

# 1. National Commitment

**I**n *pursuance* of the goal of giving priority to the health and development of adolescent members of the population of Kenya within the context of the nation's overall development, so that adolescents in Kenya achieve and maintain total health and well-being as defined by the World Health Organization;

**Guided** by the principles derived from the National Reproductive Health Strategy; the National Population Policy for Sustainable Development; the Children's Act 2001; the International Conference on Population and Development; the Universal Declaration of Human Rights; the Convention on the Elimination of All Forms of

Discrimination Against Women; the International Convention on the Rights of the Child; the Fourth World Conference on Women; the International Conference on Social Development; the United Nations World Programme for the Youth for the Year 2000 and Beyond, and other relevant statements of commitment to the health of young people;

**Acknowledging** the interest of both local and international agencies in the promotion of the health and development of young persons in furtherance of the commitments indicated above, and appreciating that

The optimal health of the adolescent population of Kenya will increase their productive capacity to contribute to the nation's development.

the various programmes and projects currently being implemented or planned require support and coordination, in accordance with the priorities, principles and strategies indicated in this Policy;

**Conferring** upon the Ministry of Health and the Ministry of Planning and National Development, through the National Council for Population and Development, the mandate to mobilize the necessary resources from the health and other sectors to effect the reorientation of existing and planned services, at all levels, to address the reproductive health and related needs of adolescents;

**The Ministry of Health and the Ministry of Planning and National Development are mandated to mobilize the necessary resources to address the reproductive health and related needs of adolescents.**

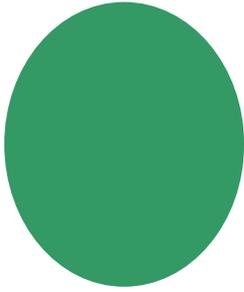
**Recognizing** the need for a specific policy framework to facilitate effective response, in terms of rearranging the nation's resources and priorities to better address the reproductive health service, information and other needs of adolescents and youth, and knowing that such a policy framework as hereby articulated was hitherto nonexistent;

**Convinced** that optimal health of the adolescent population of Kenya will increase their productive capacity to contribute to the nation's development;

**Appreciating** the devastating effect of the HIV/AIDS pandemic and its potential long-term impact on the nation owing to an increasing rate of infection among adolescents, and the need for a comprehensive policy response to this pandemic as a matter of urgency; and

**Aware** of the important role and potential of adolescents and youth themselves in making decisions and choices that will go a long way towards mitigating the problems of poor reproductive health and irresponsible sexual activities;

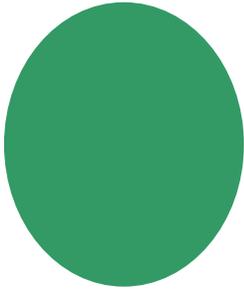
**The Government of Kenya** hereby proposes this document as the Kenya Adolescent Reproductive Health and Development (ARH&D) Policy, hereinafter referred to as 'The Policy'.



## 2. Principles

**T**his Adolescent Reproductive Health and Development Policy flows from the following basic principles:

- i) The Policy is grounded in fundamental human rights and freedoms. The Policy therefore respects human rights and freedoms relating to social, economic, cultural and religious beliefs and practices.
- ii) The Policy recognizes the critical roles adolescents themselves can play in promoting their own health and development and emphasizes the need for their participation in decision making, planning, implementation, monitoring and evaluation of programmes addressing their own needs.
- iii) The Policy recognizes that gender considerations are fundamental to adolescent and youth health because they are important determinants of access to economic resources, social services, education and other opportunities.
- iv) The Policy recognizes that not all young people are equally vulnerable. Young people who are homeless, abused, abandoned, orphaned, refugees and single parents have very different and challenging life situations.
- v) The Policy reaffirms the role of parents, communities, education institutions and religious organizations in assisting young people to develop positive norms, attitudes and values.



# 3 Current Situation

Kenya is a young nation with a wide range of challenges that are typical of a developing country, including a youthful population that is growing fast, in the face of relatively slow economic growth. These and other facets of Kenya's current position are detailed in the following sections.

## 3.1 Population Size and Growth

Kenya's population increased from 5.4 million in 1948 to 16.2 million in 1979, and thence to 23.2 million in 1989 and 28.7 million in 1999. It is projected to reach 36.5 million by 2010 and 39.7 million by 2015. The annual growth rate declined from 3.8 per cent in 1979 to 2.6 per cent in 1999. According to the 1999 population census, those aged 10–24 years number 10.3 million (5.1 million males and 5.2 million females).

**The large proportion of young people has major demographic, social and economic implications.**

**Yet they are the nation's future, an important resource whose capacities need to be tapped for development.**

## 3.2 Age Structure

The age–sex structure of Kenya's population is heavily skewed towards children and young people. The Kenyan population pyramid is wide-based,

with those below 25 years constituting 18.8 million, which represents about 66 per cent of the total population, a pattern that is typical of populations with high fertility rates and strong population momentum. The 1998 Kenya Demographic and Health Survey (KDHS) shows that the population under 15 years of age fell from 53 per cent in 1989 to 49 per cent in 1993 and to 46 per cent in 1998. As a result of this shift, the dependency ratio in Kenya dropped from 127 in 1989 to 112 in 1994 and to 98 in 1998.

### **3.3 Children**

Children, defined as persons below 18 years, constituted 52.7 per cent of Kenya's total population in 1999. This young population exerts pressure on the demand for services such as education, health, food and shelter. Socio-economic changes and poverty have led to an increase in the number of children living under difficult circumstances such as street children and families, abandoned and neglected children, abused and exploited children, teenage mothers, and refugee children.

### **3.4 Adolescents and Youth**

Whereas adolescents are defined as persons aged 10–19, the World Health Organization (WHO) defines the youth as persons aged 10–24 years. According to the 1999 Population and Housing Census, youth so defined constitute about 36 per cent and the adolescents 25.9 per cent of Kenya's population. This proportion has major demographic, social and economic implications, including strain on the national economy, pressure on the provision of social services and demand for employment, as well as high dependency. Yet adolescents and youth are the nation's future, an important resource whose capacities need to be tapped for development. These are ages of promise and opportunity, challenges and risks. The risk is related to the development of a sense of identity, including adoption of value systems. Because many of the decisions people make in adolescence and youth influence them for the rest of their lives, it is imperative that people in these age groups be supported to make responsible life choices.

### **3.5 Poverty and Socio-Economic Issues**

An estimated 52 per cent of the Kenyan population lives below the poverty line. Poverty is multifaceted and manifests itself through

**Because many of the decisions people make in adolescence and youth influence them for the rest of their lives, it is imperative that people in these age groups be supported to make responsible life choices.**

inadequacy of income, deprivation of basic needs and rights, lack of access to productive assets as well as to social infrastructure. Youth are adversely affected by the increasing incidence of poverty, which limits their access to essential social services such as basic education, health, water and sanitation. Females are disproportionately affected.

Young people constitute a major potential resource for Kenya's economic development. Yet the poor performance of the economy, coupled with the impact of structural adjustment programmes, (SAPs) have adversely affected their absorption in both public and private sectors. Consequently, the majority of the young people wishing to enter the labour force have not been able to secure employment to support themselves. Idleness among the youth leads to crime, drug and substance abuse, and involvement in other anti-social behaviour, while poverty aggravates the rate of HIV infection.

### **3.5.1 Children in the Labour Market**

According to the 1999 Population and Housing Census, 3.4 million out of 10.0 million children aged 5–17 years were reported to have worked during the seven days preceding the census. The proportion of working children was higher (about 45 per cent ) among the older ones (14–17 years) than those aged 5–9 years, who formed 26 per cent of the working children. The proportion of boys was higher. For all working children, 95 per cent resided in the rural areas. Involvement of children in the labour market denies them access to education, exposes them to exploitation, and limits their access to RH information and services as well as opportunities for self-advancement.

### **3.5.2 School Enrolment and Dropout**

The 1999 Population and Housing Census indicates that 85 per cent of persons aged 6–15 are in school, with enrolment levels being almost

equal in both rural and urban areas. However, with the introduction of universal primary education (UPE) in January 2003, enrolment increased substantially. For the age group 15–19, more boys are enrolled than girls. In rural areas more girls (55 per cent ) are enrolled in school as compared with urban areas (30 per cent ).

There has been a general declining pattern in school enrolment across all age groups, except age 6–9 years where improvements have been recorded in the last two decades. Enrolment in this age group increased remarkably from 50 per cent in 1979 to 76 per cent in 1999. But primary school enrolment, measured by the gross enrolment rate (GER), declined from 106 per cent in 1989 to 101 per cent in 1999. The proportion of the population aged 10–14 years that had dropped out of school increased from 1 per cent in 1979, through 5 per cent in 1989 to 8 per cent in 1999.

By age 20, about 85 per cent of the would-be-in-school population had dropped out of school. School retention rates are therefore highest at primary level, lower at secondary level, and lowest at tertiary and university level. Factors contributing to school dropout include poor sanitation in schools, uninteresting learning environments, sexual harassment, early and forced marriage, teenage pregnancy, poverty, and harmful practices such as female genital cutting (FGC).

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### 3.5.3 The Family

The family, the basic unit of society, is undergoing profound change, a phenomenon that has far-reaching social and economic consequences that affect development. The nuclear family, defined as consisting of a mother, father and their children, is gaining dominance over the traditional extended family system. Yet despite its diminishing influence as traditional cultural systems give way to modernization, the extended family is still a source of care of orphaned children and of guidance and counselling for adolescents, although to a lesser extent than in the past.

Among other family structures emerging as a result of social transitions and other factors are single parent families, child-headed families and families headed by elderly people. One of the impacts of the HIV/AIDS epidemic, for example, is the increasing number of child-headed households. As the family structure changes, and parents and caregivers are preoccupied with making a living or meeting social obligations, young people often lack the guidance and support they need to make responsible life decisions and yield easily to advice and misinformation from their peers.

The need to protect and maintain the family system as the fundamental unit of Kenyan society cannot be over-emphasized. Nevertheless, it is important that the rights of those adolescents who, for various reasons, find themselves part of non-traditional family units be protected as well.

### 3.5.4 Migration

Migration is a rational response of individuals to real or perceived economic, social and political differences between regions, or may result from such factors as prolonged drought that deprives people of a source of livelihood or civil unrest that forces people to flee their homes and communities. Some never return. As a rule, imbalances in the levels of social and economic development, availability of social and health amenities, perceived better standards of living, and population pressure on existing local resources determine the level of population movements. In Kenya, internal migration is dominated by rural to urban movements. Young people, most of them school leavers in search of employment and other opportunities in the urban centres, form the bulk of the rural to urban migrants.

**Sexual activity among Kenyan young people begins early and is usually unprotected, giving rise to early pregnancy, unsafe abortion and STIs including HIV/AIDS.**

## 3.6 Reproductive Health Information and Services

The World Health Organization states that reproductive health (RH) is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system, its functions and processes.

In Kenya as in other parts of Africa, young people face severe threats to their health and general well-being. They are vulnerable to sexual assault and prostitution, too-early pregnancy and childbearing, unsafe abortion, malnutrition, female genital cutting, infertility, anaemia, and reproductive tract infections (RTIs) including STIs and HIV/AIDS.

Fertility levels have remained high among Kenya's adolescents despite declines experienced among other age groups. Total fertility rate (TFR) has declined dramatically, from 7.1 children per woman in the mid-1970s to the current estimated level of 3.5 children per woman – a decline of 42 per cent over a 20-year period. Age specific fertility rate (ASFR) for 15–19 was 110/1000 in 1993 and 111/1000 in 1998; for the 20–24 age group it was 257/1000 and 248/1000 in 1993 and 1998, respectively.

By comparison, in the age group 25–29, ASFR declined from 241/1000 in 1993 to 218/1000 in 1997. Projections indicate that this scenario will continue in the foreseeable future. The high fertility rate among youth and adolescents is attributed to lack of access to needed RH information and services, perceived hostility of service providers who at any rate lack the appropriate skills for dealing with ARH problems, and a policy structure that is inadequate for the needs of young people.

Sexual activity among Kenyan young people begins early. It is, moreover, often characterized by what might be called serial monogamy – one partner after another. Adolescent liaisons are usually brief and easily replaced, so that by the time a person is ready to consider settling into marriage they have already experienced many partners. Despite this multiplicity of partners, sexual activity is usually unprotected, giving rise to early pregnancy and unsafe abortion, school dropout, STIs including HIV/AIDS, and economic hardship. According to KDHS 1998, 44 per cent of girls aged 15–19 years have had sexual intercourse and 19 per cent are sexually active. The median age at first sex for men is 16.8 years, compared with 16.7 years for women. Although men enter into sexual unions on average five years later than women, they start sexual activity at about the same age.

**The high fertility rate among Kenyan adolescents is attributed to lack of access to information and services, perceived hostility of service providers, and inadequate policies.**

In spite of high fertility and early sexual debut, contraceptive use among adolescents is relatively low. Only 6.6 per cent of persons aged 15–19 were using any method of family planning in 1998. Of these, only 4 per cent were using modern methods. Among 20–24-year-olds, only 27 per cent were using any method while 19.9 per cent were using modern methods.

Although government, private and NGO sectors provide RH services, most are not designed to take into account the special needs of young people. Where services exist, providers lack capacity to deal effectively with adolescent reproductive health issues and the range of services provided is also limited. Consequently, the majority of adolescents are hesitant to use them. While emphasizing access to reproductive health information and services, it is important to note that not all young people have the same environmental or life experiences – for example, not all are sexually active. Too many RH programmes for adolescents have left out the needs of this group. The content of information and services provided must therefore cater for the diverse needs of young people. There are those whose needs are restricted to education, counselling, life-skills building, decision making and negotiation skills to delay sexual debut, while others require a wide range of clinical services.

### 3.6.1 HIV/AIDS and STIs

According to the National AIDS Control Council (NACC) report 2002, an estimated 2.2 million Kenyans are infected with HIV/AIDS, while 1.5 million Kenyans have already died from the disease. More than 75 per cent of AIDS cases occur in adults between the ages of 20 and 45, and since this is the most economically productive part of the population, illness and death at these ages is a serious economic and social burden for the family and the society. The peak ages for AIDS cases are 25–29 years for females and 30–34 years for males. There is no significant difference between infection rates in rural and urban settings.

**Young women aged 15-24 are more than twice as likely to be infected with HIV as males the same age.**

Adolescents are more vulnerable to HIV/AIDS infection. Young women in the age groups 15–19 and 20–24 years are more than twice as likely to be infected as males in the same age group. It is

estimated that about 20 per cent of all reported AIDS patients are young people aged 15–24 years. Sexual contact accounts for 80–90 per cent of all infections, while the rest is due to exposure to infected blood and mother-to-child transmission. Mother-to-child transmission is expected to increase because of the high incidence of HIV among young women and will greatly affect infant and child mortality.

**At 590 per 1,000 live births, Kenya's maternal mortality rate is unacceptably high. Adolescents are more likely to suffer pregnancy related complications than older women.**

Kenya now has about 900,000 AIDS orphans, of whom about 78,000 aged 0–14 are infected with the virus. This number of orphans is projected to reach 1.5 million by the year 2005. Increases in the mortality rates of both children and young adults will have a substantial impact on life expectancy at birth.

Sexually transmitted infections, especially those that cause ulcerations to the genital area, significantly increase HIV transmission rate – as much as 10 per cent. On the other hand, STIs are not easily detectable amongst females, which becomes an intervention challenge.

### **3.6.2 Safe Motherhood**

Safe motherhood aims at assisting all women to go through pregnancy and childbirth with the desired outcome of a live and healthy baby and mother. Current safe motherhood programmes include preventive and health promoting activities encompassing family planning, antenatal care, safe delivery, postpartum care and maternal nutrition. However, these services are not equitably accessible to female adolescent users in all parts of the country.

At the current estimate of 590/100,000 live births, Kenya's maternal mortality rate is unacceptably high. Adolescents are more likely to suffer pregnancy related complications than older women owing to their relative immaturity as well as preventable causes such as malnutrition, infectious diseases and haemorrhage, malaria, and inadequate health care and supportive services, particularly in rural areas. A significant contributor to maternal morbidity and mortality is unsafe abortion.

**Youth who are infected with HIV/AIDS have the right to receive health care without being discriminated against because of their status.**

### 3.6.3 Reproductive Rights

Reproductive rights, embracing certain basic human rights that are already recognized in Kenyan law and in international human rights conventions and other consensus documents, have emerged as a separate area of concern requiring attention. These include the right of the youth to appropriate and relevant information and services. Furthermore, those youth who are infected with HIV/AIDS have the right to receive health care without being discriminated against because of their status. Denial of reproductive rights to young people negatively affects their general well-being.

### 3.6.4 Unsafe Abortion

Unsafe abortion contributes significantly to maternal morbidity and mortality. The majority of women seeking care for unsafe abortion complications are below 25 years of age. Effective advocacy and service provision to reduce the need for unsafe abortion are not adequate. The promotion of knowledge and adoption of appropriate attitudes towards abortion related issues will be enabled by this Policy. This includes correct and adequate information where adolescents are found, as well as improved access to contraceptive and post-abortion care services.

**A significant contributor to maternal morbidity and mortality is unsafe abortion.**

## 3.7 Harmful Practices

A number of social and cultural practices, some rooted in traditional attitudes and some of more modern origin, have a direct impact on the reproductive health activities and status of adolescents and young people. Among those of most urgent concern to this Policy are early marriage, female genital cutting (FGC), sexual abuse and violence, and drug and substance abuse.

### 3.7.1 Early Marriage

Although the age at first marriage is rising, early marriage is still prevalent in certain parts of the country. It is manifested in the forced marriage of girls as young as 12 years to older men, as well as more willing unions between young people. After marriage, these young adolescents are compelled to leave school to take on the responsibility of raising a family. This further limits their access to education and negatively affects their economic development and general well-being.

Women who marry early, whether by choice or by force, are exposed to an early and longer period of childbearing. Young women are more likely than older women to suffer pregnancy related complications.

### 3.7.2 Female Genital Cutting

Female genital cutting (FGC) remains prevalent in Kenya. Over 60 per cent of communities in 49 districts still circumcise their girls. As a result, nationwide 38 per cent of women in Kenya aged 15–49 are circumcised, while regional variations may range up to 90 per cent of women in some communities undergoing the practice.

Complications arising from FGC include, but are not limited to, haemorrhage, anaemia, cervical infections, (vesico-vaginal fistulae,) urethral damage, urinary tract infections, excessive growth of scar tissue, dermoid cysts, chronic pelvic infections, difficult and often dangerous childbirth, and a variety of other complications that may even lead to death. In addition to the physical effects, FGC also causes a range of sexual and psycho-logical problems for adoles-cent girls, significantly disempowering them both socially and economically. FGC may also lead to girls dropping out of school to get married. Recognizing that every human being has the basic right to physical health and dignity, this Policy asserts that the practice of FGC is a violation of this right.

**In addition to the physical effects, FGC also causes a range of sexual and psychological problems for adolescent girls.**

### 3.7.3 Sexual Abuse and Violence

Data on sexual abuse and violence in Kenya are limited. However, existing statistics show that 40–60 per cent of reported sexual assaults are committed against girls aged 15 years and below. Although both boys and girls can be victims of sexual abuse, girls are up to three times more likely to be sexually abused than boys. Girls who suffer sexual abuse are likely to begin sexual intercourse on average one year earlier and are much more likely to become pregnant before the age of 17.

### 3.7.4 Drug and Substance Abuse

Drug and substance abuse remains one of the major problems confronting the youth in Kenya today. Studies indicate that many in and out of school adolescents, street children and other groups of adolescents use and abuse drugs. Adolescents identified as being in most vulnerable situations include sex workers, brewers and sellers of illicit drinks, school dropouts, orphans, and young mothers. Most of the abusers are deprived and poor, unemployed, students, and those in unstable families. The most abused substances are tobacco and alcohol, khat (miraa), chang'aa (illicit liquor), marijuana (bhangi), mnazi (traditional brew), glue, heroin and 'brown sugar'.

**There is a close relationship among drug abuse, violence and reckless sexual behaviour.**

Persistent drug use is associated with suicide attempts. Like the users, most young people involved in trafficking and peddling drugs are from poor and vulnerable groups. Studies indicate that there is a close relationship among drug abuse, violence and reckless sexual behaviour whose consequences include the spread of STIs and HIV/AIDS, unplanned pregnancies, and sexual violence, among others. There are very few drug rehabilitation programmes and counselling centres available for adolescents in Kenya and these tend to be urban based.

## 3.8 Gender Perspectives

Gender is defined as the division of roles by sex, determined by any given society and dictated by cultural, religious or other values that

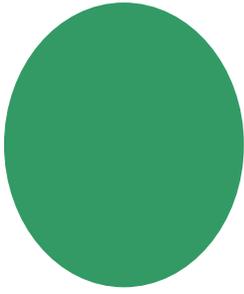
have little to do with the anatomy or genetic construct of a person. Expectations about what it means to be a man or a woman, which are an integral part of the socialization process, leave many youth and adults ill prepared to deal with their sexuality or protect their health. Gender influences sexual behaviour, especially when stereotypical assumptions are considered.

Stereotypes of submissive females and powerful males restrict access to health information, hinder communication between young couples, and encourage risky behaviour among young women and men in different, but equally dangerous, ways. Ultimately, these gender disparities increase adolescents' vulnerability to sexual health threats such as violence, sexual exploitation, unplanned pregnancy, unsafe abortion and sexually transmitted infections (STIs) including HIV/AIDS. The power imbalances between men and women can sometimes make it difficult for adolescent girls to refuse unwanted or unprotected sex, negotiate condom use, or use contraception against a partner's or husband's wishes.

Although women comprise 52 per cent of the total Kenyan population, and account for over 70 per cent of all food production in Kenya, their contribution to social and economic development is often unappreciated because it is not quantified in national economic terms. This lack of appreciation of the role women play contributes to the existence of huge gender disparities in literacy, educational attainment and economic achievement. While the literacy rate for males aged 10 and above based on the 1999 census was 78 per cent, the rate for females of the same age was 70 per cent. Although school enrolment at primary level is at par for girls and boys, disparity increases at upper primary, secondary and higher education levels owing to higher female dropout rates attributed to socio-cultural and economic factors.

Low levels of educational attainment by women, coupled with retrogressive socio-cultural practices, have resulted in low participation and representation of women in decision making positions and lack of access to economic opportunities.

**Stereotypes of submissive females and powerful males restrict access to health information, hinder communication between young couples, and encourage risky behaviour.**



# 4

## Strategic Actions for Adolescent and Youth Health

**A**dolescent and youth health is critical for development. To this end, health information and services should be available, accessible, affordable and acceptable. This Policy identifies the following priority concerns:

- i) Adolescent sexual and reproductive health and rights
- ii) Harmful practices
- iii) Drug and substance abuse
- iv) Socio-economic factors
- v) Adolescents and youth with disabilities

**Health information and services should be available, accessible, affordable and acceptable.**

To address these priority concerns, a series of specific strategic actions are proposed. These are itemized in the following sections.

### 4.1 Adolescent Sexual and Reproductive Health and Rights

- i) Provide appropriate sexual and reproductive health information and services at all levels.
- ii) Review existing or enact relevant legislation on reproductive health with a view to protecting adolescents and youth.
- iii) Incorporate adolescent sexual and reproductive health education into the curricula of all education and training institutions.

- iv) Sensitize the various groups within communities on the protection of children's rights and the provisions and enforcement of the Children's Act.
- v) Provide education to parents and the community on the sexual and reproductive rights and health of adolescents and youth.
- vi) Address gender concerns in all sexual and reproductive health programmes.
- vii) Support programmes that encourage adolescents and the youth to delay their sexual debut and practice abstinence.
- viii) Collect and analyse data for policy, programming and service delivery.
- ix) Strengthen capacities of institutions, service providers and communities to provide appropriate information and services such as post-abortion care, family planning (FP), and maternal, antenatal and delivery services for adolescents and youth.
- x) Promote appropriate HIV/AIDS education programmes for adolescents and youth in and out of school.
- xi) Advocate for behaviour change communication programmes by target groups (10–14 years, in and out of school, married, disabled, displaced including street children).
- xii) Strengthen the capacity of teachers, parents and leaders within communities to provide appropriate information on HIV/AIDS.
- xiii) Promote adolescent involvement and participation in planning, decision making, implementation and management of adolescent sexual and reproductive rights and health programmes.
- xiv) Establish and promote adolescent-friendly voluntary counselling and testing (VCT) sites, and link them to other agencies.

**Strategy:**  
**Incorporate adolescent sexual and reproductive health education into the curricula of all education and training institutions.**

## 4.2 Harmful Practices

Harmful practices include forced and early marriage, female genital cutting, sexual abuse, violence, and child trafficking, among others. In order to respond to these concerns, the following strategic actions are proposed:

- i) Advocate for raising the legal age at marriage for both women and men from 16 years to 18 years.

- ii) Support research on harmful practices to guide appropriate interventions while monitoring trends.
- iii) Reduce prevalence of harmful practices through appropriate policies, legislation, programmes and enforcement.
- iv) Enhance protection of girls through enforcement of the Children's Act at all levels.
- v) Develop safety nets and rehabilitation and rescue mechanisms for victims of sexual abuse and violence.
- vi) Reinforce mechanisms for justice and provision of legal assistance.
- vii) Strengthen the capacities of institutions, communities, families and individuals to prevent harmful practices.
- viii) Enhance measures to protect young people in penal institutions from sexual abuse.

**Strategy:**  
**Advocate for raising the legal age at marriage for both women and men from 16 years to 18 years.**

### 4.3 Drug and Substance Abuse

To counter this anti-social behaviour the following strategic actions are proposed:

- i) Promote education on the dangers of drug and substance abuse among adolescents and youth through in- and out-of-school programmes.
- ii) Establish support services at all levels for adolescents and youth exposed to drug and substance abuse.
- iii) Advocate for enforcement of legislation governing the access by adolescents and minors to tobacco, alcohol and psychoactive substances in the country.
- iv) Advocate for the enforcement of the liquor licensing act.

### 4.4 Socio-Economic Factors

Family stress and the erosion of traditional values and support systems, noted earlier, often mean that young people have no role models and little guidance in terms of responsible sexuality and reproductive health. Besides, rising poverty levels are influencing the performance of the education sector, constraining employment opportunities and limiting access to basic human needs including nutrition and shelter. Too often

young people have few options and no place to turn for reliable advice and support.

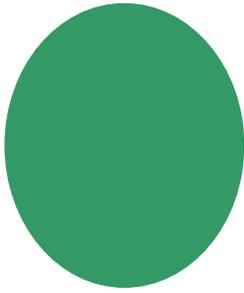
To respond to these factors the following strategic actions are proposed:

- i) Encourage youth participation and involvement in planning, implementing, monitoring and evaluating projects and programmes addressing their needs.
- ii) Support the development and implementation of programmes to address children and youth in difficult circumstances.
- iii) Support poverty reduction strategies.
- iv) Support school enrolment and completion at all levels.
- v) Advocate for enforcement of the return to school policy and a social support system for girls after pregnancy.
- vi) Address gender disparities in the education sector.
- vii) Strengthen the capacity to impart knowledge about nutrition through various channels at all levels.
- viii) Strengthen the capacity of the line ministries including, for example, Ministry of Health, Ministry of Labour and Human Resource Development, Ministry of Gender, Sport, Culture and Social Services, and other relevant ministries to monitor and enforce appropriate laws.
- ix) Support livelihood programmes and schemes for adolescents and youth.
- x) Support institutional capacities to provide mental health programmes.

## 4.5 Young People with Disabilities

Persons with disabilities are generally a marginalized group. The problem is further compounded if they are adolescents or youth. To address their needs the following strategic actions are proposed:

- i) Promote disaggregated data collection, analysis and use in programming.
- ii) Enhance the capacities of institutions, individuals and teachers to respond to the special needs of adolescents and youth with disabilities.
- iii) Ensure support for community-based programmes for adolescents and youth with disabilities.
- iv) Support establishment of appropriate recreational and other user-friendly services for adolescents and youth with disabilities.
- v) Promote access to reproductive health information and services for adolescents and youth with disabilities.



# 5. Goal, Objectives and Targets

**T**he goal of this Policy is to contribute to the improvement of the well-being and quality of life of Kenya's adolescents and youth. The Policy seeks to integrate their health and development concerns into the national development process and to enhance their participation in that process.

The goal of the Policy is to improve the well-being and quality of life of Kenya's young people.

## 5.1 Objectives

- i) To identify and define adolescent health and development needs.
- ii) To provide guidelines and strategies to address adolescent health concerns.
- iii) To promote partnership among adolescents, parents and community.
- iv) To create an enabling legal and socio-cultural environment that promotes provision of information and services for adolescent and youth.
- v) To promote and protect adolescent reproductive rights.
- vi) To strengthen inter-sector coordination and networking in the field of adolescent health and development.
- vii) To promote participation of adolescents in reproductive health and development programmes.

- viii) To identify and define monitoring and evaluation indicators for ARH&D.
- ix) To advocate for increased resource commitments for adolescent and youth health and development programmes.

## 5.2 Targets

The targets that will guide the Adolescent Reproductive Health and Development Policy and its programme planning up to the year 2015 are in the areas of health, demographics and social services. They are detailed below.

### 5.2.1 Health Targets

- i) To double the contraceptive use rate among adolescents (aged 15–19 years) from 4 per cent in 1998 to 8 per cent in the year 2015, and among youth (20–24 years) from 19.9 per cent to 40 per cent during the same period.
- ii) To increase the proportion of facilities offering basic essential obstetric care to adolescents and youth from 15 per cent to 30 per cent and comprehensive essential obstetric care from 9 per cent to 18 per cent by the year 2015.
- iii) To increase the proportion of facilities offering youth-friendly services from baseline to 85 per cent by 2015.
- iv) To increase the proportion of mothers below age 25 receiving at least two doses of tetanus toxoid during pregnancy from 25 per cent to 85 per cent by 2015.
- v) To increase antenatal attendance by mothers below age 25 from the baseline to 85 per cent by 2015.
- vi) To increase the proportion of mothers below age 25 delivering in a health facility from baseline to 60 per cent by 2015.
- vii) To increase the minimum antenatal care visits by mothers below age 25 from baseline to 80 per cent by 2015.

**Target:**  
**To double the rate of contraceptive use among adolescents by 2015.**

### 5.2.2 Demographic Targets

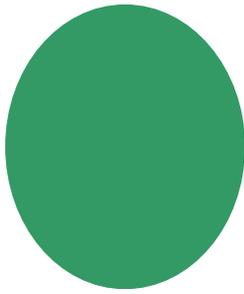
- i) To reduce the proportion of women aged below 20 with a first birth from 45 per cent in 1998 to 22 per cent by the year 2015.
- ii) To raise the median age at first sexual intercourse from 16.7 for girls and 16.8 for boys to 18 for both by 2015.
- iii) To reduce the maternal mortality ratio by 50 per cent in the 15–24 age group by 2015.

*Target:*  
**To raise the median age at first intercourse to 18 years for both boys and girls.**

### 5.2.3 Social Services Target

- i) To achieve universal primary education (UPE) by 2003 and Education For All (EFA) by 2015.
- ii) To achieve gender equity in education by 2015.

*Target:*  
**To achieve gender equity in education by 2015.**



# 6. Implementation Strategies

The following strategies will be applied to achieve the goals and objectives of this Policy:

- i) Advocacy
- ii) Behaviour change communication
- iii) Provision of reproductive health services
- iv) Research
- v) Capacity building
- vi) Resource mobilization
- vii) Networking and participation
- viii) Monitoring and evaluation

## 6.1 Advocacy

In order to bring about change in policy and resource allocation necessary for its implementation, this Policy will provide for advocacy programmes to be undertaken. These programmes will target policy makers, elected leaders, religious leaders and opinion leaders. They will aim to increase awareness of the importance and impact of adolescent and youth health needs at individual, family, community and national levels.

**Advocacy programmes will target policy makers, elected officials, religious leaders and opinion leaders to increase awareness of the importance and impact of ARH&D needs at individual, family, community and national levels.**

**Young people must learn that they are ultimately responsible for their own actions and that it is they who must live with the results of poor decisions.**

## **6.2 Behaviour Change Communication (BCC)**

Young people must learn that they are ultimately responsible for their own actions and that it is they who must live with the results of poor decisions. Programmes here will include life skills training to help them assess situations and possible outcomes, as well as efforts to help them identify risky behaviour and its consequences.

## **6.3 Provision of Adolescent-Friendly Reproductive Health Services**

To improve the utilization of health services by adolescents, efforts will be made to address factors that affect accessibility and quality of care, such as provider attitudes, privacy, confidentiality and hours of service.

## **6.4 Research**

Research forms an important component to inform and identify gaps in the implementation of this Policy.

## **6.5 Capacity Building**

Efforts will be made to strengthen capacities of youth, parents, teachers, community members, religious and political leaders, service providers, relevant institutions, and other stakeholders in order to respond to the needs of adolescents and young people.

**The Government will provide leadership and coordination in resource mobilization.**

## 6.6 Resource Mobilization

Mobilization of significant financial, human, material and technical resources is required to attain the goal and objectives of this Policy. This responsibility will be shared by all stakeholders (NGOs, private sector, religious organizations, communities). The Government, through the Ministry of Planning and National Development and the Ministry of Health, will provide leadership and coordination in resource mobilization activities.

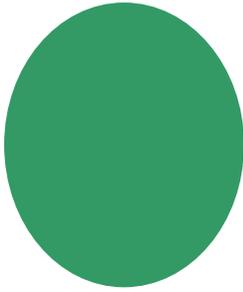
**The successful implementation of this Policy will require the efforts of all stakeholders - Government, NGOs, donor agencies, CBOs, leaders, communities, parents and young people themselves.**

## 6.7 Networking and Community Participation

The successful implementation of this Policy will require concerted efforts by all stakeholders. These include the Government, non-government organizations, donor agencies, community-based organizations, leaders, communities, parents and young people themselves.

## 6.8 Monitoring and Evaluation

The implementation of this Policy will be facilitated through the development of a comprehensive plan of action. Its success will depend on the commitment and activities of all stakeholders involved in its implementation. A monitoring and evaluation framework will be developed to assess the progress towards achieving the set goals and objectives. The Ministry of Health in collaboration with NCPD will develop guidelines for regular reporting of activities by implementing line ministries, districts, institutions and NGOs. NCPD will prepare annual reports as well as arrange special impact assessments and any other relevant studies from time to time.



# 7 Institutional Framework

Given that addressing adolescent reproductive health and development issues requires a multi-sector approach, several government ministries and agencies will be involved in the implementation of this Policy. The Ministry of Health (MOH) is responsible for the coordination and implementation of all health activities and programmes in the country and will be the primary implementer of the Policy. The National Council for Population and Development (NCPD), as the organization mandated to coordinate all population and family planning activities in Kenya, will be the co-implementer.

## 7.1 Implementation Responsibilities

As the lead agencies responsible and answerable for the implementation of this Policy, MOH and NCPD will:

- i) Advocate, promote and coordinate the implementation of the Policy at both national and sub-national levels.
- ii) Review and recommend appropriate changes in the adolescent health focus in the country and advise the government accordingly, taking

**Because the success of this Policy requires a multi-sector approach, MOH and NCPD will be the lead agencies responsible for its implementation.**

into consideration the political, economic, socio-cultural and legal realities in the country.

- iii) Advise the government on resource mobilization and the monitoring of their use to support the implementation of the Policy.
- iv) Undertake any other relevant activities that could promote sustainable adolescent health programmes to improve the well-being of young people in Kenya.

At the district level, the District Health Management Teams will incorporate other relevant government departments, NGOs and the private sector into their committees responsible for overseeing the implementation of the Policy.

These committees will:

- v) Advocate for the recognition of adolescent sexual and reproductive health (ASRH) issues at the district level.
- vi) Ensure the promotion, coordination, monitoring and evaluation of adolescent health programmes and activities in the district.
- vii) Ensure the integration of ASRH issues in all development activities at the district level.
- viii) Promote collaboration among government departments and NGOs involved in youth activities, thereby providing a link with the national level programmes.
- ix) Mobilize resources at the district level.
- x) Compile district level reports on adolescent health programmes and submit reports to the national office.

## 7.2 Roles of Government Ministries and Agencies

The expected broad roles of some of the government ministries as well as other agencies are outlined briefly below.

### 7.2.1 The Office of the President

- i) Integrating and incorporating ARH&D issues into development projects through the District Development Committees (DDC) and the Provincial Administration.

*Role:*

**Ensuring that ARH&D issues are mainstreamed into District Development Committee activities.**

- ii) Ensuring that ARH&D issues are mainstreamed into the functions of specialized subcommittees of the DDC, especially the District Population and Family Planning Committees (DPFPC), Poverty Eradication Committees, and Constituency Based AIDS committees.
- iii) Using the Provincial Administration, particularly Chiefs and Assistant Chiefs, to act as ARH&D advocates and as agents of change towards a more positive attitude to the provision of reproductive health information and services to adolescents.
- iv) Expanding coverage of civil registration and providing data on births and deaths and other vital statistics and disaggregating them to illuminate the impact of various social and reproductive health problems on adolescents and the country.
- v) Ensuring that ARH&D concerns are fully considered in the plans and programmes of the National AIDS Control Council.
- vi) Developing programmes that provide population and reproductive health information, counselling and services to young people in the armed services and police force.

### **7.2.2 Ministry of Home Affairs and National Heritage**

- i) Integrating HIV/AIDS and reproductive health education and guidance and counselling into programmes to cater for children living under difficult circumstances.
- ii) Developing programmes that provide population and reproductive health information, counselling and services to young people in prison, remand homes and other penal institutions.

### **7.2.3 Ministry of Gender, Sports, Culture and Social Services**

- i) Integrating into Community Youth Polytechnics and vocational training programmes information about population, adolescent reproductive health and development issues.

- ii) Encouraging folk media and modern theatre productions on themes related to reproductive health, family planning, population and development, and ensuring young people are directly involved in such productions.
- iii) Examining traditional cultural values and practices that promote and support adolescent reproductive health.
- iv) Providing supportive systems to girls who drop out of school because of pregnancy.
- v) Promoting ARH messages through sports.
- vi) Strengthening population and reproductive health issues under adult literacy activities, with youth-specific modules.

### 7.2.4 Ministry of Justice and Constitutional Affairs and the State Law Office

- i) Providing legal guidance and facilitating enactment of necessary laws on matters concerning adolescents and reproductive health.
- ii) Revising and enforcing relevant laws to provide adequate protection to juveniles, orphaned adolescents and children in difficult circumstances.
- iii) Enacting and enforcing legislation to provide for severe sanctions for people who sexually exploit or abuse children and young people.
- iv) Revising the law on rape to reduce the reporting burden on adolescent and child victims of rape and providing equally severe punishment for the crime of defilement as for rape.
- v) Enforcing the Dangerous Drug Addicts Law and laws against substance and drug peddlers.
- vi) Conducting research into legislative needs and requirements of the country in respect to all matters of adolescent health and well-being.

**Role:**  
**Enacting and enforcing legislation to provide severe sanctions for people who sexually exploit or abuse young people.**

### 7.2.5 Ministry of Health

The Ministry of Health's Division of Primary Health Care is one of the principal implementers of this Policy. This office will carry out its responsibility by:

- i) Coordinating and implementing reproductive health programmes including family planning and ensuring that ARH&D concerns are fully integrated into all such programmes.
- ii) Implementing and coordinating adolescent health aspects of STI/HIV/AIDS programmes.
- iii) Producing and disseminating health and education information, messages and materials with special emphasis on ARH&D.
- iv) Providing appropriate information to young people and enhancing awareness of issues related to smoking and consumption of alcohol and harmful drugs.
- v) Training health personnel at all levels and ensuring that adolescent reproductive health is integrated into the training curricula of all medical and paramedical personnel.
- vi) In liaison with other agencies, carrying out research on adolescent reproductive health issues.
- vii) Developing a strategic plan on adolescent reproductive health that will guide the implementation of the health aspects of this Policy within the government and private health services framework.
- viii) Ensuring the provision of adolescent-friendly reproductive health information and services at all government health facilities.

*Role:*  
**Ensuring the provision of adolescent-friendly reproductive health information and services at all government health facilities.**

### 7.2.6 Ministry of Planning and National Development

NCPD's mandate is to advise and guide all ministries in matters pertaining to population and development. This will now include the implementation of this Policy as well as all ARH&D projects and activities or components of the same in population and reproductive health projects. In addition to the specific activities of NCPD, the Ministry of Planning and National Development will be responsible for:

- i) Ensuring sufficient budgetary allocation for adolescent reproductive

health activities commensurate with the numbers and importance of this population age group, and enforcing full accountability of the expenditures.

- ii) Mobilizing local and international resources to support adolescent and youth programmes, especially on such critical issues as mitigating the impact of the HIV/AIDS epidemic.
- iii) Integrating and mainstreaming ARH&D issues into development planning at all levels, with special emphasis on the impact of HIV/AIDS.
- iv) Providing demographic data to all ministries, NGOs and other agencies and assisting in conducting surveys and research.
- v) Providing the relevant population information disaggregated by age and district, division and location levels.

### 7.2.7 Ministry of Education, Science and Technology

- i) Continuing to review and integrate HIV/AIDS education at all levels of the education system.
- ii) Ensuring the integration of reproductive health education into the curricula at all levels of the education system.
- iii) Mobilizing individual and organization support for the implementation of ARH&D and population education programmes.
- iv) Supporting population and ARH&D research programmes and integrating reproductive health education into the non-formal training programme.

*Role:*  
**Ensuring the integration of reproductive health education into the curricula at all levels of the education system.**

### 7.2.8 Ministry of Tourism and Information

- i) Using their facilities and infrastructure to inform and educate people about ARH&D issues, and their implications.
- ii) Providing a voice for the articulation of ARH&D issues to the public and other stakeholders through government media and broadcast services.

- iii) Developing publicity programmes that demonstrate the impact on national development of a high population dependency ratio, a high proportion of youth in the population and related issues, and the role of government, NGOs, and other agencies and individuals in combating the negative impact of such problems.
- iv) Taking decisive steps to minimize 'sex tourism', especially as it relates to young people.

### **7.2.9 Ministry of Environment, Natural Resources and Wildlife**

- i) Establishing programmes to educate the youth about the environment as a 'good' that has value, and can appreciate or depreciate. Consequently, programmes to create awareness on prudent environmental management such as proper waste disposal, guarding against environmental degradation and depletion of natural resources as a direct result of excessive population should be initiated by the ministry.
- ii) Developing population and environmental education themes and materials for incorporation into all training programmes.

### **7.2.10 Ministry of Agriculture and Livestock Development**

- i) Integrating population and reproductive health education activities into the training programmes of agricultural extension workers in order to equip them with the relevant skills for relating these issues to food production and consumption and other development activities at the local level.
- ii) Developing programmes to highlight the impact of a growing youth population on the provision and delivery of adequate food for the country.

### **7.2.11 Ministry of Labour and Human Resource Development**

- i) Continuing to provide information on primary health care including family planning and ARH&D at places of work.

- ii) Advocating for the provision of childcare services to women at the places of work.
- iii) Developing programmes aimed at protecting adolescents from exploitation and abuse at the place of work.

## 7.3 Roles of Non-Government Entities

The implementation of this Policy will require the full cooperation of a wide range of interested parties, including NGOs, community-based organizations (CBOs) and the private sector, as well as religious institutions, families and communities, mass media, and young people themselves.

### 7.3.1 NGOs, CBOs and the Private Sector

As important potential partners in the implementation of this Policy, supplementing the inputs of Government Ministries and departments, the role of these groups will include:

- i) Providing adolescents with sexual and reproductive health services within the primary health care context such as quality family planning, counselling, information, education and communication, and services.
- ii) Providing IEC materials that are culturally sensitive, comprehensive and inclusive of all relevant issues such as sexuality, STD/HIV/AIDS, unwanted pregnancies and early childbearing, unsafe abortion, contraceptives, responsible behaviour, etc., for special groups like parents, teachers, religious institutions, service providers and others.
- iii) Carrying out research on issues of relevance to the implementation of this Policy and sharing these findings with both government and non-government partners.
- iv) Providing technical support in the training and re-training of existing health care service providers on the management of adolescent reproductive health problems to enhance the provision of youth-friendly services.

*Role:*

**Building the capacity of adolescents to manage ARH&D programmes and to demand their right to quality RH services and information.**

- v) Building the capacity of adolescents to manage ARH&D programmes and to demand their own rights to access to quality services and information on reproductive health.
- vi) Mobilizing resources for ARH&D programmes.
- vii) Acting as watchdogs to ensure this Policy is implemented at all levels of the society.

### 7.3.3 Religious Institutions

- i) Providing moral and spiritual guidance in the implementation of this Policy and any programmes that will follow from it.
- ii) Providing counselling, information and services in the field of adolescent sexuality consistent with their religious beliefs.

**Role:  
Advocating,  
promoting, and  
supporting the  
implementation  
of this Policy  
and programmes  
and the  
provision of  
information and  
services to the  
youth.**

### 7.3.4 The Family and the Community

- i) Continuing with the traditional role of supporting, socialization and moulding of the lives of adolescents, while recognizing emerging socio-economic and cultural challenges.
- ii) Advocating, promoting, and supporting the implementation of this Policy and programmes and the provision of information and services to the youth.
- iii) Supporting fully the integration of youth issues into the social, legislative and policy development agenda and supporting the eradication of harmful traditional practices.

### 7.3.5 Mass Media

- i) Producing and serializing programmes and features on adolescent reproductive health and development.
- ii) Ensuring that issues of adolescent health and well-being are kept in the forefront of public consciousness through regular debates,

- features and critiques on programmes, policies and actions of the various players in this field.
- iii) Providing adequate space and airtime for the coverage of adolescent and youth reproductive health issues commensurate with the important position of this population age group in national development.
  - iv) Censoring pornographic 'entertainment', as it negatively affects the sexual behaviour of young people, who tend to imitate what they see, hear and read. Such 'entertainment' is also a hindrance to behaviour change programmes.

### 7.3.6 Young People

- i) Advocating, promoting and supporting the implementation of this Policy.
- ii) Seeking appropriate information for themselves as young people and enhancing awareness of issues related to consumption of alcohol and harmful drugs.
- iii) Mobilizing individuals, other young people, leaders and the community to support the implementation of the Policy using existing structures in folk media and modern theatre.
- iv) Articulating adolescent reproductive health issues to the public and other stakeholders.
- v) Taking the initiative to make responsible life decisions and positively change their sexual and reproductive health behaviours.
- vi) Supporting fully the integration of youth issues into the social, legislative and policy development agenda.
- vii) Helping to mobilize and sensitize the community on reproductive health aspects that affect adolescents and draw support for the same.
- viii) Advocating for the eradication of harmful social-cultural practices that affect the youth.
- ix) Seeking and using ARH counselling, information and services.

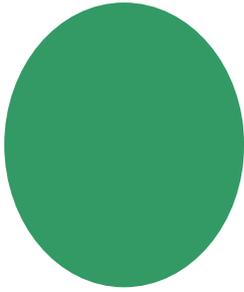
**Role:**  
**Taking the initiative to make responsible life decisions and positively change their sexual and reproductive health behaviours.**

### 7.3.7 Political Parties

- i) Supporting fully the integration of youth issues into the social, legislative and policy development agenda.
- ii) Ensuring that the issues of youth, including ARH&D, are well articulated in their manifestoes, programmes and plans.
- iii) Helping mobilize and sensitize the community on reproductive health aspects that affect adolescents and drawing up support for the same.
- iv) Providing for the direct participation of young people in political, economic and government power structures.

### 7.3.8 Universities and Colleges

- i) Providing training on adolescent health, family planning, and population and development.
- ii) Carrying out research on population, ARH&D, and related issues.
- iii) Conducting focused research into such little-understood areas as: the sexuality needs of handicapped young people and those living in difficult circumstances, incest, homosexual youth behaviour, etc., and providing for the wide dissemination of such findings.
- iv) Providing consultancy and advisory services to youth organizations, NGOs and Government on adolescent reproductive health and development.



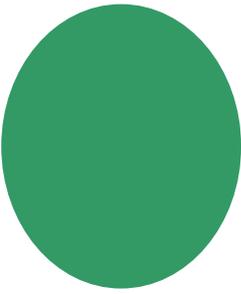
# 8

## Conclusion

The health concerns of young children, adults and the elderly have hitherto taken precedence over the needs of adolescents. This Policy is an effort to highlight adolescent health issues and bring them into the mainstream of health and other social services. Young people form a critical national resource for today, and the core of our future development efforts. Their health is a worthwhile investment for future growth and development.

Young people have great potential to contribute to the process of decision making and the implementation of programmes for their own benefit as well as the development of society at large. The understanding, adoption and implementation of this Policy will contribute positively to the efforts to emancipate young people and integrate them into social development efforts. All persons and organizations with a stake in the lives and health of adolescents are urged to take special consideration of this Policy and its ideals in their day-to-day work.

**Young people form a critical national resource for today, and the core of our future development efforts. Their health is a worthwhile investment for future growth and development.**



## Glossary

**Contraceptive prevalence rate:** The percentage of married women of reproductive age (15–49) who are using any method of family planning, whether modern or traditional, to space or limit births.

**Gross enrolment rate (GER):** Statement of the total number of children in school in standard 1–8, divided by the total number of children aged 6–13, and multiplied by 100.

**Infant mortality rate (IMR):** The number of deaths of infants under one year of age per 1,000 live births in a given year.

**Life expectancy:** Average number of years a person would live if the current mortality trends were to prevail.

**Maternal mortality rate (MMR):** The number of deaths of women resulting from pregnancy and birth complications per 100,000 live births in a given year.

**Reproductive health\*:** State of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system, its functions and processes.

**Reproductive rights:** Rights, embracing certain basic human rights that are already recognized in Kenyan law and in international human

rights documents and other consensus documents, that have emerged as a separate area of concern requiring attention. These include the right of the youth to receive adequate information on family planning and the right of couples to determine responsibly and freely the number of children they would want to have and how to space them. They also include the right of HIV/AIDS infected individuals to receive health care without being discriminated against due to their state, and the right of the spouse or partner to know that their spouse is infected. Reproductive rights embrace the medical protocols regarding consent and confidentiality. *The National Policy for Population and Sustainable Development makes it clear that abortion will not be used as a method of family planning in Kenya and every attempt will be made to eliminate the need for abortion through reliable information, counselling and services.*

**Safe motherhood:** A concept whose aim is to assist women to achieve safe pregnancy and delivery leading to healthy babies of healthy mothers.

**Sexual health and rights:** Sexual health aims at the enhancement of life and personal relations, and sexual health services should not consist merely of counselling and care related to reproduction and sexually transmitted diseases. Sexual rights include the human rights of all persons to have control over and decide freely and responsibly on matters related to their participation in and enjoyment of sexual and reproductive health free of coercion, discrimination and violence.

**Total fertility rate (TFR):** The number of children that would be born alive to a woman during her lifetime, taken as an average of a given group of women.

**Unmet need:** Term used in the context of family planning in this Policy. A married woman of reproductive age will be said to have unmet need for family planning if she wants to either space or limit births and is not using any method of family planning.

\*World Health Organization definition

