

Sexual Health and Reproductive Education Project

Final Evaluation

Uganda



FAWE
FORUM FOR AFRICAN WOMEN EDUCATIONALISTS
FORUM DES ÉDUCATRICES AFRICAINES



RIGHT TO PLAY
PROTECT. EDUCATE. EMPOWER.

Project Title

The Sexual Health and Reproductive Education (SHARE) Project

Evaluation Report Date

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Report prepared by

A BANKETHOMAS LTD

Prof Aduragbemi Banke-Thomas

Dr Suzan Doornwaard

Ms. Rima Irmayani

Dr Tope Olubodun

Mrs. Titing Martini

Data collected by

Rinecynth Advisory Uganda

Caption for cover photo

Adolescent girls playing the Spin and Wheel game to bust myth and misconceptions about menstruation.

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

Executive Summary

Introduction

The Sexual Health and Reproductive Education (*SHARE*) project was a five-year intervention (July 2021-March 2026) aimed at increasing the enjoyment of health-related human rights by adolescent girls and young women. The project sought to address the challenges by working in collaboration with local communities, schools, health care facilities and national, regional, and local government in three countries: Ghana, Mozambique and Uganda. 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 Uganda, the project was implemented in Buyende and Adjumani districts. Here, the *SHARE* project aimed to reach 42,339 girls and 25,392 boys aged 10-19 years in schools and 17,154 girls and young women and 11,289 boys and young men aged 10-24 years 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 Uganda'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 Uganda'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 Uganda.

The annual project reach in Uganda ranged from 8,009 in the period April 2022 - March 2023 to 363,987 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 or by sustaining levels that declined in comparison areas:

- 1300.2: Participation in SRHR advocacy and social action initiatives increased from baseline in treatment areas while remaining stable in comparison areas (DiD not significant)
- 1310.1: Advocacy self-efficacy among girls increased from baseline in treatment areas while declining in comparison areas (significant DiD in favour of treatment arm, though absolute numbers were very small)
- 1120.1: Positive SRHR attitudes among community members increased from baseline in both groups, with a stronger increase in treatment areas (DiD not significant)
- 1100.1: SRH service utilisation remained stable from baseline in treatment areas while declining substantially in comparison areas (significant DiD in favour of treatment arm)
- 1320.1: Social action forum participation by community members was maintained from baseline in treatment areas while declining in comparison areas (significant DiD in favour of treatment arm)

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 project's direct reach:

- 1100.2: Point estimates suggest positive attitudes toward ending SGBV increased from baseline in both groups, though more substantially in comparison areas (significant DiD in favour of comparison arm); the increase in treatment areas should be interpreted cautiously given overlapping confidence intervals
- 1110.1: SRHR knowledge increased in both groups from baseline, though more substantially in comparison areas (significant DiD in favor of comparison arm)

Several indicators showed less favourable trends, either through decline or through comparison areas outperforming treatment areas:

- 1200.2: Satisfaction with SRH services declined from baseline in treatment areas while remaining stable in comparison areas (significant DiD in favor of comparison arm)
- 1300.3: Average resilience scores declined from baseline in treatment areas while remaining stable in comparison areas (significant DiD in favor of comparison arm)
- 1120.3: Community members' knowledge of the negative consequences of gender inequality remained stable from baseline in treatment areas while increasing in comparison areas, though levels were already high in both groups at baseline (DiD not significant)

Perceived family support for SRHR access (1120.2) showed a slight decline from baseline in point estimates in treatment areas – though overlapping confidence intervals preclude firm conclusions – while a more substantial decline was observed in comparison areas (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 negotiation self-efficacy (1100.3), contraceptive use among sexually active girls (1100.4), perceived ability to seek SRHR services (1110.3), and community members' knowledge of national laws and policies (1310.2).

Health facility assessments showed improvements in the number of facilities meeting all criteria for good quality gender-responsive and adolescent-friendly services (1200.1). Waste management compliance (1200.3) and WASH IPC action plan implementation (1220.3) both showed a small proportional decline between midterm and endline. For SOP readiness and adherence (1220.2) results were mixed, with the number of facilities with SOPs in place increasing between midterm and endline, while adherence to minimum criteria among facilities with a SOP declined.

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 all 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 sexuality 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 or knowledge of gender inequality consequences. In contrast, knowledge of national laws and policies was notably higher among respondents with self-reported *SHARE* exposure. Social action forum participation showed the largest difference of all indicators, though this finding should be interpreted cautiously given the direct overlap between the exposure measure and the indicator itself.

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

Impact

The *SHARE* project has demonstrated some progress in advancing its goals of increasing the enjoyment of health-related human rights among AGYW in Uganda. Quantitative results suggest improvements in autonomous SRHR decision-making among sexually experienced women aged 15-24 years who were in a relationship at the time of the survey, in both treatment and comparison areas. However, small analytic samples and overlapping confidence intervals mean these trends should be interpreted cautiously:

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

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

Sustainability

Consideration for sustainability was at the heart of the design and implementation of the *SHARE* project. The sustainability of the *SHARE* project is rooted in its comprehensive design, contextual adaptability, and collaborative approach. Its alignment with national and district health, education, and gender policies demonstrates a strong foundation for institutionalization. Action plan development and embedding, integration of project activities and tools into routine practice, 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 Uganda. The project did so by leveraging evidence-based practices, community engagement, and gender-transformative strategies. Overall, recognising that there were similar interventions to the *SHARE* project that were being parallelly implemented in the comparator sites, different approaches used in sampling comparing baseline and endline for some indicators, and the complexity of the problem in focus, the project demonstrated strengths in its process, and some wins for effectiveness, impact, and sustainability within the Ugandan context. As the project concludes, the action plans developed offer a blueprint to foster sustainability; however, realization of these plans will require active commitment and implementation by government stakeholders, alongside continued technical support and accountability from *Right To Play* and partners.

Recommendations

For *SHARE* Consortium

- Lessons learnt on the project implementation should be curated and collated recognizing context-specific reasons that allowed for success and challenges experienced in specific countries.
- Efforts need to be made to ensure that the sustainability strategy designed for the project in Uganda is fully instituted with clear structures, roles, and guidelines on implementation of high yield and community-valued project activities such as clubs beyond the project life cycle.
- Periodic follow up with health facilities, districts, and schools after the project lifetime, even if done passively, might be helpful with sustaining some project activities.
- Advocacy to government to sustain project outcomes through their continued engagement and where possible absorption of the project activities into routine work being paid by governments.

- Sustained support to continue target project activities, even if passive, should be offered to adolescents beyond the project life cycle in order to maintain project gains.
- As there will be continuous movement and redeployment of health personnel and a decay in acquired knowledge and skills on the *SHARE* project, there is a valid justification for training and retraining health care providers on quality, gender responsive, and adolescent-friendly service provision leveraging digital training platforms and dedicated personnel to offer ‘on the job’ in-house training for health facilities beyond the project lifecycle.
- For future implementation of similar interventions, there is a need to continue to embed the *SHARE* project’s 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 support and address barriers identified still faced by adolescents as regards SRH service, as identified in this evaluation.

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 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 sexuality education as per national guidelines without fear of reprimand or safety.

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 Uganda reported a decrease from 132 in 2010 to 113 in 2020.⁴ Despite the progress, in 2021, 32,566 teenage girls became pregnant each month in Uganda, and about 250 children under 15 years old became pregnant.⁵ Uganda is among the world's 18 countries with the highest rates of child marriage, defined as marriage before 18 years of age.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 the 2022 Uganda Demographic and Health Survey, 51% of young women aged 15–19 have experienced physical violence, while 22% have experienced sexual violence.⁷ In Uganda, 12% of the audited maternal deaths reviewed and reported in the National Annual

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 Fact sheet on Adolescent Pregnancy. Available from: https://uganda.unfpa.org/sites/default/files/pub-pdf/teenpregnancy_factsheet_3.pdf

⁶ United Nations Children's Fund (UNICEF), *The State of the World's Children 2017*, 2017, <https://www.unicef.org/reports/state-worlds-children-2017>.

⁷ Uganda Bureau of Statistics 2023. *Uganda Demographic and Health Survey 2022*. Kampala, Uganda: UBOS.

Maternal and Perinatal Death Surveillance and Response Report 2018/2019 occurred among teenagers.⁸ One quarter of adolescent girls report experiencing sexual abuse in the past 12 months and more than 50% of adolescents and young people, girls and boys, report high levels of acceptance of intimate partner violence.⁹ As of 2019, there were 1.3 million child brides under the age of 15 years and five million under the age of 18.

Indeed, adolescent sexual and reproductive health (ASRH) continues to be a major public health concern in Uganda 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.¹⁰ Further, inequalities persist among adolescents based on gender, education, rural-urban residence, and other key health indicators.¹¹ These challenges predispose adolescents and young people to preventable deaths, poverty, and inequality.

To address these challenges, it is essential to tackle the socio-cultural and structural determinants of health through interventions and policies aimed at improving SRHR outcomes among adolescents and young people.¹² To this effect, the government of Uganda 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 Uganda, 40% of girls marry before 18 years, with 10% of girls married before 15 years.¹³ The COVID-19 pandemic exacerbated existing gaps and inequalities affecting AGYW in relation to SRHR.¹⁴

1.2 The Project

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

⁸ Ministry of Health (2021). The National Annual Maternal and Perinatal Death Surveillance and Response (MPDSR) Report FY 2018/2019. 2019. Sep, Available from: <https://uniph.go.ug/the-annual-maternal-and-perinatal-death-surveillance-and-response-mpdsr-report-fy-2018-19-highlighted-a-reduction-in-institutional-maternal-mortality-ratio-from-108-to-92-per-100000-deliveries-in-u/>

⁹ Ministry of Gender, L. and S. D. (2015). Violence Against Children in Uganda: Findings from a National Survey, 2015. Kampala, Uganda: UNICEF, 2015.

¹⁰ 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>

¹¹ Jessica L., Morris Hamid Rushwan (2015): Adolescent sexual and reproductive health: The global challenges

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

¹³ Uganda Demographic and Health survey (2016)

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

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 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.¹⁵

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

The *SHARE* project had the following intermediate outcomes:

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

The project also had the following immediate outcomes:

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

¹⁵ Pulerwitz, J., Blum, R., Cislighi, B., Costenbader, E., Harper, C., Heise, L., Kohli, A., & Lundgren, R. (2019). Proposing a Conceptual Framework to Address Social Norms That Influence Adolescent Sexual and Reproductive Health. *Journal of Adolescent Health*, 64(4). <https://doi.org/10.1016/j.jadohealth.2019.01.014>

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

The project aimed to accomplish the following ultimate outcome:

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

1.2.1 The Logic model

The logic model which underpins the *SHARE* project was developed jointly by all consortium partners. *SHARE*'s Ultimate Outcome is increased enjoyment of health-related human rights by the most marginalized and vulnerable right-holders, particularly AGYW, in targeted areas of Ghana, Mozambique, and Uganda. Aligned with the Government of Canada's Feminist International Assistance Policy (FIAP), specifically Action Areas 1 and 2, *SHARE* promoted gender equality and the empowerment of women and girls as essential to eradicating poverty and building a more peaceful, inclusive, and prosperous world. *SHARE* addressed the significant gender, social, and structural barriers AGYW face as regards their SRHR. The Intermediate Outcomes were to increase the use of gender-responsive SRH information and services by adolescents and young people (1100), improve the delivery of quality, gender-responsive, inclusive services that address the SRHR needs of adolescents and young people, particularly girls and young (1200), and enhance local social action by key stakeholders, especially adolescents and young women, to advocate for gender-responsive SRHR services and policies (1300) (Figure 1). The project's approach was informed by evidence that improvement in quality of health service provision is associated with increased service utilization by adolescents,¹⁶ social accountability approaches positively impact SRH outcomes,¹⁷ 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.¹⁸ 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).¹⁹ The detailed narrative of the project's theory of change is available in [Annex A](#).

¹⁶ 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>

¹⁷ 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).

¹⁸ 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)

¹⁹ PACT and USAID. (2018). Applying Rights-Based Approaches: A practical how-to note on integrating principles of empowerment into almost any development activity. www.pactworld.org.

Figure 1: The Project's Logic Model

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



Right To Play staff engaging out-of-school young woman

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

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

2.3 Evaluation Design and Methods

2.3.1 Overview of the design

To achieve the overall evaluation's objectives, the evaluation used a mixed-methods design, combining a quasi-experimental quantitative component with qualitative inquiry to contextualize findings. A summary description of the design and methods is presented below with details available in the inception report ([Annex C](#)). Ethical approval was obtained from May Mildmay Uganda Research and Ethics Committee.

For the quantitative component, a quasi-experimental difference-in-differences (DiD) design combined with Coarsened Exact Matching²⁰ was employed to assess the project's performance and effectiveness against the expected 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 levels²¹ 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. KIIs were conducted with a

²⁰ Coarsened Exact Matching (CEM) is a statistical matching method that improves the balance between treatment and comparison groups by temporarily coarsening (i.e., categorizing) each covariate into meaningful intervals or groups. Matching is then performed exactly on these coarsened variables. This method ensures that individuals in the treatment group are matched only with individuals in the comparison group who fall into the same coarsened strata across all matching variables. While CEM performs matching using coarsened data to facilitate greater overlap and reduce model dependence, the subsequent analysis is conducted on the original, un-coarsened (continuous or categorical) data, preserving statistical precision. At baseline, 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). The same matching strategy is expected to be applied at endline to maintain comparability and methodological consistency.

²¹ 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, although a small number of Ugandan clusters with very low baseline respondent numbers were excluded at endline for operational reasons. The sampling frame for the treatment clusters comprised schools located in the districts where the *SHARE* project is active (Buyende and Adjumani). For the comparison sites, the sampling frame included two purposively selected districts (Luuka and Amuru).

For the household survey components, a Different Individuals, Same Clusters (DISC)²² 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

²² 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.2411.17905arXiv>

observed baseline parameters. Adjustments were also made to account for the observed cluster structure from baseline data. In addition, 10% padding was applied to treatment clusters and 20% padding to comparison clusters to preserve a sufficiently large and diverse sample for matching and analysis. The required number of individuals per cluster (m) was calculated as follows:²³

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

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 Uganda. 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 Uganda

	Treatment		Comparison		Total sample	
	Target	Achieved	Target	Achieved	Target	Achieved
Adolescent/Youth Survey ^a	756	850	820	850	1,576	1700
Caregiver/Community Stakeholder Survey ^a						
Parents/Caregivers	126	152	126	146	252	298
Community stakeholders	35	57	35	47	70	104
Subtotal	161	209	161	193	322	402
Health Facility Survey ^b	32 (+ 3) ^c	30 (+ 3) ^c	-	-	32	30
Teacher Survey ^d	n/a	416	-	-	n/a	416

Note. ^a Achieved sample sizes reflect matched samples following Coarsened Exact Matching (CEM) with k2k procedure. ^b The additional three 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 The target was based on the 32 facilities included at baseline; however, two facilities appeared in the baseline dataset with the same name but different interview dates and data. As it could not be determined whether these represented separate facilities or duplicate entries, 30 facilities were assessed at endline. ^d No target was set as all eligible teachers present at the time of the school visit were invited to participate.

²³ 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 ([Table 1](#)).

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

For the qualitative component, participants for Key Informant Interviews (KIIs), group discussions, and individual interviews were selected purposively based on their knowledge, experiences, and involvement in the *SHARE* project, with sampling guided by criterion sampling and the principle of information power,²⁴ 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 Uganda

Location	Respondents	Planned	Achieved
Village	Community leaders, religious and women leaders, community health workers	4	4
Health Facility	Head and staff of Health Facility	4	4
School	Teacher	2	3
District/National	MoH staff and Ministry of Education	4	5
National	Consortium Partner Program Manager and staff	4	4
	INGO/NGO/UN agencies that implemented similar programs	2	1
	Other <i>SHARE</i> stakeholders (Office of the Prime Minister)		2
	Ministry of Gender		1
Total		20	24

The planned number of sessions and participations for the group discussions across the two study sites (Dsaipi and Nambula) were achieved. In total, 28 group discussions, involving 217 participants 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; out of school adolescent boys

²⁴ 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.

and young men, aged 15-24 years; and their parents, were conducted. Also, 40 interviews, more than the 36 planned were conducted across Dsaipi and Nambula. [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 Uganda

Study sites	Respondent types	Group discussions		Individual interview	
		Planned	Achieved	Planned	Achieved
Nambula	In school: Adolescent girls, 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
	In school: Adolescent boys, aged 10-14 and 15-19	2 discussions with 16 participants	2 discussions with 16 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	2 discussions with 15 participants	1 paired interview with 2 interviewees	1 paired interview with 2 interviewees
	Out of school: Adolescent boys and young men, aged 15-24 years	2 discussions with 16 participants	2 discussions with 17 participants	1 paired interview with 2 interviewees	1 paired interview with 2 interviewees
	Parents of adolescent girls/boys in school, aged 10-19 years	2 discussions with 16 participants	2 discussions with 18 participants	2 interviewees	2 interviewees
	Parents of adolescents and young women/men out of school, aged 15-24 years	2 discussions with 16 participants	2 discussions with 18 participants	2 interviewees	2 interviewees
	Total	28 discussions with 208 participants	28 discussions with 217 participants	36 interviewees	40 interviewees
Dsaipi	In school: Adolescent girls, aged 10-14 and 15-19	2 discussions with 16 participants	2 discussions with 16 participants	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 25 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	2 discussions with 16 participants	1 paired interview with 2 interviewees	1 paired interview with 2 interviewees
	Out of school: Adolescent boys and young men, aged 15-24 years	2 discussions with 16 participants	2 discussions with 16 participants	1 paired interview with 2 interviewees	1 paired interview with 2 interviewees
	Parents of adolescent girls/boys in school, aged 10-19 years	2 discussions with 16 participants	2 discussions with 18 participants	2 interviewees	2 interviewees
	Parents of adolescents and young women/men out of school, aged 15-24 years	2 discussions with 16 participants	2 discussions with 18 participants	2 interviewees	2 interviewees
	Total	28 discussions with 208 participants	28 discussions with 217 participants	36 interviewees	40 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, sexuality 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 screened, cleaned, checked for consistency and completeness, and analyzed using IBM SPSS Statistics version 30 (IBM, Armonk, New York, US).

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 standard errors, confidence intervals, and p-values. The pooled analytic dataset included up to 88 unique PSUs, depending on the outcome analyzed. No differential sampling weights were applied.

We conducted descriptive and inferential statistics to assess progress across key indicators and compare outcomes between treatment and comparison groups over time. Descriptive statistics were disaggregated by treatment status and further by sex, age, school status, and other relevant

demographic characteristics in alignment with the PMF.^{25, 26} 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).²⁷ 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

²⁵ Endline indicator levels are additionally disaggregated by district as supplementary analysis. District-level results are not discussed in the report.

²⁶ 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).

²⁷ 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.
- **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. As the same communities were sampled at both waves but with different individuals (DISC design), it is not possible to determine whether these differences reflect genuine population-level changes 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.

- **Teacher survey:** The baseline teacher sample was very small ($n = 53$), insufficient for reliable baseline estimates or over-time comparisons. In addition, different data collection approaches were used at baseline compared to endline. Teacher results should therefore be interpreted as endline status rather than programme-attributable change. Self-perceived change questions were included to partially compensate for this limitation.
- **Social desirability bias:** The evaluation also relied substantially on self-reported information relating to sensitive issues such as sexuality, contraception, menstruation, relationships, gender norms, sexual behaviours, and experiences of violence. Responses may therefore have been affected by social desirability bias or underreporting, particularly among adolescents and young people. In addition, adolescents may not always be good predictors of their own behaviour, and as such there may be bias in future-oriented questions. Adolescents may have been selective in sharing experiences, particularly during FGDs, which may have limited discussion of sensitive issues or behaviours. We attempted to address this by ensuring adolescents were aware during the consent process, and prior to asking more sensitive survey questions, that their responses were confidential to improve the likelihood they would provide truthful answers.
- **Recall bias:** The evaluation relied partly on respondents' reflections on changes over several years of implementation, including comparisons before and after the project. This may have affected the accuracy of recalling timelines, events, and the extent of change, particularly among adolescents, caregivers and community actors' respondents.
- **Limited assessment of long-term sustainability:** As the evaluation was conducted near the end of project implementation, it could not fully assess the longer-term continuation of project approaches beyond donor support. Findings related to sustainability should therefore be interpreted as early indications.
- **Inherent challenges in measuring attitudinal and behavioural change:** While the analysis triangulated evidence across respondent groups and data sources, changes related to attitudes, confidence, interpersonal relationships, and decision-making are inherently difficult to measure and may not always be independently verified therefore it should be interpreted with appropriate caution.

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



Adolescent boys in Uganda who have just participated in club activities at school

3. Findings

3.1 Participant and Facility Characteristics

3.1.1 Adolescents/Youth aged 10-24 years

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

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

		Baseline		Endline	
		Treatment (n = 740)	Comparison (n = 740)	Treatment (n = 850)	Comparison (n = 850)
District (%)	Adjumani	46 (43, 49)		47 (45, 48)	
	Buyende	54 (57, 51)		53 (55, 52)	
	Amuru		41 (42, 40)		42 (46, 40)
	Luuka		59 (58, 60)		58 (54, 60)
Age group (%)	10-14 years	29 (28, 29)	29 (28, 29)	44 (43, 45)	44 (43, 45)
	15-19 years	60 (61, 59)	60 (61, 59)	43 (45, 42)	43 (45, 42)
	20-24 years	11 (11, 12)	11 (11, 12)	13 (12, 13)	13 (12, 13)
Gender (%)	Male	49	49	45	45
	Female	51	51	55	55
School status (%)	In school	67 (68, 67)	67 (68, 67)	66 (65, 67)	66 (65, 67)
	Out-of-school	33 (32, 33)	33 (32, 33)	34 (35, 33)	34 (35, 33)
Religion (%)	Christian	83 (82, 84)	78 (81, 74)	85 (83, 87)	85 (88, 82)
	Muslim	16 (16, 16)	18 (17, 19)	15 (17, 13)	15 (12, 18)
	Other/no religion	1 (2, 0)	4 (2, 7)	<1 (0, <1)	0 (0, 0)
	χ^2 , p-value	18.69, $p < .001$		2.04, $p = .361$	
Marital status (%)^a	Single/never married	84 (93, 76)	85 (87, 83)	84 (89, 80)	84 (90, 79)
	Married	14 (7, 20)	11 (9, 12)	9 (7, 10)	10 (7, 12)
	Divorced/separated	2 (0, 4)	2 (2, 2)	5 (1, 8)	2 (1, 3)
	Widowed	0 (0, 0)	<1 (0, <1)	<1 (0, <1)	<1 (0, <1)
	Cohabiting/living together	<1 (<1, 0)	2 (2, 3)	2 (1, 2)	4 (1, 6)
	χ^2 , p-value	13.30, $p = .010$		12.59, $p = .027$	
Ever in a relationship (%)^a	Yes	66 (68, 65)	62 (60, 64)	55 (52, 58)	57 (54, 59)
	No	34 (32, 34)	38 (40, 36)	45 (48, 42)	43 (46, 41)
	χ^2 , p-value	2.37, $p = .123$		0.39, $p = .532$	
Sexual experience (%)	Had sex ever	39 (42, 37)	40 (42, 39)	22 (21, 23)	24 (21, 25)
	χ^2 , p-value	0.14, $p = .710$		0.66, $p = .418$	
Sexual activity (%)	Had sex in the past 12 months	23 (24, 22)	24 (24, 24)	17 (16, 17)	18 (17, 19)
	χ^2 , p-value	0.19, $p = .667$		0.69, $p = .406$	
National Quintile (%)	Q1 (Poorest)	2 (2, 1)	4 (4, 5)	23 (23, 23)	33 (33, 33)
	Q2	22 (20, 24)	28 (31, 26)	23 (22, 23)	17 (19, 16)
	Q3	30 (27, 34)	15 (19, 12)	22 (24, 21)	22 (21, 23)
	Q4	34 (35, 32)	36 (30, 42)	19 (21, 18)	21 (21, 21)
	Q5 (Wealthiest)	12 (16, 9)	16 (16, 16)	13 (10, 15)	7 (7, 7)
	χ^2 , p-value	55.94, $p < .001$		38.97, $p < .001$	

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

Age group, gender, and school status were balanced by design at each wave through the CEM matching procedure. At baseline, treatment and comparison groups differed significantly on religion, marital status, and national quintile/socio-economic status (SES), though the distributions across categories within each variable were broadly similar between arms. At endline, treatment and comparison groups differed on marital status and national quintile, while religion was balanced between arms (Table 4).

The sample composition also differed 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 years age group.²⁸ Consistent with this younger age profile, endline respondents also reported lower levels of sexual experience²⁹ and activity³⁰ and – in the treatment arm only – were less likely to have ever been in a relationship.³¹ Additionally, endline respondents had a somewhat lower socioeconomic profile in both arms,³² and the comparison arm showed a shift in religious composition³³ between waves. 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.

Based on these observations, religion and national quintile were included as covariates in the DiD models to control for pre-existing differences between treatment and comparison arms. Marital status and relationship experience were not included as both were only asked to a subsample of respondents, which would have introduced substantial missingness. Age group was included as covariate to account for compositional shifts across waves. Sexual experience and sexual activity were not included as covariates as controlling for variables that may themselves be affected by the intervention could distort the estimated treatment 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 differed on marital status, while at endline the groups differed on educational level. In terms of compositional changes over time, religion shifted modestly within both arms.³⁴ Moreover, there was a decline in the proportion of respondents with secondary education in both arms,³⁵ and an increase in cohabiting as a marital status category in the treatment arm³⁶ between baseline and endline. Religion,

²⁸ Treatment: $\chi^2(2) = 48.18, p < .001$; comparison: $\chi^2(2) = 48.18, p < .001$

²⁹ Treatment: $\chi^2(1) = 58.13, p < .001$; comparison: $\chi^2(1) = 52.32, p < .001$

³⁰ Treatment: $\chi^2(1) = 9.45, p = .002$; comparison: $\chi^2(1) = 7.39, p = .009$

³¹ Treatment: $\chi^2(1) = 13.98, p < .001$

³² Treatment: $\chi^2(4) = 176.09, p < .001$; comparison: $\chi^2(4) = 258.36, p < .001$

³³ Comparison: $\chi^2(2) = 42.32, p < .001$

³⁴ Treatment: $\chi^2(2) = 14.25, p < .001$; comparison: $\chi^2(2) = 13.04, p < .001$

³⁵ Treatment: $\chi^2(3) = 28.46, p < .001$; comparison: $\chi^2(3) = 52.69, p < .001$

³⁶ Treatment: $\chi^2(4) = 16.88, p = .002$

educational level, and marital status were included as covariates in the DiD models to account for these 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 = 153)	Comparison (n = 163)	Treatment (n = 209)	Comparison (n = 193)
District (%)	Adjumani	47 (39, 53)		51 (53, 49)	
	Buyende	53 (61, 47)		49 (47, 51)	
	Amuru		42 (42, 42)		41 (43, 41)
	Luuka		58 (58, 58)		59 (57, 59)
Stakeholder type	Caregiver	73 (47, 91)	78 (61, 91)	73 (57, 85)	76 (41, 97)
	Community stakeholder	27 (53, 9)	22 (39, 9)	27 (43, 15)	24 (59, 3)
	χ^2 , p-value	1.22, p = .269		0.45, p = .504	
Age group (%)	21-39 years	48 (41, 53)	43 (38, 47)	37 (27, 46)	34 (19, 43)
	40-59 years	46 (53, 40)	48 (52, 47)	52 (58, 47)	57 (69, 50)
	60+ years	6 (6, 7)	9 (10, 9)	11 (15, 7)	9 (12, 7)
	χ^2 , p-value	1.18, p = .554		1.01, p = .603	
Gender (%)	Male	42	44	44	38
	Female	58	56	56	62
	χ^2 , p-value	0.10, p = .756		1.84, p = .175	
Religion (%)	Christian	86 (89, 84)	77 (75, 79)	85 (82, 87)	83 (82, 83)
	Muslim	9 (5, 11)	15 (20, 11)	15 (18, 13)	17 (16, 17)
	Other/no religion	5 (6, 5)	8 (6, 10)	0 (0, 0)	<1 (<1, 0)
	χ^2 , p-value	4.29, p = .117		1.22, p = .543	
Highest level of education (%)	No education	13 (5, 19)	18 (4, 29)	16 (9, 22)	18 (4, 27)
	Primary/Junior High School	47 (33, 57)	44 (37, 49)	64 (60, 66)	74 (81, 70)
	Secondary and above	30 (47, 18)	32 (51, 19)	21 (31, 12)	8 (15, 3)
	Other	10 (16, 6)	6 (8, 3)	0 (0, 0)	0 (0, 0)
	χ^2 , p-value	3.69, p = .297		13.32, p < .001	
Marital status (%)	Single/never married	3 (5, 2)	2 (1, 2)	1 (1, <1)	<1 (0, <1)
	Married	84 (87, 82)	77 (87, 69)	77 (85, 70)	72 (89, 62)
	Divorced/separated	5 (3, 6)	5 (4, 5)	9 (6, 12)	7 (4, 8)
	Widowed	7 (3, 10)	9 (1, 15)	5 (0, 9)	6 (0, 9)
	Cohabiting/living together	1 (2, 0)	7 (6, 9)	8 (8, 9)	15 (7, 20)
	χ^2 , p-value	10.28, p = .036		5.84, p = .211	

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

3.1.3 Health care facilities

At endline, thirty health facilities were followed up in Uganda, two fewer than the 32 assessed at baseline (assuming none at baseline were duplicates). The sample included 20 health facilities in Adjumani and 10 in Buyende. By facility type, 14 facilities were Health Centre II, 13 were Health Centre III, and three were

Health Centre IV. In addition, three 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 (<i>n</i> = 53)	Endline Treatment (<i>n</i> = 416)
District (%)	Adjumani	30	47
	Buyende	70	53
Age group (%)	21-39 years	64	45
	40-59 years	36	55
	60+ years	0	<1
Gender (%)	Male	64	54
	Female	36	46



Home visit by a community-based mentor.

3.2 Process

3.2.1 Was the project successfully designed?

The *SHARE* project was designed a priori to be content and context-relevant for the country. As documented in the 2022-2023 project report,³⁷ in-depth consultation was prioritized as part of a formative assessment during project initiation to ensure progress achieved towards outcomes is sustainable and community driven. Given the recognized cultural taboos and sensitivities regarding SRHR issues and the significant public opposition that exists towards SRHR education for adolescents and youth in Uganda, this consultative formative assessment process was seen as critical to mitigate against risks of opposition to the project. In addition to the consultation processes directly linked to Outcome 1120, the project also prioritized engagement with parents and community gatekeepers, through other outcome areas, to build mutual understanding, trust and buy-in from local stakeholders prior to initiating training activities with adolescents and youth. In Uganda, as was the case in other project sites, a Social and Behaviour 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. The framework was developed after engaging an external consultant to lead the SBCC strategy development process. The process of developing the framework involved formative research, stakeholder consultation, audience profile and drafting of communication messages. The external consultant conducted desk reviews and interviews with project staff in Uganda (Adjumani and Buyende districts) and across Consortium-wide partners. The consultations focused on identifying barriers and enablers across the spheres of knowledge, attitudes, behaviours and norms; sources and instances of misinformation; and examples of best practices and positively disruptive voices. Based on the formative assessment, audience profiles targeting detailed insights into the characteristics, needs, behaviours, attitudes, and preferences were developed to address each target segment's specific needs and opportunities. These profiles assisted in selecting appropriate messages and communication channels for the intended audiences.

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 Uganda were not deemed to have been significantly affected. Similarly, rates of inflation saw historic increases in Uganda, as was the case globally. This resulted in increased costs to implement *SHARE* activities due to inflation, which was also deemed to have contributed to the increased economic vulnerability of project beneficiaries. The economic instability was also linked to increased supply chain disruptions. Separately, there was an outbreak of Ebola Virus Disease (Sudan Ebolavirus) in September 2022. While the initial outbreak did not occur in any areas where *SHARE* activities were implemented, further spread was expected, and as such, schools were closed for holidays earlier than planned, nationwide, to contain case spread.

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

From interviews conducted with stakeholders, many submitted that the fact that *SHARE* activities were implemented through existing structures within schools, health facilities, communities, and government systems, rather than creating stand-alone mechanisms, helped ensure efficiency in project implementation. Many stakeholders reflected on how the project became embedded within existing institutional arrangements, which appeared to strengthen uptake, coordination, and continuity. Ministry representatives described how project activities built on existing education and parenting systems rather than introducing entirely new approaches. A Ministry of Gender respondent explained that collaboration with *SHARE* strengthened the implementation of parenting systems that the government had already developed but had limited capacity to operationalize:

“Our partnership was strengthened by the unique entry of Right To Play and building on what we had.” (Assistant Commissioner of Family Affairs, Ministry of Gender, KII)

At district and facility levels, respondents also pointed to how the *SHARE* project worked through existing health systems, particularly through district health offices, health facilities, adolescent focal persons, and routine supervision structures. A district health respondent in Buyende explained:

“The involvement stretches from planning and budgeting to the implementation of activities.” (Acting District Health Officer, Buyende, KII)

In schools, respondents described how *SHARE* activities were incorporated into routine school structures, including timetables, mentorship systems, clubs, and guidance and counselling activities. Teachers frequently noted that this reduced reliance on external facilitators and created opportunities for continuity. Teachers also reflected on how SRHR discussions became institutionalized within weekly school schedules, with a head teacher in Adjumani who described how schools integrated SRHR into already existing extracurricular platforms because of the project, saying:

“We agreed... that we should incorporate these things [SRHR discussions] in our club activities.” (Head Teacher, Ofua Central Primary School, Adjumani, KII)

At the community level, many interviewees reflected on the role of existing frontline structures such as Village Health Teams (VHTs), community mentors, local councils, religious leaders, and community dialogues. These actors were often described as trusted intermediaries who helped adolescents and families navigate services and information more comfortably. A VHT in Buyende described how *SHARE* strengthened an already existing community role:

“The organisation taught us how to handle adolescents, how to manage them, and where exactly they should get medicine.” (VHT, Namusita Parish, Buyende, IDI)

Consortium members noted that the project intentionally worked through pre-existing structures, including VHTs, teachers, district committees, and community groups, rather than creating new systems. For example, FAWE initiated a review of the organization's existing "*Tuseme*"³⁹ curriculum, which is based on a participatory approach designed to empower learners to identify and address issues hindering their academic and social development, particularly those affecting girls' school participation,⁴⁰ to support SRHR club activities in secondary schools as part of the *SHARE* project. The curriculum review ensured that the content, which was initially developed way back in 2005, was current and contextually relevant.

Practical learning approaches—including role plays, peer learning, exchange visits, and mentorship—were described as particularly helpful by several stakeholders including those in ministries, adolescent focal persons, and health facility leads. Several district and national level stakeholders noted that these approaches allowed actors to observe practices directly and apply them immediately in their own settings. For some, learning through peer exchange appeared more useful than classroom instruction alone because it enabled practical problem-solving within routine service delivery. District and facility-level stakeholders reflected on how mentorship and repeated supervision reinforced skills rather than relying on one-time training alone, helping to sustain the quality and consistency of *SHARE* activities. A district focal person for adolescents in the MoH explained:

"Each time when we go to support supervise, we normally write an action plan at the facility to follow and in the next visit, we check if they have worked on [it]... knowledge that was not acquired in class came through mentorship during support supervision." (District focal person for adolescents MoH, Adjumani, KII)

Despite largely positive reflections from stakeholders engaged at endline on the project's implementation approach, small number of respondents also pointed to some limitations. For example, with the approach to training, teachers noted that staff transfers weakened continuity and not all trained individuals disseminated learning consistently. In schools, reliance on a few trained focal teachers occasionally meant knowledge remained concentrated among limited personnel. Similarly, VHTs and community actors noted that reaching all villages and households remained difficult due to limited staffing and transport.

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,

³⁹ Kiswahili word which meaning 'let us speak out'

⁴⁰ Khaita, M.L., Lumutenga, N.W., Namubiru-Auma, R.H., Fall, K., Krstic, S., Nono, D., Ogara, C., Olido, K., Otwor, D.O., Sahledengle, T., Towne, A. 2025 *Tuseme Model: A theory of Change for Empowering Girls and Building Inclusive Community-Engaged Schools for Rural Development in Sub-Saharan Africa*. *African Journal of Rural Development* 10 (2):390-415.

WaterAid supported WASH systems and adolescent-friendly environments, FAWE strengthened referral pathways and gender-related programming, while FHI360 provided technical guidance across SRHR programming. Consortium partners suggested that this 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. One respondent explained:

“We have a weekly coordination meeting... we get to know what each partner’s plans to do throughout the week... if there are challenges that will need all of us to go in front as a team.” (Representative of Right To Play, KII)

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 8,009 in the period April 2022 - March 2023 to 363,987 for April 2025 - March 2026. Number of direct compared to indirect beneficiaries reached was higher in April 2022 - March 2023 and April 2023 - March 2024, while the reverse was the case in April 2024 - March 2025 and April 2025 - March 2026 ([Table 7](#)).

Table 7: Beneficiaries reached annually during project implementation

Beneficiary	April 2022 - March 2023	April 2023 - March 2024	April 2024 - March 2025	April 2025 - March 2026
Direct beneficiaries (Young people 10-24 years)	5,454	47,760	11,206	25,653
In school adolescents	4,140	12,817	4,360	13,899
Out of School Young People	1,314	34,943	6,846	11,754
Young people 10-24 years (Female)	3,195	34,313	5,713	13,382
Young people 10-24 years (Male)	2,259	13,447	5,493	12,271
Indirect beneficiaries	2,555	31,904	55,126	338,334
Parents/Caregivers	1,944	5,834	18,962	3,584
Community members	544	25,379	34,617	333,419
Health workers	67	279	472	506
Teachers	0	26	524	915
Mentors	0	97	272	52
All beneficiaries	8,009	79,664	66,332	363,987

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, 38% (M: 40%, F: 36%) of in-school adolescents and youth in treatment areas⁴¹ reported having participated in a school-based club discussing health, relationships, and SRHR topics in the past four years. Among out-of-school respondents⁴², 22% (M: 22%, F: 21%) reported participating in a community-based SRHR group or mentorship programme. Of those who participated in either type of club or group⁴³, 54% (M: 52%, F: 56%) attended fewer than five meetings and one third (M: 32%, F: 35%) attended five or more, with approximately 11% (M: 14%, F: 9%) unable to recall. Further, 29% (M: 31%, F: 28%) of respondents in treatment areas⁴⁴ reported attending community events or activities related to SRHR.

In comparison areas, 12% (M: 9%, F: 15%) of in-school respondents⁴⁵ reported participating in a school-based SRHR club, while 11% (M: 7%, F: 14%) of out-of-school respondents⁴⁶ reported participating in a community-based SRHR group. In addition, 9% (M: 7%, F: 10%) of respondents⁴⁷ reported community event attendance. Of those who participated in a club or group⁴⁸, 51% (M: 61%, F: 46%) attended fewer than five meetings and 39% (M: 35%, F: 40%) attended five or more, with 9% (M: 3%, F: 12%) unable to recall. As *SHARE* did not operate in comparison areas, this participation reflects exposure to other programmes.

Among treatment area respondents who participated in one of the above activities, the large majority indicated that the activity was supported by *SHARE* or its partners *Right To Play*, FAWE, and WaterAid: 83% (M: 84%, F: 82%) for school-based clubs, 72% (M: 76%, F: 68%) for community groups, and 77% (M: 77%, F: 76%) for community events. Overall, 31% (M: 32%, F: 29%) of treatment area respondents reported at least some direct exposure to *SHARE* or its partners. This figure likely underestimates true project reach for several reasons. First, these questions capture only specific reported activities and do not reflect the full range of ways in which adolescents in the treatment communities may have been exposed to the *SHARE* project, which also included teacher-delivered sexuality education through trained teachers, SBCC, community awareness-raising campaigns, and enhanced adolescent-friendly SRHR services in health facilities. Second, in-school adolescents were eligible for participating in the survey if

⁴¹ Base: in-school adolescents in treatment areas (n=565)

⁴² Base: out-of-school adolescents in treatment areas (n=285)

⁴³ Base: adolescents in treatment areas who reported that they participated in a club or group (n=267)

⁴⁴ Base: all adolescents in treatment areas (n=850)

⁴⁵ Base: in-school adolescents in comparison areas (n=565)

⁴⁶ Base: out-of-school adolescents in comparison areas (n=285)

⁴⁷ Base: all adolescents in comparison areas (n=850)

⁴⁸ Base: adolescents in comparison areas who reported that they participated in a club or group (n=96)

they were enrolled in one of the *SHARE* project schools and would therefore be expected to have been exposed to project activities through their school, provided implementation took place as intended. 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, 56% (M: 68%, F: 47%) of community members in treatment areas⁴⁹ reported having participated in community dialogues or discussion sessions about ASRH in the past four years. Participation varied considerably by stakeholder type, with 91% of key community stakeholders reporting participation compared to 43% of caregivers. Of community members who participated⁵⁰, 22% (M: 17%, F: 27%) attended one session, 59% (M: 62%, F: 56%) attended two to three sessions, and 19% (M: 21%, F: 16%) attended three or more sessions. Additionally, 57% (M: 68%, F: 48%) of community members in treatment areas⁵¹ reported attending community or awareness-raising events, again with a marked difference between key community stakeholders (86%) and caregivers (46%).

In comparison areas, overall participation was lower: 32% (M: 55%, F: 18%) of community members⁵² reported participating in community dialogues and 36% (M: 56%, F: 23%) reported attending awareness-raising events. The same striking difference between stakeholder types was observed: 72% of key community stakeholders vs. 19% of caregivers for dialogue participation, and 79% vs. 22% respectively for awareness-raising events. Of community members who participated in community dialogues⁵³, 11% (M: 10%, F: 14%) attended one session, 48% (M: 45%, F: 55%) attended two to three sessions, and 39% (M: 45%, F: 27%) attended three or more sessions. As *SHARE* did not operate in comparison areas, this participation reflects exposure to other programmes.

Among treatment area respondents who participated in one of the above activities, the large majority indicated that the activity was supported by *SHARE* or its partners *Right To Play*, *FAWE*, and *WaterAid*: 85% (M: 89%, F: 80%) for community dialogues and 82% (M: 86%, F: 77%) for community or awareness-raising events. Overall, 55% (M: 67%, F: 45%) of treatment area respondents (caregivers: 45%; key community stakeholders: 81%) reported at least some direct exposure to *SHARE* or its partners.

⁴⁹ Base: all community members in treatment areas (n=209)

⁵⁰ Base: community members in treatment areas who reported that they participated (n=118)

⁵¹ Base: all community members in treatment areas (n=209)

⁵² Base: all community members in comparison areas (n=193)

⁵³ Base: community members in comparison areas who reported that they participated (n=62)



A SHARE trained mentor providing on-site mentorship to other health workers in Buyende.

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](#). Sensitivity analysis with age-restricted analysis amongst adolescents aged 15-19 years is in [Annex G](#).

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

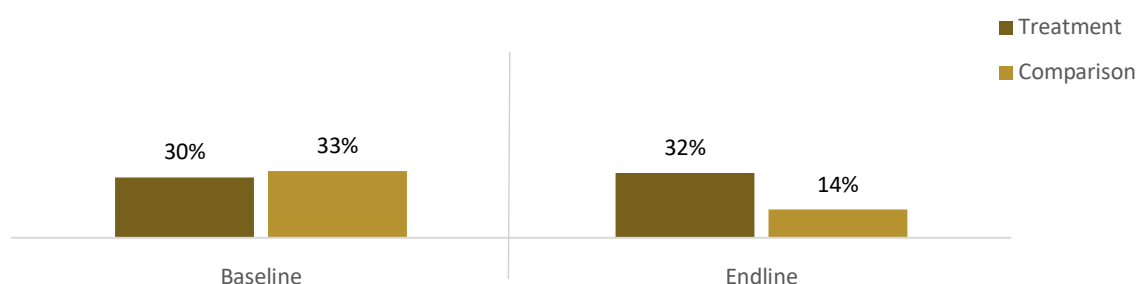
Intermediate Outcome 1100 aimed to achieve increased equitable use of gender responsive SRHR information and SRH services by adolescents and young people, particularly girls and young women. This outcome was measured using four indicators.

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 SRH 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 comparable between the treatment group (30%; 95% CI [25%, 34%]; M: 31%, F: 28%) and comparison group (33%; 95% CI [27%, 38%]; M: 31%, F: 34%), indicating similar starting points across arms. By endline, service utilization in the treatment group remained relatively stable at 32% (95% CI [26%, 39%]; M: 31%, F: 33%), while a sharp decline was observed in the comparison group, with only 14% (95% CI [10%, 19%]; M: 10%, F: 17%) of respondents reporting service utilization. It is worth noting that at midterm, treatment group utilization was 53% (M: 44%, F: 63%) compared to 26% (M: 28%, F: 23%) in the comparison group, suggesting a peak in service seeking behaviour in the treatment arm during the midterm period that was not sustained through to endline – though this pattern should

be interpreted with caution given differences in study design and age composition across waves, which may partly explain differences in levels between time points rather than reflecting a true temporal trend. The difference between groups at endline was significant (Adjusted $F(1, 83) = 21.44, p < .001$). Further analysis suggests that funding cuts might have affected supply chain in the comparison sites.⁵⁴ The DiD analysis, controlling for observed sociodemographic differences between groups, revealed a statistically significant difference between groups over time ($B = -1.21, SE = 0.32, 95\% \text{ CI } [-1.86, -0.57], p < .001$). With both groups starting at comparable baseline levels, the 21-percentage point difference-in-difference (reflecting stable utilization in the treatment group against a sharp decline in the comparison group) is consistent with the possibility that the *SHARE* project helped sustain SRH service seeking among adolescents and youth in the treatment areas, although this interpretation relies on assumptions that could not be fully verified and should therefore be treated with caution (Figure 2).



Base: All adolescents (Baseline treatment $n=740$, comparison $n=740$; Endline treatment $n=850$, comparison $n=850$)

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

Table 8 presents an overview of utilization rates for different types of SRH services. At endline, the treatment group significantly outperformed the comparison group across all five service types. Utilization rates in the treatment group remained broadly stable across service types between baseline and endline, while rates in the comparison group declined substantially across all types.

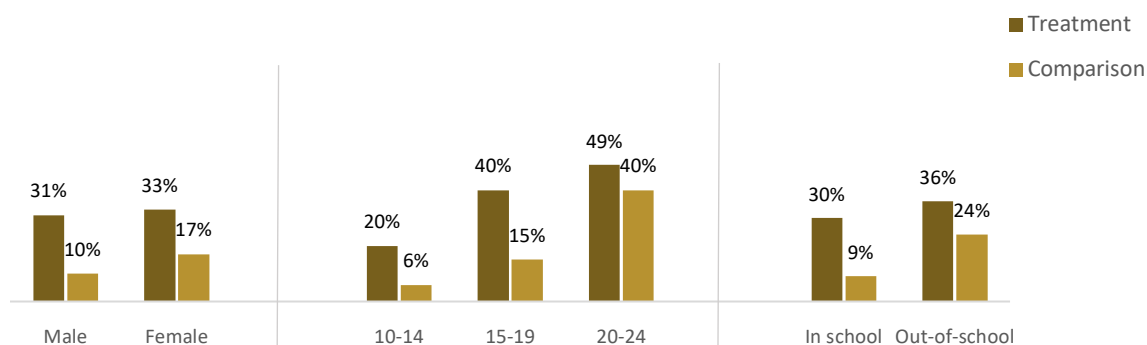
Table 8: Adolescents/youth who used different types of SRH services in the past 12 months (% [95% CI])

Service type (%)	Baseline		Endline	
	Treatment ($n = 740$)	Comparison ($n = 740$)	Treatment ($n = 850$)	Comparison ($n = 850$)
Accurate information and counselling on SRH	18 [15, 22]	16 [13, 20]	23 [18, 28]	10 [7, 14]***
Information, counselling, and care related to sexual function and satisfaction	18 [15, 22]	16 [13, 21]	18 [14, 24]	6 [4, 9]***
Prevention, detection, and management of sexual and gender-based violence and coercion	17 [14, 21]	16 [12, 20]	22 [16, 29]	6 [4, 9]***
A choice of safe and effective contraceptive methods	19 [16, 24]	18 [14, 23]	17 [13, 22]	7 [4, 10]***
Prevention, detection, and treatment of STIs and reproductive tract infections	20 [16, 25]	21 [17, 25]	17 [13, 23]	10 [7, 14]*
Used any SRH services	30 [25, 34]	33 [27, 38]	32 [26, 39]	14 [10, 19]***

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

⁵⁴ Kitagenda Y (2026) Activity Report: Assessment interviews in Control Areas of Amuru and Luuka Districts

Endline data showed broadly similar service utilization rates between male and female respondents in both the treatment and comparison groups. Moreover, SRH service utilization appeared to increase with age, with higher rates observed among older adolescents and youth in both treatment and comparison groups. In terms of school status, similar service utilization rates were observed between in-school and out-of-school youth in the treatment areas. In the comparison areas, out-of-school youth appeared to have higher service utilization compared to in-school youth (see [Figure 3](#)).



Base: All adolescents (Treatment and comparison (balanced) male n=380, female n=470, age 10-14 n=375, age 15-19 n=366, age 20-24 n=109, in school n=565, out of school n=285)

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

Survey respondents were also asked about potential barriers that would hinder them from seeking SRH services at health facilities or community/youth centers. Overall, barriers to SRH service utilization were reported at higher rates at endline compared to baseline across both treatment and comparison groups.

At endline, physical barriers were the most frequently cited barrier in both groups, with 33% of treatment and 22% of comparison group respondents indicating difficulty getting to facilities. Time required to see someone was also cited by a substantial group, reported by 32% of treatment group respondents and 21% of comparison group respondents. Other factors that hindered adolescents from seeking services were financial constraints (T: 18%, C: 20%), embarrassment (T: 19%, C: 12%), and lack of privacy (T: 9%, C: 11%). Additionally, 16% of comparison group respondents cited the lack of adolescent-specific SRH services as a barrier, compared to 8% in the treatment group.

From the qualitative data, barriers to using SRH services remained even at endline, aligning with the survey. Out-of-school girls in Adjumani mentioned long waiting times because of limited number of nurses present in health facilities. Some adolescents reported that they still experienced fear, harsh treatment, or discomfort at facilities. An out-of-school boy in Pagirinya said:

“Sometimes even the watchman will chase you away until you explain.” (Out of schoolboy 15-17 years, Adjumani, FGD)

The perspective of the out-of-school boy shared above showed that even when attitude of health workers improved, the wider facility environment, including ancillary staff working in health facilities, could still discourage adolescents SRH service utilization. For other adolescents, their concern was with being seen by community members. For example, the DHO in Buyende noted that some adolescents avoided facilities because they feared being seen by parents. In addition, some health workers were said to not have ensured privacy in service delivery. An out-of-school adolescent girl in Adjumani described feeling afraid after seeing another girl's results disclosed in front of others. She said:

“One girl was told her result in front of others, and that made me fear because such information should be private.” (Out of schoolgirl 15-17 years, Adjumani, FGD)

Misinformation and incomplete information remained a concern, especially around contraception and family planning. When discussing what they had learned about SRH, in-school adolescent girls 15-19 years in Buyende reported hearing that family planning could cause infertility or affect the womb, while girls in Adjumani described hearing that condoms were harmful and could remain inside a woman's body. Also, SRH guidance remained narrow, especially for girls. In-school girls seeking advice about relationships or sexual feelings were sometimes only told to abstain, without receiving fuller information about contraception, consent, protection, or available services.

“She told me to just abstain from sex.” (In-school girl 15-19 years, Buyende, FGD)

Implementing partners and health workers acknowledged that stigma and provider bias had not fully disappeared. An adolescent mentor in Adjumani said some providers still discouraged adolescents from using family planning, saying: *“This person is still too young.”* Reach Out a Hand, which also worked in Adjumani while the SHARE project was being implemented there, noted that community misconceptions surrounding contraceptives and SRHR remained, including fears that girls using contraception will become *“infertile”*. Similarly, one of the key informants in Adjumani explained that some parents and members of the communities still viewed SRHR information as inappropriate or believed contraceptive use encouraged sexual activity or infertility. An adolescent health mentor said:

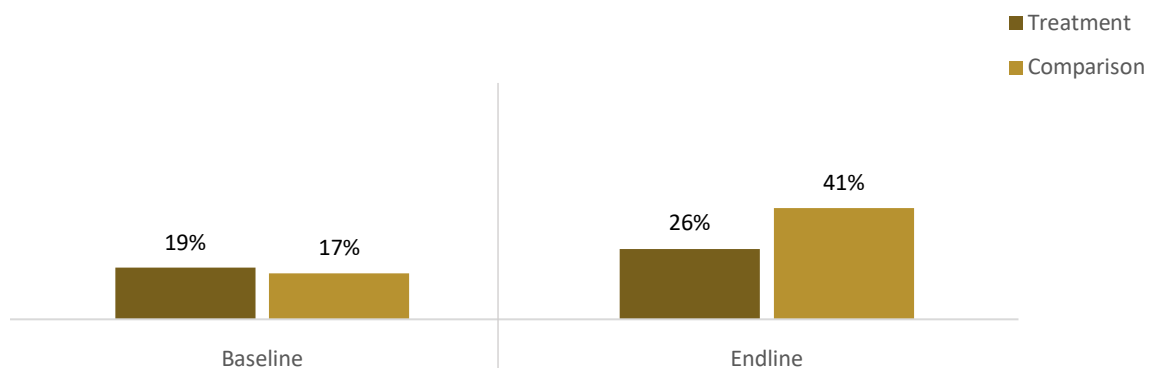
“Parents refusing their children to come to the facility... they think they are coming to learn about sex.” (ADH Mentor, Female, Adjumani, KII)

Broadly, while the project appears to have supported adolescents' confidence and helped maintain SRH service-seeking, the findings suggest that gender-responsive and adolescent-responsive quality of care remained inconsistent, particularly around confidentiality, contraceptive counselling, stigma, waiting times, and provider bias.

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

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

At baseline, the proportion of adolescents who strongly disagreed with all manifestations of SGBV was similar between treatment (19%; 95% CI [15%, 23%]; M: 17%; F: 20%) and comparison (17%; 95% CI [12%, 24%]; M: 18%, F: 16%) groups, indicating comparable starting points across arms. By endline, both groups showed increases in the rejection of these behaviors, with the comparison group (41%; 95% CI [32%, 50%]; M: 41%; F: 41%) improving considerably more than the treatment group (26%; 95% CI [20%, 33%]; M: 24%; F: 27%; see [Figure 4](#)). It is worth noting that at midterm, both groups showed substantially higher levels (treatment: 59%; M: 55%, F: 62%; comparison: 56%; M: 52%, F: 61%), suggesting that the positive attitudes observed at midterm were not sustained through to endline in either arm – though this pattern should be interpreted with caution given differences in study design and age composition across waves. The difference between groups at endline was statistically significant (Adjusted $F(1, 83) = 7.14, p = .009$).



Base: All adolescents (Baseline treatment n=740, comparison n=740; Endline treatment n=850, comparison n=850)

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

The DiD analysis, controlling for observed sociodemographic differences between groups, yielded a significant difference between groups over time in the opposite direction to what would be expected ($B = 0.80, SE = 0.36, 95\% \text{ CI } [0.08, 1.51], p = .030$), indicating that the comparison group improved significantly more than the treatment group between baseline and endline. The quantitative evidence therefore does

not support a positive contribution of *SHARE* to improvements in attitudes toward ending SGBV. 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.

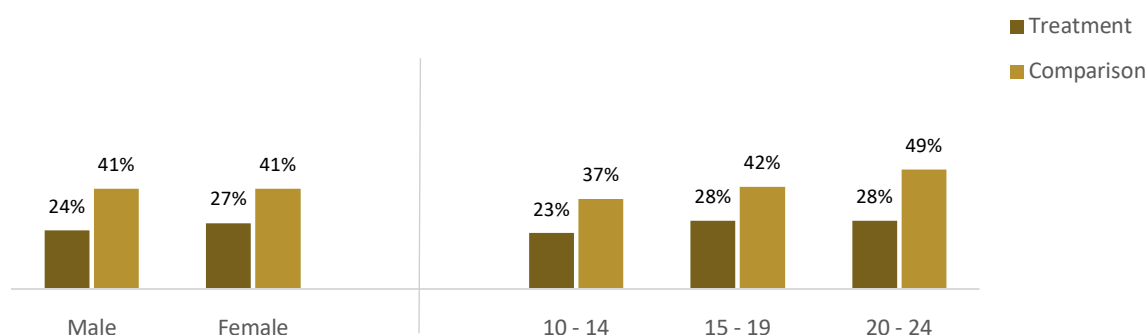
Table 9 presents the proportion of respondents that strongly disagreed with each individual statement. Compared to baseline, levels of strong disapproval were broadly similar across most statements in the treatment group, while the comparison group showed notably higher levels across most statements. The majority of adolescents (>55%) displayed a strong disapproval towards manifestations of SGBV in most of the statements. However, fewer respondents strongly disagreed with the statement “It is ok for a girl/woman to set limits on how her boyfriend dresses” (T: 35%, C: 52%).

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

	Baseline		Endline	
	Treatment (n = 740)	Comparison (n = 740)	Treatment (n = 850)	Comparison (n = 850)
It is ok for a boy to insult his girlfriend	64 [57, 70]	66 [58, 73]	64 [53, 74]	72 [64, 79]
It is ok for a boy to hit his girlfriend if she has been unfaithful	55 [48, 62]	54 [47, 62]	60 [50, 69]	66 [58, 73]
It is ok for a boy/man to hit his girlfriend if she is constantly nagging	53 [46, 60]	52 [45, 60]	57 [47, 66]	67 [59, 74]
It is ok for a boy/man to push a girl/ woman into having sex if they have been dating	60 [53, 66]	55 [47, 63]	55 [45, 64]	71 [64, 78]**
It is ok for a girl/woman to set limits on how her boyfriend dresses	36 [31, 41]	35 [28, 42]	35 [28, 43]	52 [43, 60]**
Strongly disagree with all statements	19 [15, 23]	17 [12, 24]	26 [20, 33]	41 [32, 50]**

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

At endline, results were broadly similar across gender within both treatment and comparison arms and age groups in the treatment arm. Though some age-related variation was observed in the comparison arm, these should be interpreted with caution due to overlapping confidence intervals (Figure 5).



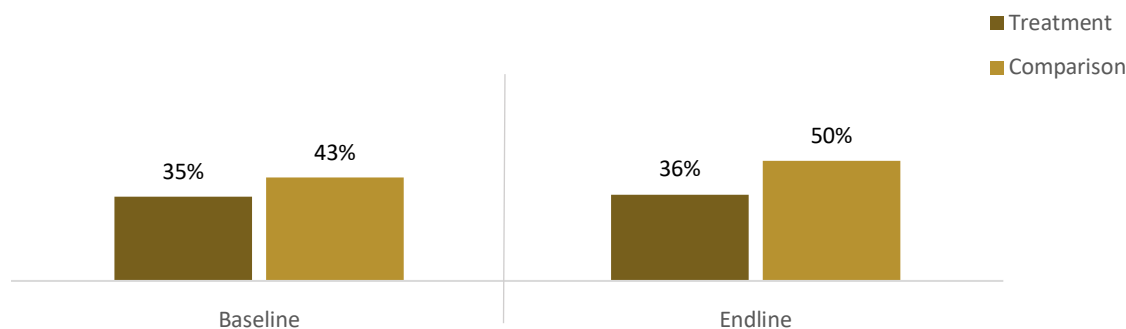
Base: All adolescents (Treatment and comparison (balanced) male n=380, female n=470, age 10-14 n=375, age 15-19 n=366, age 20-24 n=109)

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

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

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

At baseline, confidence in contraceptive negotiation was broadly similar between the treatment group (35%; 95% CI [28%, 43%]; M: 31%, F: 39%) and comparison group (43%; 95% CI [36%, 49%]; M: 40%, F: 45%), with overlapping confidence intervals indicating no conclusive difference between arms. By endline, both groups remained relatively stable, with 36% (95% CI [27%, 46%]; M: 36%, F: 36%) in the treatment group and 50% (95% CI [41%, 59%]; M: 53%, F: 48%) in the comparison group (Figure 6). Although the point estimate in the comparison group increased, the overlapping confidence intervals suggest this should not be interpreted as a definitive population-level change. The difference between groups at endline was statistically significant (Adjusted $F(1, 83) = 4.19, p = .044$).



Base: Adolescents/youth who are married, cohabiting/living together, or in a relationship (Baseline treatment $n=319$, comparison $n=276$; Endline treatment $n=191$, comparison $n=206$)

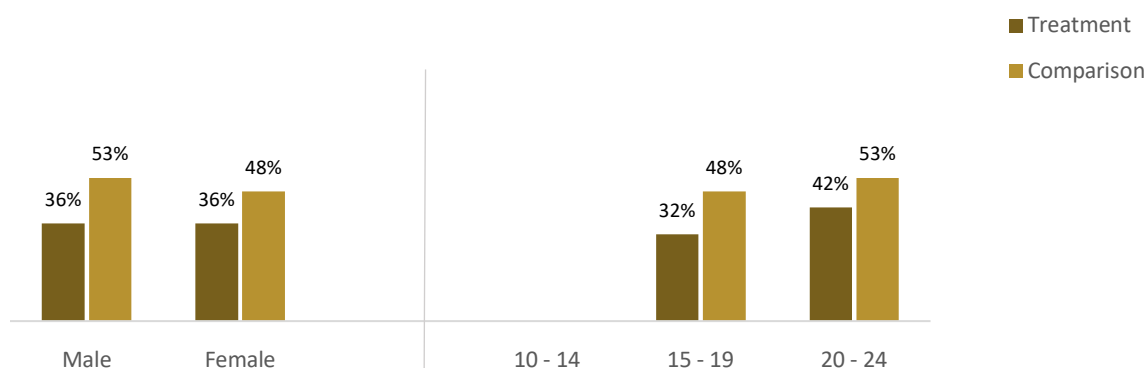
Figure 6: Adolescents/youth who are confident that they could get their partner to use contraception (%)

The DiD analysis, controlling for observed sociodemographic differences between groups, did not reveal a statistically significant effect ($B = 0.42, SE = 0.34, 95\% \text{ CI } [-0.25, 1.09], p = .214$), suggesting no differential change between arms over time. It is important to note that this finding is specific to adolescents aged 15 years and older who were in a relationship at the time of the survey rather than the full adolescent and youth population.

The absence of statistically significant change may reflect the influence of deeply entrenched gender norms, unequal power dynamics within relationships, and broader socio-cultural attitudes surrounding sexuality and contraceptive use, as established in the qualitative component of the evaluation. The similar pattern observed in both treatment and comparison groups also suggests that broader contextual factors outside the project may have influenced this outcome. At endline, girls particularly described continued discomfort discussing sensitive topics, with one saying:

“I am still shy, but it has reduced... I still fear being laughed at. But compared to before, there is change.” (Out-of-school adolescent girl, 15–19 years, Buyende, IDI)

Evidence in the literature from a 2025 cross-sectional study conducted in Busoga region, Eastern Uganda, reported that more (81.7%) AGYW who lacked confidence in discussing contraceptives with their partner did not use contraceptives compared to those who felt confident (36.5%) ($p = .005$). The study also reported that AGYW who were not confident discussing about contraceptives with their partners had a 37% higher prevalence of non-utilization (Adjusted Prevalence Ratio = 1.37; 95% CI: 1.02–1.85). The proportion of AGYW who felt confident to discuss with their partner was 14.5%.⁵⁵ This estimate is lower than the estimates from the *SHARE* project at baseline and endline (Figure 6). At endline, confidence intervals for gender and age subgroups overlapped within both treatment and comparison arms, indicating no credible differences in contraceptive negotiation self-efficacy by gender or age group beyond the overall treatment-comparison difference already discussed above (Figure 7).



Base: Adolescents/youth who are married, cohabiting/living together, or in a relationship (Treatment male $n=81$, female $n=110$, age 15-19 $n=113$, age 20-24 $n=78$; Comparison male $n=85$, female $n=121$, age 15-19 $n=120$, age 20-24 $n=86$)

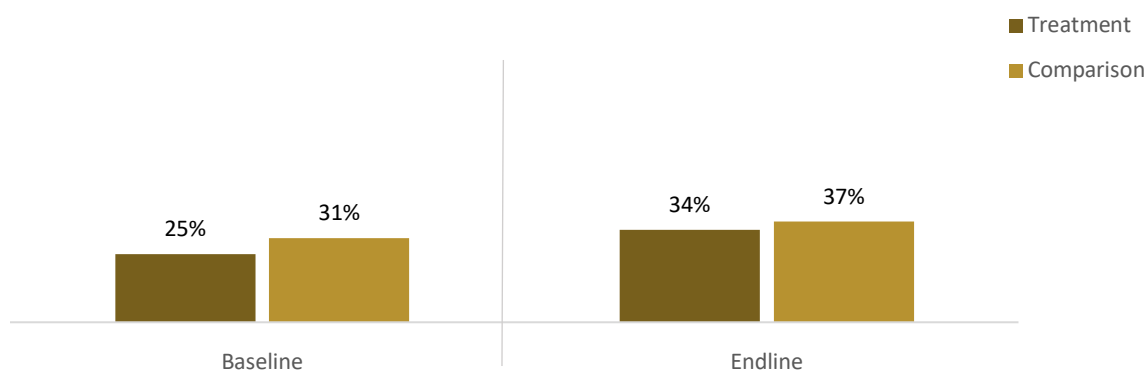
Figure 7: Adolescents/youth at endline who are confident that they could get their partner to use contraception, by gender and age (%)

⁵⁵ Tumwizere G, Bunani N, Muhumuza N, Uwera A, Kabagyenzi A. Non utilization of modern contraceptives among sexually active adolescent girls and young women aged 10-24 years in selected districts of Busoga region, Eastern Uganda: a cross-sectional study. *Contracept Reprod Med*. 2025;10:70. doi: 10.1186/s40834-025-00407-x.

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.⁵⁶

At baseline, 25% (95% CI [16%, 38%]) of sexually active girls and young women in the treatment group and 31% (95% CI [20%, 44%]) in the comparison group met both criteria. By endline, estimates shifted to 34% (95% CI [24%, 46%]) in the treatment group and 37% (95% CI [25%, 51%]) in the comparison group (Figure 8). Confidence intervals overlap substantially across all comparisons, and observed differences should not be interpreted as definitive population-level changes.



Base: Adolescent girls/young women who were sexually active in the past 12 months (Baseline treatment n=91, comparison n=83; Endline treatment n=82, comparison n=91)

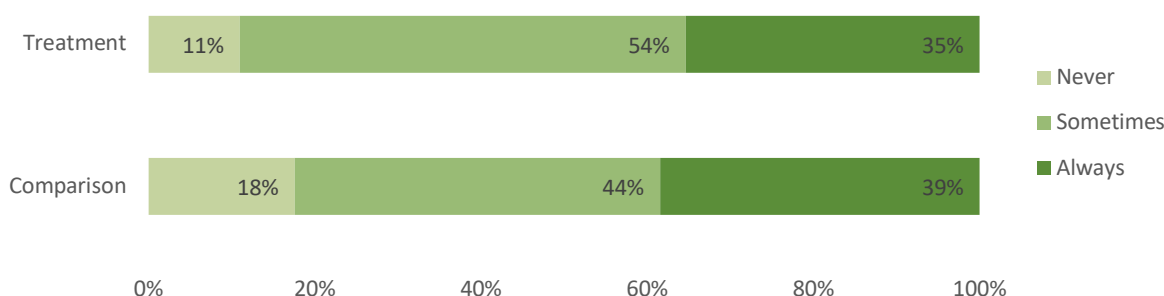
Figure 8: Adolescent girls/young women who used a modern method of contraception 'always' in the past 12 months (%)

Neither the cross-sectional comparison at endline (Adjusted $F(1, 69) = 0.13, p = .715$) nor the DiD analysis ($B = -0.16, SE = 0.66, 95\% \text{ CI } [-1.48, 1.17], p = .816$) revealed a statistically significant difference between treatment and comparison groups. Overall, the findings do not provide evidence of a statistically significant *SHARE* effect on consistent modern contraceptive use among sexually active girls and young women. Small sample sizes, wide confidence intervals, and possible external programming in comparison areas limit interpretation. The results should therefore be treated as inconclusive rather than as evidence of either program impact or no impact.

Further analysis of the data components shows that at endline, 35% (95% CI [24%, 48%]) of sexually active girls and young women in treatment areas and 38% (95% CI [26%, 53%]) in comparison areas reported always using contraception (Figure 9). Among those who reported always using contraception, 28 of 29

⁵⁶ Modern methods include: Male condoms, Female condoms, Emergency contraceptive pills, Oral contraceptive pills, Injections, Implants, Intrauterine devices (IUDs), Male and female sterilization.

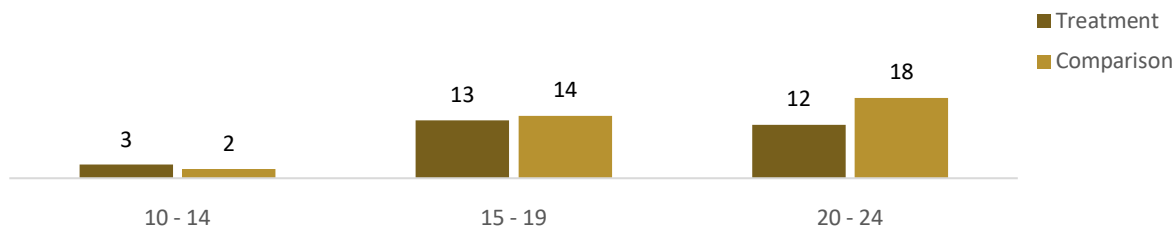
respondents (97%) in the treatment group and 34 of 35 respondents (97%) in the comparison group reported using modern methods. This suggests that when young women in these areas adopt regular contraceptive practices, they almost exclusively choose modern contraceptive options. Evidence from the literature shows that hearing about family planning through the media and discussing family planning with a health personnel were considered as being potential predictors of modern contraceptive use for women and men, including adolescents.⁵⁷ These approaches were also implemented as part of the *SHARE* project. However, the observed increases in point estimates from baseline to endline should be interpreted cautiously and may reflect a range of factors, including broader contextual influences, exposure to similar programmes (such as AMREF's *Total Health in Schools* project and Marie Stopes monthly integrated SRHR outreaches which were implemented in the comparison sites on Amuru and Luuka), and sampling variability rather than a demonstrated project-specific effect, respectively.



Base: Adolescent girls/young women who were sexually active in the past 12 months (Treatment n=82, comparison n=91)

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

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



Base: Adolescent girls/young women who were sexually active in the past 12 months (Treatment age 10-14 n=10, age 15-19 n=34, age 20-24 n=38; Comparison age 10-14 n=5, age 15-19 n=41, age 20-24 n=45)

Figure 10: Adolescent girls/young women at endline who used a modern method of contraception 'always' in the past 12 months, by age

⁵⁷ Namasivayam A, Lovell S, Namutamba S, et al. Predictors of modern contraceptive use among women and men in Uganda: a population-level analysis. *BMJ Open* 2020;10:e034675. doi: 10.1136/bmjopen-2019-034675

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

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

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

Using the Health Facility Survey, we assessed the extent to which facilities in the treatment areas are offering good quality, gender-responsive and adolescent-friendly health services. To be counted towards this indicator, facilities needed to meet eight 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 privacy in counseling and examination rooms, staff trained in adolescent reproductive health services, confidential record management, and availability of functional toilets (Table 10). Results were calculated in two ways: a strict version in which privacy in counselling rooms was 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 counselling room privacy and partial toilet functionality was included. Where the two versions yield different results, both are presented using slash notation (strict / less strict). Where only one figure is shown, both versions yielded the same result. Endline results disaggregated by treatment district are provided in Annex E.

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

	Baseline n = 32	Midterm n = 28	Endline n = 30
<i>Availability of quality service delivery to women and adolescents regardless of</i>			
Gender	31 (97%)	28 (100%)	29 (97%)
Age	16 (50%)	10 (36%)	8 (27%)
Marital status	32 (100%)	28 (100%)	29 (97%)
<i>Availability of quality service</i>			
<u>Counselling</u> and <u>examination</u> rooms provide <u>visual</u> and <u>auditory</u> privacy ^a	19 (59%)	17 (61%) / 18 (64%)	26 (87%) / 28 (93%)
Staff are trained to serve adolescents in reproductive health service	19 (59%)	28 (100%)	23 (77%)
Storing records confidentially ^b	30 (94%)	20 (71%)	27 (90%)
Accessing stored records confidentially ^b	31 (97%)	20 (71%)	26 (87%)
Have functional toilets ^c	22 (69%)	25 (89%) / 27 96%)	27 (90%) / 29 (97%)
All criteria met	1 (3%)	6 (21%)	4 (13%)

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 At midterm, 4 facilities did not store records. ^c Where two figures are presented, the first represents the strict version ('Yes, observed that all toilets are functional' only) and the second the less strict version ('Yes, observed that all toilets are functional' and 'Observed that some toilets are functional, but not all').

At baseline, only one facility (3%) met all eight criteria for good quality, gender-responsive and adolescent-friendly health services. This increased to six (21%) at midterm before declining to four (13%) at endline. A closer examination of individual criteria reveals both progress and ongoing challenges. Specifically, whereas almost all facilities at endline reported serving adolescents regardless of gender and marital status, age-inclusive service provision declined from 16 facilities (50%) at baseline to 10 (36%) at midterm and further to 8 (27%) at endline. This sustained decline from baseline to endline might be related to the continuous staff turnover with new ones having new attitude to adolescent service. However, it might also be due to respondent understanding of the survey question itself, 'Is there a minimum age requirement for adolescents to receive services? Quality service infrastructure showed improvements in some areas and declines in others. Privacy standards for counselling and examination rooms improved substantially from 19 facilities (59%) at baseline to 26 facilities (87%), or 28 (93%) when including self-reporting compliance, at endline. Staff training declined from all 28 facilities at midterm to 23 (77%) at endline, having previously improved substantially from 19 (59%) at baseline. This could be due to the effect of the USAID funding cuts in which Adjumani district lost over half of its health workforce. Confidential record storage improved from 20 facilities (71%) at midterm to 27 (90%) at endline, recovering toward baseline levels (30, 94%), and confidential record access similarly recovered from 20 (71%) at midterm to 26 (87%) at endline. It should be noted that at midterm, 4 facilities did not store records. Functional toilet availability improved across all three waves, from 22 out of 32 facilities (69%) at baseline to 25 out of 28 (89%) at midterm and 27 out of 30 (90%) at endline under the strict criterion, with 2 additional facilities reporting partial functionality at both midterm and endline decline ([Table 10](#)).

Most of the surveyed health facilities had toilets with clean ceilings, floors, toilet bowl, and walls. Functional locks and separate toilets for male and female were available in most facilities across all waves. Functional lighting remained the most persistent gap, available in only 8 facilities (27%) at endline despite slight improvement from 5 (16%) at baseline ([Table 11](#)).

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

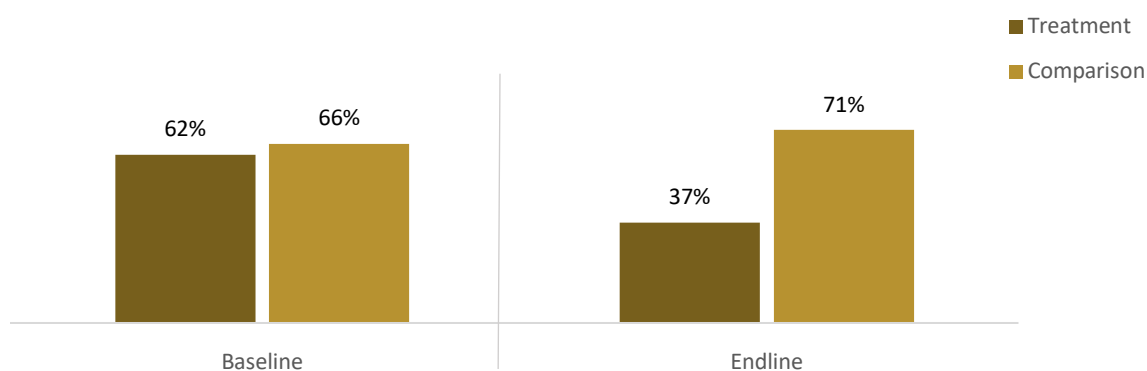
	Baseline n = 32	Midterm n = 28	Endline n = 30
<i>Toilets are clean on</i>			
Ceiling	24 (75%)	25 (89%)	23 (77%)
Floor	21 (66%)	20 (71%)	21 (70%)
Walls	25 (78%)	19 (68%)	22 (73%)
Toilet bowl	21 (66%)	16 (57%)	26 (87%)
<i>Toilets have</i>			
Functional locks	25 (78%)	20 (71%)	28 (93%)
Functional lights	5 (16%)	6 (21%)	8 (27%)
Separate toilets for male and female	27 (84%)	26 (93%)	29 (97%)

Overall, the findings suggest partial improvement in facility readiness, particularly in privacy, confidential records, and toilet functionality. However, the low number of facilities meeting all criteria, the decline in age-inclusive service provision, and the reduction in trained staff indicate that quality, gender-responsive, adolescent-friendly service delivery remains uneven and incomplete.

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

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

At baseline, satisfaction rates were relatively high and comparable between arms, with 62% (95% CI [54%, 69%]; M: 51%, F: 73%) of treatment group respondents and 66% (95% CI [58%, 72%]; M: 63%, F: 68%) of comparison group respondents reporting being (very) satisfied with the services received. By endline, satisfaction declined substantially in the treatment group to 37% (95% CI [28%, 47%], M: 36%, F: 38%), while the comparison group remained relatively stable at 71% (95% CI [59%, 81%]; M: 79%, F: 67%; see [Figure 11](#)). It is worth noting that at midterm, satisfaction rates had declined in both groups (treatment: 41%; M: 48%, F: 35%; comparison: 44%; M: 39%, F: 50%). By endline, the comparison group appears to have recovered to baseline levels, while the treatment group continued to decline, though direct comparability is limited due to the different study designs and sample compositions across waves. The difference between groups at endline was statistically significant (Adjusted $F(1, 83) = 18.81, p < .001$).



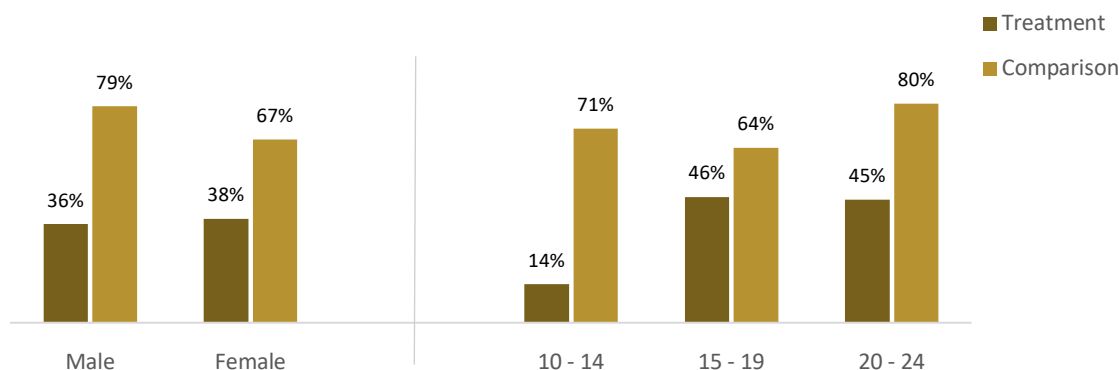
Base: Adolescents/youth who used SRHR services in the past 12 months (Baseline treatment n=220, comparison n=241; Endline treatment n=272, comparison n=120)

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

The DiD analysis, controlling for observed sociodemographic differences between groups, yielded a significant difference between groups over time in the opposite direction to what would be expected ($B = 1.13, SE = 0.40, 95\% \text{ CI } [0.33, 1.93], p = .006$), reflecting the substantial decline in satisfaction in the treatment group while the comparison group maintained satisfaction levels over time. The direction of change for this outcome was unexpected. The decline in the treatment arm could be because respondents may be more critical as they now know what they should expect from gender responsive and adolescent friendly service provision. However, while this is a possible explanation, there were similar interventions in the comparison sites where the indicator remained generally stable over time. Another plausible explanation could relate to the comparison sites, where the sustained satisfaction levels at endline might be linked to existing initiatives which were being implemented since the midline evaluation was

conducted. For example, the Ni-Yetu Youth Project, being implemented by Girl Up Initiative Uganda, leverages youth-friendly SRH camps to deliver condoms to adolescents and young people,⁵⁸ which means they do not need to engage with health providers or feel judged because of doing so, as some reported in the *SHARE* project sites. This trend might also relate to the substantial reduction in adolescents and young people who benefited from the project between April 2024 to April 2026.

Figure 12 presents service satisfaction disaggregated by gender and age group. Notably, point estimates suggest considerably lower satisfaction among 10-14-year-olds in treatment areas compared to older age groups, which may indicate that younger adolescents face particular barriers related to service experience, confidentiality, or age-appropriate care. However, small subgroup sizes and overlapping confidence intervals (not presented here) prevent drawing definitive conclusions, and these patterns should be interpreted with caution.



Base: Adolescents/youth who used SRHR services in the past 12 months (Treatment male n=118, female n=154, age 10-14 n=74, age 15-19 n=145, age 20-24 n=53; Comparison male n=38, female n=82, age 10-14 n=21, age 15-19 n=55, age 20-24 n=44)

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

When asked about factors contributing to their satisfaction, quick service delivery emerged as the most cited positive aspect in treatment areas (57% vs 40% in comparison areas), while staff friendliness was more frequently mentioned in comparison areas (56% vs 34% in treatment areas). Ease of access was similarly appreciated across both groups (T: 44%, C: 47%). Reasonable costs and availability of same-sex staff were cited more often in comparison areas (27% and 33% respectively) than in treatment areas (13% and 11%).

Among (very) dissatisfied respondents, cost concerns were cited by 39% of treatment and 32% of comparison respondents, and difficulty reaching facilities by 33% of treatment and 42% of comparison respondents. Lengthy waiting times were cited more often in comparison areas (42%) than in treatment areas (20%). Given the very small number of dissatisfied comparison group respondents ($n_c = 19$), these figures should be interpreted with caution.

⁵⁸ Girl Up Initiative Uganda (2026). Ni-Yetu Youth Project. Available at: <https://www.girlupuganda.org/ni-yetu-youth-project/>

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. Endline results disaggregated by treatment district are provided in Annex E.

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

	Baseline n = 32	Midterm n = 28	Endline n = 30
<i>Development of waste management sustainability mechanisms</i>			
A dedicated trained team is appointed for waste management	-	26 (93%)	26 (87%)
An up-to-date waste management plan is in place ^a	-	22 (79%)	22 (73%)
<i>Implementation of waste management sustainability mechanisms</i>			
At least two of the following waste management practices are implemented:	-	27 (96%)	29 (97%)
- Waste (all types) is being segregated according to type of waste in the appropriate waste bins	-	28 (100%)	28 (93%)
- Incinerator or alternative waste disposal mechanism is being properly utilized and maintained	-	20 (71%)	25 (83%)
- Waste management plan is being monitored and updated by the trained team ^b	-	13 (46%) / 16 (57%)	13 (43%) / 17 (57%)
- PPE and cleaning supplies are being properly utilized by all staff	-	27 (96%)	28 (93%)
All criteria met	-	21 (75%)	19 (63%)

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').

The first criterion required facilities to have a dedicated trained team appointed for waste management. This requirement was met by most facilities (26 out of 30, or 87%) at endline. The second criterion – an up-to-date waste management plan – was demonstrated by 22 facilities (73%).

The third criterion evaluated implementation of waste management practices, requiring facilities to demonstrate at least two out of four specific practices. Nearly all facilities (29, 97%) met this criterion at endline, although performance on individual practices varied. Waste segregation was broadly in place, with 28 facilities (93%) at endline segregating all types of waste and an additional two facilities reporting

segregating some but not all waste types. Encouragingly, waste segregation was consistently maintained through storage, transport, and final treatment/disposal in 25 cases, with four facilities partially maintaining and one not maintaining segregation after collection.

Proper utilization and maintenance of incinerators or alternative waste disposal mechanisms improved notably from 20 facilities (71%) at midterm to 25 (83%) at endline.

Personal Protective Equipment (PPE) and cleaning supply utilization remained broadly stable, with 27 facilities (96%) at midterm and 28 (93%) at endline demonstrating proper utilization of PPE and cleaning supplies by all staff. The broader PPE availability picture at endline is also largely positive: 28 out of 30 facilities reported PPE is always consistently available in sufficient quantities, while two reported generally adequate availability with occasional minor shortages. In terms of replenishment, 21 facilities reported proactive restocking and two replaced supplies soon after being used. Regarding the physical availability of PPE and cleaning supplies at waste handling areas, nearly all facilities (29) had both PPE and cleaning supplies in all waste handling areas, one had only PPE in all areas.

Monitoring and updating of waste management plans by trained teams remained the weakest area across both waves, with only 13 facilities (43%) showing observed evidence of this practice, or 17 (57%) when including self-reported compliance.

Overall, 19 of the 30 facilities (63%) met all three criteria at endline, a small decline compared to midterm (21 out of 28, 75%). While most facilities have established solid waste management infrastructure and practices, the persistent gap in active monitoring and updating of waste management plans remains an area for improvement.

From the interviews, health facility staff, consortium members, and district health official also highlighted facility improvements and WASH infrastructure such as drinking water, toilets, showers, maternity wards, and handwashing facilities. These improvements were deemed to have made facilities more usable and supportive for adolescents and youths, particularly AGYW. Several interviewees viewed that the action plan as practical tools that enabled facilities to identify gaps, prioritise improvements, mobilise resources, and monitor progress over time. According to the health facility staff and consortium members WASH and IPC action planning encouraged facilities to assess their own conditions and prioritise improvements based on identified gaps. WaterAid respondent explained that health facilities first underwent WASH assessments, after which improvement plans were developed to help facilities monitor weaknesses and identify practical solutions, saying:

“The improvement plans they developed are a tool they use to assess themselves and identify gaps.” (Project Officer, WaterAid, KII)

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

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

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

At endline, a few policies have been refined or implemented by local authorities to promote ASRHR as a direct result of advocacy initiatives led by CBOs and young people involved in the *SHARE* project. However, advocacy-driven policy changes involved strengthening the implementation of existing national frameworks rather than developing entirely new policies. One example of a local policy, because of CBO advocacy initiative, was a district by-law to curb child involvement in night fishing and night markets, which were associated with adolescent exploitation, school dropout, and gender-based violence. A FAWE Uganda representative explained that FAWE worked with CBOs, particularly Mama Africa, and district authorities to advocate for stronger child protection measures. sensitive discussions:

“We were able to come up with the by-law on issues of curbing child involvement in night markets and child fishing. The by-law was passed and disseminated.” (FAWE – Buyende, KII)

In addition, *Right To Play* and Ministry of Education respondents provided some evidence of advocacy related to school-based sexuality education. Government respondents described how training materials covering puberty, reproductive health, healthy relationships, HIV/STIs, child marriage, and GBV were developed and integrated into school mentorship and co-curricular activities.

Government respondents also highlighted how consortium partners helped operationalise national parenting frameworks as part of adolescent wellbeing and SRHR programming. A Ministry of Gender respondent explained that the Consortium partners worked with government to implement the National Parenting Guidelines, National Standards for Parenting, and National Parenting Training Manual through district systems in Adjumani and Buyende. These frameworks aimed to strengthen communication between parents and adolescents on sexuality, adolescent pregnancy, HIV, and school retention.

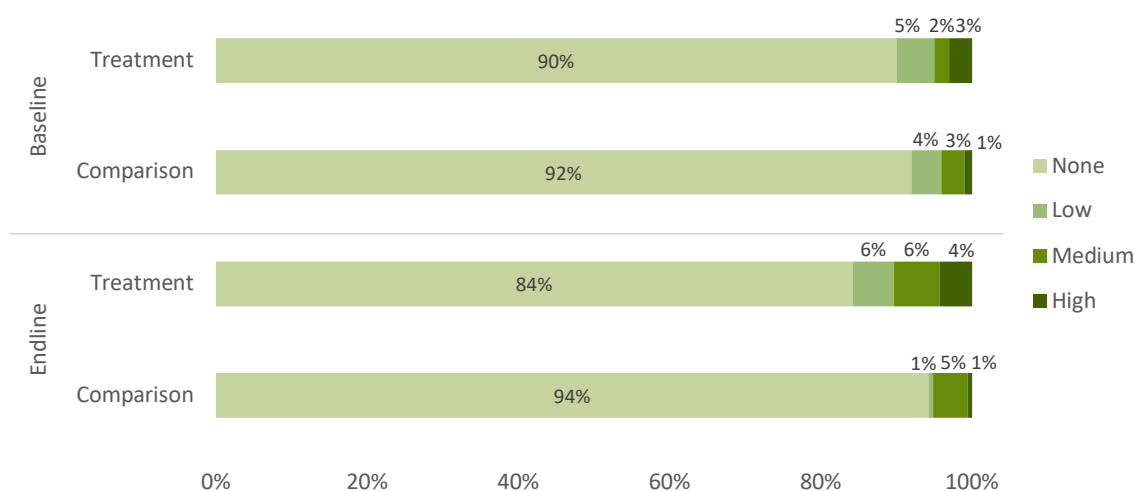
Further progress was evident in Adjumani, where the Madi cultural institution drafted a bill aimed at standardizing marriage practices in the district. This bill seeks to prohibit marriage before the age of 18 and to establish minimum standards for bride price payments in the Madi subregion (KII Consortium Member – FAWE).

However, there were no examples of young people's advocacy initiative that were identified.

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

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

Endline data indicate a modest increase in SRHR advocacy participation in treatment areas, with the distribution of engagement levels shifting slightly toward higher participation categories, while participation in comparison areas remained broadly stable ([Figure 13](#)). Specifically, the proportion of girls and young women participating in SRHR-related advocacy activities increased from 10% to 16% in treatment areas, while remaining stable around 6%-8% in comparison areas. Among those who participated ($n_T=74$; $n_C=27$), the proportion receiving feedback from adult stakeholders on their influence increased in both groups — from 43% to 65% in treatment areas and from 47% to 89% in comparison areas; however, these estimates should be treated with considerable caution given the very small sample sizes and wide confidence intervals. Girls' reported membership in ASRHR committees or associations remained broadly stable in treatment areas (5% to 6%) and declined slightly in comparison areas (3% to 1%), though overlapping confidence intervals preclude firm conclusions on both items ([Table 13](#)).



Base: Adolescent girls/young women (Baseline treatment and comparison (balanced) $n=379$, Endline treatment and comparison (balanced) $n=470$)

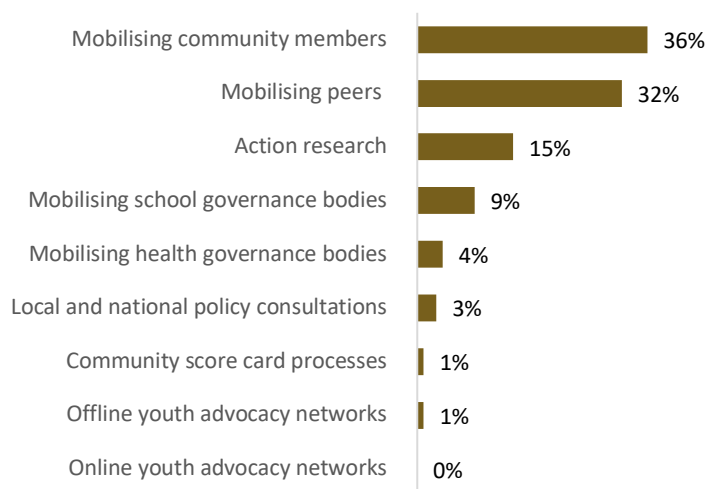
Figure 13: Level of participation of adolescent girls/young women in SRHR advocacy and social action activities (%)

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

	Baseline		Endline	
	Treatment (<i>n</i> = 379 ^a / 32 ^b)	Comparison (<i>n</i> = 379 ^a / 31 ^b)	Treatment (<i>n</i> = 470 ^a / 74 ^b)	Comparison (<i>n</i> = 470 ^a / 27 ^b)
Participated in SRHR related advocacy activities ^a	10 [6, 15]	8 [5, 11]	16 [12, 21]	6 [2, 14]*
Belong to committee or association that works on ASRHR ^a	5 [3, 8]	3 [2, 5]	6 [3, 11]	1 [1, 3]
Received feedback from adult stakeholders on their influence on outcomes ^b	43 [30, 57]	47 [28, 67]	65 [52, 76]	89 [62, 98]**

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

The difference in overall participation level between groups was significant at endline (Adjusted $F(1.87, 154.90) = 5.71, p = .007$). Despite the 8-percentage point difference-in-difference, the DiD analysis of the dichotomized participation indicator⁵⁹ did not yield a significant effect ($B = -0.87, SE = 0.61, 95\% CI [-2.09, 0.34], p = .156$). Among treatment area participants, mobilising community members (36%) and mobilising peers (32%) were the most common forms of engagement, followed by action research (15%). Comparison group results are not reported here due to the very small number of participants, which precludes meaningful interpretation of percentages (Figure 14).

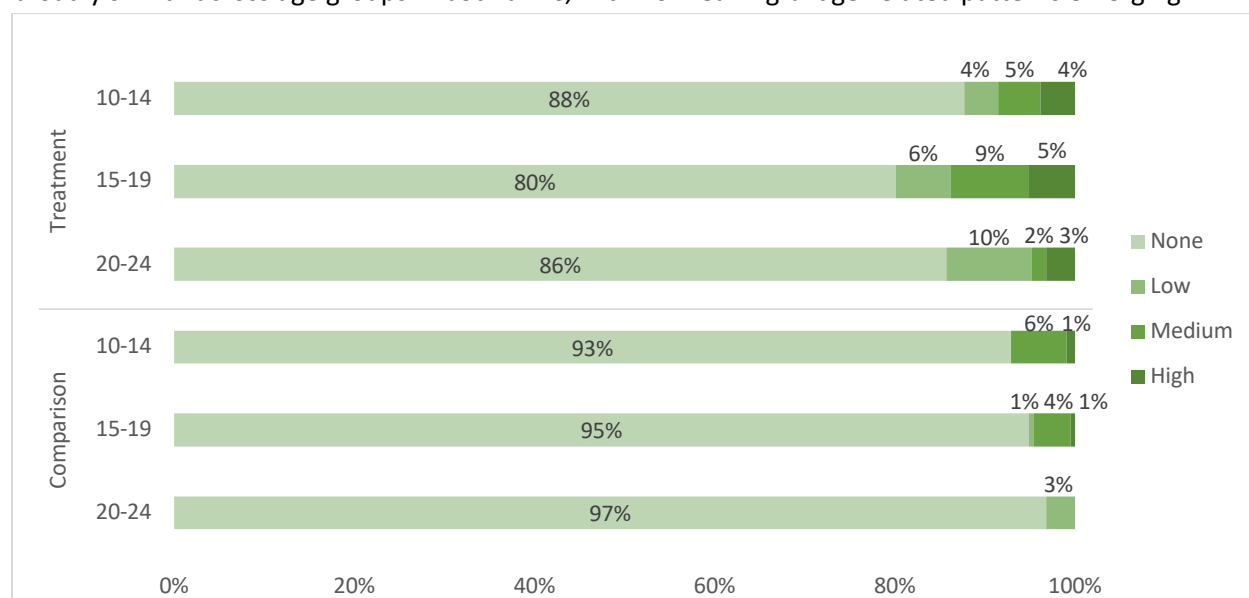


Base: Adolescent girls/young women who engaged in SRHR related advocacy activities (Treatment $n=74$)

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

⁵⁹ Based on dichotomous 0 = no participation vs 1 = any participation to improve model convergence.

The vast majority of girls in both treatment (84%; 95% CI [79%, 88%]) and comparison (94%; 95% CI [86%, 98%]) areas 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 in both groups, cited by 41% of non-participants in treatment areas and 35% in comparison areas. Parental permission emerged as a more significant barrier in comparison areas (13%) compared to treatment areas (4%), while shyness affected girls/young women in treatment areas (13%) more than in comparison areas (3%). In treatment areas, 8% of non-participants indicated that activities were perceived as being for older adolescents, compared to only 1% in comparison areas, suggesting that younger girls in treatment areas may have felt excluded from available advocacy opportunities. [Figure 15](#) presents participation levels of adolescent girls and young women at endline, broken down by age group. Participation levels were broadly similar across age groups in both arms, with no meaningful age-related patterns emerging.



Base: Adolescent girls/young women (Treatment age 10-14 n=211, age 15-19 n=196, age 20-24 n=63; Comparison age 10-14 n=211, age 15-19 n=196, age 20-24 n=63)

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

From the qualitative study, while several community stakeholders and adolescent focal persons submitted that adolescents and youth appear to be increasingly supporting peers and speaking up about SRHR issues, their voices were more audible within facilitated programme spaces than through broader community-led advocacy or adolescent-led social action.

“They are free to express their views to parents, stakeholders... they know their rights, they speak about them and even advise their peers, but maybe less so through social action.” (Community stakeholder, Adjumani, IDI)

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> = 850)	Comparison (<i>n</i> = 850)
Overall mean	2.81 [2.78, 2.83]	2.84 [2.82, 2.86]*	2.61 [2.52, 2.70]	2.83 [2.80, 2.87]***
<i>Gender</i>				
Male	2.79 [2.75, 2.83]	2.85 [2.83, 2.88]	2.61 [2.52, 2.71]	2.83 [2.79, 2.87]
Female	2.83 [2.80, 2.85]	2.83 [2.79, 2.86]	2.61 [2.52, 2.70]	2.84 [2.80, 2.88]
<i>Age</i>				
10-14	2.78 [2.72, 2.84]	2.82 [2.79, 2.85]	2.63 [2.55, 2.71]	2.83 [2.80, 2.87]
15-19	2.82 [2.80, 2.85]	2.85 [2.83, 2.87]	2.62 [2.53, 2.71]	2.83 [2.79, 2.87]
20-24	2.80 [2.75, 2.84]	2.83 [2.77, 2.89]	2.53 [2.41, 2.65]	2.83 [2.77, 2.90]

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 2.81 (95% CI [2.78, 2.83]) in the treatment group and 2.84 (95% CI [2.82, 2.86]) in the comparison group, with the difference between arms reaching statistical significance (Wald $F(1,86) = 4.00$, $p = .049$). By endline, mean resilience scores declined in the treatment group to 2.61 (95% CI [2.52, 2.70]), while the comparison group remained stable at 2.83 (95% CI [2.80, 2.87]). The difference between groups at endline was statistically significant (Wald $F(1, 83) = 21.86$, $p < .001$). It is worth noting that at midterm, resilience scores had declined in both groups. By endline, the comparison group appears to have recovered to near-baseline levels while the treatment group did not, though given the different study designs and sample compositions across waves, this pattern should be interpreted with caution. The DiD analysis, controlling for observed sociodemographic differences between groups, showed a significant difference between groups over time in the opposite direction to what would be expected ($B = 0.19$, $SE = 0.05$, 95% CI [0.09, 0.29], $p < .001$), indicating that resilience scores declined significantly more in the treatment group than in the comparison group over time. The decline in the treatment group may reflect broader contextual factors specific to treatment communities rather than a direct project effect. The analysis revealed consistent patterns across demographic subgroups, with no notable differences in resilience scores between male and female respondents or across different age categories ([Table 14](#)).

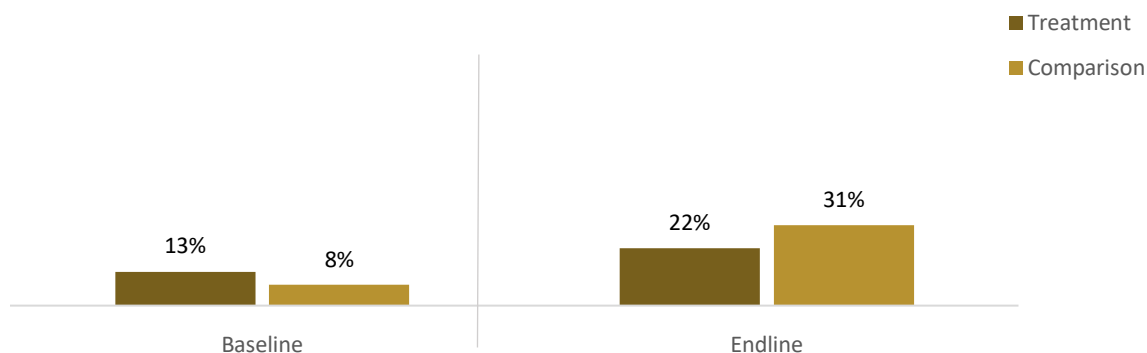
3.3.4 Immediate Outcome 1110: Improved knowledge of SRHR

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

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

The Adolescent/Youth survey assessed SRHR knowledge through a set of 10 questions covering both sexual health knowledge and support for sexual rights. To be counted toward this indicator, respondents had to demonstrate both accurate knowledge of key SRH topics (e.g., conception, contraception, and STIs), and express strong support for fundamental sexual rights. Specifically, respondents scoring 80% or higher (i.e., at least 8 out of 10 criteria) were considered knowledgeable about SRHR.⁶⁰

At baseline, treatment and comparison groups showed broadly similar levels of comprehensive SRHR knowledge, though the treatment group had a somewhat higher point estimate with 13% (95% CI [9%, 18%]; M: 11%, F: 15%) of respondents meeting the 80% threshold compared to 8% (95% CI [6%, 11%]; M: 11%, F: 5%) of comparison group respondents. The groups averaged 5.0 and 4.9 correct responses at baseline respectively. By endline, both groups demonstrated increases in SRHR knowledge, with the comparison group showing a more substantial improvement – rising from 8% to 31% (95% CI [26%, 37%]; M: 32%, F: 31%) – compared to the treatment group, which increased from 13% to 22% (95% CI [16%, 31%]; M: 21%, F: 24%). The difference between groups at endline was not statistically significant (Wald $F(1, 83) = 3.13, p = .081$). The mean number of correct responses at endline was 5.5 in the treatment group and 5.8 in the comparison group (Figure 16).



Base: All adolescents (Baseline treatment n=740, comparison n=740; Endline treatment n=850, comparison n=850)

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

⁶⁰ 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 significant difference between groups over time in the opposite direction to what would be expected ($B = 1.13$, $SE = 0.37$, 95% CI [0.39, 1.88], $p = .003$), indicating that the comparison group improved significantly more than the treatment group over time. This pattern may reflect the influence of external projects in the comparison sites or broader societal factors in comparison areas rather than a project-specific effect.

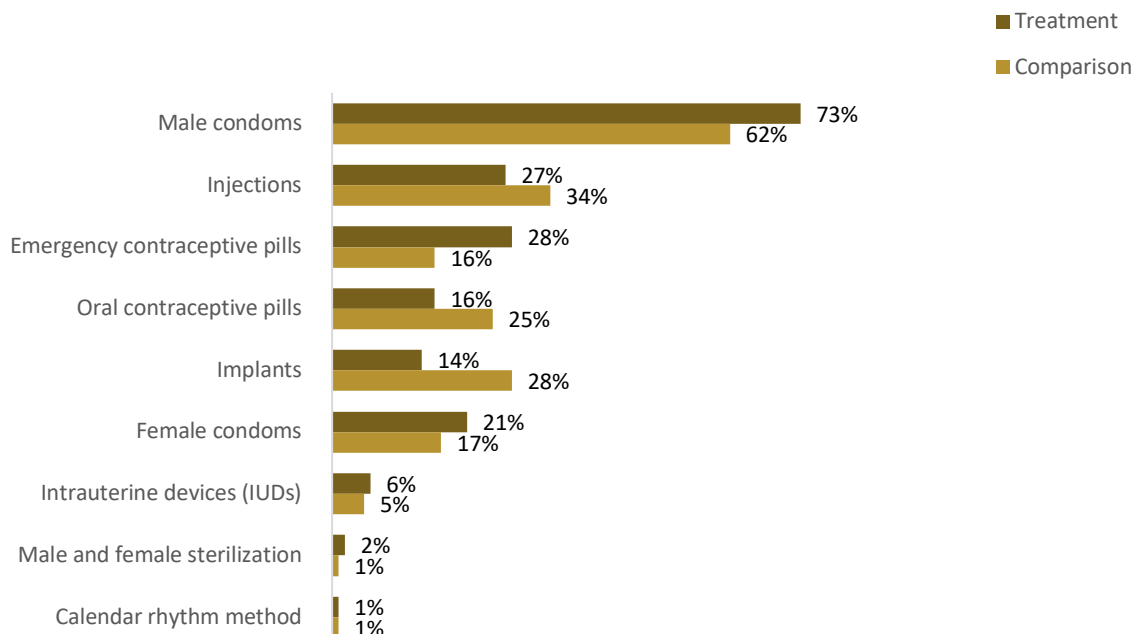
Further inspection of the individual items reveals a mixed picture of change across topics (Table 15). Knowledge of contraception improved substantially in both arms, with awareness of at least one modern contraceptive method increasing from 57% to 82% in the treatment group and from 64% to 76% in the comparison group. Similarly, awareness of ways to avoid pregnancy and of one or more STIs increased by at least 10 percentage points in both arms, whereas awareness of STI transmission methods and ways to avoid STIs remained broadly stable across groups. Knowledge of the female menstrual cycle and conception remained consistently low across both groups and both waves. In the comparison group, support for sexual rights increased across three out of four items. In the treatment group, only strong agreement that sexual rights apply to all young people showed a credible increase based on non-overlapping confidence intervals, while changes in the other items were less clear. Notably, strong disagreement that HIV transmission is linked to immoral behaviour declined in both arms, from around 40% at baseline to around 22-27% at endline, suggesting a potential increase in stigmatising attitudes toward people living with HIV.

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

	Baseline		Endline	
	Treatment (<i>n</i> = 740)	Comparison (<i>n</i> = 740)	Treatment (<i>n</i> = 850)	Comparison (<i>n</i> = 850)
Aware of female menstrual cycle and conception	3 [2, 5]	5 [3, 7]	8 [5, 13]	8 [5, 11]
Aware of at least one modern contraceptive method	57 [51, 63]	64 [59, 68]	82 [77, 87]	76 [71, 80]
Aware of ways to avoid pregnancy	75 [70, 80]	74 [68, 78]	89 [84, 93]	88 [84, 90]
Aware of one or more STIs	85 [81, 88]	82 [78, 86]	95 [92, 97]	93 [89, 95]
Aware of one or more transmission methods of STIs	76 [71, 81]	74 [68, 79]	71 [63, 77]	70 [65, 75]
Aware of one or more ways to avoid STIs	75 [69, 80]	73 [68, 77]	72 [65, 79]	72 [67, 77]
Strongly agree that sexual rights apply to all young people	28 [22, 34]	18 [14, 21]**	39 [32, 48]	57 [49, 64]**
Strongly agree that all forms of non-consensual sexual activity are forms of violence	30 [24, 37]	27 [22, 33]	38 [30, 48]	50 [42, 58]
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	30 [25, 35]	34 [29, 39]	28 [21, 36]	45 [38, 52]**
Strongly disagree that HIV transmission is linked to "immoral" behaviors so anyone living with HIV is immoral	42 [38, 47]	39 [34, 44]	22 [17, 29]	27 [21, 33]
Answered correctly to at least 80% of questions (%)	13 [9, 18]	8 [6, 11]*	22 [16, 31]	31 [26, 37]
Mean number of correct questions	5.0 [4.7, 5.3]	4.9 [4.6, 5.2]	5.5 [5.1, 5.9]	5.8 [5.6, 6.1]

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: 73%, C: 62%), followed by injectable contraceptives (T: 27%, C: 34%), emergency contraceptive pills (T: 28%, C: 16%), and oral contraceptive pills (T: 16%, C: 25%).



Base: All adolescents (Endline treatment n=850, comparison n=850)

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

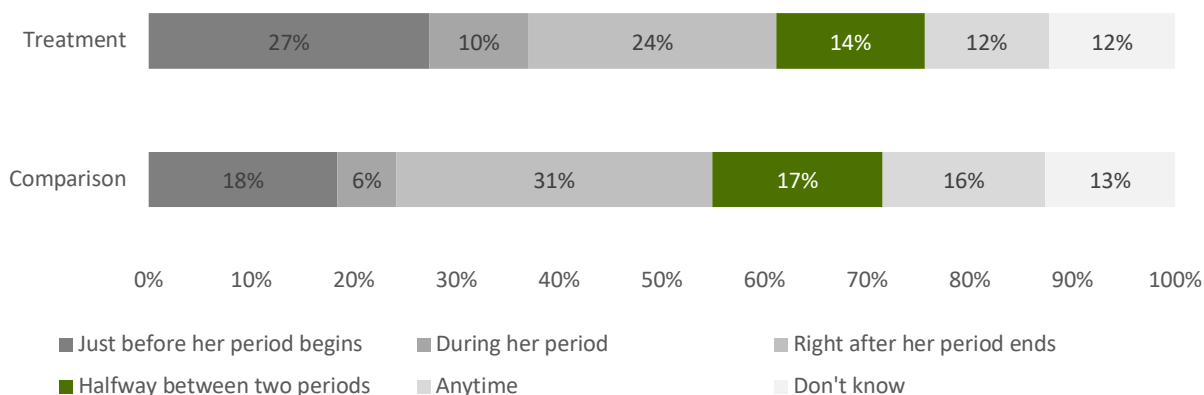
Our finding at endline is similar to those in published literature from Uganda. In research conducted in Western Uganda, the majority of adolescents are aware that contraceptives exist, with male condoms and injectables being the most widely recognized methods. However, deeper knowledge—such as understanding fertility cycles, emergency contraception, and long-acting reversible contraceptives (LARCs) like implants—remains low.⁶¹ As in this endline evaluation, in which male condoms were more widely known compared to female condoms, similar pattern was reported in the midterm evaluation.⁶² A study conducted amongst university students in Kampala reported that while knowledge of male condoms was 88% only 22% knew about female condoms.⁶³ This does suggest that there has been no change in knowledge patterns over time.

⁶¹ Namanda C, Nakafeero M, Biribawa C, Tumwesigye NM, Muhumuza J, Tumwine M, Luwaga C, Dowling R, Otai M. Knowledge and attitudes on sexual and reproductive health among adolescents and youths in Refugee Settlements: A case of Palorinya, Uganda. *Afr Health Sci.* 2025;25(4):93-103. doi: 10.4314/ahs.v25i4.11.

⁶² The Sexual Health and Reproductive Education (SHARE) Mid Term Evaluation Report Uganda

⁶³ Nsubuga, H., Sekandi, J.N., Sempeera, H. et al. Contraceptive use, knowledge, attitude, perceptions and sexual behavior among female University students in Uganda: a cross-sectional survey. *BMC Women's Health* 16, 6 (2015). Doi: 10.1186/s12905-016-0286-6

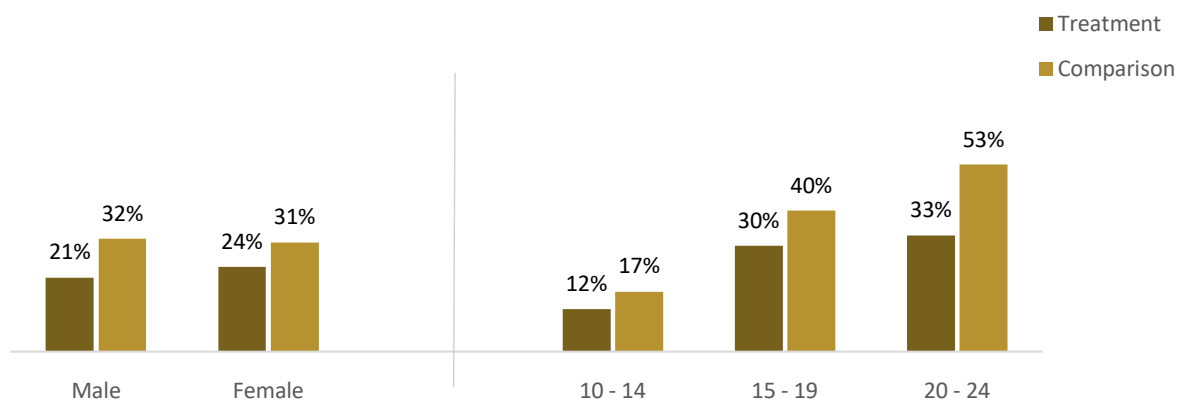
Compared to baseline (T: 5%, C: 7%), more respondents in both groups could correctly identify the period during the menstrual cycle that a woman more likely to become pregnant ([Figure 18](#)).



Base: Adolescents who mentioned there are certain days when women are more likely to become pregnant if they have sexual intercourse (Treatment n=494; Comparison n=386)

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. As expected, SRHR knowledge tended to be higher among older adolescents and young adults compared to younger adolescents ([Figure 19](#)).



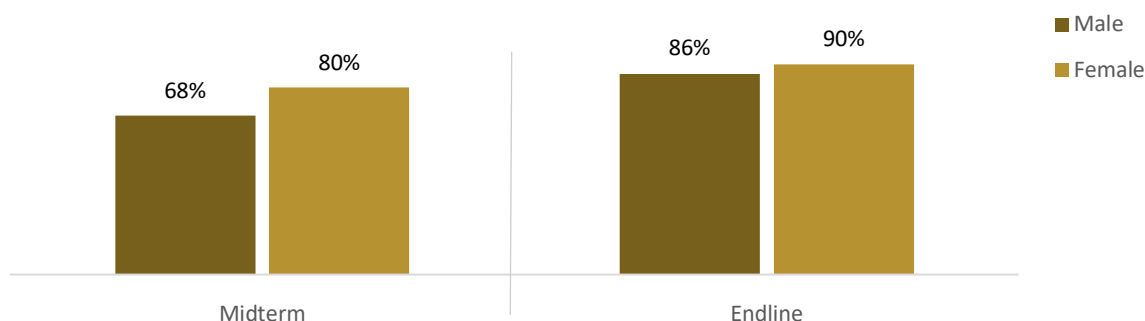
Base: All adolescents (Treatment and comparison (balanced) male n=380, female n=470, age 10-14 n=375, age 15-19 n=366, age 20-24 n=109)

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

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

The quality of SRH information that adolescents receive through their schools depends on their teachers' familiarity with the subject matter. Evidence shows that school-based sexuality education makes teachers important gatekeepers of students' access to information about SRHR. The school setting has the potential to reach large numbers of students.⁶⁴ To assess the capacity of teachers in the intervention sites to deliver sexuality education, we surveyed teachers in the *SHARE* project (treatment) areas to measure their understanding of the health benefits of sexuality education for adolescents and awareness of guidelines and policies governing sexuality education delivery in (their) schools. As the baseline sample size was insufficient to make reliable comparisons over time, results are presented for midterm and endline only.

At midterm, nearly three-quarters of the interviewed teachers (73%; 95% CI [68%, 77%]) accurately identified at least three health benefits of sexuality education. Point estimates suggest female teachers had higher knowledge levels (80%; 95% CI [73%, 87%]) compared to their male counterparts (68%; 95% CI [61%, 74%], $\chi^2(1) = 6.71, p = .010$).⁶⁵ It is important to note that the midterm Teacher Survey in Uganda was administered in paper format, which resulted in substantial missing data. This presents an interpretative challenge, as we cannot determine whether blank responses indicate a genuine lack of knowledge or other factors related to the paper-based administration. At endline, an interviewer-led approach was used, yielding more reliable results. Under this methodology, 88% (95% CI [84%, 91%]) of teachers could accurately cite at least three health benefits of sexuality education, with no clear gender differences (males: 86%; females: 90%; [Figure 20](#)). The most frequently cited benefits by teachers in Uganda were reduction in school dropout, prevention of unwanted pregnancies, and prevention of STIs and HIV ([Figure 21](#)).

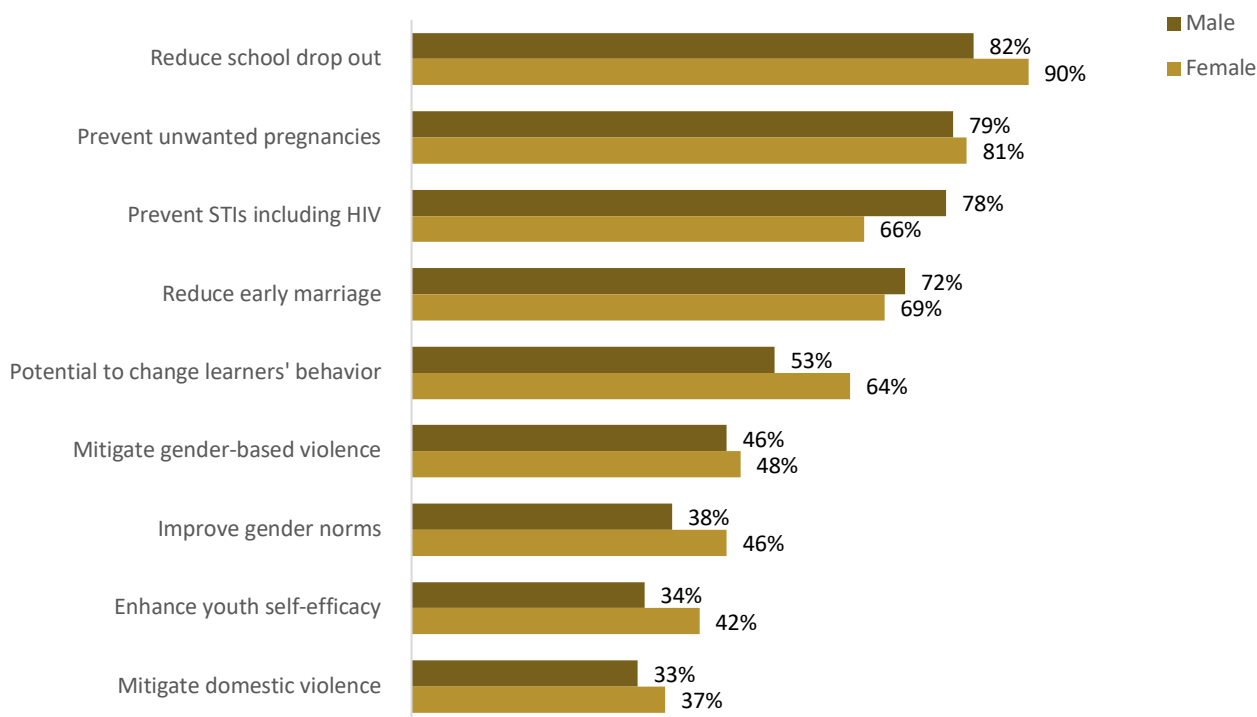


Base: All teachers (Midterm n=361; Endline n=416)

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

⁶⁴ Picot J, Shepherd J, Kavanagh J, Cooper K, Harden A, Barnett-Page E, et al. Behavioural interventions for the prevention of sexually transmitted infections in young people aged 13–19 years: a systematic review. *Health Education Research*. 2012;27(3):495-512.

⁶⁵ Because teachers' community was not captured in this survey, the analysis could not take into account the clustered nature of the data.



Base: All teachers (Endline male n=225, female n=191)

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

Awareness of Uganda's national sexuality education guidelines at endline was 74% (95% CI [69%, 79%]). Moreover, 85% (95% CI [82%, 88%]) of surveyed teachers demonstrated awareness of relevant policies in their own schools. These figures are notably higher than midterm levels (46% and 61%), though this comparison should be interpreted cautiously – at endline, only teachers responsible for delivering sexuality 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 sexuality education, rather than solely representing an improvement over time. There were no gender differences in awareness of guidelines and policies.

Of the teachers surveyed at endline, 94% had received training on sexuality education, with the majority trained within the past two years (56% in the past year, 34% one to two years ago). Most teachers were trained directly by *SHARE* or its partners, *Right To Play*, *FAWE*, and *WaterAid* (87%), with 12% trained indirectly through a Community of Practice or Professional Learning Community. Training was generally well-received, with 72% of respondents rating it as good and 15% as excellent.

Teachers reported substantial self-perceived improvements across all dimensions following training. Almost all reported their knowledge of sexuality education had improved (80% much better, 18% a bit better), with 83% attributing this improvement largely to the *SHARE* training. Attitudes toward sexuality education also shifted markedly, with 61% of respondents reporting much more positive attitudes and 37% somewhat more positive, with 88% attributing this change largely to the *SHARE* project. Similarly, comfort with teaching sexuality education improved substantially, with 73% reporting feeling much more comfortable and 25% somewhat more comfortable, and 86% attributing this predominantly to *SHARE* training. Finally, 73% of teachers rated their school environment as very supportive in delivering sexuality education to students, and 25% as somewhat supportive.

As part of interviews with teachers in Adjumani and Buyende, they reported that due to their participation in the *SHARE* project, their understanding of SRHR has improved. This training empowered teachers to provide guidance and counseling on topics like menstrual hygiene, body changes during adolescence, and rights awareness, effectively filling gaps in SRHR education. As a result, they were able to share SRHR and gender equality related issues with the parents and students. One teacher in Buyende said,

“We also train them on growth and development, like the body changes during adolescence, and even personal hygiene, including menstrual hygiene. We demonstrate how pads can be used and managed. These are all important lessons for adolescents, especially the ones growing in these times – they need it! ...and we can teach them.” (Teacher, Buyende, KII)

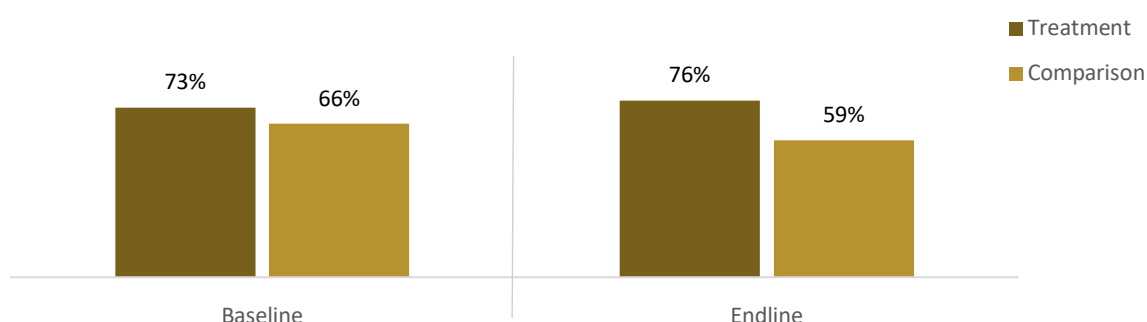
From the survey, when asked about challenges in delivering sexuality education, teachers most commonly identified lack of teaching and learning materials (79%), community opposition (58%), and lack of skilled teachers (56%). These findings are consistent with the open-ended feedback provided by teachers, which was dominated by requests for more training and teaching and learning materials, and greater community sensitization on sexuality education.

The continued challenges observed in this evaluation regarding provision of sexuality education in schools have been similarly reported across Uganda. In a 2024 study conducted in six secondary schools in Kampala, though sexuality education was viewed as important and necessary in the lives of adolescents, findings showed that teachers still expressed some unease in teaching sexuality education. Findings presented discomfort amongst teachers whereby majority confessed that they are not comfortable talking about sexual related issues (which they referred to as embarrassing) with their students. It was common in all six schools included in the study that most teachers had not taught about contraception topics and those who did found it difficult answering students’ questions.⁶⁶

⁶⁶ Atuhaire, J; Nyakato, V. N & Murembe, C. N. (2023). Teaching Sexuality Education in Secondary Schools of Uganda and its Implications: A Qualitative Assessment of the Curriculum. *Journal of Popular Education in Africa*. 7(5), 31 – 47.

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

To further measure Immediate Outcome 1110, we assessed adolescents' perceived self-efficacy in accessing SRHR information and SRH services. At baseline, 73% (95% CI [68%, 78%]; M: 71%, F: 75%) of adolescents in treatment areas and 66% (95% CI [61%, 72%]; M: 65%, F: 68%) in comparison areas believed they could access these resources if needed. By endline, the treatment group remained relatively stable at 76% (95% CI [69%, 82%]; M: 76%, F: 77%), while the comparison group declined to 59% (95% CI [52%, 66%]; M: 56%, F: 61%, see [Figure 22](#)). It is worth noting that point estimates were higher at midterm (treatment: 84%; M: 85%, F: 81%; comparison: 74%; M: 72%, F: 76%), though this pattern should be interpreted with caution given differences in study design and age composition across waves. The difference between groups at endline was statistically significant (Adjusted $F(1, 83) = 13.09, p < .001$).



Base: All adolescents (Baseline treatment n=740, comparison n=740; Endline treatment n=850, comparison n=850)

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

The DiD analysis, controlling for observed sociodemographic differences between groups, did not yield a significant difference between groups over time ($B = -0.46, SE = 0.30, 95\% \text{ CI } [-1.05, 0.14], p = .129$), suggesting that the 10-percentage point difference-in-difference (reflecting stable levels in the treatment group against a decline in the comparison group) cannot be conclusively attributed to the *SHARE* project.

However, from the qualitative component of the evaluation, adolescent girls and boys, caregivers, teachers, health workers, VHTs, district stakeholders, and consortium partners, shared the perception that adolescents had become more confident in accessing SRHR information and SRH services. Many adolescents reported being more aware of available services, having better understanding where to seek support, and feeling more comfortable discussing SRH concerns and accessing services when needed. Health workers, teachers, VHTs, and consortium partners similarly reported observing that adolescents were increasingly willing to ask questions, seek information from trusted adults, and independently access SRH services. Before *SHARE*, adolescents were often described as shy, fearful, embarrassed, or uncertain about approaching health facilities and discussing sensitive SRH topics. By endline, adolescents and other stakeholders perceived more willingness to seek information and services, including family planning, HIV testing, STI-related services, and counselling. As one adolescent focal person in Buyende explained:

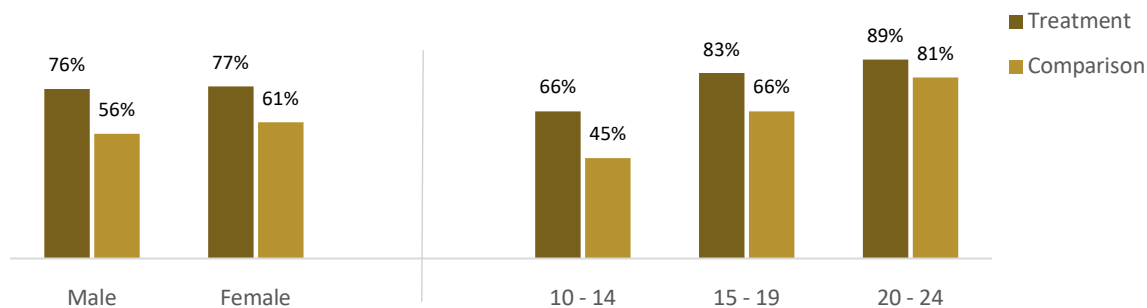
“What makes me proud is the self-seeking behavior that has been instilled in our adolescents and youths who now voluntarily come in to ask for especially family planning commodities, condoms, self-testing and check-up for STIs, attendance to ANC”. (Adolescent Focal person Kidera HCIV, Buyende, KII)

Adolescents, teachers, health workers, VHTs, district stakeholders, and consortium partners linked these changes to repeated SRHR education, mentorship, community dialogues, and health talks, which increased adolescents’ knowledge of available services and confidence in seeking support. Health workers and VHTs also highlighted the role of referral pathways, school–health facility linkages, and more respectful, confidential, and non-judgmental service delivery. As one out-of-school adolescent boy in Adjumani explained:

“Before I got this [SHARE] training, I was afraid of seeking services for my body, but after the project, I am confident to go alone to the health worker.” (Out-of-school young men, 18–24 years, M, Adjumani, FGD)

Girls most frequently described seeking support for menstruation, menstrual pain, prolonged bleeding, puberty-related concerns, and menstrual hygiene. Despite these perceived improvements, adolescents, teachers, and health workers reported ongoing barriers, including discomfort discussing sensitive topics, concerns about privacy and confidentiality, and fear of being judged or laughed at. Privacy constraints in some schools and health facilities, together with inconsistent provider attitudes, continued to discourage some adolescents from seeking support.

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



Base: All adolescents (Treatment and comparison (balanced) male n=380, female n=470, age 10-14 n=375, age 15-19 n=366, age 20-24 n=109)

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

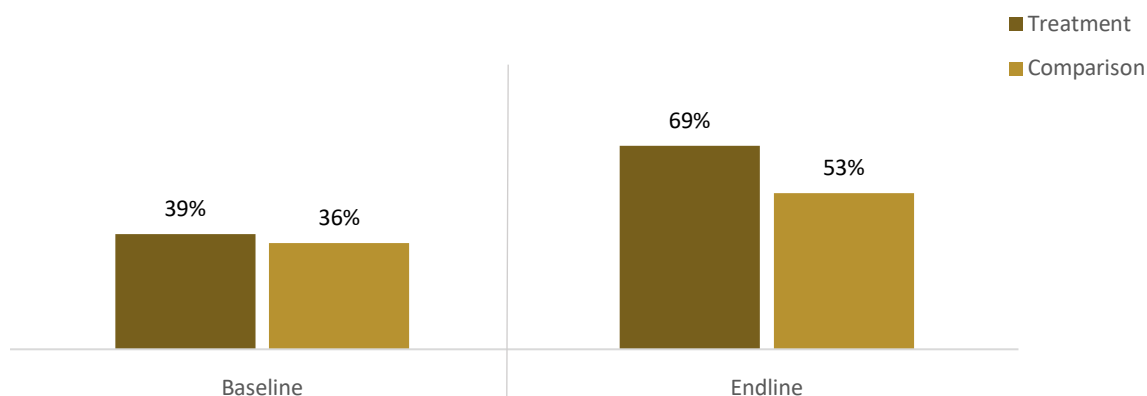
3.3.5 Immediate Outcome 1120: Improved knowledge and attitudes of accessing gender-responsive SRHR information and SRH services

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.

Endline data revealed substantial increases in support for adolescent SRHR across both areas (Figure 24). In treatment areas, the proportion of community members expressing positive attitudes increased markedly from 39% (95% CI [32%, 47%]; M: 55%, F: 28%) at baseline to 69% (95% CI [60%, 78%]; M: 75%, F: 65%) at endline. In comparison areas, a more modest increase was observed, from 36% (95% CI [29%, 43%]; M: 41%, F: 32%) at baseline to 53% (95% CI [42%, 64%]; M: 63%, F: 47%) at endline. The difference between groups at endline was statistically significant (Adjusted $F(1, 83) = 5.11, p = .026$). It is worth noting that at midterm both groups had shown similar increases in positive attitudes (T: 65%, C: 70%), suggesting that the comparison group's lower endline level may reflect a decline between midterm and endline rather than a failure to improve – though direct comparability is limited due to the different study designs.



Base: All community members (Baseline treatment n=153, comparison n=163; Endline treatment n=209, comparison n=193)

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

Despite the 13-percentage point difference-in-difference, the DiD analysis, controlling for observed sociodemographic differences between groups, did not reveal a treatment effect ($B = -0.66$, $SE = 0.43$, 95% CI [-1.51, 0.19], $p = .127$). It should be noted that the Caregiver/Community Stakeholder Survey sample was not powered for these analyses, and results should therefore be considered indicative only rather than as definitive evidence of presence or absence of a treatment effect.

The qualitative findings suggest that attitudes towards adolescent SRHR have become more supportive among parents, caregivers, community leaders, teachers, religious leaders, mentors, and health workers. Discussions about menstruation, puberty, relationships, family planning, and reproductive health are now generally more accepted and openly discussed within families and communities. Parents were described as providing more guidance on body changes, relationships, and reproductive health, while fathers were increasingly involved in supporting adolescent girls. A female caregiver in Adjumani explained:

*"During her menstruation she used to fear but these days she is free to give her view, I counsel her with advice and these days she comes to me to request."
(Caregiver of out-of-school adolescents, F, Adjumani, IDI)*

Some adolescents confirmed these changes, reporting that parents now provide explanations and advice rather than simply warning them to avoid relationships. As one in-school adolescent girl in Buyende explained:

"Before our parents never told us the exact thing. They just used to tell us to stay away from boys, but they never used to tell us what happens after engaging with the boys." (In-school adolescent girl, 15–19 years, Buyende, IDI)

Community leaders, mentors, teachers, and health workers were also seen as important sources of support. Respondents reported growing acceptance of family planning, girls' education, and gender equality, with community leaders increasingly encouraging girls to stay in school and delay marriage and pregnancy. These changes were linked to parenting sessions, mentorship activities, school programmes, and community dialogues that improved knowledge and communication about SRHR.

Despite these improvements, some barriers remain. Traditional gender norms, discomfort discussing sexuality, misinformation about contraception, poverty, family instability, peer pressure, and challenges accessing adolescent-friendly services continue to limit the full adoption of supportive SRHR attitudes and practices. Nevertheless, the overall findings indicate stronger family and community support for adolescents' health, education, and wellbeing.

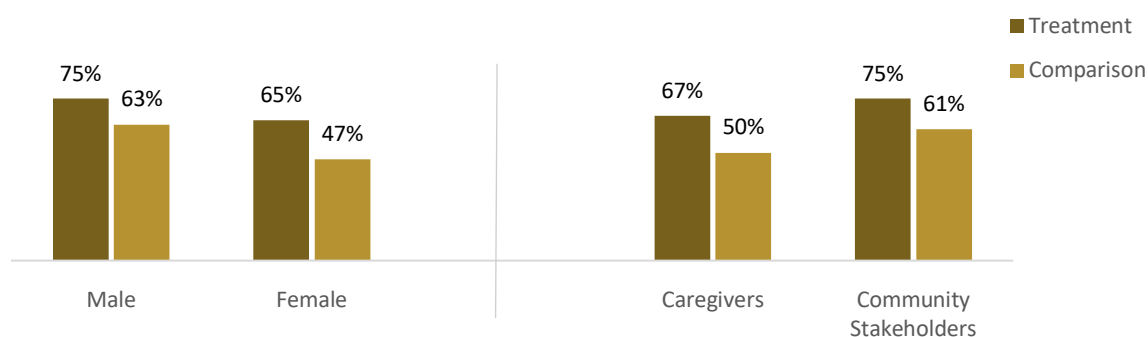
Table 16 shows the percentage of community members who agreed with the individual statements. Across all four statements about SRH service provision for young people, the treatment group demonstrated notable increases in supportive attitudes. In comparison areas, point estimates increased across most items but confidence intervals overlap between baseline and endline for all statements, precluding firm conclusions about true population-level change.

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 = 153)	Comparison (n = 163)	Treatment (n = 209)	Comparison (n = 193)
Male and female adolescents who receive sex education are less likely to engage in risky sexual activities	82 [75, 87]	77 [70, 82]	91 [86, 95]	80 [71, 87]**
There should be dedicated sexual and reproductive health services for adolescents	66 [57, 74]	60 [51, 67]	84 [76, 90]	70 [59, 79]*
Everyone should have the choice to use modern family planning methods	65 [58, 72]	75 [67, 82]	85 [77, 90]	82 [73, 88]
Both sons and daughters should participate in education programmes around sexual reproductive health at school	75 [64, 83]	81 [73, 87]	86 [79, 91]	89 [79, 95]*
Agree with all statements	39 [32, 47]	36 [29, 43]	69 [60, 77]	53 [42, 64]*

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, point estimates suggest somewhat higher positive attitudes among male community members and community stakeholders compared to female members and caregivers in both arms, though overlapping confidence intervals across all subgroups preclude meaningful conclusions (Figure 25).



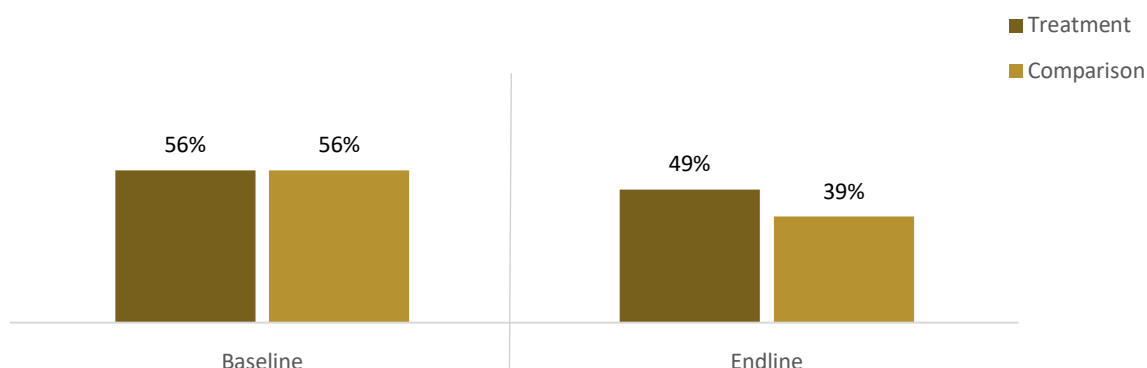
Base: All community members (Treatment male n=93, female n=116, caregiver n=152, community stakeholder n=57; Comparison male n=73, female n=120, caregiver n=146, community stakeholder n=47)

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, perceived family support was comparable between arms, with 56% (95% CI [51%, 68%]; M: 59%, F: 54%) in treatment areas and 56% (95% CI [51%, 61%]; M: 60%, F: 53%) in comparison areas. By endline, both groups declined, with the treatment group reaching 49% (95% CI [42%, 56%]; M: 48%; F: 50%) and the comparison group 39% (95% CI [32%, 47%]; M: 38%, F: 40%, see [Figure 26](#)). It is worth noting that midterm levels were higher in both groups (treatment: 68%; M: 68%, F: 67%; comparison: 59%; M: 58%, F: 59%), though this pattern should be interpreted with caution given differences in study design and age composition across waves. The difference between groups at endline did not reach statistical significance (Adjusted $F(1, 83) = 3.55, p = .063$), and the DiD analysis, controlling for observed sociodemographic differences between groups, also did not reveal a significant difference between groups over time ($B = -0.37, SE = 0.23, 95\% \text{ CI } [-0.84, 0.10] p = .118$).



Base: All adolescents (Baseline treatment $n=740$, comparison $n=740$; Endline treatment $n=850$, comparison $n=850$)

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

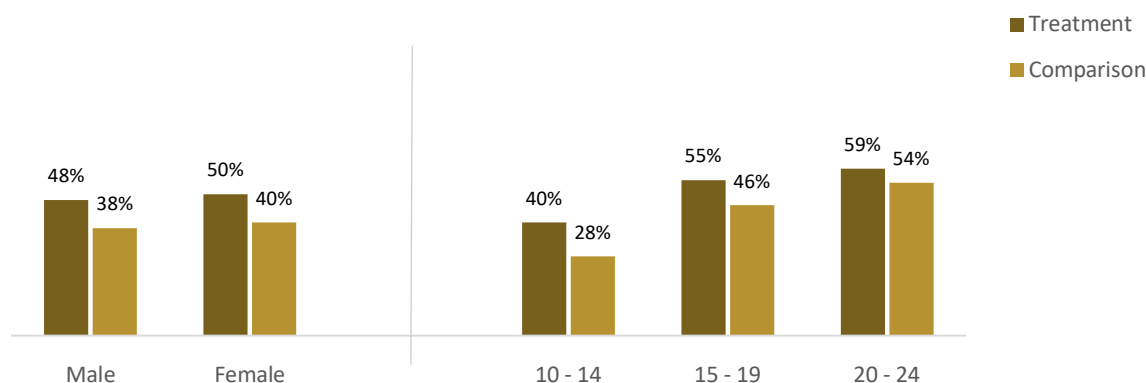
[Table 17](#) shows adolescents' perceptions of parental support across the individual support dimensions. Both arms showed declines from baseline to endline across most dimensions, with declines more pronounced in the comparison group. Differences between arms were statistically significant at endline for health facility access and financial support. Across both groups and both waves, financial support remained the dimension where adolescents reported the lowest levels of family assistance, suggesting that economic considerations continue to influence SRH access.

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

	Baseline		Endline	
	Treatment (n = 740)	Comparison (n = 740)	Treatment (n = 850)	Comparison (n = 850)
Participating in education programs around sexual reproductive health at their school	73 [68, 80]	76 [71, 80]	70 [62, 77]	58 [49, 67]
Participating or joining sexual reproductive health right clubs/mentorships at school or in their community	77 [72, 81]	78 [74, 82]	65 [58, 72]	57 [48, 66]
Seeking or attending/visiting sexual reproductive health right services and information from health facilities	78 [74, 82]	80 [77, 83]	64 [56, 71]	52 [44, 61]*
Giving financial support to seek sexual reproductive health right services and information from health facilities to them	74 [70, 77]	72 [67, 76]	56 [49, 63]	44 [37, 51]*
Report yes to all types	56 [51, 68]	56 [51, 61]	49 [42, 56]	39 [32, 47]

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 (Figure 27). In terms of age differences, 10-14-year-old adolescents reported lower perceived parental support compared to older adolescents in both treatment and comparison groups.



Base: All adolescents (Treatment and comparison (balanced) male n=380, female n=470, age 10-14 n=375, age 15-19 n=366, age 20-24 n=109)

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

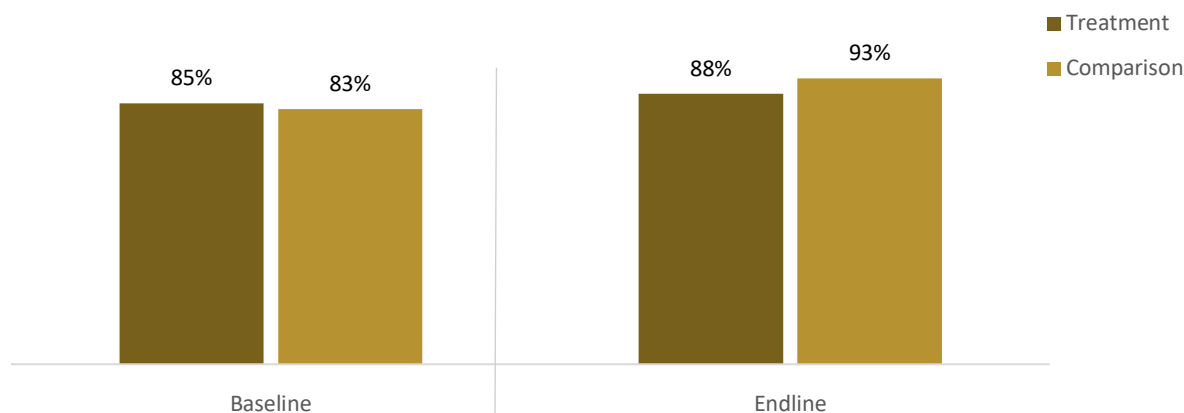
While it is not unusual for parents in Uganda to support their adolescents in accessing SRH services, it is notable that even in age groups where support is least expected (10-14 years),⁶⁷ a higher proportion of adolescents in *SHARE* intervention areas reported that their families would support and facilitate all forms of SRH access compared to the comparison areas.

⁶⁷ Jalinga Vuamaiku G, Eputai J, Andru M, Aleni M. "I Don't Support It for My Children": Perceptions of Parents and Guardians regarding the Use of Modern Contraceptives by Adolescents in Arua City, Uganda. Int J Reprod Med. 2023;2023:6289886. doi: 10.1155/2023/6289886.

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

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

Results showed consistently strong awareness of how gender inequality affects adolescent SRHR outcomes in both groups at both time points (Figure 28). The treatment group remained broadly stable, with 85% of community members showing strong awareness (95% CI [77%, 91%]; M: 89%, F: 82%) at baseline and 88% (95% CI [81%, 92%]; M: 87%, F: 88%) at endline. The comparison group demonstrated a more substantial improvement from 83% (95% CI [77%, 88%]; M: 94%, F: 75%) to 93% (95% CI [88%, 96%]; M: 92%, F: 93%). The difference between groups at endline was not statistically significant (Adjusted $F(1, 83) = 2.52, p = .116$) and the DiD analysis, controlling for observed sociodemographic differences between groups, did not reveal a significant difference between groups over time ($B = 0.63, SE = 0.49, 95\% \text{ CI } [-0.35, 1.60], p = .208$). As noted previously, these analyses were not powered for statistical significance, and results should be considered indicative only.



Base: All community members (Baseline treatment $n=153$, comparison $n=163$; Endline treatment $n=209$, comparison $n=193$)

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

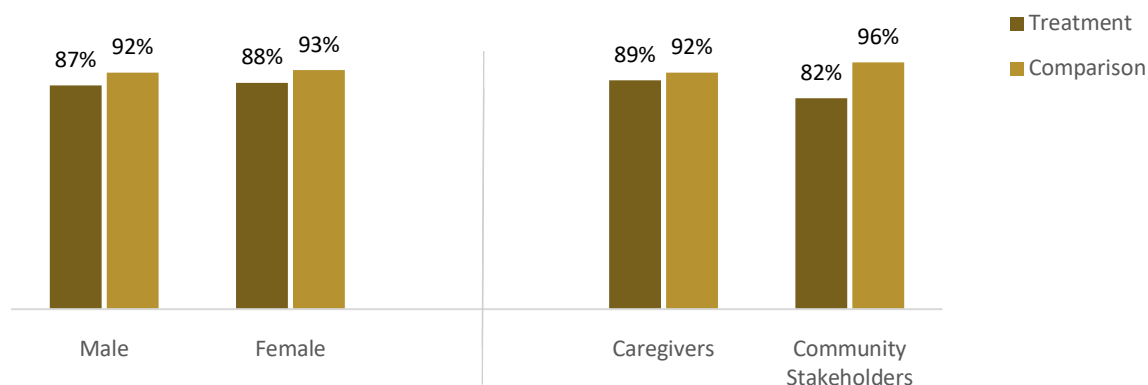
Table 18 presents the results for the individual items within this indicator. Across both arms, support for equal rights for women and girls increased notably from baseline to endline, from 65% to 93% in treatment areas and from 57% to 79% in comparison areas. A contrasting pattern emerged for attitudes toward intimate partner violence: in the treatment group, the proportion rejecting a husband hitting his wife declined from 71% to 59% between baseline and endline, while in the comparison group it increased from 59% to 83%.

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 = 153)	Comparison (n = 163)	Treatment (n = 209)	Comparison (n = 193)
Women and girls should have the same rights as men and boys in Uganda	65 [56, 72]	57 [42, 70]	93 [89, 96]	79 [71, 85]***
Avoiding getting pregnant is the responsibility of both the man and the woman	71 [63, 79]	74 [68, 80]	80 [73, 86]	80 [72, 86]**
It is equally important for boys and girls to go to school	91 [83, 95]	94 [89, 97]	85 [80, 89]	88 [81, 93]
It's more important for a girl to go to school than to get married	79 [71, 85]	85 [79, 90]	81 [73, 87]	89 [83, 92]*
A husband is never justified in hitting his wife	71 [63, 78]	59 [50, 67]*	59 [50, 67]	83 [76, 88]***
Agree with at least three statements	85 [77, 91]	83 [77, 88]	88 [81, 92]	93 [88, 96]

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=116, caregiver n=152, community stakeholder n=57; Comparison male n=73, female n=120, caregiver n=146, community stakeholder n=47)

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

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

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

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

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

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

	Baseline n = 32	Midterm n = 28	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}	-	6 (67%) / 8 (89%)	14 (78%) / 16 (89%)
HCWs are aware and trained on the SOPs ^c	-	22 (79%)	24 (80%)
All criteria data point 1 met ^a	-	6 (21%) / 8 (29%)	12 (40%) / 14 (47%)
<i>Data point 2 – Health facilities with SOPs focusing on equitable SRH service adhering to minimum criteria (Adherence) ^b</i>			
Posters providing information in a clear and youth friendly format are displayed	-	5 (56%)	12 (67%)
Health services ensure privacy and confidentiality in delivering SRH services ^{a, d}	-	7 (78%)	15 (83%) / 17 (94%)
Provision of SRH services for adolescents/young people	-	9 (100%)	18 (100%)
Clinic hours are suitable for adolescents and young people ^e	-	9 (100%)	18 (100%)
SRH services are available for adolescents regardless of gender, age, or marital status	-	3 (33%)	1 (6%)
All criteria data point 2 met	-	2 (22%)	1 (6%)

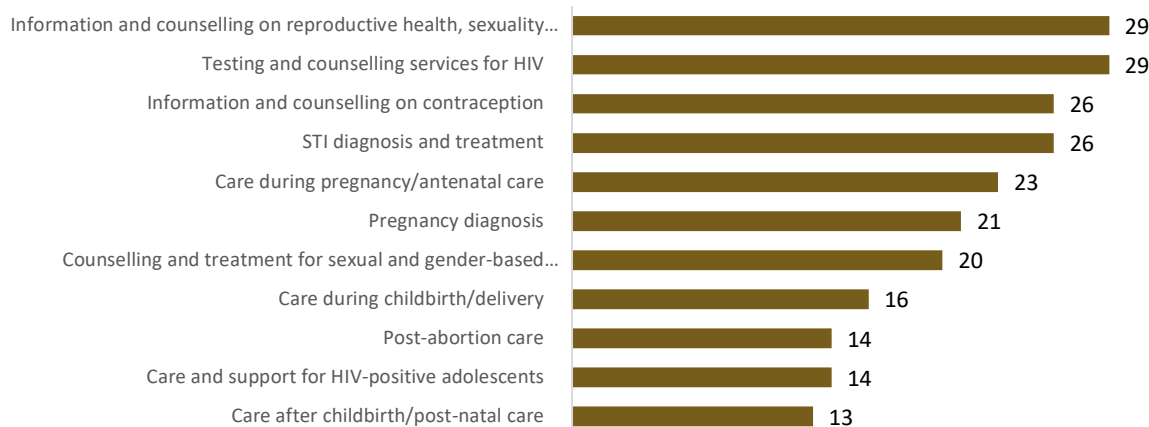
Note. ^a Where two figures are presented, the first represents the strict version ('Yes, observed' only) and the second the less strict version ('Yes, observed' and 'Yes, reported but not observed'). ^b Based on the sample with a SOP focused on equitable SRHR in place (midterm n = 9; endline n = 18). ^c Based on 'All staff' and 'Some staff'. ^d Based on a proxy of counselling and examination rooms providing visual and auditory privacy. ^e Based on '7 days per week' and/or opening hours until (early) evening.

The first data point focused on SOP readiness. At midterm, nine out of 28 facilities (32%) indicated having a SOP focusing on equitable SRHR, increasing to 18 out of 30 facilities (60%) at endline (note that SOP availability itself was not listed as an explicit criterion in [Table 19](#)). Most facilities reported that at least

some staff were aware of and trained on SOPs (22 or 79% at midterm, 24 or 80% at endline). Among those trained at endline, 12 facilities had all staff trained, three had a majority trained, three had about half of the staff trained, and six had less than half trained. Staff awareness and training on SOPs was assessed across all facilities regardless of whether a SOP is formally in place – which explains why more facilities reported trained staff than having a SOP – and may reflect cross-facility training or awareness of SOPs from other sources. Among facilities with a SOP in place, most had printed copies readily available (67% at midterm, 78% at endline). In addition, two facilities at both midterm and endline reported having printed SOPs without providing supporting evidence during the assessment. Based on strict observed criteria, six facilities (21%) met all data point 1 requirements at midterm, increasing to 12 (40%) at endline, or eight (29%) and 14 (47%) respectively when including self-reported instances.

Data point 2 was assessed only among facilities with a SOP in place – nine facilities (32%) at midterm and 18 (60%) at endline. Provision of SRH services for adolescents and young people and clinic hours suitable for adolescents remained universal across both waves. Display of youth-friendly information posters improved slightly, from five out of nine facilities (56%) at midterm to 12 out of 18 (67%) at endline. Similarly, privacy in service delivery showed modest improvements. However, the number of facilities meeting the criterion for SRH services available regardless of gender, age, or marital status declined from three (33%) at midterm to one (6%) at endline – a finding that is largely explained by age restrictions, with only one facility reporting no age restrictions on service access. As a result, only one facility (6%) met all data point 2 criteria at endline, compared to two (22%) at midterm.

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



Base: All health facilities (n=30)

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

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

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

Before presenting results, two methodological notes are warranted. At endline a preliminary question was included asking whether an action plan had been developed following WASH IPC training, which was not asked at midterm. Of the 30 facilities, 24 (80%) reported having developed an action plan, of which 17 could be verified through observation. The number of facilities reporting a developed action plan at endline through this preliminary question ($n = 24$) is lower than the number meeting the specific action plan criteria at midterm, where up to 25 facilities (89%) 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. Endline results disaggregated by treatment district are provided in [Annex E](#).

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

	Baseline $n = 32$	Midterm $n = 28$	Endline $n = 30$
A dedicated trained team is appointed to implement the action plan	-	25 (89%)	19 (63%)
The trained team meets at least quarterly to review and update/monitor the action plan	-	25 (89%)	19 (63%)
The action plan includes key activities for improvements, outlines the responsibility holders and timelines	-	25 (89%)	21 (70%)
At least 1 activity from the action plan is implemented and/or initiated per year	-	24 (86%)	21 (70%)
All criteria met	-	21 (75%)	16 (53%)

At midterm, 25 facilities (89%) had appointed a dedicated trained team, maintained at least quarterly review meetings, and met the action plan content criterion, and 24 (86%) had implemented or initiated at least one activity. Overall, 21 facilities (75%) met all four criteria at midterm. At endline, compliance declined across all four criteria. A dedicated trained team and quarterly review meetings were in place at 19 facilities (63%). The action plan content criterion was met by 21 facilities (70%). Implementation of at least one activity also declined from 24 to 21 facilities (70%). Overall, 16 facilities (53%) met all four criteria at endline, though as noted above, the observed declines should be interpreted cautiously given differences in measurement stringency between waves ([Table 20](#)).

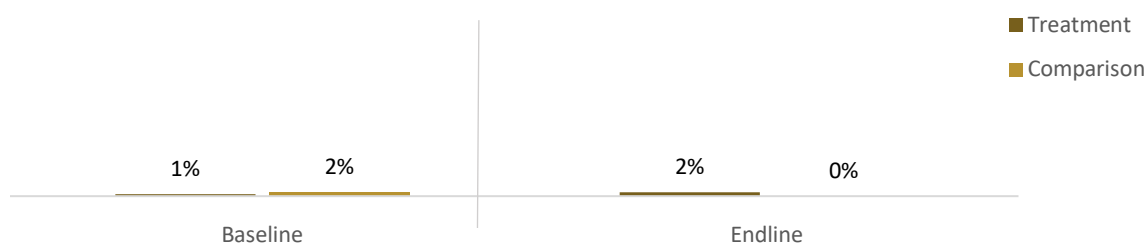
3.3.7 Immediate Outcome 1310: Capacity of key stakeholders to advocate for evidence-based, accountable and gender-responsive SRH services and SRHR policies

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

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

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

Comprehensive advocacy self-efficacy remained low across both areas and time points ([Figure 31](#)). In treatment areas, the estimated percentage of girls and young women strongly agreeing with all statements was 1% (95% CI [0%, 2%]) at baseline and 2% (95% CI [1%, 5%]) at endline. In comparison areas, estimates were 2% (95% CI [1%, 4%]) at baseline and 0% (95% CI [0%, 2%]) at endline. Given the overlapping confidence intervals, these changes should be interpreted cautiously and may not reflect a true population-level change. The difference between the groups at endline was nonetheless statistically significant (Adjusted $F(1, 83) = 4.51, p = .037$). The DiD analysis yielded a statistically significant difference between groups over time ($B = -2.82, SE = 1.05, 95\% \text{ CI } [-4.90, -0.73], p = .009$), indicating that the treatment group maintained slightly higher levels while the comparison group declined to near zero. Similar findings were evidenced following age-restricted analysis amongst adolescents aged 15-19 years ([Annex G](#)). However, this finding should be interpreted with caution, as the outcome is rare and based on very small absolute numbers – 10 respondents in the treatment group and 2 in the comparison group meeting the threshold at endline. Changes in a small number of respondents could materially influence the estimates, and the results should therefore not be considered robust evidence of a project effect.



Base: Adolescent girls/young women (Baseline treatment and comparison (balanced) $n=379$; Endline treatment and comparison (balanced) $n=470$)

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

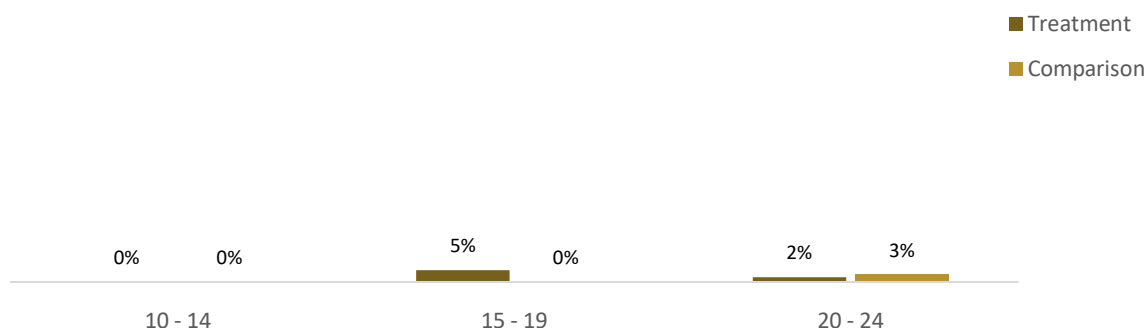
Although comprehensive advocacy self-efficacy was very low, confidence in specific advocacy-related situations was somewhat higher at the individual component level (Table 21). An examination of the individual items showed declines in point estimates (5-18%) across all four dimensions in both groups. For most items, confidence intervals do not or barely overlap between baseline and endline, suggesting these declines reflect a relatively reliable downward trend across both arms.

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 = 379)	Comparison (n = 379)	Treatment (n = 470)	Comparison (n = 470)
I can always manage to solve difficult problems if I try hard enough	33 [26, 40]	40 [32, 48]	22 [16, 30]	22 [16, 31]
If someone is against me, it is difficult for me to find ways to get what I want ^a	24 [20, 30]	31 [25, 38]	11 [6, 18]	20 [14, 27]
I am confident that I could handle unexpected events very well	31 [25, 39]	32 [26, 39]	24 [17, 32]	21 [16, 27]
I can remain calm when facing difficulties because I can rely on my own abilities	36 [28, 44]	31 [26, 37]	22 [17, 29]	26 [19, 33]
Strongly agree all types	1 [0, 2]	2 [1, 4]	2 [1, 5]	0 [0, 2]

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

Figure 32 presents endline comprehensive advocacy self-efficacy disaggregated by age group. However, because very few respondents within each age category met the indicator threshold ($n=9$, $n=1$, and $n=2$, respectively), these data do not allow for meaningful interpretation.



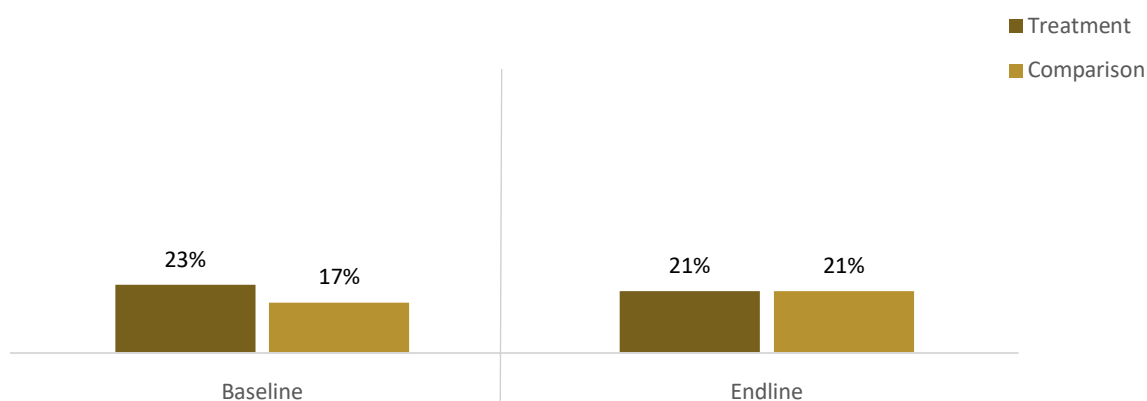
Base: Adolescent girls/young women (Treatment age 10-14 $n=211$, age 15-19 $n=196$, age 20-24 $n=63$; Comparison age 10-14 $n=211$, age 15-19 $n=196$, age 20-24 $n=63$)

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

At baseline, the proportion of community members correctly answering all questions was 23% (95% CI [17%, 30%]; M: 30%, F: 18%) in treatment areas and 17% (95% CI [13%, 23%]; M: 34%, F: 4%) in comparison areas. By endline, both groups converged at 21% (95% CI [13%, 32%]; M: 22%, F: 21% in treatment and 95% CI [14%, 30%]; M: 23%, F: 19% in comparison; [Figure 33](#)). It is worth noting that knowledge levels were higher at midterm in both groups (T: 37%, C: 29%), though direct comparability is limited due to different study designs. With both groups at virtually identical endline levels, the difference between groups was not statistically significant (Adjusted $F(1, 83) = 0.00$, $p = .960$). The DiD analysis, controlling for observed sociodemographic differences between groups, did not reveal a significant difference between groups over time ($B = 0.31$, $SE = 0.48$, 95% CI [-0.65, 1.27], $p = .521$).



Base: All community members (Baseline treatment n=153, comparison n=163; Endline treatment n=209, comparison n=193)

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

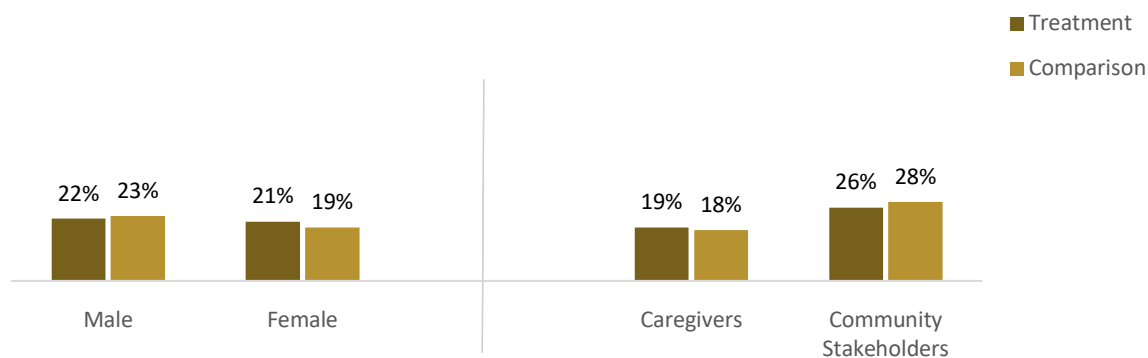
Examining the specific knowledge components ([Table 22](#)) reveals that despite overall comprehensive knowledge remaining stable in both groups, considerable change occurred at the individual item level. In the treatment group, knowledge of the legal ages of consent for sex and marriage (both 18 years in Uganda) declined across all four items. Notably, only one third of treatment respondents at endline could correctly identify the legal age for marriage. In comparison areas, point estimates increased across these same items, though overlapping confidence intervals warrant caution in interpreting these as definitive population-level changes. This resulted in statistically significant differences between arms at endline for three of these four items. Awareness of laws protecting against harmful traditional practices showed the opposite pattern, increasing in treatment areas (50% to 68%) while remaining stable in comparison areas. In contrast, knowledge of domestic violence legislation decreased in both arms from high baseline levels.

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 = 153)	Comparison (n = 163)	Treatment (n = 209)	Comparison (n = 193)
Age of consent for sex – boys	73 [65, 80]	60 [52, 67]*	53 [41, 64]	68 [58, 77]*
Age of consent for sex – girls	73 [65, 79]	64 [56, 71]	56 [46, 67]	75 [66, 82]**
Age of consent for marriage – boys	50 [41, 59]	42 [35, 50]	32 [22, 44]	56 [45, 67]**
Age of consent for marriage – girls	58 [49, 67]	44 [38, 51]*	36 [26, 47]	59 [47, 69]**
Aware of national laws to protect against harmful traditional practices such as Female Genital Mutilation	50 [43, 58]	48 [40, 57]	68 [58, 77]	51 [42, 61]*
Aware of national laws to protect against domestic violence	89 [84, 93]	86 [79, 91]*	77 [67, 84]	67 [57, 76]
Correctly answered all questions	23 [17, 30]	17 [13, 23]	21 [13, 32]	21 [14, 30]

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 the endline results disaggregated by gender and stakeholder type. The stakeholder type breakdown showed slight variations in knowledge levels, with key community stakeholders reporting slightly higher knowledge levels compared to caregivers. However, small sample sizes and overlapping confidence intervals (not reported here) preclude drawing definitive conclusions about population-based differences. No gender differences were observed.



Base: All community members (Treatment male n=93, female n=116, caregiver n=152, community stakeholder n=57; Comparison male n=73, female n=120, caregiver n=146, community stakeholder n=47)

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 (%)

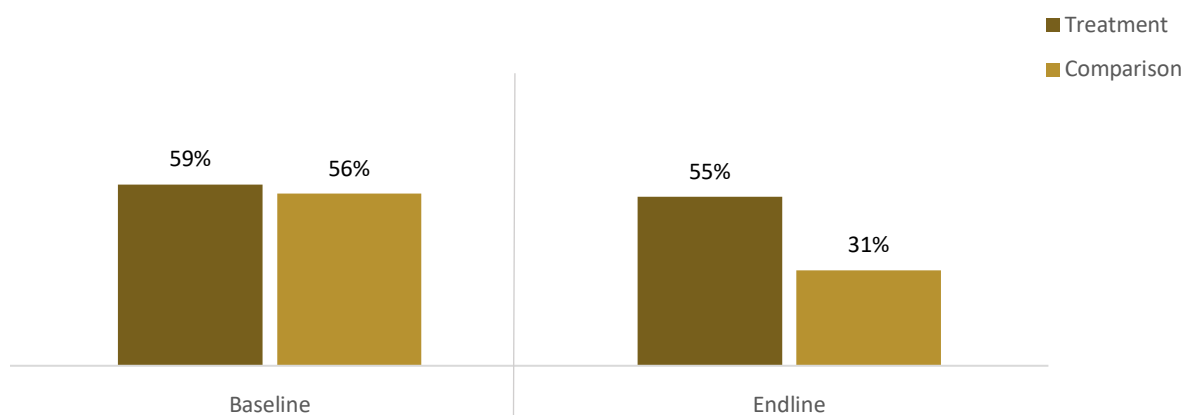
3.3.8 Immediate Outcome 1320: Increased access to evidence and knowledge exchange platforms to promote social action

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 59% (95% CI [51%, 66%]; M: 78%, F: 45%) of community members in treatment areas and 56% (95% CI [48%, 64%]; M: 65%, F: 50%) in comparison areas reporting participation in social action forums. By endline, participation in treatment areas remained relatively stable at 55% (95% CI [46%, 64%]; M: 70%, F: 44%), while participation in comparison areas dropped sharply to 31% (95% CI [24%, 39%]; M: 56%, F: 15%, see [Figure 35](#)). The difference between arms at endline was statistically significant (Adjusted $F(1, 83) = 16.27, p < .001$).



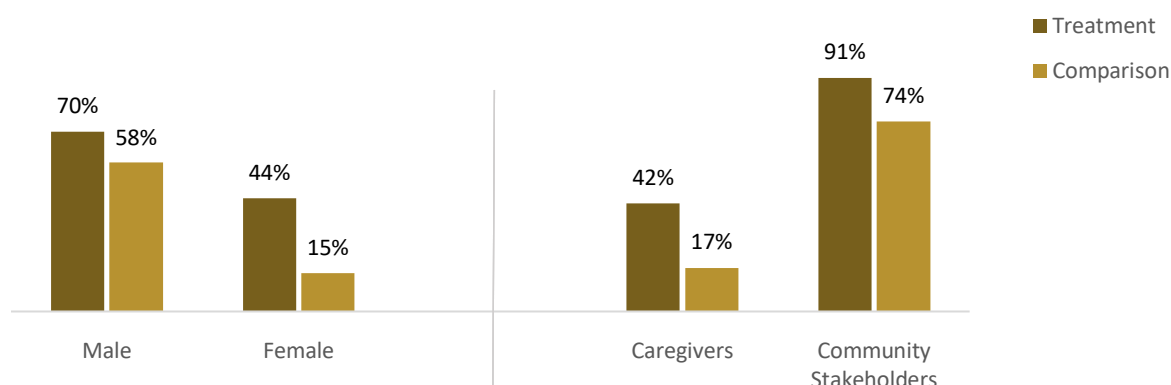
Base: All community members (Baseline treatment n=153, comparison n=163; Endline treatment n=209, comparison n=193)

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

The DiD analysis, controlling for observed sociodemographic differences between groups, confirmed a significant treatment effect ($B = -1.02, SE = 0.37, 95\% CI [-1.75, -0.29], p = .006$). Given that both groups

started at comparable baseline levels, the 21-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.

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: 91%, C: 74%) compared to caregivers (T: 42%, C: 17%). Furthermore, male community members reported higher participation rates (T: 70%, C: 58%) than female community members (T: 44%, C: 15%).



Base: All community members (Treatment male n=93, female n=116, caregiver n=152, community stakeholder n=57; Comparison male n=73, female n=120, caregiver n=146, community stakeholder n=47)

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, 56% of community members in treatment areas and 32% in comparison areas reported having participated in such sessions. Among those who participated, the majority attended multiple sessions: 22% of treatment group respondents attended 1 session, 59% attended 2-3 sessions, and 19% attended 3 or more sessions, with a similar distribution in comparison areas (11%, 48%, and 39% respectively). This suggests that the difference between arms lies in the reach of participation rather than the depth of engagement. In treatment areas, 85% 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, 57% of community members in treatment areas and 36% in comparison areas reported attending such events, with 82% 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, 49% of community members in treatment areas reported exposure to some form of campaign in the past 12 months, compared to 33% in comparison areas. Across all measures, participation and exposure were consistently higher among key community stakeholders and male community members compared to caregivers and female community members.

3.3.9 Outcome indicators, by exposure

The following analyses examine whether adolescents who reported direct engagement with *SHARE* activities showed different outcome levels compared to those who did not. It is important to note that the absence of self-reported exposure does not mean a respondent was not reached by the 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 the Ultimate Outcome indicator (described in the next section under Impact), adolescents with self-reported *SHARE* exposure consistently showed higher outcome levels across all indicators, with statistically significant differences for 10 out of 11 indicators and differences of up to 33 percentage points ([Table 23](#)). The one non-significant result – contraceptive use among sexually active girls – was in the expected direction and possibly attributable to insufficient statistical power given the small analytical sample for this indicator. As noted above, these findings cannot be interpreted as evidence of project effectiveness. Nevertheless, they suggest that adolescents reporting participation in *SHARE* activities also tended to report more favourable SRH outcomes.

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

	Total treatment (<i>n</i> = 850)	No self-reported <i>SHARE</i> exposure (<i>n</i> = 590)	Self-reported <i>SHARE</i> exposure (<i>n</i> = 260)	χ^2 / <i>t</i> , <i>p</i> -value
1000.2: Percentage of women aged 15 to 24 years who make their own decisions regarding sexual and reproductive health and rights ^a	63	63	62	0.02, <i>p</i> = .539
1100.1: Percentage of youth who used SRH services	32	22	55	88.04, <i>p</i> < .001
1100.2: Percentage of youth demonstrating positive attitudes towards ending SGBV	26	23	33	11.22, <i>p</i> < .001
1100.3: Percentage of youth who are confident that they could get their partner(s) to use contraceptives / condoms if they desired ^b	36	30	47	5.47, <i>p</i> = .027
1100.4: Percentage of sexually active girls always using (or whose partner uses) a modern method of contraception ^c	34	29	44	1.90, <i>p</i> = .217
1200.2: Percentage of adolescents and young people who are satisfied with ASRH services ^d	37	25	48	14.72, <i>p</i> < .001
1300.2: Percentage of adolescent girls participating in SRHR advocacy and social action initiatives ^e	None: 84 Low: 6 Medium: 6 High: 4	None: 90 Low: 5 Medium: 4 High: 1	None: 70 Low: 7 Medium: 12 High: 11	36.06, <i>p</i> < .001
1300.3: Average resilience score among young people	2.6	2.6	2.7	-3.27, <i>p</i> < .001
1110.1: Percentage of young people that are knowledgeable of their SRHR	22	19	29	9.83, <i>p</i> = .002
1110.3: Percentage of adolescents and youth who believe they could seek sexual and reproductive health information and services if they needed them	76	69	92	50.30, <i>p</i> < .001
1120.2: Percentage of adolescents and young people who report being supported by their families to access SRHR information and services	49	43	63	28.35, <i>p</i> < .001
1310.1: Percentage of girls and young women who feel they can advocate for improved adolescent rights in their communities ^e	2	1	5	8.14, <i>p</i> = .004

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*=26; no exposure *n*=49).

^b Restricted to adolescents in a relationship (Any exposure *n*=68; no exposure *n*=123)

^c Restricted to girls/young women who were sexually active in the past 12 months (Any exposure *n*=27; no exposure *n*=55)

^d Restricted to respondents who used SRH services (Any exposure *n*=142; no exposure *n*=130)

^e Restricted to girls/young women (Any exposure *n*=138; no exposure *n*=332)

Results show a mixed picture across the four community indicators (Table 24). No meaningful differences were observed between exposure groups for positive SRHR attitudes or knowledge of gender inequality consequences, suggesting these outcomes were broadly similar regardless of self-reported exposure. In

contrast, knowledge of national laws and policies was notably higher among *SHARE*-exposed respondents. Social action forum participation showed the largest difference of all indicators, 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 = 209)	No self-reported <i>SHARE</i> exposure (n = 95)	Self-reported <i>SHARE</i> exposure (n = 114)	χ^2 / t, p-value
1120.1: Percentage of community members that have positive attitudes towards SRHR for young people	69	69	69	0.00, $p = .978$
1120.3: Percentage of community members that have knowledge of the negative consequences of gender inequality on SRHR	88	89	86	0.59, $p = .444$
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	21	12	29	9.40, $p = .002$
1320.1: Percentage of community members that report attending a ASRHR focused social action forum	55	18	87	99.74, $p < .001$

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.



Adolescent girls making reusable pads as part of their practical session on menstrual hygiene and menstrual products.

3.4 Impact

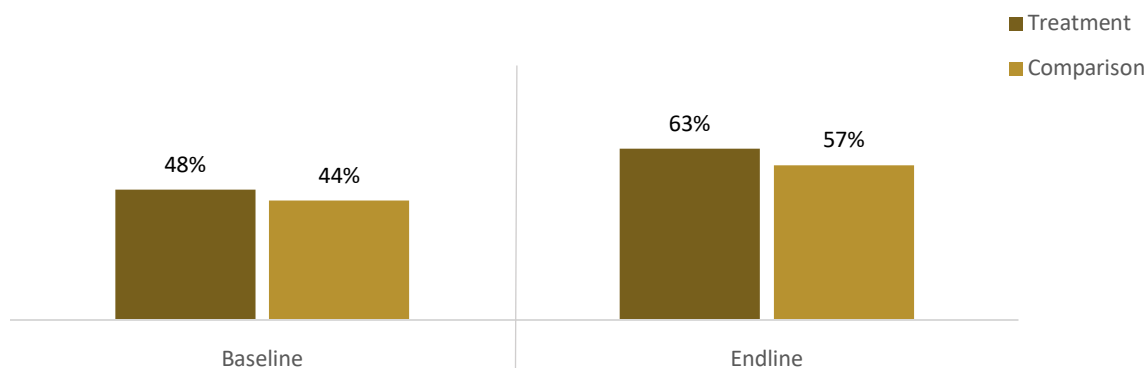
3.4.1 Ultimate Outcome 1000: Increased enjoyment of health-related human rights by the most marginalized and vulnerable rights-holders

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: $n_T = 100$, $n_C = 107$; endline: $n_T = 75$, $n_C = 91$).

At baseline, 48% (95% CI [37%, 60%]) of women in the treatment group and 44% (95% CI [33%, 56%]) in the comparison group reported autonomous decision-making across all three domains, with no statistically significant difference between arms (Adjusted $F(1, 76) = 0.24$, $p = .625$). By endline, point estimates increased in both groups, with 63% (95% CI [49%, 74%]) in the treatment group and 57% (95% CI [46%, 68%]) in the comparison group reporting full decision-making autonomy ([Figure 37](#)). However, confidence intervals overlap between baseline and endline in both arms, meaning these increases should be interpreted cautiously and may not reflect true population-level changes. The difference between arms at endline was not statistically significant (Adjusted $F(1, 69) = 0.41$, $p = .522$).



Base: Adolescent girls/young women aged 15-24 who are married, cohabiting or in a relationship and sexually experienced (Baseline treatment $n=100$, comparison $n=107$; Endline treatment $n=75$, comparison $n=91$)

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

The DiD analysis, controlling for observed sociodemographic differences between groups, did not reveal a significant effect ($B = -0.25$, $SE = 0.48$, 95% CI $[-1.20, 0.71]$, $p = .607$). Consistent with the 2-percentage point difference-in-difference, this suggests that both groups improved similarly over time.

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 76% to 91% in the treatment group and from 65% to 87% in the comparison group (Table 25).

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

	Baseline		Endline	
	Treatment ($n = 100$)	Comparison ($n = 107$)	Treatment ($n = 75$)	Comparison ($n = 91$)
Can say no to sexual intercourse with their partner if they do not want to	89 [81, 94]	84 [75, 90]	83 [69, 91]	71 [60, 80]
Decide on use of contraception	89 [80, 94]	99 [92, 100]	85 [71, 93]	86 [76, 92]
Decide on their own health care	76 [65, 85]	65 [56, 74]	91 [81, 96]	87 [78, 93]
All criteria met	48 [37, 60]	44 [33, 56]	63 [49, 74]	57 [46, 68]

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.

"Before, I could be the final person at home when making choices and decisions for my children, but now... I give my children the opportunity to make decisions for

themselves and only guide them.” (Caregiver of in-school adolescents, M, Adjumani, FGD)

“I used to judge them, but when this teaching was given, I changed. Now I talk to them slowly and with respect, and their behaviour has changed.” (Caregiver of out-of-school adolescents, M, Dzaipi, FGD)

Few caregivers described increasing recognition of women’s voices in household decisions and more shared responsibility between spouses. They associated that these changes with project-supported dialogue on gender equality and parenting. In some cases, caregivers, community health workers and adolescent also described changing attitudes toward household responsibilities, with boys and girls increasingly sharing tasks previously assigned according to traditional gender roles. These changes were often framed as reflecting greater acceptance that boys and girls should have similar opportunities and responsibilities. Adolescents increasingly appeared more comfortable asking questions and seeking support, while boys were described as becoming more supportive around menstruation and girls’ wellbeing. A district education representative in Buyende explained:

“Now the boys are already aware that girls are supposed to menstruate, and they help the girls because of the kind of information that has been given to them by the SHARE project.” (District Education Officer Representative, Buyende, KII)

Through initiatives like dialogues with cultural and religious leaders and parents, the project addresses barriers to gender equality and reproductive health. Parents and leaders have become active participants in SRHR discussions. By involving parents in parenting sessions, the project has helped dismantle harmful norms and encouraged open dialogue. In addition, through a range of tailored interventions and strategies, the project was deemed to have empowered adolescents and youth, by enhancing adolescents' knowledge, confidence, and ability to navigate SRHR-related decisions.

Across age groups, adolescents described greater confidence in addressing health concerns, body changes, menstruation, and sexual health issues. Out-of-school young women aged 20–24 years in Buyende reported that they were no longer held back by shyness and felt able to seek information and support when needed. One young woman described herself as “100 percent” confident in asking questions, including about family planning, explaining that she now speaks up because she recognises the importance of her health, whereas previously she had been too shy to do so.

“I am confident now, can say 100 percent because I can ask when I want to know something. Before, I used to feel shy, but now I know that my life is important.”
(Out of school young women 20-24, Buyende, IDI)

Other respondents reported confidence in seeking help for infections or family planning information, recognising that remaining silent could worsen problems and delay support, with out-of-school boy saying:

“Before I gained knowledge, I was afraid going to access health services like testing, but after the project, I no longer have fear, I go with confidence.” (Out-of-school boy, 18–24 years, Adjumani, IDI)

Another area of change concerned adolescents’ growing confidence negotiating relationships and setting boundaries. AGYW described becoming more able to refuse unwanted sexual advances, challenge pressure from partners, and communicate personal boundaries. Many respondents linked this change to increased awareness of rights, confidence, and practical guidance received through *SHARE* activities. One adolescent girl explained:

“There was also a time when I was with my boyfriend and he wanted to touch me, I told him no, do not touch me, I am going back home.” (In-school girl, 15–19 years, Buyunde, IDI)

Out-of-school young women also described becoming more confident negotiating safer relationships and discussing sexual health concerns with partners. One respondent explained:

“I used to even fear telling him that we should go for testing, but right now, I can tell him anything.” (Out-of-school young woman, 20–25 years, F, Buyende, IDI)

Similarly, older boys increasingly described discussing reproductive health decisions with partners. One out-of-school young man explained:

*““Before *SHARE* it was hard for me to go for testing with my girlfriend but after the project, I talked to her and we had to go for HIV testing and counselling.” (Out-of-school boy, 18–24 years, Adjumani, IDI)*

At the same time, the findings suggest that these shifts remained partial and uneven. Traditional gender expectations, parental authority, and social norms surrounding girls’ sexuality and household roles continued to shape decision-making in many settings. While respondents described greater openness to women’s and adolescents’ voices, wider gender and generational hierarchies remained influential.

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.

Interviewees from health and education official and consortium members described deliberate efforts to ensure activity implementation beyond project timelines by embedding them into annual work plans, institutional budgets, and operational priorities. During the mid-term evaluation, consortium members reported that they had developed an action plan aimed at strengthening the sustainability of project interventions. As a follow-up to this process, consortium members explained that the *SHARE* consortium organized meetings with project stakeholders to develop sustainability plans, as highlighted in interviews with representatives from the Department of Health, Department of Education, and *SHARE* consortium members. When asked if they were involved in the development of a sustainability plans for the *SHARE* project, the respondent from Department of Education replied:

“Yeah, we were involved because the SHARE project is coming to an end, we prepared our minds. The good thing in our sector we have an officer in charge of guidance and counselling who is seriously involved in the SHARE project and if it means training to continue the school-based mentorship, we have the skills we can be able to continue with it even when SHARE is gone.” (Ministry of Education representative, KII)

There were also plans at facility level to ensure sustainability. In the final months of the project, all primary health care facilities were instructed to develop sustainability plans to ensure that adolescent health activities were integrated into existing facility activities and outreach services. In Buyende, the district health official explained that *SHARE*-supported activities were incorporated into district work plans and designed around available government resources to ensure it is sustained after donor funding is terminated.

“The activities are already integrated; they are already in our work plan to ensure that they are implemented.” (District Health Officer, IDI, Buyende, KII)

“We were able to identify key activities and put this in our annual work plan and budget.” (Representative OFUA Health Centre III, Adjumani, KII)

“Being that we knew that the SHARE project is moving out, we are incorporating adolescent health activities in our work plan. And indeed, it was passed by the Health Management Committee.” (Adolescent Focal Person, KII, Kidera HC IV, Buyende, KII)

There was some positivity in the potential for sustained use of assets from the *SHARE* project expected to outlive the project. For example, respondents from the Department of Health, Department of Education, health facility and teachers highlighted the expected continued use of tools, guidelines, and referral systems introduced through the *SHARE* project.

“I think one is the issue of WASH and particularly using the health facility improvement tool for WASH to assess this facility on a regular basis, biannually and using the findings to cause improvement in the facility. I think this is really going to go beyond the SHARE project. And then, the utilisation of the Adolescent Health Educational Counselling Flip Book for health education. I think even if the SHARE project ends now, we'll continue using the flip book. And the issue of the GBV referral pathway. I think this will go beyond the SHARE project, so we shall continue to utilise this pathway so that adolescents get services when they come seeking them and the manuals: we shall continue to refer to them to reflect our knowledge, and even use the materials to build our capacity, including the school's capacity (Representative OFUA Health Centre III, Adjumani, KII)

District education officials described plans to scale up the mentorship model by leveraging expertise from intervention schools in the *SHARE* project in supporting non-participating schools. Both district education officers and teachers also described mentorship and supervision systems becoming embedded within education settings, particularly through teacher mentoring, school-based mentorship models, and support from district education structures. District education stakeholders explained that *SHARE*-supported school-based mentorship had increasingly become part of school management systems. Moving forward, they highlighted the importance of developing focal persons, distributing standardized handouts, and incorporating mentorship indicators into school monitoring and inspection systems.

“The school has made a point of putting this session of school-based mentorships... they have put in a timetable so that they can complete the session.” (District Education Officer, IDI, Adjumani, KII)

Interviews with district health officials also revealed that mentorship and supportive supervision will be integrated into routine district health management functions, noting that mentorship and supervision are no longer dependent on project support.

“The mentorship has been regular, whereby we have been having mentorship on a quarterly basis.” (District Health Officer, Buyende, KII)

Within WASH and facility quality systems, Water Aid and health facility respondents described additional institutionalized monitoring mechanisms. Regular WASH assessments were also described as part of continuing quality assurance processes.

“We were able to conduct regular WASH assessments.” (Representative, OFUA Health Centre III, Adjumani, KII)

Despite these efforts, stakeholders from health and education sectors also identified several risks to sustaining mentorship and supervision systems. Funding concerns were repeatedly mentioned as barriers to maintaining the intensity of supportive supervision after project closure. Respondents from the consortium and Ministry of Gender acknowledged threats to sustainability noting that inclusion in work plans did not necessarily guarantee implementation, particularly where funding remained insufficient or competing priorities emerged. National ministry stakeholder highlighted this concern:

*“We are doing the action plan, but where are the resources to implement?”
(Representative Ministry of Gender, KII)*

Health facility staff highlighted challenges affecting the sustainability of adolescent-responsive services. Health worker shortages, transfers, and the need for refresher training were repeatedly identified as risks. Facility respondents expressed concern that provider knowledge could decline without continued mentorship and supervision, with one saying:

*“Knowledge keeps wearing off when you don’t have regular trainings.”
(Representative, OFUA Health Centre III, Adjumani, KII)*



Right To Play staff engaging learners after their school-based mentorship session.

4. Conclusion and Recommendations

4.1 Conclusion

The *SHARE* project set out tackle a complex and contextually relevant public health issue with deep socio-cultural roots in Uganda. 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 was only one indicator for which the difference between endline and baseline estimates comparing treatment and comparison sites was shown to be statistically significant, there were a number of other indicators in *SHARE* sites that showed notable improvements, but not statistically significantly different from the difference comparator sites or in some instances outcomes maintained when there was substantial decline in the comparator sites. Though not statistically significant, the ultimate outcome to increase enjoyment of health-related human rights by the most marginalized and vulnerable rights-holders improved in the project sites. 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. 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* and partners. Below, the conclusion is presented against the specific evaluation criteria assessed in this endline evaluation (process, effectiveness, impact, and sustainability).

Process

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

At project inception, planned activities across all project sites were initially put on hold until baseline data collection had been completed to ensure there would be no contamination of baseline data results. Following this, there was historic increase in inflation rates globally, including in Uganda, which resulted in increased costs to implement *SHARE* activities and was deemed to have contributed to increased economic vulnerability of project beneficiaries. There was an Ebola Virus Disease outbreak in September 2022 which led to schools being closed for holidays earlier than planned to contain case spread.

Stakeholders generally perceived SHARE implementation positively. *SHARE* activities were implemented through existing structures within schools, health facilities, communities, and government systems, rather than creating stand-alone mechanisms, was perceived to support efficient project implementation. However, there were a few concerns relating to the limited number of teachers trained which was weakened by staff transfers. The annual project reach in Uganda ranged from 8,009 in the period April 2022 - March 2023 to 363,987 for April 2025 - March 2026.

At endline, in our sample, 38% of sampled in-school adolescents and youth in treatment areas reported having participated in a school-based club discussing health relationships, and SRHR topics in the past four years, and 22% of out-of-school respondents reported participating in a community-based SRHR group or mentorship programme. Additionally, 29% reported attending community SRHR events. Among those who participated in a club or group, the majority (54%) attended five or more meetings. Overall, 31% of treatment area respondents reported at least some direct exposure to *SHARE* or its partners, with the large majority of participants (72%-83% across activity types) indicating that their activity was organised or supported by *SHARE* or its partners.

Among community members, 56% reported having participated in community dialogues and 57% in community awareness-raising events, with considerably higher rates among key community stakeholders than caregivers (91% and 86% versus 43% and 46%, respectively). Overall, 55% of treatment area community members (caregivers: 45%; key community stakeholders: 81%) 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, 12% of in-school respondents reported participation in a school-based SRHR club, 11% of out-of-school respondents reported participation in a community-based SRHR group, and 9% reported attending community SRHR events. Among community members, 32% reported participating in community dialogues and 30% 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 results across outcome indicators. Several indicators showed favourable trends in treatment areas, either through improvement or by sustaining levels that declined in comparison areas:

- 1300.2: Participation in SRHR advocacy and social action initiatives increased from baseline in treatment areas while remaining stable in comparison areas (DiD not significant)

- 1310.1: Advocacy self-efficacy among girls increased from baseline in treatment areas while declining in comparison areas (significant DiD in favour of treatment arm, though absolute numbers were very small)
- 1120.1: Positive SRHR attitudes among community members increased from baseline in both groups, with a stronger increase in treatment areas (DiD not significant)
- 1100.1: SRH service utilisation remained stable in treatment areas while declining substantially in comparison areas (significant DiD in favour of treatment arm)
- 1320.1: Social action forum participation by community members was maintained in treatment areas while declining in comparison areas (significant DiD in favour of treatment arm)

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

- 1100.2: Point estimates suggest positive attitudes toward ending SGBV increased from baseline in both groups, though more substantially in comparison areas (significant DiD in favour of comparison arm); the increase in treatment areas should be interpreted cautiously given overlapping confidence intervals
- 1110.1: SRHR knowledge increased from baseline in both groups, though more substantially in comparison areas (significant DiD in favor of comparison arm)

Several indicators showed less favourable trends, either through decline or through comparison areas outperforming treatment areas:

- 1200.2: Satisfaction with SRH services declined from baseline in treatment areas while remaining stable in comparison areas (significant DiD in favor of comparison arm)
- 1300.3: Average resilience scores declined from baseline in treatment areas while remaining stable in comparison areas (significant DiD in favor of comparison arm)
- 1120.3: Community members' knowledge of the negative consequences of gender inequality remained stable in treatment areas while increasing in comparison areas, though levels were already high in both groups at baseline

Perceived family support for SRHR access (1120.2) showed a slight decline in point estimates in treatment areas – though overlapping confidence intervals preclude firm conclusions – while a more substantial decline was observed in comparison areas (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 negotiation self-efficacy (1100.3), contraceptive use among sexually active girls (1100.4), perceived ability to seek SRHR services (1110.3), and community members' knowledge of national laws and policies (1310.2).

Health facility assessments showed improvements in the number of facilities meeting all criteria for good quality gender-responsive and adolescent-friendly services (1200.1). Waste management compliance (1200.3) and WASH IPC action plan implementation (1220.3) both showed a small proportional decline between midterm and endline. For SOP readiness and adherence (1220.2) results were mixed, with the number of facilities with SOPs in place increasing between midterm and endline, while adherence to minimum criteria among facilities with a SOP declined.

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 all SRHR-related outcomes compared to those without self-reported exposure, though this analysis should be considered exploratory.

For community members, no meaningful differences were observed between exposure groups for positive SRHR attitudes or knowledge of gender inequality consequences. In contrast, knowledge of national laws and policies was notably higher among respondents with self-reported *SHARE* exposure. Social action forum participation showed the largest difference of all indicators, 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 Uganda. Its comprehensive multi-component approach, which integrates education, community engagement, and gender-responsive strategies, may have contributed to addressing some of the structural and socio-cultural barriers that hinder equitable access to SRHR information and SRH services. By focusing on marginalized groups, particularly AGYW, the project helped to promote gender equality and empowered adolescents to make informed decisions about their health and well-being.

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

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

The *SHARE* project may have contributed to laying foundations for greater agency regarding SRH choices, confidence, and bodily autonomy among girls and young women through mentorship, safe discussion spaces, adolescent-responsive services, 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 Uganda 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.
- Strengthen advocacy efforts to institutionalize comprehensive sexuality education and gender-responsive policies within education systems.
- Sustained support to continue target project activities, even if passive, should be offered to adolescents beyond the project life cycle to maintain gains of the *SHARE* project.
- As there will be continuous movement and redeployment of health workers and a decay in acquired knowledge and skills on the *SHARE* project, there is a valid justification for training and retraining health care providers on quality, gender responsive, and adolescent-friendly service provision. One cost-effective option to consider will be to explore remote or digitalized training materials to sustain health worker capacity for service delivery. Additionally, the project might consider using 'health personnel champions' who will be dedicated personnel to offer 'on the job' in-house training for health facilities beyond the project lifecycle. Tailored training should be extended to ancillary facility staff who may also perpetuate stigma that prevents access.
- For future implementation of similar interventions, there is a need to continue to embed *SHARE* project's gender-transformative approaches that challenge traditional gender roles and power dynamics into programming. Engaging boys and men alongside adolescent girls and women ensures shared responsibility and collective action. 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.^{68,69}

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.
- Support and encourage adolescents and youth who want to be involved in advocacy initiatives to drive social action.

For Government

- Governments should deliberately build on gains of the *SHARE* project in communities where the project was implemented and beyond, leveraging the current community momentum.
- Supportive supervision, which has been shown to generally improve adherence to clinical guidelines⁷⁰ combined with more routine assessment of youth-friendly service delivery in health facilities should be continued to ensure health workers are providing services as per protocol. This will help ensure that adolescents and youths can get the high-quality care, as needed.
- Linking non-financial or financial (performance payments) to compliance with evidence-based guidelines for adolescent youth-friendly care as delivered on the *SHARE* project or patient satisfaction,⁷¹ should be considered as a way to sustain gains from the project.
- Continue to improve infrastructure that promotes privacy, dignity, menstrual health management, and accessibility, particularly in schools and health facilities serving adolescents.
- Efforts are needed to ensure that teachers are made to feel confident that they can deliver sexuality education as per national guidelines without fear of reprimand or safety.

⁶⁸ 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>.

⁶⁹ 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.

⁷⁰ 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.

⁷¹ 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