Nigeria

A. We Lead Programme Overview

CoA Member Organizations

The Community of Action (CoA) in Nigeria consisted of 13 organisations.[1] The members of the CoA represent a diverse range of rightsholders including young women living with HIV, women with disabilities, internally displaced persons (IDPs), [redacted] youth, and intersex persons. CoA organizations were located across Lagos, Calabar, Uyo, Abuja, Port Harcourt, and Yola.

Main Activities

- **Capacity building and training**: Training on intersectionality and Sexual Orientation Gender Identity; Expression and Sex Characteristics (SOGIESC); Youth-Led Research; Looking In, Looking Out (LILO) workshops developed by Positive Vibes; capacity strengthening on proposal writing, project management, monitoring and evaluation, interpersonal communication, organisational development, financial management, peer-to-peer mentoring, and leadership; in-country linking and learning events between Nigeria and Niger.
- **Public awareness and community engagement on SRH-R**: Radio, social media (including TikTok), and community dialogues e.g SGBV awareness and prevention campaign carried out by social mobilizers (rightsholders); Saatchi Campaign on GBV.
- **Engagement with health services**: Equipping providers with skills on disability inclusion, SRH-R awareness and service delivery, youth-friendly services, and non-discrimination e.g training on intersex experiences for healthcare practitioners.
- **Policy and legislative advocacy**: Engaging ministries and parliaments to advance SRH-R legislation (e.g., review of national SRH-R policies for people with disabilities, support for domestication of the VAPP Act).

B. End Term Evaluation Fieldwork

Number of stakeholders interviewed	11 women; 1 man
Number of participants of CoA Sensemaking Workshop	5 women, 1 non-binary, 1 man
Number of participants of Rightsholder Sensemaking Workshops	23 women, 3 non-binary
Total number of participants	**45**

C. Country Context

The most recent general presidential election was held in 2023, with Bola Tinubu of the All Progressives Congress (APC), a center-right party, winning the presidency. The political climate remains socially conservative with the APC government maintaining conservative stances

[1] [redacted]

especially regarding [redacted] rights.[2] Women's rights face structural and cultural constraints particularly in Northern states dominated by Islamic law and customs. Women represent around 4.3% of seats in Nigeria's National Assembly reflecting low female political participation nationally. Nigeria is Africa's largest economy with a GDP growth rate of approximately 3.4% for 2024 (World Bank). However, economic challenges include inflation, high youth unemployment, poverty, and ongoing security issues.

Abortion is heavily restricted and illegal in all scenarios except to save a woman's life.[3] Unsafe abortion are widespread and half of those who die from unsafe abortions are adolescents.[4] Contraception is legal and available through public and private sectors supported by the National Population Policy and FP2030 National Commitment, but modern contraceptive prevalence remains low at 12% among married women with large rural-urban and socioeconomic disparities.[5] The Violence Against Persons (Prohibition) Act 2015 (VAPP) criminalizes SGBV federally but adoption and enforcement vary by state with reporting, prosecution, and survivor support hampered by stigma and resource shortfalls. There have also been recent threats to repeal the VAPP Act. Sexuality education is included in school curricula in some states but not mandated federally although a national policy dialogue in 2025 aims to make access more equitable for adolescents.

Same-sex relationships are criminalized under the Same-Sex Marriage Prohibition Act with harsh penalties prescribed for [redacted] relationships and no legal protections for [redacted] individuals.[6] Violence against [redacted] individuals is rampant. As one rightsholder from the [redacted] community noted, "*Being queer alone is a mental struggle and we get constantly bullied. [...] There are people who will never be satisfied because of who you are and what you represent*."[7] Meanwhile, several participants highlighted the persistence of stigma against women living with HIV, with one NGO representative describing how "*young women often avoid health facilities for fear of being seen and labelled*" while highlighting that "*talking about sexual rights is still seen as a taboo. Young women, especially those living with HIV, are judged before they are heard.*"[8]

The healthcare system is decentralized (Federal, State, Local tiers) with the private sector delivering approximately 60% of health services, and total health expenditure approximately 4.2% of GDP (World Bank). Out-of-pocket spending is the highest among comparable countries at approximately 76% of total health expenditure (World Bank). The Maternal Mortality Ratio is extremely high at 993 per 100,000 live births,[9] the Under-5 mortality rate is 105 per 1,000 live births (World Bank), and only 43% of births have skilled attendance showing wide regional variance (urban over 80%, rural under 30%). The fertility rate is high at 4.5 children per woman (World Bank) with an adolescent birth rate of 86.4 per 1,000 girls aged 15-19 (World Bank), and Northern states have the worst SRH-R indicators including lower contraceptive uptake and higher maternal and child mortality.

Nigeria faces a complex security crisis with over 5,000 violent incidents recorded resulting in more than 20,000 casualties between 2020 and 2024, including terrorism, banditry, farmer-herder conflicts, kidnapping for ransom, communal and cult clashes, and extra-judicial killings.[10] Boko Haram and Islamic State West Africa Province (ISWAP) remain active in the Northeast and have

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[2] NALTF (2025) Women occupying only 64 of 1460 seats in Nigeria parliament – Reps Deputy Speaker,

[3] Criminal Code (South, Section 228-230) and the Penal Code (North, Section 232-236)

[4] Raufu A. Unsafe abortions cause 20 000 deaths a year in Nigeria. BMJ. 2002 https://pmc.ncbi.nlm.nih.gov/articles/PMC1169586/

[5] Abubakar IB, Abubakar HB. Nigerian Women's Modern Contraceptive Use: Evidence from NDHS 2018. Reprod Fertil. 2024 Jan 1;5(2) https://pmc.ncbi.nlm.nih.gov/articles/PMC11227064/

[6] Equaldex (2025) https://www.equaldex.com/region/nigeria

[7] FG4

[8] E4

[9] UNICEF (2025) Maternal Mortality

[10] Nextier Violent Conflict Database Reported here

been responsible for frequent attacks.[11] Gender-based violence remains prevalent particularly in conflict-affected and Northern regions with forced child marriages, sexual violence, and exploitation reportedly affecting thousands annually. Civic space is shrinking due to government crackdowns on activists and journalists with media freedom restricted through harassment, arrests, and attacks on journalists reporting on corruption and conflicts, while protests including those by secessionist groups in the South-East often face police or military repression with documented unlawful killings and forced disappearances by security forces. Both NGOs and host organisations reported threats and backlash following high-visibility campaigns. In some northern states, insecurity restricted mobility of CoA organisations and limited rightsholder engagement. Additionally, rightsholders in rural or IDP settings faced greater barriers, including long distances to clinics and lack of transport.

D. Evaluation results

Relevance

The words that CoA member organisations would most use to describe the programme in Nigeria, according to the survey, emphasise the leadership and empowerment aspects of the programme's design and activities. Respondents also highlight that the activities are transformational, intentional, and supportive, whilst being rooted in equality, equity and feminist principles:

The survey results found that in Nigeria the programme was perceived by 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 communities. Women affected by displacement are perceived to have been the best served by the programme's design with 91% of the organisations who answered the survey saying that they had been very well served. Women living with HIV were considered to be less well served by the programme, with just 55% saying that the programme in Nigeria was very well designed for them.

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:

[11] EUAA (2024) Nigeria – Country Focus Country of Origin Information Report https://www.euaa.europa.eu/sites/default/files/publications/2024-07/2024_07_EUAA_COI_Report_Nigeria_Country_Focus.pdf

	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	83%	83%	55%	91%	64%
Fairly well	17%	17%	36%	0%	36%
Neither well nor badly	0%	0%	9%	9%	0%
Fairly badly	0%	0%	0%	0%	0%
Very badly	0%	0%	0%	0%	0%
Don't know	0%	0%	0%	0%	0%

The We Lead programme's strategies in Nigeria were largely evidence-based and contextually appropriate. The programme was widely recognised as highly relevant by all rightsholders and CoA organizations. The programme's flexibility allowed the different CoA members to adapt and localize activities to fit the various peculiarities of their target rightsholders and SRH-R challenges at state levels.[12] For example, persons living with HIV/AIDS said that the SRH-R awareness, drive towards reduction in stigmatization, and their empowerment to speak up for their rights was highly relevant to their real needs as young people. Similarly, persons with disabilities (PWDs) highlighted that it helped improve their access to services at healthcare facilities, while increasing their confidence towards speaking openly with healthcare providers, and empowering them to make informed decisions about their health.

Its participatory design, centred on CoA-led localisation of the Theory of Change (ToC), meant that activities addressed real, lived barriers faced by rightsholders. For example, programme activities that promoted disability access to services at healthcare facilities were explicitly included[13], and stigma reduction efforts amongst PWDs and people living with HIV aligned with national SRH-R gaps. Inclusion was operationalized through practices like budgeting for sign language interpreters and considering accessibility features. A rightsholder with a disability also emphasized, "*A safe space gave me the opportunity to be seated at the decision table and be part of the design of the project*".[14] Another stated: *"This was the first time someone asked us what we needed and then built activities around that".*[15]

> *"From the onset of the programme, we were involved in the design of the Theory of Change. Rightsholders were given priority representation in the design, and to create a more inclusive document, there were focus group discussions with different rightsholder groups, capturing and welcoming varying perspectives. The midterm review was also inclusive."*[16]

The annual ToC "sense-making" process allowed CoA members and rightsholders to locally adapt the programme, ensuring activities responded directly to evolving needs. For example, the ToC review in October 2024 led to a strategic pivot from general capacity strengthening of CoA members, healthcare providers, and rightsholders to focusing on transforming that capacity into tangible policy analysis and impact.[17] Another adaptation to the programme was the integration of mental health and psychosocial support into the advocacy framework and organizational policies. This integration involved bringing on psychologists and, in Rivers State, the creation of

[12] CoA survey
[13] E1
[14] CoA survey
[15] FG5
[16] FG1
[17] E1

dedicated psychotherapy units. CoA organisations also adopted policies to improve their wellbeing and mental health. Additionally, strengthened inter-CoA solidarity led to the emergence of advocacy on intersex issues like care and diagnosis for intersex people, Intersex persons genital mutilation (IGM), and hasty medical decisions on intersex children who present physical variations etc.

However, one important gap identified in the programme was the need to support economic empowerment. As an IDP camp participant stated, "*After the Focal Point training, we were not financially empowered to access the commodities that are used for family planning*"[18] .

Effectiveness

Outcome 1: Strengthening the capacity of CoA members and rights holders

Outcome 1 was reported as an area of clear success by CoA members and rightsholders. Over the programme cycle, the capacity of CoAs evolved significantly. Initially, many CoA organisations entered the programme with limited organisational systems, while rightsholders entered with weak advocacy skills and limited confidence in engaging public authorities. Through the We Lead approach, they transitioned into empowered leaders who could mobilise their peers, advocate at state and national levels, and engage directly with service providers and policymakers. Workshops documented testimonies of rightsholders describing their growth from being “silent and limited” to “empowered, outspoken leaders” who now speak publicly about SRH-R.

To achieve this, the We Lead programme implemented numerous training activities for CoA member organisations and local CSOs, focusing on leadership, advocacy, organisational management, and psychosocial and safety skills.[19] Restless Development conducted leadership training for CoA members in 2024, with post-assessment results showing 17 participants achieved significant knowledge gains, with scores increasing from 46.5% to 76.3%. Advocacy and thematic skills training included FEMNET's 5-day training on SRH-R policy, evidence-based advocacy, and opposition monitoring held in Abuja in October 2023.[20] FEMNET also facilitated Gender Responsive Budgeting Advocacy training in 2024, while a comprehensive one-day SOGIESC and intersectionality training was organised for 16 staff and volunteers of the Sustainable Impact and Development Initiative in April 2024[21] Psychosocial Well-being and Safety Training included training on the LILO Methodology including a 'Sing of Freedom' workshop and Safety and Security Training,[22] LILO Women training in March 2022, LILO Identity (jointly with F2BM) in June 22,, LILO Voice (with different participants from Africa) in June 22 and LILO Inclusion in Nov 2021 and March 2022.[23] FEMNET conducted a training on sustainability and men-to-men engagement in 2025, this also covered project learning.[24]

Organisational strengthening included Theory of Change and M&E training for the CoA Facilitator in 2021, followed by refresher M&E training on Outcome Harvesting for 16 CoA members in 2024. Restless Development's virtual youth-led research training for seven CoA organisations in 2023 led to collaborations with UNFPA and the Ministry of Health.[25] Safety and Security Focal Points

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[18] FG3

[19] .2. New doc_ 2021 We Lead Annex 2 Results framework - Submitted to MFA on 28.4.2022.pdf; WE LEAD PROGRAM 2024 ANNUAL PLAN -SUBMITTED TO MOFA.pdf

[20] Nigeria Outcome Harvesting Consolidation - Shared with Coralie.xlsx - Nigeria.pdf; Consolidated - We Lead Year 3 Financial Progress Report 2023 final.pdf

[21] WE LEAD CONSOLIDATED ANNUAL REPORT 2024 FINAL.pdf; Nigeria Outcome Harvesting Consolidation - Shared with Coralie.xlsx - Nigeria.pdf

[22] 1.0 2023 We Lead Annual Plan submitted on 1.11.2022.pdf

[23] E13

[24] E15

[25] 0.2. New doc_ 2021 We Lead Annex 2 Results framework - Submitted to MFA on 28.4.2022.pdf; WE LEAD CONSOLIDATED ANNUAL REPORT 2023 FINAL.pdf; 2025 Consolidated Annual Plan_We Lead.pdf

received training in 2021 in Kenya and ongoing coaching to enhance capacity for threat prevention, monitoring, and response.[26]

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. 67% reported a very substantial contribution for their improved capacities for promotion of SRH-R realisation. A small minority of the organisations reported moderate contributions or limited contributions to capacity development. For safety, security and practicing collective care, a quarter of the organisations recognise just a moderate contribution from 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	50%	58%	58%	67%	50%	50%
A substantial contribution	42%	33%	42%	25%	25%	42%
A moderate contribution	8%	8%	0%	8%	25%	8%
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%

The We Lead programme also implemented capacity-strengthening training initiatives specifically for rightsholders. The [redacted] conducted an Advocacy Leadership Workshop in January 2024 for seven young women and girls living with HIV in Rivers State, who subsequently reached 390 other young women and girls living with HIV with SRH-R information across 10 Local Government Areas through peer-to-peer education.[27] [redacted] Initiative delivered SMART Advocacy capacity-building for eight displaced women in Wassa IDP Camp in April 2024, enabling them to conduct their own training for 53 girls in May 2024 while developing advocacy messages for a Federal Ministry of Health visit. [redacted] organized a two-day comprehensive SRH-R advocacy training in March 2024 in Oyo State for 20 rightsholders, with 10 participants independently organizing their first SRH-R outreach reaching 42 girls in two health facilities.[28] Additional training initiatives included [redacted] training for 30 displaced women and girls as social mobilizers in Wassa IDP camp in April 2023, leading to their mobilization of 189 community members for an International Women's Day advocacy event in 2024, and the [redacted] Initiative's one-day SRH-R training in March 2024 for displaced rightsholders in Adamawa State, resulting in twelve participants reaching 204 other displaced young women through peer-to-peer dialogue sessions.[29]

The Advocacy for Women with Disabilities Initiative trained 20 rightsholders in four states in 2023, with these trained leaders independently conducting step-down SRH-R training sessions in 50

[26] 0.2. New doc_ 2021 We Lead Annex 2 Results framework - Submitted to MFA on 28.4.2022.pdf; 2025 Consolidated Annual Plan_We Lead.pdf

[27] Nigeria Outcome Harvesting Consolidation - Shared with Coralie.xlsx - Nigeria.pdf

[28] Nigeria Outcome Harvesting Consolidation - Shared with Coralie.xlsx - Nigeria.pdf

[29] Nigeria Outcome Harvesting Consolidation - Shared with Coralie.xlsx - Nigeria.pdf

communities across Ekiti, Lagos, Edo, Kogi states, and the Federal Capital Territory in December 2023. Other interventions included the 'Sing of Freedom' LILO methodology workshops, safety and security training for 32 rightsholders, and programmes on risk management, conflict resolution, mental health support, and emergency response.[30]

Finally, We Lead conducted capacity building work aimed at media professionals, which was instrumental in amplifying SRH-R messages (see outcome 2). For example, FEMNET conducted media training for rights holders on social media, influencer collaborations, and campaign creation with safety emphasis for marginalized groups. Intersex Nigeria trained nine media professionals in decision-making roles on intersex-inclusive reporting in April 2025, leading to commitments for integrating intersex perspectives into publications.[31]

As a result of these activities, CoA organisations reported significant improvements in organisational systems leading to more developed robust internal systems (particularly those related to finance, advocacy, and M&E). Through a combination of capacity building training, holding leadership roles in their organizations, and representing their organization in conferences, rightsholders described increased confidence and leadership; some moved into public advocacy roles, some others transitioned from passive beneficiaries to confident leaders. A rightsholder with a disability stated, "*I have built my confidence and spoken at the Society for Adolescent and Young People's Health in Nigeria (SAYPHIN) conference*".[32]

A current CoA member also observed that the programme was "very intentional," about including young women in their activities, including organizational skills and gap assessments, suggesting such improvements to the confidence and leadership by young women rightsholders would not have occurred without it. Intersectionality approaches (e.g., LILO workshops) broadened understanding of diversity. One participant noted, "*The LILO workshop changed mindsets and opened doors — it showed policymakers that inclusivity is possible and necessary*."[11]

Another CoA member mentioned that the training on intersectionality and SOGIESC enabled other CoA members to understand [redacted] issues and experiences and incorporate intersectionality into programme design. She stated, "*as a result of this, we have seen a huge improvement around understanding intersex and [redacted] rights and experiences. The in-country linking and learning also helped CoA members to understand different rightsholder groups*".[33]

The capacity assessment results for the rightsholders demonstrate 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 and being politically conscious.

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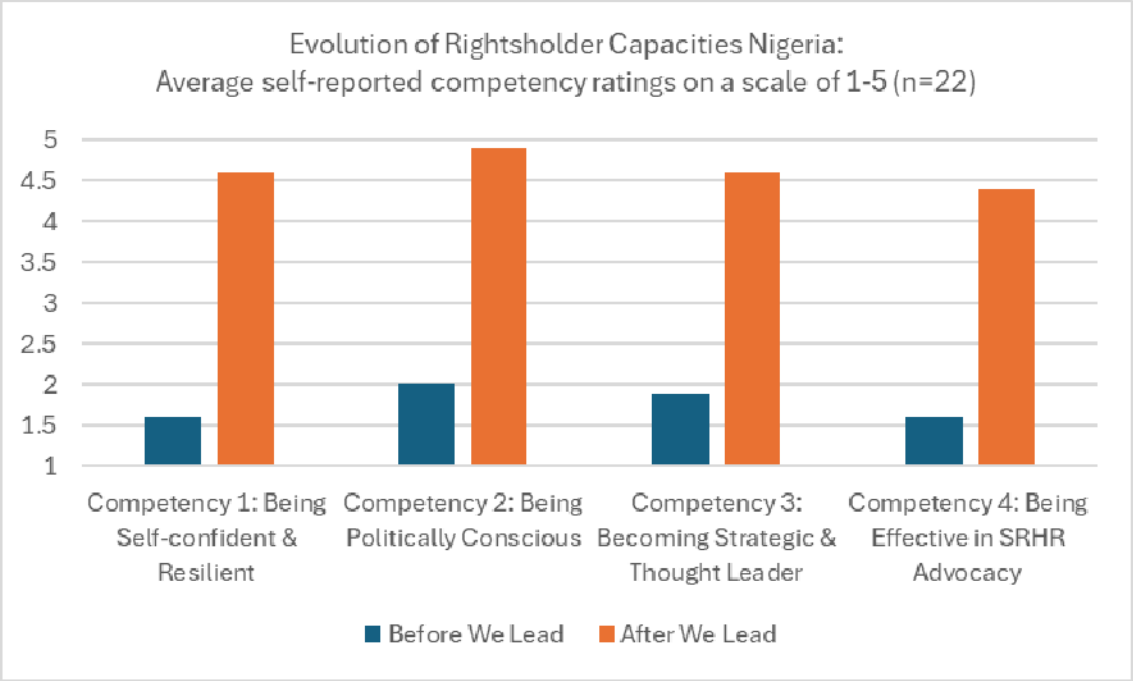
[30] Nigeria Outcome Harvesting Consolidation - Shared with Coralie.xlsx - Nigeria.pdf; 2025 Consolidated Annual Plan_We Lead.pdf

[31] Consolidated - We Lead Year 3 Financial Progress Report 2023 final.pdf; 1.0 2023 We Lead Annual Plan submitted on 1.11.2022.pdf

[32] FG1

[33] FG5



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

The We Lead programme implemented significant public awareness-raising activities in Nigeria to increase support for the SRH-R of young women and girls from rightsholder groups. Innovative communication campaigns targeting parents, teachers, community leaders, service providers successfully shifted public narratives.

The flagship initiative was the "#MakeWeHalla" campaign on gender-based violence which ran from March to June 2024, a partnership between the Nigerian CoA and M&C Saatchi that collaborated with prominent Nigerian film stars Charles Inojie and Ali Nuhu to challenge the notion that GBV is a private matter and encourage public intervention in domestic violence cases. The campaign's core video reached over 11 million Nigerians, generating over 2,000 comments and more than 500 posts using the hashtag, while measuring a 9% decrease in beliefs that violence is private and a 14% increase in likelihood of showing disapproval of domestic violence.[34]

Additional awareness activities included targeted media outreach such as Nigerian YouTube vlogger Damilola Fajimi's video in March 2024 advocating for parents to provide Comprehensive Sexuality Education following [redacted] Initiative training, multilingual radio jingles broadcast by GWIHR on Wazobia FM Port Harcourt in English, Pidgin, and Igbo addressing HIV prevention, family planning, and stigma reduction for marginalized groups, and the Nigerian CoAs' first symposium for rights holders bringing stakeholders together for inclusive SRH-R conversations[35].

Rightsholders in camps reported behaviour change, with some using GBV referral services. For instance, the SGBV awareness and prevention campaign carried out by 30 social mobilizers to 800 households within their camp, in partnership with the FCT SGBV response unit (a government owned agency) led to the provision of SGBV referral phone numbers from the FCT SGBV unit to the women. A policy actor from Rivers State observed that, "*Community support improved, e.g. fathers bringing daughters for SRH-R check-ups", thanks, in part, to the public awareness campaigns*.[36]

Additionally, We Lead contributed to [redacted] non-clinical research, which set the ground for most of Intersex Nigeria's advocacy work e.g successfully creating a level of awareness on

[34] WE LEAD CONSOLIDATED ANNUAL REPORT 2024 FINAL.pdf

[35] Nigeria Outcome Harvesting Consolidation - Shared with Coralie.xlsx - Nigeria.pdf; Revised MTR Global Report We Lead Oct '23.pdf

[36] E5

intersex experiences that can no longer be dismissed in the country. A CoA member reflected "w*hile we still have a long way to go, [my organisation] is proud of the level of awareness we have on intersex issues in the country. However, for the* [redacted] *community, the level of success was minimal as a result of the Same Sex Marriage Prohibition Act*".[37]

However, campaigns also led to public backlash, highlighting risks associated with increased visibility. One campaign to increase public awareness of SRH-R led to targeted harassment and threats toward CoA members and the host organization itself in one of the states. These incidents underscored the need for cautious visibility and strengthened security protocols during programme planning.

Please capture on FEMNET engagement of the men allies, the duty bearers and the traditional leaders.

Outcome 3: Awareness among health service providers and service delivery

The programme achieved meaningful, though varied, gains in awareness raising among health service providers. Direct service collaboration was established through the [redacted] partnership with the Medical Women Association of Nigeria in December 2022, providing monthly breast and cervical cancer screening services for rightsholders including young women living with HIV and sex workers in Rivers State.[38] Other engagement with health professionals included training 25 Ministry of Health staff on inclusive SRH-R in 2024, engaging 28 health workers and facility managers in 'Open' CoA sessions creating dialogue spaces between providers and rightsholders, and training two healthcare workers as advocacy champions within a national health forum.[39]

At the community level, Positive Vibes´ Health System Monitoring and Accountability (HSMA) work, including the Setting the Levels dialogue process in Port Harcourt, resulted in signed MoUs with healthcare facilities and improved provider-community relationships. It also resulted in material changes at facility level and various successful advocacy interventions. For example, the quality improvement fund was used to create IEC material about inclusion and standards for service delivery.[40] Monitoring work also included the use of the Integrated Monitoring and Accountability for Quality Improvement (IMAQI) system, supported by Positive Vibes, which includes an iMAQI (Integrated Monitoring and Accountability data collection process using an online suggestion toolbox (Ma'yBox) to track feedback on treatment received by patients as well as attitude and values of healthcare providers. Other community-led work included three research projects on SRH-R undertaken by rightsholders in 2024 with 12 rightsholders using available data to advocate for improved services, the use of FEMNET's innovative scorecard research tool for creating campaigns and holding health providers accountable, and FEMNET's VCAT training for healthcare providers.[41]

Thanks to these interventions, trained healthcare professionals demonstrated improved attitudes and greater respect toward PWDs and young women. A healthcare provider from [redacted] Initiative shared, "*Through structured dialogues and monitoring initiatives, providers' attitudes improve*d".[42] Another COA member stated "*we train and work with healthcare practitioners to ensure proper care and diagnosis for intersex people, and our current relationship with the Federal Ministry of Health and Social Welfare makes it even easier. These are practitioners we have trained and engaged over time and now, they are aware of the challenges that come with IGM or*

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[37] FG5

[38] WE LEAD CONSOLIDATED ANNUAL REPORT 2023 FINAL.pdf; 2024 Consolidated Results Framework Final.pdf; 1.0 2023 We Lead Annual Plan submitted on 1.11.2022.pdf

[39] 1.0 2023 We Lead Annual Plan submitted on 1.11.2022.pdf; 2024 Consolidated Results Framework Final.pdf

[40] E13, E14

[41] WE LEAD CONSOLIDATED ANNUAL REPORT 2023 FINAL.pdf; 2024 Consolidated Results Framework Final.pdf; 1.0 2023 We Lead Annual Plan submitted on 1.11.2022.pdf

[42] E6

hasty medical decisions on intersex children who present physical variations. However, we currently do not have an institutionalised guideline for intersex healthcare in Nigeria".[43]

Survey respondents also reported improved access to healthcare facilities. For example, [redacted] is now reportedly open to partnering with other CoA members from the [redacted] communities. In Kuje General Hospital, Abuja, healthcare providers are helping deaf women access SRH services, even without interpreters, and rightsholders have reportedly gained improved knowledge and self-esteem.[44]

In addition, the integration of mental health services and cervical screening as part of sexual and reproductive health at the health facilities improved the quality and reach of healthcare service delivery. This included the addition of psychologists and the creation of a new psychotherapy unit altogether in some facilities. This was in response to some members of the [redacted] community who had expressed the need for mental health support.

While there was progress on attitudes and service access for Persons with Disabilities, physical barriers to healthcare services (e.g. wheelchair ramps in the healthcare facilities) and communication barriers during CoA meetings (sign language interpreter for the deaf) remained. Providers described both barriers and improvements as facilities were often ill-equipped, with inaccessible infrastructure and provider biases against marginalised groups: "*Before, we didn't think of ramps or sign language. Now we are learning that these are basic rights, not extras."*[45] Systemic issues like frequent staff transfers also posed challenges to sustainability.

Outcome 4: Influence policy change

The We Lead programme implemented extensive public policy advocacy and legal reform activities in Nigeria, despite operating within a challenging context of shrinking civic space and political repression. National-level institutional and policy advocacy achieved some progress through direct engagement with federal government bodies and the National Assembly.

Policy-level changes included the Federal Ministry of Health's appointment of a Disability Desk Officer in March 2023, creating a crucial entry point for rightsholders, partly in response to advocacy from the Advocacy for Women with Disabilities Initiative.[46] The Federal Capital Territory Hospital Management Board Director General committed in 2025 to make all general hospitals inclusive and accessible to women with disabilities, including purchasing adjustable beds, installing accessible toilets, and integrating sign language interpreters for inclusion in the 2026 public health budget. Healthcare facilities began accessibility modifications triggered by advocacy (visits and structured dialogues), such as the rebuilding of a Primary Health Centre in Calabar to be disability friendly. Meanwhile the [redacted] advocacy led to the reinstatement of the Adamawa State SRH Working Group in April 2023. We Lead also partnered with the Ministry of Health to develop Adamawa State's first SRH-R roadmap in June 2023, outlining clear CSO roles in SRH-R programming.[47] Cross River State's Minister of Health and Commissioner for Women Affairs made verbal commitments in July 2024 to support SRH commodity distribution and inclusive law formulation. [redacted] Right advocacy efforts prompted the Executive Secretary of Rivers State to develop a monitoring framework for improving accountability and stigma-free SRH-R service access.[48]

Several Federal Ministry of Health and Social Welfare departments agreed to collaborate with Intersex Nigeria on developing an advocacy brief for a National Intersex Health Guideline embedded in the National Health Policy, while the [redacted] advocacy secured a February 2024 verbal commitment from the Federal Ministry of Health to revive the Mobile Health Clinic at Wassa IDP Camp that had been non-operational for over two years. [redacted] was

[43] FG5

[44] CoA survey

[45] CoA survey

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

[47] Nigeria Outcome Harvesting Consolidation - Shared with Coralie.xlsx - Nigeria.pdf

[48] Nigeria Outcome Harvesting Consolidation - Shared with Coralie.xlsx - Nigeria.pdf

granted official membership within the National Assembly's House Committee on Disabilities in December 2023, enabling direct participation in legislative discussions on disability rights and policies.[49]

The programme also successfully mobilized against the repeal of the VAPP Act through the "Amend not Repeal" campaign. CoA members were actively involved in policy reviews, particularly the national SRH-R law review and other PWD-inclusive SRH-R policy reforms. As one CoA member stated, "*We Lead organizations actively spearheaded the impactful 'Amend not Repeal' campaign*"[50]. The programme also supported the domestication of the VAPP Act at state levels. A policy actor confirmed, "*We pushed for review of SRH-R law to remove discriminatory language*", a process that is still ongoing[51]. Concurrently, the We Lead team submitted a memorandum for the amendment of the 1999 constitution, specifically addressing critical SRH-R aspects, gender equality, and enhancing women's representation, demonstrating a commitment to systemic change.

International and regional advocacy included FEMNET supported Nigerian CoAs in designing AU-level policy campaigns and consistent targets for UPR recommendations on SRH-R acceptance .[52] FEMNET also supported the Nigeria CoAF, CoA, and RHs in different regional and global spaces that influence policy change. E.g., GIMAC, Africa Disrupt CSW, CPD, AWID, SRH-R Charter, Beijing +30, and Girls Festivals etc.

Coherence

We Lead's partnership and locally- led approach was highlighted as a strength of the programme in Nigeria. The model of intentionally funding small, women-led grassroots organisations was praised for building capacity where it was most needed. Stakeholders noted that the CoA created inclusive spaces for rightsholder leadership, while funder flexibility allowed adaptation. Participants noted that the structures in place encouraged openness, inclusivity, and joint learning.[53] While the programme successfully implemented principles of 'Leading from the South', a noted challenge was the host organisation's initial exclusion from the programme design phase, though this improved over time. Furthermore, delays in fund disbursement reportedly affected the timely implementation of planned activities, reduced momentum at the community level and the ability of CoA members to respond promptly to emerging needs or opportunities for advocacy and engagement.[54]

More generally, the programme thus successfully fostered collaboration among diverse rightsholder groups. A rightsholder from the [redacted] community reflected, "*It's amazing how the We Lead Programme promoted collaboration and partnerships. Now I have friends in intersex organizations that I can always reach out to*".[55] However, as much as the intersectionality was effective, one survey respondent felt that more intention needed to be driven towards this approach, noting how the intersex and [redacted] communities did not get visibility as much as the other groups.[56]

Coordination with other initiatives was strong, with CoA members recognized as "thought leaders" and integrated into other feminist groups. Partnerships with government (Federal Ministry of Health and Social Welfare, Federal Ministry of Humanitarian Affairs and Poverty Reduction, National Commission for Refugees, Migrants and Internally Displaced Persons) and media (investigative journalists, media houses) was key to strengthening advocacy as the partnerships ensured key agencies were actively involved in implementation processes. This helped ensure

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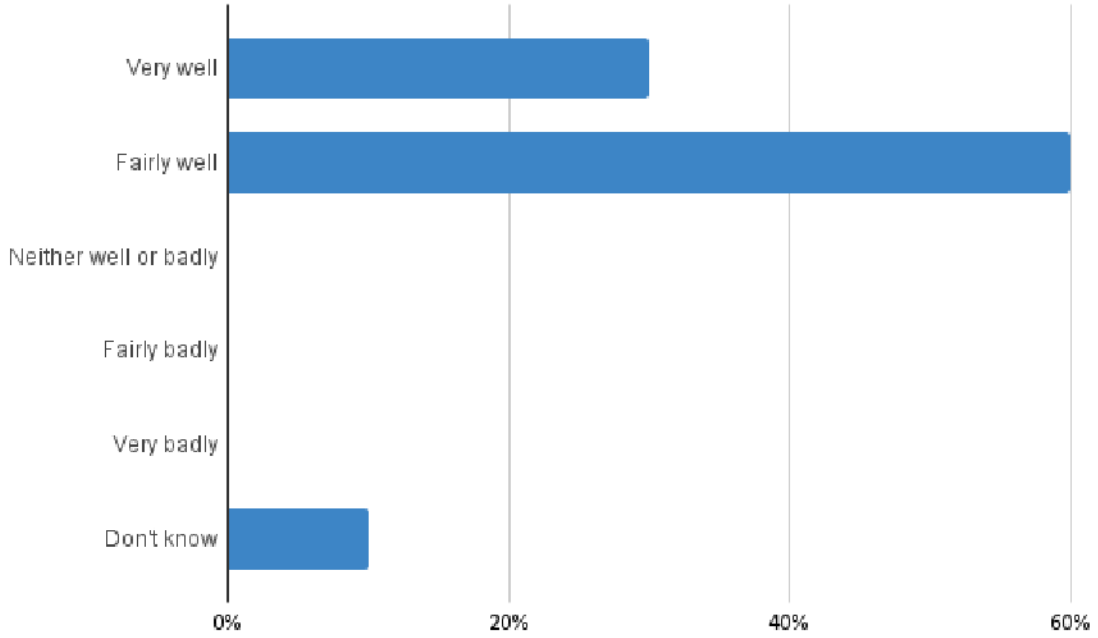
[49] Nigeria Outcome Harvesting Consolidation - Shared with Coralie.xlsx - Nigeria.pdf
[50] E1
[51] E5
[52] 2024 We Lead Results Framework
[53] CoA survey
[54] CoA survey
[55] FG4
[56] CoA survey

that the needs and rights of rightsholders were met and their stories were covered in a dignified and positive framing. It also helped raise awareness on issues such as the lack of properly furnished and equipped medical commodities and the availability of PHCs at IDP camps etc. In terms of coordinating with other relevant international initiatives, the survey of CoA organisations indicates this was done fairly well, with a further third of organisations thinking international coordination was done very well.

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



CoA members affirmed that integrating security risk assessments into their activities was quite effective as rightsholders felt safer attending activities e.g having an hotel checklist as part of security protocol, blacklisting hotels that do not comply with these checklists etc. On the other hand there were some concerns raised about project monitoring requirements and the support provided with one participant noting that "*the templates were not clearly defined and we struggled a lot*".[57]

Sustainability

There are reasons to suggest that some of the programme's outcomes are likely to continue. As the Host Organisation noted, "*The most enduring achievements are the internal systems and policies developed by CoA organizations*".[58] Rightsholders have emerged as confident advocates; a woman from an IDP camp stated, "*We will continue advocacy on GBV within the camp long after the programme has ended because we have the phone numbers that we can still call and report these cases"*.[59]**.** Key policy processes initiated are ongoing.

Participants highlighted the establishment of the "Generation Inclusion Network (Gen-I)" as a particularly strong prospect for sustainability. Gen-I is a movement of young women from diverse groups from the 6 southwestern states in Nigeria, who have come together to demand and advocate for their SRH-R starting from local to national, regional and ultimately, global level. This is the first time in Nigeria that a network of [redacted] persons, young women with disabilities and

[57] FG5
[58] E7
[59] FG3

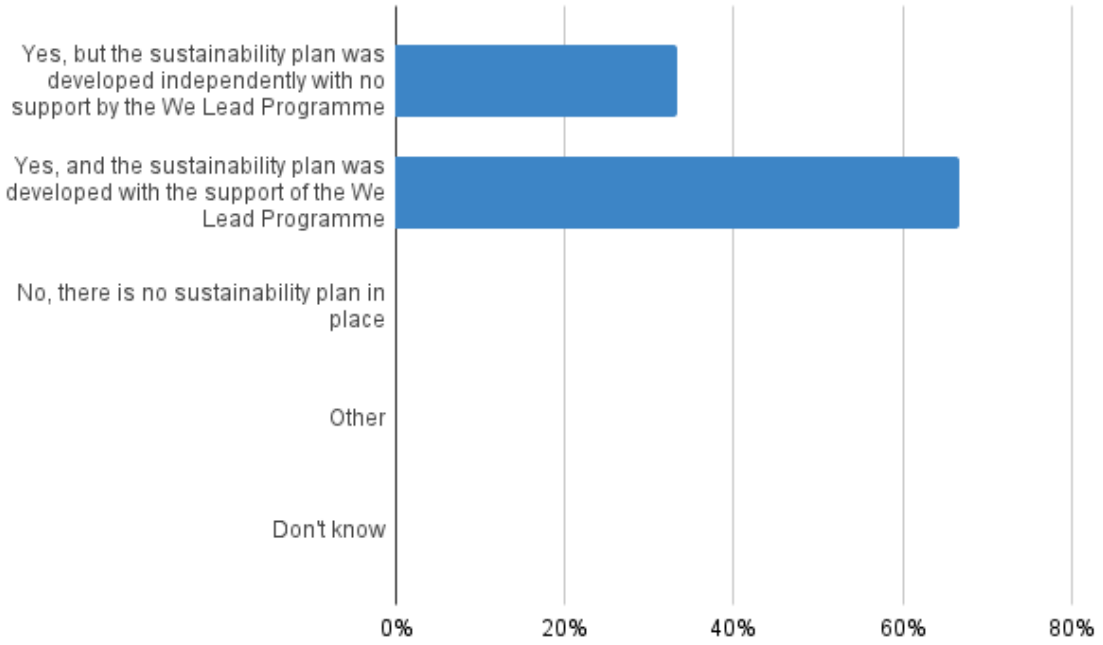
those living HIV have come together to demand SRH-R accountability.[60] Similarly, the SRH-R Drivers Program was identified as one of the key initiatives that should provide long-term benefits for rightsholders. This initiative empowers trained community influencers to lead SRH-R conversation and advocacy within their own communities. By building local capacity and fostering peer-to-peer learning, it ensures sustainability and ownership beyond the project timeline.[61]

A number of service delivery reforms, meanwhile, have been institutionalized. For example, Kuje General Hospital continues to provide services to deaf women without interpreters by retaining an in-house sign language interpreter as an employee of the facility. In Port Harcourt, the University Primary Care Management Board has adopted the iMAQI process (an online data collection toolbox called MyBox, to review how rightsholders (PLWHIV and [redacted] persons living with HIV) are treated based on healthcare service provider's values and attitudes. Using the toolbox, data from patients are collated to track feedback. Afterwards, these responses are reviewed quarterly, and collectively with the rightsholders, the healthcare facilities prioritize practical issues they can resolve before the next quarterly review cycle. In Lagos state, healthcare providers, as part of their practices, are now directly reaching out to [redacted] to report cases of Intersex persons genital mutilation.

While sustainability prospects are strong, continued investment is needed to address structural barriers such as restrictive cultural norms, government bureaucracy, and persistent accessibility gaps (healthcare service and health services). Positively, the survey indicates that all the organisations who took the survey have a sustainability plan in place, and for a majority of the organisations We Lead supported its development. It is also worth noting that Positive Vibes ran a Pathways to Sustainability workshop in June 2025 with 24 participants, 15 of whom were We Lead participants representing 5 organisations, including the host organisation.[62]

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

[60] CoA survey
[61] CoA survey
[62] E13, E14



E. Recommendations

1. Expand geographical reach to rural areas.
2. In future programmes, integrate explicit economic empowerment and mental health support components to address additional needs of rightsholders.
3. Invest further in litigation strategies alongside advocacy to set legal precedents for SRH-R, as litigation provides a more lasting solution than advocacy alone.
4. Strengthen joint lobbying efforts, including the development of position statements on issues affecting rightsholders by CoA members.
5. Formalize the network of CoAs into a national SRH-R consortium to enhance sustainability, collective bargaining power, and resource mobilization. This could include establishing an annual “We Lead SRH-R Conference” where all CoA members, young advocates, and stakeholders can come together to showcase achievements, share lessons learned, and build stronger networks. This would not only celebrate progress but also inspire continuity and sustainability.
6. Develop a standardized, simplified reporting and MEL toolkit for grassroots partners to ease the administrative burden
7. Provide more flexible funding and reporting structures so CoAs can adapt their work to realities in their communities without being constrained by rigid processes
8. Extend capacity strengthening with more sessions over a longer period of time and ensuring more inclusive support (using sign language, ensuring accessible venues, providing mentoring).