

Sexual Health and Reproductive Education Project

Final Evaluation

Ghana



Project Title

The Sexual Health and Reproductive Education (SHARE) Project

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Caption for cover photo

Adolescent girls playing a game to help them better understand their sexual and reproductive health and rights.

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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
CSL	Country Study Lead
DAC	Development Assistance Committee
DEO	District Education Officer
DHO	District Health Officer
DiD	Difference-in-Differences
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
GES	Ghana Education Service
GHS	Ghana Health Service
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
PMF	Performance Management Framework
PPE	Personal Protective Equipment
SGBV	Sexual and Gender-Based Violence
<i>SHARE</i>	Sexual Health and Reproductive Education
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. The project was implemented as a consortium that is constituted by *Right To Play* who are the lead in partnership with WaterAid, the Forum for African Women Educationalists and FHI 360 as technical partner.

In Ghana, the project was implemented in Builsa North Municipal, Kasena-Nankana Municipal, Kasena-Nankana West District, and Bongo District. *SHARE* aims to reach a total of 89,021 beneficiaries in the country, including 15,684 direct beneficiaries constituting adolescents both in school and out of school.

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 program effects relative to comparison areas. 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 Ghana'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 Ghana'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 Ghana.

The annual project reach in Ghana ranged from 18,713 in the period April 2024 - March 2025 to 435,900 for April 2025 - March 2026.

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, by improving more than comparison areas, or by sustaining levels that declined in comparison areas:

- 1100.3: Contraceptive negotiation self-efficacy increased from baseline in treatment areas, while remaining stable in comparison areas (DiD not significant despite 22-percentage point difference-in-difference, likely reflecting insufficient statistical power given the reduced analytical sample)
- 1300.2: Participation in SRHR advocacy and social action initiatives among girls increased from baseline in treatment areas while declining in comparison areas (DiD not significant)
- 1110.1: SRHR knowledge increased from baseline in treatment areas, while remaining stable in comparison areas (significant DiD in favour of treatment)
- 1110.3: Perceived ability to seek SRHR services increased from baseline in treatment areas, while remaining stable in comparison areas (significant DiD in favour of treatment)
- 1120.2: Perceived family support for SRHR access increased in treatment areas, while remaining stable in comparison areas (significant DiD in favour of treatment)

- 1120.3: Community members' knowledge of the negative consequences of gender inequality remained stable in treatment areas while declining in comparison areas, though levels were already near-universal at baseline, and overlapping confidence intervals in the comparison arm preclude firm conclusions about change (DiD not significant)
- 1320.1: Social action forum participation by community members was maintained in treatment areas while declining in comparison areas (significant DiD)

For several indicators, improvements were observed in both groups compared to baseline, 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 by a similar magnitude (DiD not significant)
- 1310.2: Community members' knowledge of national laws and policies showed modest increases from baseline in both groups (DiD not significant)

Several indicators showed less favourable trends:

- 1100.1: Point estimates for SRH service utilisation declined from baseline in both arms by a similar magnitude (though overlapping confidence intervals in the treatment arm preclude firm conclusions about change; DiD not significant)
- 1310.1: Advocacy self-efficacy among girls declined from baseline in both arms by a similar magnitude (though overlapping confidence intervals preclude firm conclusions about change; DiD not significant)

Several indicators showed no meaningful changes between baseline and endline, either due to broadly stable trends in both groups or inconclusive results due to small analytical samples: contraceptive use among sexually active girls (1100.4), satisfaction with SRH services (1200.2), average resilience scores among young people (1300.3), positive attitudes towards SRHR among community members (1120.1).

Health facility assessments showed a modest improvement in the number of facilities meeting all criteria for good quality gender-responsive and adolescent-friendly services (1200.1), increasing from one facility at baseline to two under strict conditions or five under less strict conditions at endline. Waste management compliance (1200.3) remained broadly stable between midterm and endline, as did WASH IPC action plan implementation (1220.3). For SOP readiness and adherence (1220.2), results were mixed: the number of facilities with printed SOPs readily available remained stable under strict conditions but increased substantially under less strict conditions between midterm and endline, while adherence to minimum criteria improved markedly from no facilities at midterm to 12 at endline.

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 most SRHR-related outcomes compared to those without self-

reported exposure. It should be noted that all treatment area respondents were in principle eligible for *SHARE* activities – in-school respondents were enrolled in *SHARE* project schools and out-of-school respondents were sampled from *SHARE* implementation areas – meaning that those without self-reported exposure may still have been reached through other project channels such as teacher-delivered reproductive health education or community awareness campaigns, or may have been exposed to specific *SHARE* activities without recalling or recognising them as such. Furthermore, adolescents who actively participated in specific *SHARE* activities may differ systematically from those who did not in ways correlated with outcomes. This analysis should therefore be considered exploratory only.

For community members, no meaningful differences were observed between exposure groups for positive SRHR attitudes, suggesting this outcome was broadly similar regardless of self-reported exposure. Knowledge of gender inequality consequences and national laws and local policies regarding adolescents/young people's SRHR were both higher among respondents with self-reported *SHARE* exposure. Social action forum participation also differed significantly, 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 adolescents and young women in Ghana. Quantitative results suggest a substantial improvement in autonomous SRHR decision-making among sexually experienced women aged 15-24 who were in a relationship at the time of the survey in treatment areas (28% to 71%), while the comparison group remained broadly stable. The 35-percentage point difference-in-difference was statistically significant, consistent with the possibility that the *SHARE* project contributed to this improvement, though this interpretation relies on assumptions that could not be fully verified. Given the very small analytical sample, these results should be interpreted with caution.

- *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, has proven critical in addressing some 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 has successfully promoted 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, and plans to scale up activities to non-participating schools have been instituted as part of the sustainability plan. However, concerns relating to funding and effect of health workforce shortage and 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 Ghana. The project did so by leveraging evidence-based practices, community engagement, and gender-transformative strategies. Overall, the project demonstrated strengths in its process, effectiveness, impact, and sustainability within the Ghanaian 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 all *SHARE* Consortium members.

Recommendations

For *SHARE* Consortium partners

- 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 Ghana 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, the project must continue to embed its gender-transformative approaches into programming. Also, providing services in camps, using self-care and leveraging digital devices to aid confidential request of modern contraceptives and smart lockers for discrete pick up of the requested commodities, are viable alternatives to adolescent sexual and reproductive health service delivery.

For Schools and District Offices for Education

- Sustain activities of the *SHARE* project including the school-based mentorship.
- 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, which has been shown to generally improve adherence to clinical guidelines 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.
- Efforts are needed to ensure that teachers are made to feel confident that they can deliver reproductive health education as per national guidelines without fear of reprimand or safety.
- Review content of reproductive health education to ensure clarity of messaging for all actors.

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 WHO, the adolescent birth rate in Ghana reported a decrease from 71 per 1,000 girls in 2010 to 62 per 1,000 in 2020.⁴ Despite the progress, in 2021, Ghana recorded 542,131 pregnancies amongst adolescent girls aged 15-19 years and 13,444 pregnancies amongst young teenagers aged 10-14 years between 2016 and 2020.⁵ In Ghana, 27% of girls aged 15-18 years are forced into early marriage.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. According to a UNICEF report on the State of Adolescents in Ghana, one in five girls reported experiencing sexual violence within the past 12 months, including rape and sexual coercion, and 28% of adolescent girls aged 15-19 years experienced physical violence.⁷

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 Adolescent Pregnancy in Ghanaian Communities – A worrying trend amid MTCT of HIV. Available from: [https://ghana.unfpa.org/en/news/adolescent-pregnancy-ghanaian-communities-%E2%80%93-worrying-trend-amid-mtct-hiv-0#:~:text=Between%202016%20and%202020%2C%20Ghana,Management%20Health%20System%20\(DHIMS\).](https://ghana.unfpa.org/en/news/adolescent-pregnancy-ghanaian-communities-%E2%80%93-worrying-trend-amid-mtct-hiv-0#:~:text=Between%202016%20and%202020%2C%20Ghana,Management%20Health%20System%20(DHIMS).)

⁶ Ministry of Gender, Children and Social Protection & UNICEF Ghana, ‘Resource Guide on Ending Child Marriage in Ghana’. p.9.

⁷ UNICEF. The situation of adolescents in Ghana. Analysis of data from the MICS 2017/18 and other recent surveys. Available from: <https://www.unicef.org/ghana/media/4081/file/Summary%20Report%20-%20Situation%20of%20Adolescents%20in%20Ghana.pdf>

Contraceptive access and utilization among adolescents also remain suboptimal. Less than one quarter of sexually active unmarried girls use a modern method of contraception, and approximately two-thirds of those who wish to delay or avoid childbearing are not using any form of contraception.

Indeed, adolescent sexual and reproductive health (ASRH) continues to be a major public health concern in Ghana 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.⁸ Further, inequalities persist among adolescents based on gender, education, rural-urban residence, and other key health indicators.⁹ 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.¹⁰ To this effect, the government of Ghana has prioritised the empowerment and advancement of SRHR for adolescents and young men and women. 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: In Ghana, of women 20-24 years, 592 thousand were married before age 15 and 2.5 million were married before age 18.¹¹ The COVID-19 pandemic exacerbated existing gaps and inequalities affecting AGYW in relation to SRHR.¹²

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. Each consortium 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; and FHI 360

⁸ WHO Africa, 2015. Adolescent Health in the African Region. <https://www.afro.who.int/sites/default/files/2018-05/ASRH-%20AFRO%20-%20AH%20workshop%20report.pdf>

⁹ Jessica L., Morris Hamid Rushwan (2015): Adolescent sexual and reproductive health: The global challenges

¹⁰ 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

¹¹ The child marriage data profile. Ghana. Available from: <https://childmarriagedata.org/country-profiles/ghana/>

¹² SHARE Project Implementation Plan (2021 – 2026): Country Appendix: Ghana/Mozambique/Uganda

provided proven methodologies in girl-focused health services and empowerment. *SHARE*'s approach is grounded in Pulerwitz et al.'s conceptual framework that builds on the socio-ecological model of change.¹³

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;
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.

¹³ 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>

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](#)). *SHARE* builds on evidence-based SRHR and gender equality interventions, leveraging the experience of its three consortium partners through *Right To Play*'s Gender-Responsive Play-based Learning approach, WaterAid's WASH expertise, FAWE's experience in gender equality focused advocacy and policy change, as well as technical partner FHI 360's girl-focused health service and empowerment methodologies. The project's approach was informed by evidence that improvement in quality of health service provision is associated with increased service utilization by adolescents,¹⁴ social accountability approaches positively impact SRH outcomes,¹⁵ 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.¹⁶ 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).¹⁷ The detailed narrative of the project's theory of change is available in [Annex A](#).

¹⁴ 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>

¹⁵ 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).

¹⁶ 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)

¹⁷ 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

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 boys after *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 (*Right To Play*, WaterAid, FAWE, and FHI 360) 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? 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 Ethics Committee for the Humanities at the Institute of Statistical, Social and Economic Research, University of Ghana, and the Ghana Health Service Ethics Review Committee.

For the quantitative component, a quasi-experimental difference-in-differences (DiD) design combined with Coarsened Exact Matching¹⁸ 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 levels¹⁹ to assess progress and impact. 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. KIs were conducted with a

¹⁸ 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 both 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).

¹⁹ For several health facility indicators, only midterm data are available and will therefore serve as the basis for comparison.

diverse range of relevant stakeholders including *SHARE* Consortium members (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 KIIs 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 (Builsa North Municipal, Kasena-Nankan Municipal, Kasena-Nankan West District, Bongo District). For the comparison sites, the sampling frame included three purposively selected districts (Bolgatanga East District, Builsa South District, Talensi District).

For the household survey components, a Different Individuals, Same Clusters (DISC)²⁰ 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. However, 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. 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 is that findings represent community-level changes in key indicators rather than changes among the same individuals over time. The DISC design supports valid 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. Importantly, midterm data – collected under the original panel approach – are not directly comparable to baseline and endline results, and are therefore used for contextual triangulation only rather than formal comparisons across waves.

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

²⁰ 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

structure from baseline data. In addition, 10% padding was applied to treatment clusters and 20% padding to comparison clusters to preserve a sufficiently large and diverse sample for matching and analysis²¹. The required number of individuals per cluster (m) was calculated as follows:²²

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

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 Ghana. 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 Ghana

	Treatment		Comparison		Total sample	
	Target	Achieved	Target	Achieved	Target	Achieved
Adolescent/Youth Survey ^a	684	620	840	620	1,524	1240
Caregiver/Community Stakeholder Survey ^a						
Parents/Caregivers	126	134	126	140	252	274
Community stakeholders	35	38	35	44	70	82
<i>Subtotal</i>	<i>161</i>	<i>172</i>	<i>161</i>	<i>184</i>	322	356
Health Facility Survey ^b	30 (+ 8)	30 (+ 8)	-	-	30 (+ 8)	30 (+ 8)
Teacher Survey ^c	n/a	351	-	-	n/a	351

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 eight 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 No target was set as all eligible teachers present at the time of the school visit were invited to participate.

²¹ 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.

²² 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 30 facilities per country, focusing primarily on facilities previously assessed at baseline and midterm, 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.

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,²³ 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 Ghana

Location	Respondents	Planned	Achieved
Village	Community Group (community leaders, religious leaders, women leaders, community health workers)	4	3
Health Facilities Level	Head and staff of Health Facility including those participated in the trainings, such as WASH FIT and IPC and those who are part of the WASH FIT committees	4	4
School	Teacher	2	2
District and national levels	MoH staff and Ministry of Education	4	3
National Level	Consortium Partner Program Manager and staff	4	4
	INGO/NGO/UN agencies that implemented similar programs	2	1
Total		20	17

The planned number of sessions and participants for the group discussions across all study sites was 26 group discussions involving 208 participants. A total of 19 group discussions involving 146 participants were achieved, comprising 99 adolescents and young people (including 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, and out-of-school adolescent boys and young men aged 15-

²³ 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.

24 years), and 47 parents. We planned to conduct 32 individual interviews, and this target was achieved, although there were variations between the planned and achieved numbers across some participant sub-groups. [Table 3](#) presents the targeted and achieved sample sizes for the group discussions and individual interviews of the evaluation.

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

Study sites	Respondent types	Group discussions		Individual interviews	
		Planned	Achieved	Planned	Achieved
Zorko	In school: Adolescent girls, aged 10-14 and 15-19	3 discussions with 24 participants	3 discussions with 22 participants	2 paired interviews with 4 interviewees	2 paired interviews with 4 interviewees
	In school: Adolescent boys, aged 10-14 and 15-19	2 discussions with 16 participants	3 discussions with 24 participants	2 paired interviews with 4 interviewees	2 paired interviews with 4 interviewees
	Out of school: Adolescent girls and young women, aged 15-24 years	2 discussions with 16 participants	1 discussion with 8 participants	1 paired interview with 2 interviewees	1 interviewee
	Out of school: Adolescent boys and young men, aged 15-24 years	2 discussions with 16 participants	1 discussion with 6 participants	1 paired interview with 2 interviewees	0
	Parents of adolescent girls/boys in school, aged 10-19 years	2 discussions with 16 participants	2 discussions with 16 participants	2 interviewees	3 interviewees
	Parents of adolescents and young women/men out of school, aged 15-24 years	2 discussions with 16 participants	1 discussion with 8 participants	2 interviewees	2 interviewees
Saboro and Kassena Nankana Municipality	In school: Adolescent girls, aged 10-14 and 15-19	2 discussions with 16 participants	0	2 paired interviews with 4 interviewees	2 paired interviews with 4 interviewees
	In school: Adolescent boys, aged 10-14 and 15-19	3 discussions with 24 participants	3 discussions with 24 participants	2 paired interviews with 4 interviewees	2 paired interviews with 4 interviewees
	Out of school: Adolescent girls and young women, aged 15-24 years	2 discussions with 16 participants	0	1 paired interview with 2 interviewees	2 paired interviews with 4 interviewees
	Out of school: Adolescent boys and young men, aged 15-24 years	2 discussions with 16 participants	2 discussions with 15 participants	1 paired interview with 2 interviewees	0
	Parents of adolescent girls/boys in school, aged 10-19 years	2 discussions with 16 participants	2 discussions 15 participants	2 interviewees	2 interviewees
	Parents of adolescents and young women/men out of school, aged 15-24 years	2 discussions with 16 participants	1 discussion with 8 participants	2 interviewees	4 interviewees
Total		26 discussions with 208 participants	19 discussions with 146 participants	32 interviewees	32 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, reproductive health education, 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.

For qualitative data collection, topic guides explored perspectives of stakeholders on the *SHARE* project implementation, effectiveness, impact, sustainability, and policy engagement relating to adolescent SRHR and gender equality. Group discussion guides collected information on beneficiaries' experiences and perceived changes in areas such as access to SRH services, quality of services, gender norms, and adolescent empowerment. Individual stories of change provided deeper insights into participants lived experiences and perceived changes in knowledge, attitudes, behaviours, and broader social experiences relating to SRHR and gender equality. Where necessary and possible, we conducted document review to capture data needed to contextualise findings.

2.3.4 Data Analysis

Quantitative data were cleaned, checked for consistency and completeness, 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. 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 81 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.^{24, 25} 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 was not conducted (e.g., for disaggregated endline estimates or specific item-level changes over time).²⁶ Adjusted *F*-tests and Wald *F*-tests were used to assess whether differences between treatment and comparison arms were statistically significant.

DiD models were used to estimate project effects while accounting 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 were also exposed to other SRHR initiatives during 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 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

²⁴ Endline indicator levels are additionally disaggregated by district as supplementary analysis. District-level results are not discussed in the report.

²⁵ We also conducted age-restricted sensitivity analysis focusing the analysis on respondents aged 15-19 years to assess if results remained similar despite the variation in sample composition across waves (baseline and endline).

²⁶ 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.

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.

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 cannot be empirically 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 during the implementation period, meaning that they do 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.
- **Sample composition shifts across waves:** The endline sample was younger on average than the baseline sample in both arms, with a larger proportion of 10–14-year-olds and fewer 15-19- and 20–24-year-olds. This was accompanied by lower levels of sexual experience, activity, and relationship experience at endline. Most notably, the proportion of in-school respondents was substantially higher at endline (88%) compared to baseline (51%). As a result, endline findings are

more reflective of in-school youth, and subgroup analyses for out-of-school youth are based on smaller samples and should be interpreted with caution. Because the same communities were sampled but different individuals were interviewed at each timepoint, it is not possible to determine whether these differences reflect genuine population-level or sampling variability. However, the shift towards a younger age profile might be partially explained by the underlying sampling protocol, which stratified target sample sizes by school status (proportionate to population estimates of in-school and out-of-school youth) and then allocated respondents equally across age groups within each school status stratum. Because 20–24-year-olds are only included in the out-of-school stratum, this approach inherently produces a younger age profile. The endline sample closely aligned with these intended distributions, whereas the baseline sample deviated from them. Age group was included as covariate in all DiD models to account for the compositional shifts across waves. The age-restricted sensitivity analyses for all primary indicators (restricting the sample to respondents aged 15-19 years at both baseline and endline) conducted as part of this evaluation aimed to assess if the age group variations led to differences in the conclusions. This analysis produced consistent results with no differences in conclusions, and as such only included in annexes attached to the report.

- **Matched sample size at endline:** The raw endline sample showed notable imbalances across strata defined by gender, age group, and school status - particularly with fewer out-of-school and older respondents in the treatment arm relative to the comparison arm. As a result, the matching procedure reduced the analytic sample from 1,578 to 1,240 respondents. While the final matched sample remained adequate for primary analysis, this reduction may have reduced statistical power.
- **Study design (DISC) and implications for inference of the Adolescent/Youth Survey:** Although the Adolescent/Youth Survey was initially designed as a longitudinal panel study 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.
- **Teacher survey:** Differences in data collection methods and eligibility criteria between baseline and endline limit comparability. The baseline survey was self-administered, whereas the endline survey was interviewer-administered, and endline respondents were restricted to teachers delivering CSE content. Teacher results should therefore be interpreted as reflecting endline status rather than changes attributable to the project.
- **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.
- **Qualitative sampling challenges:** The qualitative component did not fully meet recruitment targets for some respondent groups, particularly out-of-school adolescents, who were more difficult to identify and engage. While mitigation strategies (e.g., repeated visits, community engagement, and complementary use of interviews and focus group discussions) ensured representation of key perspectives, these challenges may limit the completeness of insights for certain groups.
- **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.



Out-of-school young women's mentorship group in Ghana.

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 = 843)	Comparison (n = 843)	Treatment (n = 620)	Comparison (n = 620)
District (%)	Bongo District	26 (26, 26)		25 (25, 25)	
	Builsa North Municipal	19 (19, 18)		20 (19, 21)	
	Kasena-Nankan Municipal	28 (28, 29)		32 (33, 31)	
	Kasena-Nankan West District	27 (28, 27)		23 (23, 24)	
	Bolgatana East		22 (20, 23)		22 (23, 21)
	Builsa South		25 (26, 24)		25 (25, 25)
	Talensi		53 (54, 53)		53 (53, 54)
Age group (%)	10-14 years	26 (28, 23)	26 (28, 23)	49 (48, 50)	49 (48, 50)
	15-19 years	51 (50, 52)	51 (50, 52)	41 (41, 40)	41 (41, 40)
	20-24 years	23 (22, 25)	23 (22, 25)	10 (10, 10)	10 (10, 10)
Gender (%)	Male	49	49	51	51
	Female	51	51	49	49
School status (%)	In school	51 (51, 50)	51 (51, 50)	88 (88, 88)	88 (88, 88)
	Out-of-school	49 (49, 50)	49 (49, 50)	12 (12, 12)	12 (12, 12)
Religion (%)	Christian	83 (75, 90)	79 (65, 94)	87 (81, 93)	78 (67, 90)
	Muslim	6 (6, 7)	4 (4, 4)	5 (5, 6)	5 (8, 3)
	Traditional/Spiritualist	6 (12, 1)	14 (28, 1)	4 (7, 1)	11 (18, 3)
	Other/no religion	4 (7, 2)	2 (3, 1)	4 (7, <1)	6 (8, 4)
	χ^2 , p-value	36.72, p < .001		23.00, p < .001	
Marital status (%)^a	Single/never married	87 (93, 80)	82 (94, 71)	93 (96, 89)	92 (98, 85)
	Married	13 (6, 19)	18 (6, 29)	7 (4, 11)	8 (2, 15)
	Divorced/separated	<1 (0, <1)	<1 (0, <1)	0 (0, 0)	0 (0, 0)
	Cohabiting/living together	<1 (0, <1)	0 (0, 0)	0 (0, 0)	0 (0, 0)
	Others/Refuse to answer	<1 (<1, 0)	0 (0, 0)	0 (0, 0)	0 (0, 0)
	χ^2 , p-value	8.22, p = .084		0.20, p = .655	
Ever in a relationship (%)^a	Yes	56 (44, 67)	54 (40, 67)	46 (40, 53)	42 (35, 50)
	No	44 (56, 33)	46 (60, 33)	54 (60, 47)	58 (65, 50)
	χ^2 , p-value	0.36, p = .548		1.09, p = .296	
Sexual experience (%)	Had sex ever	33 (26, 41)	27 (15, 38)	19 (16, 21)	18 (15, 21)
	χ^2 , p-value	8.86, p = .003		0.14, p = .713	
Sexual activity (%)	Had sex in the past 12 months	20 (14, 26)	17 (9, 24)	12 (11, 12)	10 (8, 12)
	χ^2 , p-value	2.69, p = .101		1.22, p = .269	
National Quintile (%)	Q1 (Poorest)	45 (44, 46)	54 (56, 51)	48 (49, 47)	54 (54, 53)
	Q2	25 (28, 22)	25 (24, 25)	28 (28, 27)	24 (25, 23)
	Q3	19 (18, 20)	16 (14, 18)	15 (14, 15)	12 (11, 14)
	Q4	7 (6, 8)	4 (4, 4)	6 (6, 7)	6 (6, 6)
	Q5 (Wealthiest)	3 (4, 3)	2 (2, 2)	3 (3, 4)	4 (4, 4)
	χ^2 , p-value	18.74, p < .001		5.27, p = .261	

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 baseline, treatment and comparison groups differed significantly on religion, sexual experience, and national quintile (SES), though the distributions across categories within each variable were broadly similar between arms. At endline, treatment and comparison groups differed on religion only ([Table 4](#)).

The sample composition also differed somewhat between baseline and endline within each arm. Compared to baseline, endline respondents in both arms were younger on average, with a larger proportion in the 10-14 years age group and fewer in the 15-19 and 20-24 groups.²⁷ Consistent with this younger age profile, respondents at endline also reported lower levels of sexual experience²⁸ and activity²⁹ and were less likely to have ever been in a relationship.³⁰ Additionally, the endline sample included a larger proportion of in-school adolescents (88%) than the baseline sample (51%).³¹ The comparison arm additionally showed shifts in religious composition³², marital status³³ and national quintile³⁴ between waves ([Table 4](#)). As the same communities were sampled at both waves but with different individuals, 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, age group, school status, religion, and national wealth quintile were included. Marital status and relationship experience were excluded, as these variables were collected only for a subsample of respondents, and their inclusion would have substantially reduced the analytical sample due to missing data. Sexual experience and sexual activity were also excluded, as these variables may lie on the causal pathway between the intervention and key outcomes; adjusting for such variables could bias estimates of the project effect.

3.1.2 Caregivers and community stakeholders

[Table 5](#) shows socio-demographic characteristics of the sample of caregivers and community stakeholders in treatment and comparison arms at both time points. At baseline, treatment and comparison groups were well balanced across all socio-demographic variables with no significant differences. At endline, the groups differed on gender and age group, with the treatment arm having a higher proportion of male respondents and a larger share of respondents in the 40-59 age group compared to the comparison arm.

²⁷ Treatment: $\chi^2(2) = 99.52, p < .001$; comparison: $\chi^2(2) = 99.52, p < .001$

²⁸ Treatment: $\chi^2(1) = 39.36, p < .001$; comparison: $\chi^2(1) = 16.20, p < .001$

²⁹ Treatment: $\chi^2(1) = 17.56, p < .001$; comparison: $\chi^2(1) = 14.98, p < .001$

³⁰ Treatment: $\chi^2(1) = 7.86, p = .005$; comparison: $\chi^2(1) = 12.28, p < .001$

³¹ Treatment: $\chi^2(1) = 219.95, p < .001$; comparison: $\chi^2(1) = 219.95, p < .001$

³² Comparison: $\chi^2(3) = 18.90, p < .001$

³³ Comparison: $\chi^2(2) = 16.58, p < .001$

³⁴ Comparison: $\chi^2(4) = 9.85, p = .043$

In terms of compositional changes over time, the treatment arm showed shifts in both gender³⁵ and age composition³⁶ between baseline and endline, while the comparison arm was stable across all variables. Gender and age group were included as covariates in the DiD models to account for observed differences.

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

		Baseline		Endline	
		Treatment (n = 169)	Comparison (n = 171)	Treatment (n = 172)	Comparison (n = 184)
District (%)	Bongo District	25 (20, 28)		29 (27, 32)	
	Builsa North Municipal	15 (13, 17)		20 (14, 28)	
	Kasena-Nankan Municipal	29 (32, 27)		29 (35, 21)	
	Kasena-Nankan West District	31 (35, 28)		22 (24, 19)	
	Bolgatana East		21 (25, 18)		22 (19, 24)
	Builsa South		26 (29, 24)		24 (24, 25)
	Talensi		53 (46, 58)		54 (57, 51)
Stakeholder type	Caregiver	79 (61, 92)	75 (46, 94)	78 (62, 96)	76 (53, 93)
	Community stakeholder	21 (39, 8)	25 (54, 6)	22 (38, 4)	24 (47, 7)
	χ^2 , p-value	0.95, p = .331		0.17, p = .684	
Age group (%)	21-39 years	36 (35, 37)	35 (32, 37)	25 (17, 34)	30 (23, 35)
	40-59 years	39 (38, 39)	47 (42, 51)	66 (73, 57)	52 (57, 49)
	60+ years	20 (26, 16)	15 (23, 9)	9 (10, 9)	18 (20, 16)
	Don't know	5 (1, 8)	3 (3, 3)	0 (0, 0)	0 (0, 0)
	χ^2 , p-value	4.27, p = .234		8.36, p = .015	
Gender (%)	Male	41	40	54	43
	Female	59	60	46	57
	χ^2 , p-value	0.08, p = .929		4.41, p = .036	
Religion (%)	Christian	69 (51, 82)	69 (49, 82)	72 (60, 85)	64 (44, 79)
	Muslim	6 (3, 8)	3 (6, 1)	4 (5, 2)	7 (10, 4)
	Traditional/Spiritualist	20 (38, 8)	25 (41, 15)	17 (25, 8)	24 (41, 11)
	Other/no religion	5 (9, 2)	3 (4, 3)	7 (10, 5)	5 (5, 6)
	χ^2 , p-value	3.40, p = .333		4.49, p = .213	
Highest level of education (%)	No education	50 (38, 58)	50 (36, 59)	46 (43, 49)	54 (48, 59)
	Primary/Junior High School	27 (29, 26)	32 (27, 35)	28 (24, 34)	24 (14, 31)
	Secondary and above	23 (32, 16)	18 (37, 6)	26 (33, 17)	22 (38, 10)
	χ^2 , p-value	1.35, p = .510		2.52, p = .283	
Marital status (%)	Single/never married	4 (4, 4)	6 (12, 2)	2 (2, 3)	2 (4, 0)
	Married	75 (91, 64)	75 (83, 71)	85 (94, 75)	77 (86, 70)
	Divorced/separated	5 (4, 6)	4 (1, 5)	4 (2, 5)	2 (4, 1)
	Widowed	15 (0, 26)	15 (4, 22)	9 (2, 16)	19 (5, 29)
	Cohabiting/living together	0 (0, 0)	0 (0, 0)	0 (0, 1)	<1 (1, 0)
	χ^2 , p-value	1.13, p = .769		9.57, p = .088	

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

³⁵ Treatment: $\chi^2(1) = 5.99$, p = .014

³⁶ Treatment: $\chi^2(3) = 31.52$, p < .001

3.1.3 Health care facilities

At endline, thirty health facilities were followed up in Ghana. This included eight facilities in Bongo, eight in Builsa North, seven in Kasena-Nankan Municipal, and seven in Kasena-Nankan West. By facility type, 23 CHPS, one clinic, four health centres, and two hospitals were included. In addition, eight health facilities were sampled that were not part of the longitudinal sample and had not been assessed at baseline or midterm. 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 baseline and endline. Given the vastly different sample sizes and different study designs across waves, no formal comparison of profiles between time points is made.

Table 6: Socio-demographic characteristics of teachers at baseline and endline (%)

		Baseline Treatment (n = 140)	Endline Treatment (n = 351)
District (%)	Bongo District	55	30
	Builsa North Municipal	10	21
	Kasena-Nankan Municipal	17	24
	Kasena-Nankan West District	18	25
Age group (%)	21-39 years	40	70
	40-59 years	58	30
	60+ years	2	0
Gender (%)	Male	67	56
	Female	33	44



Out-of-school boys at a session.

3.2 Process

3.2.1 Was the project successfully designed?

The *SHARE* project was designed to be both contextually and culturally relevant to the Ghanaian setting. As documented in the 2022-2023 project report³⁷ As documented in the 2022-2023 project report,^[1] a formative assessment was conducted during project initiation, with a strong emphasis on stakeholder consultation to ensure that planned activities were locally appropriate, community-driven, and aligned with existing needs and priorities. Given the recognized sensitivity regarding SRHR issues and the documented public opposition that exists towards SRHR education for adolescents in Ghana, this consultative process was critical for identifying potential sources of opposition to the project and mitigating risks to implementation. In addition to the consultation processes linked to Outcome 1120, the project prioritized early and sustained engagement with parents, community leaders, and other gatekeepers across other outcome areas. These efforts aimed to build trust and shared understanding, and to garner local buy-in prior to program activities with adolescents and youth.

In Ghana, as was the case in other project sites, a Social and Behavior Change Communication (SBCC) and messages framework (Output 1111) was drafted to identify key messages and mediums that will be most relevant and effective to achieve intended results with targeted audience segments. This framework was developed through a structured process led by an external consultant and informed by formative research and stakeholder consultation. The development process included desk reviews and key informant interviews with project staff and consortium partners, including those in Ghana (Kasena-Nankana Municipal and Bongo districts). The formative research focused on identifying key barriers and enablers across domains of knowledge, attitudes, behaviors, and social norms; sources of misinformation; and examples of effective and innovative approaches. Based on these findings, detailed audience profiles were developed to characterize the needs, preferences, and behavioral drivers of different target groups. These profiles informed the selection of appropriate messaging strategies and communication channels tailored to each audience segment. Overall, the project design reflects a structured and context-sensitive approach, grounded in formative evidence and stakeholder engagement, with explicit attention to addressing sociocultural barriers and tailoring interventions to the Ghanaian context.

3.2.2 How well was the project implemented?

For the first year of implementation,³⁸ 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, though achievement of outputs and progress towards outcomes in Ghana were not deemed to have been massively affected. Also, five areas (Azaasi, Abunkongo, Akoka, Akunkongo, and Azuzale) within the Kasena Nankana West District witnessed increased violence associated with the Doba – Kandiga conflict. This was a long-standing conflict stemming from land disputes, traditional allegiance, and diverse

³⁷ Sexual Health and Reproductive Education (SHARE). Annual Project Results Report: April 2022– March 2023

³⁸ Sexual Health and Reproductive Education (SHARE). Annual Project Results Report: April 2022– March 2023

political interests. In July 2022, the *SHARE* consortium undertook consultations with stakeholders, including the regional security council chaired by the regional minister, and other NGOs working in the area, to assess the situation. The decision was made in collaboration with *SHARE*'s regional stakeholders to cease activities in the five localities to ensure the safety of staff and intended project beneficiaries, and to ensure *SHARE* activities did not unintentionally exacerbate existing conflicts. Overall, 35 schools and 15 health facilities were directly affected by the conflict. Additional schools and health facilities were added within other geographic areas aimed at ensuring that there was no overall change to the anticipated reach, impact, and intended outcomes of the *SHARE* project.

From interviews conducted with stakeholders, many recognized that *SHARE* used several approaches to engage adolescents through schools, health facilities, and communities, combining mentorship, play-based learning, school-health collaboration, outreach activities, supervision and community engagement to reach adolescents with different circumstances and needs. Education and health sector stakeholders, and consortium members perceived this combination was appropriate because adolescents accessed information and support through different settings depending on their age, schooling status, and social environment. They argued that this multi-pronged implementation approach underpinned the project's gains in the country. Mentorship was one of the most widely highlighted activity during interviews with stakeholders. Teachers and community mentors jointly implemented the school mentorship sessions using a hybrid approach, while nurses engaged out-of-school adolescents and young mothers through health facilities and community activities. Stakeholders described mentorship as creating regular spaces where adolescents could discuss SRHR, relationships, menstruation, gender norms, and personal concerns in ways that were often not possible during routine classroom teaching. A *Right To Play* staff explained:

"The mentorship has been very good... teachers are doing in school; nurses are doing in the health facility. So that comprehensive approach of the mentorship has been very, very good in helping the project reach its potential." (Consortium partner, KII)

Teachers and health workers also highlighted the use of participatory and play-based approaches during mentorship and school sessions. Games, role play, demonstrations, and interactive discussions were mentioned as methods used to help adolescents engage with sensitive topics. Health workers explained that these approaches often made discussions less intimidating and encouraged adolescents to participate more openly, particularly when discussing relationships, sexuality, or gender-related concerns. Health facility staff in Zorko explained that recreational activities and interactive exercises were especially useful for engaging out-of-school adolescents and maintaining participation during sessions.

The integrated implementation approach on the project that linked health system to education system was well valued. School and community activities were also linked to health facilities through school visits, health talks, mentorship, and referrals. Diverse stakeholders described different forms of collaboration between schools, communities, and health workers. Health facility staff in Bongo and Namolo described

being invited to schools to support sessions on SRHR topics that teachers felt less confident delivering. Their role included providing practical demonstrations, such as menstrual hygiene management, answering students' questions, and delivering health education using demonstration materials, while community outreach activities often involved nurses supporting awareness raising and referral to services, as shared by one the health facility staff:

“Sometimes when they need some topics, they do inform us and we go and help them deliver the content or education to the students... I think it was on drug abuse at Namolo school, and we went and gave the education.” (Health Facility staff, F, KII)

Also, a community leader reported that nurses joined community outreach activities to discuss adolescent health and encourage school retention. A health facility staff member in Bongo described how the project strengthened collaboration between the Ghana Health Service and the Ghana Education Service, making referrals more coordinated:

“Previously, if a student fell ill, the headteacher would often struggle to navigate the healthcare system alone. Now, they simply call ahead to notify us that a student is coming, and the process is seamless. I also negotiated with the District Girl Child Coordinator to establish adolescent-focused support within three Senior High Schools (SHS) in this district. This project has truly fostered a partnership between the GES and GHS, allowing us to work as a unified team to support adolescent development.” (Health facility staff, F, Bongo District, KII)

Compared with routine quarterly supervision, some health stakeholders noted that *SHARE* introduced more regular follow-up through weekend visits, joint review, and ongoing feedback between supervisors and frontline providers. A Ministry of Health official explained that supervision became more frequent during the project, with health promotion officers and adolescent coordinators regularly visiting facilities and community sessions, followed by feedback discussions during health management meetings:

“This one becomes a routine as part of our services. They continuously visit those facilities... On Mondays, we have our health management committee meetings. So, they then brief us on happenings during their visits.” (Ministry of Health, KII)

Community engagement and outreach services further expanded the project's reach beyond schools and health facilities. Community stakeholders described radio programmes, town hall meetings, and community announcements as ways to involve caregivers, traditional leaders, and wider communities in discussions on adolescent health and rights. Outreach activities were also used to engage adolescents who were hesitant to seek support through health facilities. *Right To Play* staff explained that outreach

became increasingly important after concerns emerged about stigma associated with adolescent access to SRHR services.

Interviews with consortium members, teachers, health facility staffs, health and education officials, and community member revealed that *SHARE* project worked through existing systems and structures particularly schools and health facilities, rather than creating separate delivery systems. Teachers, health workers and district officers carried out activities as part of their routine roles, while the project provided training, technical support and resources to strengthen these existing mechanisms. Rather than setting up a separate governance structure, *SHARE* drew on existing government coordination and oversight mechanisms to guide implementation. This way of working was echoed by consortium members. A *Right To Play* staff member explained that rather than organising monitoring separately, the project conducted monitoring together with district authorities and incorporated activities into existing district processes. She perceived that this approach has strengthened project ownership. Beyond government systems, the project also built on existing community and civil society networks. Community platforms were also used to support awareness raising. A community stakeholder in Saboro explained that the project used local radio programmes and community announcement systems to discuss adolescent rights and health issues, drawing on communication channels that communities already accessed.

Stakeholders across the consortium organisations described implementation as highly interdependent, with partners contributing different expertise while working toward shared objectives. Rather than operating independently, consortium members described regular coordination and joint planning as important for ensuring activities complemented one another. There was role differentiation amongst the Consortium partners. *Right To Play* focused primarily on school-based and play-based interventions, WaterAid supported WASH systems and adolescent-friendly environments, FAWE strengthened referral pathways and gender-related programming, while FHI360 provided technical guidance across SRHR programming. A WaterAid consortium member explained that partners deliberately relied on one another's established relationships and experience when implementing activities.

"We centered our approach to make sure that the strength of the consortium partners [was used] ... since FAWE had some of those religious leaders and community leaders, we met with FAWE directly to implement that activity."
(Consortium partner, WaterAid, KII)

Despite largely positive reflections from stakeholders engaged at endline on the project's implementation approach, some highlighted some implementation issues. For example, consortium partners noted that radio programmes helped raise awareness among caregivers and communities but were less effective in directly reaching younger adolescents. School stakeholders also noted that limited time within school schedules sometimes affected the depth of discussion during mentorship and classroom sessions. In addition, interviewees from education and health sectors, consortium members, and community

members noted challenges related to institutional sensitivities around SRHR. District education stakeholders and consortium members highlighted the sensitivity of SRHR topics in school settings remained a pervading issue in Ghana. A district education stakeholder highlighted tensions between abstinence-focused school messaging and information adolescents might receive from health workers or other institutions regarding contraception:

“Our official stance is the promotion of abstinence... providing students with a ‘leeway’ to use condoms might be seen as promoting sexual activity.” (District education stakeholder, M, KII)

Consortium partners similarly noted that sensitivities around some SRHR topics influenced what could be discussed in schools and required adaptations to implementation approaches.

Other issues highlighted by consortium partners and teachers included limited time and resources in schools and implementation delays. A teacher in Awe Junior High School reported that competing curriculum demands limited the time available to cover SRHR topics in depth. The same teacher also noted a lack of teaching materials, explaining that lessons often relied on drawings on the board because additional SRHR materials were not available. As a result, they often relied on verbal explanations, drawings, or examples to continue discussions. Consortium member and partner also described implementation delays. A Planned Parenthood Association of Ghana staff member explained that funding delays postponed follow-up activities and field supervision, resulting in activities being delivered in clusters rather than according to the planned schedule. Similarly, an FHI 360 staff member noted that health worker training started later than anticipated because developing, pre-testing and obtaining government approval for training materials took longer than expected. This division of roles was also reflected by district stakeholders. A Ghana Education Service official explained that *Right To Play* focused on adolescent engagement, WaterAid supported sanitation-related activities, FHI 360 contributed to curriculum development, while Ghana Education Service provided monitoring and oversight through existing government systems. Collaboration also extended to joint implementation of activities. For example, a FAWWE consortium member explained that mentors trained by *Right To Play* participated in FAWWE's radio programming and community advocacy, while partners jointly expanded the use of radio discussions to disseminate SRHR information.

“...using some of the trained mentors to be part of the radio programming and advocacy within the community level.” (Consortium partner, FAWWE, M, KII)

“...most of the partners were able to come together to increase their radio time, to do more of the radio discussion and to engage more, to disseminate and share information.” (Consortium partner, FAWWE, M, KII)

Consortium partners explained that this coordination enabled partners to build on one another's expertise and reduce duplication of effort. Also, according to the consortium partners the division of roles reduced overlap and allowed partners to focus on their comparative strengths. Weekly planning meetings reportedly enabled partners to discuss upcoming activities, identify challenges, and coordinate responses.

Consortium partners also described examples of joint implementation where multiple organisations contributed to the same activity. For instance, referral pathways led by FAWE were translated and contextualised with support from *Right To Play* and district stakeholders, while technical guidance from FHI360 strengthened programme quality. They highlighted that implementation required flexibility and adjustment. Several noted that activities were not always implemented exactly as initially planned but were adapted in response to operational realities and feedback from stakeholders.

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 18,713 in the period April 2024 - March 2025 to 435,900 for April 2025 - March 2026. 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 all through 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)	0	47,722	3437	56,174
In school adolescents	0	41,490	1,936	53,395
Out of School Young People	0	6,232	1,501	2,779
Young people 10-24 years (Female)	0	24,518	2065	25,602
Young people 10-24 years (Male)	0	23,204	1372	30,572
Indirect beneficiaries	74,612	13,362	15,276	379,726
Parents/Caregivers	420	2,236	9691	8,024
Community members	73,907	7,276	4201	368,004
Health workers	285	324	567	1,102
Teachers	0	2,943	400	1,835
Mentors (Community and in school)	0	294	200	304
All beneficiaries	74,612	61,084	18,713	435,900

*Please note that all years does not reflect unique project beneficiaries.

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, 54% (M: 50%, F: 58%) of in-school adolescents and youth in treatment areas³⁹ reported having participated in a school-based club discussing health, relationships, and SRHR topics in the past four years. Among out-of-school respondents,⁴⁰ 34% (M: 29, F: 38%) reported participating in a community-based SRHR group or mentorship programme. Of those who participated in either type of club or group⁴¹, 40% (M: 40%, F: 40%) attended fewer than five meetings and 58% (M: 57%, F: 59%) attended five or more, with approximately 2% (M: 3%, F: <1%) unable to recall. Further, 37% (M: 36%, F: 38%) of respondents in treatment areas⁴² reported attending community events or activities related to sexual and reproductive health.

In comparison areas, 9% (M: 8%, F: 10%) of in-school respondents⁴³ reported participating in a school-based SRHR club, while 4% (M: 0%, F: 9%) of out-of-school respondents⁴⁴ reported participating in a community-based SRHR group. In addition, 2% (M: <1%, F: 4%) of respondents⁴⁵ reported community event attendance. Of those who participated in a club or group⁴⁶, 69% (M: 82%, F: 59%) attended fewer than five meetings and 22% attended five or more (M: 9%, F: 31%), with 10% (M: 9%, F: 10%) unable to recall. As *SHARE* did not operate in comparison areas, this participation reflects exposure to other programmes, including one implemented by Youth Advocates Ghana in Bolgatanga East District which had peer led education delivered through school health and wellness clubs that also covered SRHR issues.

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*, FAWE, and WaterAid: 98% (M: 99%, F: 97%) for school-based clubs, 78% (M: 90%, F: 69%) for community groups, and 98% (M: 100%, F: 96%) for community events. Overall, 52% (M: 49%, F: 54%) 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 CSE 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

³⁹ Base: in-school adolescents in treatment areas (n=545)

⁴⁰ Base: out-of-school adolescents in treatment areas (n=75)

⁴¹ Base: adolescents in treatment areas who reported that they participated in a club or group (n=318)

⁴² Base: all adolescents in treatment areas (n=620)

⁴³ Base: in-school adolescents in comparison areas (n=545)

⁴⁴ Base: out-of-school adolescents in comparison areas (n=75)

⁴⁵ Base: all adolescents in comparison areas (n=620)

⁴⁶ Base: adolescents in comparison areas who reported that they participated in a club or group (n=51)

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. Third, the relatively low 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. Finally, the endline sample included a larger proportion of respondents in the youngest age category (10-14 years) compared to baseline, who may have had more limited exposure to *SHARE* if they were not yet of participating age when the project was most active.

Caregivers and key community stakeholders

At endline, 37% (M: 45%, F: 28%) of community members in treatment areas⁴⁷ reported having participated in community dialogues or discussion sessions about ASRH in the past four years. Participation varied considerably by stakeholder type, with 74% of key community stakeholders reporting participation compared to 27% of caregivers. Of community members who participated⁴⁸, 19% (M: 21%, F: 14%) attended one session, 42% (M: 38%, F: 50%) attended two to three sessions, and 39% (M: 40%, F: 36%) attended three or more sessions. Additionally, 35% (M: 38%, F: 33%) of community members in treatment areas⁴⁹ reported attending community or awareness-raising events, again with a marked difference between key community stakeholders (63%) and caregivers (28%).

In comparison areas, overall participation was lower: 10% (M: 13%, F: 9%) of community members⁵⁰ reported participating in community dialogues and 8% (M: 10%, F: 7%) reported attending awareness-raising events. The same difference between stakeholder types was observed: 27% of key community stakeholders vs. 5% of caregivers for dialogue participation, and 18% vs. 5% respectively for awareness-raising events. Of community members who participated in community dialogues⁵¹, 16% (M: 30%, F: 9%) attended one session, 42% (M: 40%, F: 44%) attended two to three sessions, and 37% (M: 30%, F: 44%) attended three or more sessions, with 5% unable to recall. As the *SHARE* project did not operate in comparison areas, this participation reflects exposure to other interventions.

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, FAWE, and WaterAid: 86% (M: 83% F: 91%) for community dialogues and 84% (M: 80%, F: 88%) for community or awareness-raising events. Overall, 35% (M: 39%, F: 30%) of treatment area respondents (caregivers: 25%; key community stakeholders: 68%) reported at least some direct exposure to *SHARE* or its partners.

⁴⁷ Base: all community members in treatment areas (n=172)

⁴⁸ Base: community members in treatment areas who reported that they participated (n=64)

⁴⁹ Base: all community members in treatment areas (n=172)

⁵⁰ Base: all community members in comparison areas (n=184)

⁵¹ Base: community members in comparison areas who reported that they participated (n=19)

3.3 Effectiveness

This section presents the outcomes achieved at Endline compared to the baseline and, where relevant, midterm figures. Specifically, it details project results as it relates to its intermediate and 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](#). Age-restricted sensitivity analysis amongst adolescents aged 15-19 years is presented in [Annex G](#).

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 rates were significantly higher in the treatment group (25%; 95% CI [21%, 30%]; M: 19%, F: 32%) compared to the comparison group (13%; 95% CI [10%, 16%]; M: 6%, F: 19%), indicating that the two groups were not fully comparable on this outcome prior to the intervention. This baseline difference should be considered when interpreting the DiD results, as it may affect the validity of the parallel trends assumption underlying this analysis. By endline, declines in service utilization were observed in both groups, with 16% (95% CI [10%, 26%]; M: 15%, F: 18%) of respondents in the treatment group reporting service utilization and 4% (95% CI [2%, 7%]; M: 2%, F: 6%) in the comparison group ([Figure 2](#)).

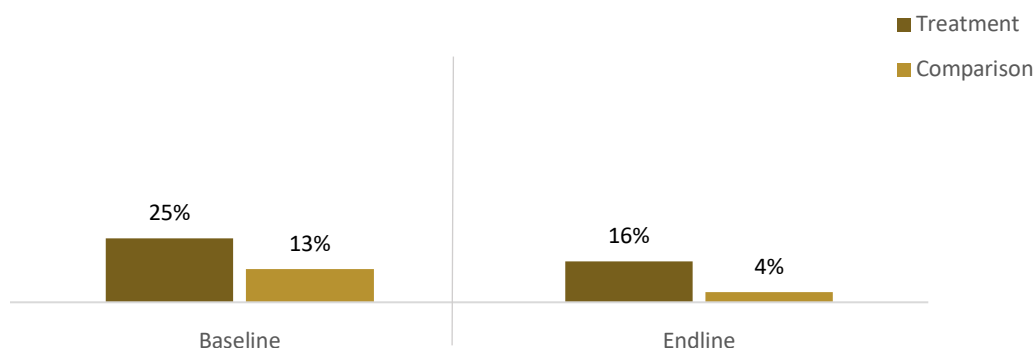


Figure 2: Adolescents/youth who used any SRH services in the past 12 months (%)

Although the point estimates suggest a decline in both arms, for the treatment group the confidence intervals at endline overlap with the respective baseline estimates, meaning we cannot draw definitive conclusions about whether a true population-level decline occurred. The treatment group maintained significantly higher utilization rates at endline compared to the comparison group (Adjusted $F(1, 80) = 15.97, p < .001$). It is worth noting that a declining trend in SRH service utilization in both arms was already visible at midterm, though this observation should be interpreted with caution given differences in study design. The DiD analysis, controlling for observed sociodemographic differences between groups, did not reveal a statistically significant effect ($B = -0.69, SE = 0.43, 95\% \text{ CI } [-1.54, 0.16], p = .110$), indicating no evidence of differential change in SRH service seeking behaviour between treatment and comparison groups over time.

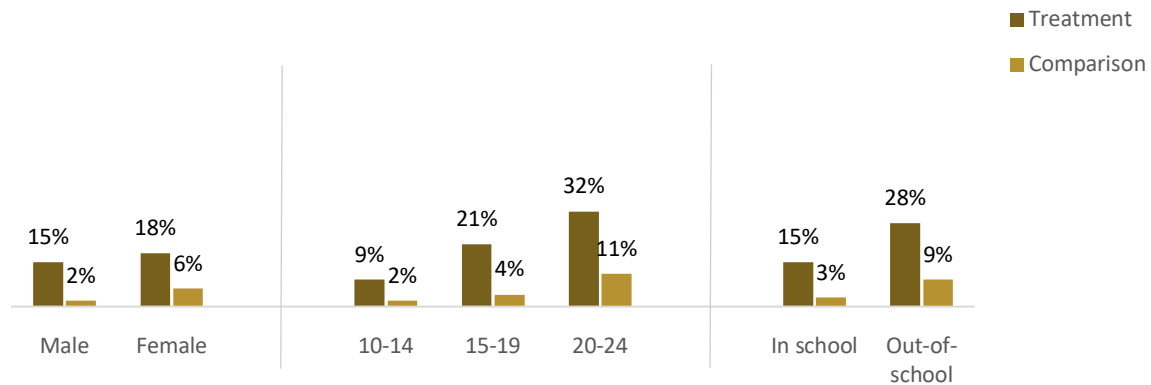
Table 8 presents an overview of utilization rates for different types of SRH services. At endline, the treatment group significantly outperformed the comparison group across all five service types.

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

Service type	Baseline		Endline	
	Treatment (n = 843)	Comparison (n = 843)	Treatment (n = 620)	Comparison (n = 620)
Accurate information and counselling on SRH	11 [8, 14]	7 [5, 10]*	14 [8, 24]	4 [2, 7]***
Information, counselling, and care related to sexual function and satisfaction	11 [8, 14]	5 [4, 8]**	11 [5, 22]	3 [2, 6]**
Prevention, detection, and management of sexual and gender-based violence and coercion	11 [8, 15]	4 [3, 6]***	11 [5, 22]	3 [1, 6]**
A choice of safe and effective contraceptive methods	13 [11, 17]	7 [5, 9]***	11 [5, 22]	3 [1, 6]**
Prevention, detection, and treatment of STIs and reproductive tract infections	14 [11, 18]	8 [6, 11]**	11 [5, 22]	3 [1, 6]**
Used any SRH services	25 [21, 30]	13 [10, 16]***	16 [10, 26]	4 [2, 7]***

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

Endline data showed slightly higher SRH service utilization among girls and young women compared to boys and young men in both groups, and utilization increased with age across both arms. Out-of-school youth reported higher utilization rates than in-school youth in both groups, which likely reflects the older age profile of out-of-school respondents. Given overlapping confidence intervals across all disaggregated results, these patterns should be interpreted as indicative rather than conclusive (see [Figure 3](#)).



Base: All adolescents (Treatment and comparison (balanced) male n=317, female n=303, age 10-14 n=306, age 15-19 n=252, age 20-24 n=62, in school n=545, out of school n=75)

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 or stop them from seeking SRHR services at health facilities or community/youth centers. Overall, barriers to SRHR service utilization were reported at higher rates at endline compared to baseline across both treatment and comparison groups. This general increase in perceived barriers coincides with the observed decline in service utilization over the same period.

The pattern of barriers was broadly similar between treatment and comparison groups at endline. The most reported barriers were embarrassment (32% treatment, 34% comparison), financial constraints (30% treatment, 22% comparison), time required to see someone (27% treatment, 29% comparison), physical access difficulties (26% treatment, 18% comparison), and insufficient privacy (26% treatment, 18% comparison). One notable exception is that lack of adolescent-specific SRH services was reported considerably more often in the comparison group (13%) than in the treatment group (3%). Unlike the comparison group, where reporting of this barrier doubled compared to baseline, the treatment group did not report this barrier more frequently at endline, potentially suggesting that the *SHARE* project contributed to improving the availability or visibility of adolescent-friendly services in treatment areas.

Although many respondents described improvements in adolescents' use of SRHR information and for some SRH services, the findings also showed that change remained uneven and incomplete. Across respondent groups, adolescents, caregivers, teachers, health workers, and consortium partners pointed to barriers that continued to shape adolescents' experiences of SRH service utilization. Fear of judgement,

discomfort discussing sensitive topics, uneven trust in adults and providers, and social norms around age and sexuality remained important constraints. A number of adolescents reported that embarrassment around certain topics continued, particularly among younger adolescents and girls. Menstruation remained one of the most sensitive issues. Teachers explained that while girls participated more openly in discussions than before, some still felt uncomfortable discussing menstruation publicly.

Among younger adolescents, discomfort also remained around discussions of sexuality and relationships. Although adolescents increasingly asked questions, some still preferred discussing sensitive issues privately or avoided them altogether. Fear of judgement from adults also discouraged some adolescents from openly discussing SRH concerns. Several boys in Saboro community felt that adolescents asking questions about relationships or sexuality risked criticism from adults. During a focus group discussion, boys aged 15–19 years reflected:

“You were branded as a spoilt child when you attempt asking such questions or accessing such services.” (In-school adolescent boys, 15–19 years, FGD, Saboro)

For some adolescents, judgement was particularly expected from teachers or authority figures. One in-school adolescent boy in Saboro community felt uncomfortable raising relationship concerns at school. Some teachers expressed discomfort discussing condom use with younger adolescents. While some pointed out that trusted relationships with caregivers, teachers, mentors, and health workers strengthened over time, not all adolescents felt equally comfortable seeking support. Concerns about confidentiality remained particularly important for younger adolescents. In Saboro, younger boys expressed concerns that adults might not keep private conversations confidential:

“Sometimes we do entertain fears that when we confide in them, they will not keep the issues discussed with them private and confidential” (In-school adolescent boys, 10–14 years, FGD, Saboro)

Some girls expressed concerns about confidentiality when discussing personal health issues with peers. They worried that information shared with friends could be passed on to others, making it difficult to discuss sensitive concerns openly.

Although many respondents described more respectful and confidential SRH services, experiences remained uneven across facilities and providers. Health workers themselves acknowledged that judgemental attitudes toward adolescents had previously discouraged care-seeking and that not all providers changed at the same pace. Adolescents reported more positive experiences, but some still encountered providers who felt difficult to approach. A 20-year-old out-of-school young woman in Pungu South explained that provider experiences varied:

“Some of them [health care providers] are very accommodative... but some remain difficult to approach” (Out-of-school young woman, 20 years, IDI, Pungu South)

There appeared to be some differences based on schooling status in the most reported way adolescents accessed sought care. In-school adolescents often relied on school-based support systems and trusted adults but remained less likely to independently access services. Out-of-school adolescents, by contrast, appeared more likely to seek care directly because of more immediate SRH concerns, but they also had fewer structured opportunities for repeated engagement through school settings. Age restrictions further limited access to SRH information and services, particularly for younger in-school adolescents. For example, boys aged 15–19 years in Saboro community reported challenges accessing condoms because they were not expected to be engaging in sexual activity at their age. Consortium partners and education stakeholders pointed out tensions between protecting adolescents and acknowledging their SRH realities. Even when adolescents gained SRHR knowledge, applying that knowledge was often constrained by cultural expectations, religion, and parental authority. As one stakeholder put it, the adolescents still lived within households and communities where discussions of sexuality remained sensitive or discouraged.

“They are considered as being too young... even sometimes there are restrictions on what to tell them. (Consortium staff, RTP, F, KII)

“When they go home and want to practice those things, if it doesn’t conform to their culture or religion... they feel a lot of pressure from their guardians.” (GHS, M, KII)

Education stakeholders also pointed to continuing institutional tensions around SRHR messaging. In Kassena Nankana Municipality, a Ghana Education Service official described conflicting views between abstinence-based education and health-sector messaging on contraception

“Our official stance is the promotion of abstinence... while health officials explained that while they support our goals, they must address the reality that sexual activity does occur.” (GES, M Kassena Nankana Municipality, KII)

This tension appeared to shape the type of information adolescents received, particularly in schools where sexuality discussions were approached cautiously. Also, misinformation and long-standing beliefs around contraception remained barriers in some communities. Health providers in Bongo district reported that some adolescents, particularly girls, continued to receive discouraging messages from others.

“People ‘pollute’ the minds of young girls by telling them that if they used family planning before having their first child, they will become permanently infertile.” (Health facility staff, F, KII)

The misinformation did not appear limited to adolescents, caregivers who potentially could support adolescents with their SRH choices, also had similar misconceived beliefs. For example, a caregiver of an in-school adolescent girl in Pungu, where one caregiver explicitly worried about future fertility:

“I support her choices only when it concerns general health care, but not regarding family planning, because I still have the perception that if she accesses any of those methods, she may not be able to give birth later.” (Caregiver of in-school adolescent girl, F Pungu South community, IDI)

Similarly, another caregiver expressed concern that adolescent girls remained distracted by relationships despite greater SRH awareness. Some caregivers also framed SRH learning through a moral and protective lens, often emphasising abstinence or behavioural restraint rather than adolescent choice

“I always advise my adolescent children to avoid sexual relationship till they are independent, they should not see the physical development as maturity.” (Caregiver of in-school adolescent girls 10–19 years, F, Namolo community, FGD)

However, despite these reservations, there were also signs of gradual change. A small number of caregivers expressed more openness toward family planning information and safer choices for adolescents, especially where pregnancy risks were perceived to be high. For example, in an FGD in Gaani, one caregiver described actively encouraging safer sexual behaviour:

“I sat her down and told her to go for family planning services so she can be safe just in case.” (Caregiver of out-of-school adolescent girls, F, Gaani community, FGD)

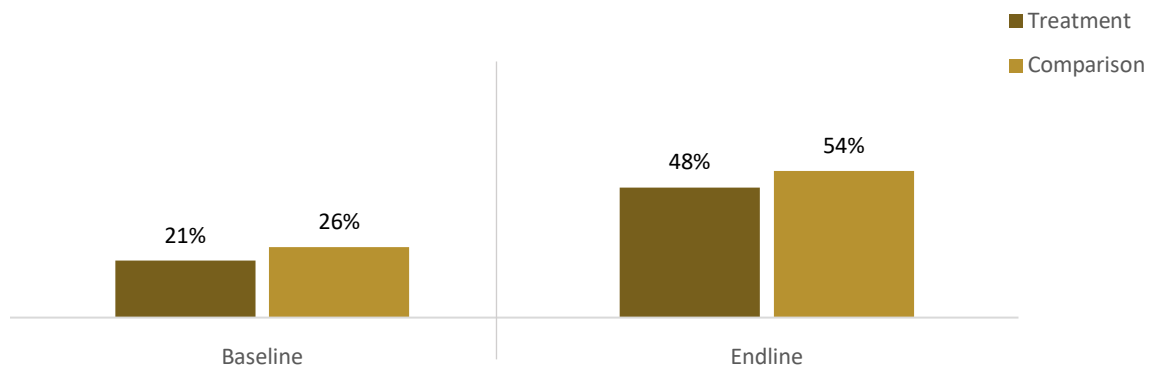
Health workers and MoH stakeholders highlighted infrastructure-related barriers, particularly inadequate adolescent spaces, poor WASH facilities, and lack of privacy. Respondents in Bongo and Zorkor described adolescent corners as facilitating service use, but facilities without these spaces reported continued challenges. These barriers appeared particularly important for girls seeking confidential care. Some adolescent boys and young men highlighted overcrowding, and lack of space sometimes discouraged them from making facility visits, because privacy was not guaranteed. An out-of-school young man explained:

“Sometimes I come and I feel that the crowd is too much, I may change my mind and decide to leave.” (Out-of-school young man, 15–24 years, Gaani community, FGD)

Indicator 1100.2: Percentage of adolescents/youth aged 10-24 years 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 behaviours in intimate relationships, including physical violence, sexual coercion, verbal abuse, and controlling behaviour. If they answered that they 'strongly disagreed' with each of these scenarios, they were counted towards the indicator.

At baseline, the proportion of adolescents who strongly disagreed with all manifestations of SGBV was slightly higher in the comparison group (26%; 95% CI [23%, 30%]; M: 20%, F: 32%) compared to the treatment group (21%; 95% CI [18%, 25%]; M: 18%, F: 24%), though overlapping confidence intervals suggest this difference should be interpreted cautiously. By endline, both groups showed substantial increases in the rejection of these behaviours, with the comparison group reaching 54% (95% CI [45%, 63%]; M: 53%, F: 55%) and the treatment group reaching 48% (95% CI [38%, 59%]; M: 47%, F: 50%, [Figure 4](#)).



Base: All adolescents (Baseline treatment n=843, comparison n=843; Endline treatment n=620, comparison n=620)

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

The difference between treatment and comparison groups at endline was not statistically significant (Adjusted $F(1, 80) = 0.60$, $p = .440$). The DiD analysis, controlling for observed sociodemographic differences between groups, did not reveal a statistically significant effect ($B = -0.07$, $SE = 0.30$, 95% CI [-0.67, 0.54], $p = .827$), suggesting no differential change between arms over time. The quantitative evidence therefore does not support a positive contribution of *SHARE* to improvements in attitudes towards ending SGBV. 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.

[Table 9](#) presents the proportion of respondents that strongly disagreed with each individual statement. At endline, most adolescents (>76%) displayed a strong disapproval towards most manifestations of SGBV.

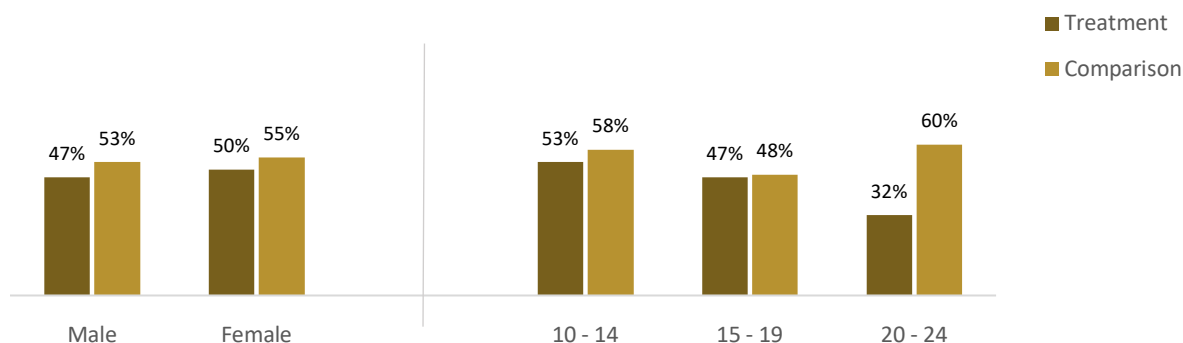
However, fewer respondents strongly disagreed with the statement *"It is ok for a girl/woman to set limits on how her boyfriend dresses"* (T: 56%, C: 62%), which also showed a markedly different pattern from the other statements at baseline, where levels of strong disagreement were considerably lower among both groups (T: 40%, C: 26%). 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 = 843)	Comparison (n = 843)	Treatment (n = 620)	Comparison (n = 620)
It is ok for a boy to insult his girlfriend	70 [65, 74]	84 [81, 87]***	79 [69, 86]	81 [73, 88]
It is ok for a boy to hit his girlfriend if she has been unfaithful	68 [64, 73]	80 [76, 83]***	78 [69, 85]	79 [70, 86]
It is ok for a boy/man to hit his girlfriend if she is constantly nagging	66 [62, 69]	77 [73, 80]***	79 [71, 86]	78 [69, 86]
It is ok for a boy/man to push a girl/ woman into having sex if they have been dating	80 [76, 83]	86 [82, 90]*	76 [66, 85]	79 [69, 87]
It is ok for a girl/woman to set limits on how her boyfriend dresses	40 [36, 44]	36 [32, 40]	56 [45, 66]	62 [52, 71]
Strongly disagree with all statements	21 [18, 25]	26 [23, 30]*	48 [38, 59]	54 [45, 63]

Note. Base: All adolescents. Differences between treatment and comparison groups in 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 within both treatment and comparison arms. Similarly, observed age-related variations should be interpreted with caution due to small sample sizes in some age categories and overlapping confidence intervals (Figure 5).



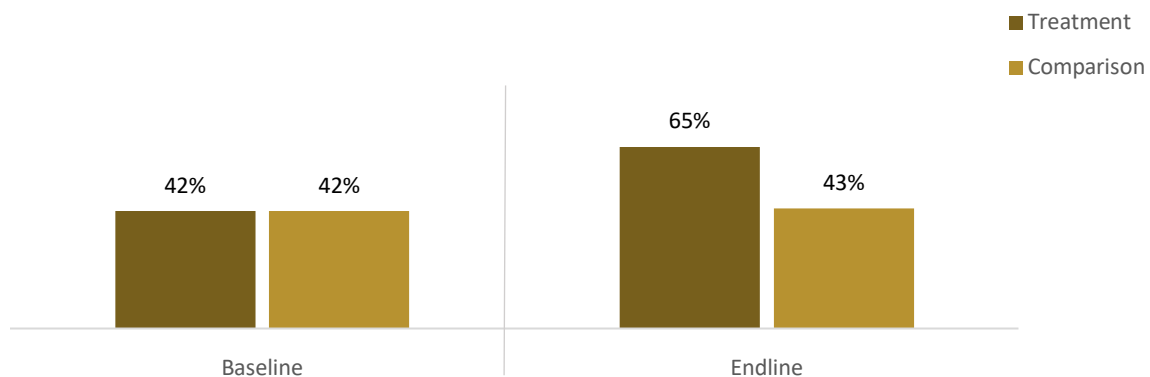
Base: All adolescents (Treatment and comparison (balanced) male n=317, female n=303, age 10-14 n=306, age 15-19 n=252, age 20-24 n=62, in school n=545, out of school n=75)

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 years 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, 42% (95% CI [37%, 48%]; M: 35%, F: 46%) of both the treatment and comparison (95% CI [37%, 48%]; M: 37%, F: 45%) groups expressed confidence in their ability to negotiate contraceptive use with their partners. By endline, the treatment group showed a substantial increase of 23 percentage points (65%; 95% CI [48%, 79%]; M: 79%, F: 59%), while the comparison group remained relatively stable at 43% (95% CI [29%, 58%]; M: 58%, F: 36%) (Figure 6). It should be noted that at midterm, a strong increase was observed in the comparison group (63%) while the treatment group remained stable (42%), though the different study design at midterm limits direct comparability. By endline, this pattern appeared to have reversed, with the comparison group returning to near-baseline levels while the treatment group showed a substantial increase.



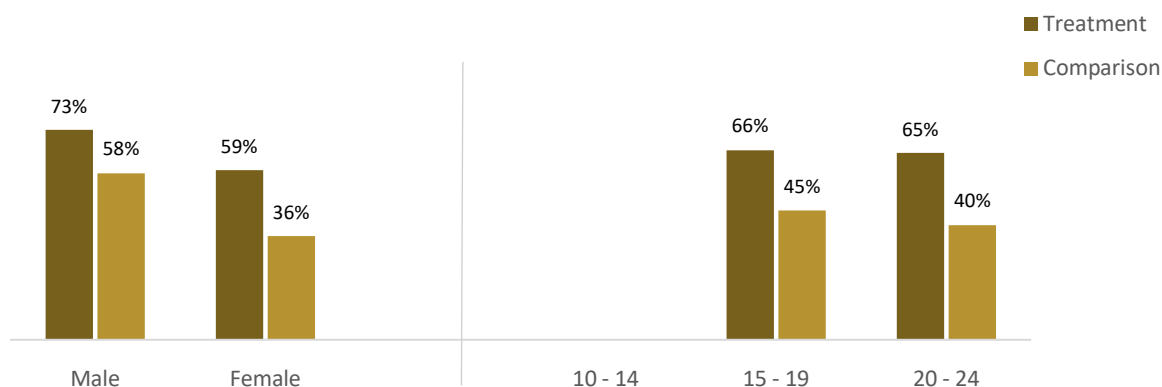
Base: Adolescents/youth who are married, cohabiting/living together, or in a relationship (Baseline treatment n=289, comparison n=297; Endline treatment n=121, comparison n=100)

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

The difference between groups at endline was marginally statistically significant (Adjusted $F(1, 62) = 3.79$, $p = .056$). The DiD analysis, controlling for observed sociodemographic differences between groups, did

not reveal a statistically significant effect ($B = -0.87$ ($SE = 0.52$, 95% CI $[-1.91, 0.18]$, $p = .102$), suggesting no differential change between arms over time. These results should be interpreted in light of the substantially reduced analytical sample for this indicator – only 586 respondents at baseline and only 221 respondents at endline were included due to the restriction to those currently in a relationship – which considerably limits statistical power. The observed 22-percentage point difference-in-difference in favour of the treatment group may be attributable to insufficient statistical power rather than a genuine absence of effect. These findings should therefore be considered inconclusive rather than as evidence of no project effect.

Disaggregated results should be interpreted with particular caution given the already restricted analytical sample for this indicator, resulting in very small subgroup sizes. While point estimates suggest that male respondents in both groups more often reported confidence in contraceptive negotiation than female respondents, overlapping confidence intervals preclude drawing definitive conclusions about gender-related differences (Figure 7).



Base: Adolescents/youth who are married, cohabiting/living together, or in a relationship (Treatment male $n=52$, female $n=69$, age 15-19 $n=67$, age 20-24 $n=54$; Comparison male $n=31$, female $n=69$, age 15-19 $n=60$, age 20-24 $n=40$)

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

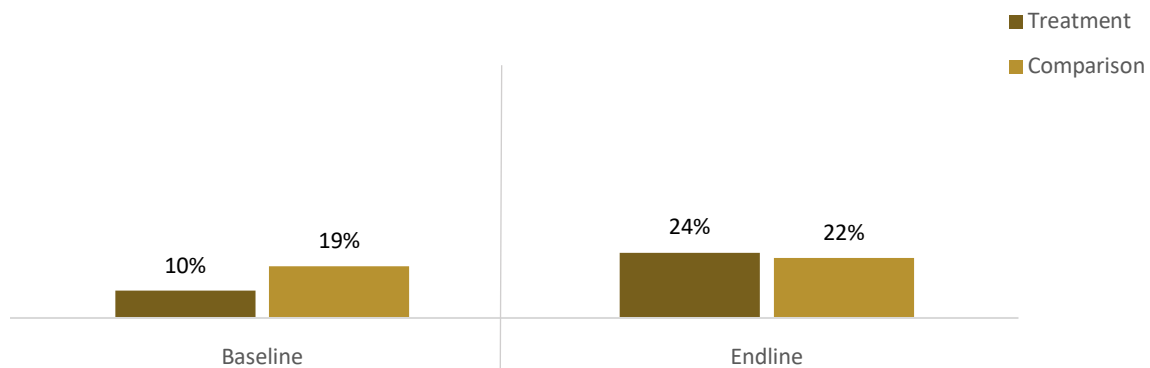
There was some evidence from the qualitative gathered as part of this evaluation that indicated growing confidence amongst adolescent girls to reject unwanted sexual relationships and make decisions about their reproductive health. One adolescent girl from Namolo said:

“We have been taught that we matter a lot and nobody can do anything to me without my permission. I have the ability to take decisions about my health and education.” (In-school adolescent girl, 15 years, Namolo community, IDI)

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.⁵²

At baseline, 10% (95% CI [6%, 17%]) of sexually active girls and young women in the treatment group reported consistent modern contraceptive use compared to 19% (95% CI [11%, 30%]) of the comparison group. By endline, both groups showed increases in point estimates, with the treatment group reaching 24% (95% CI [11%, 45%]) and the comparison group reaching 22% (95% CI [10%, 43%]; [Figure 8](#)). However, the analytical sample for this indicator was very small, with only 37 treatment and 36 comparison respondents at endline — considerably smaller than the already limited baseline sample (treatment $n=111$, comparison $n=102$) and likely reflecting the younger and less sexually active profile of the endline sample. As a result, confidence intervals are substantially wide, spanning over 30 percentage points in both groups, and any observed differences should be interpreted with great caution.



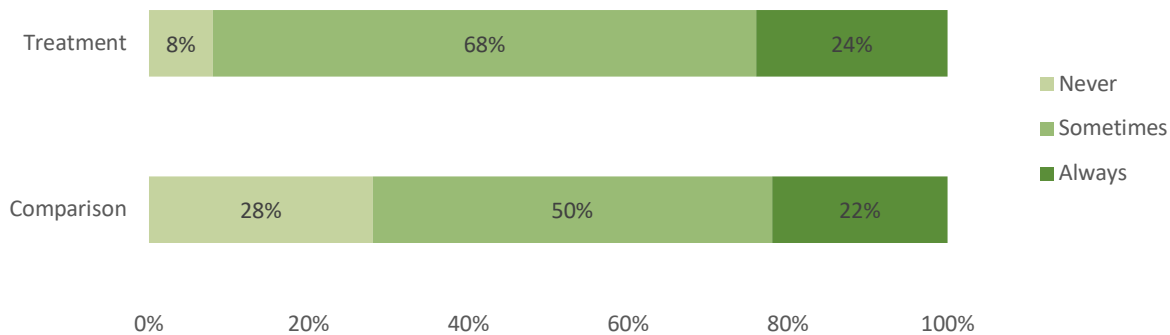
Base: Adolescent girls/young women who were sexually active in the past 12 months (Baseline treatment $n=111$, comparison $n=102$; Endline treatment $n=37$, comparison $n=36$)

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 $F(1, 36) = 0.31$, $p = .860$) nor the DiD analysis ($B = -0.90$, $SE = 0.81$, 95% CI [-2.51, 0.72], $p = .271$) revealed a statistically significant difference between treatment and comparison groups. Given the very small sample size, these analyses are severely underpowered, and results should be considered inconclusive rather than evidence of either project impact or no impact.

⁵² Modern methods include: Male condoms, Female condoms, Emergency contraceptive pills, Oral contraceptive pills, Injections, Implants, Intrauterine devices (IUDs), Male and female sterilization.

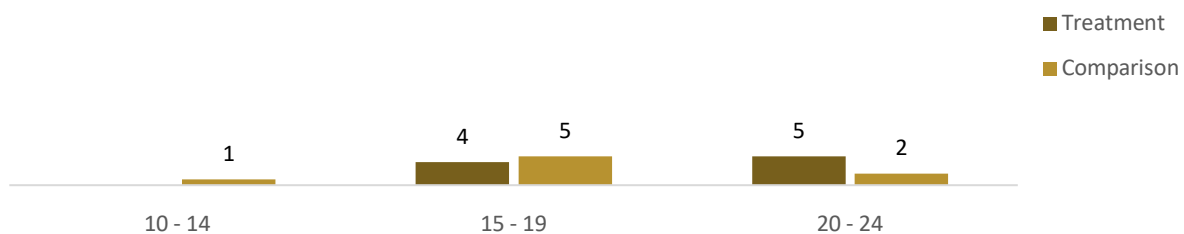
Further analysis of the data components shows that at endline, 24% (95% CI [11%, 45%]) of sexually active girls and young women in treatment areas and 22% (95% CI [10%, 43%]) in comparison areas reported always using contraception (Figure 9). Hence, among these consistent contraceptive users, all respondents (100% in both groups) reported using modern methods. This suggests that when young women in these areas adopt regular contraceptive practices, they exclusively choose modern contraceptive options. A notable difference between groups is observed in the proportion of never users: 28% of sexually active girls and young women in the comparison areas reported never using contraception, compared to only 8% in the treatment areas. While these findings should be interpreted cautiously given the very small sample sizes, this pattern is consistent with the possibility that the *SHARE* project contributed to reducing non-use of contraception among sexually active young women, with a larger proportion of treatment respondents reporting at least some contraceptive use.



Base: Adolescent girls/young women who were sexually active in the past 12 months (Treatment n=37, Comparison n=36)

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 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=17, age 20-24: n=20. Comparison age 10-14: n=3, age 15-19: n=19, age 20-24: n=14)

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 30 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 measures 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.

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

	Baseline n = 30	Midterm n = 30	Endline n = 30
<i>Availability of quality service delivery to women and adolescents regardless of</i>			
Gender	30 (100%)	30 (100%)	30 (100%)
Age	13 (43%)	11 (37%)	27 (90%)
Marital status	27 (90%)	30 (100%)	30 (100%)
<i>Availability of quality service</i>			
Separate waiting areas for adolescents ^a	13 (43%)	11 (37%) / 13 (43%)	2 (7%) / 10 (33%)
Counselling and examination rooms provide visual and auditory privacy ^a	20 (66%) / 21 (70%)	17 (57%) / 22 (73%)	18 (60%) / 20 (66%)
Staff are trained to serve adolescents in reproductive health service	26 (87%)	30 (100%)	30 (100%)
Storing records confidentially	23 (77%)	22 (73%)	29 (97%)
Accessing stored records confidentially	23 (77%)	27 (90%)	30 (100%)
Have functional toilets ^{b, c}	16 (53%)	16 (53%) / 18 (60%)	14 (47%) / 28 (60%)
All criteria met	1 (3%)	2 (7%) / 4 (13%)	2 (7%) / 5 (17%)

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'). ^c At midterm, 12 facilities reported not having toilet facilities; at endline, 9 facilities reported not having toilet facilities.

At baseline, only one facility met all nine criteria for good quality, gender-responsive and adolescent-friendly health services. This increased to two at midterm, or four when applying the less strict version. At endline, two facilities met all criteria under the strict version, and five under the less stringent version.

While the overall number of fully compliant facilities remained limited across all three time points, a closer examination of individual criteria reveals a more nuanced picture. Non-discriminatory service delivery showed consistent improvement over time. All 30 facilities served adolescents regardless of gender at each time point. Service provision regardless of marital status improved from 27 facilities at baseline to all 30 at midterm and remained universal at endline. Age-inclusive service provision declined slightly from 13 facilities at baseline to 11 at midterm, before increasing substantially to 27 facilities at endline.⁵³ The assessment of quality service infrastructure showed mixed trends. Staff training in adolescent reproductive health services reached all 30 facilities at midterm, up from 26 at baseline, and was maintained at endline. Confidential record storage improved from 23 facilities at baseline to 29 at endline. Confidential access to records showed consistent improvement across all three waves, from 23 facilities at baseline to 27 at midterm and all 30 facilities at endline.

In contrast, the availability of separate waiting areas for adolescents declined from 13 observed facilities at baseline to 11 at midterm and only two at endline under the strict observed-only criterion. Including facilities that self-reported having separate waiting areas increases the endline total to ten, though this remains below baseline levels. The availability of fully functional toilets remained low across all three waves: 16 facilities at baseline, 16 at midterm, and 14 at endline met the strict all-toilets-functional criterion. Including facilities with partial toilet functionality increases the endline total to 18. [Table 11](#) presents further details on the cleanliness and functionality of toilet facilities.

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

	Baseline n = 30	Midterm n = 30	Endline n = 30
<i>Toilets are clean on</i>			
Ceiling	18 (60%)	14 (47%)	13 (43%)
Floor	16 (53%)	15 (50%)	17 (57%)
Walls	15 (50%)	15 (50%)	16 (53%)
Toilet bowl	16 (53%)	15 (50%)	13 (43%)
<i>Toilets have</i>			
Functional locks	15 (50%)	15 (50%)	12 (40%)
Functional lights	14 (47%)	10 (33%)	10 (33%)
Separate toilets for male and female	10 (33%)	10 (33%)	11 (37%)

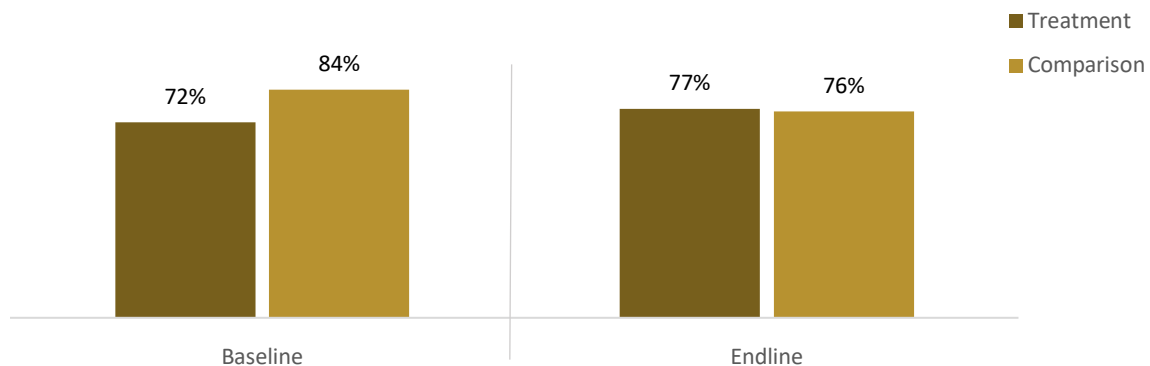
Note. 12 facilities at midterm and 9 facilities at endline reported having no toilet facilities.

⁵³ The endline figure for age-inclusive service provision was verified through follow-up field visits after initial data collection indicated an unexpectedly low response. The verified figure of 27 facilities is used throughout.

Indicator 1200.2: Percentage of adolescents/youth aged 10-24 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 – particularly at endline (treatment $n=79$, comparison $n=19$).

At baseline, satisfaction rates appeared somewhat higher in the comparison group (84%; 95% CI [74%, 91%]; M: 88%, F: 83%) compared to the treatment group (72%; 95% CI [62%, 80%]; 65%, F: 76%), though this difference was not statistically significant (Adjusted $F(1, 80) = 3.49$, $p = .065$). By endline, satisfaction rates were broadly similar between groups, with 77% (95% CI [63%, 88%]; M: 79%, F: 76%) of respondents in treatment areas and 76% (95% CI [51%, 91%]; M: 86%, F: 72%) of respondents in comparison areas indicating that they were (very) satisfied with SRH services (Figure 11). It should be noted that the confidence interval for the comparison group at endline spans 40 percentage points, reflecting the very small sample of only 19 respondents, and observed trends should therefore be interpreted with great caution.



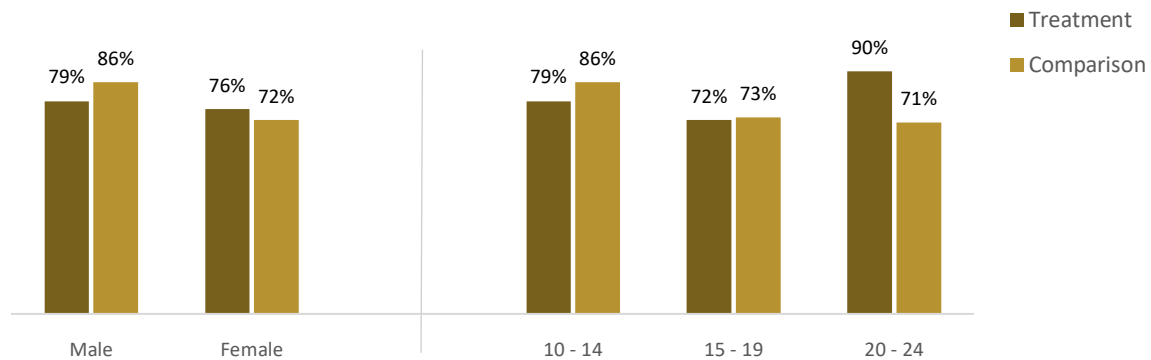
Base: Adolescents/youth who used SRHR services in the past 12 months (Baseline treatment $n=213$, comparison $n=106$; Endline treatment $n=79$, comparison $n=19$)

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

Neither the cross-sectional comparison at endline (Adjusted $F(1, 80) = 0.02$, $p = .903$) or the DiD analysis revealed a statistically significant effect ($B = -0.86$, $SE = 0.82$, 95% CI [-2.50, 0.77], $p = .297$). However, these analyses are severely underpowered, and results should be considered inconclusive rather than evidence of any effect or no effect. Regardless, it is important to situate and interpret these findings considering the status of affairs in the comparison areas selected for this evaluation (Bolgatanga East and Builsa South). In both districts, there were several other projects similar to diverse components of the SHARE project being implemented. For example, Youth Advocates Ghana implemented adolescent and youth focused Sexual and Reproductive Health and Rights interventions under the Youth for Health

project.⁵⁴ Youth Advocates Ghana implemented its activities from 2022 to 2025. The initiative aimed to improve adolescents' knowledge of sexual and reproductive health, promote positive health-research behaviors, and strengthen access to adolescent friendly services. There was another project called '1 Million Smiles', implemented by AfriKids Ghana which utilized adolescent youth friendly centers to deliver SRH services integrated within existing health service structures.⁵⁵ In addition, Ghana Health Service, Bolgatanga East District continued to provide routine adolescent friendly health services throughout the project implementation period.

Figure 12 presents service satisfaction disaggregated by gender and age group. Due to the small sample sizes, these subgroups cannot be meaningfully compared.



Base: Adolescents/youth who used SRHR services in the past 12 months (Treatment male n=47, female n=55, age 10-14 n=29, age 15-19 n=53, age 20-24 n=20; Comparison male n=7, female n=18, age 10-14 n=7, age 15-19 n=11, age 20-24 n=7)

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

Among respondents who were (very) satisfied, ease of access was the most frequently cited positive aspect (T: 63%, C: 47%), followed by staff friendliness (T: 77%, C: 37%) and quick service delivery (T: 42%, C: 53%). Given the small analytical sample underlying these percentages, these patterns should be considered indicative only.

Among (very) dissatisfied respondents, the numbers were too small to report percentages meaningfully ($n_T = 9$, $n_C = 5$). In absolute terms, difficulty reaching facilities was cited by five treatment and one comparison respondent, wait times by four treatment and one comparison respondent, and cost concerns by four treatment respondents. These figures are reported for completeness but should not be interpreted as representative of broader patterns.

⁵⁴ MSI Reproductive Choices, 2023. An Introduction to Youth for Health (Y4H) Expanding Access to Life-Changing Adolescent Sexual and Reproductive Healthcare in Ethiopia, Ghana, Kenya, Sierra Leone, Tanzania and Zambia. Available from: https://www.msichoice.org/wp-content/uploads/2023/10/youth-for-health-leaflet_march-2023.pdf

⁵⁵ AfriKids Ghana, 2025. 1 MILLION SMILES Making Ghana a beacon for child rights Our 2021-2025 Strategy. Available from: https://afrikids.org/wp-content/uploads/2024/07/2021-2025-Strategy-WEB_RGB_spreads_v2.pdf

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 midterm and 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.

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

	Baseline n = 30	Midterm n = 30	Endline n = 30
<i>Development of waste management sustainability mechanisms</i>			
A dedicated trained team is appointed for waste management	-	23 (77%)	21 (70%)
An up-to-date waste management plan is in place ^a	-	15 (50%)	22 (73%)
<i>Implementation of waste management sustainability mechanisms</i>			
At least two of the following waste management practices are implemented:	-	23 (77%)	21 (70%) / 25 (83%)
- Waste (all types) is being segregated according to type of waste in the appropriate waste bins	-	26 (87%)	22 (73%)
- Incinerator or alternative waste disposal mechanism is being properly utilized and maintained	-	17 (57%)	17 (57%)
- Waste management plan is being monitored and updated by the trained team ^b	-	2 (7%) / 9 (30%)	2 (7%) / 21 (70%)
- PPE and cleaning supplies are being properly utilized by all staff	-	26 (87%)	15 (50%)
All criteria met	-	14 (47%)	13 (43%) / 15 (50%)

Note. Base: all surveyed facilities. ^a At midterm, this item was measured as Yes/No. At endline, the response options were expanded to Yes, observed/ Yes, reported but not observed/No. For comparability across time points, both 'Yes, observed' and 'Yes, reported but not observed' are counted towards this criterion. ^b 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').

Regarding the first criterion, a dedicated trained team appointed for waste management was present in 23 facilities at midterm, declining slightly to 21 at endline. It should be noted that six facilities responded 'Don't know' at endline, which may indicate insufficient awareness of waste management responsibilities among the respondents interviewed at those facilities. The second criterion, an up-to-date waste

management plan, showed a notable improvement, increasing from 15 facilities at midterm to 22 at endline. The third criterion evaluated implementation of waste management practices, requiring facilities to demonstrate at least two out of four specific practices. The number of facilities meeting this criterion remained relatively stable: 23 at midterm and 21 at endline under the strict version, with four additional facilities included under the less strict version. Performance on individual practices varied considerably.

Waste segregation remained broadly in place, though with some decline – 26 facilities demonstrated full segregation at midterm compared to 22 at endline. An additional eight facilities at endline reported segregating some but not all waste types. Encouragingly, waste segregation at endline was consistently maintained through storage, transport, and final treatment/disposal in 28 cases, with only one facility partially maintaining and one not maintaining segregation after collection.

Proper utilization and maintenance of incinerators or alternative waste disposal mechanisms remained stable at 17 facilities across both waves.

PPE and cleaning supply utilization declined from 26 facilities at midterm to 15 at endline. Among the 15 facilities not fully meeting this criterion, eight indicated that no PPE use was required at the time of the interview as staff were not attending to clients or performing cleaning tasks, while seven cited inadequate supply. The broader PPE availability picture at endline does reveal persistent supply challenges: only two facilities reported PPE is always consistently available in sufficient quantities, while 24 reported generally adequate availability with occasional minor shortages, and four facilities reported intermittent or no availability. In terms of replenishment, only one facility reported proactive restocking, while 17 replaced supplies soon after being used, ten only after a stock-out, and two reported irregular and delayed replenishment. Regarding the physical availability of PPE and cleaning supplies at waste handling areas, only eight facilities had both PPE and cleaning supplies in all waste handling areas, 17 had only PPE in all areas, and three had only cleaning supplies in all areas.

Monitoring and updating of waste management plans by trained teams remained the weakest area across both waves. Only two facilities showed observed evidence of active monitoring at both midterm and endline. The number of facilities self-reporting this practice increased substantially from seven at midterm to 19 at endline, though the reliability of self-reported compliance without observed evidence remains uncertain.

Overall, 14 out of 30 facilities (47%) met all three criteria for waste management sustainability mechanisms at midterm, declining slightly to 13 facilities (43%) at endline under the strict version, with two additional facilities meeting all criteria (50%) when applying the less strict version. These findings suggest that while many facilities have established basic waste management infrastructure and safety practices, there are still substantial opportunities for improvement, particularly in ensuring consistent PPE availability and strengthening the active monitoring of waste management plans.

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 project stakeholders i.e. consortium members, district officials, and community member respondents provided limited evidence that new ASRHR policies were developed and executed by the local authorities as a direct result of CBO, consortium members and young people's advocacy. However, respondents reported several context-specific policy, regulatory and institutional changes that strengthened the local environment for ASRH. One of the examples is declarations by traditional authorities and community by-laws that reinforced existing child protection legislation. The respondent further noted that this declaration was followed by enforcement action when a reported child marriage case resulted in police intervention and arrest. A representative of the Ghana Health Service also reported that local leaders and community members had adopted rules intended to discourage adolescent pregnancy and strengthen protection for girls. Although this was not a formal district policy, it represents a locally driven protection mechanism aligned with broader child protection laws.

As of the midterm review, significant progress was made at the output level, including supporting 20 CBOs to host 39 events and engaging 20 Master Trainers from GES and local implementing partners to assist teachers and mentors in advocacy action planning for adolescent girls and young women.⁵⁶ Following the mid-term review, traditional and religious leaders were engaged to strengthen their understanding of national laws related to adolescent rights and protection. According to a consortium respondent, these orientation activities aimed to increase leaders' awareness of their role in addressing harmful practices and supporting the implementation of laws affecting adolescents within their communities.

While the respondents from district officials and consortium members did not directly attribute the changes to youth advocacy, consortium partners reported that adolescents were increasingly included in community dialogues, cultural performances and engagement platforms where they could raise concerns and discuss issues affecting their lives with caregivers, caregivers and local leaders. These spaces may contribute to greater recognition of adolescent perspectives in local discussions on child marriage, gender norms and reproductive health.

⁵⁶ SHARE Project Operations Report, April 1, 2024 -September 30, 2024

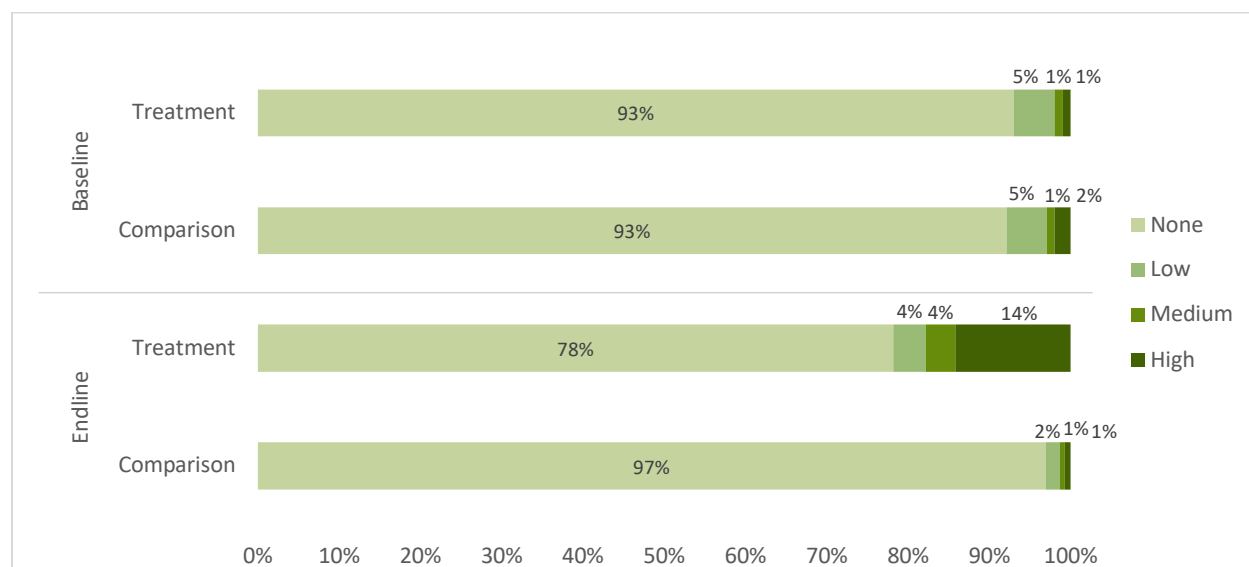
Indicator 1300.2: Level of active participation in SRHR advocacy and social action initiatives by girls and young women aged 10-24 years

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 (Table 13). 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 (Figure 13).

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

	Baseline		Endline	
	Treatment (n = 427 ^a / 32 ^b)	Comparison (n = 427 ^a / 31 ^b)	Treatment (n = 303 ^a / 66 ^b)	Comparison (n = 303 ^a / 9 ^b)
Participated in SRHR related advocacy activities ^a	7 [5, 11]	7 [5, 11]	22 [14, 33]	3 [1, 7]***
Belong to committee or association that works on ASRHR ^a	4 [3, 6]	7 [4, 10]	17 [10, 28]	1 [0, 4]***
Received feedback from adult stakeholders on their influence on outcomes ^b	28 [15, 46]	35 [20, 54]	82 [63, 92]	44 [11, 84]

Note. ^a Base: Adolescent girls/young women. ^b Base: Adolescent girls/young women who participated in SRHR related advocacy activities. 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. * $p < .05$, ** $p < .01$, *** $p < .001$.

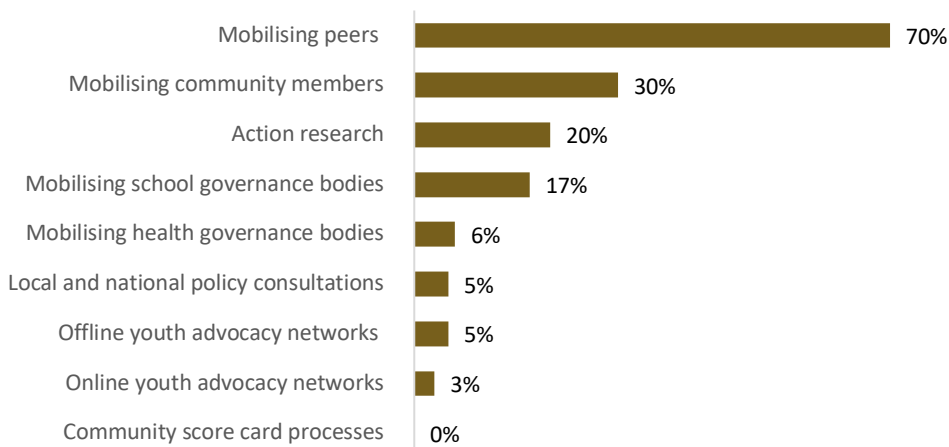


Base: Adolescent girls/young women (Baseline treatment and comparison (balanced) n=427, Endline treatment and comparison (balanced) n=303)

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

Endline data indicate increased engagement in SRHR advocacy and social action in treatment areas, while participation levels declined in comparison areas. Specifically, the proportion of girls and young women participating in SRHR-related advocacy activities rose substantially in treatment areas, from 7% at baseline to 22% at endline. In contrast, in comparison areas, participation rates decreased from 7% to 3%; however, given overlapping confidence intervals, this change should be interpreted with caution and may not reflect a true population-level shift. Among those who participated (treatment $n=66$; comparison $n=9$), 82% in treatment areas reported receiving feedback from adult stakeholders on their influence, compared to 28% at baseline. Estimates for the comparison group are highly uncertain due to the very small sample size, as reflected in the wide confidence interval, and are therefore not interpreted further. Reported membership in ASRHR committees or associations among girls also increased in treatment areas from 4% to 17%, while declining in comparison areas from 7% to 1% (Table 13).

The difference in overall participation levels between treatment and comparison groups was significant at endline (Adjusted $F(2.27, 181.33) = 11.25, p < .001$). The DiD analysis of the dichotomized participation indicator,⁵⁷ controlling for observed sociodemographic differences between groups, showed a statistically ($B = -2.19$ ($SE = 0.60$, 95% CI $[-3.37, -1.00]$, $p < .001$). These findings are consistent with the possibility that the SHARE project interventions contributed to increased engagement in SRHR advocacy and social action among girls and young women in the treatment areas, though this interpretation relies on assumptions that could not be fully verified and should therefore be treated with caution. Mobilizing peers and mobilizing community members emerged as the most common forms of engagement among girls and young women in the treatment areas. Comparison group results are not reported here due to the very small number of participants, which precludes meaningful interpretation of percentages (Figure 14).



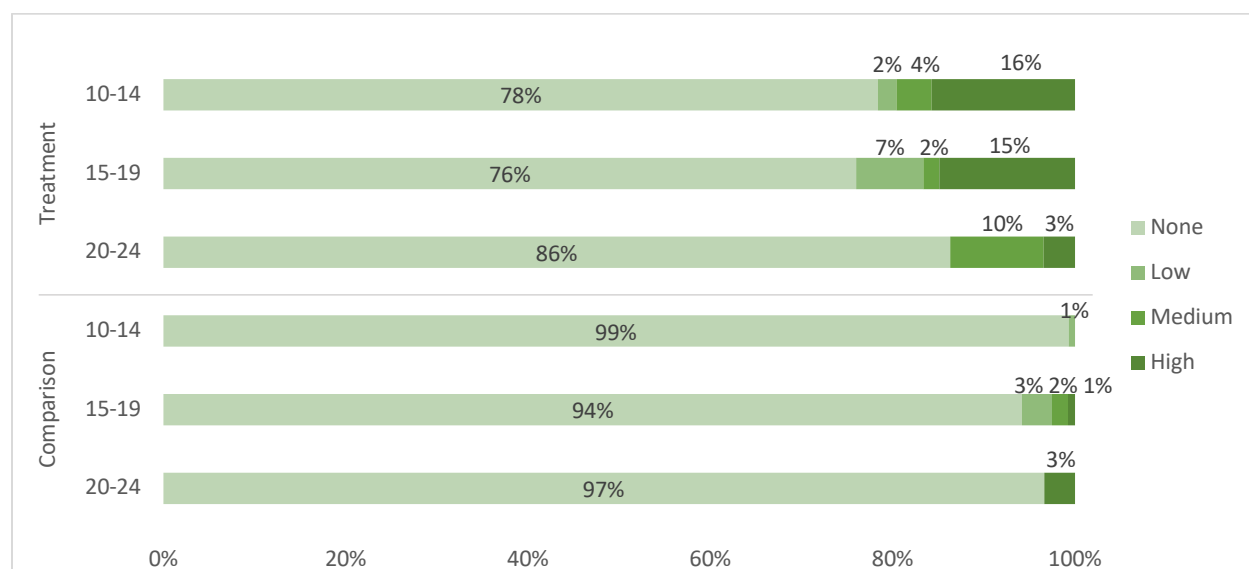
Base: Adolescent girls/young women who engaged in SRHR related advocacy activities (Treatment $n=66$)

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

⁵⁷ Based on dichotomous 0 = no participation vs 1 = any participation to improve model convergence.

Despite these positive developments in treatment areas, the majority of girls in both treatment (78%; 95% CI [67%, 86%]) and comparison areas (97%; 95% CI [93%, 99%]) were not involved in any SRHR advocacy and social action activities. When examining barriers to participation, lack of knowledge about how to engage was the predominant obstacle, cited by 40% of non-participants in treatment areas and 47% in comparison areas. Furthermore, feelings of shyness were cited by similar proportions of girls/young women in both groups (T: 14%, C: 14%).

Figure 15 presents participation levels of adolescent girls/young women at endline, disaggregated by age group. Across all age groups in both treatment and comparison areas, over 76% of respondents remained in the 'none' category. The minimal variation in participation rates and the small sample sizes within each age group preclude drawing definitive conclusions about age-related differences.



Base: Adolescent girls/young women (Treatment age 10-14 n=153, age 15-19 n=121, age 20-24 n=29; Comparison age 10-14 n=153, age 15-19 n=121, age 20-24 n=29)

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

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 and midterm, 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> = 843)	Comparison (<i>n</i> = 843)	Treatment (<i>n</i> = 620)	Comparison (<i>n</i> = 620)
Overall mean	2.76 [2.73, 2.78]	2.79 [2.77, 2.81]*	2.82 [2.79, 2.86]	2.79 [2.70, 2.88]
<i>Gender</i> ^a				
Male	2.78 [2.75, 2.81]	2.83 [2.81, 2.85]	2.82 [2.78, 2.86]	2.78 [2.69, 2.87]
Female	2.73 [2.70, 2.76]	2.74 [2.71, 2.78]	2.83 [2.79, 2.87]	2.81 [2.72, 2.89]
<i>Age</i>				
10-14	2.75 [2.71, 2.79]	2.79 [2.76, 2.82]	2.84 [2.80, 2.88]	2.82 [2.74, 2.90]
15-19	2.76 [2.72, 2.79]	2.79 [2.76, 2.81]	2.82 [2.78, 2.86]	2.77 [2.67, 2.88]
20-24	2.76 [2.73, 2.79]	2.78 [2.75, 2.82]	2.75 [2.66, 2.85]	2.73 [2.60, 2.85]

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 2.76 (95% CI [2.73, 2.78]) in the treatment group and 2.79 (95% CI [2.77, 2.81]) in the comparison group, with the difference between arms reaching statistical significance (Wald $F(1,80) = 4.46$, $p = .038$). By endline, mean resilience scores increased slightly in the treatment group to 2.82 (95% CI [2.79, 2.86]), while the comparison group remained stable at 2.79 (95% CI [2.70, 2.88]), with no statistically significant difference between arms at endline (Wald $F(1, 80) = 0.44$, $p = .509$). The DiD analysis, controlling for observed sociodemographic differences between groups, did not reveal a significant effect ($B = -0.06$, $SE = 0.05$, 95% CI [-0.16, 0.04], $p = .211$), suggesting no differential change between groups over time. Although at baseline male respondents scored higher than female respondents across both arms, this gender effect was no longer apparent at endline. No notable differences in resilience scores were observed across age categories at either wave (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 who are knowledgeable of their sexual and reproductive health and rights

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.⁵⁸

At baseline, treatment and comparison groups showed similar levels of comprehensive SRHR knowledge, with 29% (95% CI [24%, 32%]; M: 24%, F: 33%) of treatment group respondents and 32% (95% CI [28%, 36%]; M: 20%, F: 43%) of comparison group respondents meeting the 80% threshold, averaging 5.8 and 5.9 correct responses respectively.

By endline, point estimates suggested an increase in SRHR knowledge in the treatment group, with 42% (95% CI [32%, 53%]; M: 39%, F: 46%) of respondents meeting the threshold, while knowledge levels in the comparison group remained relatively stable (27%; 95% CI [20%, 35%]; M: 27%, F: 26%). This resulted in a significant difference between arms at endline (Wald $F(1, 80) = 5.49$, $p = .022$). The mean number of correct responses at endline was 6.8 in the treatment group and 5.9 the comparison group (Figure 16).

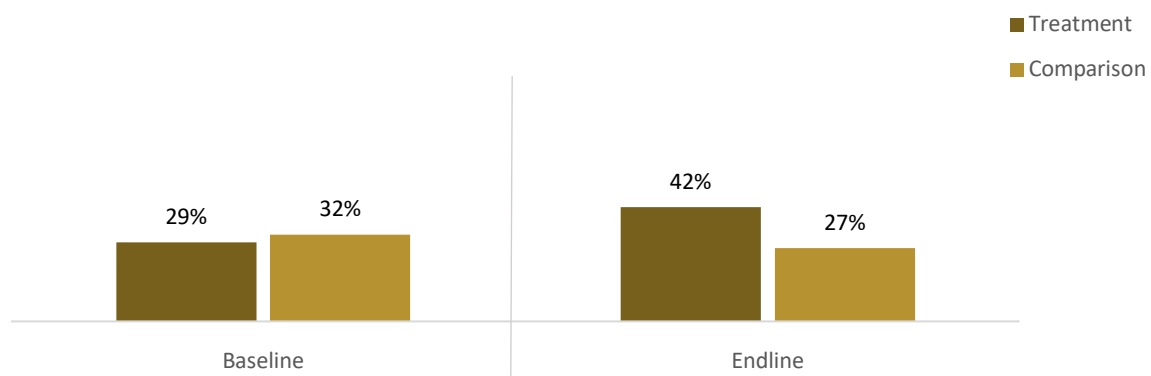


Figure 16: Adolescents/youth who are knowledgeable of their sexual and reproductive health and rights (%)

⁵⁸ At baseline and midterm, a different set of questions and threshold was used. The baseline (presented here) and midterm (presented in PMF) results have since been recalculated and updated.

The DiD analysis, controlling for observed sociodemographic differences between groups, yielded a statistically significant difference between groups over time ($B = -0.89$, $SE = 0.34$, 95% CI [-1.56, -0.22], $p = .010$), reflecting the 18-percentage point difference-in-difference. Given that both groups started at comparable baseline levels, these findings are consistent with the possibility that the *SHARE* project activities contributed to increased SRHR knowledge in treatment areas, though this interpretation relies on assumptions that could not be fully verified and should therefore be treated with caution.

Inspection of the individual items (Table 15) indicates that the overall improvement in comprehensive SRHR knowledge in the treatment group was primarily driven by increased awareness around contraception and STIs, with improvements of approximately 15-20 percentage points (based on point estimates). In contrast, support for sexual rights remained largely stable over time, although a higher proportion of respondents at endline agreed that sexual rights apply to all people.

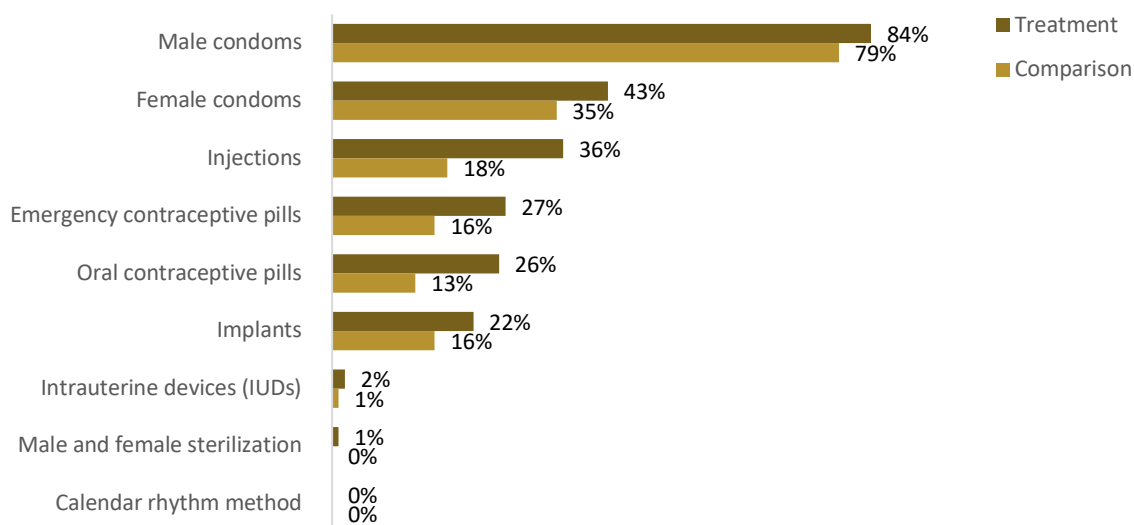
Table 15: Adolescents/youth who demonstrate knowledge of different key SRHR topics (% [95% CI])

	Baseline		Endline	
	Treatment ($n = 843$)	Comparison ($n = 843$)	Treatment ($n = 620$)	Comparison ($n = 620$)
Aware of female menstrual cycle and conception	8 [6, 10]	6 [5, 8]	11 [7, 19]	5 [2, 8]*
Aware of at least one modern contraceptive method	68 [63, 73]	76 [71, 80]*	88 [82, 93]	84 [77, 88]
Aware of ways to avoid pregnancy	80 [76, 83]	85 [82, 89]*	95 [92, 97]	95 [91, 97]
Aware of one or more STIs	78 [73, 82]	83 [78, 87]	98 [96, 99]	91 [86, 94]***
Aware of one or more transmission methods of STIs	70 [64, 74]	80 [72, 83]*	88 [81, 92]	69 [60, 77]***
Aware of one or more ways to avoid STIs	70 [64, 75]	77 [71, 82]	87 [80, 92]	70 [61, 77]**
Strongly agree that sexual rights apply to all young people	46 [40, 51]	42 [36, 47]	60 [51, 69]	52 [42, 62]
Strongly agree that all forms of non-consensual sexual activity are forms of violence	62 [57, 67]	62 [58, 67]	59 [48, 69]	57 [46, 66]
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	63 [58, 67]	48 [44, 52]***	54 [44, 64]	37 [28, 47]*
Strongly disagree that HIV transmission is linked to "immoral" behaviours so anyone living with HIV is immoral	38 [34, 42]	34 [30, 38]	40 [32, 50]	35 [26, 44]
Answered correctly to at least 80% of questions (%)	29 [24, 34]	32 [28, 36]	42 [32, 53]	27 [20, 35]*
Mean number of correct questions	5.8 [5.5, 6.1]	5.9 [5.6, 6.2]	6.8 [6.4, 7.3]	5.9 [5.6, 6.3]

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: 84%, C: 79%), followed by female condoms (T:

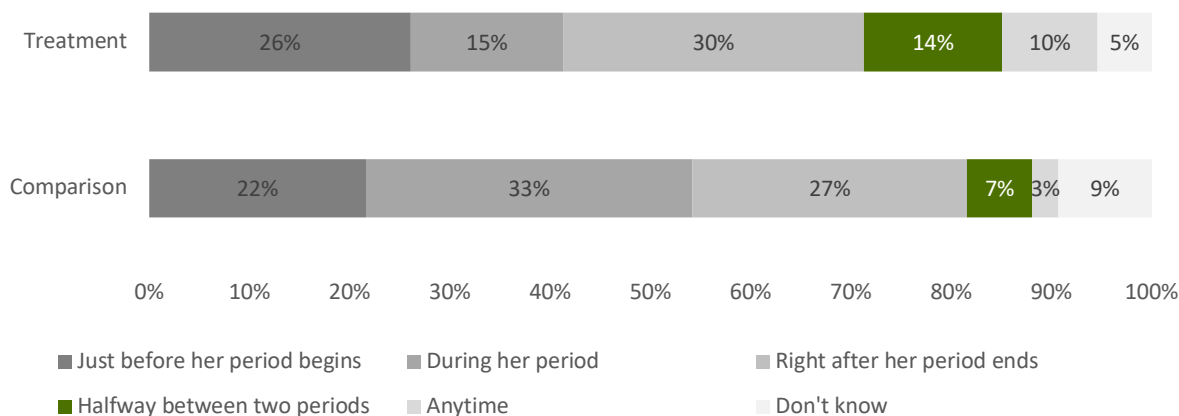
43%, C: 35%), injectable contraceptives (T: 36%, C: 18%), emergency contraceptive pills (T: 27%, C: 16%), and oral contraceptive pills (T: 26%, C: 13%).



Base: All adolescents (Endline treatment n=620, comparison n=620)

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

Similar to baseline findings, knowledge of the female menstrual cycle and conception remained consistently low across both groups, hovering around 7-14% (Figure 18).

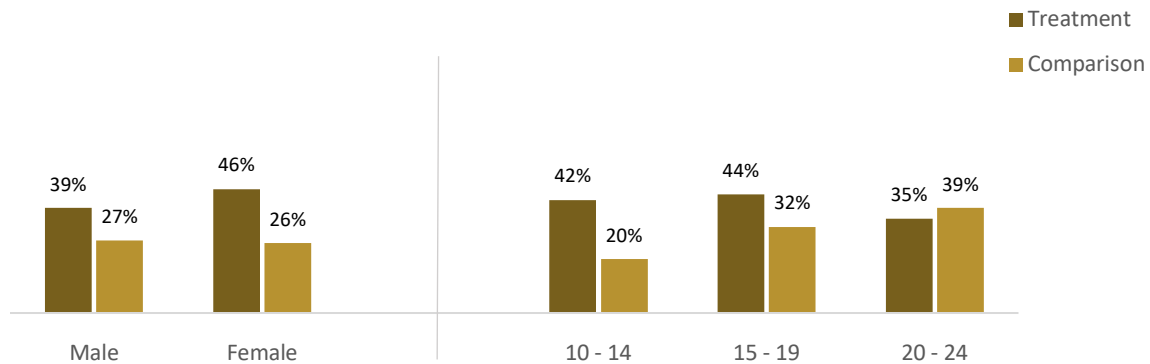


Base: adolescents who mentioned there are certain days when women are more likely to become pregnant if they have sexual intercourse (Treatment n=514, Comparison n=430)

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

SRHR knowledge was broadly similar between genders at both the composite and the individual item levels. However, females in the treatment group demonstrated somewhat higher awareness of the

menstrual cycle and contraception (15%, 95% CI [9%, 26%]) compared to males in the same group (8%, 95% CI [4%, 14%]). As expected, knowledge increased with age in the comparison group. This pattern was not evident in the treatment group, where knowledge levels were relatively similar across age groups. This divergence may possibly reflect the school-based delivery of the intervention, which likely reached younger adolescents more consistently ([Figure 19](#)).



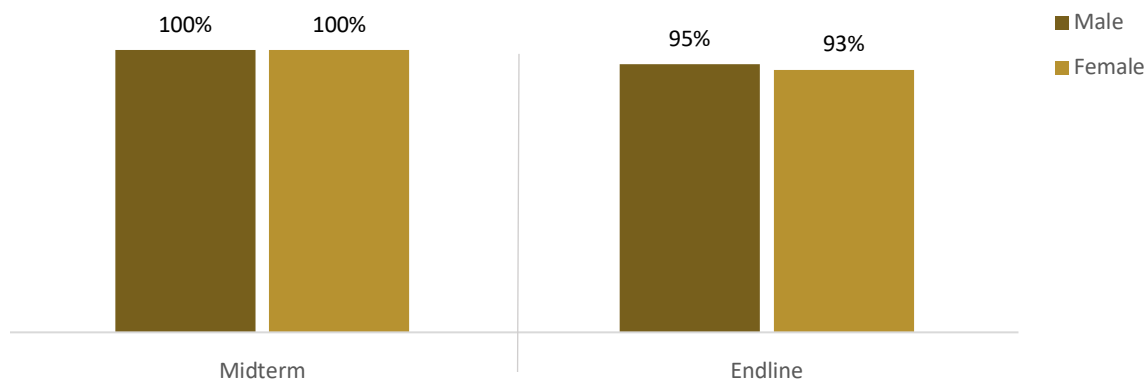
Base: All adolescents (Treatment and comparison (balanced) male n=317, female n=303, age 10-14 n=306, age 15-19 n=252, age 20-24 n=62, in school n=545, out of school n=75)

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

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

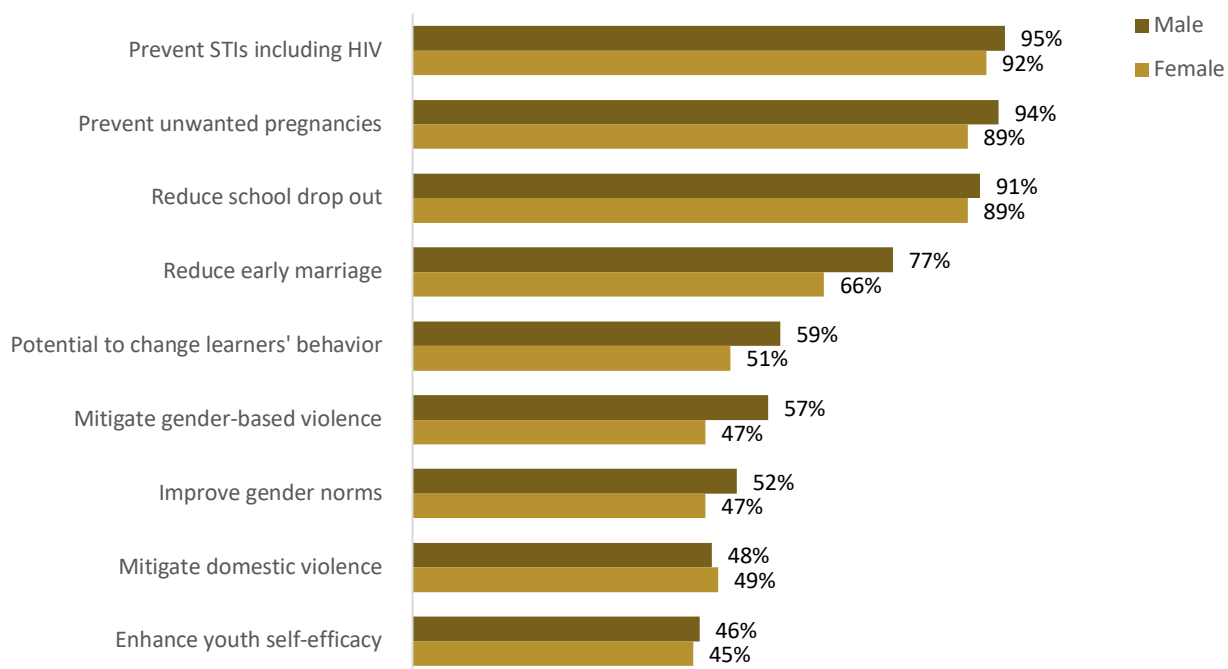
The quality of SRH information that adolescents receive through their schools depends on their teachers' familiarity with the subject matter. To assess this, we surveyed teachers in the *SHARE* project (treatment) areas to measure their understanding of the health benefits of reproductive health education for adolescents and awareness of guidelines and policies governing reproductive health education delivery in (their) schools. As the baseline sample size was insufficient to make reliable comparisons over time, results are presented for midterm and endline only.

At midterm, nearly universal knowledge of reproductive health education benefits was reported among teachers. However, as the midterm assessment used a self-administered format in which teachers could read benefits from a provided list rather than recalling them independently, these results are likely to overestimate true knowledge levels and should be interpreted with caution. At endline, an interviewer-led approach was used, yielding more reliable results. Under this methodology, 94% (95% CI [91%, 96%]) of teachers could accurately cite at least three health benefits of reproductive health education. There were no clear gender differences in teachers' knowledge at endline (males: 95%; females: 93%; [Figure 20](#)). The most frequently cited benefits by teachers in Ghana were prevention of STIs and HIV, prevention of unwanted pregnancies, and reduction in school dropout ([Figure 21](#)).



Base: All teachers (Midterm n=994, Endline n=351)

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



Base: All teachers (Endline male n=197, female n=154)

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

Awareness of Ghana's national reproductive health education guidelines was high at endline at 91% (95% CI [87%, 94%]; M: 92%, F: 89%), as was awareness of relevant policies in respondents' own schools (91%; 95% CI [87%, 93%]; M: 90%, F: 92%). These figures are notably higher than midterm levels (44% and 60%),

though this comparison should be interpreted cautiously – at endline, only teachers responsible for delivering reproductive health education content were considered eligible, whereas this criterion was not applied at midterm. The higher endline figures may therefore partly reflect a more targeted sample of teachers with direct responsibility for reproductive health education, rather than solely representing an improvement over time. There were no gender differences in awareness of guidelines and policies.

All teachers surveyed at endline had received training on reproductive health education, with the majority trained within the past two years (70% in the past year, 23% one to two years ago). Nearly all were trained directly by *SHARE* or its partners *Right To Play*, FAWE, and WaterAid (95%), with 4% trained indirectly through a Community of Practice or Professional Learning Community. Training quality was rated highly, with 47% of respondents rating it as good and 49% as excellent.

Teachers reported substantial self-perceived improvements across all dimensions following training. Almost all reported their knowledge of reproductive health education had improved (91% much better, 8% a bit better), with 93% attributing this improvement largely to the *SHARE* training. Attitudes toward reproductive health education also shifted markedly, with 71% of respondents reporting much more positive attitudes and 28% somewhat more positive, with 94% attributing this change largely to the *SHARE* project. Similarly, comfort with teaching reproductive health education improved substantially, with 84% reporting feeling much more comfortable and 14% somewhat more comfortable, and 92% attributing this predominantly to *SHARE* training. This is an important achievement for the project, especially considering that many teachers in Ghana report that religious commitments and personal biases inform them when it relates to reproductive health issues.⁵⁹ Finally, from the endline evaluation, 72% of teachers rated their school environment as very supportive in delivering reproductive health education to students, and 23% as somewhat supportive.

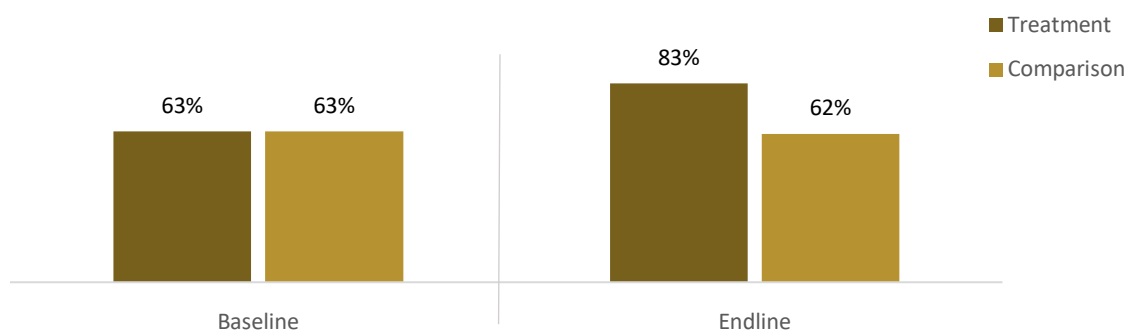
When asked about challenges in delivering reproductive health education, teachers most commonly identified lack of teaching and learning materials (87%) and insufficient time (58%). These findings are consistent with the open-ended feedback provided by teachers, which was dominated by requests for more training and teaching and learning materials. The qualitative findings complemented the survey findings regarding the practical challenges with limited teaching and learning materials which affected them in delivering SRHR education. These included lack of materials, limited classroom time, and discomfort discussing some SRHR topics. In Saboro, a teacher explained:

“We would have wished to have the teaching and learning materials but unfortunately, we don’t have.” (Teacher, F, Saboro, KII)

⁵⁹ Nyarko, John Abbam, Perception of Students & Teachers on Reproductive Health Education (August 30, 2022). Available at SSRN: <https://ssrn.com/abstract=4204835> or <http://dx.doi.org/10.2139/ssrn.4204835>

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

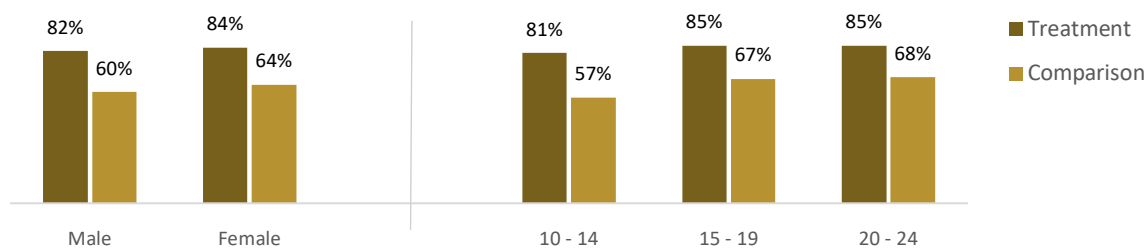
To further measure Immediate Outcome 1110, we assessed adolescents' perceived self-efficacy in accessing SRHR information and SRH services. At baseline, nearly two-thirds of adolescents in treatment (63%; 95% CI [59%, 67%]; M: 59%, F: 66%) and comparison (63%; 95% CI [58%, 67%]; M: 55%, F: 71%) areas believed they could access these resources if needed. By endline, the treatment group increased substantially to 83% (95% CI [75%, 89%]; M: 82%, F: 84%), while the comparison group remained unchanged at 62% (95% CI [51%, 72%]; M: 60%, F: 64%), [Figure 22](#). This difference at endline was statistically significant (Adjusted $F(1, 80) = 11.57, p < .001$).



Base: All adolescents (Baseline treatment n=843, comparison n=843; Endline treatment n=620, comparison n=620)

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

The DiD analysis, controlling for observed sociodemographic differences between groups, yielded a statistically significant difference between groups over time ($B = -1.19, SE = 0.36, 95\% \text{ CI } [-1.90, -0.48], p < .001$). With both groups starting at identical baseline levels, the 21-percentage point difference-in-difference is consistent with the possibility that the *SHARE* project activities contributed to strengthening adolescents' belief in their ability to access SRHR information and SRH services, though this interpretation relies on assumptions that could not be fully verified and should therefore be treated with caution. At endline, results were broadly consistent across gender and age groups, with no notable differences in self-efficacy observed within either arm. The treatment effect was evident across all subgroups ([Figure 23](#)).



Base: All adolescents (Treatment and comparison (balanced) male n=317, female n=303, age 10-14 n=306, age 15-19 n=252, age 20-24 n=62)

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

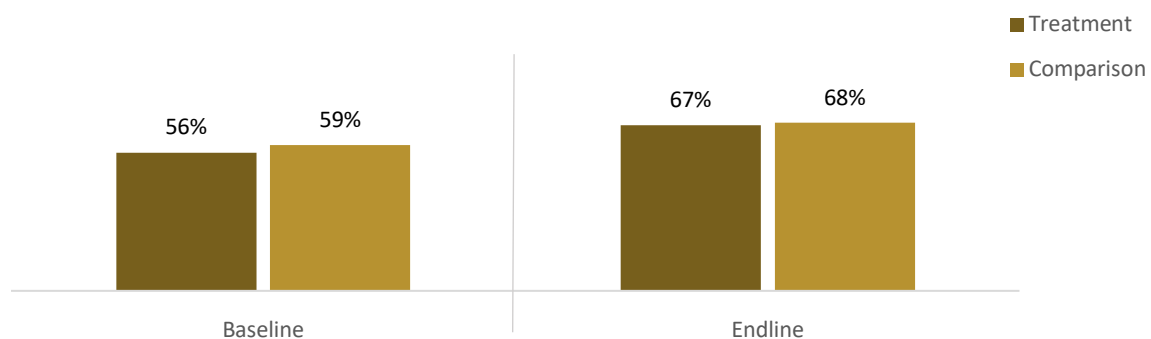
3.3.5 Immediate Outcome 1120: Improved knowledge and attitudes of accessing gender-responsive SRHR information and SRH services

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.

At baseline, levels of positive attitudes toward adolescent SRHR were comparable between arms, with 56% (95% CI [48%, 64%]; M: 49%, F: 61%) in treatment areas and 59% (95% CI [51%, 67%]; M: 55%, F: 62%) in comparison areas meeting the indicator threshold. By endline, both groups showed slight increases in point estimates, with the treatment group reaching 67% (95% CI [55%, 77%]; M: 62%, F: 72%) and the comparison group reaching 68% (95% CI [59%, 77%]; M: 68%, F: 69%, see [Figure 24](#)). Given the overlapping confidence intervals in both groups, these increases should be interpreted cautiously. The difference between the two groups at endline was not statistically significant (Adjusted $F(1, 80) = 0.53$, $p = .818$), and the DiD analysis, controlling for observed sociodemographic differences between groups, did not reveal a significant effect ($B = -0.09$, $SE = 0.40$, 95% CI [-0.88, 0.70], $p = .818$), suggesting no differential change between groups over time.



Base: All community members (Baseline treatment n=169, comparison n=171; Endline treatment n=172, comparison n=184)

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

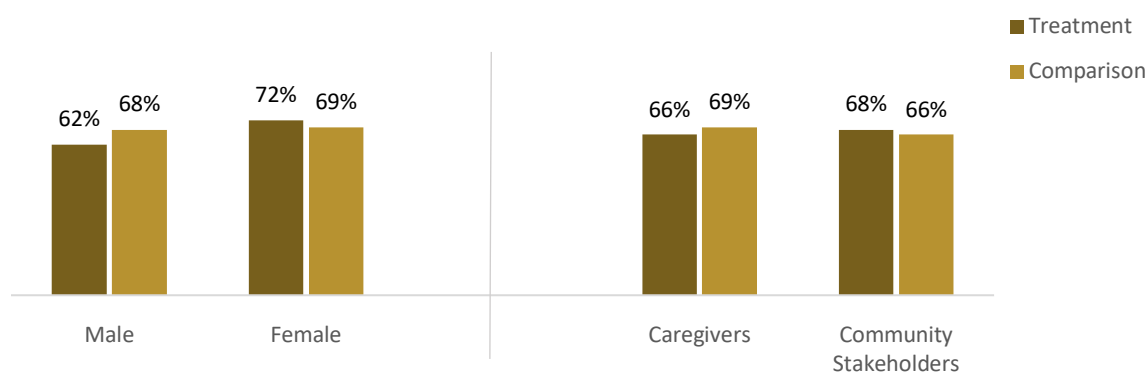
Table 16 presents results for the individual statements. Attitudes remained relatively stable across most items in both groups. The most notable change was the near-universal support at endline in the treatment group for both sons and daughters participating in SRH education programs at school (98%; 95% CI [93%, 99%]), up from the already high baseline level of 91%.

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 = 169)	Comparison (n = 171)	Treatment (n = 172)	Comparison (n = 184)
Male and female adolescents who receive sex education are less likely to engage in risky sexual activities	84 [78, 88]	88 [81, 92]	85 [77, 90]	89 [80, 94]
There should be dedicated sexual and reproductive health services for adolescents	79 [71, 86]	85 [79, 89]	86 [79, 91]	87 [79, 92]
Everyone should have the choice to use modern family planning methods	78 [70, 84]	75 [68, 82]	81 [71, 88]	88 [80, 93]
Both sons and daughters should participate in education programs around sexual reproductive health at school	91 [85, 94]	93 [88, 96]	98 [93, 99]	91 [83, 95]
Agree with all statements	56 [48, 64]	59 [51, 67]	67 [55, 77]	68 [59, 77]

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, patterns of support for adolescent SRHR at endline were relatively consistent across both male and female community members as well as caregivers and key community stakeholders such as local and religious leaders and community health workers (Figure 25).



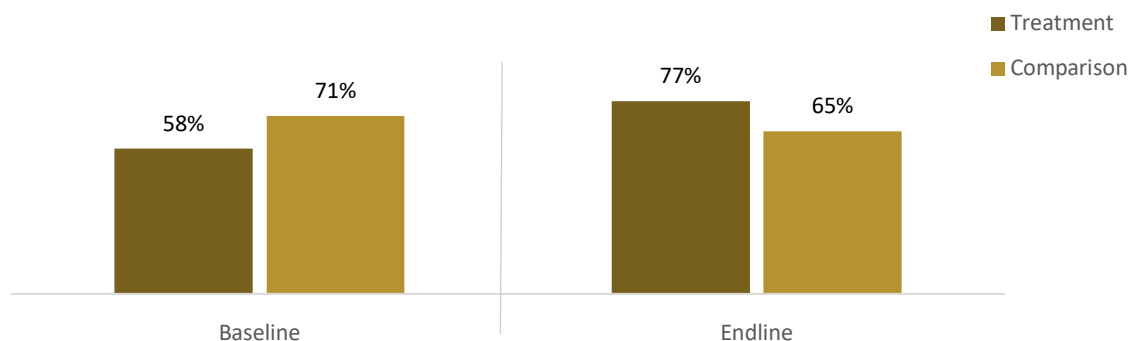
Base: All community members (Treatment male n=93, female n=79, caregiver n=134, community stakeholder n=38; Comparison male n=79, female n=105, caregiver n=140, community stakeholder n=44)

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 programs, 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, the comparison group reported higher levels of perceived family support (71%; 95% CI [67%, 75%]; M: 64%, F: 78%) compared to the treatment group (58%; 95% CI [54%, 62%]; M: 52%, F: 64%). By endline, this pattern had reversed, with the treatment group increasing substantially to 77% (95% CI [67%, 83%]; M: 76%, F: 77%) while the comparison group declined to 65% (95% CI [54%, 75%]; M: 64%, F: 67%, see [Figure 26](#)). The cross-sectional difference at endline did not reach statistical significance (Adjusted $F(1, 80) = 2.70, p = .104$), likely reflecting the wider confidence intervals and the baseline imbalance between arms. However, the DiD analysis, controlling for observed sociodemographic differences between groups, yielded a statistically significant difference between groups over time ($B = -1.10, SE = 0.34, 95\% \text{ CI } [-1.78, -0.42], p = .002$). The 25-percentage point difference-in-difference – reflecting a 19-percentage point increase in the treatment group against a 6-percentage point decline in the comparison group – is consistent with the possibility that the *SHARE* project meaningfully strengthened perceived family support for adolescent SRHR access during this period, though this interpretation relies on assumptions that could not be fully verified and should therefore be treated with caution.



Base: All adolescents (Baseline treatment n=843, comparison n=843; Endline treatment n=620, comparison n=620)

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. In treatment areas, perceptions of family support increased across all dimensions from baseline to endline, ranging from 8 to 13 percentage points. Conversely, in the comparison areas, perceived support declined across all individual dimensions, ranging from 9 to 18 percentage points. This diverging pattern is

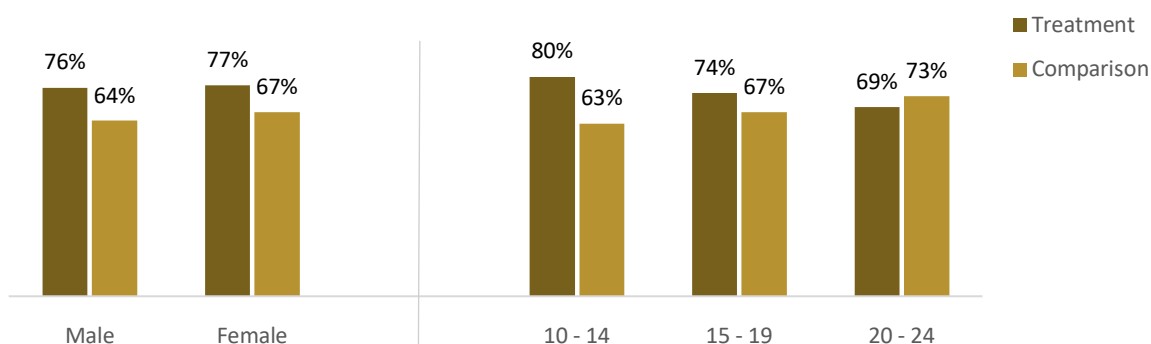
particularly noteworthy given that the comparison group started from a higher baseline across all dimensions. Financial support remained the dimension where adolescents reported the lowest levels of family assistance in both arms and both waves, suggesting that economic considerations continue to be a barrier to SRH access regardless of intervention exposure.

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

	Baseline		Endline	
	Treatment (n = 843)	Comparison (n = 843)	Treatment (n = 620)	Comparison (n = 620)
Participating in education programs around sexual reproductive health at their school	79 [76, 83]	86 [84, 89]**	91 [85, 95]	72 [61, 84]***
Participating or joining sexual reproductive health right clubs/mentorships at school or in their community	80 [76, 83]	88 [85, 90]***	89 [82, 93]	72 [60, 81]**
Seeking or attending/visiting sexual reproductive health right services and information from health facilities	80 [77, 83]	88 [85, 90]***	88 [80, 93]	70 [58, 80]**
Giving financial support to seek sexual reproductive health right services and information from health facilities	68 [65, 72]	76 [72, 79]**	81 [73, 87]	67 [55, 77]**
Report yes to all types	58 [54, 62]	71 [67, 75]***	77 [67, 83]	65 [54, 75]

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 relatively consistent across both male and female adolescents as well as across different age groups (Figure 27).



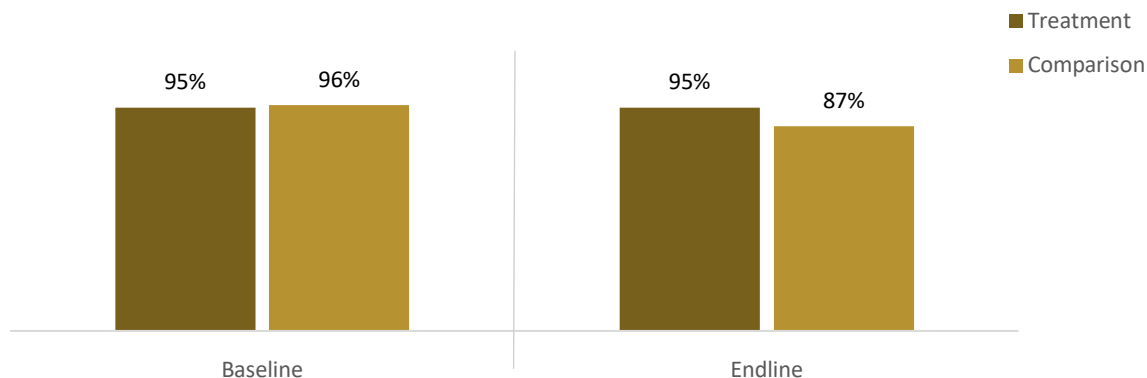
Base: All adolescents (Treatment and comparison (balanced) male n=317, female n=303, age 10-14 n=306, age 15-19 n=252, age 20-24 n=62, in school n=545, out of school n=75)

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

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 out of five statements.

Results showed consistently strong awareness in both groups at both time points of how gender inequality affects adolescent SRHR outcomes (Figure 28). In the treatment group, 95% (95% CI [90%, 97%]; M: 97%, F: 93%) of community members met the threshold at baseline, remaining stable at 95% (95% CI [87%, 98%]; M: 94%, F: 96%) at endline. In the comparison group, the proportion declined from 96% (95% CI [91%, 98%]; M: 97%, F: 95%) at baseline to 87% (95% CI [78%, 93%]; M: 89%; F: 86%) at endline, though the overlapping confidence intervals suggest this decline should be interpreted cautiously. The difference between groups at endline was not statistically significant differences (Adjusted $F(1, 80) = 2.89$, $p = .093$). Likewise, the DiD analysis, controlling for observed sociodemographic differences between groups, did not reveal a significant effect ($B = -1.05$, $SE = 0.72$, 95% CI [-2.49, 0.39], $p = .151$). As noted previously, these analyses were not powered for statistical significance, and results should be considered indicative only. Furthermore, the already near-universal baseline levels in both groups may create a ceiling effect, leaving limited scope for differential change.



Base: All community members (Baseline treatment $n=169$, comparison $n=171$; Endline treatment $n=172$, comparison $n=184$)

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 statements. Across both arms, agreement that women and girls should have equal rights increased notably from baseline to endline, though this increase was more pronounced in the comparison group. In the comparison group, support for prioritising girls' schooling over marriage declined from 92% to 79% at endline. In contrast, the treatment group remained stable on this item (87% to 90%). Across both treatment and comparison areas, the lowest support levels were

observed for the statement that a husband is never justified in hitting his wife, though the majority still believed so.

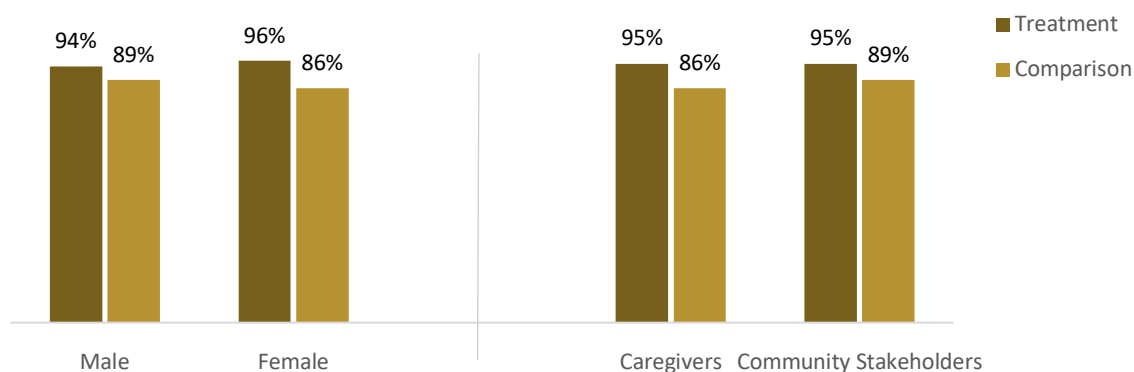
Table 18: Community members (caregivers and key community stakeholders) who agree with different statements regarding gender inequality and adolescents' SRHR (% [95% CI]).

	Baseline		Endline	
	Treatment (n = 169)	Comparison (n = 171)	Treatment (n = 172)	Comparison (n = 184)
Women and girls should have the same rights as men and boys in Ghana	68 [61, 74]	70 [62, 76]	83 [74, 89]	91 [85, 95]
Avoiding getting pregnant is the responsibility of both the man and the woman	81 [74, 87]	74 [66, 81]	85 [75, 92]	74 [64, 82]
It is equally important for boys and girls to go to school	96 [92, 98]	95 [90, 97]	94 [87, 98]	96 [91, 98]
It's more important for a girl to go to school than to get married	87 [79, 92]	92 [85, 96]	90 [83, 94]	79 [70, 86]*
A husband is never justified in hitting his wife	76 [70, 82]	88 [82, 92]**	78 [69, 86]	66 [53, 77]
Agree with at least three statements	95 [90, 97]	96 [91, 98]	95 [87, 98]	87 [78, 93]

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=93, female n=79, caregiver n=134, community stakeholder n=38; Comparison male n=79, female n=105, caregiver n=140, community stakeholder n=44)

Figure 29: Community members at endline who agree with at least three statements regarding gender inequality and adolescents' SRHR, by 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 SRHR access across 30 health facilities in *SHARE* project areas. The indicator assessed both the readiness and implementation of SOPs through two distinct sets of criteria ([Table 20](#)). Since this assessment was not conducted at baseline, only midterm and endline results are available.

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

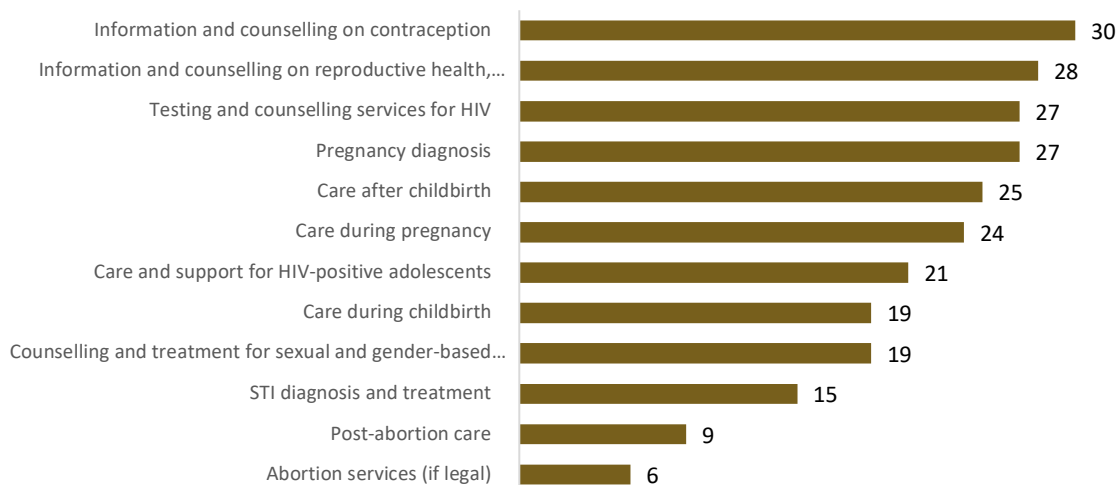
	Baseline n = 30	Midterm n = 30	Endline n = 30
<i>Data point 1 – Health facilities equipped with SOPs focused on equitable SRHR (Readiness)</i>			
SOPs are printed and available for HCWs to use ^{a, b}	-	5 (33%) / 15 (100%)	5 (20%) / 23 (92%)
HCWs are aware and trained on the SOPs ^c	-	28 (93%)	30 (100%)
All criteria data point 1 met	-	5 (17%) / 14 (47%)	5 (17%) / 23 (77%)
<i>Data point 2 – Health facilities with SOPs focusing on equitable SRHR adhering to minimum criteria (Adherence) ^b</i>			
Posters providing information in a clear and youth friendly format are displayed	-	4 (27%)	21 (84%)
Health services ensure privacy and confidentiality in delivering SRHR services ^{a, d}	-	11 (73%) / 13 (87%)	17 (68%) / 19 (76%)
Provision of SRH services for adolescents/young people	-	15 (100%)	25 (100%)
Clinic hours are suitable for adolescents and young people ^e	-	12 (80%)	18 (72%)
SRH services are available for adolescents regardless of gender, age, or marital status	-	5 (33%)	22 (88%)
All criteria data point 2 met	-	0 (0%)	12 (48%)

Note. ^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 (midterm n=15, endline n=25). ^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. Of the 30 facilities surveyed, 15 facilities (50%) at midterm indicated having a SOP focusing on equitable SRHR, increasing to 25 facilities (83%) at endline (note that SOP availability itself was not listed as an explicit criterion in [Table 20](#)). All 30 facilities reported that at least some staff were aware of and trained on SOPs at endline, up from 28 at midterm. Among those

trained at endline, seven facilities had all staff trained, 18 had a majority trained, one had about half of the staff trained, and four had less than half of the staff 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. The availability of printed SOPs for healthcare workers to reference remained limited, as this criterion is restricted to facilities with a SOP in place. Only five facilities had printed copies readily available at both midterm and endline. In addition, ten facilities at midterm and 18 at endline reported having printed SOPs without providing supporting evidence during the assessment. As with other criteria in this survey, the reliability of self-reported compliance without observed evidence remains uncertain. Based on strict observed criteria, five facilities met all data point 1 requirements at both midterm and endline, rising from 14 at midterm to 23 at endline when including self-reported instances.

Data point 2 was assessed only among facilities with a SOP in place – 15 facilities at midterm and 25 at endline. All facilities with a SOP in place at both time points provided SRH services for adolescents and young people. Specifically, (nearly) all facilities offered information and counselling on contraception and reproductive health, with most also providing HIV testing and counselling, pregnancy diagnosis, and maternal care services. Fewer facilities offered STI diagnosis and treatment, post-abortion care, and abortion services (Figure 30). The display of youth-friendly information posters increased substantially, from four out of 15 facilities (27%) at midterm to 21 out of 25 (84%) at endline. Access to SRH services regardless of gender, age, or marital status improved from five out of 15 (33%) to 22 out of 25 facilities (88%). When evaluating all adherence criteria collectively, 12 facilities (48%) at endline met all data point 2 criteria, compared to zero at midterm.



Base: all health facilities (n=30)

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

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

At midterm and endline, we assessed the development and implementation of WASH IPC action plans across 30 health facilities, evaluating four key criteria that reflect both planning and execution of these protocols.

Before presenting results, two methodological notes are warranted. At endline, a preliminary question was added asking whether an action plan had been developed following WASH IPC training; this question was not included at midterm. Of the 30 facilities, 26 reported having developed an action plan through this question, of which nine could be verified through observation. This is lower than the number meeting the specific action plan criteria at midterm, where up to 29 facilities reported compliance ([Table 20](#)). Since action plans developed following WASH IPC training are unlikely to have been discontinued, this discrepancy may reflect differences in measurement stringency between waves rather than a genuine decline and should be considered when interpreting trends across time points. Second, the criterion covering action plan content – key activities, responsibility holders, and timelines – is not fully comparable between waves, as it was measured using a single item at midterm and three items at endline. Results should be interpreted in this context.

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

	Baseline n = 30	Midterm n = 30	Endline n = 30
A dedicated trained team is appointed to implement the action plan	-	26 (87%)	25 (83%)
The trained team meets at least quarterly to review and update/monitor the action plan	-	25 (83%)	25 (83%)
The action plan includes key activities for improvements, outlines the responsibility holders and timelines	-	29 (97%)	25 (83%)
At least 1 activity from the action plan is implemented and/or initiated per year	-	29 (97%)	24 (80%)
All criteria met	-	23 (77%)	24 (80%)

At midterm, nearly all facilities (29 out of 30) had developed comprehensive action plans that clearly outlined improvement activities, responsibilities, and timelines, and had successfully implemented or initiated at least one activity from these plans within the past year. Additionally, 26 facilities had appointed a dedicated and trained team to oversee the action plans, and 25 facilities maintained at least quarterly review and monitoring meetings. Overall, 23 facilities at midterm met the full requirements for both the development and implementation of WASH IPC action plans. At endline, results remained broadly stable across most criteria. A dedicated trained team and quarterly review meetings were in place at 25 facilities, comparable to midterm. The number of facilities meeting the action plan content criterion declined from 29 to 25, though this should be interpreted cautiously given the expanded measurement at endline. Implementation of at least one activity also declined from 29 to 24 facilities. Despite these declines on individual criteria, the overall number of facilities meeting all criteria increased marginally from 23 to 24.

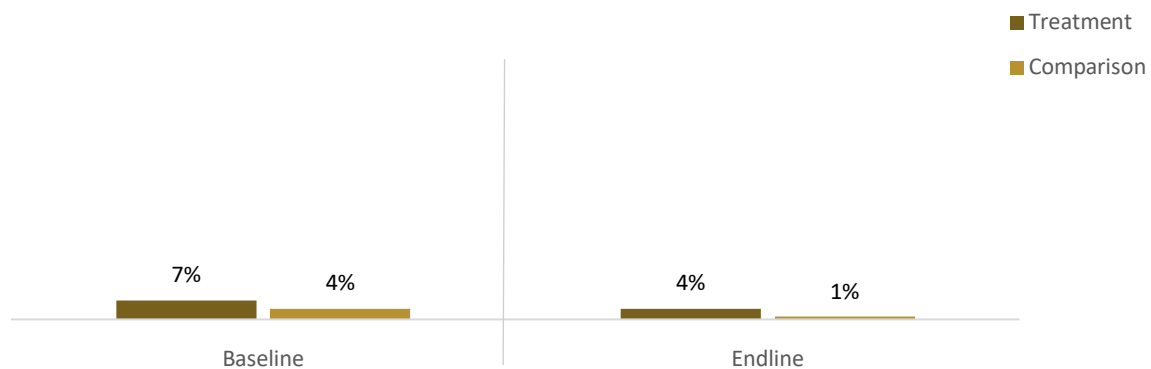
3.3.7 Immediate Outcome 1310: Capacity of key stakeholders to advocate for evidence-based, accountable and gender-responsive SRH services and SRHR policies

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, 7% (95% CI [5%, 11%]) of girls and young women strongly agreed with all statements at baseline and 4% at endline (95% CI [2%, 7%]). Given the overlapping confidence intervals, this decline should be interpreted cautiously and may not reflect a true population-level change. The comparison group showed a similar pattern, from 4% (95% CI [3%, 7%]) at baseline to 1% (95% CI [0%, 3%]) at endline. While the treatment group maintained significantly higher levels than the comparison group at endline (Adjusted $F(1, 80) = 6.37$, $p = .013$), the DiD analysis revealed no differential change between arms over time ($B = -1.18$, $SE = 0.83$, 95% CI [-2.84, 0.48], $p = .161$), as both groups declined by a similar margin.



Base: Adolescent girls/young women (Baseline treatment and comparison (balanced) $n=427$; Endline treatment and comparison (balanced) $n=303$)

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

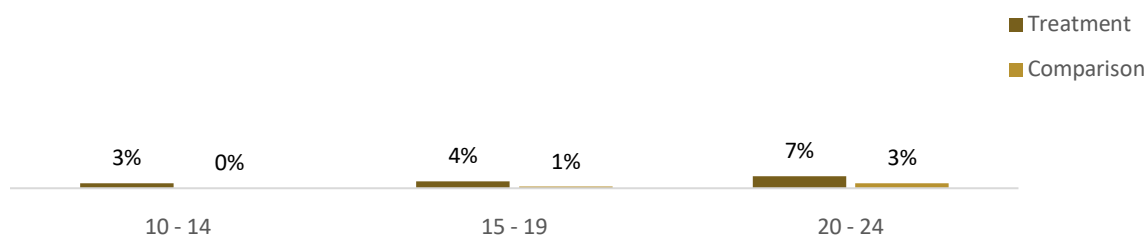
Although comprehensive advocacy self-efficacy was very low, confidence in specific advocacy-related situations was somewhat higher at the individual component level (Table 21). An examination of the individual confidence components showed declines in point estimates across all four dimensions in both groups, though for most items, confidence intervals overlap between baseline and endline. Remaining calm during difficulties in both arms and problem-solving confidence in the treatment arm had non-overlapping confidence intervals and thus indicate a more reliable downward trend.

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 = 427)	Comparison (n = 427)	Treatment (n = 303)	Comparison (n = 303)
I can always manage to solve difficult problems if I try hard enough	52 [45, 59]	44 [38, 51]	36 [28, 45]	34 [24, 45]
If someone is against me, it is difficult for me to find ways to get what I want ^a	31 [26, 36]	30 [25, 36]	28 [20, 37]	25 [16, 37]
I am confident that I could handle unexpected events very well	39 [33, 46]	39 [33, 46]	32 [24, 41]	26 [18, 37]
I can remain calm when facing difficulties because I can rely on my own abilities	49 [42, 55]	48 [41, 56]	31 [22, 41]	28 [20, 38]
Strongly agree all types	7 [5, 11]	4 [3, 7]	4 [2, 7]	1 [0, 3]*

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’. * $p < .05$, ** $p < .01$, *** $p < .001$.

At endline, older adolescents more often expressed strong confidence on all dimensions compared to their younger counterparts (Figure 32). This pattern aligns with the expectation that confidence in advocacy abilities may develop over time as young women gain more experience and maturity. However, the small sample sizes within subgroups and overlapping confidence intervals (not reported here) warrant caution in interpretation. The consistently low prevalence across all age groups indicates that strong advocacy self-efficacy remains uncommon regardless of age.



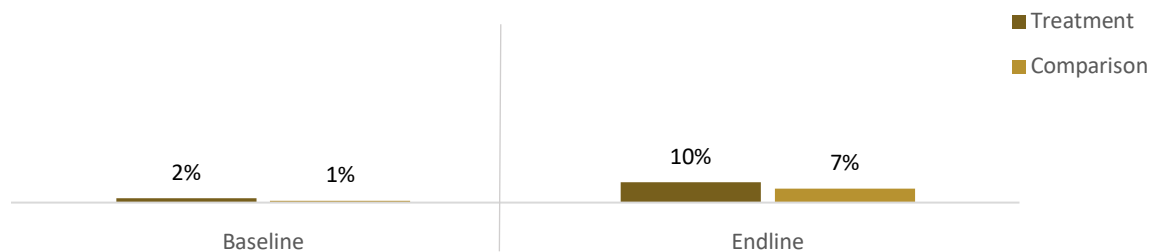
Base: adolescent girls/young women (Treatment age 10-14: n=153, age 15-19: n=121, age 20-24: n=29. Comparison age 10-14: n=153, age 15-19: n=121, age 20-24: n=29)

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 Ghana. To be counted toward this indicator, respondents needed to correctly answer all six questions.

Overall knowledge levels remained low at both time points, though modest increases were observed in both groups. In treatment areas, the proportion of community members correctly answering all questions increased from 2% (95% CI [1%, 6%]; M: 4%, F: 1%) at baseline to 10% (95% CI [6%, 15%]; M: 16%, F: 3%) at endline. In comparison areas, the proportion changed from 1% (95% CI [0%, 5%]; M: 3%, F: 0%) at baseline to 7% (95% CI [4%, 13%]; M: 14%, F: 2%) at endline (Figure 33). While treatment areas maintained slightly higher knowledge levels at endline, this difference was not statistically significant (Adjusted $F(1, 80) = 0.84, p = .361$). The DiD analysis, controlling for observed sociodemographic differences between groups, did not reveal a significant difference between groups over time ($B = -0.43, SE = 0.99, 95\% \text{ CI } [-1.54, 2.39], p = .667$). As noted previously, these analyses were not powered for statistical significance, which may limit the ability to detect meaningful program effects.



Base: All community members (Baseline treatment n=169, comparison n=171; Endline treatment n=172, comparison n=184)

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 specific knowledge components (Table 22) helps explain why overall composite scores remained low despite improvements on several individual items: the composite is heavily driven by the weakest knowledge areas, particularly age of consent for sex, meaning that even substantial improvements on other items may not translate into meaningful gains on the composite. Though knowledge of the legal age of consent for sex (16 years) increased, it remained low, with 16-18% of respondents in treatment areas and 10% in comparison areas correctly identifying this age at endline. Awareness of the legal marriage age (18 years) showed a more substantial increase in the treatment group, rising from around 19-22% to 38-40%, while the comparison group remained at 17%. This divergence is noteworthy given that at midterm both groups had demonstrated similarly increased awareness of legal marriage age, suggesting that gains in the comparison group were not sustained – though direct comparability is limited due to the different study designs. Conversely, awareness of protective legislation declined considerably in both groups. Knowledge of laws protecting against harmful

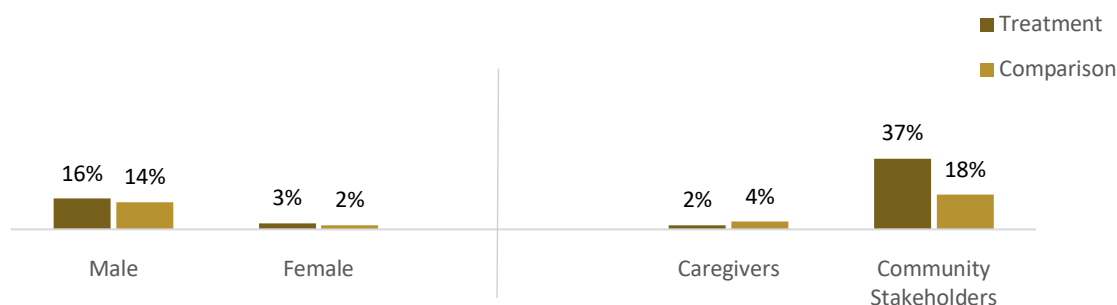
traditional practices fell from 96% to 72% in treatment areas and from 88% to 49% in comparison areas – a trend already visible at midterm (72% and 78% respectively). Knowledge of domestic violence legislation declined similarly, from 94% to 77% in treatment areas and from 91% to 57% in comparison areas, despite both groups demonstrating high knowledge (>89%) at midterm.

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 = 169)	Comparison (n = 171)	Treatment (n = 172)	Comparison (n = 184)
Age of consent for sex – boys	7 [4, 12]	2 [1, 6]*	16 [11, 23]	10 [6, 16]
Age of consent for sex – girls	6 [3, 10]	6 [3, 11]	18 [13, 25]	10 [6, 16]*
Age of consent for marriage – boys	19 [13, 26]	16 [11, 23]	38 [30, 47]	17 [11, 25]***
Age of consent for marriage – girls	22 [16, 31]	19 [14, 26]	40 [31, 49]	17 [11, 26]***
Aware of national laws to protect against harmful traditional practices such as Female Genital Mutilation	96 [91, 98]	88 [82, 92]*	72 [59, 82]	49 [39, 59]**
Aware of national laws to protect against domestic violence	94 [88, 97]	91 [87, 94]*	77 [64, 86]	57 [46, 67]**
Correctly answered all questions	2 [1, 6]	1 [0, 5]	10 [6, 15]	7 [4, 13]

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. * $p < .05$, ** $p < .01$, *** $p < .001$.

Figure 34 presents endline results disaggregated by gender and stakeholder type. Community stakeholders demonstrated substantially higher comprehensive knowledge than caregivers in both arms (37% vs 2% in treatment areas, 18% vs 4% in comparison areas). Male community members also showed higher knowledge levels than female community members in both groups. However, this pattern may reflect the overrepresentation of males among community stakeholders. Given the small subgroup sample sizes, these patterns should be interpreted cautiously.



Base: All community members (Treatment male n=93, female n=79, caregiver n=134, community stakeholder n=38; Comparison male n=79, female n=105, caregiver n=140, community stakeholder n=44)

Figure 34: Community members at endline who correctly answered all questions about national laws and local policies affecting adolescent SRHR and gender equality, by gender and stakeholder type (%)

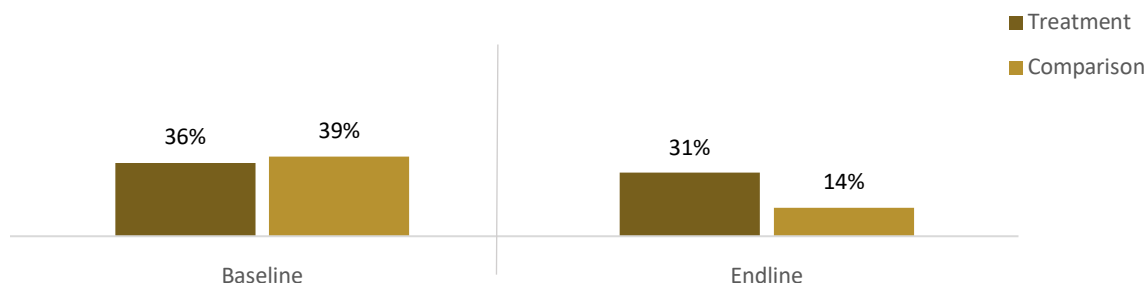
3.3.8 Immediate Outcome 1320: Increased access to evidence and knowledge exchange platforms to promote social action

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.

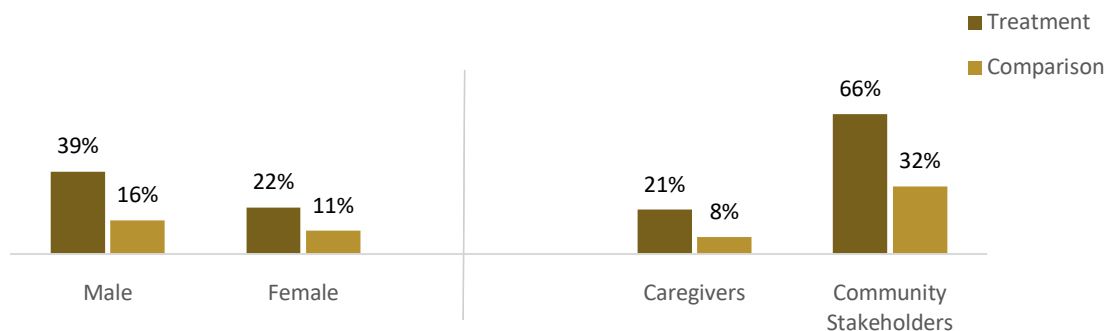
At baseline, participation levels were comparable between arms, with 36% (95% CI [27%, 46%]; M: 46%, F: 29%) of community members in treatment areas and 39% (95% CI [33%, 45%]; M: 46%, F: 34%) in comparison areas reporting participation in social action forums. By endline, participation in treatment areas remained relatively stable at 31% (95% CI [23%, 40%]; M: 39%, F: 22%), while participation in comparison areas dropped sharply to 14% (95% CI [8%, 21%]; M: 16%, F: 11%, see [Figure 35](#)). This pattern represents a notable deviation from midterm, where participation levels were 45% and 40% in treatment and comparison areas, respectively, suggesting that the decline in comparison areas occurred in the period between midterm and endline (though direct comparability is limited due to the different study designs). The difference between arms at endline was statistically significant (Adjusted $F(1, 80) = 9.88$, $p = .002$). The DiD analysis, controlling for observed sociodemographic differences between groups, yielded a statistically significant difference between groups over time ($B = -1.19$, $SE = 0.42$, 95% CI [-2.02, -0.36], $p = .005$). Given that both groups started at comparable baseline levels, the 20-percentage point difference-in-difference is consistent with the possibility that the *SHARE* project helped sustain social action forum participation in treatment areas, although this interpretation relies on assumptions that could not be fully verified and should therefore be treated with caution.



Base: All community members (Baseline treatment n=169, comparison n=171; Endline treatment n=172, comparison n=184)

Figure 35: Community members (caregivers and key community stakeholders) who participated or attended any social action forum in the past 12 months (%)

Figure 36 presents endline results disaggregated by gender and stakeholder type. In both treatment and comparison areas, key community stakeholders showed considerably higher participation rates (T: 66%, C: 32%) compared to caregivers (T: 21%, C: 8%). Furthermore, in the treatment group, male community members (39%) appeared to report higher participation rates compared to female community members (22%), though given the small subgroup sample sizes all disaggregated results should be interpreted cautiously.



Base: All community members (Treatment male n=93, female n=79, caregiver n=134, community stakeholder n=38; Comparison male n=79, female n=105, caregiver n=140, community stakeholder n=44)

Figure 36: 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 or midterm, results cannot be compared over time. At endline, 37% of community members in the treatment areas and 10% in the comparison areas reported having participated in such sessions. Among those who participated, the majority attended multiple sessions: 19% of treatment group respondents attended 1 session, 42% attended 2-3 sessions, and 39% attended 3 or more sessions, with a nearly identical distribution in comparison areas (16%, 42%, and 37% respectively). This suggests that the difference between arms lies in the reach of participation rather than the depth of engagement. In treatment areas, 86% 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, 35% of community members in treatment areas and 8% in comparison areas reported attending such events, with 84% 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, 32% of community members in treatment areas reported exposure to some form of campaign in the past 12 months, compared to 10% in comparison areas. It should be noted that these figures are considerably lower than at midterm, where 54% and 42% of treatment and comparison community members respectively reported campaign exposure, though

direct comparability is limited due to the different study designs. Across all measures, participation and exposure were consistently higher among key community stakeholders compared to caregivers.

From the qualitative component of the evaluation, across caregiver and community stakeholder interviews, respondents described taking part in a range of community activities on adolescent SRHR. These included community dialogues, school sessions, radio programmes, awareness campaigns, and public meetings involving adolescents, caregivers, teachers, health workers, community volunteers, and traditional leaders. Respondents said these activities created opportunities to discuss issues that had previously received little attention. Community stakeholders provided the clearest examples of direct participation. A community volunteer in Zorkor explained that outreach combined radio programmes with community discussions and visits to public places.

"We also went there some days to talk to the market people and the surroundings about adolescence rights and health." (Community volunteer, IDI, Zorkor community)

The respondent explained that using different platforms helped reach a wider audience.

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 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 participated 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.

With the exception of advocacy self-efficacy among girls (Indicator 1310.1), adolescents with self-reported *SHARE* exposure consistently showed higher outcome levels across all indicators, with statistically significant differences for 8 out of 12 indicators and differences of up to 39 percentage points ([Table 23](#)). Three non-significant results – 1000.2 SRHR decision-making among women in relationships, 1100.4 contraceptive use among sexually active girls, and 1200.2 satisfaction with SRH services – showed differences in the expected direction and are possibly attributable to insufficient statistical power given the small analytical samples for these indicators. As noted above, these findings cannot be interpreted as

evidence of project effectiveness. Nevertheless, they suggest that adolescents who engaged with *SHARE* activities showed meaningfully higher levels of SRHR-related outcomes.

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

	Total treatment (n = 620)	No self-reported <i>SHARE</i> exposure (n = 299)	Self-reported <i>SHARE</i> exposure (n = 321)	χ^2 / t, p-value
1000.2: Percentage of women aged 15 to 24 years who make their own decisions regarding sexual and reproductive health and rights ^a	71	61	83	2.92, p = .088
1100.1: Percentage of youth who used SRH services	16	11	21	12.32, p < .001
1100.2: Percentage of youth demonstrating positive attitudes towards ending SGBV	48	37	59	27.62, p < .001
1100.3: Percentage of youth who are confident that they could get their partner(s) to use contraceptives / condoms if they desired ^b	65	49	88	20.48, p < .001
1100.4: Percentage of sexually active girls always using (or whose partner uses) a modern method of contraception ^c	24	21	28	0.23, p = .634
1200.2: Percentage of adolescents and young people who are satisfied with ASRH services ^d	77	67	83	3.25, p = .071
1300.2: Percentage of adolescent girls participating in SRHR advocacy and social action initiatives ^e	None: 78 Low: 4 Medium: 4 High: 14	None: 95 Low: 3 Medium: 1 High: 1	None: 64 Low: 5 Medium: 6 High: 25	45.47, p < .001
1300.3: Average resilience score among young people	2.8	2.8	2.9	-2.93, p = .004
1110.1: Percentage of young people that are knowledgeable of their SRHR	42	35	49	12.07, p < .001
1110.3: Percentage of adolescents and youth who believe they could seek sexual and reproductive health information and services if they needed them	83	74	92	34.38, p < .001
1120.2: Percentage of adolescents and young people who report being supported by their families to access SRHR information and services	77	63	89	62.07, p < .001
1310.1: Percentage of girls and young women who feel they can advocate for improved adolescent rights in their communities ^e	4	4	4	0.00, p = .995

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=23; no exposure n=28).

^b Restricted to adolescents in a relationship (Any exposure n=51; no exposure n=70)

^c Restricted to girls/young women who were sexually active in the past 12 months (Any exposure n=18; no exposure n=19)

^d Restricted to respondents who used SRH services (Any exposure n=69; no exposure n=22)

^e Restricted to girls/young women (Any exposure n=165; no exposure n=138)

Results show a mixed picture across the four community indicators (Table 24). No meaningful differences were observed between exposure groups for positive SRHR attitudes, suggesting this outcome was broadly similar regardless of self-reported exposure. Knowledge of gender inequality consequences and national laws and local policies regarding adolescents/young people's SRHR were both higher among *SHARE*-exposed respondents, though for the former the difference should be interpreted in light of the nearly universal levels for both groups. Social action forum participation also differed significantly, 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 (n = 172)	No self-reported <i>SHARE</i> exposure (n = 112)	Self-reported <i>SHARE</i> exposure (n = 60)	χ^2 / t, p-value
1120.1: Percentage of community members that have positive attitudes towards SRHR for young people	67	64	72	0.96, $p = .327$
1120.3: Percentage of community members that have knowledge of the negative consequences of gender inequality on SRHR	95	92	100	5.09, $p = .024$
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	10	2	25	25.64, $p < .001$
1320.1: Percentage of community members that report attending a ASRHR focused social action forum	31	5	26	78.14, $p < .001$

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 recognized their right to health in Ghana.

3.4 Impact

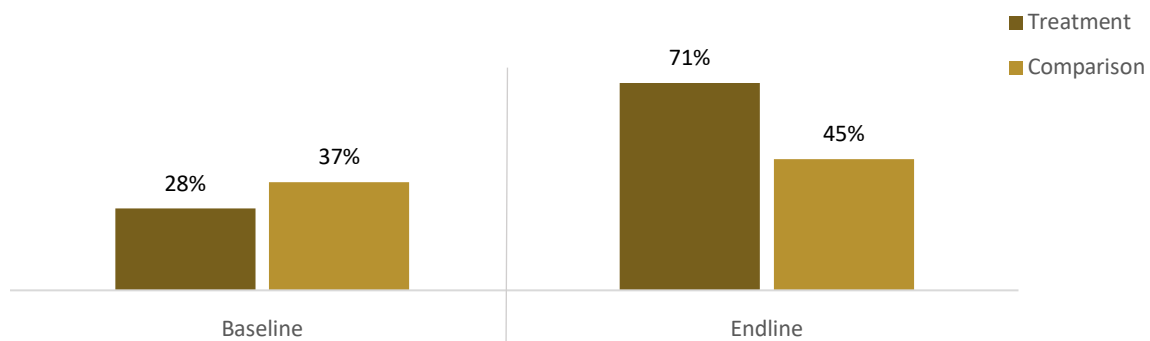
3.4.1 Ultimate Outcome 1000: Increased enjoyment of health-related human rights by the most marginalized and vulnerable rights-holders

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 $n=140$, comparison $n=144$; Endline treatment $n=51$, comparison $n=51$).

At baseline, 28% (95% CI [20%, 38%]) of women in the treatment group and 37% (95% CI [26%, 49%]) in the comparison group reported autonomous decision-making across all three domains, with no statistically significant difference between arms (Adjusted $F(1, 78) = 2.60$, $p = .224$). By endline, the treatment group showed a substantial increase to 71% (95% CI [56%, 82%]), while the comparison group remained broadly stable at 45% (95% CI [29%, 63%]; [Figure 37](#)). The difference between arms at endline was statistically significant (Adjusted $F(1, 40) = 5.11$, $p = .029$). Given the very small analytical samples – particularly at endline – all findings should be interpreted with considerable caution as they may not reflect true population-level changes.



Base: adolescents and young women aged 15-24 who are married, cohabiting or in a relationship and sexually experienced (Baseline treatment $n=140$, comparison $n=144$; Endline treatment $n=51$, comparison $n=51$)

Figure 37: Adolescent girls/young women who make their own decisions regarding SRHR (%)

The DiD analysis, controlling for observed sociodemographic differences between groups, indicated a statistically significant difference between groups over time ($B = -1.53$, $SE = 0.59$, 95% CI $[-2.71, -0.35]$, $p = .012$). The 35-percentage point difference-in-difference is consistent with the possibility that the *SHARE* project may have meaningfully contributed to improving women's autonomous decision-making regarding SRHR, though this interpretation relies on assumptions that could not be fully verified and should therefore be treated with caution. Together with the very small analytical sample, however, these results should therefore be interpreted with caution.

At the individual domain level, the ability to say no to sexual intercourse and contraception decision-making remained broadly stable in the treatment group, while the comparison group showed declines on both items. In contrast, healthcare decision-making improved in both arms, from 46% to 88% in the treatment group and from 52% to 90% in the comparison group ([Table 25](#)).

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

	Baseline		Endline	
	Treatment ($n = 140$)	Comparison ($n = 144$)	Treatment ($n = 51$)	Comparison ($n = 51$)
Can say no to sexual intercourse with their partner if they do not want to	88 [81, 92]	85 [79, 90]	80 [64, 90]	57 [39, 73]*
Decide on use of contraception	97 [88, 99]	100 [100, 100]	90 [81, 95]	88 [70, 96]
Decide on their own health care	46 [35, 58]	52 [41, 63]	88 [78, 94]	90 [79, 96]
All criteria met	28 [20, 38]	37 [26, 49]	71 [56, 82]	45 [29, 63]*

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. This for them has been a change over time. Several girls reflected on how domestic work had traditionally been assigned according to gender but felt these expectations were beginning to shift. A 15-year-old in-school girl from Namolo explained:

“Some of our caregivers think that roles like sweeping, cleaning and cooking are meant for girls while boys were meant to do roles like feeding animals but after the SHARE project they have understood that both boys and girls can do the same role.” (In-school adolescent girl, 15 years, Namolo community, IDI)

“Roles used to be segmented based on gender... But with the coming of SHARE, we have been made aware that such statements are not progressive.” (Out-of-school adolescent boy, 15–24 years, Namolo community, FGD)

Some girls extended these reflections beyond daily activities and challenged wider assumptions about women's capabilities. A 13-year-old girl from Zorko questioned stereotypes about careers and leadership, noting:

“People often think women are too weak for the military. But I now believe girls can do what boys can do, and women can even perform better in some areas.” (In-school adolescent girl, 13 years, Zorko community, IDI)

Among adolescents, changes were most often discussed in terms of having a stronger voice and greater control over personal decisions. A 19-year-old out-of-school adolescent girl from Zorko felt that adults were now more willing to listen to young people:

“They have come to understand that we have a say when it comes to life of adolescents, they respect us as we do to them, the communication is mutual now.” (Out-of-school adolescent girl, 19 years, Zorko community, IDI)

Other girls described becoming more confident in setting boundaries and making choices about their own lives. Agency was often linked to decisions about education, marriage, sexual relationships, and future aspirations. A 14-year-old girl from Zorko explained that she had gained a clearer understanding of her right to decide whether and when to marry:

“Before joining, I did not know I had the right to decide whether to engage in sex at an early age or enter early marriage. Now I understand that nobody should force such decisions on me.” (In-school adolescent girl, 14 years, Zorko community, IDI)

Community stakeholders observed greater participation of girls in leadership and community activities. A community volunteer from Zorkor recalled an occasion where a young girl took the lead in speaking to community members about local concerns:

“It was a small girl who took the lead to come and engage the community members about some of the issues affecting them.” (Community volunteer, F, Zorkor, KII)

The community volunteer viewed this example as evidence of growing confidence among girls and greater willingness within the community to listen to young people's perspectives. Similar views were expressed by a women's group leader in Soboro, who felt that adolescents were becoming more involved in expressing their opinions, although she noted that progress remained uneven. Consortium partners from FAWA and *Right To Play* also reported that girls were taking on more visible leadership roles within schools and communities through mentoring, leadership training, youth forums, and advocacy activities designed to strengthen girls' participation and voice. Community stakeholders also observed improved communication between adolescents and adults. Respondents noted that girls and boys appeared more willing to seek support, raise concerns, and engage in discussions with caregivers, teachers, and community leaders. They felt that conversations about adolescent issues were becoming more common within households and communities, creating opportunities for greater understanding between generations. Consortium partners attributed some of these changes to community dialogues, youth forums, and school-based activities that brought adolescents and adults together. Despite these positive accounts, change was not perceived to be universal. A number of community leaders noted that some caregivers still believed decisions should be made by adults rather than adolescents.

Across respondent groups, many participants described growing awareness of adolescents' rights, consent, and protection from harmful practices. Among adolescents, awareness of rights was often linked to greater confidence in making decisions about their own lives. Several girls explained that they had gained a stronger understanding of their right to decide about education, marriage, and sexual relationships. Several adolescents also described changing attitudes towards child marriage and girls' education. Girls from Zorko and Namolo reported learning that marriage should be based on their own choice and that continuing education was an important right. One girl in Zorko explained:

“My rights that no one can make me marry someone when I am not interested and the right to go to school.” (In-school adolescent girl, Zorko community, FGD)

Respondents from *Right To Play* and other community stakeholders also referred to ongoing support for practices such as FGM among some community members and suggested that progress in changing attitudes towards GBV had been slower than improvements in SRHR knowledge and awareness more broadly.

3.5 Sustainability

Consideration for sustainability was at the heart of the design and implementation of the *SHARE* project. Several factors, including the continuous training and capacity building, community engagement and support, and the ownership and involvement of local stakeholders all through were deemed crucial for sustainability. 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.

Caregivers, teachers, health workers, and community leaders viewed sustainability in terms of retained knowledge and practices that had become embedded in daily life. For these respondents, sustainability was not necessarily understood as the continuation of externally funded activities, but rather as the continued application and sharing of lessons learned through *SHARE*. Caregivers expressed confidence that the knowledge gained through *SHARE* would remain within families and communities. Discussions with caregivers of in-school in Zorko suggested that sustainability was linked to lasting awareness and behavioural habits that had developed during implementation. Participants described how learning and practices introduced through the project had become part of daily life, as shared by one of discussants:

“SHARE was not operating in isolation. It was working with men and women in this area and beyond and I know of some men and women in this community who have been very passionate of the activities and impact of SHARE. These people will do everything it takes to ensure that the ideals of SHARE stay beyond the life of the project (Caregiver in school adolescent boys, M, Saboro, IDI)”

During the mid-term evaluation, consortium members reported that they had developed an action plan aimed at strengthening the sustainability of project interventions. Data gathered in this endline evaluation suggested that discussions on sustainability planning and follow-up after the mid-term evaluation were reported primarily by consortium partners and few government stakeholders involved in programme oversight and implementation. Respondents described sustainability planning as an ongoing process that gained stronger attention following the mid-term review, with efforts focused on strengthening institutional ownership, broadening stakeholder engagement, integrating activities into routine systems, and preparing local actors to continue implementation beyond donor support. Rather than introducing entirely new approaches, respondents suggested that the post-midterm period focused on reinforcing and refining existing strategies to improve continuity.

Consortium stakeholders explained that findings from the mid-term evaluation were used to strengthen implementation and encourage institutions to take greater ownership of activities. A representative

from *Right To Play* noted that the project increasingly emphasized institutional involvement because stakeholders recognized that external funding would eventually end. These included greater involvement of district education and health officials in training and monitoring, joint supervision with government representatives, stronger positioning of interventions as part of government systems, and efforts to document institutional commitments. Formal sustainability planning also appeared to advance after the mid-term period. Consortium stakeholders described the development of documented sustainability plans, including strategies, institutional responsibilities, and budget considerations for continuation. According to a *Right To Play* representative:

“The plans have been documented already... stakeholders have one from their own aspect... education, health, assembly has.” (Consortium partner representative, RTP KII)

Other consortium partners similarly described updating sustainability plans and strengthening accountability mechanisms. A WaterAid representative explained that sustainability plans had been revised to clarify district responsibilities and expectations for continuation. Government stakeholders also discussed sustainability planning, although primarily from an implementation perspective rather than the design or ownership of sustainability plans. They described involvement in identifying practical approaches to continue activities using existing resources and systems after project closure. A GES official explained that district stakeholders had worked together to develop a practical way forward based on available resources:

“Yes, I was involved. We collaborated to design a way forward using the resources the project left behind.” (Ghana Education Service, M, Kassena Nankana Municipality, KII)

Stakeholders described several ways in which *SHARE* interventions had become embedded within existing systems and structures. Sustainability was often linked to the extent to which activities had moved beyond project implementation and become integrated into routine government practices, school schedules, health service delivery, supervision systems, and multisectoral coordination mechanisms. They emphasized that *SHARE* was implemented through existing institutions rather than parallel systems, increasing confidence that some interventions will most likely continue after *SHARE* project support ended. For example, school representatives, district education officials, and *SHARE* consortium members highlighted efforts to embed *SHARE* activities within routine school systems through mentorship sessions, teacher training, curriculum integration, and strengthened involvement of district education authorities. A school representative in Kassena Nankana West District explained that *SHARE* content had already been incorporated into weekly school routines:

*“All the teachers do integrate the SHARE content in their lessons, and we have a day in the week dedicated to espousing the content of SHARE in the school.”
(Teacher, Awe Junior High School, F, Kassena Nankana West District, KII)*

Health sector stakeholders similarly mentioned that adolescent-friendly SRHR services had become integrated into routine health service delivery. Health facility staff, health workers and district health officials referred to mentorship, counselling, adolescent corners, outreach sessions, supervision systems, and reporting mechanisms as practices that had become embedded within health facilities. A district health representative in Bongo District described how support for adolescents had become part of routine responsibilities and existing Ghana Health Service mandates:

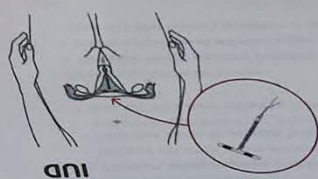
“We cannot simply stop providing these services or tell adolescents they no longer have the right to participate; it is part of the Ghana Health Service policy to continue this care.” (District health representative, M, Bongo District, KII)

Although respondents expressed confidence that many *SHARE* activities will continue, they also identified several risks that may affect sustainability after donor support ends. Funding was the most cited challenge to sustaining *SHARE* activities. Education stakeholders highlighted financial constraints as a barrier to continuing refresher training and monitoring activities. A Ghana Education Service representative explained that although trained personnel remained available, implementation still required logistical support.

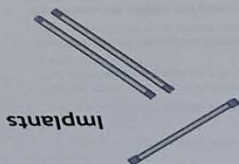
“We likely cannot sustain the monthly stipends that the project provided to school-based monitors because we lack the funds.” (GES, M, Kassena Nankana Municipality, KII)

Respondents from health and education sectors, and consortium members acknowledged that while skills, structures, and systems had been established, continued implementation will still require resources for training, monitoring, transport, supervision, and community mobilization. Staff turnover and transfers emerged as another concern across education and health sectors. Respondents from consortium members and health facility staff explained that trained teachers, nurses, mentors, and government officials could be reassigned or transferred, creating risks to institutional memory and continuity. Separately, a public health nurse emphasized that continued implementation of outreach and adolescent-focused activities would still require financial resources. Funding concerns were also raised in relation to WASH improvements. A WaterAid representative noted that maintaining infrastructure and continued implementation may become difficult if WASH financing is not prioritized.

CONTRACEPTIVE METHODS LONG-TERM METHODS



IUD



Implants



Tubal Ligation



Vasectomy

10.3 Discussion on Pregnancy | Time: 20 minutes

OBJECTIVE:

- Ask and answer questions about pregnancy and pregnancy prevention.

INSTRUCTIONS:

1. Say: Today we will discuss how women become pregnant and how young men and young women can prevent pregnancy.
2. Ask: How does a woman become pregnant?
3. Encourage participants to explain how a woman or girl gets pregnant. [Allow HCWs to guide this discussion; for reference, here's a simple definition of pregnancy: Pregnancy happens when sperm meets up with an egg. The egg is then fertilized. Pregnancy starts when the fertilized egg implants in the lining of a woman's uterus. It takes up to two to three weeks after sex for pregnancy to happen.]
4. As participants discuss, write down questions about pregnancy and pregnancy prevention, and make note of myths and misconceptions in the parking lot section of the flipbook to be addressed by the midwife later in this session.
5. Allow the midwife to respond to questions and correct any myths or misconceptions.
6. Instruct participants to break into groups of three to five people.
7. Ask each group to discuss: How can pregnancy be prevented? What are the ways or methods that young men and young women can prevent pregnancy?
8. Instruct participants to come back together as one group. Allow one member of each small group to present their group's main points. If no one mentions abstinence, be sure to include it as an option to prevent pregnancy.
9. Say: It is not just a woman's responsibility to prevent pregnancy. Men have a role in how pregnancy happens, and they have a responsibility to prevent pregnancy.
10. Say: The midwife will describe the contraceptive methods available to prevent pregnancy. This will be followed by small group discussions between the young women and the midwife and young men and the in-charge to answer your questions, the parking lot questions, and any questions from earlier that were collected in the hat/jar.



4. Conclusion and Recommendations

4.1 Conclusion

The *SHARE* project set out to tackle a complex and contextually relevant public health issue with deep socio-cultural roots in Ghana. 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 there were only three indicators that showed statistically significant differences between treatment and comparison groups over time, there were several other indicators where changes were observed in both groups, with no statistically significant differences detected in the difference-in-differences analysis. In some cases, outcomes in the treatment group did not decline relative to declines observed in comparison areas; however, these findings should be interpreted cautiously given the limitations of the study design. At the impact level, though caution warranted in the interpretation, a statistically significant difference was observed for select outcomes.

Overall, recognizing 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, findings should be interpreted with caution and Any improvement or stabilization of outcomes may reflect the project's contribution to these changes, while identifying areas for further strengthening. 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*. 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 the country. Given the recognized cultural taboos and sensitivity regarding SRHR issues and the significant public opposition that exists towards SRHR education for adolescents and youth in Ghana, 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. Also, Kasena Nankana West District witnessed increased violence associated with the Doba – Kandiga conflict, which affected project implementation. Subsequent consultations with stakeholders were held to assess the situation with the decision made to cease activities in localities most affected within the

district to ensure the safety of staff and intended project beneficiaries, and to ensure *SHARE* activities did not unintentionally exacerbate existing conflicts. Overall, 35 schools and 15 health facilities were directly affected by the conflict. Additional schools and health facilities were added within other geographic areas to maintain overall coverage, although the extent to which this offset disruptions to implementation and potential impacts is unclear.

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. The annual project reach in Ghana ranged from 18,713 in the period April 2024 - March 2025 to 435,900 for April 2025 - March 2026.

At endline, in our study sample, 54% of in-school adolescents and youth in treatment areas reported having participated in a school-based club discussing health, relationships, and sexual and reproductive health topics in the past four years, and 34% of out-of-school respondents reported participating in a community-based SRHR group or mentorship programme. Additionally, 37% reported attending community SRHR events. Among those who participated in a club or group, the majority (58%) 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 (78–98% across activity types) indicating that their activity was organised or supported by *SHARE* or its partners.

Among community members, 37% reported having participated in community dialogues and 35% in community awareness-raising events, with considerably higher rates among key community stakeholders than caregivers (74% and 63% versus 27% and 28%, respectively). Overall, 35% of treatment area community members (caregivers: 25%, community stakeholders: 68%) 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, 9% 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, 10% reported participating in community dialogues and 8% 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, by improving more than comparison areas, or by sustaining levels that declined in comparison areas:

- 1100.3: Contraceptive negotiation self-efficacy increased from baseline in treatment areas, while remaining stable in comparison areas (DiD not significant despite 22-percentage point difference-in-difference, likely reflecting insufficient statistical power given the reduced analytical sample)
- 1300.2: Participation in SRHR advocacy and social action initiatives among girls increased from baseline in treatment areas while declining in comparison areas (DiD not significant)
- 1110.1: SRHR knowledge increased from baseline in treatment areas, while remaining stable in comparison areas (significant DiD in favour of treatment)
- 1110.3: Perceived ability to seek SRHR services increased from baseline in treatment areas, while remaining stable in comparison areas (significant DiD in favour of treatment)
- 1120.2: Perceived family support for SRHR access increased in treatment areas, while remaining stable in comparison areas (significant DiD in favour of treatment)
- 1120.3: Community members' knowledge of the negative consequences of gender inequality remained stable in treatment areas while declining in comparison areas, though levels were already near-universal at baseline, and overlapping confidence intervals in the comparison arm preclude firm conclusions about change (DiD not significant)
- 1320.1: Social action forum participation by community members was maintained in treatment areas while declining in comparison areas (significant DiD)

For some indicators, improvements were observed in both groups compared to baseline, 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 by a similar magnitude (DiD not significant)
- 1310.2: Community members' knowledge of national laws and policies showed modest increases from baseline in both groups (DiD not significant)

Some other indicators showed less favourable trends:

- 1100.1: Point estimates for SRH service utilisation declined from baseline in both arms by a similar magnitude (though overlapping confidence intervals in the treatment arm preclude firm conclusions about change; DiD not significant)
- 1310.1: Advocacy self-efficacy among girls declined from baseline in both arms by a similar magnitude (though overlapping confidence intervals preclude firm conclusions about change; DiD not significant)

Several indicators showed no meaningful changes between baseline and endline, either due to broadly stable trends in both groups or inconclusive results due to small analytical samples: contraceptive use among sexually active girls (1100.4), satisfaction with SRH services (1200.2), average resilience scores among young people (1300.3), positive attitudes towards SRHR among community members (1120.1)

Health facility assessments showed a modest improvement in the number of facilities meeting all criteria for good quality gender-responsive and adolescent-friendly services (1200.1), increasing from one facility at baseline to two under strict conditions or five under less strict conditions at endline. Waste management compliance (1200.3) remained broadly stable between midterm and endline, as did WASH IPC action plan implementation (1220.3). For SOP readiness and adherence (1220.2), results were mixed: the number of facilities with printed SOPs readily available remained stable under strict conditions but increased substantially under less strict conditions between midterm and endline, while adherence to minimum criteria improved markedly from no facilities at midterm to 12 at endline.

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 most 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, suggesting this outcome was broadly similar regardless of self-reported exposure. Knowledge of gender inequality consequences and national laws and local policies regarding adolescents/young people's SRHR were both higher among respondents with self-reported *SHARE* exposure. Social action forum participation also differed significantly, 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 Ghana. Its comprehensive multi-component approach, which integrates education, community engagement, and gender-responsive strategies, has proven critical in addressing some the structural and socio-cultural barriers that hinder equitable access to SRHR information and SRH services.

Quantitative results suggest a substantial improvement in autonomous SRHR decision-making among sexually experienced women aged 15-24 who were in a relationship at the time of the survey in treatment areas (28% to 71%), while the comparison group remained broadly stable. The 35-percentage point difference-in-difference was statistically significant, consistent with the possibility that the *SHARE* project contributed to this improvement, though this interpretation relies on assumptions that could

not be fully verified. Given the very small analytical sample, these results should be interpreted with caution.

- *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, 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 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, and plans to scale up activities to non-participating schools. However, concerns relating to funding and effect of health workforce shortage and 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 Ghana 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 of the activities that have been mapped into action plans.

- Advocacy to government to support efforts 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 gains made as a result of the *SHARE* project.
- As there will be continuous movement and redeployment of SHP 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. Tailored training should be extended to ancillary facility staff who may also perpetuate stigma that prevents access.
- For future implementation of similar interventions, the project must continue to embed its gender-transformative approaches that challenge traditional gender roles and power dynamics into programming. Engaging boys and men alongside adolescent girls and women ensure shared responsibility and collective action. In addition, leveraging more innovation in delivery of adolescent youth friendly services will be helpful. For example, in response to the decline in the proportion of adolescents/youth aged 10-24 years who are satisfied with SRH services in the treatment area, a future project should consider providing services in camps, as was done in the comparison area, as opposed (or in addition) to clinics. Such supplementary innovative service delivery for adolescents minimizes risk of stigma, which was reported by several adolescents and young persons in this evaluation. Other projects have used self-care and leveraged digital devices to aid confidential request of SRH commodities and smart lockers for discrete pick up of the requested commodities.^{60,61}

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.

⁶⁰ USAID. Innovative smart lockers help a young patient stay on treatment 2023. Available from:

<https://www.usaid.gov/southern-africa-regional/news/apr-05-2023-innovative-smart-lockers-help-young-patient-stay-treatment>.

⁶¹ Narasimhan M, Logie CH, Gauntley A, Gomez Ponce de Leon R, Gholbzouri K, Siegfried N, et al. Self-care interventions for sexual and reproductive health and rights for advancing universal health coverage. *Sex Reprod Health Matters*. 2020;28(2):1778610.

- 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. This needs to leverage current community motivation.
- Supportive supervision, which has been shown to generally improve adherence to clinical guidelines⁶² 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) for health workers to compliance with evidence-based guidelines for adolescent youth-friendly care as delivered on the *SHARE* project or patient satisfaction,⁶³ should be considered as a way to sustain gains from the project.
- Efforts are needed to ensure that teachers are made to feel confident that they can deliver reproductive health education as per national guidelines without fear of reprimand or safety.
- Review content of reproductive health education to ensure clarity of messaging for all actors.

⁶² 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.

⁶³ 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

Annex G: Age-restricted sensitivity analysis

Submitted separately