

## ORIGINAL RESEARCH ARTICLES

# Improving Health, Improving Lives: Impact of the African Youth Alliance and New Opportunities for Programmes

*Ugochi Daniels*

### ABSTRACT

The African Youth Alliance (AYA) was a partnership to improve adolescent sexual and reproductive health, and prevent HIV/AIDS in Botswana, Ghana, Tanzania and Uganda. The AYA model was a comprehensive range of integrated interventions, implemented concurrently and at scale using a multi-sectoral approach. **AYA was funded for five years (2000-2005) with \$56.7 million from the Bill and Melinda Gates Foundation.** Over 35,000,000 stakeholders were reached through media campaigns, almost 400,000 young people received Life Planning Skills training, and over 2,500,000 visits were made by young people to static clinics and outreach services.

A post-test evaluation was conducted by John Snow Inc. (JSI) in 2006 and combined case-control and self-reported exposure design. Case-control design data were analyzed using Propensity Score Matching (PSM), and the Self-Reported Exposure design data were analyzed using PSM and Instrumental Variable (two-stage regression) (IV). The results show AYA's significant and positive treatment effects on sexual knowledge, attitudes, and behaviours. The research suggests **a comprehensive, multi-component approach such as AYA's can be effective in improving some key ASRH variables.** (*Afr J Reprod Health* 2007; 11[3]:18-27).

---

KEY WORDS: *African Youth Alliance, programmes, young people, impact*

---

*Africa Division, United Nations Population Fund, New York, NY, United States daniels@unfpa.org*

## Introduction

Various global commitments to decrease prevalence of HIV among young people focus on increasing young people's access to core interventions for the prevention of HIV, as well as decreasing their vulnerability to HIV/AIDS. A global consultation held in Tailloires, France, May 2004<sup>1</sup> concluded that young people remain at the centre of the HIV/AIDS pandemic in terms of transmission, vulnerability, impact and potential for change. Prevention works, but interventions need to be taken to a scale capable of halting and reversing the pandemic. Though progress is being made, we are still far from achieving 2010 and 2015 global targets. From Tailloires, we know that effective, practical and doable interventions exist.

In 2005, world leaders recognized that achieving the Millennium Development Goals requires achieving universal access to reproductive health. We also recognize that we urgently need to link our HIV/AIDS efforts with sexual and reproductive health. Based on the experience and results from multi-country programmes for young people, lessons have been learned that provide ideal opportunities to scale up SRH and HIV prevention programmes for young people.

## Multi-country Programmes for Young People: An Overview of AYA

The African Youth Alliance (AYA) was a partnership of the United Nations Population Fund (UNFPA), PATH, and Pathfinder International (PI) with the goal to improve adolescent sexual and reproductive health (ASRH), including the prevention of HIV/AIDS, among young people aged 10-24. The AYA programme was implemented in four countries — Botswana, Ghana, Tanzania and Uganda — in partnership with their governments, non-

governmental organizations (NGOs), community-based organizations (CBOs), and key stakeholders including: youth, parents, religious leaders, the media and policy makers.

To accomplish AYA's goal, six programme components were developed using evidence-based strategies:

- Policy and Advocacy (P&A)
- Behaviour Change Communication (BCC)
- Youth Friendly Services (YFS)
- Integration of ASRH into Livelihood Programmes
- Institutional Capacity Building (ICB)
- Coordination and Dissemination (C&D)

AYA also integrated partnerships, youth participation, gender equity, sustainability, scaling up, and community involvement in each component. At the country level, programme components and crosscutting objectives were adapted to meet the specific needs and context. AYA developed a results framework that guided programme planning, implementation, monitoring and evaluation. Using various country-specific approaches, youth were involved and played a significant role in all stages of the AYA programme.

The AYA model was designed as a comprehensive range of integrated interventions, implemented concurrently and at scale using a multi-sectoral approach. Funded for five years (2000-2005) with US \$56.7 million from the Bill and Melinda Gates Foundation as "venture capital", AYA was an unprecedented innovation to implement this model and build the capacity required for governments and other development agencies to sustain and scale up SRH and HIV prevention interventions for young people.

---

<sup>1</sup>Please access the programme component evaluation reports for full details on the data including disaggregation by age and sex at [www.ayaonline.org](http://www.ayaonline.org).

## Summary of Results

### I. **Programme Coverage<sup>1</sup>: Who did AYA Reach?**

Fundamental in the delivery of AYA model, was ensuring that young people (and key stakeholders) were reached with consistent messages, multiple times, using multiple approaches, in multiple settings. Over 35,000,000 stakeholders were reached through media campaigns, almost 400,000 young people received Life Planning Skills training, over 2,500,000 visits were made by young people to static clinics and outreach services. Table I summarizes AYA's process results and reach of the programme.

### II. **AYA Outputs: What were the programme components and outputs achieved?**

The AYA programme was made up of six components which were evaluated in 2005-2006. Evaluations show significant improvements in antecedents of behaviour changes as well as improved capacity to enable behaviour change<sup>[FNA]</sup>:

- **Policy and Advocacy (P&A):** was designed to improve the legal and policy environment by assuring implementation of supportive ASRH policies in order to successfully carry out AYA interventions. The longer-term objective was to create a sustainable, enabling environment for ongoing work in ASRH. *An evaluation of the P&A component found improved knowledge and supportive attitudes of stakeholders, an increase in commitments and actions supportive of ASRH by stakeholders, and increased resource allocation for ASRH.*
- **Behaviour Change Communication (BCC):** aimed to enable and sustain healthy behaviour adoption by building the necessary skills of young people. The implementation of Life Planning Skills (LPS) training with

both in- and out-of-school young people was a cornerstone of the component. *Evaluations and process data from this component demonstrated improvements in ASRH knowledge, perceptions, attitudes and behaviours among students who received LPS training.*

- **Youth Friendly Services (YFS):** made services youth-friendly and available to young people, and set the stage for scaling up. AYA worked with public health facilities, NGOs and FBOs to improve quality of services for young people, through both static clinic facilities and outreach. *Component evaluations determined that the availability of YFS increased, the quality of and client satisfaction with YFS improved and utilization of YFS increased. In all AYA countries, ASRH/YFS was integrated in pre-service training.*
- **Integrating ASRH into Livelihood Programmes<sup>[FNB]</sup>:** supported the integration of ASRH activities into existing livelihood programmes for young people, and advocated for increased recognition and funding for livelihood programming. *And, importantly, LPS was mandated in the Zanzibar Vocational Education Policy in Tanzania.*
- **Institutional Capacity Building (ICB):** provided technical or material assistance to strengthen one or more elements of organizational effectiveness, with the aim of overall sustainability. *The evaluation showed improvements by Implementing Partners in each country, and several have secured funding to sustain ASRH programming.*
- **Coordination and Dissemination (C&D):** ensured effective implementation and integration of programme components within AYA, as well as externally within government and other important programmes. Government structures were supported to ultimately assume this coordination. *The*

Table I: AYA Processes and Coverage

AYA Programme Coverage 2002-2005 <sup>3</sup>					
Policy and Advocacy	Botswana	Ghana	Tanzania	Uganda	TOTAL
Media campaign contacts	-	7,000,000	16,558,400	12,000,000	35,558,400
Young people, community members and stakeholders reached through advocacy activities (network activities, workshops, campaigns, student essay competitions and debates, etc.)	111,535	163,071	8309	46,853	329,768
Advocacy materials distributed (reports on review of ASRH laws, policies and practices; advocacy strategy; newsletters; brochures; booklets; fact sheets; flyers; posters; etc.)	78,765	51,958	363,000	58,000	551,723
Condoms distributed during advocacy campaigns	260,251	-	-	-	260,251
<b>Policies Created, Changed, and/or Harmonized</b>	Yes, by Religious Council.	Yes, by Govt.	Yes, by Govt	Yes, by Kingdoms, Religious Groups	
Behaviour Change Communication	Botswana	Ghana	Tanzania	Uganda	TOTAL
Young people reached in-school with LPS	24,147	39,668	114,111	112,828	290,754
Young people reached out-of-school with LPS	-	31,150	23,803	35,101	90,054
Young people reached by peer educators (individually and group activities)	14,412	61,641	103,541	Data not available	179,594
Young people reached through enter-educate activities (debates, jam sessions, drama, festivals, sport events)	64,346	142,012	149,558	210,518	566,434
BCC materials distributed (LPS manuals, LPS workbooks, brochures, posters, pull-outs, etc.)	128,000	~250,000	~500,000	272,248	1,150,248
Teachers trained in LPS (does not include supervisors, education officers, trainers, etc.)	279	202	357	475	1313
Peer Educators trained in LPS	2007	80	2612	730	5429
<b>LPS Curriculum Institutionalized by Government</b>	Yes, in all secondary schools	Yes	Yes, in all vocational institutions in Zanzibar	No	
Youth Friendly Services	Botswana	Ghana	Tanzania	Uganda	TOTAL
Facilities established as youth friendly	20	65	58	76	219
Visits by young people to YFS facilities	24,325	281,296	216,719	209,571	731,911
Outreach visits with young people (by peer educators, peer service providers, nontraditional condom distributors, etc.)	10,629	1,150,915	96,547	588,078	1,846,169
Condoms distributed (male and female, through clinic and outreach)	41,881	1,954,194	1,108,764	1,574,510	4,679,349
Visits by young people to VCT (clinic and outreach)	329	2775	92,910	14,921	110,935
Trainers, service providers, and supervisors trained in ASRH/YFS	224	871	649	285	2,029
Peer providers trained in ASRH/YFS	25	497	529	647	1,698
ASRH/YFS Curriculum Institutionalized in MOH In-Service Training (*AYA/PI Curriculum)	*Yes	N/A <sup>+</sup>	*Yes	Yes	
<b>ASRH/YFS Integrated into Pre-Service Training (*Institutionalized)</b>	Yes, by	*Yes, by	Yes, by	*Yes, by	
	Institute of Health Sciences,	NMCG (course and licen-	College of Health Sciences,	Makerere Medical School	

	University of Botswana	sure exam for all nurses and midwives)	Zanzibar		
<b>Integrating ASRH into Livelihood Programmes</b>	<b>Botswana</b>	<b>Ghana</b>	<b>Tanzania</b>	<b>Uganda</b>	<b>TOTAL</b>
Vocational institution instructors trained in LPS	79	60	73	34	246
<b>Institutional Capacity Building</b>	<b>Botswana</b>	<b>Ghana</b>	<b>Tanzania</b>	<b>Uganda</b>	<b>TOTAL</b>
IPs that received general TA	10	12	24	24	70
IPs that also received intensive TA	0	0	7	6	13
<b>Coordination and Dissemination</b>	<b>Botswana</b>	<b>Ghana</b>	<b>Tanzania</b>	<b>Uganda</b>	<b>TOTAL</b>
Proportion of AYA districts where IP work plans were shared, and districts integrated ASRH in plans/ budgets	7/8	20/20	10/10	6/13	43/51

*evaluation determined that improvements were made in each country: IP work plans were shared, networking and collaboration among implementing partners and district coordination offices occurred at all levels through various channels, and youth participation increased.*

### III. AYA's Impact: Did programme objectives collectively achieve Behaviour Change?:

In 2005, John Snow, Inc. was engaged by The Bill and Melinda Gates Foundation to conduct an independent impact evaluation of the effect of exposure to AYA programmes on ASRH behaviours. The essential research question was:

*Among sexually active 17 to 22 year olds, are those who report exposure to AYA more likely to:*

- use condoms
- have fewer sexual partners
- use modern contraceptives,
- abstain from sex or delay first intercourse than those not exposed to AYA?<sup>2-4</sup>

The evaluation was post-test only, and combined case-control and self-reported

exposure design. Data was collected from early March through the beginning of June 2006 by local research organizations, using a one-stage (Tanzania) or two-stage (Ghana, Uganda) cluster sampling (cases and controls (purposive), random selection of segments, and random selection (or census) of households within segments)<sup>2</sup>. Household, individual and community questionnaires were applied. Case-control design data were analyzed using Propensity Score Matching (PSM), and the Self-Reported Exposure design data were analyzed using PSM and Instrumental Variable (two-stage regression) (IV).

Results of the impact evaluation (Table 2) indicate evidence of significant, positive AYA treatment effects on sexual knowledge, attitudes, and behaviours. Across all three AYA countries evaluated, there were more treatment effects for females; and, among sexually active females, there were significant positive effects on: condom use at first sex, always use condom with current partner, and modern contraceptive use at first and last sex.

JSI concludes that the research suggests a **comprehensive, multi-component approach such as AYA's can be effective in improving some key ASRH variables.**

<sup>2</sup>Botswana was not included in the evaluation due to budget constraints.

<sup>3</sup>Time periods for activity implementation vary and in some cases are as short as 1.5 years; in addition, not all programme sites (e.g. schools, clinics, group events) reported consistently or completely. Results should be viewed for a general sense of scope rather than as specific numerical achievements under standardized conditions.

<sup>4</sup>The government of Ghana had already developed and adopted an in-service training curriculum on adolescent health prior to AYA.

#### IV. Implications: Why are these results important?:

AYA as a programme was an unprecedented innovation to implement a multi-sectoral model and build the capacity required for government and her development partners to sustain and scale up SRH and HIV prevention programmes for young people. These results demonstrate the model's success at achieving behaviour change among young people reached by the programme and that the model has contributed to an enabling and sustainable programme environment that will continue to support ASRH programming.

Therefore these outcomes are significant for a number of reasons:

- Given youth demographics and the epidemiology of HIV in sub-Saharan Africa where young people constitute 30% of the population but represent 50% of new infections, evidence of successful approaches are vital. No other programme in the region has been able to demonstrate efficacy at a similar scale.
- These results validate the level of investment in a programme for young people. In 2000,

Table 2: AYA Impact on Sexual Behaviour of Young People

Comparing the impact of AYA on 17 to 22 year old male and female respondents on selected sexual behaviours obtained from three different types of models, AYA impact evaluation survey, 2006 (JSI): Preliminary Results

Sexual behaviour	Females			Males		
	Ghana	Tanzania	Uganda	Ghana	Tanzania	Uganda
Delay of sexual onset	++					
Abstains from sex <sup>5</sup>	+	-	-	-		
Fewer than two sex partners during past 12 months	++	++				
Condom use at first sex	++	++	++		++	
Condom use at last sex	+	++	++			
Ever used condom with current partner	++	+	++			
Always use condom with current partner	++	++	++		++	+
Modern contraceptive used at first sex	++	++	++		++	
Modern contraceptive used at last sex	++	++	++			

A '++' sign indicates strong significant impact of AYA in the expected direction; a '+' sign indicates significant impact of AYA in the expected direction; while a '-' sign indicates the opposite.

Strong significance is demonstrated by effect across two models, or the IV model. Significance is demonstrated by effect using the PSM Model.

A blank cell indicates no impact

Footnotes

FNA

Please access the full evaluation reports on each component at [www.ayaonline.org](http://www.ayaonline.org)

FNB

The Integration of ASRH into Livelihood Programmes component was not evaluated.

<sup>5</sup>The group studied for the impact evaluation – young people aged 17-22 – were not the AYA target group for abstinence messages. These messages were targeted at 10-14 year olds, who were not included in the evaluation study group.



AYA represented the biggest investment ever made in ASRH programming.

- These results, and documentation on programme strategies and experiences are valuable resources to achieve high impact programming (particularly amongst females) as well as areas for improvement.
- Developing a good quality, cost effective evaluation methodology for multi-country, multi-component, multi-partner programmes, can be a major challenge. In such programmes, there is often great variability from site to site, the problem of identifying controls with so many other similar or related programmes ongoing as well as data from baseline surveys conducted at the beginning of the programme that are no longer applicable by the time of the endline survey. The evaluation of AYA has provided the field with a methodology for evaluation that responds to the practical challenges of programming in the “real world”.
- The results provide evidence to support advocacy and resource mobilization for SRH and HIV prevention programmes for young people. A lack of evidence has been a real stumbling block in raising the visibility of the SRH needs and rights of young people.

#### **IV. Challenges**

- The impressive impact of AYA on females was not equally demonstrated in males. A review of the process data has shown that overall males and females were reached equally by the programme, though there is some variance by strategy, and that programme messages did not specifically target females at the expense of males. Further qualitative research is necessary to better understand the social context of behavior change in young males. Anecdotal evidence seems to indicate that the duration, intensity, content and approach of programme interventions to achieve behavioral change in males and females varies greatly.

- Establishing a partnership first at the international level and then at the national level with over sixty partners required significant time and investment in the development of systems and procedures.
- The initial expectation was that the programme could immediately go to scale, but this was based on the assumption that effective models and capacity were available. The reality proved otherwise, and significant investment had to be made to build and strengthen the capacity required to support replication and expansion.
- AYA did not address the issue of costing until midway into the programme. At that point, the emphasis was reaching young people and scaling up given the significant amount of time that had already been devoted to establishing the partnership and building the capacity for scale up of interventions. Unavailability of costing data has hampered advocacy for scale up.
- During the programme, shortage of RH supplies (e.g., condoms, VCT kits) was a constant challenge. Once young people and their communities had been mobilized and demand generated, the resulting increase in clientele often led to stock outs. Commodity supply and logistics are often not a component of ASRH programmes.
- Delivering the multi-sectoral response requires simultaneous implementation of a comprehensive range of interventions. Achieving integration (across components) is a major challenge as the natural inclination is for partners to focus on their specific components.
- While there was improved data collection and reporting (especially by service organizations), consistent and comprehensive data collection and reporting were constant challenges.
- It is important to recognize that monitoring and evaluating the AYA model was an intensive effort that included designing and conducting baseline data collection;

conducting Participatory Learning Activities; developing a comprehensive M&E Plan to monitor goals, programme objectives, crosscutting objectives and processes; constituting and convening an M&E Technical Advisory Committee; developing monitoring tools and guidelines; building capacity to implement the M&E Plan; conducting a Mid-term Assessment; conducting evaluation of programme components; assessing crosscutting objectives; designing and implementing an evaluation strategy; and documenting and disseminating results. To compound these processes further, there was also the need to build consensus and implement these activities with a broad spectrum of partners. These activities were neither planned nor budgeted for at the design phase and the level of effort required was grossly underestimated.

- Though sustainability was an AYA cross-cutting objective and a strategy was developed to ensure sustainability of interventions, actually operationalizing this concept was difficult. It was necessary to develop an exit strategy and ensure participatory and coordinated close out of programme interventions. However AYA only started this in the fourth year of the programme when there were also many other competing interests that equally had to be addressed as the programme was drawing to a close. At the same time, AYA was facing staff attrition as staff secured other positions.

#### **IV. Lessons Learned and Recommendations: How can we improve our programmes?**

Given AYA's achievements, challenges faced, and insights gained in designing and implementing a complex, multi-sectoral programme, there were common lessons learned across countries. The following recommendations are offered for consideration:

*African Journal of Reproductive Health Vol. 11 No.3 December, 2007*

### **Planning**

- Defining the structure, relationships, operating procedures and a plan for integration for a large, multi-sectoral programme are important key, early tasks to lay a firm programme foundation. It is critical that roles, responsibilities, systems and procedures are detailed, well understood and accepted. It is necessary to clearly designate oversight and accountability for individual programme components as well as their integration. Strong coordinating mechanisms and networking are needed for large partnerships.
- Do not underestimate the significant amount of time needed to deploy a multi-sectoral partnership in which multiple stakeholders are involved, ownership is encouraged, and capacities built before effective outcomes can be expected. This is especially true if sustainability and scaling up are to be achieved.
- At programme inception, plan for and prepare at programme inception good evaluation design as part of an overall results-based management strategy, then assure adequate funding and human resources upfront.
- Plan for the end at the beginning; sustainability should be addressed for as early as possible, including building programme activities into ongoing institutions, so that an effective transfer of programme responsibilities can occur when a time-funded programme is scheduled to terminate support.
- Ensure that the phasing out of the programme is well planned, effectively communicated and participatory. Engage stakeholders and partners in strategic planning for a comprehensive exit strategy and for future efforts beyond the life of the programme.

### **Implementation**

- Integration is key to increasing programme impact: AYA improved health-seeking behaviour: Percentages of young people who



in the past 12 months went to a health facility to receive information and services increased in all countries. Integration of the P&A, BCC and YFS components improved knowledge, skills and attitudes of young people as well as the availability and quality of health services. Advocacy work improved knowledge and attitudes of community members. Ultimately, utilization of services by both males and females increased. Determine which components can be integrated from the start, recognizing that not all components can be integrated before they are operational.

- Quality data for trend analysis and evaluation remain difficult to obtain from clinic staff and outreach volunteers. Standardized collection instruments must be implemented and data collectors must be recruited and trained: lack of dependable data can compromise use of data for planned expansion and scaling up.
- Focus must be maintained at both the national level to ensure sustained commitment and support, and at the district/village level to ensure implementation. Promote national government structures that address ASRH at the district and community level to facilitate comprehensive and complementary approaches that districts and communities can sustain and own.

### **Programme Components**

- In AYA, condom messages effectively resulted in increased use (ever and at last sex) and intent to use. Given their ease of use, that they are the identified method of preference by adolescents, their effectiveness for both pregnancy and HIV/STI prevention, and recognizing mixed results with abstinence messages, condoms should be a fundamental element of SRH services for young people. AYA's experience reaffirms this lesson consistently learned in ASRH programmes.
- ASRH interventions must be customized for

distinct groups of adolescents. Evidence from all the evaluations consistently underscores the heterogeneity of youth—programme interventions affected segments of the target population differently. Data across all countries showed that more females visited clinics for counselling, more males obtained condoms through outreach. In-school evaluations of the LPS curriculum found that for young people in primary school the most significant change was in condom knowledge and intent to use, whereas for those in secondary school the most significant change was in building healthy relationships, confidence to refuse sex and negotiating condom use. The JSI impact evaluations demonstrated more positive effects on outcomes for females. Lack of impact on 17-22 year olds with regard to abstinence, underscores the importance of targeting abstinence messages to 10-14 year olds who are still forming behaviours.

### **Crosscutting Objectives**

- There are two significant components to scaling up programmes: establishing the capacity to support a large-scale programme and replication of effective models. AYA found many talented organizations committed to implementing ASRH interventions; however, in order for the organizations to reach large numbers of youth, substantial capacity building was necessary.
- Scaling up requires that fundamentals must be addressed before actual expansion occurs; these include identification of effective models, formation of enabling policies, preparation of a capable infrastructure and capacity to implement, and institutionalization of tools and strategies. Be prepared to devote required resources to first achieve this and to sustain it.
- Youth participation, sustainability, scaling up,

partnerships, community involvement and gender sensitivity are typical principles of ASRH programmes. Success at achieving these requires operational modalities to ensure effective implementation as well as measurement systems to demonstrate the contribution to programme outcomes.

### The AYA Legacy: Conclusions and Opportunities

AYA's legacy is both behaviour change in the young people reached directly by the programme and the enabling and sustainable programme environment that continues to support sexual and reproductive health programming for young people in the four AYA countries.

The AYA experience benefits the larger sexual and reproductive health field; demonstrates efficacy of the model for donors and programmers; provides best practices that ASRH programmers can collectively address; provides a tested methodology for evaluation; and affords specific lessons learned for both technical programme components and for managing each stage of the programming process.

### Scaling up the multi-sectoral approach would include:

- Replication of the model to improve determinants and achieve behaviour change, maintaining a strong gender focus on girls' empowerment and increasing emphasis on male responsibility and involvement;
- Further study of the context of and motivation for behaviour change among young people, particularly males;
- Study of the impact on abstinence; delay of sexual debut and negotiation skills and very young adolescents (10-14 year olds);
- Support to national and district governments to improve institutional and technical capacity to deliver and sustain good quality programmes for young people;

- Advocacy to both national governments and district councils, as well as community-based advocacy to guarantee implementation of national policies at the district, local government and community level;
- Dissemination and capacity building for programme staff to ensure integration of the approach and improve the quality and effectiveness of the programmes.

AYA's contribution will continue to benefit the lives of young people in Africa for many years to come. As civil society and government work to eradicate poverty and hunger, improvements in the health of young people will remain a fundamental strategy for youth empowerment, well-being and overall development. The effort and experience of the African Youth Alliance will help to position ASRH as a key strategy in the achievement of Millennium Goals, the cornerstone of collective global development efforts.

### REFERENCE

1. World Health Organization, UNAIDS Inter-Agency Task Team on Young People. *Steady... Ready...Go! The Talloires consultation to review the evidence for policies and programmes to achieve the global goals on young people and HIV/AIDS* 2004.
2. JSI Research & Training Institute. *Results of an Evaluation of the African Youth Alliance program in Ghana: Impact on Youth People's Sexual and Reproductive Health*. Arlington, VA: JSI Research & Training Institute, 2007.
3. JSI Research & Training Institute. *Results of an Evaluation of the African Youth Alliance program in Tanzania: Impact on Youth People's Sexual and Reproductive Health*. Arlington, VA: JSI Research & Training Institute, 2007.
4. JSI Research & Training Institute. *Results of an Evaluation of the African Youth Alliance program in Uganda: Impact on Youth People's Sexual and Reproductive Health*. Arlington, VA: JSI Research & Training Institute, 2007.