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REPORT

JUNE 22, 2016

# The Road Ahead for Young People and Family Planning

## Costed Implementation Plan Analysis*

**Today, governments, donors, and public health professionals are paying more attention to the number of young people in the world. Currently, there are 1.8 billion people between the ages of 10 and 24 and almost 90% of them live in less developed countries.[1] Most of these young people do not have access to basic sexual and reproductive health care and information.**

Young people need to have access to information and services that will allow them to take full control of their sexual lives. This includes being knowledgeable about what contraceptive method is right for them, and being able to access it from a pharmacy or clinic. As ministries of health and countries plan out where they currently have gaps in increasing access to family planning, young people's sexual and reproductive health needs are a crucial area that should be addressed.

Many countries have started developing adolescent reproductive health plans and strategies, but activities under these plans do not always have allocated funds. One potential mechanism for ensuring funding for adolescent and youth specific activities is a country's costed implementation plan (CIP). Many CIPs were developed in response to FP2020 and Ouagadougou partnership commitments, and have been supported by USAID.[2] The plans give countries a clear path for

*CIPs can provide insight into which areas of family planning a government is prioritizing and where resource gaps are present.*

### Defining Young People

Definitions of young people, adolescents, and youth often vary by country and entity. UNFPA, UNICEF, and WHO recognize **young people** as those between 10 and 24 years old, **adolescents** between 10 and 19 years old, and **youth** between 15 and 24 years old.[5] PAI believes that young people, adolescents, and youth should have access to family planning information, services, and supplies. Thus, for the purposes of this document, PAI's definition of "young people" encompasses the ages of 10-24 years, with the acknowledgement that other bodies may define this differently.

*This report was updated in April 2016 to reflect new publicly available full CIP budget documents for Uganda and Zambia. Tanzania and Kenya's full budgets were already accounted for and Nigeria's full costing document is not currently available.

how they will address their family planning goals; make progress on commitments; and improve family planning knowledge and access to methods. Each country prepares their CIP slightly differently. FP2020 has a resource kit, developed by Futures Group, that countries can use to help develop their CIPs[3], but countries can adapt the tools to fit their context, and the toolkit is not a requirement when developing a CIP. Ultimately, CIPs are country-owned and country driven.

CIPs act as a roadmap that takes broad commitments to family planning and costs them out by each individual program and activity for measurable time-bound goals.[4] CIPs can provide insight into which areas of family planning a government is prioritizing and where resource gaps are present.

With the growing awareness of young people's needs, how countries have prioritized young people in their CIPs is an important marker for what adolescent and youth family planning services will look like in countries over the next several years. If the country has made public commitments to increasing access to adolescent and youth services, but has not committed a budget line to these efforts, advocates should call attention to these gaps, and encourage the government to align their commitments and pressing health needs to their financial plans. Additionally, if a country has a large adolescent and youth population that lacks access to contraceptive services, but has not outlined goals for increasing young people's access in their CIP, advocates can use this data to push governments to ensure all citizens have equal rights and access.

This analysis will focus on the activities and strategies specific to young people's access to contraception outlined in country CIPs. Based on current health statistics, it will also assess if proposed interventions are the most appropriate to increase access, and reach a country's stated family planning goals. Part of what makes CIPs unique is the ability to see where gaps are present in its full family planning program. This report acknowledges this, yet examines how countries have or have not allocated funds to programming for young people, and if the activities costed are the most effective for achieving their goals. Goals related to young people should cross over several country plans, however this analysis looks solely at CIP commitments. More analysis is needed on young people's representation in country plans and the implementation of these plans. This report is part of an ongoing series that will first focus on the CIPs of five countries: Kenya, Tanzania, Uganda, Zambia, and Nigeria.

**Table 1.0 At a Glance: Young People's SRHR in Costed Implementation Plans of Kenya, Nigeria, Tanzania, Uganda and Zambia**

| | KENYA | NIGERIA | TANZANIA | UGANDA | ZAMBIA |
|---|---|---|---|---|---|
| COMPREHENSIVE SEXUALITY EDUCATION | – | Average | – | – | Great |
| INCLUSION OF 10-14 AGE GROUP | – | – | Great | Great | Great |
| MEDIA CAMPAIGNS | Great | – | – | Great | Great |
| YOUTH SPACES IN CLINICS | – | Average | Average | Average | Average |
| YFS PROVIDER TRAINING | – | Poor | Average | Average | Great |
| PEER EDUCATORS | Average | Poor | – | Average | Average |
| ADOLESCENT REPRODUCTIVE HEALTH POLICY | ✓ | ✓ | ✓ | ✓ | ✓ |
| BUDGETING | ● | ▼ | ● | ● | ● |

**RANK**
- Great
- Average
- Poor

**BUDGETING**
- ● Activities almost all costed
- ▼ Some activities costed
- ⬣ Very few youth activities costed

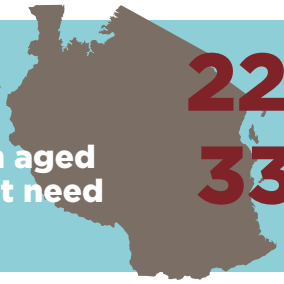
- ✓ Countries with Adolescent RH Policies
- – Not mentioned in the CIP in relation to increasing youth access

# Tanzania

Tanzania developed its first CIP in 2010 as part of an effort to increase modern CPR from 20% to 60% by 2015.[6] The CIP was developed for implementation over five years, 2010-2015. In 2012, the CIP was updated following a mid-term evaluation of the plan that highlighted gaps in programmatic areas that needed more emphasis, such as young people and provision of integrated services. The CIP informed Tanzania's FP2020 country commitments made at the London Summit for Family Planning. The National Family Planning Technical Working Group headed by the Ministry of Health and Social Welfare and several INGOs and NGOs contributed to the original and updated version of the CIP.

**47% of the population is under the age of 15**[7]

**22.8% of women aged 15-19 have begun childbearing**[8]



**22.7% of married women aged 15-24 have an unmet need for family planning**[9]

**33.1% of unmarried women aged 15-24 have an unmet need for family planning**[10]

The updated CIP has a price tag of $156.4 million USD (344.8 million Tshs), an increase from the original $60.4 million USD (133 million Tshs) five-year projection. This price tag includes activities for strengthening availability and choice of contraceptive methods, capacity building of providers, and strengthening health management systems.

## What the CIP Gets Right

While Tanzania's CIP is focused on broader topics to improve family planning access and use for everyone, interventions and programs for youth are outlined and budgeted under almost every strategic result. When considering where to prioritize youth interventions, the government used DHS data, which showed youth consistently have trouble accessing family planning services, leading to the prioritization of youth in the service delivery strategic area of the CIP. Five regions were selected for targeted youth-friendly-services interventions, as they are potential high-yield areas for increasing youth access to and use of contraceptives.

Tanzania's CIP calls for the increase in access to contraceptives for young people aged 10-24. The 10-14 age group is an age group that is frequently missed in programming and data collection. Tanzania's commitment to increasing access for this particular age group will require age-specific interventions and programs, and additional monitoring to increase access.

## What the CIP Could Do Better

Despite Tanzania's data based approach, the CIP missed the mark on several key components that could help meet the family planning and reproductive health needs of young people. The CIP includes and highlights meeting the needs of young people, but programming and budgets as outlined in the second version of the CIP are insufficient to fully implement any of these youth-focused ideas due to scope and funds. The youth-specific strategic result under the service delivery strategic area where youth are prioritized still only comprises 13% of the funding needed for this area.

Using data to inform where youth interventions would have the highest impact based on population is a positive aspect of Tanzania's CIP, but there needs to be a concentrated effort to reach high-risk youth throughout Tanzania. The CIP has budget lines for increasing demand in low CPR regions of Tanzania, but does not outline specific interventions for underserved populations such as youth.

While there is an action item in both the original and modified CIP to "increase availability of FP-related, youth-friendly services (YFS)", Tanzania has struggled to meet this goal. 106 service providers were trained on YFS in the first two years of the CIP, but family planning trainers were not updated on key YFS strategies. With the updated CIP, there are budget lines to train service providers on YFS. However, even with this, only 25% of the districts have budgeted for YFS.[11] Additionally, while the CIP calls for an increase in access for 10-24 year olds, the services are not disaggregated by age groups. To ensure the 10-14 year old age group does receive information and services, disaggregated data, and targeted and budgeted interventions are necessary.

Reinvigorating advocacy is one of the strategic action goals of the CIP, and the plan includes a budget line for advocacy activities for the implementation of the adolescent reproductive health strategy. However, there is only money allocated for consultants to review the strategy and hold three meetings with key decision makers on the strategy. Funding is needed to support CSO advocacy around implementation of the adolescent reproductive health strategy. In total, targeted advocacy for implementation of the national adolescent reproductive health strategy is 0.2% of the advocacy and communications strategic action area.

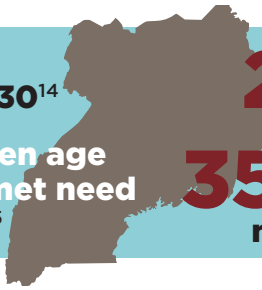
# Uganda

Uganda began developing its CIP in 2014 with leadership input from the Ministry of Health and extensive stakeholder participation from INGOs, multiple CSOs, advocates, and youth representatives. The resulting plan will be implemented from 2015-2020 with the goal of reaching Uganda's FP2020 target of increasing the modern contraceptive prevalence rate for married women and women in union from 26%[12] to 50%, reducing unmet need for family planning to 10%, and increasing users of modern contraception to 3.7 million by 2020.[13] The CIP outlines activities and strategic priorities to help achieve this goal. One of the main objectives in the CIP is to increase efforts to reach young people aged 10-24 with family planning services.

The CIP total cost is $184.6 million USD (622 billion UGX). This includes increasing information and services for family planning for youth, behavior change, task sharing efforts, policy implementation, and improved commodity security.

**75.8% of Ugandans are under the age of 30[14]**

**31.3% of married women age 15-19 have an unmet need for family planning[15]**



**23.8% of women age 15-19 have begun childbearing[16]**

**35.3% of sexually active unmarried women age 15-19 are using a modern method of contraception[17]**

## What the CIP Gets Right

As with Tanzania's CIP, Uganda has included youth aged 10-14 in their strategic priorities for increasing access to family planning. This again is an important recognition of the lack of services this age group has historically gotten, and recognition of Uganda's very young population.

One of the initiatives to increase access for this age group is to create YFS in clinics and to train providers on YFS. There is a budget to train 250 providers on YFS over the course of five years and provide incentives to providers who offer YFS. Out of all components of increasing YFS in clinics, training providers has proven to be the most effective when done in isolation.

Developing and implementing a mass media campaign is another activity costed to help increase knowledge about family planning and empower youth to use services. While there are specific youth focused messages, there are also activities to educate parents and community members on how to talk with their children about sexual education. Working with community members so they are also aware of adolescent sexual health needs is one of the best ways to ensure acceptance of youth using family planning services.[18]

The CIP acknowledges there is a lack of funding for family planning services for youth, and highlights several other areas where Uganda falls short in funding family planning supplies, and lacks systems to appropriately monitor and implement activities. Uganda's goal is to use the CIP as a way to assess which areas should be prioritized to achieve its family planning goals and to identify the areas that have the most potential to reduce unmet need.

## What the CIP Could Do Better

Many of the budgeted activities for reaching youth and increasing knowledge about family planning methods involve training peer educators in communities around the country. Evidence has shown that peer educators are effective at increasing knowledge about family planning but have not proven effective at increasing contraceptive use.[19] Given that family planning knowledge is high across Uganda, there is a clear disconnect between knowledge and use. There could be multiple causes for this—accessibility, affordability, and/or stigma in the community, along with many others. The resources put toward peer education could be more effective if applied toward increasing access in one of these other ways.

Under the activity to create YFS in clinics, in addition to training health workers, there is also money to create 400 new youth spaces in clinics and train 800 peer educators over the five years of the plan. While peer education has shown to improve attitude and knowledge toward family planning, it has proven less effective at increasing actual contraceptive behaviors.[20,21] To be effective, youth-friendly services need to be integrated into existing clinics rather than creating separate parallel spaces.[22] The money costed out for this could be used to train more providers with a particular focus on the prioritized 10-14 year old age group.

Currently, 12% of the CIP budget is allocated for demand creation, and 20% for service delivery. The CIP aims to align its efforts with the current policies around reproductive health, but only 1% of the allocated money from the CIP is going to efforts for policy advocacy and implementation. While each area is crucial for funding, some of the money funding activities that utilize ineffective methods could be re-allocated to policy advocacy and implementation efforts.

Post 2020, Uganda will be able to better assess if more youth have access to contraceptive services, and if they are closer to reaching their goals to increase CPR and reduce unmet need.

# Kenya

In an attempt to reposition family planning and contraceptive services in Kenya, the Ministry of Public Health and Sanitation, the Ministry of Medical Services, and other partners developed their CIP for implementation from 2012-2016. The plan costs out activities needed to increase CPR from 46% to 56% by 2015, and then to 70% by 2030 — all part of the FP2020 goals.[23] One of the main strategies they are employing to meet this goal is increasing contraceptive use among youth.

The CIP total cost is $256 million USD (26.6 Billion KES), which is broken out in five thematic areas. The thematic areas are human resources, commodity security, youth, demand creation and integration and cross-cutting issues. The youth thematic area accounts for 21.7% of CIP funds.

**45% of the population is under the age of 15**[24]

**23.2% of sexually active unmarried women use a modern method of contraception**[25]

**29.7% of married women aged 15-19 have an unmet need for family planning**[26]

## What the CIP Gets Right

Based on the current low level of contraceptive usage among youth, Kenya used research from Population Council to assess where young girls were accessing their contraceptives to fund appropriate interventions. The research showed that about 30% of girls aged 15-19 accessed their contraceptives from private health facilities.[27] Based on this data, the Kenya CIP has outlined interventions to build the capacity of private pharmacies to provide short-term contraceptive methods.

Females aged 15-24 had the highest rate of CPR change from 2003-2009 in Kenya.[28] One of the suspected causes for this was media-based family planning messages on the radio. Based on this, Kenya has budgeted for increased youth focused family planning messaging through a behavior change communication strategy that will be youth owned and operated.

The foreword of the CIP calls for advocates to use the CIP as an advocacy and monitoring tool for all family planning programs. At the end of the CIP budgeted period advocates will be able to look back at this plan and see what has been attained, what areas still need additional attention and resources, and where their advocacy efforts were and were not successful or welcome.

## What the CIP Could Do Better

Even though there are interventions in the CIP to build the capacity of private pharmacies to provide short-term methods, there are no line items to help pharmacies support a larger youth client base, either through pharmacist training in YFS or structural improvements. Additionally, there is no funding for improving contraceptive services at public facilities, where a large number of youth still access their contraceptives. The only money allocated to increasing the availability of youth friendly services is earmarked for workshops to determine where YFS should go and regional workshops to train service providers. These account for 0.3% of the total budget for youth interventions for 2012-2013. However, as these are the only workshops and the funding is only earmarked for one year, this will likely not be an adequate intervention to increase youth access.

One of the interventions under the youth thematic area is to "increase availability of condoms as a dual protection against pregnancy and STIs, including, HIV".[29] While dual protection is important, only 7.6% of all sexually active women age 15-19 use male condoms whereas 13.5% use injectables.[30] When breaking out the number to married and unmarried women, unmarried women are more likely to use male condoms, but married women still have high levels of unmet need for contraception.[31] The CIP should be stressing access to a larger method mix than just condoms, for young people, especially among married young women. Increasing method mix is part of the CIP, however it is not included under the youth objectives, and there is no mention of this population in the plan. Given the high levels of provider bias, high unmet need will remain persistent for this group if specific interventions are not planned.

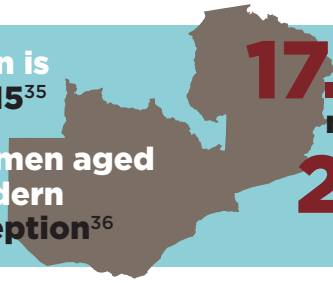
As with other CIPs, there is a line item to train four peer educators per county. While activities are costed out for mapping how to facilitate clinic-community links with input from youth, it is unclear how the peer educators will engage with the larger community to ensure buy-in for adolescent family planning services, as many of the planned activities (such as transporting youth to clinics) will need to involve community support.

One of the biggest omissions from Kenya's CIP is their failure to include the 10-14 age group for budgeted youth interventions. Provider training, pharmacy access and school-based interventions would all benefit this target age group, and should be advocated for including in the next CIP development. Additionally, some objectives that are for family planning do not actually have family planning activities aligned with them. For example, under the advocacy objective "increased demand for FP by improving advocacy", there is an activity to mobilize donor funds to purchase sanitary pads for girls 15-19 in schools within the 20 poorest counties. Sanitary pads should not be included in this objective, as it does not increase demand for family planning. While this activity is not costed, it detracts from the other activities in this objective such as including family planning issues on politician's manifestos, implementing the Adolescent Reproductive Health Policy, and cultivating champions.

# Zambia

Zambia developed its CIP in 2013 in response to the London Summit on Family Planning and commitments they made there. The Ministry of Community Development and Mother Child Health developed the plan with key inputs from ministries of health, donors, civil society, and implementers. In addition to meeting goals set at the London Summit, the plan has the goal of reducing maternal mortality and morbidity by increasing the provision of quality integrated family planning services.[32]

The total cost of Zambia's plan is $76.5 million USD (591 million ZMW) from 2013-2020. One of the gaps Zambia identified when assessing family planning access and use was among adolescents and youth. Based on this, adolescent and youth access to contraceptives is a component of the strategic priorities in the CIP, and accounts for 6 million ZMW of the plan. As a specific objective, Zambia aims to reduce teenage pregnancy from 28% to 18% by 2020.[33] To help achieve this, the plan outlines demand generation efforts targeted at youth that include incorporating family planning education in schools, training peer educators, and training health providers on youth-friendly services.[34]



**50% of the population is under the age of 15**[35]

**35.8% of married women aged 15-19 use a modern method of contraception**[36]

**17.9% of unmarried sexually active women aged 15-19 use a modern method of contraception**[37]

**25.1% of married women aged 15-19 have an unmet need for family planning**[38]

## What the CIP Gets Right

Zambia has outlined strong activities for integrating adolescent sexual and reproductive health (SRH) curriculums in schools for grades 5-12. Starting SRH curriculum at younger ages is an excellent way to integrate SRH curriculum across ages early. In addition to integrating SRH curriculum in schools, the CIP has included funded programs for family planning education materials to be distributed in the community. These will include information on LARC method provision, TV and radio spots aimed at youth, and youth-specific messaging on topics ranging from delaying pregnancy, to continuing education, and the importance of family planning. Adolescent family planning messaging will also be integrated into other key issue messages including post-abortion care, HIV, safe motherhood, and male circumcision.

While the current Zambian HMIS system does not have youth family planning method indicators, it has included recommended indicators for adoption in the next HMIS system review. These include age-disaggregated data for youth aged 15-19 and 20-24. The age group of 10-14 year olds is not included, but the current push for youth disaggregated data could lead to a potential advocacy opportunity.

Zambia has also done an analysis on barriers to adolescent access to family planning in its current family planning guidelines. Based on this analysis, age restrictions and parental consent laws were identified as barriers for youth under 16 years to access contraceptives. In the CIP, there are specific activities to assess and recommend new, less-restrictive language for youth under 16 years to access contraceptives.

This activity was completed, and Zambia's Family Planning Guidelines and Protocols are currently being updated.[39] In these guidelines, parental, spousal, and guardian consent is not required for adolescent access of reproductive health or family planning services. There is also specific language on counseling for youth under 16, ensuring they know what services are available to them and promoting a positive reproductive health environment.

The CIP includes budgeted money for integrating the new guidelines into provider training. When the CIP is at its mid-point, there will be an assessment that includes interviews with youth stakeholders to assess how the plan has addressed their needs. There will be a full review of the 2014 DHS to see if activities or objectives should be changed based on the new data.

## What the CIP Could Do Better

One of the activities for increasing access for youth is establishing youth-friendly service points in each district that will be staffed by peer educators. While the inclusion of youth-friendly service points is a step in the right direction, neither youth-friendly service areas of clinics, nor peer educators have proven effective at increasing contraceptive use. With this model, peer educators will be trained to dispense pills and condoms and cannot provide all contraceptive methods. Injectables are the most commonly used contraceptive method for those aged 15-24[40], and clinics need staff trained to work with adolescents and willing to provide these methods to them. The money budgeted for the youth-friendly service points should be re-allocated to train providers and ensure youth have access to an appropriate method mix.

# Nigeria

Nigeria developed its CIP in response to commitments made at the 2012 London Summit on Family Planning. The Federal Ministry of Health developed the plan with input from donors and other implementing partners. The plan will run for five years, with the goal of achieving a national CPR of 36%, reducing maternal mortality by 75%, and reducing infant mortality by 66% by 2018.[41]

The cost of the CIP plan will be $603 million USD (119.2 billion naira). The CIP is divided into six areas of health that are further divided into costed activities. Youth are mentioned only under demand generation activities for high-priority segments of the population, of which adolescents and young people are included. The sub-activities under this include incorporating family planning education into the classroom, training peer educators and training providers on youth-friendly services.

Of all the CIPs reviewed in this report, Nigeria mentions youth the least. While one of the stated CIP goals is to more than double current CPR, there is very little mention of educating, empowering, and ensuring access for the almost 50% of the population that will need contraception very soon.

## What the CIP Gets Right

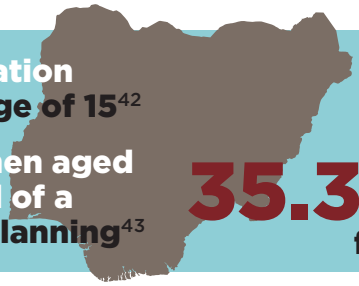
The CIP places strong emphasis on increasing access to LARCs; however, there is no mention of which populations will be specifically targeted for this increase, and given stigma around youth and LARC use, specific provider training will need to be done on this topic. Nigeria has predicted an increase in use of injectables, implants, and IUDs due to task shifting and increases in provider training on these methods. However, for this method use to increase for adolescents and youth, providers need training on youth-friendly services, and legal barriers for youth accessing LARCs need to be removed.

## What the CIP Could Do Better

As one of the sub-activities, family planning education in schools is an important way to ensure youth get accurate information that they may not receive at home or in their communities. However, the plan does not state what type of family planning education this will be, only detailing it as "Family Life and HIV Education" curriculum with the goal of increasing appropriate family planning messaging to adolescents and youth. This curriculum needs to include comprehensive messages about family planning that includes all types of contraception and incorporates a rights perspective to family planning. Teachers also need to be trained on how to deliver different family planning messages for different ages.

Another activity under the service delivery strategic area is "making primary health centers youth-friendly." This includes orientation for family planning providers, defining youth-friendly spaces and training peer educators. While this is an activity, the only money allocated in the actual costing is for renovating the spaces. There is no detail on how these spaces will be renovated, and no money for provider or peer educator trainings. Studies have shown that just having youth-friendly spaces is not enough to ensure contraceptive use behaviors will change.

In the section on policy and environment, there is a narrative on advocacy to ensure policies and guidelines for family planning promote access to populations such as youth. However, this is a broad reference and there should be more nuance to ensure achievable policies are put in place. With the next round of CIPs, Nigeria should ensure youth intervention activities are fully elaborated on and each activity is costed in the budget.



**About 46% of the population is under the age of 15**[42]

**64.4% of married women aged 15-19 have heard of a modern method of family planning**[43]

**13.1% of married women 15-19 have an unmet need for family planning**[44]

**35.3% of unmarried sexually active women have an unmet need for family planning**[45]

# Conclusion

While most of the CIPs had youth as a focus, continued advocacy is needed to ensure the line items put forth in the CIPs are realized and attained. CIPs are meant to be roadmaps, and governments are not held accountable to any of the budget lines put in the CIP, but the activities in CIPs represent an important commitment governments want to achieve. The activities included in CIPs also show where a government sees the most need, and where it wants to invest resources. Advocates can use the CIP to hold governments accountable for promises they made, and see where gaps remain. As some CIPs come to an end, it is the perfect time for advocates to assess what has and has not been achieved. Advocates can encourage their governments to prioritize more effective interventions in the next round of CIPs, or follow through on commitments they have made.

**ACKNOWLEDGEMENTS**

Many thanks to Amos Mwale, Halima Shariff, Moses Muwonge, and Sabrina Karklins for their review and input.

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