

Sexual Health and Reproductive Education Project

Final Evaluation

Mozambique



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WaterAid



In partnership with
Canada

Project Title

The Sexual Health and Reproductive Education (SHARE) Project

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Caption for cover photo

Adolescent girls after a *SHARE* event in Mozambique.

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Table of Contents

ACKNOWLEDGEMENTS.....	II
LIST OF TABLES.....	IV
LIST OF FIGURES.....	V
LIST OF ACRONYMS.....	VII
EXECUTIVE SUMMARY.....	VIII
1. BACKGROUND.....	1
1.1 CONTEXT.....	1
1.2 THE PROJECT.....	2
2. EVALUATION PURPOSE, QUESTIONS, DESIGN AND METHODS.....	7
2.1 EVALUATION PURPOSE.....	7
2.2 EVALUATION QUESTIONS.....	7
2.3 EVALUATION DESIGN AND METHODS.....	8
2.4 METHODOLOGICAL LIMITATIONS.....	16
3. FINDINGS.....	20
3.1 PARTICIPANT AND FACILITY CHARACTERISTICS.....	20
3.2 PROCESS.....	25
3.3 EFFECTIVENESS.....	32
3.4 IMPACT.....	80
3.5 SUSTAINABILITY.....	84
4. CONCLUSION AND RECOMMENDATIONS.....	89
4.1 CONCLUSION.....	89
4.2 RECOMMENDATIONS.....	93
5. ANNEXES.....	96
ANNEX A: DETAILED NARRATIVE OF PROJECT’S THEORY OF CHANGE.....	96
ANNEX B: EVALUATION MATRIX.....	96
ANNEX C: INCEPTION REPORT.....	96
ANNEX D: PERFORMANCE MONITORING FRAMEWORK.....	96
ANNEX E: DISTRICT DISAGGREGATED HEALTH FACILITY INDICATORS.....	96
ANNEX F: DISTRICT DISAGGREGATED HOUSEHOLD AND TEACHER INDICATORS.....	96

List of Tables

TABLE 1: TARGET AND ACHIEVED ENDLINE SAMPLE SIZES FOR QUANTITATIVE STUDY COMPONENTS IN MOZAMBIQUE	11
TABLE 2: TARGET AND ACHIEVED ENDLINE SAMPLE SIZES FOR KEY INFORMANT INTERVIEWS IN MOZAMBIQUE	12
TABLE 3: TARGET AND ACHIEVED ENDLINE SAMPLE SIZES FOR GROUP DISCUSSIONS AND INDIVIDUAL INTERVIEWS IN MOZAMBIQUE	13
TABLE 4: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF ADOLESCENTS/YOUTH AT BASELINE AND ENDLINE, DISAGGREGATED BY GENDER (% (%M, %F))	20
TABLE 5: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF CAREGIVERS AND COMMUNITY STAKEHOLDERS AT BASELINE AND ENDLINE, DISAGGREGATED BY GENDER (% (%M, %F))	22
TABLE 6: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF TEACHERS AT BASELINE AND ENDLINE, DISAGGREGATED BY GENDER (% (%M, %F))	23
TABLE 7: BENEFICIARIES REACHED ANNUALLY DURING PROJECT IMPLEMENTATION	28
TABLE 8: ADOLESCENTS/YOUTH WHO USED DIFFERENT TYPES OF SRH SERVICES IN THE PAST 12 MONTHS (% [95% CI])	33
TABLE 9: ADOLESCENTS/YOUTH WHO ‘STRONGLY DISAGREE’ WITH DIFFERENT STATEMENTS RELATED TO SGBV (% [95% CI])	37
TABLE 10: HEALTH FACILITIES MEETING CRITERIA FOR OFFERING QUALITY GENDER-RESPONSIVE AND ADOLESCENT-FRIENDLY HEALTH SERVICES (N (%))	42
TABLE 11: CLEANLINESS AND FUNCTIONALITY OF TOILET FACILITIES AT HEALTH FACILITIES (N (%))	44
TABLE 12: HEALTH FACILITIES MEETING THE DIFFERENT CRITERIA FOR DEVELOPING AND IMPLEMENTING WASTE MANAGEMENT SUSTAINABILITY MECHANISMS (N (%))	46
TABLE 13: ADOLESCENT GIRLS/YOUNG WOMEN WHO HAVE PARTICIPATED IN DIFFERENT SRHR ADVOCACY AND SOCIAL ACTION INITIATIVES (% [95% CI])	50
TABLE 14: ADOLESCENTS’/YOUTHS’ AVERAGE RESILIENCE SCORE (M [95% CI])	52
TABLE 15: ADOLESCENTS/YOUTH WHO DEMONSTRATE KNOWLEDGE OF DIFFERENT KEY SRHR TOPICS (% [95% CI])	54
TABLE 16: COMMUNITY MEMBERS (CAREGIVERS AND KEY COMMUNITY STAKEHOLDERS) WHO AGREE WITH DIFFERENT STATEMENTS REGARDING THE PROVISION OF SRH SERVICES TO ADOLESCENTS (% [95% CI])	62
TABLE 17: ADOLESCENTS/YOUTH WHO REPORT THEIR FAMILIES WOULD SUPPORT/FACILITATE THEM ACCESSING DIFFERENT FORMS OF SRH (%, [95% CI])	64
TABLE 18: COMMUNITY MEMBERS (CAREGIVERS AND KEY COMMUNITY STAKEHOLDERS) WHO AGREE WITH DIFFERENT STATEMENTS REGARDING GENDER INEQUALITY AND ADOLESCENTS’ SRHR (% [95% CI])	67
TABLE 19: HEALTH FACILITIES MEETING CRITERIA FOR READINESS AND ADHERENCE TO SOPs FOCUSED ON EQUITABLE SRH SERVICE ACCESS (N (%))	68
TABLE 20: HEALTH FACILITIES MEETING CRITERIA FOR DEVELOPING AND IMPLEMENTING ACTION PLANS FOLLOWING WASH IPC TRAINING (N (%))	70
TABLE 21: ADOLESCENT GIRLS/YOUNG WOMEN WHO ‘STRONGLY AGREE’ WITH DIFFERENT STATEMENTS ON THEIR ABILITY TO ADVOCATE FOR ADOLESCENT RIGHTS IN THEIR COMMUNITIES (% [95% CI])	72
TABLE 22: COMMUNITY MEMBERS (CAREGIVERS AND KEY COMMUNITY STAKEHOLDERS) WHO CORRECTLY ANSWER DIFFERENT QUESTIONS ABOUT NATIONAL LAWS AND LOCAL POLICIES AFFECTING ADOLESCENT SRHR AND GENDER EQUALITY (% [95% CI])	73
TABLE 23: OUTCOME INDICATOR LEVELS AMONG TREATMENT ARM ADOLESCENTS/YOUTH AT ENDLINE BY SELF-REPORTED <i>SHARE</i> EXPOSURE (%)	77
TABLE 24: OUTCOME INDICATOR LEVELS AMONG TREATMENT ARM COMMUNITY MEMBERS AT ENDLINE BY SELF-REPORTED <i>SHARE</i> EXPOSURE (%)	78
TABLE 25: ADOLESCENTS AND YOUNG WOMEN AGED 15-24 WHO MAKE THEIR OWN DECISIONS REGARDING SRHR (% [95% CI])	81

List of Figures

FIGURE 1: THE PROJECT'S LOGIC MODEL	5
FIGURE 2: ADOLESCENTS/YOUTH WHO USED ANY SRH SERVICES IN THE PAST 12 MONTHS (%).....	33
FIGURE 3: ADOLESCENTS/YOUTH AT ENDLINE WHO USED ANY SRH SERVICES IN THE PAST 12 MONTHS, BY GENDER, AGE, AND SCHOOL STATUS (%)	34
FIGURE 4: ADOLESCENTS/YOUTH WHO 'STRONGLY DISAGREE' WITH ALL STATEMENTS RELATED TO SGBV (%).....	36
FIGURE 5: ADOLESCENTS/YOUTH AT ENDLINE WHO 'STRONGLY DISAGREE' WITH ALL STATEMENTS RELATED TO SGBV, BY GENDER AND AGE (%)	37
FIGURE 6: ADOLESCENTS/YOUTH WHO ARE CONFIDENT THAT THEY COULD GET THEIR PARTNER TO USE CONTRACEPTION (%)	38
FIGURE 7: ADOLESCENTS/YOUTH AT ENDLINE WHO ARE CONFIDENT THAT THEY COULD GET THEIR PARTNER TO USE CONTRACEPTION, BY GENDER AND AGE (%)	39
FIGURE 8: ADOLESCENT GIRLS/YOUNG WOMEN WHO USED A MODERN METHOD OF CONTRACEPTION 'ALWAYS' IN THE PAST 12 MONTHS (%)	40
FIGURE 9: FREQUENCY WITH WHICH ADOLESCENT GIRLS/YOUNG WOMEN AT ENDLINE USED CONTRACEPTION IN THE PAST 12 MONTHS ..	41
FIGURE 10: ADOLESCENT GIRLS/YOUNG WOMEN AT ENDLINE WHO USED A MODERN METHOD OF CONTRACEPTION 'ALWAYS' IN THE PAST 12 MONTHS, BY AGE (N; RESULTS SHOULD BE INTERPRETED WITH CAUTION DUE TO SMALL SAMPLE SIZES)	41
FIGURE 11: ADOLESCENTS/YOUTH WHO ARE (VERY) SATISFIED WITH SRH SERVICES (%)	45
FIGURE 12: ADOLESCENTS/YOUTH AT ENDLINE WHO ARE (VERY) SATISFIED WITH SRH SERVICES, BY GENDER AND AGE (%)	45
FIGURE 13: LEVEL OF PARTICIPATION OF ADOLESCENT GIRLS/YOUNG WOMEN IN SRHR ADVOCACY AND SOCIAL ACTION ACTIVITIES (%) ..	49
FIGURE 14: TYPE OF SRHR RELATED ACTIVITIES ENGAGED IN BY ADOLESCENT GIRLS/YOUNG WOMEN AT ENDLINE (%).....	50
FIGURE 15: LEVEL OF PARTICIPATION OF ADOLESCENT GIRLS/YOUNG WOMEN IN SRHR ADVOCACY AND SOCIAL ACTION ACTIVITIES AT ENDLINE, BY AGE (%)	51
FIGURE 16: ADOLESCENTS/YOUTH WHO ARE KNOWLEDGEABLE OF THEIR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (%)	53
FIGURE 17: TYPES OF CONTRACEPTIVE METHODS THAT ADOLESCENTS/YOUTH AT ENDLINE ARE AWARE OF (%)	55
FIGURE 18: ADOLESCENTS/YOUTH AT ENDLINE WHO CORRECTLY IDENTIFIED FERTILE PERIODS IN THE MENSTRUAL CYCLE (%)	56
FIGURE 19: ADOLESCENTS/YOUTH AT ENDLINE WHO ARE KNOWLEDGEABLE OF THEIR SRHR (%), BY GENDER AND AGE (%)	56
FIGURE 20: TEACHERS WHO COULD CITE AT LEAST THREE HEALTH BENEFITS OF SEXUALITY EDUCATION FOR ADOLESCENTS (%).....	57
FIGURE 21: TEACHERS AT ENDLINE WHO COULD CITE DIFFERENT HEALTH BENEFITS OF SEXUALITY EDUCATION FOR ADOLESCENTS, BY GENDER (%)	58
FIGURE 22: ADOLESCENTS/YOUTH WHO BELIEVE THEY COULD SEEK SRHR INFORMATION AND SERVICES IF THEY NEEDED THEM (%).....	59
FIGURE 23: ADOLESCENTS/YOUTH AT ENDLINE WHO BELIEVE THEY COULD SEEK SRHR INFORMATION AND SERVICES IF THEY NEEDED THEM, BY GENDER AND AGE (%)	60
FIGURE 24: COMMUNITY MEMBERS (CAREGIVERS AND KEY COMMUNITY STAKEHOLDERS) WHO AGREE WITH ALL STATEMENTS REGARDING THE PROVISION OF SRH SERVICES TO ADOLESCENTS (%)	61
FIGURE 25: COMMUNITY MEMBERS AT ENDLINE WHO AGREE WITH ALL STATEMENTS REGARDING THE PROVISION OF SRH SERVICES TO ADOLESCENTS, BY GENDER AND STAKEHOLDER TYPE (%)	62
FIGURE 26: ADOLESCENTS/YOUTH WHO REPORT THEIR FAMILIES WOULD SUPPORT AND FACILITATE ALL FORMS OF SRH ACCESS (%).....	63
FIGURE 27: ADOLESCENTS/YOUTH AT ENDLINE WHO REPORT THEIR FAMILIES WOULD SUPPORT AND FACILITATE ALL FORMS OF SRH ACCESS, BY GENDER AND AGE (%)	64
FIGURE 28: COMMUNITY MEMBERS (CAREGIVERS AND KEY COMMUNITY STAKEHOLDERS) WHO AGREE WITH AT LEAST THREE STATEMENTS REGARDING GENDER INEQUALITY AND ADOLESCENTS' SRHR (%).....	66

FIGURE 29: COMMUNITY MEMBERS AT ENDLINE WHO AGREE WITH AT LEAST THREE STATEMENTS REGARDING GENDER INEQUALITY AND ADOLESCENTS' SRHR, BY GENDER AND STAKEHOLDER TYPE (%)	67
FIGURE 30: TYPES OF SRHR SERVICES PROVIDED TO ADOLESCENTS BY HEALTH CARE FACILITIES AT ENDLINE (N).....	69
FIGURE 31: ADOLESCENT GIRLS/YOUNG WOMEN WHO 'STRONGLY AGREE' WITH ALL STATEMENTS ON THEIR ABILITY TO ADVOCATE FOR ADOLESCENT RIGHTS IN THEIR COMMUNITIES (%)	71
FIGURE 32: ADOLESCENT GIRLS/YOUNG WOMEN AT ENDLINE WHO 'STRONGLY AGREE' WITH ALL STATEMENTS ON THEIR ABILITY TO ADVOCATE FOR ADOLESCENT RIGHTS IN THEIR COMMUNITIES, BY AGE (%)	72
FIGURE 33: COMMUNITY MEMBERS (CAREGIVERS AND KEY COMMUNITY STAKEHOLDERS) WHO CORRECTLY ANSWERED ALL QUESTIONS ABOUT NATIONAL LAWS AND LOCAL POLICIES AFFECTING ADOLESCENT SRHR AND GENDER EQUALITY (%)	73
FIGURE 34: COMMUNITY MEMBERS (CAREGIVERS AND KEY COMMUNITY STAKEHOLDERS) WHO PARTICIPATED OR ATTENDED ANY SOCIAL ACTION FORUM IN THE PAST 12 MONTHS (%)	74
FIGURE 35: COMMUNITY MEMBERS AT ENDLINE WHO PARTICIPATED OR ATTENDED ANY SOCIAL ACTION FORUM IN THE PAST 12 MONTHS, BY GENDER AND STAKEHOLDER TYPE (%).....	75
FIGURE 37: ADOLESCENT GIRLS/YOUNG WOMEN WHO MAKE THEIR OWN DECISIONS REGARDING SRHR (%).....	80

List of acronyms

AGYW	Adolescent Girls and Young Women
ASRHR	Adolescent Sexual and Reproductive Health and Rights
CBO	Community-based organizations
CEM	Coarsened Exact Matching
CEFM	Child, Early and Forced Marriage
CI	Confidence Intervals
CSE	Comprehensive Sexuality Education
CSL	Country Study Lead
DAC	Development Assistance Committee
DEO	District Education Officer
DHO	District Health Officer
DiD	Difference-in-Differences
DISC	Different Individuals, Same Clusters
ECP	Emergency Contraceptive Pills
FAWE	Forum for African Women Educationalists
FGD	Focus Group Discussions
FHI 360	Family Health International
FIAP	Feminist International Assistance Policy
GAC	Global Affairs Canada
HCW	Health Care Workers
HIV	Human Immuno-deficiency Virus
INGO	(international) Non-Governmental Organizations
IPC	Infection Prevention and Control
KII	Key Informant Interviews
MNCH	Maternal, Newborn and Child Health
MoH	Ministry of Health
NGO	Non-government organisation
OECD	Organisation for Economic Co-operation and Development
OPM	Office of the Prime Minister
PMF	Performance Management Framework
PPE	Personal Protective Equipment
SE	Standard Error
SGBV	Sexual and Gender-Based Violence
SHARE	Sexual and Reproductive Education
SOP	Standard Operation Procedures
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

Executive Summary

Introduction

The Sexual Health and Reproductive Education (*SHARE*) project was a five-year intervention (July 2021-March 2026) aimed at increasing the enjoyment of health-related human rights by adolescent girls and young women. The project sought to address the challenges by working in collaboration with local communities, schools, health care facilities and national, regional, and local government in three countries: Ghana, Mozambique and Uganda. In Mozambique, the project was implemented as a consortium that is constituted by *Right To Play* who are the lead in partnership with WaterAid and FHI 360 as technical partner.

In Mozambique, the project was implemented in Boane, Namaacha, Chongoene, and Chokwe districts. Here, the *SHARE* project aimed to reach 67,560 girls and 67,410 boys aged 10-19 years in primary and secondary schools. It also targeted 12,600 out-of-school adolescent girls and young women and 12,600 out-of-school adolescent boys and young men between 10-24 years.

Methods

The overall objective was to assess the project's performance in accordance with the Organisation for Economic Co-operation and Development's Development Assistance Committee Evaluation Criteria and the project's performance measurement framework including process, effectiveness, impact, and sustainability.

To achieve the evaluation's objectives, the endline evaluation used a summative, mixed-methods design, integrating quantitative and qualitative data and triangulating findings across multiple sources.

For the quantitative component of the evaluation, we employed a quasi-experimental difference-in-differences (DiD) design combined with Coarsened Exact Matching (CEM) to estimate changes in key outcomes. Data on intermediate, immediate, and ultimate outcome indicators were collected from samples across both treatment and matched comparison sites. These data were compared to baseline levels of key indicators to measure progress and impact. The DiD approach assumes that treatment and comparison groups would have followed similar trends in the absence of the intervention. As data were collected at two time points only, this assumption could not be formally tested and represents a key limitation for causal inference.

For the qualitative arm of the evaluation, a phenomenological design was used to explore the project's processes, perceived effectiveness, and sustainability, including the application of a gender-transformative approach. In-depth data were gathered through key informant Interviews and focus group discussions to gain insights into beneficiary experiences and to complement, contextualize, and enrich the quantitative findings.

In addition, secondary data and project documents were reviewed to verify selected indicators, assess implementation processes, identify potential unintended outcomes, and inform recommendations.

Findings

Process

The coherence of the *SHARE* project reflects its strategic alignment with international, national, and district policies. This includes global frameworks, such as the Sustainable Development Goal and Canada's Feminist International Assistance Policy.

The *SHARE* project demonstrates strong alignment with Mozambique's health, education, and gender policy standards, ensuring its interventions are coherent with national strategies and priorities. Ministry of Health stakeholders and consortium members highlighted the consistency of *SHARE*'s activities with Mozambique's broader goals, such as improving adolescent sexual and reproductive health, promoting gender equality, and fostering inclusive community engagement.

Furthermore, *SHARE*'s design incorporates a culturally sensitive approach, emphasizing local context and participatory methods. The involvement of community stakeholders, such as religious and cultural leaders, ensures that the project resonates with diverse community values and needs in Mozambique.

Stakeholders interviewed identified other operational challenges including resource limitations prevented the project from reaching every school and flooded roads and damaged schools which disrupted regular mentorship sessions.

The annual project reach in Mozambique ranged from 943 in the period April 2022 - March 2023 to 427,958 for April 2023 - March 2024.

Effectiveness

The endline evaluation found a mixed picture of results across outcome indicators. Several indicators showed favourable trends in treatment areas, either through improvement where comparison areas remained stable or declined, or by improving more than comparison areas:

- 1300.2: Participation in SRHR advocacy and social action initiatives among girls increased in treatment areas while declining in comparison areas (significant DiD in favour of treatment arm)

- 1110.1: SRHR knowledge increased in treatment areas, while slightly declining in comparison areas (significant DiD in favour of treatment arm)
- 1110.3: Perceived ability to seek SRHR services showed diverging point estimates, with a modest increase in treatment areas and a modest decline in comparison areas (significant DiD in favour of treatment arm); within-arm changes should be interpreted cautiously given overlapping confidence intervals
- 1120.2: Perceived family support for SRHR access increased substantially in both groups, with a more substantial increase in treatment areas (significant DiD in favour of treatment); the improvement in comparison areas suggests that broader contextual factors may have also contributed to this positive trend

For several indicators, improvements were observed in both treatment and comparison groups, suggesting that broader contextual factors – including potential exposure to similar programmes in comparison areas – may have contributed to these changes beyond the direct reach of the project:

- 1100.2: Positive attitudes toward ending SGBV increased from baseline in both groups, though more substantially in comparison areas (significant DiD in favour of comparison arm)
- 1100.3: Contraceptive negotiation self-efficacy increased from baseline in both arms, with similar levels at endline in treatment and comparison areas (DiD not significant)
- 1300.3: Average resilience scores increased from baseline in both arms, with a more pronounced increase in comparison areas resulting in a significant difference at endline; however, there was no evidence for differential change over time (DiD not significant)
- 1120.1: Positive SRHR attitudes among community members increased substantially from baseline in both arms, with a more pronounced increase in comparison areas (DiD in favour of comparison arm)
- 1120.3: Community members' knowledge of the negative consequences of gender inequality increased from baseline in both arms, though levels were already near-universal at baseline, leaving limited room for meaningful change (DiD not significant)

Several indicators showed stable trends in both the treatment and comparison groups:

- 1100.4: Percentage of sexually active girls or young women always using (or whose partner uses) a modern method of contraception (DiD not significant)
- 1200.2: Percentage of adolescents/youth aged 10-24 years who are satisfied with SRH services (DiD not significant)
- 1310.1: Percentage of girls and young women who feel they can advocate for improved adolescent rights in their communities (DiD not significant)
- 1310.2: Percentage of community members with knowledge of national laws and local policies that affect adolescents/young people's SRHR and gender equality (DiD not significant)

Some indicators showed decline in treatment as well as comparison areas, though overlapping confidence intervals preclude firm conclusions:

- 1100.1: Point estimates for SRH service utilisation declined from baseline in both arms (though overlapping confidence intervals in the treatment arm preclude firm conclusions about change),

with a larger decline in the comparison group resulting in a significant difference at endline; however, there was no evidence for differential change over time (DiD not significant)

- 1320.1: Point estimates for social action forum participation by community members declined from baseline in both arms (though overlapping confidence intervals in the treatment arm preclude firm conclusions about change), with a larger decline in comparison areas resulting in a significant difference at endline; however, there was no evidence of differential change over time (DiD not significant)

Health facility assessments showed a decline in the number of facilities meeting all criteria for good quality gender-responsive and adolescent-friendly services from two (6%) at baseline to none (0%) at endline (1200.1). Other facility-level indicators were only assessed at endline, with 16 out of 28 (57%) facilities meeting all waste management criteria (1200.3), 14 out of 28 (50%) meeting all WASH IPC action plan criteria (1220.3), and 15 out of 28 (54%) meeting all SOP readiness criteria under strict conditions, while only one facility (5%) met all SOP adherence criteria (1220.2).

Among adolescents with self-reported *SHARE* exposure (e.g., participation in *SHARE* school-based clubs or community-based SRHR mentorship programmes, attending *SHARE* community events), meaningfully higher levels were observed across 10 out of 12 SRHR-related outcomes compared to those without self-reported exposure, though this analysis should be considered exploratory.

For community members, no meaningful differences were observed between exposure groups for positive SRHR attitudes or knowledge of gender inequality consequences. In contrast, social action forum participation was notably higher among respondents with self-reported *SHARE* exposure, though this finding should be interpreted cautiously given the direct overlap between the exposure measure and the indicator itself.

There was also qualitative evidence to suggest that the project may be influencing improved SRHR knowledge, attitudes, and behaviors among adolescents. Stakeholders and beneficiaries perceived better use of SRH services. Adolescents highlighted their newfound confidence and knowledge, such as learning about mutual respect in relationships and hygiene practices. The project was deemed to have equipped adolescents with essential SRHR knowledge and skills. Further, there were some reports that the project improved the delivery of gender-responsive and adolescent-friendly health services, though this was not universal.

Impact

The *SHARE* project has demonstrated some progress in advancing its goals of increasing the enjoyment of health-related human rights among AGYW in Mozambique. Quantitative results suggest improvements in autonomous SRHR decision-making among sexually experienced women aged 15-24 years who were in a

relationship at the time of the survey, in both treatment and comparison areas. However, small analytic samples and overlapping confidence intervals mean these trends should be interpreted cautiously:

- *1000: Increased enjoyment of health-related human rights by the most marginalized and vulnerable rights-holders*

Its comprehensive approach, which integrates education, community engagement, and gender-responsive strategies, may have contributed to addressing some of the structural and socio-cultural barriers that hinder equitable access to SRHR information and SRH services. By focusing on marginalized groups, particularly AGYW, the project helped to promote gender equality and empowered adolescents to make informed decisions about their health and well-being.

Sustainability

Consideration for sustainability was at the heart of the design and implementation of the *SHARE* project. The sustainability of the *SHARE* project is rooted in its comprehensive design, contextual adaptability, and collaborative approach. Its alignment with national and district health, education, and gender policies demonstrates a strong foundation for institutionalization. Action plan development and embedding, integration of project activities and tools into routine practice have been instituted as part of the sustainability plan. However, concerns relating to funding gap and effect of health and education workforce rotation which were expected to have a negative effect on sustainability.

Conclusion and Recommendations

Conclusion

The *SHARE* project set out tackle a complex and relevant public health issue with deep socio-cultural roots in Mozambique. The project did so by leveraging evidence-based practices, community engagement, and gender-transformative strategies. Overall, recognising that there were similar interventions to the *SHARE* project that were being parallelly implemented in the comparator sites, different approaches used in sampling comparing baseline and endline for some indicators, and the complexity of the problem in focus, the project demonstrated strengths in its process, and some wins for effectiveness, impact, and sustainability within the Mozambican context. As the project concludes, the action plans developed offer a blueprint to foster sustainability; however, realization of these plans will require active commitment and implementation by government stakeholders, alongside continued technical support and accountability from *Right To Play* and partners.

Recommendations

For *SHARE* Consortium

- Lessons learnt on the project implementation should be curated and collated recognizing context-specific reasons that allowed for success and challenges experienced in specific countries.

- Efforts need to be made to ensure that the sustainability strategy designed for the project in Mozambique is fully instituted with clear structures, roles, and guidelines on implementation of high yield and community-valued project activities such as clubs beyond the project life cycle.
- Periodic follow up with health facilities, districts, and schools after the project lifetime, even if done passively, might be helpful with sustaining some project activities.
- Advocacy to government to sustain project outcomes through their continued engagement and where possible absorption of the project activities into routine work being paid by governments.
- Sustained support to continue target project activities, even if passive, should be offered to adolescents beyond the project life cycle in order to maintain project gains.
- As there will be continuous movement and redeployment of health personnel and a decay in acquired knowledge and skills on the *SHARE* project, there is a valid justification for training and retraining health care providers on quality, gender responsive, and adolescent-friendly service provision leveraging digital training platforms and dedicated personnel to offer ‘on the job’ in-house training for health facilities beyond the project lifecycle.
- For future implementation of similar interventions, there is a need to continue to embed *SHARE* project’s gender-transformative approaches that challenge traditional gender roles and power dynamics into programming. Engaging boys and men alongside adolescent girls and women ensures shared responsibility and collective action.

For Schools and District Offices for Education

- Sustain activities of the *SHARE* project including the school-based mentorship.
- Continue strengthening collaboration between schools and health facilities to support referral systems and adolescent access to youth-friendly SRHR services.
- Support and encourage adolescents and youth who want to be involved in advocacy initiatives.

For Government

- Governments should deliberately build on gains of the *SHARE* project in communities where the project was implemented and beyond, leveraging the current momentum in the community.
- Supportive supervision combined with more routine assessment of youth-friendly service delivery in health facilities should be continued to ensure health workers are providing services as per protocol.

- Linking non-financial or financial (performance payments) to compliance with evidence-based guidelines for adolescent youth-friendly care as delivered on the *SHARE* project or patient satisfaction, should be considered as a way to sustain project gains.
- Continue to improve infrastructure that promotes privacy, dignity, menstrual health management, and accessibility, particularly in schools and health facilities serving adolescents.
- Sustain implementation of CSE in educational policy by integrating SRHR into routine classroom teaching, supervision, lesson planning, and school monitoring systems, while maintaining the cascade training approach for teachers.
- Continue efforts to strengthen parents' and communities' support for adolescent SRHR through community dialogue, social and behaviour change interventions, and engagement of community and religious leaders to address persistent stigma, misconceptions, and restrictive gender norms.

1. Background

1.1 Context

Adolescence is a period of rapid physical, emotional, social, and cognitive changes that influence adolescents' thinking and decision.¹ Supporting adolescents as they undergo these changes and their transition into young adulthood is an opportunity to reduce health risks that will shape their adulthood and future generations. Numbering over 250 million as of 2020, adolescents in sub-Saharan Africa account for 20% of all adolescents globally, with the proportion expected to grow substantially by 2050.²

The Sustainable Development Goal 3, which focuses on “ensuring healthy lives and promoting well-being for all at all ages” including adolescents, has as one of its targets to ensure universal access to sexual and reproductive health (SRH) services — including family planning, information and education — and the integration of reproductive health into national strategies and programs by 2030.³ There has been substantial progress in improving the sexual and reproductive health and rights (SRHR) of adolescent girls and young women (AGYW) globally and across many sub-Saharan African countries. In 2014, a World Health Organization (WHO) report indicated that the global adolescent birth rate was 49 per 1,000 girls aged 15 to 19 years old. By 2019, this rate had declined to 44 per 1,000.

According to the World Health Organization (WHO), the adolescent birth rate in Mozambique decreased marginally from 161 births per 1,000 girls aged 15–19 years in 2010 to 159 births per 1,000 in 2020, indicating limited progress in reducing adolescent childbearing over the decade and highlighting the continued burden of adolescent pregnancy in the country.⁴ Mozambique has one of the highest rates of child marriage in the world, affecting half of all girls.⁵ According to the 2022–23 Mozambique Demographic and Health Survey, 48% of women aged 20–24 years had given birth before the age of 18 years.⁶ This has consequentially limited their opportunities in education and economic advancement. It also increases health risks for the girls and their children. At the same time, adolescent boys and young men are also faced with challenges, including harmful social norms related to masculinity, which limit their SRHR and result in adverse SRHR outcomes.⁷ In Mozambique, approximately 1 in 4 girls (23.9%) reported having experienced physical violence before the age of 18 years, while about 1 in 7 females

¹ Ahmed, S. P., Bittencourt-Hewitt, A., & Sebastian, C. L. (2015). Neurocognitive bases of emotion regulation development in adolescence. *Developmental Cognitive Neuroscience*, 15, 11–25.

² Population Reference Bureau (PRB). (2021). World population data sheet. Available from: <https://interactives.prb.org/2021-wpds/>

³ Targets of Sustainable Development 3. Available from: <https://www.who.int/europe/about-us/our-work/sustainable-development-goals/targets-of-sustainable-development-goal-3>

⁴ Adolescent birth rate (per 1,000 females aged 15–19 years) (SDG 3.7.2) – Ghana, Mozambique, And Uganda. Available from: [https://platform.who.int/data/maternal-newborn-child-adolescent-ageing/indicator-explorer-new/MCA/adolescent-birth-rate-\(per-1-000-females-aged-15-19-years\)](https://platform.who.int/data/maternal-newborn-child-adolescent-ageing/indicator-explorer-new/MCA/adolescent-birth-rate-(per-1-000-females-aged-15-19-years))

⁵ UNICEF. Child Marriage In Brief. <https://www.unicef.org/mozambique/en/child-marriage-brief>

⁶ Instituto Nacional de Estatística (INE), Ministério da Saúde (MISAU), and ICF. (2024). *Mozambique Demographic and Health Survey 2022–23*. Maputo, Mozambique, and Rockville, Maryland, USA: INE, MISAU, and ICF.

⁷ United Nations Population Fund (UNFPA). (2012). *Por escolha, não por acaso: Planeamento familiar, direitos humanos e desenvolvimento* (Suplemento do Relatório sobre a Situação da População Mundial 2012 – Moçambique). Maputo, Mozambique: UNFPA.

(14.3%) reported having experienced sexual violence before age 18.⁸ Studies reviewing institutional data—including records from the Maternal Death Surveillance and Response (MPDSR) system—indicate that teenagers account for approximately 20% to 22% of audited maternal deaths in Mozambique.^{6,9}

Indeed, adolescent sexual and reproductive health (ASRH) continues to be a major public health concern in Mozambique due to a multiplicity of structural and socio-cultural factors that contribute to poor outcomes such as child marriage, adolescent childbearing, new HIV infections, and low uptake of modern contraceptives. Further, inequalities persist among adolescents based on gender, education, rural-urban residence, and other key health indicators.^{10,11} These challenges predispose adolescents and young people to preventable deaths, poverty, and inequality.

To address these challenges, it is essential to tackle the socio-cultural and structural determinants of health through interventions and policies aimed at improving SRHR outcomes among adolescents and young people.¹² To this effect, the Government of Mozambique has prioritized the empowerment and advancement of SRHR for adolescents and young women and men through various national health, education, and youth development policies.¹³ However, there remains a lag in terms of opportunities and resources available to adolescents and young women regarding their SRHR. This is evident from the high rates in child marriage. The COVID-19 pandemic exacerbated existing gaps and inequalities affecting AGYW in relation to SRHR.¹⁴

1.2 The Project

The Sexual Health and Reproductive Education (*SHARE*) project was a five-year intervention (July 2021–March 2026) implemented to address the SRH challenges affecting AGYW. It sought to address these challenges by working in collaboration with local communities, schools, health care facilities, and national, regional, and local government in three countries: Ghana, Mozambique, and Uganda. The project adopted integrated, gender-responsive, and adolescent-friendly approaches across schools, communities, and health facilities to improve access to SRHR information and services. It was funded by Global Affairs Canada (GAC) and implemented through a consortium led by *Right To Play*, in partnership with WaterAid, the Forum for African Women Educationalists (FAWE), and FHI 360 as technical partner. Across the

⁸ Unicef Mozambique. Protection against violence, exploitation, abuse, neglect, and harmful practices

<https://www.unicef.org/mozambique/en/protection-against-violence-exploitation-abuse-neglect-and-harmful-practices>

⁹ Sacoer C, Payne B, Augusto O, Vilanculo F, Nhacolo A, Vidler M, Makanga PT, Munguambe K, Lee T, Macete E, von Dadelshen P, Sevene E; CLIP Working Group. Health and socio-demographic profile of women of reproductive age in rural communities of southern Mozambique. *PLoS One*. 2018 Feb 2;13(2):e0184249. doi: 10.1371/journal.pone.0184249.

¹⁰ Jessica L., Morris Hamid Rushwan (2015): Adolescent sexual and reproductive health: The global challenges

¹¹ República de Moçambique, Ministério do Género, Criança e Acção Social (MGCAS). *Estratégia Nacional de Prevenção e Combate aos Casamentos Prematuros em Moçambique 2016–2019*. Maputo: MGCAS; 2015.

¹² United Nations, Convention on the Rights of the Child. General Comment No. 4 (2003). Adolescent health and development in the context of the Convention on the Rights of the Child CRC/GC/2003/4

¹³ Ministério da Saúde (MISAU). *Estratégia de Saúde Sexual e Reprodutiva dos Adolescentes e Jovens*. Maputo: Ministério da Saúde; 2015.

¹⁴ SHARE Project Implementation Plan (2021 – 2026): Country Appendix: Ghana/Mozambique/Uganda

consortium, each member brought a unique area of expertise to the initiative: *Right To Play* contributed its gender-responsive, play-based learning approach; WaterAid offered its expertise in Water, Sanitation, and Hygiene (WASH); FAWE brought extensive experience in advocacy and policy change though FAWE was not active in Mozambique; and FHI 360 provided proven methodologies in girl-focused health services and empowerment.¹⁵ *SHARE*'s approach is grounded in Pulerwitz et al.'s conceptual framework that builds on the socio-ecological model of change.¹⁶

The *SHARE* project aimed to increase the use of gender-responsive SRH information and services, improve the delivery of such services, and enhance social action by key stakeholders to advocate for adolescent-friendly, gender-responsive SRH services and policies. The project sought to advance gender equality by improving access to SRHR education and gender-responsive health care for young people, especially AGYW. The project adopted an intersectional approach to equipping adolescents and young people with the knowledge and tools to make informed decisions about their reproductive health. It supported adolescents and young people in protecting themselves from disease, avoiding early or unwanted pregnancies, and becoming advocates for their own health, well-being, and rights.

The *SHARE* project had the following intermediate outcomes:

1. 1100: Increased equitable use of gender-responsive SRH information and services by adolescents and young people, particularly girls and young women;
2. 1200: Improved delivery of quality, gender-responsive, inclusive services to address SRH needs of adolescents and young people, particularly girls and young women;
3. 1300: Enhanced social action by key stakeholders, especially AGYW, to advocate for gender responsive SRH services and policies.

The project also had the following immediate outcomes:

1. 1110: Increased knowledge of SRHR amongst adolescents and young people, particularly girls and young women;
2. 1120: Improved knowledge and attitudes of men and women, including parents, caregivers, community leaders and other responsibility holders, to support adolescents and young people, particularly girls and young women, to access gender responsive SRHR information and services;
3. 1210: Increased capacity among healthcare workers in the community and at health facilities to provide gender-responsive, safe, and sanitary, inclusive and accountable services to adolescents and young people, particularly girls and young women;
4. 1220: Improved equitable access to quality, adolescent-friendly and gender-responsive, safe and sanitary SRH services for adolescents and young people, particularly girls and young women;

¹⁵ FAWE was not active in Mozambique.

¹⁶ Pulerwitz, J., Blum, R., Cislighi, B., Costenbader, E., Harper, C., Heise, L., Kohli, A., & Lundgren, R. (2019). Proposing a Conceptual Framework to Address Social Norms That Influence Adolescent Sexual and Reproductive Health. *Journal of Adolescent Health*, 64(4).
<https://doi.org/10.1016/j.jadohealth.2019.01.014>

5. 1310: Increased capacity of key stakeholders, particularly AGYW and CBOs, to advocate for evidence-based, accountable and gender-responsive SRH services and SRHR policies;
6. 1320: Increased access to evidence and knowledge exchange platforms to promote social action for gender and adolescent responsive SRH services and SRHR policies.

The project aimed to accomplish the following ultimate outcome:

1. Increased enjoyment of health-related human rights by the most marginalized and vulnerable rights-holders, particularly adolescent girls and young women in targeted areas of Ghana, Mozambique and Uganda.

1.2.1 The Logic model

The logic model which underpins the *SHARE* project was developed jointly by all consortium partners. *SHARE*'s Ultimate Outcome is increased enjoyment of health-related human rights by the most marginalized and vulnerable right-holders, particularly AGYW, in targeted areas of Ghana, Mozambique, and Uganda. Aligned with the Government of Canada's Feminist International Assistance Policy (FIAP), specifically Action Areas 1 and 2, *SHARE* promoted gender equality and the empowerment of women and girls as essential to eradicating poverty and building a more peaceful, inclusive, and prosperous world. *SHARE* addressed the significant gender, social, and structural barriers AGYW face as regards their SRHR. The Intermediate Outcomes were to increase the use of gender-responsive SRH information and services by adolescents and young people (1100), improve the delivery of quality, gender-responsive, inclusive services that address the SRHR needs of adolescents and young people, particularly girls and young (1200), and enhance local social action by key stakeholders, especially adolescents and young women, to advocate for gender-responsive SRHR services and policies (1300) (Figure 1). The project's approach was informed by evidence that improvement in quality of health service provision is associated with increased service utilization by adolescents,¹⁷ social accountability approaches positively impact SRH outcomes,¹⁸ and AGYW actively advocating for gender-responsive SRH services help build a culture of accountability that is vital for the protection and fulfilment of their SRHR.¹⁹ Across all three intermediate outcomes, the project integrated the three principles of a rights-based approach: participation (consultation with beneficiaries and key stakeholders), accountability (strengthening the capacity of AGYW to hold governments accountable), and equality and non-discrimination (seeking to reach a wide range of beneficiaries, both in and out of school, and working to advocate for inclusive policies and laws).²⁰ The detailed narrative of the project's theory of change is available in [Annex A](#).

¹⁷ Chandra-Mouli, V., Chatterjee, S., & Bose, K. (2016). Do efforts to standardize, assess and improve the quality of health service provision to adolescents by government-run health services in low and middle income countries, lead to improvements in service-quality and service-utilization by adolescents. *Reproductive Health*, 13(1): 10. <https://doi.org/10.1186/s12978-015-0111-y>

¹⁸ Gullo, S., Galavotti, C., Kuhlmann, A. S., Msiska, T., Hastings, P., & Marti, C. N. (2017). Effects of a social accountability approach, CARE's Community Score Card, on reproductive health-related outcomes in Malawi: A cluster-randomized controlled evaluation. *PLoS ONE*, 12(2).

¹⁹ Starrs, A. M., Ezeh, A. C., Barker, et al. (2018). Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission. *The Lancet* 391, 10140. [https://doi.org/10.1016/S0140-6736\(18\)30293-9](https://doi.org/10.1016/S0140-6736(18)30293-9)

²⁰ PACT and USAID. (2018). Applying Rights-Based Approaches: A practical how-to note on integrating principles of empowerment into almost any development activity. www.pactworld.org.

Figure 1: The Project's Logic Model

ULTIMATE OUTCOME	Increased enjoyment of health-related human rights by the most marginalized and vulnerable rights-holders, particularly adolescent girls and young women in targeted areas of Ghana, Mozambique and Uganda					
INTERMEDIATE OUTCOMES	1100 Increased equitable use of gender-responsive SRH information and services by adolescents and young people, particularly girls and young women		1200 Improved delivery of quality, gender-responsive, inclusive services to address SRH needs of adolescents and young people, particularly girls and young women		1300 Enhanced social action by key stakeholders especially adolescent girls and young women to advocate for gender responsive SRHR services and policies	
IMMEDIATE OUTCOMES	1110 Increased knowledge of SRHR amongst adolescents and young people, particularly girls and young women	1120 Improved knowledge and attitudes of men and women, including parents, caregivers, and community leaders to support adolescents and young people, particularly girls and young women, to access gender-responsive SRHR information and SRH services	1210 Increased capacity among healthcare workers in the community and at health facilities to provide gender-responsive, safe and sanitary, inclusive and accountable services to adolescents and young people, particularly girls and young women	1220 Improved equitable access to quality, adolescent-friendly and gender-responsive, safe and sanitary SRH services for adolescents and young people, particularly girls and young women	1310 Increased capacity of key stakeholders, particularly adolescent girls, young women and CBOs, to advocate for evidence-based, accountable and gender-responsive SRH services and SRHR policies	1320 Increased access to evidence and knowledge exchange platforms to promote social action for gender and adolescent responsive SRH services and SRHR policies
APPROACHES	• Social behavior change communication • Training of peer educators • Establish, support, monitor and mentor school-based health clubs and out-of-school youth groups • Support the delivery of CSE • Community of Practice – teachers • Community dialogues • Parent groups • Training of caregivers and community members • Mass media for community awareness		• Training of CHWs and HWs on adolescent-friendly &gender-responsive services, minimum standards for SRH, WASH and IPC • Ongoing supervision • Assess and rehabilitate HCFs as needed • Gender-responsive SRH outreach services • Support the management systems • Standard Operating Procedures for referrals • Link SGBV referrals with community and legal structures		• Training of girls on leadership and advocacy • Research on advocacy issues • Develop specific advocacy strategies and action plans • Community mechanisms for social accountability • Training on advocacy for SRH	
BARRIERS	Adolescents and young people’s lack of access to existing SRH services. Comprehensive Sexuality Education not implemented. Negative social norms and political and cultural sensitivity around SRHR. Poor capacity and technical skills among health providers to deliver quality SRH services, including understanding of gender-responsivity. Negative attitude of health providers towards adolescents and young people SRHR service needs. Limited resources, capacity, and availability of existing health facilities. Weak mechanisms for generating and sharing knowledge and learning. Limited or weak implementation of SRHR laws and policies. Resistance or pushback from various movements.					
PROBLEMS	Adolescent pregnancies, early marriage, gender-based violence, girls missing school during menstruation, lack of MHM facilities and sanitary materials, limited knowledge of SRHR issues, limited access to contraception, higher HIV rates among adolescent girls and young women, harmful traditional practices, etc.					



Adolescent girls singing at a Right To Play event.

2. Evaluation Purpose, Questions, Design and Methods

2.1 Evaluation Purpose

The *SHARE* Endline Evaluation was commissioned by the *SHARE* Consortium led by *Right To Play*. The purpose of the evaluation was to assess the project's performance in accordance with the Organisation for Economic Co-operation and Development (OECD)'s Development Assistance Committee (DAC) Evaluation Criteria and the project's performance measurement framework (PMF). The evaluation was conducted from March 2026 to May 2026, at the end of the project implementation period. Specifically, the evaluation aimed to:

- Collect endline values of outcome-level indicators as defined in the project's PMF.
- Assess the *SHARE* project's performance and achievements at endline vis-à-vis intended outcomes, baseline results, and comparison groups.
- Assess the *SHARE* project's contributions to observed results.
- Identify best practices in project implementation.
- Generate specific recommendations for each country and across the project to inform future project design and implementation.

The primary users of the *SHARE* endline evaluation results include members of the *SHARE* Consortium alongside implementing and technical partners, and the donor, GAC. Additionally, key stakeholders in the project countries, such as government ministries, (international) Non-Governmental Organizations (INGO/NGO), local authorities, school representatives, and communities are considered interested parties of the findings. The evaluation findings are intended to inform policy engagement, implementation and scale-up of future SRHR programmes, and to support organisational learning, accountability, and guide evidence-informed decision-making.

2.2 Evaluation Questions

The evaluation questions are aligned with the program theory of change and are structured to assess changes in key outcome domains, implementation processes, and sustainability. The endline evaluation of the *SHARE* project was guided by the following key questions aligned with the OECD's DAC Criteria for Evaluating Development Assistance:

- Process – Was the project successfully designed and implemented?
- Effectiveness – What worked (and did not work) to increase the main outcomes of interest for the different stakeholder groups as defined by the project? Which context variables are linked to the success of the project? Were prioritised gender equality and human rights results achieved? Did processes that led to these results align with human rights and gender equality principles (e.g., Inclusion, non-discrimination, accountability, participation, etc.)? To what extent did all stakeholders, regardless of their sex, origin, age, disabilities, have access to the processes promoted by the project and benefited from the results of the project?

- Impact - What impact did the project have on the main outcomes of interest and specifically its contribution to increased enjoyment of health-related human rights by adolescent girls and young women (focus on outcome-level indicators, including adolescent fertility rate)? How and why was this impact achieved? How did the project contribute to gender equality and advancing girls' and women's empowerment? Has the project contributed to shifting power dynamics and enabling youth, especially AGYW, to participate meaningfully in decisions affecting their health and rights? How?
- Sustainability – What steps were taken to institutionalize practices within local health systems, youth structures, or community organizations?

A detailed evaluation matrix capturing the evaluation questions, the specific topics that were explored, and the stakeholders who were targeted is presented in [Annex B](#).

2.3 Evaluation Design and Methods

2.3.1 Overview of the design

To achieve the overall evaluation's objectives, the evaluation used a mixed-methods design, combining a quasi-experimental quantitative component with qualitative inquiry to contextualize findings. A summary description of the design and methods is presented below with details available in the inception report ([Annex C](#)). Ethical approval was obtained from the Comité Nacional de Bioética para a Saúde (CNBS) in Maputo and social permission to conduct the evaluation sought from the Ministry of Health, after endorsement from the Directorates of Health in the selected provinces.

For the quantitative component, a quasi-experimental difference-in-differences (DiD) design combined with Coarsened Exact Matching²¹ was used to estimate changes in key outcomes outlined in *SHARE*'s PMF. Data on intermediate and immediate outcome indicators were collected across both treatment and purposively selected comparison sites and compared to baseline levels²² to assess changes in key outcomes over time. Surveys conducted included the Adolescent/Youth Survey, Caregiver and Community Stakeholder survey, Health Facility Survey, and Teacher Survey.

For the qualitative component, a phenomenological design was used to evaluate the *SHARE* project's process, effectiveness, impact, and sustainability. The approach centered on understanding participants lived experiences and perceptions of change resulting from the project. Key Informant Interviews (KIIs) were conducted with a diverse range of relevant stakeholders including *SHARE* Consortium members

²¹ Coarsened Exact Matching (CEM) is a statistical matching method that improves the balance between treatment and comparison groups by temporarily coarsening (i.e., categorizing) each covariate into meaningful intervals or groups. Matching is then performed exactly on these coarsened variables. This method ensures that individuals in the treatment group are matched only with individuals in the comparison group who fall into the same coarsened strata across all matching variables. While CEM performs matching using coarsened data to facilitate greater overlap and reduce model dependence, the subsequent analysis is conducted on the original, un-coarsened (continuous or categorical) data, preserving statistical precision. At baseline and endline, individuals in the treatment and comparison groups were matched on three key variables: sex (male/female), age (10-14, 15-19, 20-24), and school status (in or out of school)..

²² For several health facility indicators, only endline data are available.

(global and national levels), Ministry of Health staff at district and national levels, Ministry of Education staff at district and national levels, community health workers, religious and traditional leaders, community leaders, including women leaders and NGOs or networks working on SRHR/gender issues. The KIs aimed to provide a comprehensive understanding of how the project has influenced systems, policies, and practices at various levels. Group interviews were conducted among adolescents, young men and women and parents to document experiences of stakeholders at the target beneficiary level. In-depth interviews (IDIs) were done, as paired interviews with two interviewees from adolescents/children and parents/caregivers, to collect in-depth, personal stories of change. These interviews aimed to explore meaningful, individual-level changes in participants' knowledge, attitudes, behaviors, and lived experiences related to SRHR, as well as broader gender norms and social dynamics.

To guide the exploration of change, the evaluation drew on the principles of the Most Significant Change (MSC) approach—particularly the use of Domains of Change to elicit and structure change. However, this did not constitute a full MSC process; rather, MSC principles were adapted to help frame and interpret meaningful changes as described by participants, particularly adolescents and their parents or caregivers. These stories were structured around predefined Domains of Change, i.e., access to and use of gender-responsive SRH services; availability and quality of gender-responsive SRH services; gender norms, roles, and relations related to SRHR; and empowerment and agency of adolescents, aligned with the project's Theory of Change (ToC), to ensure consistency while allowing space for unexpected or emergent outcomes to surface. Data were collected through a combination of individual and group interviews using a 'stories of change' approach with youth and their parents/caregivers, aiming to capture shifts in the above four Domains of Change.

To further enrich and contextualize the findings, secondary data sources from both intervention and comparator sites and project documents were reviewed. This supported triangulation, helped verify outcome indicators, document implementation processes and good practices, and identify unintended outcomes. The insights generated will inform practical and strategic recommendations.

2.3.2 Sampling Approach

For the quantitative component of the endline evaluation, a multistage cluster sampling approach was employed to support efficient and cost-effective data collection across the project's geographically dispersed implementation area. Data were collected from the same villages or communities sampled at baseline in both treatment and comparison areas. The sampling frame for the treatment clusters comprised schools located in the districts where the *SHARE* project is active (Boane, Namaacha, Chongoene, and Chokwe). For the comparison sites, the sampling frame included four purposively selected districts (Chibuto, Mandlakaze, Magude, and Manhica).

For the household survey components, a Different Individuals, Same Clusters (DISC)²³ design was adopted, in which new random samples of individuals were drawn within the same clusters selected at baseline. The rationale for this design choice and its implications for analysis is explained in the Technical Note below.

Technical Note: Shift from panel design to DISC design

The *SHARE* evaluation was originally designed as a panel study, with the intention of tracking the same individuals from baseline through midterm and endline across all three countries. In Uganda and Ghana, significant challenges emerged during midterm data collection and cleaning, including higher-than-anticipated attrition, participant mobility, incomplete baseline personally identifiable information needed to locate panel respondents, and substantial identity verification issues such as mismatches in names, ages, and dates of birth. In Mozambique, where no midterm evaluation was conducted, similar operational challenges were anticipated at endline. These challenges compromised the feasibility and validity of maintaining a longitudinal cohort over time.

In response, the endline evaluation adopted a Different Individuals, Same Clusters (DISC) design. This approach represents a hybrid between a panel and a repeated cross-sectional sampling design: the same clusters are retained across time points, while new cross-sectional samples of eligible individuals are randomly drawn within those clusters at each wave. In addition to avoiding the operational challenges of individual tracking, DISC offers several advantages: it maintains adequate sample sizes by avoiding cumulative attrition, preserves many of the precision benefits associated with following the same clusters over time, and provides estimates that better reflect the realities of dynamic communities in which young people move in and out over the course of programme implementation.

The key implication of this design shift for the analysis is that the findings do not permit assessment of individual-level change in key indicators over time, as would be possible in a panel study. Instead, it enables estimation of changes at the community (cluster) level between baseline and endline. The DISC design supports difference-in-differences analyses at the group level using the original treatment and comparison clusters subject to the standard assumptions underlying DiD – including the parallel trends assumption – which are discussed in the Limitations section.

The target sample size for the Adolescent/Youth Survey was initially established at baseline and designed to detect a 13-percentage point difference-in-differences in Outcomes 1100.1 and 1100.2. For endline, the sample size calculations were reviewed and revised using updated assumptions and observed baseline parameters. Adjustments were also made to account for the observed cluster structure from baseline data. In addition, 10% padding was applied to treatment clusters and 20%

²³ Downey, J., & Kenny, A. (2024). Repeated sampling of different individuals but the same clusters to improve precision of difference-in-differences estimators: The DISC design. arXiv. <https://doi.org/10.48550/arXiv.2411.17905>arXiv

padding to comparison clusters to preserve a sufficiently large and diverse sample for matching and analysis²⁴. The required number of individuals per cluster (m) was calculated as follows:²⁵

$$m = \frac{8\sigma^2(z_{\alpha/2} + z_{\beta})^2[1 + (m - 1) \times ICC]}{MDES^2 \times K \times 4}$$

where:

m = number of individuals per cluster per time point (solved iteratively)

$\sigma^2 = \bar{p}(1 - \bar{p})$ the variance of the outcome at baseline, with $\bar{p}$ as the average of treatment and comparison proportions

$z_{\alpha/2} = 1.96$, the critical value for 95% confidence level

$z_{\beta} = 0.84$, the critical value for 80% power

$MDES = 0.13$, the minimum detectable effect size of 13 percentage points difference-in-differences

$ICC = 0.15$ or calculated from baseline data

K = effective number of clusters per arm

Table 1 presents the targeted and achieved sample sizes for the quantitative components of the Endline Evaluation conducted in Mozambique. The target sample for adolescents and youth was stratified by school status, proportionate to population estimates of in-school and out-of-school youth, with age groups equally distributed within each school status stratum. No explicit gender target was set, though enumerators aimed for an equal split between male and female respondents.

Table 1: Target and achieved endline sample sizes for quantitative study components in Mozambique

	Treatment		Comparison		Total sample	
	Target	Achieved	Target	Achieved	Target	Achieved
Adolescent/Youth Survey ^a	648	633	741	633	1,389	1,266
Caregiver/Community Stakeholder Survey ^a						
Parents/Caregivers	126	143	126	126	252	269
Community stakeholders	35	41	35	31	70	72
Subtotal	161	184	161	157	322	341
Health Facility Survey ^b	32 (+ 5)	28 (+ 5) ^c	-	-	32	28
Teacher Survey ^c	n/a	61	-	-	n/a	61

Note. ^a Achieved sample sizes reflect matched samples following Coarsened Exact Matching (CEM) with k2k procedure. For the Adolescent/Youth Survey, targets include a matching buffer of 10% for treatment and 20% for comparison clusters applied on top of the minimum sample size required for adequate statistical power. The achieved matched sample falls within the range anticipated given these buffers. ^b The additional five health facilities were included at endline only as part of a separate assessment. These facilities are not included in the analyses presented in this report. ^c Four facilities could not be reached due to logistical constraints (n=3) or refusal to participate (n=1). ^d No target was set as all eligible teachers present at the time of the school visit were invited to participate.

²⁴ The higher inflation factor for comparison areas was applied to account for greater anticipated uncertainty in achieving comparable matched samples, including potential variability in population characteristics across purposively selected comparison districts.

²⁵ In this study, the number of clusters (K) is fixed because the baseline cluster structure was already established under an original panel design. As a result, power calculations for the endline focused on identifying the minimum required number of individuals per cluster per wave (m) to detect the target effect size, holding K constant. In a DISC design implemented from the outset, it would be equally valid (or in or in some cases preferable) to determine K based on a fixed m .

The Caregiver/Community Stakeholder Survey sample size was set at approximately 25% of the Adolescent/Youth Survey sample, with community stakeholders identified through recommendations from the *SHARE* country team and local representatives. The Health Facility Survey targeted 32 facilities per country, focusing primarily on facilities previously assessed at baseline, alongside an additional cross-sectional sample of facilities that received WASH infrastructure support. The Teacher Survey adopted a census approach within selected treatment schools, with all eligible teachers available during data collection invited to participate ([Table 1](#)).

Within selected clusters, households and eligible respondents were identified using Bauer’s random walk procedure, with enumerators following predefined directions and household skip patterns to ensure random selection. Fixed respondent targets were established for each cluster, and where multiple eligible individuals were present within a household, one respondent was selected based on predefined quotas to ensure balanced representation across participant groups.

For the qualitative component, participants for Key Informant Interviews (KIIs), group discussions, and individual interviews were selected purposively based on their knowledge, experiences, and involvement in the *SHARE* project, with sampling guided by criterion sampling and the principle of information power,²⁶ to ensure adequate coverage of relevant perspectives. [Table 2](#) presents the targeted and achieved sample sizes for the KIIs conducted as part of this endline evaluation.

Table 2: Target and achieved endline sample sizes for key informant interviews in Mozambique

Location	Respondents	Planned	Achieved
Village	Community leaders, religious and women leaders, community health workers	4	4
Health Facility	Head and staff of Health Facility	4	4
School	Teacher	2	3
District/National	MoH staff and Ministry of Education	4	3
National	Consortium Partner Program Manager and staff	2	2
	INGO/NGO/UN agencies that implemented similar programs	2	2
Total		18	18

The planned sample size for the group discussions was not fully achieved across the two study sites (Namaache and Lionde). A total of 22 group discussions involving 149 participants were conducted, compared with the 26 discussions involving 208 participants that were planned. Participants included in-school adolescent girls aged 10–14 and 15–19 years, in-school adolescent boys aged 10–14 and 15–19 years, out-of-school adolescent girls and young women aged 15–24 years, out-of-school adolescent boys and young men aged 15–24 years, and parents of adolescents in both in-school and out-of-school

²⁶ Malterud K, Siersma VD, Guassora AD. Sample Size in Qualitative Interview Studies: Guided by Information Power. *Qual Health Res.* 2016;26(13):1753-1760. doi: 10.1177/1049732315617444.

groups. In contrast, more individual interviews than planned were conducted. A total of 54 individual interviews, compared with the 32 interviews originally planned, were completed across Namaache and Lionde. [Table 3](#) presents the targeted and achieved sample sizes for the group discussions and individual interviews conducted as part of the evaluation.

Table 3: Target and achieved endline sample sizes for group discussions and individual interviews in Mozambique

Study sites	Respondent types	Group discussions		Individual interview	
		Planned	Achieved	Planned	Achieved
Namaache	In school: Adolescent girls, aged 10-14 and 15-19	3 discussions with 24 participants	2 discussions with 9 participants	2 paired interviews with 4 interviewees	2 paired interviews with 4 interviewees, and 2 interviews
	In school: Adolescent boys, aged 10-14 and 15-19	2 discussions with 16 participants	5 discussions with 38 participants	2 paired interviews with 4 interviewees	3 paired interviews with 6 interviewees, and 2 interviews
	Out of school: Adolescent girls and young women, aged 15-24 years	2 discussions with 16 participants	1 discussion with 6 participants	1 pair interview with 2 interviewees	1 pair interview with 2 interviewees
	Out of school: Adolescent boys and young men, aged 15-24 years	2 discussions with 16 participants	1 discussion with 7 participants	1 pair interview with 2 interviewees	1 pair interview with 2 interviewees and 1 interview
	Parents of adolescent girls/boys in school, aged 10-19 years	2 discussions with 16 participants	1 discussion with 10 participants	2 interviewees	2 interviewees
	Parents of adolescents and young women/men out of school, aged 15-24 years	2 discussions with 16 participants	2 discussions with 12 participants	2 interviewees	2 interviewees
Lionde	In school: Adolescent girls, aged 10-14 and 15-19	2 discussions with 16 participants	3 discussions with 29 participants	2 paired interviews with 4 interviewees	2 paired interviews with 4 interviewees, and 1 interview
	In school: Adolescent boys, aged 10-14 and 15-19	3 discussions with 24 participants	4 discussions with 24 participants	2 paired interviews with 4 interviewees	1 pair interview with 2 interviewees, and 4 interviews
	Out of school: Adolescent girls and young women, aged 15-24 years	2 discussions with 16 participants	0	1 pair interview with 2 interviewees	1 pair interview with 2 interviewees, and 4 interviews
	Out of school: Adolescent boys and young men, aged 15-24 years	2 discussions with 16 participants	1 discussion with 6 participants	1 pair interview with 2 interviewees	1 pair interview with 2 interviewees, and 4 interviews
	Parents of adolescent girls/boys in school, aged 10-19 years	2 discussions with 16 participants	1 discussion with 5 participants	2 interviewees	5 interviewees
	Parents of adolescents and young women/men out of school, aged 15-24 years	2 discussions with 16 participants	1 discussion with 3 participants	2 interviewees	3 interviewees
Total		26 discussions with 208 participants	22 discussions with 149 participants	32 interviewees	54 interviewees

2.3.3 Data Collection Tools

Quantitative data were collected using structured questionnaires administered through the Adolescent/Youth Survey, Caregiver/Community Stakeholder Survey, Health Facility Survey, and Teacher Survey. These tools collected information on key areas including SRHR knowledge and attitudes, access to adolescent-friendly SRH services, sexual and gender-based violence, gender norms, advocacy participation, resilience, comprehensive sexuality education (CSE), and the availability and quality of adolescent-responsive health services, including WASH and infection prevention and control (IPC) practices. The tools were adapted and refined in collaboration with country teams to reflect local contexts, implementation approaches, and programmatic priorities within each country. Standardised quantitative tools were translated into relevant local languages, piloted prior to data collection, and administered electronically using KoBoCollect forms.

2.3.4 Data Analysis

Quantitative data were checked for consistency and completeness, cleaned, and analyzed using IBM SPSS Statistics version 30 (IBM, Armonk, New York, US).

Analyses of the household survey data were conducted at the group (cluster) level, consistent with the repeated cross-sectional (DISC) design, as individual respondents were not tracked over time. To improve comparability between treatment and comparison groups, Coarsened Exact Matching (CEM) with k2k was applied, using sex, age group, and school status as matching variables, consistent with the approach used at baseline. Residual imbalances on unmatched characteristics and compositional shifts between waves were assessed through balance checks and, where present, controlled for as covariates in the DiD models.

Given the multistage cluster sampling design, individuals within the same community are not statistically independent. All analyses accounted for clustering at the village/community level (primary sampling unit, PSU) using SPSS Complex Samples procedures with Taylor series linearization (with-replacement estimator) to obtain design-adjusted *F*-statistics, standard errors, confidence intervals, and *p*-values. The pooled analytic dataset included up to 73 unique PSUs, depending on the outcome analyzed. No differential sampling weights were applied.

We conducted descriptive and inferential statistics to describe patterns in key indicators over time and compare outcomes between treatment and comparison groups. Descriptive statistics were disaggregated by treatment status and further by sex, age, school status, and other relevant demographic characteristics in alignment with the PMF.²⁷ Health facility and teacher survey data were analyzed primarily using descriptive statistics. For all descriptive statistics, 95% confidence intervals (CIs) were calculated to guide interpretation of observed differences, particularly where statistical testing

²⁷ Endline indicator levels are additionally disaggregated by district as supplementary analysis. District-level results are not discussed in the report.

was not conducted (e.g., for disaggregated endline estimates or specific item-level changes over time).²⁸ Adjusted *F*-tests and Wald *F*-tests were used to assess whether differences between treatment and comparison arms were statistically significant.

Whereas descriptive statistics are used to characterise observed patterns in the data, inferential conclusions regarding differential change over time (and thus potential project effects) are based on DiD models that account for observed sociodemographic differences between arms and compositional changes between waves. Binary outcomes were modelled using logistic regression (CSLOGISTIC) and continuous outcomes using linear regression (CSGLM), both implemented within the SPSS Complex Samples framework to account for clustering. The validity of DiD estimates depends on the parallel trends assumption, namely that, in the absence of the intervention, outcomes in treatment and comparison groups would have changed similarly over time. Because only one pre-intervention measurement (baseline) was available, this assumption could not be empirically assessed. Moreover, given that treatment districts were purposively selected as pre-designated *SHARE* implementation areas and comparison districts were selected using different criteria, and that comparison areas could also have been exposed to other SRHR initiatives around the implementation period, this assumption may not hold. Accordingly, DiD findings should be interpreted cautiously as estimates were derived under a potentially violated assumption rather than definitive causal effects.

We examined self-reported exposure to *SHARE* and similar SRHR projects among adolescents and youth, and caregivers and key community stakeholders. Respondents were asked about their participation in specific activities in the past four years, including school-based clubs, community-based mentorship activities, community dialogues or discussion sessions, and community events related to SRHR – as well as whether these were supported by the *SHARE* project (treatment areas only). We also conducted exploratory analyses comparing outcomes between respondents who self-reported exposure to *SHARE* activities and those who reported no exposure, to examine potential patterns associated with reported participation.

All significance tests were two-sided with alpha set at 0.05.

Qualitative data from KIIs, group discussions, and individual stories of change were transcribed, translated into English where necessary, and analyzed using content analysis supported by Dedoose software (SocioCultural Research Consultants, LLC., Los Angeles, California, US). Analysis combined deductive coding based on predefined themes and inductive coding to capture emerging themes. Themes were synthesized to identify patterns related to program implementation, perceived effects, and contextual factors influencing outcomes.

²⁸ While CIs are not displayed in figures to maintain visual clarity, they were reviewed for all (subgroup) analyses and played an essential role in interpreting observed patterns.

Quantitative and qualitative findings were triangulated to identify areas of convergence and divergence and to provide contextual explanations for observed quantitative patterns

2.4 Methodological Limitations

The following methodological limitations should be considered in interpreting the evaluation findings.

- **Parallel trends assumption:** The validity of the DiD estimates relies on the parallel trends assumption, which could not be formally tested due to the availability of only one pre-intervention measurement. Comparison districts were selected at baseline to be broadly similar to treatment districts on observable characteristics, including the number of SRHR interventions, school and health infrastructure, socioeconomic status, population size, urban–rural composition, youth population size, and dominant livelihood activities. However, treatment districts were purposively selected as pre-designated *SHARE* implementation areas, which is likely to be associated with unobserved characteristics such as institutional prioritisation of SRHR, NGO presence, and community readiness for programming. In addition, comparison areas were exposed to other SRHR-related interventions before the implementation period, meaning that they might not constitute a clean no-intervention counterfactual. These factors limit the extent to which DiD estimates can be interpreted as causal effects and should be considered a fundamental constraint of the analysis. In particular, exposure of comparison areas to other SRHR-related interventions may have attenuated observed differences between arms, meaning that true project effects could be larger than what the DiD estimates suggest.
- **Absence of verified exposure data:** The evaluation did not include programme-level participation or dosage data (e.g., attendance registers, session logs, or verified exposure records). As a result, it is not possible to confirm who was exposed to *SHARE* activities, the intensity of exposure, or the specific components received. Exposure measures are therefore based on respondent self-report, which may be affected by recall error, social desirability bias, and difficulties distinguishing *SHARE* activities from other SRHR initiatives implemented in the same areas. This limitation constrains attribution of observed changes to the *SHARE* project.
- **Study design (DISC) and implications for inference:** Although the Adolescent/Youth Survey was initially designed as a longitudinal panel study, challenges related to participant tracking necessitated a shift to repeated cross-sectional (DISC) design at endline. Consequently, the analysis reflects group-level rather than individual-level change over time. While a panel design would in principle allow for stronger control of time-invariant individual characteristics, the operational challenges encountered made maintaining a valid panel infeasible, and the DISC design was considered the more defensible approach under the circumstances.

- **Incomplete health facility survey coverage:** Health facility data collection did not achieve full coverage of the intended sample. Four out of the 32 targeted facilities could not be included due to a combination of logistical constraints and non-participation. Inaccessible facilities were primarily located in remote areas with limited road access and were not reached despite targeted field team efforts and reallocation of enumerators. In addition, one facility declined participation at endline despite having been included at baseline, citing lack of formal partnership with *SHARE*. Follow-up attempts to secure participation were undertaken through local coordination channels but could not be completed within the fieldwork timeframe. As a result, a small shortfall in the intended facility sample remains.
- **Teacher survey:** As no teacher data were collected at baseline, over-time comparisons for this beneficiary group were not possible. Teacher results therefore reflect endline status rather than (programme-attributable) change. Self-reported change questions were included to provide contextual information on perceived changes over time.
- **Qualitative sample achievement:** Twenty-two of the planned 26 focus group discussions (FGDs) were completed. Lower participation among some caregiver and out-of-school groups, particularly the absence of an out-of-school girls' discussion in Lionde, reduced the depth of perspectives. While additional individual interviews were conducted to address the gaps, these did not fully replace the collective perspectives generated through FGDs. Therefore, perspectives from underrepresented groups are less extensive and should be interpreted with appropriate caution.
- **Social desirability bias:** Many indicators rely on self-reported information relating to sensitive issues (such as contraception, gender norms, sexual behaviours, and experiences of violence). Responses may have been affected by social desirability bias, underreporting, or limited ability to accurately predict future behavior. While measures were taken to enhance confidentiality and encourage honest reporting, these biases cannot be fully ruled out.
- **Recall bias:** The evaluation relied partly on respondents' reflections on changes over several years of implementation, including comparisons before and after the project. This may have affected the accuracy of recalling timelines, events, and the extent of change, particularly among adolescents, caregivers and community actors' respondents.
- **Limited assessment of long-term sustainability:** As the evaluation was conducted near the end of project implementation, it could not fully assess the longer-term continuation of project approaches beyond donor support. Findings related to sustainability should therefore be interpreted as early indications.

- **Inherent challenges in measuring attitudinal and behavioural change:** While the analysis triangulated evidence across respondent groups and data sources, changes related to attitudes, confidence, interpersonal relationships, and decision-making are inherently difficult to measure and may not always be independently verified therefore it should be interpreted with appropriate caution.

Despite these limitations, the use of mixed methods, triangulation of multiple data sources, and the inclusion of treatment and comparison sites strengthened the overall credibility and comprehensiveness of the evaluation findings.



Adolescent boy asking questions in Mozambique during club activities at school

3. Findings

3.1 Participant and Facility Characteristics

3.1.1 Adolescents/Youth aged 10-24 years

Table 4 presents socio-demographic profiles of the adolescent and youth sample at both time points.

Table 4: Socio-demographic characteristics of adolescents/youth at baseline and endline, disaggregated by gender (% (M, %F))

		Baseline		Endline	
		Treatment (n = 833)	Comparison (n = 833)	Treatment (n = 633)	Comparison (n = 633)
District (%)	Boane	29 (25, 33)		28 (31, 25)	
	Namaacha	19 (21, 16)		19 (21, 17)	
	Chongoene	24 (26, 23)		24 (23, 25)	
	Chokwe	28 (28, 28)		29 (25, 33)	
	Chibuto		39 (39, 39)		30 (25, 33)
	Mandlakaze		22 (21, 22)		32 (32, 33)
	Magude		9 (9, 8)		12 (14, 10)
	Manhica		30 (30, 31)		26 (29, 24)
Age group (%)	10-14 years	47 (49, 46)	47 (49, 46)	41 (37, 43)	41 (37, 43)
	15-19 years	48 (47, 48)	48 (47, 48)	46 (48, 44)	46 (48, 44)
	20-24 years	5 (4, 6)	5 (4, 6)	13 (14, 12)	13 (14, 12)
Gender (%)	Male	43	43	44	44
	Female	57	57	56	56
School status (%)	In school	85 (86, 84)	85 (86, 84)	79 (75, 81)	79 (75, 81)
	Out-of-school	15 (14, 16)	15 (14, 16)	21 (25, 19)	21 (25, 19)
Religion (%)	Christian	91 (88, 93)	87 (82, 91)	94 (90, 96)	91 (86, 94)
	Muslim	2 (<1, 3)	2 (2, 1)	2 (2, 1)	2 (1, 2)
	Traditional/Spiritualist	<1 (<1, 1)	2 (1, 3)	0 (0, 0)	0 (0, 0)
	Other	<1 (0, <1)	<1 (<1, <1)	<1 (1, 0)	0 (0, 0)
	No religion	7 (11, 3)	9 (14, 5)	4 (7, 2)	8 (13, 3)
	χ^2 , p-value	11.13, p = .025		9.85, p = .020	
Marital status (%)^a	Single/never married	94 (98, 91)	94 (97, 91)	94 (97, 93)	95 (98, 93)
	Married	<1 (0, <1)	<1 (<1, 0)	<1 (0, 1)	2 (0, 3)
	Divorced/separated	<1 (0, <1)	0 (0, 0)	0 (0, 0)	<1 (<1, 0)
	Widowed	<1 (0, <1)	0 (0, 0)	0 (0, 0)	0 (0, 0)
	Cohabiting/living together	5 (2, 8)	6 (2, 9)	5 (3, 6)	3 (2, 4)
	χ^2 , p-value	2.66, p = .617		4.70, p = .320	
Ever in a relationship (%)^a	Yes	71 (72, 71)	67 (67, 67)	67 (75, 61)	69 (73, 66)
	No	29 (28, 29)	33 (33, 33)	33 (25, 39)	31 (27, 34)
	χ^2 , p-value	2.13, p = .145		0.22, p = .638	
Sexual experience (%)	Had sex ever	40 (44, 37)	40 (46, 35)	34 (40, 30)	39 (43, 34)
	χ^2 , p-value	0.03, p = .960		1.66, p = .198	
Sexual activity (%)	Had sex in the past 12 months	32 (34, 31)	32 (34, 31)	29 (35, 24)	32 (36, 28)
	χ^2 , p-value	0.03, p = .958		1.50, p = .221	
National Quintile (%)	Q1 (Poorest)	<1 (<1, 0)	<1 (<1, 0)	<1 (<1, 0)	<1 (0, <1)
	Q2	<1 (<1, 0)	<1 (<1, 0)	<1 (<1, <1)	2 (1, 2)
	Q3	4 (7, 2)	5 (6, 4)	3 (4, 3)	4 (4, 4)
	Q4	46 (44, 47)	51 (49, 53)	36 (33, 37)	45 (42, 48)
	Q5 (Wealthiest)	50 (48, 51)	44 (44, 43)	60 (62, 59)	48 (52, 46)
	χ^2 , p-value	6.74, p = .150		20.09, p < .001	

Note. ^a Only asked to respondents 15 years and older. Differences between treatment and comparison groups within each wave were tested using chi-square tests. Chi-square tests are not reported for age group, gender, and school status as these variables were used as matching criteria in the CEM procedure, resulting in perfect balance between arms within each wave by design.

Age group, gender, and school status were balanced by design at each wave through the CEM matching procedure. At both baseline and endline, statistically significant differences between treatment and comparison groups were observed for religion, though distribution across categories were broadly similar between arms. At endline, a statistically significant difference was observed for wealth quintile ([Table 4](#)).

The sample composition also differed somewhat between baseline and endline within each arm. Compared to baseline, endline respondents in both arms were slightly older on average, with a larger proportion in the 20-24 years age group and a smaller proportion aged 10-14 years.²⁹ In addition, the endline sample included a slightly larger proportion of out-of-school adolescents (21%) than the baseline sample (15%).³⁰ Both arms also showed modest shifts in religious composition³¹ and socioeconomic profile.³² Treatment respondents at endline were somewhat less likely to report having had sexually experience (34%) than those at baseline (40%),³³ while the proportion of cohabiting respondents in the comparison group declined slightly from 6% to 3%.³⁴ As shown in [Table 4](#), however, these compositional differences were generally small. Because the same communities were sampled at both waves, but different individuals were interviewed, it is not possible to determine whether these differences reflect genuine population-level changes over time or sampling variability between waves.

To address observed differences between treatment and comparison arms and account for compositional shifts across waves, selected covariates were included in the DiD models. Specifically, religion³⁵, national wealth quintile³⁶, age group, and school status were included. Marital status was excluded because this variable was collected only for a subsample of respondents, and its inclusion would have substantially reduced the analytical sample due to missing data. Sexual experience was also excluded, as it may lie on the causal pathway between the intervention and key outcomes; adjusting for this variable could therefore bias estimates of the project effect.

3.1.2 Caregivers and community stakeholders

[Table 5](#) presents the socio-demographic characteristics of the caregivers and community stakeholder sample in treatment and comparison arms at baseline and endline. The two groups were broadly comparable on most socio-demographic characteristics at both time points, except for stakeholder type at baseline. In terms of compositional changes over time, endline respondents in both arms were somewhat older on average, with a larger proportion in the 40-59 years age group and a smaller proportion aged 21-39 years.³⁷ The proportion of married respondents also increased, while cohabiting

²⁹ Treatment: $\chi^2(2) = 31.92, p < .001$; comparison: $\chi^2(2) = 31.92, p < .001$

³⁰ Treatment: $\chi^2(1) = 8.74, p = .003$; comparison: $\chi^2(1) = 8.74, p = .003$

³¹ Treatment: $\chi^2(4) = 11.48, p = .022$; comparison: $\chi^2(4) = 18.27, p = .001$

³² Treatment: $\chi^2(4) = 19.76, p < .001$; comparison: $\chi^2(4) = 17.77, p < .001$

³³ Treatment: $\chi^2(1) = 4.77, p = .029$

³⁴ Comparison: $\chi^2(4) = 11.28, p = .024$

³⁵ Religion was recoded into three categories (Christian, Muslim, Other/No religion) due to small cell sizes to ensure stable estimation in the DiD models

³⁶ Wealth quintiles 1, 2 and 3 were collapsed due to small cell sizes to ensure stable estimation in the DiD models

³⁷ Treatment: $\chi^2(3) = 8.07, p = .045$; comparison: $\chi^2(3) = 13.14, p = .004$

declined and in both arms between baseline and endline³⁸. The comparison arm additionally showed shifts in gender composition³⁹ and educational level⁴⁰ over time. To adjust for these observed differences, gender, age, educational level, and marital status were included as covariates in the DiD models.

Table 5: Socio-demographic characteristics of caregivers and community stakeholders at baseline and endline, disaggregated by gender (% (M, %F))

		Baseline		Endline	
		Treatment (n = 225)	Comparison (n = 311)	Treatment (n = 184)	Comparison (n = 157)
District (%)	Boane	41 (36, 42)		36 (49, 30)	
	Namaacha	13 (15, 13)		23 (28, 21)	
	Chongoene	27 (25, 27)		21 (9, 25)	
	Chokwe	19 (24, 18)		21 (13, 24)	
	Chibuto		35 (34, 35)		27 (14, 34)
	Mandlakaze		23 (22, 23)		32 (30, 33)
	Magude		3 (3, 4)		12 (16, 10)
	Manhica		39 (40, 38)		29 (40, 23)
Stakeholder type (%)	Caregiver	82 (51, 92)	89 (61, 96)	78 (55, 87)	80 (54, 93)
	Community stakeholder	18 (49, 8)	11 (39, 4)	22 (45, 13)	20 (46, 7)
	χ^2 , p-value	5.21, p = .022		0.33, p = .567	
Age group (%)	21-39 years	45 (22, 52)	48 (30, 52)	33 (19, 39)	34 (14, 43)
	40-59 years	38 (42, 36)	35 (42, 34)	48 (45, 50)	50 (64, 43)
	60+ years	16 (35, 11)	15 (28, 11)	19 (36, 11)	17 (22, 14)
	Don't know	<1 (2, 1)	2 (0, 3)	0 (0, 0)	0 (0, 0)
	χ^2 , p-value	1.51, p = .681		0.22, p = .898	
Gender (%)	Male	24	22	29	32
	Female	76	78	71	68
	χ^2 , p-value	0.63, p = .429		0.37, p = .542	
Religion (%)	Christian	93 (94, 93)	89 (84, 90)	98 (98, 98)	96 (92, 97)
	Muslim	2 (2, 2)	2 (1, 3)	0 (0, 0)	1 (0, 2)
	Traditional/Spiritualist	2 (0, 2)	2 (3, 2)	0 (0, 0)	0 (0, 0)
	Other	<1 (0, 1)	2 (0, 2)	<1 (0, 1)	<1 (2, 0)
	No religion	2 (4, 2)	5 (12, 3)	1 (2, 1)	3 (6, <1)
	χ^2 , p-value	3.95, p = .413		3.45, p = .327	
Highest level of education (%)	No education	13 (2, 17)	17 (12, 18)	7 (4, 8)	9 (6, 10)
	Primary/Junior High School	49 (63, 45)	47 (46, 48)	57 (40, 63)	56 (42, 63)
	Secondary and above	38 (35, 38)	36 (42, 34)	37 (57, 29)	35 (52, 26)
	χ^2 , p-value	1.18, p = .555		0.79, p = .673	
Marital status (%)	Single/never married	21 (11, 25)	20 (21, 19)	26 (7, 34)	22 (12, 26)
	Married	13 (27, 9)	9 (16, 7)	24 (47, 14)	25 (44, 16)
	Divorced/separated	5 (0, 6)	6 (3, 7)	6 (4, 7)	6 (0, 8)
	Widowed	7 (0, 9)	14 (5, 16)	9 (4, 11)	8 (8, 8)
	Cohabiting/living together	53 (62, 51)	51 (55, 50)	35 (38, 34)	39 (36, 41)
	χ^2 , p-value	8.46, p = .076		1.14, p = .888	

Note. Differences between treatment and comparison groups within each wave were tested using chi-square tests.

³⁸ Treatment: $\chi^2(4) = 15.04$, $p = .005$; comparison: $\chi^2(4) = 24.25$, $p < .001$

³⁹ Comparison: $\chi^2(1) = 5.91$, $p = .015$

⁴⁰ Comparison: $\chi^2(2) = 6.28$, $p = .043$

3.1.3 Health care facilities

At endline, 28 health facilities were followed up in Mozambique, four fewer than the 32 assessed at baseline (assuming none at baseline were duplicates). The sample included four health facilities in Boane, seven in Namaacha, five in Chongoene, and 12 in Chokwe. By facility type, 14 facilities were HCF Type 1, 13 were HCF Type 2, and 1 was HCF Type 3. In addition, five health facilities were sampled that were not part of the longitudinal sample and had not been assessed at baseline. These facilities are not included in the analyses presented in this report.

3.1.4 Teachers

[Table 6](#) presents socio-demographic characteristics of the teacher sample at endline. No baseline data are available for the teacher survey in Mozambique, as the baseline assessment used a self-administered web-based format distributed through WhatsApp groups, which did not yield any responses. Teacher results should therefore be interpreted as reflecting endline status only.

Table 6: Socio-demographic characteristics of teachers at baseline and endline, disaggregated by gender (% (M, %F))

		Baseline Treatment (n = 0)	Endline Treatment (n = 61)
District (%)	Boane	-	3
	Namaacha	-	11
	Chongoene	-	54
	Chokwe	-	31
Age group (%)	21-39 years	-	49
	40-59 years	-	49
	60+ years	-	2
Gender (%)	Male	-	33
	Female	-	67



Amizade
Saudável

Adolescent boys holding up sign advocating for their health.

3.2 Process

3.2.1 Was the project successfully designed?

The *SHARE* project was designed a priori to be content and context-relevant for the country. As documented in the 2022-2023 project report,⁴¹ in-depth stakeholder consultation was prioritized as part of a formative assessment during project initiation to ensure progress achieved towards outcomes is sustainable and community driven. The stakeholder consultation was conducted in Boane and Chongoene districts in Mozambique. In all, a total of 124 stakeholders (89 F /35 M) were engaged in consultations to support adaptation of the community-based toolkit for mentors which included NGOs, government representatives, community leaders, parents and girls. The consultations focused on identifying barriers and enablers across the spheres of knowledge, attitudes, behaviours and norms; sources and instances of misinformation; and examples of best practices and positively disruptive voices. Based on the formative assessment, audience profiles targeting detailed insights into the characteristics, needs, behaviours, attitudes, and preferences were developed to address each target segment's specific needs and opportunities. These profiles assisted in selecting appropriate messages and communication channels for the intended audiences. After initial development, the draft messages underwent testing in before production to ensure the messages and materials were effectively tailored to the targeted communities. This testing phase will assess the messages' cultural sensitivity, comprehensibility, and appeal, ensuring that they are understood by the target audiences. Following the testing, the messages were refined and validated based on the feedback gathered from the pretesting. The validated messages served as the foundation for developing various communication materials on the project.

In Mozambique, CSE had never previously been operationalized and therefore the Ministry of Education, through its School Health and Nutrition department, worked with a consultant (supported by United Nations Educational, Scientific and Cultural Organization) to develop the CSE training materials. One District Education Service official reflected that the project addressed weaknesses in earlier approaches to SRHR education. He explained that previous activities relied largely on children passing information to their families, whereas the project broadened this approach by integrating SRHR into classroom teaching and involving teachers and parents.

"Our working model was already showing its limitations because of parents' reluctance to accept information when it is passed on by their own children. But the design of the SHARE project was different." (District Education Service official, male, KII, Chókwè)

3.2.2 How well was the project implemented?

Stakeholders from communities, consortium organisations, and partner NGOs described rather than introducing a completely new agenda, the *SHARE* project built on existing efforts to improve ASRH,

⁴¹ Sexual Health and Reproductive Education (SHARE). Annual Project Results Report: April 2022– March 2023

strengthen school retention, and promote gender equality. A District Education Service official in Chókwè described how the *SHARE* project built on the earlier national ASRH programme, *Geração Biz* programme.⁴² Stakeholders noted that previous initiatives had already introduced aspects of SRHR, but *SHARE* expanded their reach. District Education Service officials, teachers, health facility staff and consortium representatives also mentioned that activities in schools were linked with adolescent-friendly health services, while caregivers and community actors were also engaged. They considered this combination important because adolescents received consistent information and support across schools, health facilities and communities instead of through one setting alone.

Stakeholders from consortium partners, district education and health offices, schools, health facilities, and partner NGOs highlighted that *SHARE* was implemented through existing government and community structures rather than through parallel systems. The project implementation relied on district government departments, local implementing partners, community mentors, schools, and health facilities, with activities jointly planned and delivered across sectors. A consortium respondent explained that mentors were deliberately recruited from the project districts and communities:

"Our day-to-day work was carried out by staff in the four districts, who are actually from the community. The mentors were identified within the community."

(Consortium member, Water Aid, KII)

Health facility staff in Namaacha further noted the project's implementation approach as different from previous practice because it deliberately linked activities across schools, health facilities, and communities while engaging parents, religious leaders, community mentors, and health workers. Also, stakeholders from schools and health facilities described implementation as becoming part of routine service delivery and was delivered through their existing roles. For example, teachers incorporated CSE into classroom teaching, while health workers extended activities beyond health facilities to schools and communities.

Interviews with communities, government, consortium organisations, and partner NGOs also revealed that *SHARE* as introducing several elements that had been absent from previous adolescent SRHR programmes. While many explained that similar initiatives had already been implemented, they noted that *SHARE* broadened the scope of support by engaging boys alongside girls, involving parents and caregivers, strengthening links between schools and health facilities, and combining education, health, and WASH interventions within a single programme. A community leader explained that:

"...previous projects where I participated... the sharing of information was only for girls. The new thing was when the SHARE project said that the boys too, the parents

⁴² Chandra-Mouli, V., Gibbs, S., Badiani, R. et al. Programa Geração Biz, Mozambique: how did this adolescent health initiative grow from a pilot to a national programme, and what did it achieve?. *Reprod Health* 12, 12 (2015). <https://doi.org/10.1186/1742-4755-12-12>

must be included in the project... So, that was something new for me." (Community leader, Female, Namaacha, KII)

Interviews across stakeholder groups identified training and capacity building as one factor that supported effective project implementation. Teachers mentioned receiving training that enabled them to deliver CSE. Health facility staff reported using the approaches introduced through the project when working with adolescents in schools, health facilities, and communities. Practical training methods, particularly play-based approaches, were also mentioned as useful because they helped health workers engage adolescents during service delivery. As one health facility staff member in Chókwè explained:

"The methodology of the training sessions... was very recreational. There is a lot of play inside the training itself... We work with young people, so this helps a great deal in delivering services." (Health facility staff, female, Chókwè, KII)

Interviews with consortium members indicated that they viewed the consortium model as one of the project's strengths. They explained that each partners brought a different area of expertise while working towards the project's shared objectives, allowing the project to address ASRH through a broader range of interventions than would have been a challenge for a single organisation. A consortium member explained that:

"It was a complementary effort. The reason for creating this consortium was that we had to bring a little bit of everything to the beneficiaries... we complemented each other." (Consortium member, WaterAid, male, KII)

Consortium respondents further explained that implementation was carried out jointly with government institutions rather than independently. They described quarterly planning meetings with government representatives, joint decision-making, and implementation through existing government systems.

Despite generally positive views on project implementation, some respondents identified several factors that affected implementation. Consortium members explained that delays in obtaining baseline approval, completing the baseline study, and developing training materials postponed the start of field activities and reduced the time available for implementation. They described how political unrest, elections, cyclones, and flooding disrupted planned activities and required implementation to be adjusted. One consortium respondent reflected:

"This was a five-year project on paper, but in practice we implemented for only two and a half years... we still had to deal with months of civil unrest, on top of cyclones and floods." (Consortium member, F, Right To Play, KII)

Respondents explained that the project responded by adapting implementation, including rescheduling activities, redirecting resources, and developing an acceleration plan to complete planned activities within the remaining implementation period.

Stakeholders interviewed identified other operational challenges. For example, a District Education Service official explained that resource limitations prevented the project from reaching every school, while a teacher reported that delays to the activity schedule meant some project materials had not been fully used. Flooded roads and damaged schools disrupted regular mentorship sessions. Some AGYW could not attend sessions due to displacement, as families were moved to accommodation centers.

NGO respondents suggested that a longer implementation period would have enabled more wider reach and noted that Safe Corners were not established in all participating schools. Consortium members further explained that implementation through government systems sometimes took longer because administrative procedures had to be followed before activities could proceed.

3.2.3 Did the project reach its target?

Annual reach of the project was tracked all through implementation, between April 2022 and March 2026. The annual project reach ranged from 943 in the period April 2022 - March 2023 to 427,958 for April 2023 - March 2024. Number of direct compared to indirect beneficiaries reached was higher in April 2022- March 2023, April 2024 - March 2025 and April 2025 - March 2026, while the reverse was the case in April 2023 - March 2024 ([Table 7](#)).

Table 7: Beneficiaries reached annually during project implementation

Beneficiary	April 2022 - March 2023	April 2023 - March 2024	April 2024 - March 2025	April 2025 - March 2026
Direct beneficiaries (Young people 10-24 years)	565	162,420	70,538	209,887
In school adolescents	104	137,220	65,160	171,687
Out of School Young People	461	25,200	5378	38,200
Young people 10-24 years (Female)	378	99,480	41,825	126,765
Young people 10-24 years (Male)	187	62,940	28,713	83,122
Indirect beneficiaries	378	265,538	6,428	188,212
Parents/Caregivers	0	8,000	5,897	24,874
Community members	350	256,752	17	67,577
Health workers	18	280	89	282
Teachers	10	328	153	1,031
Mentors (School)	0	56	56	112
Mentors (Community)	0	42	42	42
All beneficiaries	943	427,958	76,966	398,099

From the exposure analysis conducted as part of this endline evaluation, adolescent and youth, and caregivers and key community stakeholders reported varying exposure to various *SHARE* activities.

Adolescents/Youth

At endline, in our study sample, 61% (M: 54%, F: 66%) of in-school adolescents and youth in treatment areas⁴³ reported having participated in a school-based club discussing health, relationships, and SRHR topics in the past four years.⁴⁴ Among out-of-school respondents,⁴⁵ 31% (M: 25%, F: 36%) reported participating in a community-based SRHR group or mentorship programme. Of those who participated in either type of club or group,⁴⁶ 42% (M: 43%, F: 42%) attended fewer than five meetings and 57% (M: 55%, F: 58%) attended five or more, with 2 respondents (<1%) unable to recall. Further, 41% (M: 40%, F: 41%) of respondents in treatment areas⁴⁷ reported attending community events or activities related to SRHR.

In comparison areas, <1% ($n=4$; M: $n=3$, F: $n=1$) of in-school respondents⁴⁸ reported participating in a school-based SRHR club, while 4% ($n=5$; M: $n=3$, F: $n=2$) of out-of-school respondents⁴⁹ reported participating in a community-based SRHR group. In addition, 2% ($n=13$; M: $n=6$, F: $n=7$) of respondents⁵⁰ reported community event attendance. Of those who participated in a club or group,⁵¹ 6 respondents attended fewer than five meetings, and 2 respondents attended five or more. As *SHARE* did not operate in comparison areas, this participation might reflect exposure to other programmes.

Among treatment area respondents who participated in one of the above activities, the large majority indicated that the activity was supported by *SHARE* or its partners, *Right To Play* and WaterAid: 88% (M: 89%, F: 86%) for school-based clubs, 92% (M: 88%, F: 95%) for community groups, and 89% (M: 91%, F: 88%) for community events. Overall, 52% (M: 46%, F: 56%) of treatment area respondents reported at least some direct exposure to *SHARE* or its partners. This figure likely underestimates true project reach for several reasons. First, these questions capture only specific reported activities and do not reflect the full range of ways in which adolescents in the treatment communities may have been exposed to the *SHARE* project, which also included teacher-delivered sexuality education through trained teachers, SBCC, community awareness-raising campaigns, and enhanced adolescent-friendly SRHR services in health facilities. Second, in-school adolescents were eligible for participating in the survey if they were enrolled in one of the *SHARE* project schools and would therefore be expected to have been exposed to project activities through their school, provided implementation took place as intended. However, enumerators in the field established a number of schools listed as *SHARE* schools, but where respondents mentioned they had not experienced any *SHARE* intervention or where only specific interventions had been experienced. For example, in Gimo (Boane district), the only *SHARE* intervention reported by respondents

⁴³ Base: in-school adolescents in treatment areas ($n=497$)

⁴⁴ In Mozambique, these school-based clubs are called Circles of Interest.

⁴⁵ Base: out-of-school adolescents in treatment areas ($n=136$)

⁴⁶ Base: adolescents in treatment areas who reported that they participated in a club or group ($n=340$)

⁴⁷ Base: all adolescents in treatment areas ($n=633$)

⁴⁸ Base: in-school adolescents in comparison areas ($n=497$)

⁴⁹ Base: out-of-school adolescents in comparison areas ($n=136$)

⁵⁰ Base: all adolescents in comparison areas ($n=633$)

⁵¹ Base: adolescents in comparison areas who reported that they participated in a club or group ($n=9$)

was after-school mentorship sessions and in Mundavene (Namaacha district), enumerators reported that "no *SHARE* schools present; no *Right To Play* mentor". In Chókwè district communities (Chiguedela, Malhazene, Hokwe, Xilembene, Mudada), several enumerators described communities where *SHARE* activities happened, with mentors present, confirming some intervention, but reported exposure being confined to schools rather than reaching the wider community. As a result, out-of-school adolescents in these communities reported no awareness of the project at all. Finally, self-reported exposure to the listed activities may reflect recall limitations given the four-year reference period, difficulty distinguishing *SHARE* activities from other school-based activities, or uncertainty about whether their experiences qualified.

Caregivers and key community stakeholders

At endline, 32% (M: 57%, F: 21%) of community members in treatment areas⁵² reported having participated in community dialogues or discussion sessions about ASRH in the past four years. Participation varied considerably by stakeholder type, with 76% of key community stakeholders reporting participation compared to 19% of caregivers. Of community members who participated⁵³, 12% (M: 3%, F: 21%) attended one session, 21% (M: 23%, F: 18%) attended two to three sessions, and 67% (M: 73%, F: 61%) attended three or more sessions. Additionally, 32% (M: 53%, F: 24%) of community members in treatment areas⁵⁴ reported attending community or awareness-raising events, again with a marked difference between key community stakeholders (73%) and caregivers (20%).

In comparison areas, overall participation was lower: 25% (M: 46%, F: 15%) of community members⁵⁵ reported participating in community dialogues and 20% (M: 40%, F: 11%) reported attending awareness-raising events. The same striking difference between stakeholder types was observed: 52% of key community stakeholders vs. 18% of caregivers for dialogue participation, and 48% vs. 13% respectively for awareness-raising events. Of community members who participated in community dialogues,⁵⁶ 23% (M: 22%, F: 25%) attended one session, 44% (M: 44%, F: 44%) attended two to three sessions, and 33% (M: 35%, F: 31%) attended three or more sessions. As *SHARE* did not operate in comparison areas, this participation might reflect exposure to other programmes.

Among treatment area respondents who participated in one of the above activities, the large majority indicated that the activity was supported by *SHARE* or its partners, *Right To Play* and WaterAid: 69% (M: 63%, F: 75%) for community dialogues and 66% (M: 68%, F: 65%) for community or awareness-raising events. Overall, 25% (M: 38%, F: 20%) of treatment area respondents (caregivers: 17%; key community stakeholders: 51%) reported at least some direct exposure to *SHARE* or its partners. Enumerators reported several caregivers in Chókwè district communities reported no awareness of the project at all.

⁵² Base: all community members in treatment areas (n=184)

⁵³ Base: community members in treatment areas who reported that they participated (n=58)

⁵⁴ Base: all community members in treatment areas (n=184)

⁵⁵ Base: all community members in comparison areas (n=157)

⁵⁶ Base: community members in comparison areas who reported that they participated (n=36)



Adolescent girls in Mozambique during clubs.

3.3 Effectiveness

This section presents findings for the project's intermediate outcomes (1100, 1200 and 1300) and their associated immediate outcomes. For each indicator, descriptive statistics are presented to summarize observed patterns at baseline and endline for the treatment and comparison groups. While these descriptive results account for the clustered sampling design through adjusted standard errors and confidence intervals, they do not adjust for observed differences in sample composition between groups or across survey waves. Consequently, changes in observed proportions may partly reflect compositional changes in the sample rather than true changes in the outcome indicators. They should therefore be interpreted as descriptive estimates rather than as evidence of project effects. Conclusions regarding differential change over time – and thus potential project effects – are based on adjusted DiD analyses, which account for observed sociodemographic differences between groups and compositional shifts between waves (see [Section 3.1](#)). The full results table is presented in [Annex D](#) and disaggregated by treatment district in [Annex E and F](#).

3.3.1 Intermediate Outcome 1100: Increased use of equitable, gender-responsive SRH information and services

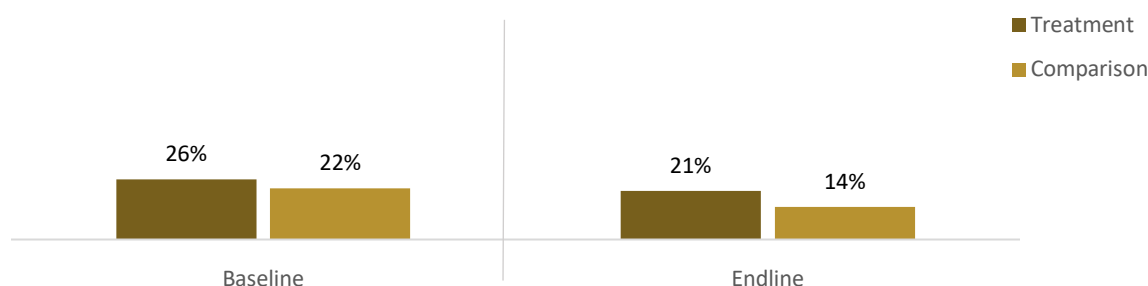
Intermediate Outcome 1100 aimed to increase equitable use of gender responsive SRHR information and SRH services by adolescents and young people, particularly girls and young women. This outcome was measured using four indicators.

Indicator 1100.1: Percentage of adolescents/youth aged 10-24 years who visited or sought help for SRH services in the past 12 months

As part of the Adolescent/Youth survey, respondents were asked if they had visited or sought help for five different SRHR services – (a) accurate information and counselling on sexual and reproductive health; (b) information, counselling, and care related to sexual function and satisfaction; (c) prevention, detection, and management of sexual and gender-based violence and coercion; (d) choice of safe and effective contraceptive methods; and (e) prevention, detection, and treatment of STIs and reproductive tract infections – in the past 12 months. Respondents were counted towards the indicator if they had used one or more of these services.

At baseline, service utilization was slightly higher in the treatment group (26%; 95% CI [24%, 29%]; M: 27%, F: 25%) than in the comparison group (22%; 95% CI [19%, 26%]; M: 19%, F: 24%), although the difference should be interpreted cautiously given overlapping confidence intervals. By endline, point estimates declined in both arms, with 21% (95% CI [18%, 26%]; M: 18%, F: 24%) of treatment group respondents and 14% (95% CI [11%, 15%]; M: 10%, F: 17%) of comparison group respondents reporting service utilization. The difference between groups at endline was significant (Adjusted $F(1, 70) = 7.76$, $p = .007$). The DiD analysis, controlling for observed sociodemographic differences between groups, did not reveal a statistically significant effect ($B = -0.33$, $SE = 0.27$, 95% CI [-0.87, 0.21], $p = .230$), indicating no

evidence of differential change in service utilization between treatment and comparison groups over time (Figure 2).



Base: All adolescents (Baseline treatment n=833, comparison n=833; Endline treatment n=633, comparison n=633)

Figure 2: Adolescents/youth who used any SRH services in the past 12 months (%)

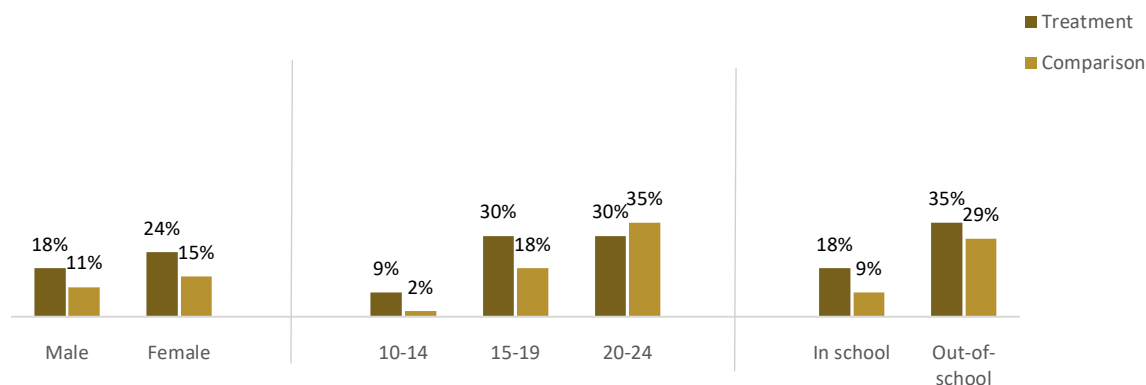
Table 8 presents an overview of utilization rates for different types of SRH services. Results show a mixed picture across service types between baseline and endline. In the treatment group, utilization of information and counselling on SRH increased, while other service types generally declined, although confidence intervals overlapped for some estimates. In the comparison group, declines were observed across most service types, whereas utilization of information and counselling on SRH remained broadly stable. At endline, statistically significant differences between arms were observed for information and counselling on SRH and for SGBV-related services.

Table 8: Adolescents/youth who used different types of SRH services in the past 12 months (% [95% CI])

Service type	Baseline		Endline	
	Treatment (n = 833)	Comparison (n = 833)	Treatment (n = 633)	Comparison (n = 633)
Accurate information and counselling on SRH	11 [9, 14]	7 [5, 9]*	16 [13, 19]	8 [6, 11]**
Information, counselling, and care related to sexual function and satisfaction	11 [9, 14]	6 [5, 9]**	7 [5, 10]	4 [3, 7]
Prevention, detection, and management of sexual and gender-based violence and coercion	8 [6, 11]	4 [3, 7]*	5 [3, 7]	1 [0, 2]***
A choice of safe and effective contraceptive methods	18 [15, 20]	15 [11, 18]	11 [8, 15]	8 [5, 11]
Prevention, detection, and treatment of STIs and reproductive tract infections	15 [13, 18]	12 [9, 15]	6 [4, 8]	4 [3, 6]
Used any SRH services	26 [24, 29]	22 [19, 26]	21 [18, 26]	14 [10, 18]**

Note. Base: All adolescents. Differences between treatment and comparison groups within each wave were tested using Adjusted F-tests. Confidence intervals and p-values are adjusted for the complex sampling design. * $p < .05$, ** $p < .01$, *** $p < .001$.

At endline, point estimates suggest slightly higher service utilization among female respondents in both arms, though overlapping confidence intervals preclude drawing definitive conclusions. As expected, SRH service utilization appeared to increase with age, with higher rates observed among older adolescents and youth in both groups. In terms of school status, out-of-school youth reported higher utilization rates than in-school youth in both treatment and comparison groups ([Figure 3](#)).



Base: All adolescents (Treatment and comparison (balanced) male n=278, female n=355, age 10-14 n=258, age 15-19 n=291, age 20-24 n=84, in school n=497, out of school n=136)

Figure 3: Adolescents/youth at endline who used any SRH services in the past 12 months, by gender, age, and school status (%)

Survey respondents were also asked about potential barriers that would hinder them from seeking SRH services at health facilities or community or youth centres. At baseline, barriers were reported by very few respondents across both arms (less than 3%), precluding meaningful conclusions about barriers to service utilization at that time point. At endline, barriers remained infrequently reported, with the highest cited barrier – embarrassment – reported by 14% of treatment group respondents and 6% of comparison group respondents. Difficulty reaching facilities was cited by 6% of treatment and 5% of comparison respondents. Given the very small proportions reporting any barrier, these findings should be interpreted as indicative only and do not allow for reliable conclusions about the nature or prevalence of barriers to SRH service utilization in the study areas.

Contrary to the survey, many health workers and district health officials interviewed as part of the qualitative component of the evaluation perceived that more adolescents sought SRH services during the project period. Specifically, they highlighted that adolescents were increasingly seeking counselling, HIV testing, family planning, contraceptive methods (including condoms, pills and implants), antenatal care and counselling, with several returning for follow-up care and some encouraging partners or peers to seek services after learning about SRHR through the project. They also perceived an increase in demand for ASRH services. District health officials explained that the *SHARE* project had strengthened adolescent engagement with SRH services by making them more accessible and creating new patterns of service utilisation.

Out-of-school young women in Namaacha described seeking advice from nurses about contraception and menstrual concerns, returning for follow-up consultations, and becoming increasingly confident to seek care independently whenever they experienced health concerns. An out-of-school young woman in Lionde described SRH care including using contraception as part of her routine health practices.

*"It [reasons for using services] was because of things like looking after my body, going to hospital appointments, and using contraception to avoid getting pregnant."
(Out-of-school young woman, 15–24 years, Lionde, IDI)*

In-school girls in Lionde likewise reported accessing family planning and contraceptive implants, receiving counselling on procedures, possible side effects and follow-up care, and generally described these services positively.

Out-of-school young men in Namaacha and Lionde reported obtaining condoms from pharmacies, accessing HIV self-tests and HIV testing, accompanying partners for contraceptive implants, and consulting health workers when they had questions. They also participated in outreach activities where health workers distributed condoms, HIV tests and SRH information.

Improved SRHR knowledge, mentorship, adolescent-friendly infrastructure and supportive provider attitudes were identified as factors that encouraged adolescents to seek SRH services. Privacy during consultations was equally valued. Adolescents appreciated spaces where they could discuss sensitive issues without fear of being overheard, while health workers noted that private, adolescent-friendly environments helped young people feel comfortable using the services. Girls also highlighted that access to both male and female providers made it easier for adolescents to discuss sensitive issues with a provider of their preferred sex. Referral pathways and community engagement further supported utilisation. Teachers, mentors and health workers described referring adolescents between schools and health facilities, while community dialogues and parental engagement sessions helped ease some caregivers' concerns about adolescents accessing SRH care. Girls in one FGD in Lionde noted that improved communication with caregivers following these dialogues reinforced their confidence to seek services.

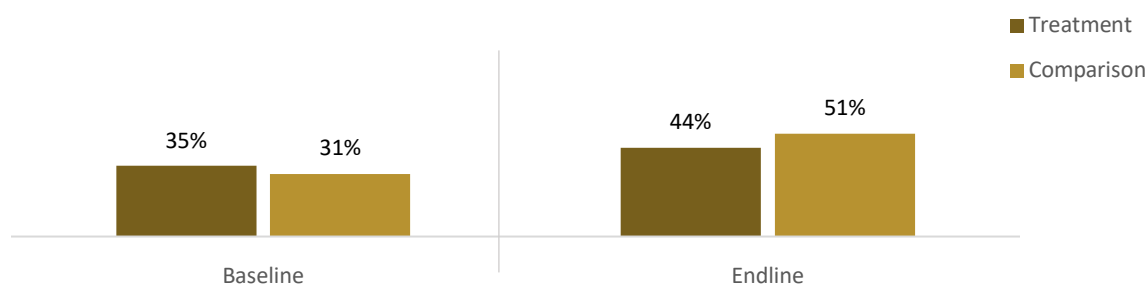
Despite these gains, respondents identified several barriers that continued to limit access and utilisation, particularly among younger adolescents and girls. Shame and embarrassment remained the most commonly reported barrier, particularly around requesting condoms. Participants noted that some young people were reluctant to request condoms from health facilities because they feared being judged by health workers or community members. One participant explained:

"People are still deeply ashamed to go looking for condoms" (Out-of-school young man, 15–24 years, Maelane, Paired interview)

Indicator 1100.2: Percentage of adolescents/youth aged 10-24 who demonstrate positive attitudes towards ending SGBV

To further measure Intermediate Outcome 1100, we assessed changes in adolescents' attitudes toward SGBV topics and issues. Survey respondents were asked to indicate their level of agreement with five statements about controlling and violent behaviors in intimate relationships, including physical violence, sexual coercion, verbal abuse, and controlling behavior. If they answered that they 'strongly disagreed' with each of these scenarios, they were counted towards the indicator. It should be noted that this represents a conservative threshold: respondents who selected 'disagree' rather than 'strongly disagree' were not counted towards the indicator, meaning the reported figures likely underestimate the broader proportion of adolescents with positive attitudes toward ending SGBV.

At baseline, the proportion of adolescents who strongly disagreed with all manifestations of SGBV was similar in the treatment group (35%; 95% CI [31%, 39%]; M: 36%; F: 34%) and the comparison group (31%; 95% CI [27%, 35%]; M: 37%, F: 27%). By endline, both groups showed increases in the rejection of these behaviors, with the comparison group (51%; 95% CI [45%, 58%]; M: 54%; F: 49%) improving considerably more than the treatment group (44%; 95% CI [38%, 49%]; M: 48%; F: 41%; [Figure 4](#)). The difference between groups at endline was not statistically significant (Adjusted $F(1, 70) = 2.87, p = .095$).



Base: All adolescents (Baseline treatment $n=833$, comparison $n=833$; Endline treatment $n=633$, comparison $n=633$)

Figure 4: Adolescents/youth who 'strongly disagree' with all statements related to SGBV (%)

The DiD analysis, controlling for observed sociodemographic differences between groups, yielded a significant difference between groups over time in the opposite direction to what would be expected ($B = 0.46, SE = 0.22, 95\% \text{ CI } [0.03, 0.89], p = .035$), indicating that the comparison group improved significantly more than the treatment group between baseline and endline. The quantitative evidence therefore does not support a positive contribution of *SHARE* to improvements in attitudes toward ending SGBV relative to comparison areas. The improvement observed in both groups may reflect a range of factors beyond the project, including broader societal factors and exposure to other programmes, such as the United Nations Population Fund (UNFPA) Mozambique 10th Country Program (2022-2026)⁵⁷ and the Gaza-Mandlakaze—VIVA+ SRHR program⁵⁸ which were being implemented in comparator sites over the timeline of the intervention.

⁵⁷ UNFPA, 2025. United Nations Population Fund (UNFPA) Mozambique 10th Country Programme (2022-2026). Available from: https://www.unfpa.org/sites/default/files/2026-02/Mozambique%2010th%20CPE%20Report_Revised%20Final%20282%29.pdf

⁵⁸ Inquerito sobre ONG OCB's da saude sexual reprodutiva Distrito de Mandlakazi 2026

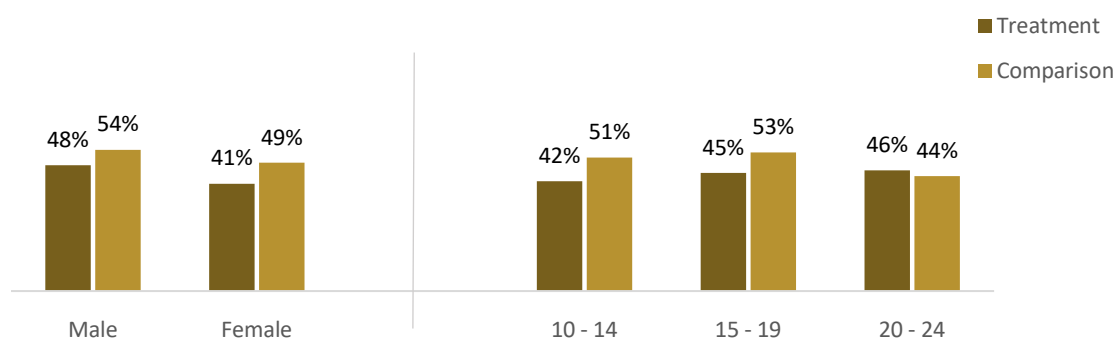
Table 9 presents the proportion of respondents that strongly disagreed with each individual statement. Strong disapproval of hitting if unfaithful declined in both arms, while strong disapproval of nagging-related hitting and sexual coercion increased in both arms. Most adolescents (>54%) displayed a strong disapproval towards manifestations of SGBV in most of the statements. The item showing consistently lower levels of strong disagreement was the statement *“It is ok for a girl/woman to set limits on how her boyfriend dresses”* (T: 54%, C: 60% at endline); however, which also increased from baseline in both arms. Unlike the other statements – which address male-perpetrated violence and coercion – this item concerns controlling behaviour by girls toward their partners and may therefore measure a conceptually distinct dimension of gender dynamics in relationships.

Table 9: Adolescents/youth who ‘strongly disagree’ with different statements related to SGBV (% [95% CI])

	Baseline		Endline	
	Treatment (n = 833)	Comparison (n = 833)	Treatment (n = 633)	Comparison (n = 633)
It is ok for a boy to insult his girlfriend	89 [86, 91]	90 [88, 92]	91 [89, 93]	90 [87, 93]
It is ok for a boy to hit his girlfriend if she has been unfaithful	91 [89, 93]	91 [89, 93]	82 [79, 85]	82 [78, 86]
It is ok for a boy/man to hit his girlfriend if she is constantly nagging	80 [78, 83]	80 [77, 83]	90 [87, 92]	88 [85, 91]
It is ok for a boy/man to push a girl/ woman into having sex if they have been dating	80 [78, 81]	81 [79, 84]	91 [88, 93]	89 [86, 92]
It is ok for a girl/woman to set limits on how her boyfriend dresses	42 [38, 46]	40 [35, 44]	54 [48, 59]	60 [54, 66]
Strongly disagree with all statements	35 [31, 39]	31 [27, 35]	44 [38, 49]	51 [45, 58]

Note. Base: All adolescents. Differences between treatment and comparison groups within each wave were tested using Adjusted F-tests. Confidence intervals and *p*-values are adjusted for the complex sampling design. * *p* < .05, ** *p* < .01, *** *p* < .001.

At endline, results were broadly similar across gender and age groups in both treatment and comparison arms, with only slight variations in point estimates and overlapping confidence intervals (**Figure 5**).



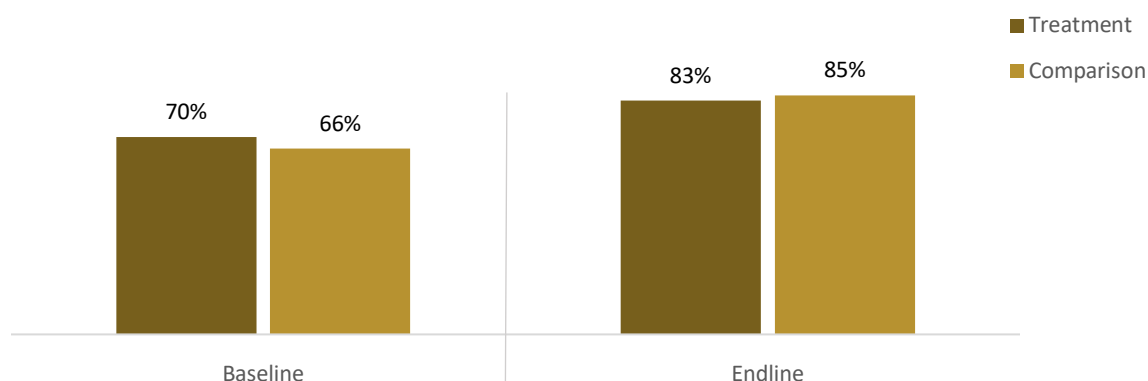
Base: All adolescents (Treatment and comparison (balanced) male n=278, female n=355, age 10-14 n=258, age 15-19 n=291, age 20-24 n=84)

Figure 5: Adolescents/youth at endline who 'strongly disagree' with all statements related to SGBV, by gender and age (%)

Indicator 1100.3: Percentage of adolescents/youth aged 15-24 who are confident that they could get their partner(s) to use contraceptives/condoms if they desired

As a third indicator for Intermediate Outcome 1100, we measured adolescents' perceived self-efficacy in contraceptive negotiations with (future) partners. Respondents were asked about their confidence in being able to get a partner to use modern contraceptives if they wanted to, with the question framed in the context of future sexual activity for those not yet sexually active. At baseline, these questions were only asked to respondents aged 15 years and older in relationships (married, cohabiting, or dating). At endline, we expanded the survey to include all respondents, recognizing that contraceptive negotiation self-efficacy is relevant beyond current relationships and can reflect anticipated future sexual scenarios. However, to ensure comparability with baseline, the analysis presented here uses the same restricted subsample at both baseline and endline: adolescents/youth aged 15 years and older who were married, cohabiting, or in a relationship.

At baseline, confidence in contraceptive negotiation was broadly similar between the treatment group (70%; 95% CI [65%, 75%]; M: 67%, F: 73%) and comparison group (66%; 95% CI [61%, 71%]; M: 66%, F: 66%), with overlapping confidence intervals indicating no conclusive difference between arms. By endline, both groups increased, with 83% (95% CI [74%, 89%]; M: 84%, F: 81%) in the treatment group and 85% (95% CI [79%, 89%]; M: 89%, F: 81%) in the comparison group (Figure 6). The difference between groups at endline was not statistically significant (Adjusted $F(1, 70) = 0.18$, $p = .669$).



Base: Adolescents/youth who are married, cohabiting/living together, or in a relationship (Baseline treatment $n=283$, comparison $n=301$; Endline treatment $n=196$, comparison $n=200$)

Figure 6: Adolescents/youth who are confident that they could get their partner to use contraception (%)

The DiD analysis, controlling for observed sociodemographic differences between groups, did not reveal a statistically significant effect ($B = 0.35$, $SE = 0.36$, 95% CI [-0.38, 1.08], $p = .340$), suggesting no differential change between arms over time. The quantitative evidence therefore does not support a positive contribution of *SHARE* to improvements in perceived self-efficacy in contraceptive negotiations. The improvement observed in both groups may reflect a range of factors beyond the program, including

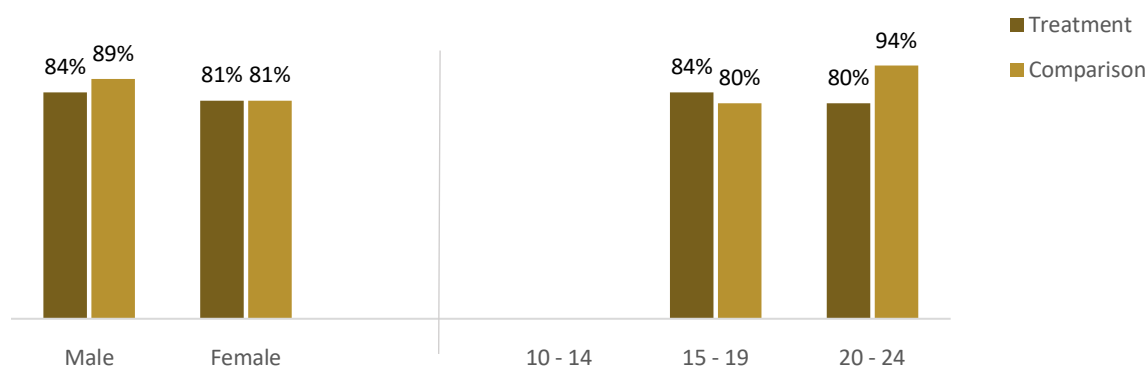
broader societal factors and exposure to other programmes, although the available data do not permit determination of the reasons underlying this pattern. It is important to note that this finding is specific to adolescents aged 15 years and older who were in a relationship at the time of the survey rather than the full adolescent and youth population.

While there was no statistically significant difference in the quantitative evidence, the qualitative evidence gathered revealed some adolescents and young people including boys and girls who described increased confidence to discuss and agree on contraceptive use within relationships. An in-school girl in Lionde in an FGD described a change in relationship dynamics. She explained that relationships had become more equal and that she now felt able to insist on condom use before sex:

“But now we know that sex is a negotiation. I tell my boyfriend: we’re going to use a condom. If he says he can’t, nothing happens” (In-school girls, 15–19 years, Lionde, FGD).

However, some adolescents remained hesitant to discuss contraception and relationships. An in-school young man from Namaacha explained that although he felt more comfortable talking about sexual and reproductive health than before, he did not often discuss contraception and relationships with the opposite sex. Asked what made him afraid or shy, he answered, “lack of confidence”.

At endline, overlapping confidence intervals suggested that levels of contraceptive negotiation self-efficacy were broadly similar across most gender and age subgroups. The only exception was in the comparison arm, where respondents aged 20-24 appeared to have higher self-efficacy than those aged 15-19 years (Figure 7).



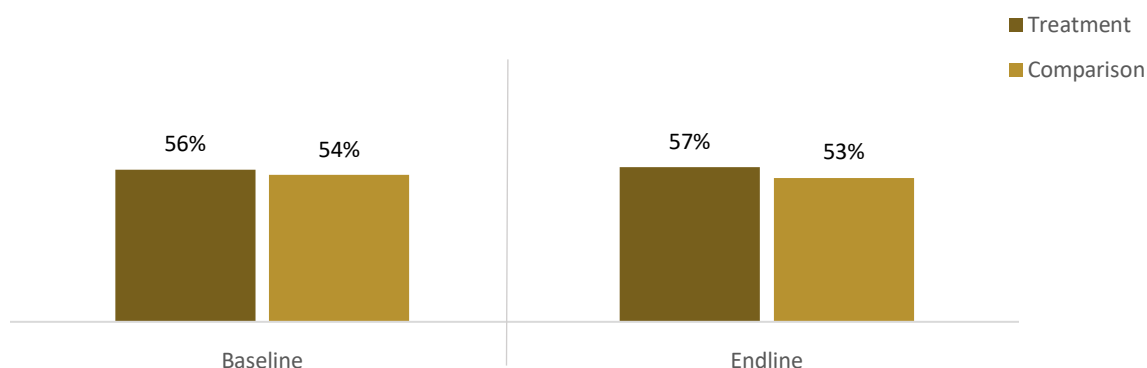
Base: Adolescents/youth who are married, cohabiting/living together, or in a relationship (Treatment male n=102, female n=94, age 15-19 n=109, age 20-24 n=65; Comparison male n=91, female n=109, age 15-19 n=116, age 20-24 n=65)

Figure 7: Adolescents/youth at endline who are confident that they could get their partner to use contraception, by gender and age (%)

Indicator 1100.4: Percentage of sexually active girls or young women always using (or whose partner uses) a modern method of contraception

To assess consistent use of modern contraception among sexually active female youth, we examined two key aspects of contraceptive behaviour: the frequency of use and the type of method. Respondents were counted towards this indicator only if they reported both always using contraception and specifically using modern contraceptive methods.⁵⁹

At baseline, 56% (95% CI [48%, 63%]) of sexually active girls and young women in the treatment group and 54% (95% CI [46%, 61%]) in the comparison group met both criteria. By endline, estimates remained stable at 57% (95% CI [44%, 69%]) in the treatment group and 53% (95% CI [44%, 62%]) in the comparison group ([Figure 8](#)).



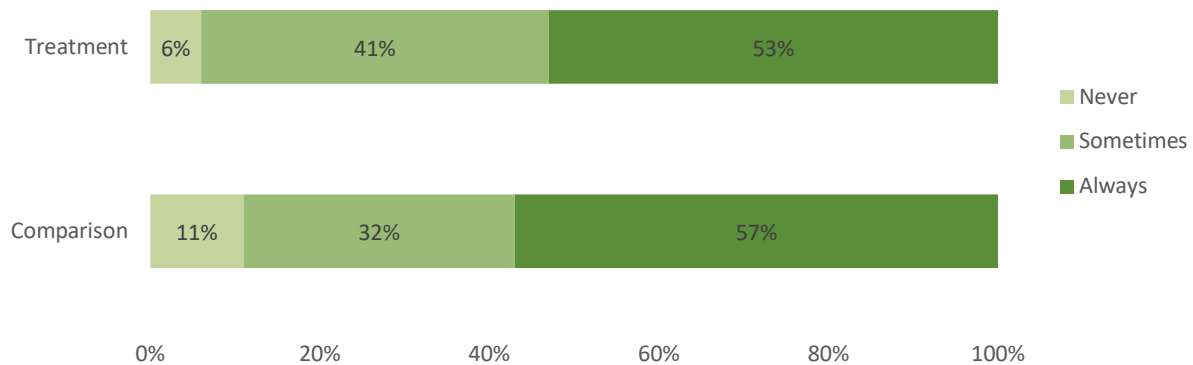
Base: Adolescent girls/young women who were sexually active in the past 12 months (Baseline treatment n=148, comparison n=147; Endline treatment n=84, comparison n=100)

Figure 8: Adolescent girls/young women who used a modern method of contraception 'always' in the past 12 months (%)

Neither the cross-sectional comparison at endline (Adjusted $F(1, 63) = 0.28, p = .602$) nor the DiD analysis ($B = -0.14, SE = 0.41, 95\% \text{ CI } [-0.95, 0.66], p = .725$) revealed a statistically significant difference between treatment and comparison groups, consistent with the broadly stable patterns observed in both arms. Given the small analytical sample of sexually active girls and young women, these results should be considered inconclusive rather than as evidence of no impact.

Further analysis of the data components shows that at endline, 57% (95% CI [44%, 69%]) of sexually active girls and young women in treatment areas and 53% (95% CI [44%, 62%]) in comparison areas reported always using contraception ([Figure 9](#)). Among those who reported always using contraception, all respondents (100%) in both the treatment and comparison group reported using modern methods. This suggests that when young women in these areas adopt regular contraceptive practices, they tend to choose modern contraceptive options.

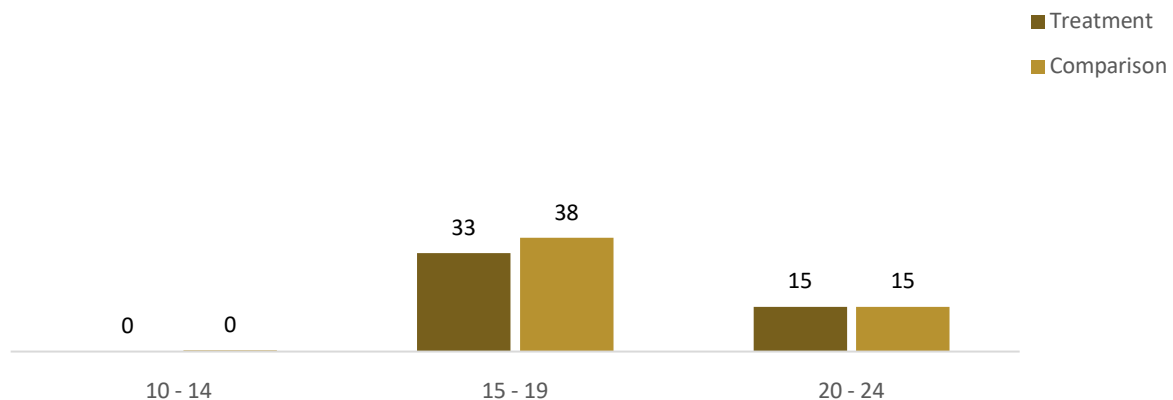
⁵⁹ Modern methods include: Male condoms, Female condoms, Emergency contraceptive pills, Oral contraceptive pills, Injections, Implants, Intrauterine devices (IUDs), Male and female sterilization.



Base: Adolescent girls/young women who were sexually active in the past 12 months (Treatment n=84, comparison n=100)

Figure 9: Frequency with which adolescent girls/young women at endline used contraception in the past 12 months

Figure 10 presents modern contraceptives use disaggregated by age group. Due to the very small sample sizes, these results are presented in counts only and should be considered exploratory.



Base: Adolescent girls/young women who were sexually active in the past 12 months (Treatment age 10-14 n=0, age 15-19 n=52, age 20-24 n=32; Comparison age 10-14 n=1, age 15-19 n=66, age 20-24 n=45)

Figure 10: Adolescent girls/young women at endline who used a modern method of contraception 'always' in the past 12 months, by age (n; results should be interpreted with caution due to small sample sizes)

3.3.2 Intermediate Outcome 1200: Delivery of quality, gender-responsive, inclusive services to address SRH needs

Intermediate Outcome 1200 aims to achieve improved delivery of quality, gender-responsive, inclusive services to address SRH needs of adolescents and young people, particularly girls and young women. This outcome was measured using three indicators.

Indicator 1200.1: Number of health facilities offering good quality gender-responsive and adolescent-friendly health services

Using the Health Facility Survey, we assessed the extent to which facilities in the treatment areas are offering good quality, gender-responsive and adolescent-friendly health services. To be counted towards this indicator, facilities needed to meet nine specific criteria covering both non-discriminatory service delivery and quality of service infrastructure. The criteria for non-discriminatory service delivery assessed whether facilities provided services to all adolescents regardless of their gender, age, or marital status. The quality service infrastructure criteria evaluated the presence of separate waiting areas for adolescents, privacy in counseling and examination rooms, staff trained in adolescent reproductive health services, confidential record management, and availability of functional toilets ([Table 10](#)). Results were calculated in two ways: a strict version in which separate waiting areas and privacy in counselling rooms were required to be directly observed by the enumerator and all toilets required to be functional, and a less strict version in which self-reported compliance was accepted for waiting areas and counselling room privacy, and partial toilet functionality was included. Where the two versions yield different results, both are presented using slash notation (strict / less strict). Where only one figure is shown, both versions yielded the same result. Endline results disaggregated by treatment district are provided in [Annex E](#).

Table 10: Health facilities meeting criteria for offering quality gender-responsive and adolescent-friendly health services (n (%))

	Baseline n = 32	Endline n = 28
<i>Availability of quality service delivery to women and adolescents regardless of</i>		
Gender	24 (75%)	27 (96%)
Age	13 (41%)	4 (14%)
Marital status	30 (94%)	26 (93%)
<i>Availability of quality service</i>		
Separate waiting areas for adolescents ^a	13 (41%)	14 (50%)
Counselling and examination rooms provide <u>visual</u> and <u>auditory</u> privacy ^a	18 (56%) / 21 (66%)	20 (71%) / 23 (82%)
Staff are trained to serve adolescents in reproductive health service	27 (84%)	27 (96%)
Storing records confidentially	31 (97%)	24 (86%)
Accessing stored records confidentially	30 (94%)	26 (93%)
Have functional toilets ^b	22 (69%)	14 (50%) / 20 (71%)
All criteria met	2 (6%)	0 (0%)

Note. Base: all surveyed facilities. ^a Where two figures are presented, the first represents the strict version ('Yes, observed' only) and the second the less strict version ('Yes, observed' and 'Yes, reported but not observed'). ^b Where two figures are presented, the first represents the strict version ('Yes, observed that all toilets are functional' only) and the second the less strict version ('Yes, observed that all toilets are functional' and 'Observed that some toilets are functional, but not all').

At baseline, two facilities (6%) met all nine criteria for good quality, gender-responsive and adolescent-friendly health services. At endline, none of the assessed facilities met all criteria.

A closer examination of individual criteria reveals both progress and ongoing challenges. Non-discriminatory service delivery showed a mixed picture. Almost all facilities at endline reported serving adolescents regardless of gender (96%), a notable improvement from baseline (75%). Service provision regardless of marital status remained broadly stable at 93%. However, age-inclusive service provision – defined as not having a minimum age requirement for adolescents to receive services – declined from 13 facilities (41%) at baseline to 4 (14%) at endline. This decline warrants careful interpretation. Follow-up questions on minimum-age requirements revealed inconsistent responses – for example, in seven facilities a minimum age of 10 or 11 years was recorded for girls but 24 years for boys, a pattern that appears implausible and was also observed in other countries, suggesting the decline may partly reflect respondent or enumerator misunderstanding of the survey question. However, even setting aside these implausible responses, the number of facilities reporting any minimum age increased from 19 (59%) to 24 (86%) at endline. Hence, a genuine deterioration in age-inclusive service delivery cannot be fully ruled out. Had the age criterion been excluded from the composite indicator, six facilities at endline would have met the threshold under strict conditions and 10 under less strict conditions.

Quality service infrastructure showed improvements in some areas and declines in others. Privacy standards for counselling and examination rooms improved from 56% of facilities at baseline to 71% at endline, or 82% when including self-reported compliance. Staff trained to serve adolescents in SRH services increased from 84% at baseline to near universal levels (96%) at endline. This is particularly notable as funding cuts severely crippled SRH services in Mozambique, leading to mass staff layoffs, clinic closures, and halted commodity distributions. For example, funding cuts to the International Planned Parenthood Federation resulted in nearly 1,000 lost staff across member associations and the shutdown of over 1,300 service delivery points nationwide.⁶⁰ On the other hand, results from the evaluation revealed that confidential record storage declined from 97% at baseline to 86% at endline, while confidential record access remained stable (93%).

Functional toilet availability remained broadly stable when comparing baseline (69%) to the less strict endline criterion (71%), though under the strict criterion only 14 facilities (50%) met the threshold at endline. [Table 11](#) presents additional insights (not part of the composite indicator) on toilet cleanliness and functionality. The majority of the surveyed facilities had toilets with clean ceilings, floors, toilet bowl, and walls, though no improvements were observed at endline. Functional locks and separate toilets for male and female are both critical for the privacy and safety of women and adolescent girls accessing

⁶⁰ Jesse Copelyn. Death in Mozambique: After US funding cuts, a health system crumbles. Spotlight. Published 25th June 2025 | Available from: <https://www.spotlightnsp.co.za/2025/06/25/death-in-mozambique-after-us-funding-cuts-a-health-system-crumbles/>

services. Functional locks were available in just under half of the facilities at both time points (47% and 46%, respectively), while separate toilets improved from 44% of facilities at baseline to 19 facilities (68%) at endline. Functional lighting remained the most persistent gap, available in only 9 facilities (32%) at endline.

Table 11: Cleanliness and functionality of toilet facilities at health facilities (n (%))

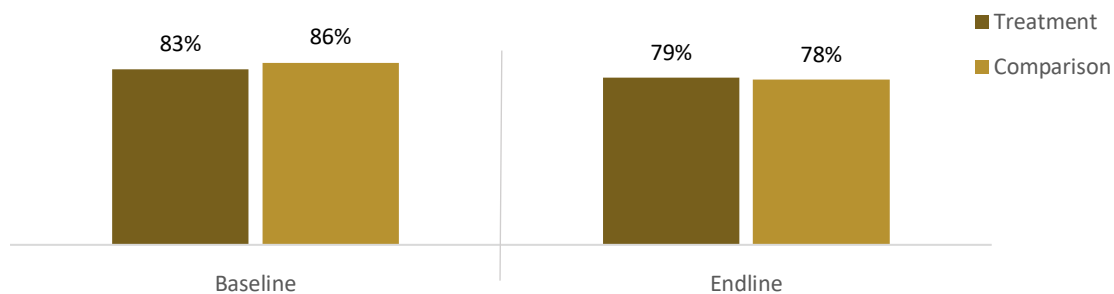
	Baseline <i>n</i> = 32	Endline <i>n</i> = 28
<i>Toilets are clean on</i>		
Ceiling	23 (72%)	21 (75%)
Floor	24 (75%)	19 (68%)
Walls	22 (69%)	18 (64%)
Toilet bowl	21 (66%)	16 (57%)
<i>Toilets have</i>		
Functional locks	15 (47%)	13 (46%)
Functional lights	13 (41%)	9 (32%)
Separate toilets for male and female	14 (44%)	19 (68%)

Overall, the findings suggest partial and uneven progress in facility readiness, particularly in privacy and availability of services regardless of gender. However, the absence of any facility meeting all criteria at endline, the decline in age-inclusive service provision – which may partly reflect measurement issues – and the decline in functional toilet availability under strict criteria indicate that quality, gender-responsive, adolescent-friendly service delivery remains incomplete.

Indicator 1200.2: Percentage of adolescents/youth aged 10-24 years who are satisfied with SRH services

To further evaluate Intermediate Outcome 1200, we asked respondents in the Adolescent/Youth survey to rate their satisfaction with the quality of SRH services they received during their most recent visit. This analysis was restricted to respondents who had used SRH services, resulting in a considerably reduced analytical sample at both waves.

At baseline, satisfaction rates were high and comparable between arms, with 83% (95% CI [76%, 88%]; M: 77%, F: 88%) of treatment group respondents and 86% (95% CI [80%, 91%]; M: 81%, F: 89%) of comparison group respondents reporting being (very) satisfied with the services received. At endline, point estimates remained broadly stable in both groups: 79% (95% CI [71%, 86%], M: 80%, F: 79%) in the treatment group and 78% (95% CI [67%, 86%]; M: 90%, F: 71%) in the comparison group, with overlapping confidence intervals indicating no clear evidence of change over time; see [Figure 11](#). The difference between groups at endline was not statistically significant (Adjusted $F(1, 70) = 0.05, p = .823$). It should be noted that the analytical sample for this indicator was considerably reduced at both waves due to the restriction to respondents who had used SRH services, limiting the precision of the estimates and statistical power.

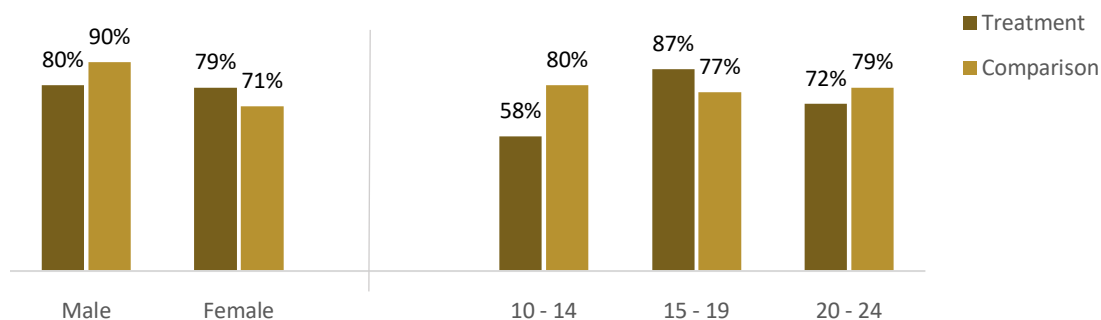


Base: Adolescents/youth who used SRHR services in the past 12 months (Baseline treatment n=217, comparison n=183; Endline treatment n=135, comparison n=86)

Figure 11: Adolescents/youth who are (very) satisfied with SRH services (%)

The DiD analysis, controlling for observed sociodemographic differences between groups, did not reveal a statistically significant effect ($B = -0.53$, $SE = 0.52$, 95% CI $[-1.57, 0.52]$, $p = .318$), consistent with the broadly stable pattern observed in both arms.

Figure 12 presents service satisfaction disaggregated by gender and age group. Point estimates suggest lower satisfaction among 10-14-year-olds in treatment areas compared to older age groups, which may indicate that younger adolescents face particular barriers related to service experience, confidentiality, or age-appropriate care. However, estimates for this subgroup are highly imprecise, with very wide confidence intervals reflecting the very small number 10-14-year-old respondents who had used SRH services. As a result, these patterns should be interpreted as suggestive only and do not provide reliable evidence of age-related differences in satisfaction. No consistent differences are observed across gender groups.



Base: Adolescents/youth who used SRHR services in the past 12 months (Treatment male n=51, female n=84, age 10-14 n=24, age 15-19 n=86, age 20-24 n=25; Comparison male n=31, female n=55, age 10-14 n=5, age 15-19 n=52, age 20-24 n=29)

Figure 12: Adolescents/youth at endline who are (very) satisfied with SRH services, by gender and age (%)

When asked about factors contributing to their satisfaction, quick service delivery emerged as the most cited positive aspect in both treatment (61%) and comparison areas (51%), followed by staff friendliness (T: 54%, C: 39%). Ease of access (T: 28%, C: 27%) and reasonable costs (T: 19%, C: 16%) were reported at similar levels across both groups.

Indicator 1200.3: Number of health facilities with waste management sustainability mechanisms developed and implemented

Using the Health Facility Survey, we assessed waste management practices among health facilities in the treatment areas. This assessment was not conducted at baseline, so findings are presented for endline only. The indicator focused on both the development and implementation of waste management sustainability mechanisms, encompassing three main criteria ([Table 12](#)). Results are again calculated in two ways: a strict version requiring direct observation by the enumerator and a less strict version in which self-reported compliance was accepted. Where the two versions yield different results, both are presented using slash notation (strict / less strict). Where only one figure is shown, both versions yielded the same result. Endline results disaggregated by treatment district are provided in [Annex E](#).

Table 12: Health facilities meeting the different criteria for developing and implementing waste management sustainability mechanisms (n (%))

	Baseline <i>n</i> = 32	Endline <i>n</i> = 28
<i>Development of waste management sustainability mechanisms</i>		
A dedicated trained team is appointed for waste management	-	24 (86%)
An up-to-date waste management plan is in place	-	20 (71%)
<i>Implementation of waste management sustainability mechanisms</i>		
At least two of the following waste management practices are implemented:	-	25 (89%)
- Waste (all types) is being segregated according to type of waste in the appropriate waste bins	-	25 (89%)
- Incinerator or alternative waste disposal mechanism is being properly utilized and maintained	-	19 (68%)
- Waste management plan is being monitored and updated by the trained team ^a	-	8 (29%) / 14 (50%)
- PPE and cleaning supplies are being properly utilized by all staff	-	24 (86%)
All criteria met	-	16 (57%)

Note. Base: all surveyed facilities. ^a Where two figures are presented, the first represents the strict version ('Yes, observed' only) and the second the less strict version ('Yes, observed' and 'Yes, reported but not observed').

The first criterion required facilities to have a dedicated trained team appointed for waste management. This requirement was met by most facilities (24 out of 28, or 86%) at endline. The second criterion – an up-to-date waste management plan – was demonstrated by 20 facilities (71%).

The third criterion evaluated implementation of waste management practices, requiring facilities to demonstrate at least two out of four specific practices. Most facilities (25, 89%) met this criterion at endline, although performance on individual practices varied. Waste segregation was broadly in place, with 25 facilities (89%) at endline segregating all types of waste and an additional two facilities reporting

segregating some but not all waste types. Based on follow up questions, waste segregation was consistently maintained through storage, transport, and final treatment/disposal in 18 cases, with five facilities partially maintaining and four not maintaining segregation after collection. Proper utilization and maintenance of incinerators or alternative waste disposal mechanisms was demonstrated in 19 facilities (68%) at endline.

Personal Protective Equipment (PPE) and cleaning supply utilization were broadly in place, with 24 facilities (86%) at endline demonstrating proper utilization by all staff of PPE and cleaning supplies. The broader PPE availability picture at endline was mixed: 8 out of 28 facilities (29%) reported PPE is always consistently available in sufficient quantities, while 10 (36%) reported generally adequate availability with occasional minor shortages and the remainder reported less reliable availability. In terms of replenishment, 11 facilities (39%) reported proactive restocking and six (21%) replaced supplies soon after being used, while 8 facilities (29%) reported irregular and often delayed restocking. Regarding the physical availability of PPE and cleaning supplies at waste handling areas, the majority of facilities (18, 64%) had both PPE and cleaning supplies in all waste handling areas, one had only PPE in all areas.

Monitoring and updating of waste management plans by trained teams was the weakest area, with only eight facilities (29%) showing observed evidence of this practice, or 14 (50%) when including self-reported compliance.

Overall, 16 of the 28 facilities (57%) met all three criteria at endline. While most facilities have established solid waste management infrastructure and practices, active monitoring and updating of waste management plans remains an area for improvement.

Interviews with consortium members, health workers and district health officials indicated that the project strengthened health facility infrastructure through investments in water, sanitation and waste management systems. Respondents reported the establishment of hospital waste management services, installation of water systems, construction of toilet blocks and incinerators, and rehabilitation of adolescent-friendly service areas. A consortium representative from WaterAid further explained that these infrastructure investments were accompanied by training of health committees in the operation and maintenance of the facilities, helping to strengthen local ownership and support their continued use after project implementation:

"We were able to ensure access to water, we created conditions for the availability of hospital waste management services, we created conditions for sanitation in some health facilities... we installed water pipes... built incinerators in health facilities... built toilet blocks... we had to bring in members of the health committee... trained to address the operation and maintenance of the infrastructure in the health facilities "
(Consortium member, WaterAid, male, KII)

3.3.3 Intermediate Outcome 1300: Social action for gender-responsive SRH services and SRHR policies

Intermediate Outcome 3 aims to achieve enhanced social action by key stakeholders especially adolescent girls and young women to advocate for gender-responsive SRH services and SRHR policies. We measured Intermediate Outcome 1300 through 3 indicators.

Indicator 1300.1: Number of context specific policies developed and executed by the local authorities to promote ASRHR as a result of CBOs and young people's advocacy initiatives

Across interviews with district education and health officials, teachers, health workers, community leaders, consortium partners and local NGOs, respondents did not identify any new local ASRHR policies that had been developed or implemented because of advocacy by CBOs and young people. Instead, these stakeholders described how the *SHARE* project strengthened the implementation of existing education, health and community systems to promote adolescent SRHR. Rather than introducing new policies, the project reinforced existing government structures and approaches. A district education official explained that although the national curriculum had not formally changed, the project supported the development of a handbook to integrate SRHR into classroom teaching:

"I won't talk about the curriculum itself because, in practical terms, the curricular changes haven't yet been implemented in schools. But it was thanks to this project that a handbook was produced... a handbook that amends the educational curriculum to incorporate this aspect of sexual and reproductive rights." (District Education Services, M, Namaacha, KII)

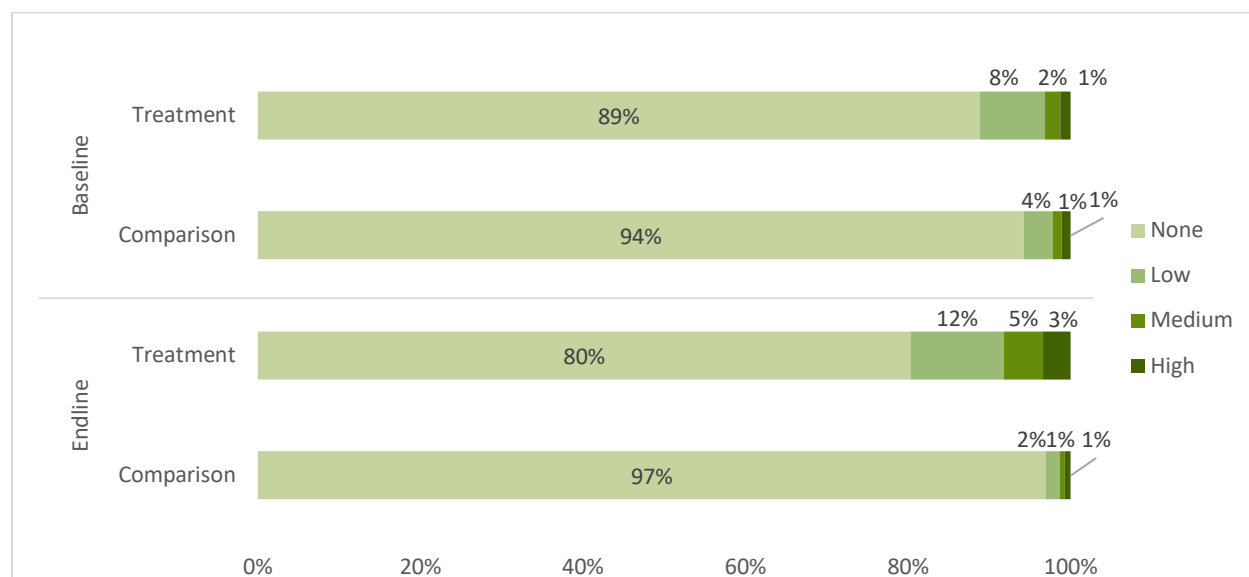
Interviews with the district education officials, district health officials, teachers and health workers highlighted the establishment of institutional mechanisms that strengthened implementation of existing ASRHR policies. The respondents described stronger collaboration between education and health sectors through joint planning, routine communication and referral systems. They explained that schools, health facilities and district focal points worked together to identify adolescents requiring support, monitor referrals and coordinate responses, particularly for cases involving sexual violence or protection concerns.

The district education official also noted that project strengthened opportunities for adolescent participation through school interest groups, peer mentors and advocacy sessions with local officials, and were introduced to referral and reporting mechanisms. Teachers corroborated that students became more confident discussing SRHR topics in the classroom, while health workers described stronger links between schools and health services that supported adolescents' access to information and services. While these mechanisms strengthened adolescent voice and participation, respondents did not report that they resulted in the adoption of new district policies.

Indicator 1300.2: Level of active participation in SRHR advocacy and social action initiatives by girls and young women aged 10-24 years

We assessed girls' engagement in SRHR advocacy and social action through three key dimensions: participation in SRHR advocacy activities, membership in ASRHR committees or associations, and receipt of feedback from adult stakeholders on their influence on outcomes. To capture different levels of engagement, we created a composite measure in which meeting all three criteria indicated high participation, meeting both advocacy participation and stakeholder feedback indicated medium participation, and participation in advocacy activities alone indicated low participation.

Endline data indicate an increase in SRHR advocacy participation in treatment areas, with the distribution of engagement levels shifting toward higher participation categories, while participation in comparison areas declined ([Figure 13](#)). Specifically, the proportion of girls and young women participating in SRHR-related advocacy activities increased from 11% to 20% in treatment areas, while declining from 6% to 2% in comparison areas, with statistically significant differences between arms at both baseline and endline. Among those who participated in advocacy activities, the proportion reporting feedback from adult stakeholders on their influence increased from 28% to 41% in treatment areas, though this finding should be treated with considerable caution given the small sample sizes and overlapping confidence intervals. The corresponding comparison figure at endline was based on only eight respondents and is therefore too unreliable to interpret meaningfully, as reflected in the wide confidence interval [9%, 54%]. Girls' reported membership in ASRHR committees or associations also increased in treatment areas (5% to 14%) while declining to near zero in comparison areas (2% to <1%), with a statistically significant difference between study arms at endline ([Table 13](#)).



Base: Adolescent girls/young women (Baseline treatment and comparison (balanced) n=473, Endline treatment and comparison (balanced) n=355)

Figure 13: Level of participation of adolescent girls/young women in SRHR advocacy and social action activities (%)

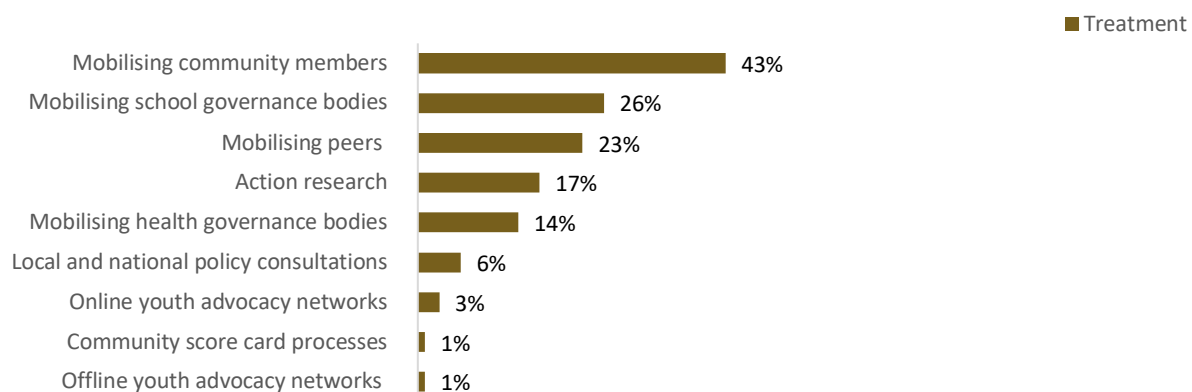
Table 13: Adolescent girls/young women who have participated in different SRHR advocacy and social action initiatives (% [95% CI])

	Baseline		Endline	
	Treatment (n = 473 ^a / 53 ^b)	Comparison (n = 473 ^a / 27 ^b)	Treatment (n = 355 / 70 ^b)	Comparison (n = 355 / 8 ^b)
Participated in SRHR related advocacy activities ^a	11 [9, 14]	6 [4, 9]**	20 [14, 27]	2 [1, 5]***
Belong to committee or association that works on ASRHR ^a	5 [4, 8]	2 [1, 4]*	14 [9, 21]	<1 [0, 2]***
Received feedback from adult stakeholders on their influence on outcomes ^b	28 [17, 42]	37 [20, 58]	41 [31, 53]	25 [9, 54] ^c

Note. ^a Base: Adolescent girls/young women. ^b Base: Adolescent girls/young women who participated in SRHR related advocacy activities. ^c Results should be interpreted with caution due to small sample sizes. Differences between treatment and comparison groups within each wave were tested using Adjusted F-tests. Confidence intervals and p-values are adjusted for the complex sampling design. * $p < .05$, ** $p < .01$, *** $p < .001$.

The difference in overall participation level between groups was significant at endline (Adjusted $F(2.55, 176.15) = 13.91$, $p < .001$), and the DiD analysis of the dichotomized participation indicator,⁶¹ controlling for observed sociodemographic differences between groups, showed a significant difference between groups over time ($B = -1.65$, $SE = 0.54$, 95% CI [-2.73, -0.57], $p = .003$). These findings are consistent with the possibility that *SHARE* project activities contributed to increased engagement in SRHR advocacy and social action among girls and young women in treatment areas, though this interpretation relies on assumptions that could not be fully verified and should therefore be treated with caution.

Among treatment area participants, mobilising community members ($n=30$, 43%), mobilising school governance bodies ($n=18$, 26%), and mobilising peers ($n=16$, 23%) were the most common forms of engagement. Comparison group results are not reported here due to the very small number of participants, which precludes meaningful interpretation of percentages (Figure 14).

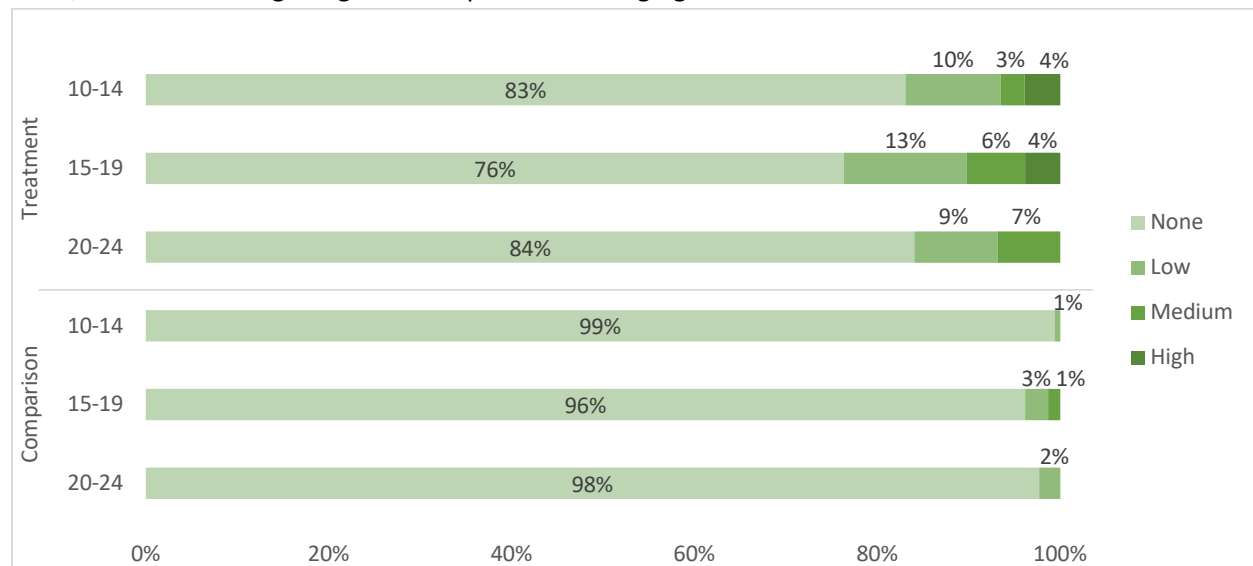


Base: Adolescent girls/young women who engaged in SRHR related advocacy activities (Treatment $n=70$)

Figure 14: Type of SRHR related activities engaged in by adolescent girls/young women at endline (%)

⁶¹ Based on dichotomous 0 = no participation vs 1 = any participation to improve model convergence.

The vast majority of girls in both treatment (80%; 95% CI [73%, 86%]) and comparison (98%; 95% CI [95%, 99%]) areas were not involved in any SRHR advocacy and social action activities. When examining barriers to participation, limited awareness and knowledge emerged as the predominant theme – reflected both in the most commonly cited barrier (lack of knowledge about how to engage; T: 39%, C: 26%) and in the substantial proportion of adolescents who responded ‘Don’t know’ when asked about barriers (T: 47%, C: 65%), suggesting that many girls have limited familiarity with SRHR advocacy opportunities. Open-ended questions similarly reflected limited information or awareness, alongside other barriers such as lack of opportunities or invitations (less frequently mentioned). [Figure 15](#) presents participation levels of AGYW at endline, broken down by age group. Participation levels were broadly similar across age groups in both arms, with no meaningful age-related patterns emerging.



Base: Adolescent girls/young women (Treatment age 10-14 n=154, age 15-19 n=157, age 20-24 n=44; Comparison age 10-14 n=154, age 15-19 n=157, age 20-24 n=44)

Figure 15: Level of participation of adolescent girls/young women in SRHR advocacy and social action activities at endline, by age (%)

Interviews and group discussions with adolescent girls, teachers, community leaders, district education officials, and consortium members suggested that AGYW participated in SRHR advocacy and social action although participation was largely observed at school and community levels rather than through formal policy advocacy. Adolescents also described participating in community sensitization by sharing SRHR and violence-prevention messages with peers and community members. One adolescent explained:

“When we go to any place in the community, sometimes we meet with friends and say, ‘Don’t do this, because this is wrong. This is violence, and this is what hurts others.’ That’s how we spread the news.” (Adolescent boy, 15–19 years, out-of-school, FGD, Namaacha)

Indicator 1300.3: Average resilience score of adolescents/youth aged 10-24 years

To measure the third indicator for Intermediate Outcome 1300, we employed the Child and Youth Resilience Measure (CYRM) tool, which assesses youth social-ecological resilience by evaluating both the challenges they face and the resources available to them for navigating these challenges. The tool consists of 17 statements, with respondents rating how well each statement applies to them using a three-point scale: "Yes" (3 points), "Sometimes" (2 points), or "No" (1 point). At baseline, resilience was originally scored as the sum of all 17 items, with a possible score ranging from 17-51. However, one item regarding school belonging was not applicable to a small number of respondents who had never attended school, which would have artificially lowered their sum scores. Resilience is therefore now calculated as a mean score across applicable items (range 1-3), with higher scores indicating greater resilience. Baseline scores have been recalculated accordingly ([Table 14](#)).

Table 14: Adolescents'/youths' average resilience score (*M* [95% CI])

	Baseline		Endline	
	Treatment (<i>n</i> = 833)	Comparison (<i>n</i> = 833)	Treatment (<i>n</i> = 633)	Comparison (<i>n</i> = 633)
Overall mean	2.80 [2.78, 2.83]	2.82 [2.79, 2.84]	2.85 [2.83, 2.87]	2.89 [2.87, 2.91]**
<i>Gender</i>				
Male	2.80 [2.77, 2.83]	2.84 [2.81, 2.86]	2.85 [2.83, 2.87]	2.89 [2.87, 2.92]
Female	2.80 [2.77, 2.83]	2.80 [2.77, 2.83]	2.85 [2.82, 2.88]	2.89 [2.87, 2.91]
<i>Age</i>				
10-14	2.79 [2.77, 2.82]	2.80 [2.77, 2.83]	2.87 [2.85, 2.90]	2.90 [2.87, 2.92]
15-19	2.81 [2.77, 2.84]	2.83 [2.81, 2.85]	2.84 [2.81, 2.87]	2.90 [2.87, 2.92]
20-24	2.79 [2.73, 2.86]	2.80 [2.75, 2.86]	2.82 [2.77, 2.86]	2.86 [2.82, 2.91]

Note. Base: All adolescents. Differences between treatment and comparison groups within each wave were tested using Wald F-tests. Confidence intervals and p-values are adjusted for the complex sampling design. * $p < .05$, ** $p < .01$, *** $p < .001$.

At baseline, both groups demonstrated high resilience levels, with mean scores of 2.80 (95% CI [2.78, 2.83]) in the treatment group and 2.82 (95% CI [2.79, 2.84]) in the comparison group. By endline, point estimates increased in both groups, with the treatment group reaching 2.85 (95% CI [2.83, 2.87]), and the comparison group reaching 2.89 (95% CI [2.87, 2.91]). The difference between groups at endline was statistically significant (Wald $F(1, 70) = 7.11$, $p = .009$). The DiD analysis, controlling for observed sociodemographic differences between groups, did not reveal a significant effect ($B = 0.03$, $SE = 0.02$, 95% CI [-0.01, 0.06], $p = .174$), suggesting no differential change between groups over time. The increases in both groups may reflect broader contextual factors rather than a direct project effect.

The analysis revealed consistent patterns across demographic subgroups, with no notable differences in resilience scores between male and female respondents or across different age categories ([Table 14](#)).

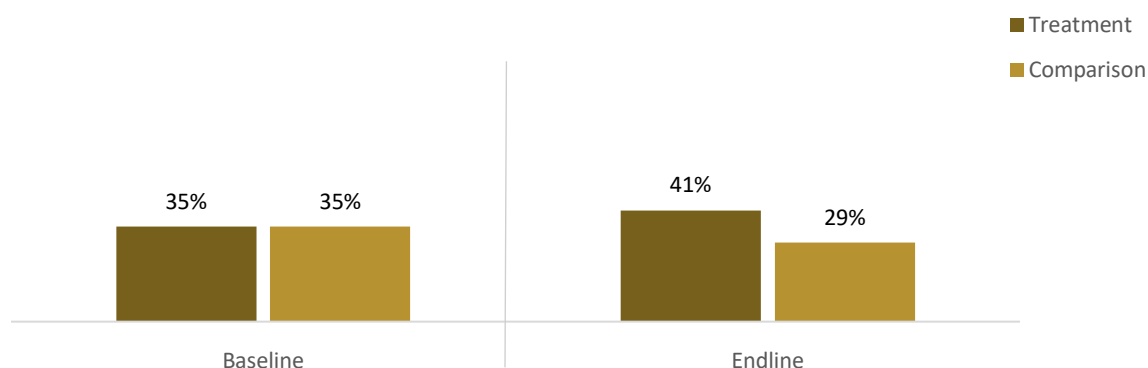
3.3.4 Immediate Outcome 1110: Improved knowledge of SRHR

Immediate Outcome 1110 aims to achieve improved SRHR skills amongst adolescents and young people, particularly girls and young women. We measured progress toward this outcome by evaluating: 1) adolescents' knowledge of SRHR, 2) teachers' knowledge of sexual education guidelines, and 3) adolescents' perceived self-efficacy to access SRH services.

Indicator 1110.1: Percentage of adolescents/youth aged 10-24 years that are knowledgeable of their SRHR

The Adolescent/Youth survey assessed SRHR knowledge through a set of 10 questions covering both sexual health knowledge and support for sexual rights. To be counted toward this indicator, respondents had to demonstrate both accurate knowledge of key SRH topics (e.g., conception, contraception, and STIs), and express strong support for fundamental sexual rights. Specifically, respondents scoring 80% or higher (i.e., at least 8 out of 10 criteria) were considered knowledgeable about SRHR.⁶²

At baseline, treatment and comparison groups showed similar levels of comprehensive SRHR knowledge, with 35% (95% CI [32%, 39%]; M: 35%, F: 36%) of treatment group respondents and an equal proportion (35%; 95% CI [32%, 39%]; M: 37%, F: 35%) of comparison group respondents meeting the 80% threshold. The groups averaged 5.9 and 6.0 correct responses at baseline respectively. By endline, point estimates diverged between the two groups, with the treatment group reaching 41% (95% CI [36%, 46%]; M: 45%, F: 37%) while comparison group declined to 29% (95% CI [24%, 35%]; M: 35%, F: 25%). However, confidence intervals overlap between baseline and endline in both arms, meaning these changes should be interpreted cautiously and may not reflect true population-level shifts. The difference between groups at endline was statistically significant (Wald $F(1, 70) = 9.24, p = .003$). The mean number of correct responses at endline was 6.5 in the treatment group and 5.6 in the comparison group ([Figure 16](#)).



Base: All adolescents (Baseline treatment n=833, comparison n=833; Endline treatment n=633, comparison n=633)

Figure 16: Adolescents/youth who are knowledgeable of their sexual and reproductive health and rights (%)

⁶² At baseline, a different threshold was used. The baseline results have since been recalculated and updated.

The DiD analysis, controlling for observed sociodemographic differences between groups, yielded a significant difference between groups over time ($B = -0.56$, $SE = 0.20$, 95% CI [-0.96, -0.16], $p = .007$), reflecting a 12-percentage point difference-in-difference driven by diverging trends. These findings are consistent with the possibility that the *SHARE* project activities contributed to relatively higher SRHR knowledge in treatment areas, though this interpretation relies on assumptions that could not be fully verified and should therefore be treated with caution.

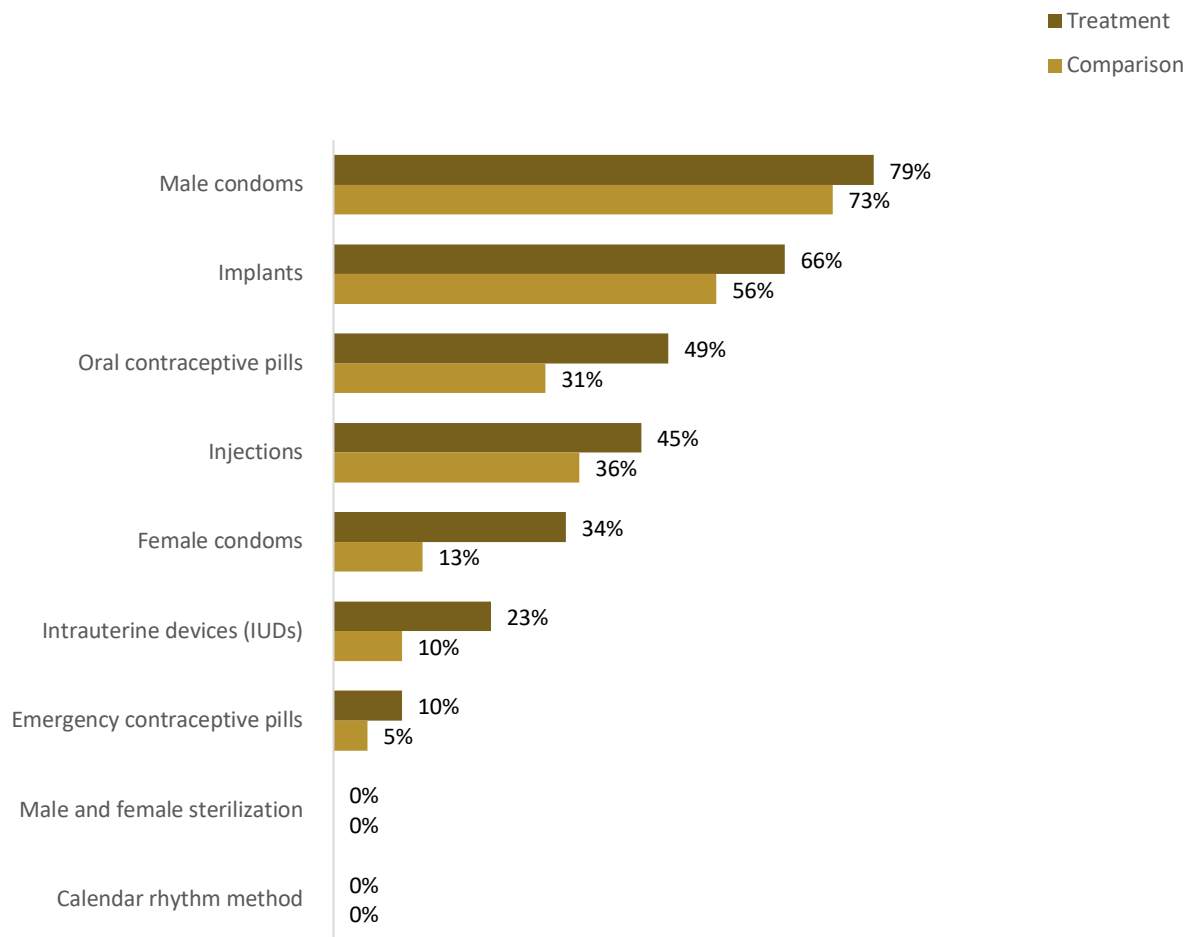
Further inspection of the individual items reveals a mixed picture of change across topics (Table 15). Across almost all items, levels were significantly higher in the treatment group than in the comparison group at endline. Knowledge of contraception and pregnancy avoidance showed increases in the treatment group, while remaining broadly stable in the comparison group. STI awareness increased markedly in both arms, from 75% to 96% in the treatment group and from 77% to 91% in the comparison group. In contrast, awareness of STI transmission methods and ways to avoid STIs declined in both arms. Knowledge of the female menstrual cycle and conception remained consistently low across both groups and both waves. In the treatment group, support for sexual rights increased across three out of four items. Only strong agreement that all young people have the right to access contraception methods of their choice remained stable in the treatment group, while declining in the comparison group.

Table 15: Adolescents/youth who demonstrate knowledge of different key SRHR topics (% [95% CI])

	Baseline		Endline	
	Treatment ($n = 833$)	Comparison ($n = 833$)	Treatment ($n = 633$)	Comparison ($n = 633$)
Aware of female menstrual cycle and conception	3 [2, 4]	3 [2, 5]	3 [1, 5]	3 [2, 5]
Aware of at least one modern contraceptive method	80 [76, 82]	82 [80, 85]	89 [85, 91]	81 [77, 85]**
Aware of ways to avoid pregnancy	76 [73, 78]	79 [76, 82]	87 [83, 89]	78 [72, 83]**
Aware of one or more STIs	75 [71, 78]	77 [74, 80]	96 [93, 97]	91 [89, 93]**
Aware of one or more transmission methods of STIs	60 [57, 64]	62 [58, 65]	48 [42, 53]	37 [32, 42]**
Aware of one or more ways to avoid STIs	59 [55, 62]	59 [56, 63]	48 [43, 53]	36 [31, 42]**
Strongly agree that sexual rights apply to all young people	44 [40, 47]	43 [39, 46]	64 [59, 68]	50 [44, 56]**
Strongly agree that all forms of non-consensual sexual activity are forms of violence	65 [62, 68]	64 [59, 68]	81 [77, 84]	71 [66, 76]***
Strongly agree that all young people have the right to access a range of contraception methods and choose the method that is best for them	75 [73, 77]	75 [72, 78]	78 [73, 83]	66 [61, 71]***
Strongly disagree that HIV transmission is linked to "immoral" behaviors so anyone living with HIV is immoral	50 [46, 54]	52 [48, 57]	62 [56, 67]	53 [48, 58]*
Answered correctly to at least 80% of questions (%)	35 [32, 39]	35 [32, 39]	41 [36, 46]	29 [24, 35]**
Mean number of correct questions	5.9 [5.7, 6.0]	6.0 [5.8, 6.2]	6.5 [6.3, 6.8]	5.6 [5.3, 6.0]

Note. Base: All adolescents. Differences between treatment and comparison groups within each wave were tested using Adjusted F-tests and Wald F-tests. Confidence intervals and p-values are adjusted for the complex sampling design. * $p < .05$, ** $p < .01$, *** $p < .001$.

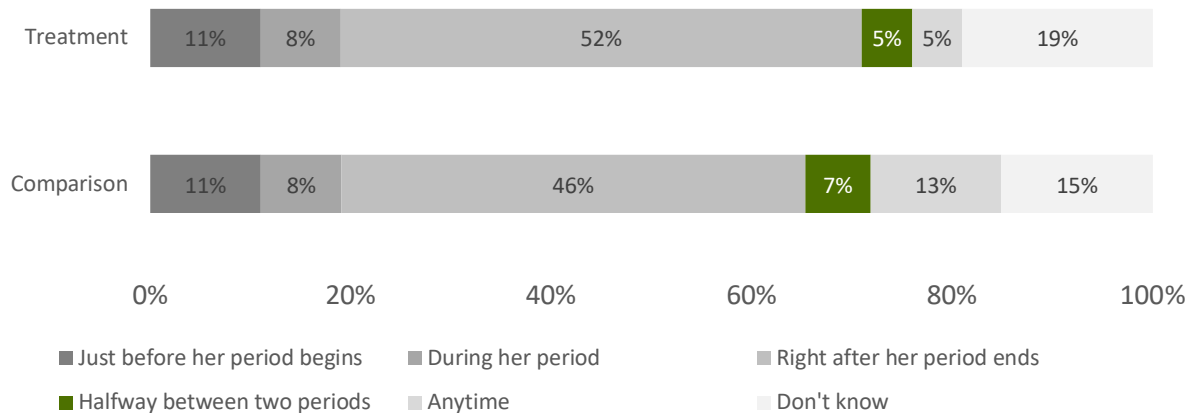
Figure 17 presents the types of contraceptive methods that adolescents/youth at endline were aware of. Male condoms were the most widely known method (T: 79%, C: 73%), followed by implants (T: 66%, C: 56%), oral contraceptive pills (T: 49%, C: 31%), and injections (T: 45%, C: 36%).



Base: All adolescents (Endline treatment n=633, comparison n=633)

Figure 17: Types of contraceptive methods that adolescents/youth at endline are aware of (%)

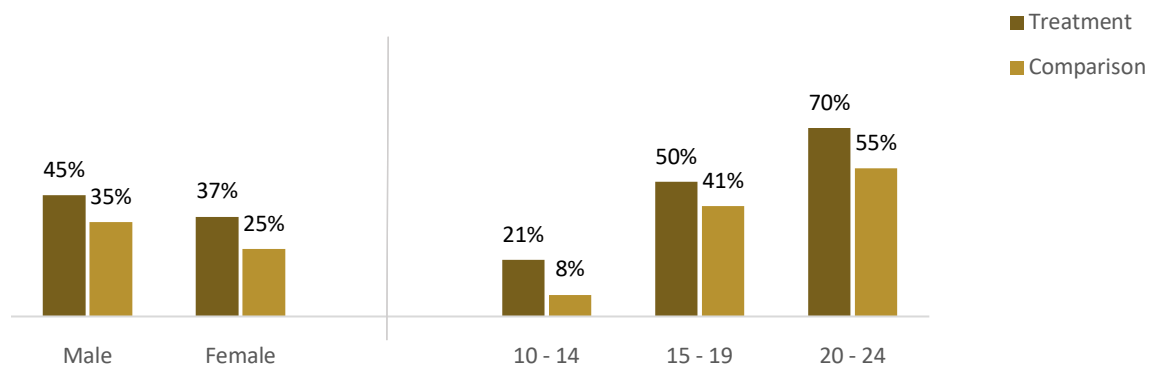
Among respondents who indicated that there are certain days in the menstrual cycle when women are more likely to become pregnant, only 5% in the treatment group and 7% in the comparison group could correctly identify that period (Figure 18).



Base: Adolescents who mentioned there are certain days when women are more likely to become pregnant if they have sexual intercourse (Treatment n=387; Comparison n=289)

Figure 18: Adolescents/youth at endline who correctly identified fertile periods in the menstrual cycle (%)

Point estimates suggest somewhat higher SRHR knowledge among male respondents compared to female respondents in both arms, though overlapping confidence intervals preclude drawing definitive conclusions about gender differences. As expected, SRHR knowledge tended to be higher among older adolescents and young adults compared to younger adolescents (Figure 19).



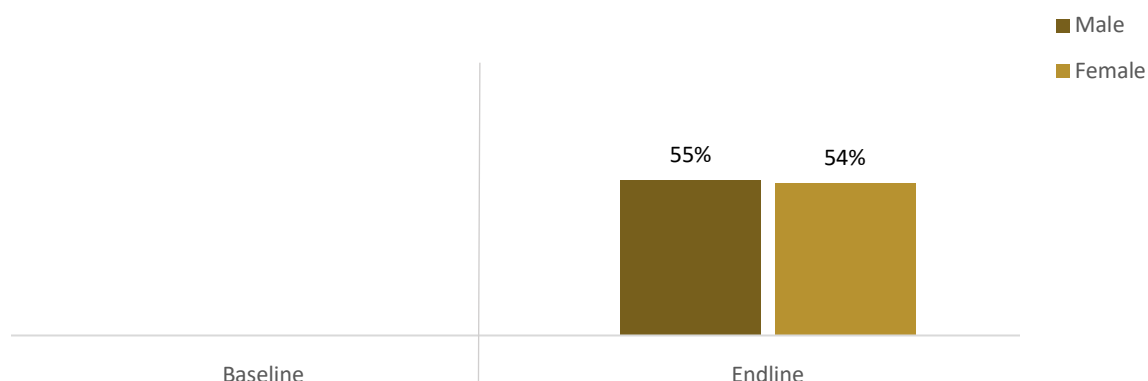
Base: All adolescents (Treatment and comparison (balanced) male n=278, female n=355, age 10-14 n=258, age 15-19 n=291, age 20-24 n=84)

Figure 19: Adolescents/youth at endline who are knowledgeable of their SRHR (%), by gender and age (%)

Indicator 1110.2: Percentage of teachers with knowledge of sexuality education guidelines, as per national standards

The quality of SRH information that adolescents receive through their schools depends on their teachers' familiarity with the subject matter. Evidence shows that school-based sexuality education makes teachers important gatekeepers of students' access to information about SRHR. The school setting has the potential to reach large numbers of students.⁶³ To assess the capacity of teachers in the treatment sites to deliver sexuality education, we surveyed teachers in the *SHARE* project (treatment) areas to measure their understanding of the health benefits of sexuality education for adolescents and awareness of guidelines and policies governing sexuality education delivery in (their) schools. As the baseline study did not yield any responses, results are presented for endline only.

At endline, point estimates suggest that approximately half of the interviewed teachers (54%; 95% CI [39%, 69%]) accurately identified at least three health benefits of sexuality education. Knowledge levels were broadly comparable between male (55%; 95% CI [33%, 75%]) and female (54%; 95% CI [37%, 70%]) teachers (Adjusted $F(1) = 0.013$, $p = .911$; see [Figure 20](#)). The most frequently cited benefits by teachers in Mozambique were prevention of unwanted pregnancies, prevention of STIs and HIV, and reduction in school dropout ([Figure 21](#)). Given the small analytical sample ($n=61$) and wide confidence intervals, particularly for subgroup estimates, these findings should be interpreted with considerable caution.

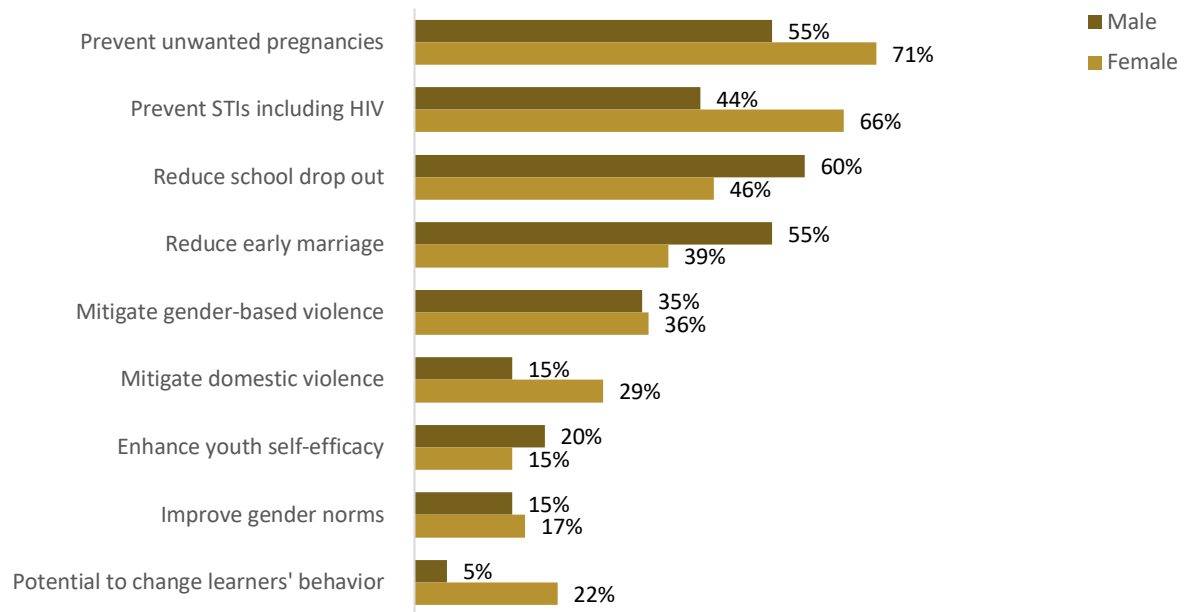


Base: All teachers (Endline $n=61$)

Figure 20: Teachers who could cite at least three health benefits of sexuality education for adolescents (%)

Awareness of Mozambique's national sexuality education guidelines at endline was 61% (95% CI [48%, 72%]; M: 75%, F: 54%). Moreover, 66% (95% CI [55%, 75%]; M: 75%, F: 61%) of surveyed teachers demonstrated awareness of relevant policies in their own schools. Although point estimates suggested that male teachers had higher awareness of sexuality education guidelines and policies, overlapping confidence intervals preclude drawing definitive conclusions about gender differences in awareness.

⁶³ Picot J, Shepherd J, Kavanagh J, Cooper K, Harden A, Barnett-Page E, et al. Behavioural interventions for the prevention of sexually transmitted infections in young people aged 13–19 years: a systematic review. *Health Education Research*. 2012;27(3):495-512.



Base: All teachers (Endline male n=20, female n=41)

Figure 21: Teachers at endline who could cite different health benefits of sexuality education for adolescents, by gender (%)

Of the teachers surveyed at endline, 93% had received training on sexuality education, with two thirds trained within the past two years (35% in the past year, 32% one to two years ago). Most teachers were trained directly by *SHARE* or its partners, *Right To Play* and *WaterAid* (89%), with 4% trained indirectly through a Community of Practice. Training was generally well-received, with 64% of respondents rating it as good and 26% as excellent.

Teachers reported substantial self-perceived improvements across all dimensions following training. Almost all reported their knowledge of sexuality education had improved (89% much better, 9% a bit better), with 87% attributing this improvement largely to the *SHARE* training. Attitudes toward sexuality education also shifted markedly, with 79% of respondents reporting much more positive attitudes and 19% somewhat more positive, with 85% attributing this change largely to the *SHARE* project. Similarly, comfort with teaching sexuality education improved substantially, with 87% reporting feeling much more comfortable and 13% somewhat more comfortable, and 85% attributing this predominantly to *SHARE* training. Finally, 80% of teachers rated their school environment as very supportive in delivering sexuality education to students, and 15% as somewhat supportive.

When asked about challenges in delivering sexuality education, teachers most commonly identified lack of teaching and learning materials (43%) and community opposition (20%). Other cited challenges relate to student shyness and reluctance to engage openly with sexuality topics. These findings are consistent with the open-ended feedback provided by teachers, which was dominated by requests for more training and teaching and learning materials.

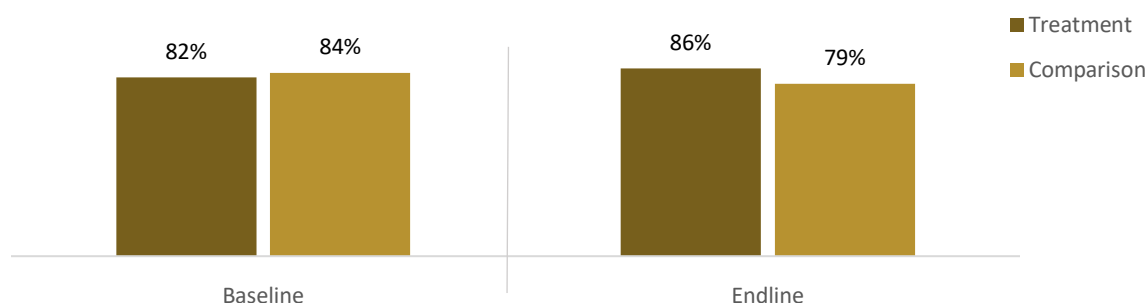
From the qualitative component of the evaluation, teachers described how the training improved their understanding of sexuality education and changed the way they approached these subjects. Several explained that before participating in the project they found sexuality education difficult to discuss because these topics were considered taboo. Following the training, they reported feeling more confident using correct terminology and discussing SRHR openly with students.

"Before, there were certain topics... that we used to teach with a lot of secrecy and hesitation... But since joining this project... I knew I had to call things by their proper names." (Teacher, F, Lionde, IDI)

"I cannot treat a 6th-grade topic the same way as a child in 1st grade... I learned to introduce these themes at an appropriate age." (Teacher, female, Lionde, IDI)

Indicator 1110.3: Percentage of adolescents/youth aged 10-24 years who believe they could seek SRH information and services if they needed them

To further measure Immediate Outcome 1110, we assessed adolescents' perceived self-efficacy in accessing SRHR information and SRH services. At baseline, 82% (95% CI [79%, 84%]; M: 76%, F: 86%) of adolescents in treatment areas and 84% (95% CI [80%, 87%]; M: 84%, F: 83%) in comparison areas believed they could access these resources if needed, indicating comparable starting points across arms. By endline, point estimates diverged slightly, with the treatment group reaching 86% (95% CI [82%, 89%]; M: 87%, F: 85%) and the comparison group declining modestly to 79% (95% CI [73%, 84%]; M: 83%, F: 76%, [Figure 22](#)). Given the overlapping confidence intervals, these changes should be interpreted cautiously. The difference between groups at endline was statistically significant (Adjusted $F(1, 70) = 4.33, p = .041$).

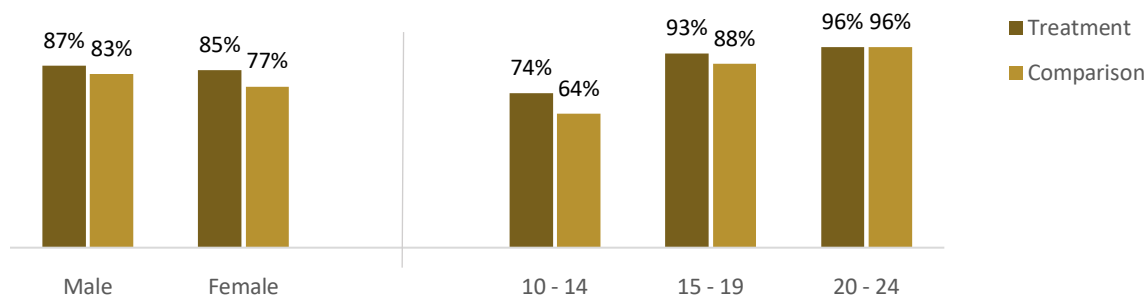


Base: All adolescents (Baseline treatment n=833, comparison n=833; Endline treatment n=633, comparison n=633)

Figure 22: Adolescents/youth who believe they could seek SRHR information and services if they needed them (%)

The DiD analysis, controlling for observed sociodemographic differences between groups, yielded a significant difference between groups over time ($B = -0.64$, $SE = 0.28$, 95% CI $[-1.21, -0.08]$, $p = .027$) with a 9-percentage point difference-in-difference. Given that within-arm changes were small and confidence intervals overlapped between baseline and endline in both groups, these findings should be interpreted cautiously and are at most consistent with the possibility that the *SHARE* project contributed to sustaining perceived self-efficacy in treatment areas relative to comparison areas.

No gender differences were observed in perceived ability to access SRH information and services. Perceived ability increased consistently with age in both arms, with older respondents more likely to believe they could access services (Figure 23).



Base: All adolescents (Treatment and comparison (balanced) male $n=278$, female $n=355$, age 10-14 $n=258$, age 15-19 $n=291$, age 20-24 $n=84$)

Figure 23: Adolescents/youth at endline who believe they could seek SRHR information and services if they needed them, by gender and age (%)

From the qualitative component of the evaluation, many adolescents and young people expressed that they felt more confident that they could seek SRH information and services if they needed them. Many expressed their confidence in returning to health facilities, asking questions and seeking further advice whenever concerns arose. An out-of-school young woman from Lionde explained:

"When I have a doubt, I trust myself—I have to go, no matter what. That confidence comes from within, though health professionals also transmit confidence by giving positive answers." (out-of-school young woman, 15–24 years, Lionde, IDI)

Many adolescents linked this confidence to having trusted adults whom they believed they could approach without fear. Mentors, adolescent-friendly health providers and teachers were frequently described as approachable and supportive, giving adolescents confidence that they could ask questions, discuss sensitive issues and seek SRH services when required. Others explained that respectful treatment, privacy and confidentiality increased their confidence that they could seek support if needed. Also, adolescents explained that learning about puberty, contraception, sexually transmitted infections and available services helped them recognise when they needed information or care and where they could obtain it.

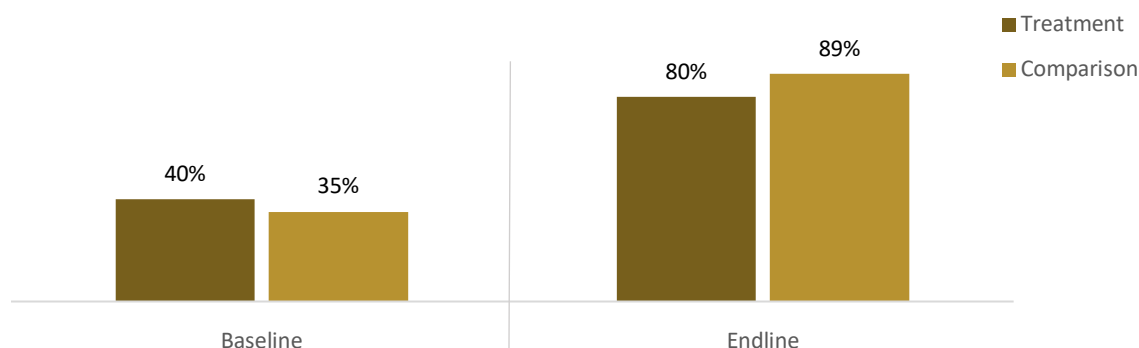
3.3.5 Immediate Outcome 1120: Improved knowledge and attitudes of accessing gender-responsive SRHR information and SRH services

Immediate Outcome 1120 aims to achieve improved knowledge and attitudes of men and women, including parents, caregivers, community leaders and other responsibility holders, to support adolescents and young people, particularly girls and young women, to access gender-responsive SRHR information and SRH services. We measured progress toward this outcome by evaluating: 1) community members attitudes towards SRHR for young people, 2) perceived family support for SRHR, and 3) community members' knowledge of the negative consequences of gender inequality on SRHR.

Indicator 1120.1: Percentage of community members that have positive attitudes towards SRHR for young people

Through the Caregiver/Community Stakeholder Survey, we examined attitudes toward adolescent SRHR by assessing agreement with four key statements about the provision of SRH services to young people. Respondents needed to express agreement with all four statements to be counted towards the indicator.

Endline data revealed substantial increases in support for adolescent SRHR across both areas ([Figure 24](#)). In treatment areas, the proportion of community members expressing positive attitudes doubled from 40% (95% CI [32%, 50%]; M: 35%, F: 42%) at baseline to 80% (95% CI [74%, 86%]; M: 79%, F: 81%) at endline. In comparison areas, an even stronger increase was observed, from 35% (95% CI [28%, 42%]; M: 34%, F: 35%) at baseline to 89% (95% CI [83%, 92%]; M: 90%, F: 88%) at endline. The difference between groups at endline was statistically significant (Adjusted $F(1, 68) = 4.56, p = .036$).



Base: All community members (Baseline treatment $n=225$, comparison $n=311$; Endline treatment $n=184$, comparison $n=157$)

Figure 24: Community members (caregivers and key community stakeholders) who agree with all statements regarding the provision of SRH services to adolescents (%)

The DiD analysis, controlling for observed sociodemographic differences between groups, yielded a significant difference between groups over time in the opposite direction to what would be expected ($B = 0.86, SE = 0.38, 95\% CI [0.09, 1.62], p = .028$), indicating that the comparison group improved significantly more than the treatment group between baseline and endline. The quantitative evidence therefore does not support a positive contribution of *SHARE* to improvements in positive attitudes toward SRHR for young

people relative to comparison areas. The improvement observed in both groups may potentially reflect broader societal factors or exposure to other programmes.

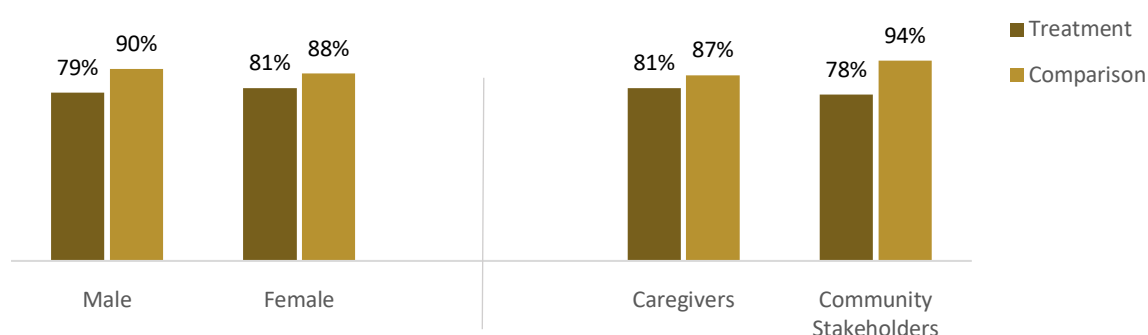
Table 16 shows the percentage of community members who agreed with the individual statements. Across both treatment and comparison areas, point estimates increased for all four statements. The most notable change across both arms was the strong increase in the proportion of community members who believe that everyone should have the choice to use modern family planning methods, from 56% to 96% in the treatment group and from 57% to 99% in the comparison group.

Table 16: Community members (caregivers and key community stakeholders) who agree with different statements regarding the provision of SRH services to adolescents (% [95% CI])

	Baseline		Endline	
	Treatment (n = 225)	Comparison (n = 311)	Treatment (n = 184)	Comparison (n = 157)
Male and female adolescents who receive sex education are less likely to engage in risky sexual activities	83 [79, 87]	83 [77, 88]	90 [85, 94]	97 [93, 99]*
There should be dedicated sexual and reproductive health services for adolescents	81 [75, 86]	80 [75, 84]	92 [86, 95]	93 [88, 96]
Everyone should have the choice to use modern family planning methods	56 [47, 65]	57 [47, 67]	96 [92, 98]	99 [95, 100]
Both sons and daughters should participate in education programmes around sexual reproductive health at school	91 [85, 94]	87 [82, 91]	98 [93, 99]	94 [90, 97]
Agree with all statements	40 [32, 50]	35 [28, 42]	80 [74, 86]	89 [83, 92]*

Note. Base: all community members. Differences between treatment and comparison groups within each wave were tested using Adjusted F-tests. Confidence intervals and p-values are adjusted for the complex sampling design. * $p < .05$, ** $p < .01$, *** $p < .001$.

Apart from the main effect of study arm described above, positive attitudes towards SRHR at endline were broadly similar among male and female community members, and among caregivers and community stakeholders (Figure 25).



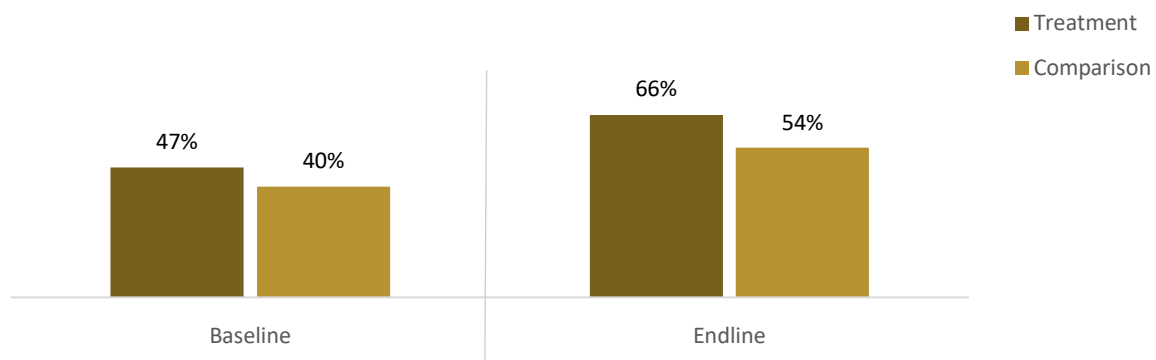
Base: All community members (Treatment male n=53, female n=131, caregiver n=143, community stakeholder n=41; Comparison male n=50, female n=107, caregiver n=126, community stakeholder n=31)

Figure 25: Community members at endline who agree with all statements regarding the provision of SRH services to adolescents, by gender and stakeholder type (%)

Indicator 1120.2: Percentage of adolescents/youth aged 10-24 years who report being supported by their families to access SRHR information and SRH services

To assess family support for adolescent SRHR access, we asked adolescents a series of questions to gauge the level of support they would receive from their parents if they chose or needed to access SRH services, including participation in school-based education programmes, involvement in SRHR clubs and mentorships, access to health facility services, and financial support for SRH services. Respondents were counted toward the indicator only if they reported that their families would support or facilitate access in all circumstances.

At baseline, perceived family support was somewhat higher in treatment areas (47%; 95% CI [44%, 51%]; M: 39%, F: 53%) than in comparison areas (40%; 95% CI [35%, 45%]; M: 35%, F: 43%). By endline, perceived family support had increased in both groups, reaching 66% (95% CI [59%, 72%]; M: 69%; F: 64%) in treatment areas and 54% (95% CI [49%, 59%]; M: 59%, F: 52%) in comparison areas ([Figure 26](#)). The difference between groups at endline was statistically significant (Adjusted $F(1, 70) = 8.89, p = .004$). The DiD analysis, controlling for observed sociodemographic differences between groups, did not reveal a significant effect ($B = -0.19, SE = 0.22, 95\% \text{ CI } [-0.63, 0.26] p = .400$), suggesting no differential change between arms over time. The quantitative evidence therefore does not support a positive contribution of *SHARE* to improvements in perceived family support to access SRHR information and SRH services. The improvement observed in both groups may reflect a range of factors beyond the program, including broader societal factors and exposure to other programmes, although the available data do not permit determination of the reasons underlying this pattern.



Base: All adolescents (Baseline treatment n=833, comparison n=833; Endline treatment n=633, comparison n=633)

Figure 26: Adolescents/youth who report their families would support and facilitate all forms of SRH access (%)

[Table 17](#) shows adolescents' perceptions of parental support across the individual support dimensions. The treatment group showed consistent increases from baseline to endline across all dimensions. In the comparison arm, point estimates remained broadly stable or increased modestly, with gains generally smaller than those observed in the treatment group. Differences between arms were statistically significant at endline across all dimensions of support. Across both groups and both waves, financial

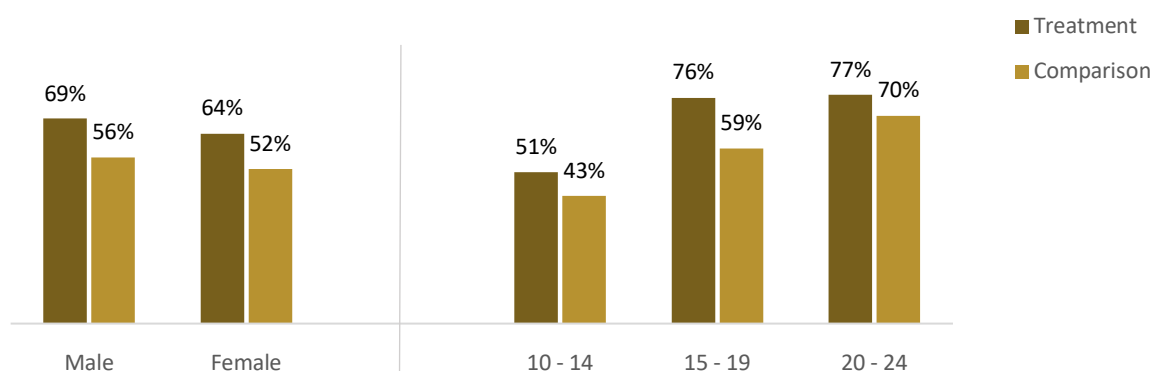
support remained the dimension where adolescents reported the lowest levels of family assistance, suggesting that economic considerations continue to influence SRH access.

Table 17: Adolescents/youth who report their families would support/facilitate them accessing different forms of SRH (% [95% CI])

	Baseline		Endline	
	Treatment (n = 833)	Comparison (n = 833)	Treatment (n = 633)	Comparison (n = 633)
Participating in education programs around sexual reproductive health at their school	65 [61, 69]	60 [56, 64]	86 [82, 90]	69 [63, 74]***
Participating or joining sexual reproductive health right clubs/mentorships at school or in their community	66 [63, 69]	59 [55, 64]*	86 [81, 90]	68 [63, 74]***
Seeking or attending/visiting sexual reproductive health right services and information from health facilities	65 [62, 68]	61 [57, 65]	80 [76, 84]	67 [62, 73]***
Giving financial support to seek sexual reproductive health right services and information from health facilities to them	59 [55, 62]	57 [54, 61]	71 [66, 76]	56 [51, 62]***
Report yes to all types	47 [44, 51]	40 [35, 45]*	66 [59, 72]	54 [49, 59]**

Note. Base: all adolescents. Differences between treatment and comparison groups within each wave were tested using Adjusted F-tests. Confidence intervals and p-values are adjusted for the complex sampling design. * $p < .05$, ** $p < .01$, *** $p < .001$.

Patterns of perceived family support at endline were broadly similar for male and female adolescents within each study arm (Figure 27). In terms of age differences, 10-14-year-old adolescents reported lower perceived parental support compared to older adolescents in both treatment and comparison groups.



Base: All adolescents (Treatment and comparison (balanced) male n=278, female n=355, age 10-14 n=258, age 15-19 n=291, age 20-24 n=84)

Figure 27: Adolescents/youth at endline who report their families would support and facilitate all forms of SRH access, by gender and age (%)

The qualitative findings suggest that some parents and caregivers have become more supportive of adolescent SRHR. Several parents and caregivers reported becoming more willing to discuss puberty, menstruation, sexual relationships and pregnancy prevention with adolescents after participating in community dialogue sessions, school meetings, and health education sessions. Parents described talking with both girls and boys about physical changes during adolescence, encouraging them to seek advice from health facilities, and emphasising that menstruation signals a stage of growth rather than readiness for sexual relationships. One mother explained that:

"I used to think that using them could cause some problem for adolescents... Now I can let him go to fetch condoms without any problem...condoms protect against pregnancy and diseases." (Caregivers in-school adolescent, M, Namaacha, IDI)

Adolescents echoed changes in their parents' attitudes. Many reported that conversations about puberty, relationships, menstruation, and health became more open after the project. An in-school girl explained:

"There are certain parents who used to be embarrassed to talk about the body with their children. But after the project... they also started speaking more." (In-school adolescent girl, 10–14 years, Namaacha, IDI)

An in-school adolescent girl explained that knowledge gained through the project enabled her to discuss SRHR topics at home and even correct her parents' misconceptions about HIV transmission. She also observed that these conversations improved family relationships, noting that her father became less aggressive and discussions at home became more open. Similar experiences were reported by out-of-school adolescents. Participants in a paired interview with out-of-school young men in Lionde further explained that involving caregivers in SRHR education encouraged more open discussions at home and increased adolescents' confidence to talk about SRHR with their parents.

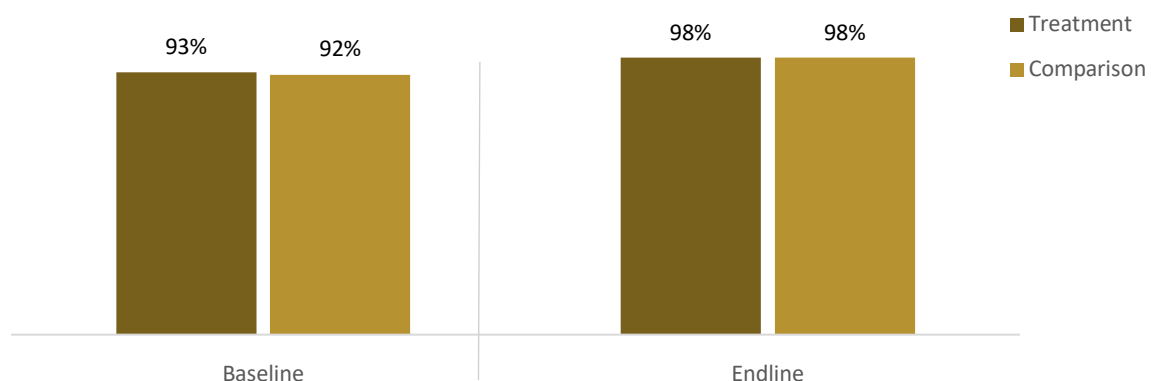
Among AGYW, mothers appeared to be the main source of SRHR information and advice. Some girls described going to their mothers when they had questions about menstruation or when they were worried about changes in their body.

"Through the talks, I learned to share my menstruation secrets with my mother. If I cannot see my period, I go to her, she advises me." (Out-of-school girls, 15–24 years, Namaacha, FGD)

Indicator 1120.3: Percentage of community members with knowledge of the negative consequences of gender inequality on adolescents' SRHR

To evaluate community understanding of how gender inequality affects adolescent SRHR outcomes, we measured community members' agreement with several key statements linking gender dynamics to SRHR. Community members were counted towards the indicator if they expressed agreement with at least three statements.

Results showed consistently strong awareness of how gender inequality affects adolescent SRHR outcomes in both groups at both time points (Figure 28). At baseline, 93% (95% CI [88%, 97%]; M: 95%, F: 93%) of community members in the treatment group met the indicator threshold, compared to 92% (95% CI [89%, 95%]; M: 97%, F: 91%) in the comparison group. By endline, point estimates increased further to 98% (95% CI [94%, 99%]; M: 98%, F: 97%) in both groups, though overlapping confidence intervals warrant caution in interpreting these as definitive population-level changes. The difference between groups at endline was not statistically significant (Adjusted $F(1, 68) = 0.57, p = .812$) and the DiD analysis, controlling for observed sociodemographic differences between groups, did not reveal a significant difference between groups over time ($B = -0.39, SE = 0.81, 95\% \text{ CI } [-1.65, 1.57], p = .961$). Given the already high baseline levels and near-ceiling estimates, the absence of a significant effect likely reflects the limited scope for differential change.



Base: All community members (Baseline treatment $n=225$, comparison $n=311$; Endline treatment $n=184$, comparison $n=157$)

Figure 28: Community members (caregivers and key community stakeholders) who agree with at least three statements regarding gender inequality and adolescents' SRHR (%)

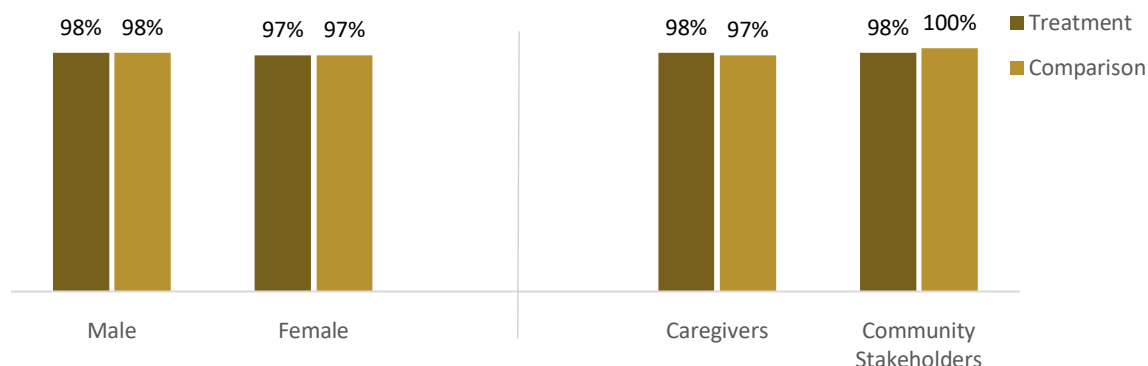
Table 18 presents the results for the individual items within this indicator. Across both arms, support for equal rights for women and girls increased notably from baseline to endline, from 68% to 88% in treatment areas and from 68% to 89% in comparison areas. A similar pattern emerged for attitudes toward intimate partner violence: in the treatment group, the proportion rejecting a husband hitting his wife increased from 82% to 96% between baseline and endline, while in the comparison group it increased from 83% to 92%. In both arms, community members least agreed with the statement that avoiding pregnancy is the responsibility of both men and women (T: 78%, C: 82%).

Table 18: Community members (caregivers and key community stakeholders) who agree with different statements regarding gender inequality and adolescents' SRHR (% [95% CI])

	Baseline		Endline	
	Treatment (n = 225)	Comparison (n = 311)	Treatment (n = 184)	Comparison (n = 157)
Women and girls should have the same rights as men and boys in Mozambique	68 [63, 73]	68 [61, 75]	88 [82, 92]	89 [83, 93]
Avoiding getting pregnant is the responsibility of both the man and the woman	71 [65, 77]	75 [70, 80]	78 [71, 84]	82 [75, 87]
It is equally important for boys and girls to go to school	94 [90, 97]	96 [94, 98]	94 [89, 97]	96 [91, 98]
It's more important for a girl to go to school than to get married	84 [78, 89]	85 [81, 89]	89 [84, 93]	93 [87, 96]
A husband is never justified in hitting his wife	82 [76, 87]	83 [78, 87]	96 [91, 98]	92 [87, 96]
Agree with at least three statements	93 [88, 97]	92 [89, 95]	98 [94, 99]	98 [94, 99]

Note. Base: All community members. Differences between treatment and comparison groups within each wave were tested using Adjusted F-tests. Confidence intervals and p-values are adjusted for the complex sampling design. * $p < .05$, ** $p < .01$, *** $p < .001$.

At endline, awareness was consistently high across gender and stakeholder type in both arms, with no meaningful differences observed (Figure 29).



Base: All community members (Treatment male n=53, female n=131, caregiver n=143, community stakeholder n=41; Comparison male n=50, female n=107, caregiver n=126, community stakeholder n=31)

Figure 29: Community members at endline who agree with at least three statements regarding gender inequality and adolescents' SRHR, by gender and stakeholder type (%)

3.3.6 Immediate Outcome 1220: Improved equitable access to quality, adolescent-friendly and gender-responsive, safe and sanitary SRH services for adolescents and young people, particularly girls and young women

Immediate Outcome 1220 aims to achieve improved equitable access to quality, adolescent-friendly and gender-responsive, safe and sanitary SRH services for adolescents and young people, particularly girls and young women. We measured progress toward this outcome by evaluating: 1) the availability of and adherence to standard operating procedures (SOPs) focused on equitable SRH access, and 2) the development and implementation of action plans following WASH IPC training.

Indicator 1220.2: Number of health facilities equipped with and adhering to SOPs focused on equitable SRH service access

Through the Health Facility Survey, we evaluated the status of SOPs for equitable SRH service access across health facilities in *SHARE* project areas. The indicator assessed both the readiness and implementation of SOPs through two distinct sets of criteria ([Table 19](#)). Since this assessment was not conducted at baseline, only endline results are available.

Table 19: Health facilities meeting criteria for readiness and adherence to SOPs focused on equitable SRH service access (n (%))

	Baseline n = 32	Endline n = 28
<i>Data point 1 – Health facilities equipped with SOPs focused on equitable SRHR (Readiness)</i>		
SOPs are printed and available for HCWs to use ^{a, b}	-	15 (71%) / 20 (95%)
HCWs are aware and trained on the SOPs ^c	-	27 (96%)
All criteria data point 1 met ^a	-	15 (54%) / 20 (71%)
<i>Data point 2 – Health facilities with SOPs focusing on equitable SRH service adhering to minimum criteria (Adherence) ^b</i>		
Posters providing information in a clear and youth friendly format are displayed	-	14 (67%)
Health services ensure privacy and confidentiality in delivering SRH services ^{a, d}	-	15 (71%) / 18 (86%)
Provision of SRH services for adolescents/young people	-	21 (100%)
Clinic hours are suitable for adolescents and young people ^e	-	6 (29%)
SRH services are available for adolescents regardless of gender, age, or marital status	-	1 (5%)
All criteria data point 2 met	-	1 (5%)

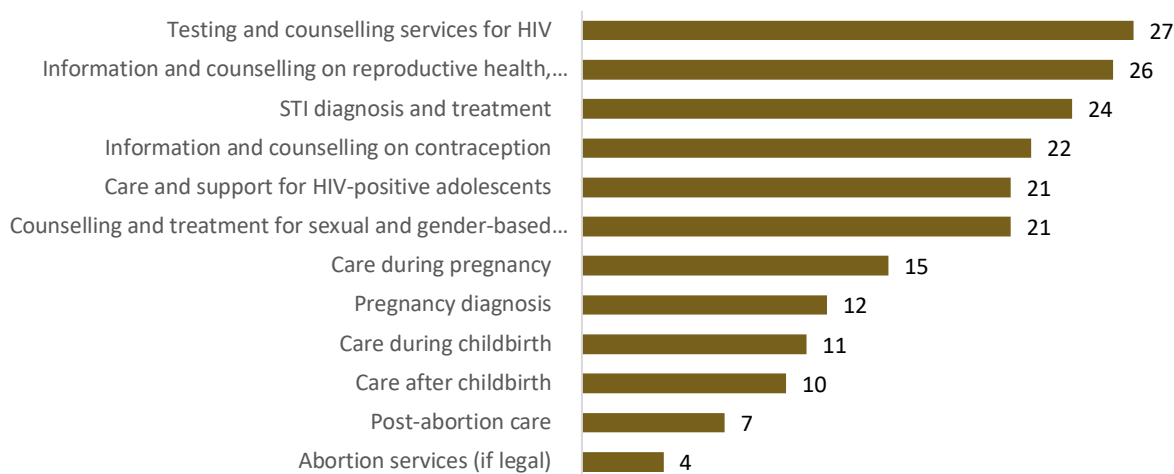
Note. Base: all surveyed facilities, unless otherwise indicated. ^a Where two figures are presented, the first represents the strict version ('Yes, observed' only) and the second the less strict version ('Yes, observed' and 'Yes, reported but not observed'). ^b Based on the sample with a SOP focused on equitable SRHR in place (n = 21). ^c Based on 'All staff' and 'Some staff'. ^d Based on a proxy of counselling and examination rooms providing visual and auditory privacy. ^e Based on '7 days per week' and/or opening hours until (early) evening.

The first data point focused on SOP readiness. At endline, 21 out of 28 facilities (75%) indicated having a SOP focusing on equitable SRHR (note that SOP availability itself was not listed as an explicit criterion in [Table 19](#)). Nearly all facilities reported that at least some staff were aware of and trained on SOPs (27 or 96%). Among those trained at endline, 14 facilities had all staff trained, two had a majority trained, one had about half of the staff trained, and ten had less than half trained. Staff awareness and training on

SOPs was assessed across all facilities regardless of whether a SOP is formally in place – which explains why more facilities reported trained staff than having a SOP – and may reflect cross-facility training or awareness of SOPs from other sources. Among facilities with a SOP in place, most (71%) demonstrated that they had printed copies readily available. In addition, five facilities reported having printed SOPs without providing supporting evidence during the assessment. Based on strict observed criteria, 15 facilities (54%) met all data point 1 requirements at endline, or 20 (71%) when including self-reported instances.

Data point 2 was assessed only among facilities with a SOP in place – 21 facilities (75%) at endline. Provision of SRH services for adolescents was universal across all 21 facilities (100%). Youth-friendly information posters were displayed in 14 facilities (67%). Privacy in service delivery was demonstrated in 15 facilities (71%) under strict criteria, or 18 (86%) when including self-reported compliance. However, clinic hours suitable for adolescents – defined as seven days per week and/or opening hours until early evening – were available in only six facilities (29%). The criterion most rarely met was availability of SRH services regardless of gender, age, or marital status, with only one facility (5%) meeting this requirement. This was largely driven by age restrictions, with only one facility reporting no age restrictions on service access. As discussed under Indicator 1200.1, the age criterion should be interpreted with caution given inconsistent responses observed regarding minimum age requirements across facilities. As a result, only one facility (5%) met all data point 2 criteria at endline.

At endline, almost all facilities offered HIV testing and counselling, and information and counselling on reproductive health, sexuality, and safe sex. STI diagnosis and treatment, information and counselling on contraception, care and support for HIV-positive adolescents, and counselling and treatment for sexual and gender-based violence were available in the majority of facilities. Fewer facilities offered post-abortion care and care during and after childbirth ([Figure 30](#)).



Base: All health facilities (n=28)

Figure 30: Types of SRHR services provided to adolescents by health care facilities at endline (n)

Indicator 1220.3: Number of health facilities with action plans developed and implemented following WASH IPC training

At endline, we assessed the development and implementation of WASH IPC action plans across health facilities in the *SHARE* treatment areas, evaluating four key criteria that reflect both planning and execution of these protocols.

A preliminary question established whether an action plan had been developed following WASH IPC training. Out of 28 facilities, 19 (68%) confirmed this was the case. Among all surveyed facilities, a dedicated trained team was in place in 15 facilities (54%). Eighteen facilities (64%) maintained at least quarterly review meetings, and 17 (61%) met the action plan content criterion. Implementation or initiation of at least one activity was reported by 17 facilities (61%). Overall, 14 facilities (50%) met all four criteria at endline ([Table 20](#)).

Table 20: Health facilities meeting criteria for developing and implementing action plans following WASH IPC training (n (%))

	Baseline <i>n</i> = 32	Endline <i>n</i> = 28
A dedicated trained team is appointed to implement the action plan	-	15 (54%)
The trained team meets at least quarterly to review and update/monitor the action plan	-	18 (64%)
The action plan includes key activities for improvements, outlines the responsibility holders and timelines	-	17 (61%)
At least 1 activity from the action plan is implemented and/or initiated per year	-	17 (61%)
All criteria met	-	14 (50%)

Note. Base: all surveyed facilities.

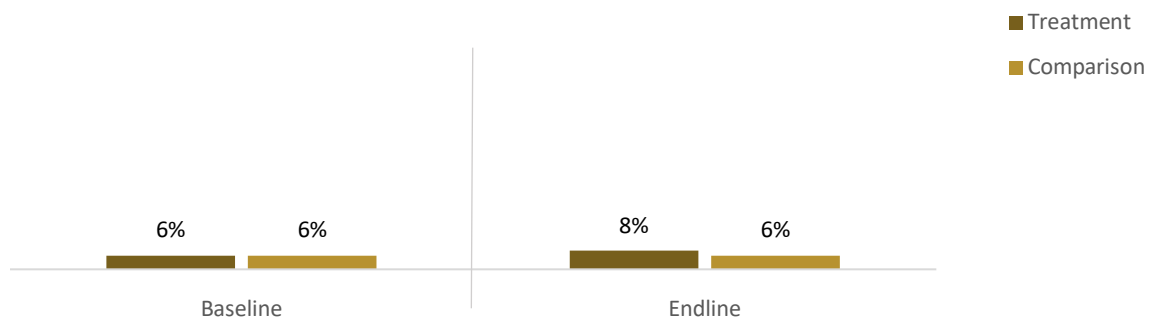
3.3.7 Immediate Outcome 1310: Capacity of key stakeholders to advocate for evidence-based, accountable and gender-responsive SRH services and SRHR policies

Immediate Outcome 1310 aims to achieve increased capacity of key stakeholders, particularly adolescent girls, young women, and CBOs, to advocate for evidence-based, accountable and gender-responsive SRH services and SRHR policies in their communities. We measured progress toward this outcome by evaluating: 1) adolescent girls' and young women's perceptions of their ability to effectively advocate for themselves in their communities, and 2) community members' knowledge of national laws and local policies that affect adolescents' SRHR and gender equality.

Indicator 1310.1: Percentage of girls and young women who feel they can advocate for improved adolescent rights in their communities

We assessed adolescent girls' and young women's perceived advocacy capacity by evaluating their confidence in four areas: problem-solving, negotiation, handling unexpected events, and maintaining composure during difficulties. To be counted toward this indicator, respondents needed to strongly agree with all four statements.

Comprehensive advocacy self-efficacy remained low across both areas and time points ([Figure 31](#)). In treatment areas, the estimated percentage of girls and young women strongly agreeing with all statements was 6% (95% CI [5%, 8%]) at baseline and 8% (95% CI [6%, 12%]) at endline. In comparison areas, estimates were 6% (95% CI [4%, 9%]) at both baseline and endline. Overlapping confidence intervals suggest little evidence of meaningful change over time within either group. The difference between the groups at endline was not statistically significant (Adjusted $F(1, 69) = 2.06, p = .156$), and the DiD analysis, controlling for observed sociodemographic differences between groups, did not reveal a statistically significant difference between groups over time ($B = -0.43, SE = 0.36, 95\% \text{ CI } [-1.15, 0.29], p = .241$).



Base: Adolescent girls/young women (Baseline treatment and comparison (balanced) $n=473$; Endline treatment and comparison (balanced) $n=355$)

Figure 31: Adolescent girls/young women who 'strongly agree' with all statements on their ability to advocate for adolescent rights in their communities (%)

Although comprehensive advocacy self-efficacy was very low, confidence in specific advocacy-related situations was somewhat higher at the individual component level ([Table 21](#)). Overall, patterns were

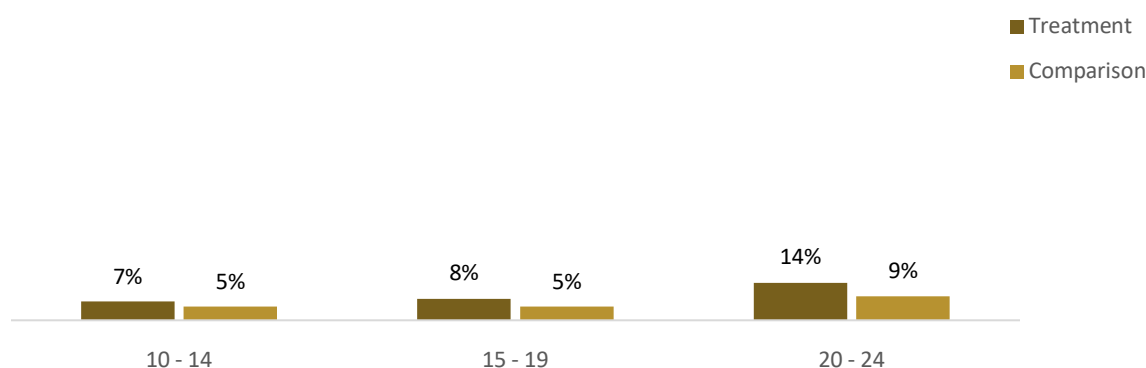
broadly stable over time in both study arms, with point estimates showing only small fluctuations and confidence intervals largely overlapping between baseline and endline.

Table 21: Adolescent girls/young women who ‘strongly agree’ with different statements on their ability to advocate for adolescent rights in their communities (% [95% CI])

	Baseline		Endline	
	Treatment (n = 473)	Comparison (n = 473)	Treatment (n = 355)	Comparison (n = 355)
I can always manage to solve difficult problems if I try hard enough	41 [36, 47]	40 [33, 47]	42 [37, 48]	37 [32, 44]
If someone is against me, it is difficult for me to find ways to get what I want ^a	33 [29, 37]	39 [34, 44]*	34 [27, 41]	28 [22, 35]
I am confident that I could handle unexpected events very well	36 [32, 41]	34 [28, 40]	44 [38, 50]	39 [33, 44]
I can remain calm when facing difficulties because I can rely on my own abilities	58 [53, 62]	56 [50, 62]	55 [49, 60]	50 [45, 57]
Strongly agree all types	6 [5, 8]	6 [4, 9]	8 [6, 12]	6 [4, 9]

Note. Base: Adolescent girls/young women. Differences between treatment and comparison groups within each wave were tested using Adjusted F-tests. Confidence intervals and p-values are adjusted for the complex sampling design. ^a Scores represent those who ‘strongly disagree’. * $p < .05$, ** $p < .01$, *** $p < .001$.

Figure 32 presents endline comprehensive advocacy self-efficacy disaggregated by age group. However, very small numbers of respondents within each age category meeting the indicator threshold ($n=4-14$), together with wide confidence intervals, limit the interpretability of age-disaggregated estimates and preclude meaningful inference on age-related differences in this indicator.



Base: Adolescent girls/young women (Treatment age 10-14 $n=154$, age 15-19 $n=157$, age 20-24 $n=44$; Comparison age 10-14 $n=154$, age 15-19 $n=157$, age 20-24 $n=44$)

Figure 32: Adolescent girls/young women at endline who ‘strongly agree’ with all statements on their ability to advocate for adolescent rights in their communities, by age (%)

Indicator 1310.2: Percentage of community members with knowledge of national laws and local policies that affect adolescents and young people's SRHR and gender equality

Through the Caregiver/Community Stakeholder Survey, we assessed community members' knowledge of six key aspects of national laws and local policies affecting young people's SRHR and gender equality in Mozambique. To be counted toward this indicator, respondents needed to correctly answer all questions.

At both baseline and endline, no community members in either treatment or comparison areas were able to correctly answer all questions ([Figure 33](#)).



Base: All community members (Baseline treatment n=225, comparison n=311; Endline treatment n=184, comparison n=157)

Figure 33: Community members (caregivers and key community stakeholders) who correctly answered all questions about national laws and local policies affecting adolescent SRHR and gender equality (%)

Examining the specific knowledge components ([Table 22](#)) reveals that overall low knowledge levels are primarily driven by very limited awareness of the legal age of consent for sex. In Mozambique, the age of consent for sex is set at 16 years for both boys and girls. Yet only a handful of respondents in either arm correctly identified this. In contrast, knowledge of the legal ages of consent for marriage (18 years in Mozambique) increased substantially between baseline and endline in both groups, with a more pronounced increase in the treatment arm. Awareness of laws protecting against harmful traditional practices remained low, though it increased in treatment areas from 28% to 41%. Community members showed comparatively high awareness of domestic violence legislation at both baseline and endline.

Table 22: Community members (caregivers and key community stakeholders) who correctly answer different questions about national laws and local policies affecting adolescent SRHR and gender equality (% [95% CI])

	Baseline		Endline	
	Treatment (n = 225)	Comparison (n = 331)	Treatment (n = 184)	Comparison (n = 157)
Age of consent for sex – boys	4 [3, 7]	2 [1, 4]	2 [1, 5]	1 [0, 5]
Age of consent for sex – girls	4 [2, 7]	4 [2, 7]	2 [0, 12]	<1 [0, 5]
Age of consent for marriage – boys	14 [10, 19]	19 [15, 25]	43 [35, 52]	32 [26, 40]*
Age of consent for marriage – girls	18 [13, 25]	19 [14, 25]	47 [39, 55]	35 [27, 42]
Aware of national laws to protect against harmful traditional practices such as Female Genital Mutilation	28 [23, 35]	27 [22, 33]	41 [32, 50]	32 [23, 43]
Aware of national laws to protect against domestic violence	87 [83, 90]	81 [76, 85]	81 [73, 87]	76 [69, 82]
Correctly answered all questions	0 [0, 0]	0 [0, 0]	0 [0, 0]	0 [0, 0]

Note. Base: All community members. Differences between treatment and comparison groups within each wave were tested using Adjusted F-tests. Confidence intervals and p-values are adjusted for the complex sampling design. * $p < .05$, ** $p < .01$, *** $p < .001$.

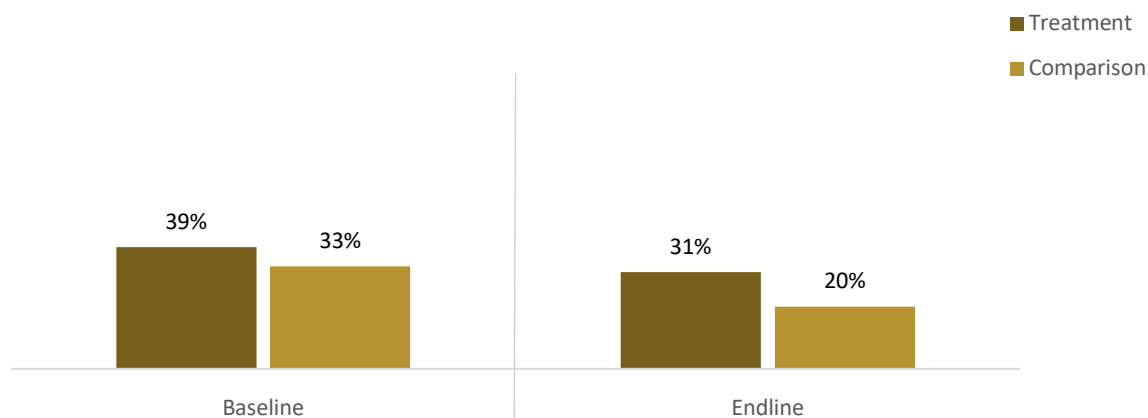
3.3.8 Immediate Outcome 1320: Increased access to evidence and knowledge exchange platforms to promote social action

Immediate Outcome 1320 aims to achieve increased access to evidence and knowledge exchange platforms to promote social action for gender and adolescent responsive SRH services and SRHR policies. We measured progress toward this outcome with one indicator.

Indicator 1320.1: Percentage of community members that report attending a ASRHR focused social action forum

To assess knowledge exchange around SRHR in the surveyed communities, we examined community members' participation in social action forums. It is important to note that the survey question broadly asked about participation in any social action forums in the past 12 months (including community discussions, in-school dialogues, and community score card processes) rather than specifically focusing on adolescent SRHR forums, as specified in the indicator.

At baseline, participation levels were broadly comparable between arms, with 39% (95% CI [31%, 48%]; M: 53%, F: 35%) of community members in treatment areas and 33% (95% CI [27%, 39%]; M: 46%, F: 29%) in comparison areas reporting participation in social action forums. By endline, point estimates in treatment areas were somewhat lower at 31% (95% CI [23%, 40%]; M: 51%, F: 23%), though overlapping confidence intervals warrant caution in interpreting this as a definitive population-level change. Participation in comparison areas dropped more substantially to 20% (95% CI [14%, 28%]; M: 40%, F: 10%, see [Figure 34](#)). The difference between arms at endline was statistically significant (Adjusted $F(1, 68) = 4.13, p = .046$).

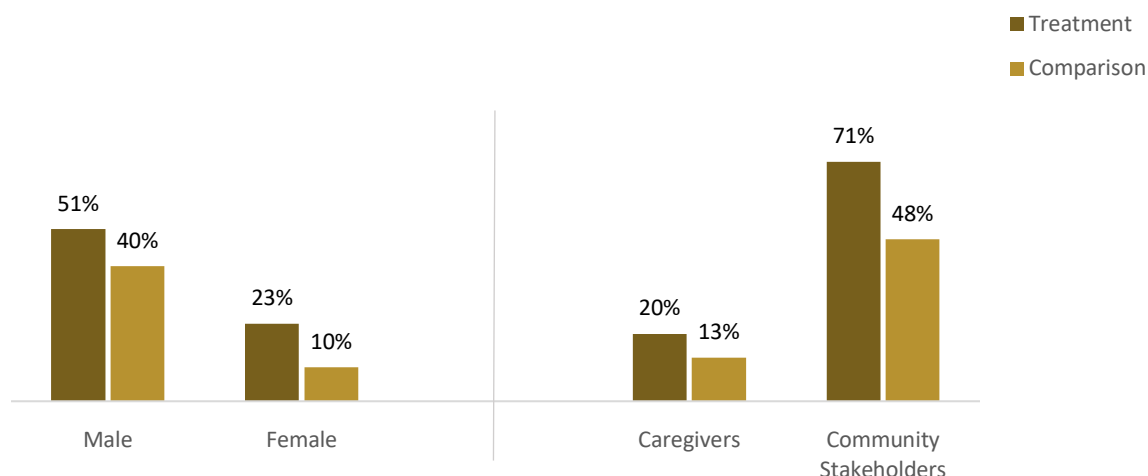


Base: All community members (Baseline treatment n=225, comparison n=311; Endline treatment n=184, comparison n=157)

Figure 34: Community members (caregivers and key community stakeholders) who participated or attended any social action forum in the past 12 months (%)

The DiD analysis, controlling for observed sociodemographic differences between groups, did not reveal a significant difference between groups over time ($B = -0.41$, $SE = 0.40$, 95% CI $[-1.20, 0.38]$, $p = .305$), consistent with the modest 5 percentage point difference-in-difference. While point estimates suggest that participation declined less in treatment areas than in comparison areas, results do not provide evidence of a differential project effect. It should be noted that the Caregiver/Community Stakeholder Survey sample was not powered for these analyses, and results should therefore be considered indicative only rather than as definitive evidence of presence or absence of a treatment effect.

Figure 35 presents endline results disaggregated by gender and stakeholder type. In both treatment and comparison areas, key community stakeholders showed considerably higher participation rates (T: 71%, C: 48%) compared to caregivers (T: 20%, C: 13%). Furthermore, male community members reported higher participation rates (T: 51%, C: 40%) than female community members (T: 23%, C: 10%).



Base: All community members (Treatment male n=53, female n=131, caregiver n=143, community stakeholder n=41; Comparison male n=50, female n=107, caregiver n=126, community stakeholder n=31)

Figure 35: Community members at endline who participated or attended any social action forum in the past 12 months, by gender and stakeholder type (%)

To obtain further insight into the focus of social action forum participation among community members, we asked respondents at endline whether they had participated in any community dialogues or discussion sessions about adolescent sexual and reproductive health in the past four years. As this question was not asked at baseline, results cannot be compared over time. At endline, 32% of community members in treatment areas and 25% in comparison areas reported having participated in such sessions. Among those who participated, respondents in treatment areas attended more sessions than respondents in comparison areas, with 12% of treatment group respondents having attended 1 session (vs. 23% of

comparison group respondents), 21% having attended 2-3 sessions (vs. 44% comparison), and 67% having attended 3 or more sessions (vs. 33% comparison). This suggests that where community sessions took place in treatment areas, engagement tended to be more sustained. In treatment areas, 69% of participants indicated these dialogues were organised by *SHARE* or its partners.

We also asked community members about their attendance at community or awareness-raising events related to health, women's rights, or adolescent issues, such as events celebrating International Women's Day or World Menstrual Hygiene Day. At endline, 32% of community members in treatment areas and 20% in comparison areas reported attending such events, with 66% of treatment area participants indicating these were organised by *SHARE* or its partners. In addition, community members were asked about their exposure to communication campaigns. At endline, 29% of community members in treatment areas reported exposure to some form of campaign in the past 12 months, compared to 15% in comparison areas. Across all measures, participation and exposure were consistently higher among key community stakeholders and male community members compared to caregivers and female community members.

3.3.9 Outcome indicators, by exposure

The following analyses examine whether adolescents who reported direct engagement with *SHARE* activities showed different outcome levels compared to those who did not. It is important to note that the absence of self-reported exposure does not mean a respondent was not reached by the *SHARE* project; as discussed in [Section 3.2.3](#), self-reported exposure likely underestimates true project reach (i.e., respondents may have been exposed through other pathways, and responses may be affected by recall limitations or uncertainty about whether particular experiences qualified as *SHARE* activities, among other factors). The comparison between self-reported exposed and non-exposed respondents within the treatment arm should therefore be interpreted as a comparison of higher versus lower or differently measured exposure, rather than exposed versus unexposed. At the same time, adolescents who participate in specific *SHARE* activities likely differ systematically from non-participants in ways correlated with outcomes. Given the limitations of self-reported exposure measurement and the potential for self-selection bias, these analyses should therefore be considered exploratory and hypothesis-generating only.

Apart from Outcome Indicator 1200.2, adolescents with self-reported *SHARE* exposure consistently showed higher outcome levels across indicators, with statistically significant differences for 10 out of 12 indicators and differences of up to 25 percentage points ([Table 23](#)). As noted above, these findings cannot be interpreted as evidence of *SHARE* project effectiveness. Nevertheless, they suggest that adolescents reporting participation in *SHARE* activities also tended to report more favourable SRHR outcomes, which is a notable finding.

Table 23: Outcome indicator levels among treatment arm adolescents/youth at endline by self-reported *SHARE* exposure (%)

	Total treatment (<i>n</i> = 633)	No self-reported <i>SHARE</i> exposure (<i>n</i> = 305)	Self-reported <i>SHARE</i> exposure (<i>n</i> = 328)	χ^2 / <i>t</i> , <i>p</i> -value
1000.2: Percentage of women aged 15 to 24 years who make their own decisions regarding sexual and reproductive health and rights ^a	77	66	86	4.61, <i>p</i> = .032
1100.1: Percentage of youth who used SRH services	21	14	28	18.33, <i>p</i> < .001
1100.2: Percentage of youth demonstrating positive attitudes towards ending SGBV	44	33	54	28.80, <i>p</i> < .001
1100.3: Percentage of youth who are confident that they could get their partner(s) to use contraceptives / condoms if they desired ^b	83	80	86	0.98, <i>p</i> = .323
1100.4: Percentage of sexually active girls always using (or whose partner uses) a modern method of contraception ^c	57	45	67	4.36, <i>p</i> = .037
1200.2: Percentage of adolescents and young people who are satisfied with ASRH services ^d	79	79	79	0.00, <i>p</i> = .970
1300.2: Percentage of adolescent girls participating in SRHR advocacy and social action initiatives ^e	None: 80 Low: 12 Medium: 5 High: 3	None: 94 Low: 3 Medium: 3 High: <1	None: 69 Low: 19 Medium: 6 High: 6	35.25, <i>p</i> < .001
1300.3: Average resilience score among young people	2.85	2.82	2.88	-3.65, <i>p</i> < .001
1110.1: Percentage of young people that are knowledgeable of their SRHR	41	34	47	11.39, <i>p</i> < .001
1110.3: Percentage of adolescents and youth who believe they could seek sexual and reproductive health information and services if they needed them	86	80	91	16.13, <i>p</i> < .001
1120.2: Percentage of adolescents and young people who report being supported by their families to access SRHR information and services	66	57	74	18.92, <i>p</i> < .001
1310.1: Percentage of girls and young women who feel they can advocate for improved adolescent rights in their communities ^e	8	4	12	5.65, <i>p</i> = .017

Note. Base: All adolescents in the treatment group, unless indicated otherwise with superscripts. Self-reported *SHARE* exposure is defined as having participated in a *SHARE*-supported school club, community-based mentorship group, or community / awareness-raising event.

^a Restricted to girls/young women aged 15 years and older in a relationship and sexually experienced (Any exposure *n*=43; no exposure *n*=38)

^b Restricted to adolescents in a relationship (Any exposure *n*=90; no exposure *n*=106)

^c Restricted to girls/young women who were sexually active in the past 12 months (Any exposure *n*=46; no exposure *n*=38)

^d Restricted to respondents who used SRH services (Any exposure *n*=92; no exposure *n*=43)

^e Restricted to girls/young women (Any exposure *n*=199; no exposure *n*=156)

Results show a mixed picture across the four community indicators ([Table 24](#)). No meaningful differences were observed between exposure groups for positive SRHR attitudes or knowledge of gender inequality consequences, suggesting these outcomes were broadly similar regardless of self-reported exposure. In contrast, social action forum participation was notably higher among *SHARE*-exposed respondents,

though this finding should be interpreted cautiously as there is a direct overlap between the exposure measure – which includes community dialogues and awareness-raising events – and the social action forum indicator itself, meaning the difference partly reflects the same activities being measured twice rather than an independent project effect.

Table 24: Outcome indicator levels among treatment arm community members at endline by self-reported *SHARE* exposure (%)

	Total treatment (<i>n</i> = 184)	No self-reported <i>SHARE</i> exposure (<i>n</i> = 138)	Self-reported <i>SHARE</i> exposure (<i>n</i> = 46)	χ^2 / <i>t</i> , <i>p</i> -value
1120.1: Percentage of community members that have positive attitudes towards SRHR for young people	80	83	72	2.95, <i>p</i> = .086
1120.3: Percentage of community members that have knowledge of the negative consequences of gender inequality on SRHR	98	99	96	1.36, <i>p</i> = .243
1310.2: Percentage of community members that have knowledge of national laws and local policies that affect adolescents/young people's SRHR and gender equality	0	0	0	-
1320.1: Percentage of community members that report attending a ASRHR focused social action forum	31	16	76	58.37, <i>p</i> < .001

Note. Base: all community members in the treatment group. Self-reported *SHARE* exposure is defined as having participated in a *SHARE*-supported community dialogues or community / awareness-raising event.

As with the adolescent analysis, the dose-response analyses should be considered exploratory and hypothesis-generating only, given the limitations of self-reported exposure measurement and the likelihood that non-exposed respondents may also have been reached through other programme activities.



Adolescents partaking in school club activities.

3.4 Impact

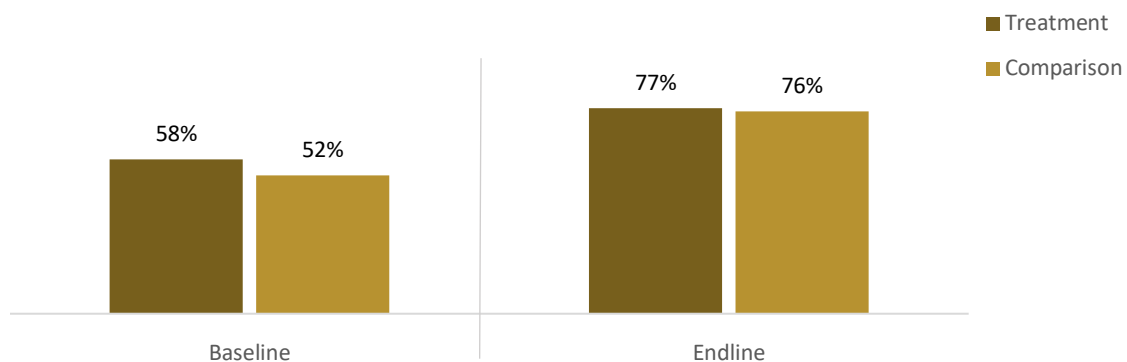
3.4.1 Ultimate Outcome 1000: Increased enjoyment of health-related human rights by the most marginalized and vulnerable rights-holders

The Ultimate Outcome of the *SHARE* project is increased enjoyment of health-related human rights by the most marginalized and vulnerable rights holders, particularly girls and young women. The endline evaluation assessed this outcome through the following indicator.

Indicator 1000.2: Percentage of women aged 15 to 24 years who make their own decisions regarding sexual and reproductive health and rights

We assessed Ultimate Outcome 1000 through indicator 1000.2, which measures the percentage of women aged 15 to 24 years who make their own decisions regarding SRHR across three domains: the ability to say no to sexual intercourse with their partner if they do not want to, decisions about contraception use, and decisions about their own healthcare. To be counted towards the indicator, respondents needed to report autonomous decision-making across all three domains. As these questions are only relevant to those with direct experience of sexual relationships, the analysis was restricted to adolescent girls and young women aged 15-24 who were married, cohabiting, or in a relationship and sexually experienced (Baseline treatment $n=128$, comparison $n=134$; Endline treatment $n=81$, comparison $n=96$).

At baseline, 58% (95% CI [47%, 68%]) of adolescent girls and young women in the treatment group and 52% (95% CI [45%, 60%]) in the comparison group reported autonomous decision-making across all three domains, with no statistically significant difference between arms (Adjusted $F(1, 72) = 0.72$, $p = .400$). By endline, point estimates were higher in both groups, reaching 77% (95% CI [68%, 84%]) in the treatment group and 76% (95% CI [64%, 85%]) in the comparison group (Figure 36). The difference between arms at endline was not statistically significant (Adjusted $F(1, 63) = 0.01$, $p = .941$). Given the restricted analytical sample underlying the analyses, these estimates should be interpreted with caution.



Base: Adolescent girls/young women aged 15-24 who are married, cohabiting or in a relationship and sexually experienced (Baseline treatment $n=128$, comparison $n=134$; Endline treatment $n=81$, comparison $n=96$)

Figure 36: Adolescent girls/young women who make their own decisions regarding SRHR (%)

The DiD analysis, controlling for observed sociodemographic differences between groups, did not reveal a significant effect ($B = 0.22$, $SE = 0.43$, 95% CI [-0.64, 1.08], $p = .612$). Both groups showed increases in autonomous SRHR decision-making over time, with the comparison group improving somewhat more than the treatment group, resulting in a 5-percentage point difference-in-difference in favour of the comparison arm. The quantitative evidence therefore does not support a differential contribution of *SHARE* to improvements in autonomous SRHR decision-making among this subgroup.

At the individual domain level, healthcare decision-making improved in both arms, from 64% to 87% in the treatment group and from 60% to 87% in the comparison group. The ability to say no to sexual intercourse and contraception decision-making remained broadly stable in both groups (Table 25).

Table 25: Adolescents and young women aged 15-24 who make their own decisions regarding SRHR (% [95% CI])

	Baseline		Endline	
	Treatment ($n = 128$)	Comparison ($n = 134$)	Treatment ($n = 81$)	Comparison ($n = 96$)
Can say no to sexual intercourse with their partner if they do not want to	93 [86, 96]	89 [83, 93]	85 [78, 90]	85 [75, 90]
Decide on use of contraception	97 [92, 99]	96 [90, 98]	94 [90, 97]	93 [88, 96]
Decide on their own health care	64 [53, 74]	60 [54, 67]	87 [82, 90]	87 [80, 92]
All criteria met	58 [47, 68]	52 [45, 60]	77 [68, 84]	76 [64, 85]

Note. Base: Adolescent girls/and young women aged 15-24 who are married, cohabiting or in a relationship and sexually experienced. Differences between treatment and comparison groups within each wave were tested using Adjusted F-tests. Confidence intervals and p-values are adjusted for the complex sampling design. * $p < .05$, ** $p < .01$, *** $p < .001$.

From the qualitative component of the evaluation, the findings showed that the *SHARE* project may have contributed to laying foundations for greater agency regarding SRH choices, confidence, and bodily autonomy among AGYW through mentorship, safe discussion spaces, adolescent-responsive services, teacher engagement, caregiver involvement, and changing attitudes toward gender equality. Rather than fundamentally transforming power relations, the evidence points to early but meaningful shifts in relational power dynamics within households, schools, and SRH services were deemed to have occurred. Stakeholders opined that these shifts have been due to perceived increase in girls' confidence to express concerns, negotiate boundaries, seek support, participate in decisions, and increasingly view themselves as capable of shaping their own futures. Similarly, while broader social norms and authority structures remained influential, respondents described more supportive communication and greater openness to adolescents' and women's voices than before. Within households, many parents and caregivers frequently described moving away from more hierarchical decision-making and communication toward greater dialogue with AGYW and increased recognition of their voices and described becoming more respectful in communication with adolescents.

Interviews and FGDs with young women, and health workers indicated that the *SHARE* project was seen to have strengthened young women's autonomy to make decisions regarding their SRHR and increased their confidence to make decisions about sexual relationships, contraception, pregnancy, and use of SRH services. AGYW specifically highlighted that they felt they were better equipped in making their own decisions about sexual relationships and refusing unwanted sexual activity. All these changes were commonly linked to increased knowledge of SRHR, increased self-esteem, mentoring, peer support, and availability of adolescent-friendly health services. An out-of-school young woman in Namaacha explained how she ended a relationship after repeatedly refusing pressure to have sex:

"I said no. He insisted. I said no again... this is not going to work here" (Out-of-school girls, 15–24 years, FGD, Namaacha)

Similarly, an in-school girl in Lionde emphasised that girls should be able to refuse unwanted sexual activity and expect their decisions to be respected:

"When we have a boyfriend and he starts pressuring us—we have to know how to refuse. Say no. Whatever we say, he has to accept it. This is a clear understanding that we got from those events." (In-school girls, 15–19 years, FGD, Lionde)

Young women also demonstrated greater autonomy in making decisions about contraception and pregnancy prevention. Participants reported deciding whether to use contraceptive methods, selecting methods that suited their needs, and negotiating condom use with partners. An in-school girl in Lionde explained that contraceptive use had become a shared decision rather than something determined by her boyfriend. An out-of-school young woman in Lionde similarly described independently deciding both to become sexually active and to ensure contraceptive protection:

"Despite it being difficult, I decided for myself. Nobody influenced me... I cannot maintain sexual relations without any method." (Out-of-school young woman, 15–24 years, IDI, Lionde)

Many participants described greater confidence to make decisions for themselves, becoming less dependent on others' opinions, trust their own judgement and take responsibility for choices relating to their health, relationships and future. An out-of-school young woman in Namaacha explained:

"I know how to make my own decisions, I have self-esteem. I do not need someone to tell me: you have to do this... I know how to say yes to this and no to that." (Out-of-school young women, 15–24 years, Namaacha, FGD)

Greater exposure to SRHR information, mentoring, peer learning opportunities and adolescent-friendly health services appeared to strengthen young women's confidence and decision-making autonomy. Young women explained that safe spaces created by mentors and health workers enabled them to ask questions without fear of judgement, while respectful and confidential services increased their confidence to seek information and care. Health workers and other stakeholders also observed that girls had become more willing to ask questions, express their views and participate in decisions regarding their reproductive health.

Despite these improvements, young women, community leaders, and health workers identified barriers that continued to constrain young women's decision-making. Family expectations, parental authority, partner influence, restrictive gender norms and fear of violence remained important challenges. Health workers and community stakeholders explained that some parents and partners discouraged girls from using contraception or acting on information received through the project. One health worker summarized this challenge:

"No, they [adolescents] aren't the ones who decide—it's the parents who decide. It will really take a lot more to change certain parents" (Health worker, Namaacha, KII)

Young women also reported that discussing SRHR remained difficult in some families because parents avoided conversations about sexuality:

"Many parents don't say anything. This is what many of my friends say. I shared what I learned with my parents, but they quickly change the subject. This remains a challenge when we try to speak to them." (Out-of-school young women, 15–24 years, Lionde, Paired interview)

Adolescents explained that parents avoided discussing sexuality or continued to treat SRHR as a taboo topic, while caregiver interviews indicated that some parents in particular fathers remained uncomfortable discussing reproductive health with daughters and misconceptions about contraception persisted in some families. This persistent issue relating to social norms have been highlighted at the end of implementation of similar ASRH programmes, including Programa Geração Biz, despite its documented success.⁶⁴ It highlights the persistent nature of the challenge and the justification for sustained efforts with an inter-generational approach.

⁶⁴ Chandra-Mouli V, Gibbs S, Badiani R, Quinhas F, Svanemyr J. Programa Geração Biz, Mozambique: how did this adolescent health initiative grow from a pilot to a national programme, and what did it achieve? *Reprod Health*. 2015 Feb 17;12:12. doi: 10.1186/1742-4755-12-12.

3.5 Sustainability

Across stakeholder groups, including teachers, health workers, government officials, consortium members, community leaders, and adolescents, participants believed that several activities introduced through the *SHARE* project would continue after project completion. They most frequently referred to SRHR education in schools, adolescent-friendly health services, community awareness sessions, peer mentoring, and the continued use of educational materials and approaches. Several stakeholders viewed that these activities could continue due to the knowledge and skills developed through the project, which they believed had become embedded within existing schools, health facilities, government systems, and community structures.

Teachers described SRHR education as part of their routine responsibilities rather than a project activity. Although one teacher anticipated difficulties in replacing educational materials, classroom planning and implementation were expected to continue because these activities had become part of routine school practice.

"Perhaps what we'll have to deal with is a lack of materials... But in terms of planning and implementation in the classroom, I don't think that will stop. It won't stop. It's already part of our daily routine." (Teacher, male, Namaacha, KII)

Health workers expressed similar views. They would continue providing adolescent-friendly services using the approaches learned through the project because the knowledge would remain even after project completion.

"I will continue giving the sessions... Because the project may go, but the knowledge stays... I will continue to work the same way: giving sessions at school, in the community, at the health unit, using the same methodologies learned within the project." (Health worker, female, Lionde, KII)

Teachers, government officials, and consortium members further mentioned how project knowledge had spread beyond those who directly participated in the training. Trained teachers had shared what they learned with colleagues, allowing SRHR education to be delivered more widely within the school. As one teacher explained:

"It is no longer just the teachers who participated in the project doing this work. Some teachers who didn't participate have also adopted it and are doing the work. We passed these teachings along so they could be used across other classrooms." (Teacher, female, Lionede, KII)

Several stakeholders also discussed the importance of maintaining project materials, infrastructure, and partnerships to support activities after the project ended. Teachers, health workers, government officials, consortium members, and NGO representatives considered these resources useful for continuing adolescent SRHR education and services, although some noted that they would require ongoing maintenance and support. Teachers frequently referred to educational materials such as posters, leaflets, and teaching aids. They explained that these materials should be preserved so they could continue to be used by future groups of students.

Consortium members explained that district coordination meetings had created opportunities for government departments and other organisations to continue discussing adolescent SRHR after the project ended. In some districts, consortium members had already shared project materials with organisations that would continue working in the area. An NGO respondent also considered the establishment of multisectoral forums as an important achievement. According to the respondent, bringing together health workers, traditional practitioners, local leaders, and other stakeholders created a platform that could continue supporting discussion and coordination on adolescent sexual and reproductive health beyond the project period.

Community leaders, adolescents, health workers, and consortium members noted local ownership as an important factor supporting sustainability. Across these groups, participants believed that the knowledge gained through the project would continue to spread through existing community networks rather than relying solely on project staff. Community leaders mentioned continuing discussions through parents, local leaders, and religious leaders after the project ended. Adolescents also noted examples of these activities continuing in their communities. One out-of-school adolescent noted:

"The block chiefs come in December, on Saturdays, and ask people to be at the community space to talk about health — even though the project is no longer there." (Out-of-school adolescent boy, IDI)

Consortium members linked this continuity to efforts made during project implementation, including training community members, junior mentors, and adolescent groups, and strengthening community committees before project closure. Health workers similarly recognised the contribution of community activists in connecting adolescents with health services, although they noted that sustaining these roles would depend on the continued commitment of volunteers and local leaders.

Consortium members explained that this transition was supported through sustainability planning with ministries and district authorities. Rather than being developed at the end of the project, the sustainability plan was introduced during implementation to identify which activities could continue through existing education and health systems.

"The sustainability plan was thought through from the very beginning... saying what will happen after I leave—what can you continue doing after I'm gone?"
(Consortium member, female, KII)

At the same time, consortium members recognized that these plans had limitations. While activities integrated into schools and health facilities were considered more likely to continue, sustaining community-based interventions remained more challenging because of limited financial and technical resources. One consortium member questioned whether district plans could be fully implemented given the country's financial constraints.

Interviews with consortium members, government officials, and health workers also revealed that they were less confident that community outreach, mentoring, supervision, and other activities requiring operational support could continue at the same level without project resources. As one consortium member explained:

"Inside schools, the Ministry of Education can easily continue those activities. But in the community, it was mentors. Who is going to pay mentors?" (Consortium member, female, KII)

While many believed that the knowledge and skills developed through the project would remain, they questioned whether the same level of implementation could be maintained without continued financial support. The funding needs described by participants varied according to their roles and responsibilities. One district education official explained that the education sector lacked the capacity to continue supporting community interest groups because the project had previously provided incentives. The same respondent also highlighted the need to better support community mentors. Another government official noted that although district plans were in place, implementation remained constrained by limited budgets. Health workers also associated sustainability with continued operational support. Although they believed adolescent-friendly services would continue, they expected community outreach and infrastructure maintenance to become more difficult without partner support.

"Without the partner it will continue — but very limited. Infrastructure maintenance will be difficult." (Health worker, female, KII)

Teachers and health workers highlighted that continued capacity building as essential for maintaining project results. While many felt confident that those already trained would continue applying their knowledge, they recognised that teachers and health workers are regularly replaced or transferred. Without ongoing training, respondents believed the quality of activities could gradually decline. A health worker highlighted this challenge, explaining:

"Providers are always on the move. When they move, others come who were not trained." (Health worker, female, KII)

Further, volunteer motivation was another issue raised by a district education official. While recognizing the important contribution of community mentors, the respondent suggested that limited allowances and the absence of recognition could reduce their willingness to continue supporting project activities. One consortium member noted that improving ASRH depended on an ongoing process of behaviour change among adolescents, parents, teachers, and health workers, arguing that without continued discussions in schools and communities, these changes could gradually decline over time. Schools, communities, and government institutions would need to continue reinforcing key messages after the project ended.

Despite these concerns, community leaders, adolescents, government stakeholders, consortium members, and NGO representative respondents also identified several factors that could strengthen sustainability. These included preserving educational materials, maintaining collaboration between education, health, and community stakeholders, supporting local champions, and encouraging parents and community leaders to continue sharing information. Community respondents described continuing discussions through community meetings, churches, and local leaders, while consortium members highlighted sustainability plans, district ownership, and partnerships with government and other organisations as mechanisms to support continuation. NGO representatives similarly viewed multisectoral collaboration as an important platform for maintaining attention to adolescent sexual and reproductive health beyond the project period.

Taken together, teachers, health workers, government officials, consortium members, community leaders, adolescents, and NGO representatives believed that the knowledge, skills, and approaches introduced through the *SHARE* project are likely to continue, and at the same time, they recognized that sustaining these activities would require continued training, collaboration, and financial support, particularly for community-based activities that depended on outreach and volunteers.

An NGO respondent representative explained that the local mentors trained through *SHARE* later supported activities under another project.

"We found out that there were local mentors who had already worked with the SHARE project... supported us in delivering that activity... the session was facilitated by an adolescent from the community itself." (NGO representative, F, KII)



4. Conclusion and Recommendations

4.1 Conclusion

The *SHARE* project set out to tackle a complex and contextually relevant public health issue in Mozambique. The project did so by leveraging evidence-based practices, community engagement, and gender-transformative strategies. There were varying implementation challenges, however, the project aligned with existing structures, which was viewed positively by stakeholders. While four indicators showed statistically significant differential change in favour of treatment areas, several other indicators showed notable improvements in treatment areas that were not significantly different from comparison areas. In other instances, outcomes were maintained in both treatment and comparison sites. The indicator used to assess the ultimate outcome (the percentage of women aged 15–24 years who make their own decisions regarding SRHR) improved in the project sites, although this change was not statistically significantly different from the change observed in comparison areas. Taken together, these findings are consistent with the possibility that the *SHARE* project contributed to improvements in SRHR outcomes among adolescents and community members in the treatment areas, while also identifying areas for further strengthening. At the same time, findings should be interpreted with caution, given that a UNFPA-funded intervention similar to the *SHARE* project was being parallelly implemented in the comparison sites (though exposure appears to have been limited), limitations of the DiD design constrained the extent to which estimates can be interpreted as causal effects, and the inherent complexity of the problem in focus. As the project concludes, the action plans developed offer a blueprint to foster sustainability, however, commitments need to be matched by action from government and passive support and accountability from *Right To Play* and partners. Below, the conclusion is presented against the specific evaluation criteria assessed in this endline evaluation (process, effectiveness, impact, and sustainability).

Process

The *SHARE* project was designed to be content and context-relevant for Mozambique. Given the recognized sensitivity regarding SRHR issues, this consultative formative assessment process was seen as critical to mitigate against risks of opposition to the project. These formative consultations were held and insights gathered from them used in targeting specific needs and opportunities of different segments of the population.

At project inception, planned activities across all project sites were initially put on hold until baseline data collection had been completed to ensure there would be no contamination of baseline data results. Following this, there was historic increase in inflation rates globally, including in Mozambique, which resulted in increased costs to implement *SHARE* activities and was deemed to have contributed to increased economic vulnerability of project beneficiaries. There were issues relating to political unrest, elections, cyclones, and flooding which disrupted planned activities and required implementation to be adjusted.

Stakeholders generally perceived *SHARE* implementation positively. *SHARE* activities were implemented through existing structures within schools, health facilities, communities, and government systems, rather than creating stand-alone mechanisms, was perceived to support efficient project implementation. However, there were a few concerns relating to political unrest, elections, cyclones, and flooding which disrupted planned activities and required implementation to be adjusted. The annual project reach in Mozambique ranged from 943 in the period April 2022 - March 2023 to 427,958 for April 2023 - March 2024.

At endline, in our sample, 61% of sampled in-school adolescents and youth in treatment areas reported having participated in a school-based club discussing health relationships, and SRHR topics in the past four years, and 31% of out-of-school respondents reported participating in a community-based SRHR group or mentorship programme. Among those who participated in a club or group, the majority (57%) attended five or more meetings. Overall, 52% of treatment area respondents reported at least some direct exposure to *SHARE* or its partners, with most participants (86%-92% across activity types) indicating that their activity was organised or supported by *SHARE* or its partners.

Among community members, 32% reported having participated in community dialogues and 32% in community awareness-raising events, with considerably higher rates among key community stakeholders than caregivers (76% and 73% versus 19% and 20%, respectively). Overall, 25% of treatment area community members (caregivers: 17%; key community stakeholders: 51%) reported exposure to *SHARE*. These figures likely underestimate overall project reach, as they capture only selected reported activities and do not reflect exposure through other project channels such as teacher-delivered sexuality education, SBCC campaigns, and health facility-based interventions. Self-reported exposure may also be affected by recall limitations given the four-year reference period and challenges distinguishing *SHARE* activities from other programmes.

Exposure in comparison areas was substantially lower. Among adolescents and youth, <1% of in-school respondents reported participation in a school-based SRHR club, 4% of out-of-school respondents reported participation in a community-based SRHR group, and 2% reported attending community SRHR events. Among community members, 25% reported participating in community dialogues and 20% reported community event attendance. As *SHARE* did not operate in comparison areas, this participation reflects exposure to other programmes with similar objectives.

Effectiveness

The endline evaluation found a mixed picture of results across outcome indicators. Several indicators showed favourable trends in treatment areas, either through improvement where comparison areas remained stable or declined, or by improving more than comparison areas:

- 1300.2: Participation in SRHR advocacy and social action initiatives among girls increased in treatment areas while declining in comparison areas (significant DiD in favour of treatment arm)
- 1110.1: SRHR knowledge increased in treatment areas, while slightly declining in comparison areas (significant DiD in favour of treatment arm)
- 1110.3: Perceived ability to seek SRHR services showed diverging point estimates, with a modest increase in treatment areas and a modest decline in comparison areas (significant DiD in favour of treatment arm); within-arm changes should be interpreted cautiously given overlapping confidence intervals
- 1120.2: Perceived family support for SRHR access increased substantially in both groups, with a more substantial increase in treatment areas (significant DiD in favour of treatment); the improvement in comparison areas suggests that broader contextual factors may have also contributed to this positive trend

For several indicators, improvements were observed in both treatment and comparison groups, suggesting that broader contextual factors – including potential exposure to similar programmes in comparison areas – may have contributed to these changes beyond the direct reach of the project:

- 1100.2: Positive attitudes toward ending SGBV increased from baseline in both groups, though more substantially in comparison areas (significant DiD in favour of comparison arm)
- 1100.3: Contraceptive negotiation self-efficacy increased from baseline in both arms, with similar levels at endline in treatment and comparison areas (DiD not significant)
- 1300.3: Average resilience scores increased from baseline in both arms, with a more pronounced increase in comparison areas resulting in a significant difference at endline; however, there was no evidence for differential change over time (DiD not significant)
- 1120.1: Positive SRHR attitudes among community members increased substantially from baseline in both arms, with a more pronounced increase in comparison areas (DiD in favour of comparison arm)
- 1120.3: Community members' knowledge of the negative consequences of gender inequality increased from baseline in both arms, though levels were already near-universal at baseline, leaving limited room for meaningful change (DiD not significant)

Several indicators showed stable trends in both the treatment and comparison groups:

- 1100.4: Percentage of sexually active girls or young women always using (or whose partner uses) a modern method of contraception (DiD not significant)
- 1200.2: Percentage of adolescents/youth aged 10-24 years who are satisfied with SRH services (DiD not significant)
- 1310.1: Percentage of girls and young women who feel they can advocate for improved adolescent rights in their communities (DiD not significant)
- 1310.2: Percentage of community members with knowledge of national laws and local policies that affect adolescents/young people's SRHR and gender equality (DiD not significant)

Some indicators showed decline in treatment as well as comparison areas, though overlapping confidence intervals preclude firm conclusions:

- 1100.1: Point estimates for SRH service utilisation declined from baseline in both arms (though overlapping confidence intervals in the treatment arm preclude firm conclusions about change), with a larger decline in the comparison group resulting in a significant difference at endline; however, there was no evidence for differential change over time (DiD not significant)
- 1320.1: Point estimates for social action forum participation by community members declined from baseline in both arms (though overlapping confidence intervals in the treatment arm preclude firm conclusions about change), with a larger decline in comparison areas resulting in a significant difference at endline; however, there was no evidence of differential change over time (DiD not significant)

Health facility assessments showed decline in the number of facilities meeting all criteria for good quality gender-responsive and adolescent-friendly services from two (6%) at baseline to none (0%) at endline (1200.1). Other facility-level indicators were only assessed at endline, with 16 out of 28 (57%) facilities meeting all waste management criteria (1200.3), 14 out of 28 (50%) meeting all WASH IPC action plan criteria (1220.3), and 15 out of 28 (54%) meeting all SOP readiness criteria under strict conditions, while only one facility (5%) met all SOP adherence criteria (1220.2).

Among adolescents with self-reported *SHARE* exposure (e.g., participation in *SHARE* school-based clubs or community-based SRHR mentorship programmes, attending *SHARE* community events), meaningfully higher levels were observed across 10 out of 12 SRHR-related outcomes compared to those without self-reported exposure, though this analysis should be considered exploratory.

For community members, no meaningful differences were observed between exposure groups for positive SRHR attitudes or knowledge of gender inequality consequences. In contrast, social action forum participation was notably higher among respondents with self-reported *SHARE* exposure, though this finding should be interpreted cautiously given the direct overlap between the exposure measure and the indicator itself.

Impact

The *SHARE* project has demonstrated some progress in advancing its goals of increasing the enjoyment of health-related human rights among AGYW in Mozambique. Its comprehensive multi-component approach, which integrates education, community engagement, and gender-responsive strategies, may have contributed to addressing some of the structural and socio-cultural barriers that hinder equitable access to SRHR information and SRH services. By focusing on marginalized groups, particularly AGYW, the project helped to promote gender equality and empowered adolescents to make informed decisions about their health and well-being.

Quantitative results suggest improvements in autonomous SRHR decision-making among sexually experienced women aged 15-24 years who were in a relationship at the time of the survey, in both treatment and comparison areas. However, small analytic samples and overlapping confidence intervals mean these trends should be interpreted cautiously:

- *1000: Increased enjoyment of health-related human rights by the most marginalized and vulnerable rights-holders*

The *SHARE* project may have contributed to laying foundations for greater agency regarding SRH choices, confidence, and bodily autonomy among girls and young women through mentorship, safe discussion spaces, adolescent-responsive services, caregiver involvement, and changing attitudes toward gender equality. Rather than fundamentally transforming power relations, the evidence points to early but meaningful shifts in relational power dynamics within households, schools, and health services were deemed to have occurred.

Sustainability

Consideration for sustainability was at the heart of the design and implementation of the *SHARE* project. The perspectives of various stakeholder groups highlighted that *SHARE* sought to enhance sustainability by working through existing government systems rather than establishing parallel implementation structures. Stakeholders engaged as part of this evaluation described deliberate efforts to align interventions with national policies, district priorities, institutional mandates, and existing service delivery systems, with the intention that activities would continue beyond the project period. There were clear examples of sustainability in action including action plan development and embedding, integration of project activities and tools into routine practice. However, concerns relating to funding gap and effect of health and education workforce rotation which were expected to have a negative effect on sustainability.

4.2 Recommendations

For *SHARE* consortium

- Lessons learnt on the implementation of the *SHARE* project need to be curated and collated recognizing context-specific reasons that allowed for success and challenges experienced in specific countries compared to other countries.
- Efforts need to be made to ensure that the sustainability strategy designed for the project in Mozambique is fully instituted with clear structures, roles, and guidelines on implementation of high yield and community-valued project activities such as peer mentorship, clubs, and community awareness events, beyond the project life cycle.

- Periodic follow up with health facilities, districts, and schools after the project lifetime, even if done passively, might be helpful with sustaining some of the activities that have been mapped into action plans and integrated into education, health and community systems.
- Advocacy to government to support efforts to sustain project outcomes through their continued engagement and where possible absorption of the project activities into routine health sector programming and budgeting, including continued implementation of adolescent-friendly health services.
- Strengthen advocacy efforts to institutionalize CSE, adolescent-responsive services, and gender-responsive policies within education systems.
- Sustained support to continue target project activities, even if passive, should be offered to adolescents beyond the project life cycle to maintain gains of the *SHARE* project.
- As there will be continuous movement and redeployment of health workers and a decay in acquired knowledge and skills on the *SHARE* project, there is a valid justification for training and retraining health care providers on quality, gender responsive, and adolescent-friendly service provision. One cost-effective option to consider will be to explore remote or digitalized training materials to sustain health worker capacity for service delivery. Additionally, the project might consider using ‘health personnel champions’ who will be dedicated personnel to offer ‘on the job’ in-house training for health facilities beyond the project lifecycle.
- For future implementation of similar interventions, there is a need to continue to embed *SHARE* project’s gender-transformative approaches that challenge traditional gender roles and power dynamics into programming. Engaging boys and men alongside adolescent girls and women ensures shared responsibility and collective action.

For Schools and District Offices for Education

- Sustain activities of the *SHARE* project including the school-based mentorship which is already part of school management systems by assigning focal persons and incorporating mentorship indicators into school monitoring and inspection systems.
- Continue strengthening collaboration between schools and health facilities to support referral systems and adolescent access to youth-friendly SRHR services.
- Support and encourage adolescents and youth who want to be involved in advocacy initiatives to drive social action.

For Government

- Governments should deliberately build on gains of the *SHARE* project in communities where the project was implemented and beyond, leveraging the current community momentum.
- Supportive supervision, which has been shown to generally improve adherence to clinical guidelines⁶⁵ combined with more routine assessment of youth-friendly service delivery in health facilities should be continued to ensure health workers are providing services as per protocol. This will help ensure that adolescents and youths can get the high-quality care, as needed.
- Linking non-financial or financial (performance payments) to compliance with evidence-based guidelines for adolescent youth-friendly care as delivered on the *SHARE* project or patient satisfaction,⁶⁶ should be considered as a way to sustain gains from the project.
- Continue to improve infrastructure that promotes privacy, dignity, menstrual health management, and accessibility, particularly in schools and health facilities serving adolescents.
- Sustain implementation of CSE in educational policy by integrating SRHR into routine classroom teaching, supervision, lesson planning, and school monitoring systems, while maintaining the cascade training approach for teachers.
- Continue efforts to strengthen parents' and communities' support for adolescent SRHR through community dialogue, social and behaviour change interventions, and engagement of community and religious leaders to address persistent stigma, misconceptions, and restrictive gender norms.

⁶⁵ Avortri GS, Nabukalu JB, Nabyonga-Orem J. Supportive supervision to improve service delivery in low-income countries: is there a conceptual problem or a strategy problem? *BMJ Glob Health* (2019) 4:e001151.

⁶⁶ Ergo et al. (2012) Creating Stronger Incentives for High-Quality Health Care in Low- and Middle-Income Countries. Available at: https://mchip.net/sites/default/files/QoC%20and%20PBI_Full%20report_Final.pdf

5. Annexes

Annex A: Detailed narrative of project's theory of change

Annex B: Evaluation Matrix

Annex C: Inception Report

Annex D: Performance Monitoring Framework

Annex E: District disaggregated health facility indicators

Annex F: District disaggregated household and teacher indicators

Submitted separately