2

[60] E1

[61] E1

anchored advocacy in formal policymaking but also created recurring forums, such as technical working groups and budget hearings, where rightsholders sat alongside duty bearers. In this way, movement agendas were embedded inside government processes, shifting advocacy from external pressure to institutionalised influence. These elements suggested that the coalition was increasingly proceduralised, with routines and reference points, rather than dependent on individual personalities.

The enabling environment shifted through linked mechanisms. County processes translated rightsholder inputs into appropriations and bylaws, offering accountability levers in annual cycles. National engagement tied local demands to higher-level frameworks, such as disability legislation and intersex recognition. Facility-level changes, ranging from signage and privacy curtains to provider sensitisation, created both visible and behavioural shifts, legitimising rightsholders' claims to respectful services. Partnerships with local radio and creatives normalised SRH-R discussions and embedded rightsholder narratives in familiar channels, reducing reputational risks of seeking services.

Coherence

A central feature of coherence lay in the programme's collaborative approach. The CoAs brought together organisations representing disability, HIV, [redacted] and displaced young women, creating opportunities for networking, mutual learning, and bridging divides between rightsholder groups.[62] Participants consistently emphasised that "*working in numbers gave us a stronger voice*" and that advocacy gained legitimacy when rightsholders themselves spoke about their own challenges.[63] However, some participants noted that underlying stereotypes and unequal emphasis across groups occasionally created tensions.[64] Others described how intersecting identities, such as living with HIV and being displaced, were not always fully addressed, leading to feelings of invisibility.[65] These dynamics did not derail collaboration but highlighted the need for continued attention to equity and inclusivity within coalitional spaces. In response, the programme deliberately emphasised intersectionality and inclusivity to mitigate prioritisation tensions. (See relevance section). CoA members also piloted integrated activities, such as [redacted]s free medical camp for [redacted]- and young women living with HIV, or [redacted]s dual-focus radio dramas on SRH-R for both women with disabilities and PLHIV. At the policy level, simultaneous advocacy tracks ensured that gains for one group did not exclude another, for example, [redacted]s work on gazetting the Kilifi County PWDs Act alongside [redacted] legal victory protecting transgender rights. These deliberate strategies strengthened collaboration, helped reduce perceptions of imbalance, and modelled an approach where multiple identities were addressed jointly rather than competitively.

While almost half of the CoA organisations felt that the programme had done well at aligning with international initiatives, many felt either ambivalent or that the programme had done badly, suggesting this is an area for further elaboration with future programming.

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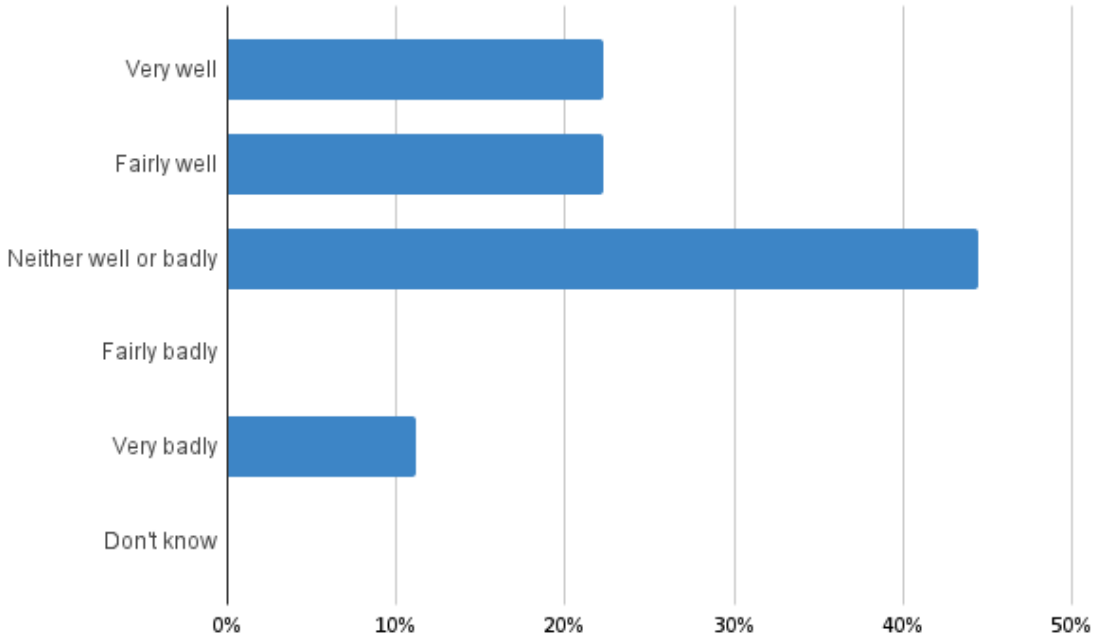
[62] FG4
[63] E1
[64] FG1, FG2
[65] FG4

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



CoAs adopted safety, security, psychosocial support, and GESI policies, budget calendars, and M&E templates, which standardised collaboration and reduced duplication.[66] These institutional tools lowered coordination costs and enabled repeatable, rather than one-off, joint actions. Technical assistance in finance and strategy development helped smaller groups strengthen their systems and graduate into more credible partners, thereby widening the coalition's collective capacity. In parallel, the programme deliberately supported collaboration practices around transparency, power-sharing, and collective leadership. For example, right holders were placed at the centre of workplan design, partnerships operated more horizontally than in typical donor–CSO models, and digital platforms were used to reduce information gaps between larger and smaller organisations. These measures aimed to build trust, create space for shared decision-making, and ensure that diverse actors could contribute equitably to collective advocacy efforts.

The partnership architecture was described as "complex but useful," involving direct grantees, consortium partners such as FEMNET and Restless Development, and technical partners like Trust Law and TRF, who provided legal and communications expertise.[67] This multi-layered structure enabled cross-learning, rapid access to expertise, and shared advocacy targets, though it also contributed to challenges in coordination. At times,trainings overlapped, with different partners calling on the same core members simultaneously, creating fatigue and missed

[66] FG4
[67] E1

opportunities.[68] This issue was later addressed through joint calendars and clearer scopes of work.[69]

Despite these strengths, collaboration was sometimes undermined by slow, hierarchical communication between consortium, host, and CoA levels, which led to rushed timelines and reduced opportunities for joint decision-making.[70] The coalition-building process itself was described as "amorphous," with weak structures for sustaining collective advocacy beyond the programme cycle. While CoAs engaged in county-level forums and occasionally collaborated with allies such as the Network of African National Human Rights Institutions (NANHRI) and the SRHR Alliance of Kenya, there was little evidence of systematic connection with broader national SRH-R platforms or coalitions. Participants suggested that limited budgets, the localised design of CoAs and an emphasis on event-based collaboration constrained opportunities for wider network building. As a result, without stronger national platforms or coalitions, the momentum risked dissipating once funding ended.[71]

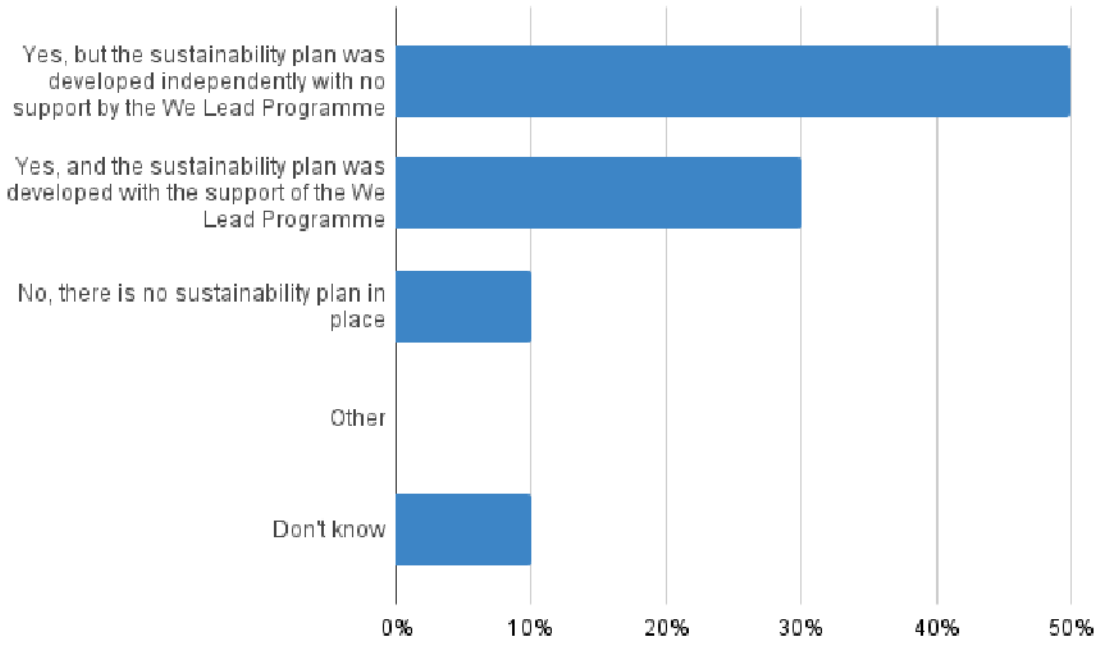
Donor perspectives highlighted this tension: while acknowledging the innovation of rightsholder-led approaches, they expressed a desire to see more visible synergies with other Dutch-funded programmes such as *She Leads* and *Make Way*.[72] Yet evidence from the We Lead Kenya programme indicates that such linkages were already emerging. For example, We Lead collaborated closely with *She Leads* in advocating for the National Disability Act 2025 through joint membership and co-chairing of the National Disability Mainstreaming Working Group. In addition, We Lead COAs and rightsholders were supported to join the National UPR Stakeholder Forum, where they contributed to the development of both the SRH-R Thematic Report[73] and the Women's Rights Report[74]. These examples show that while collaboration within the programme and at county level was strong and some cross-programme linkages were initiated, opportunities for broader and more systematic coherence at the national and regional levels remained only partially realised

Sustainability

Sustainability was embedded as a central concern throughout the programme's design and implementation. The localisation of the ToC each year allowed activities to respond to contextual shifts, strengthening long-term relevance. Capacity strengthening of CoA organisations and rightsholders ensured that advocacy, communication, and leadership skills were not only built but institutionalised within community structures. Positively, the majority of the CoA organisations report having a sustainability plan in place, although only 30% received support from We Lead to develop it.

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

[68] FG4
[69] E1
[70] FG4
[71] FG4
[72] E2
[73] https://gem.or.ke/wp-content/uploads/2025/02/Final-UPR-Kenya_SRH-R-Thematic-Group-Summary.rev2_.pdf
[74] https://gem.or.ke/wp-content/uploads/2025/02/UPR-Women-Rights-Report-1_240927_111024.pdf



Rightsholders themselves highlighted that the personal confidence and advocacy skills they gained would remain with them regardless of the programme's future. As one reflected, "*confidence is something no one can take away from me… even if the project ends*". Organisational capacities were also enhanced, with CoAs adopting financial management systems, safeguarding policies, MEL tools and GESI frameworks. These shifts positioned them to secure future funding and credibility beyond the programme cycle.

At the systems level, the programme influenced government policies and planning processes, such as the Kilifi County Persons with Disability Act, the Siaya RMNCAH policy, and allocation of resources on menstrual health and youth friendly services in County budgets in Mombasa..[75] These formal policy shifts signalled the embedding of rightsholder priorities within state frameworks, creating avenues for continuity beyond We Lead.

Yet concerns about sustainability persisted. Movement-building was described as "amorphous," with limited structures for collective advocacy once donor support ended. CoAs feared that without resources to maintain coalitions, momentum would dissipate. While CSOs gained skills in digital campaigning and media engagement, maintaining visibility required ongoing funding and partnerships with mainstream outlets. Smaller organisations in rural and refugee settings often lacked the resources to sustain regular campaigns beyond the programme cycle. As one rightsholder commented, *"we learnt how to do podcasts and online campaigns, but without data bundles or funds for equipment, it is difficult to continue"*.[76]

Health service improvements, such as provider sensitisation, risked reversal due to staff transfers and the absence of regular refresher trainings. While the programme has demonstrated that provider attitudes could change and that facilities could adopt more inclusive practices, sustaining these gains requires systemic investment in infrastructure, continuous training, and stronger accountability mechanisms to prevent reversals once external support diminishes. Moreover, civic space restrictions, hostile laws like the Family Protection Bill, and limited political goodwill towards [redacted] rights threatened to erode gains.

The programme created strong foundations for sustainability at individual and organisational levels and embedded some progress within formal institutions. However, sustaining collective

[75] E9

[76] FG4

advocacy and ensuring continuity in service delivery and policy implementation remained contingent on resources, enabling environments, and continued political support.

E. Recommendations

1. **Anchor coalitions in national and county platform:** Future SRH-R programmes should maintain the focus on investing in formalising coalition structures by linking rightsholder organisations into existing county and national SRH-R platforms, rather than creating parallel initiatives. This helps strengthen sustainability, reduce duplication, and ensure advocacy momentum continues beyond individual funding cycles.
2. **Institutionalise capacity building systems:** Given frequent staff transfers in the health sector and the evolving needs of grassroots CSOs, capacity-building should be continuous and structured. Programmes should adopt training-of-trainers models accredited by county health systems, pair rightsholders and providers in joint training, and build political literacy among rightsholders to strengthen engagement in national policy forums.
3. **Set minimum standards for inclusivity:** To translate intersectionality into practice, programmes should establish concrete inclusion benchmarks, such as producing accessible training materials (Braille, sign language, easy-to-read formats), and advocate for concrete budgeting for ramps, signage, adapted equipment in facilities, and interpretation services. Caregiver should be engaged from the very start of programming, as their attitudes and support are often decisive in enabling young women with disabilities to access SRH-R services. Structured caregiver dialogues, training, and support groups should be integrated into programme design to reduce stigma at home and sustain rightsholders' participation. Engaging men and boys as allies should also be deliberately planned and budgeted from the outset, rather than treated as optional.
4. **Strengthen monitoring tools:** In order to better align reporting frameworks with participants' lived experiences, monitoring systems should be adapted to capture incremental but meaningful outcomes (e.g., young women in displacement joining decision-making spaces), not only large policy shifts. A simple advocacy tracker should be introduced to record commitments made by duty bearers and follow up on implementation, ensuring accountability.
5. **Provide predictable and flexible financing:** Grassroots organisations require multi-year, flexible funding that covers core costs, accessibility needs, and caregiver support. Funding should also support sustained community engagement tools, such as radio programmes and peer support groups, which have proved effective but difficult to maintain once funding ends.
6. **Deliberately integrate cross-sectoral linkages:** Future programmes should recognise the interdependence of SRH-R with other sectors, such as nutrition, WASH, climate resilience, and youth-friendly clinic services, by building partnerships with specialised agencies. This would avoid programme overstretch while ensuring that rightsholders' intersecting needs are addressed in a coordinated way.