Lonnie Embleton*, Celestine Ashimosi, Sheila Kirwa, Ava Boal, Ashley Chory, Thiyasha Kodituwakku, Camila Johanek, Mary A. Ott, Rachel C. Vreeman and Irene Marete

Contextual challenges of implementing adolescent and youth-friendly health services in Uasin Gishu county Kenya: a qualitative analysis

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Abstract

Objectives: Substantial gaps in the implementation of adolescent and youth-friendly health services (AYFHS) have been identified in Uasin Gishu (UG) county, Kenya, across all eight domains of the WHO global standards, particularly with respect to adolescent health literacy, community support, provider competencies, and equity and non-discrimination. To respond, we undertook a qualitative analysis to explore contextual challenges of implementing AYFHS from the perspectives of adolescents and young adults (AYA) aged 10-24 years, policymakers, caregivers of AYA, healthcare providers, peer mentors, and community leaders.
Methods: We used a hybrid inductive/deductive thematic analysis to explore contextual and systems-level determinants of implementing AYFHS in UG county, Kenya.
Results: Our analysis generated four major themes: 1) priorities of political leadership and health systems management; 2) financial challenges; 3) human resources and facility infrastructure; and 4) social-cultural barriers. Participants perceived political will, leadership, and health systems management to be obstacles to implementing AYFHS. Further, participants stated that financial challenges were a leading barrier to the implementation of AYFHS in the county, and that dispersion of funds from the county government to facilities was inadequate. Intersecting with the political-economic context, participants discussed limited human resources, poor facility infrastructure, and supply issues as determinants of implementation. Lastly, social-cultural norms in association with sexual and reproductive health discussed as a substantial issue.
Conclusions: Addressing implementation determinants of AYFHS, including political, economic, and social-cultural barriers, can enable adoption and facilitate implementation and scale of AYFHS that are a fundamental component of living healthy and productive lives for AYA in Kenya.

Keywords: implementation; youth-friendly; health services; policy; Kenya; adolescents

Introduction

All too often, we have the tools, knowledge, and evidence to solve a problem or address an issue but fall short when it comes to translating research and policy into practice – referred to as the *know-do gap*. To ensure health services are 'adolescent and youth-friendly', there are robust global evidence-based guidelines, which include eight standards, and criteria to support improving the quality of health services for adolescents and young adults (AYA) developed by the World Health Organization (WHO) [1]. In their first release of the eight global standards for quality health-care services for adolescents, the WHO developed an implementation guide and monitoring tools, which outlines actions at the national, district, and facility levels to provide detailed guidance on the steps that need to be taken to implement and evaluate the standards [2, 3].

For over 20 years, Kenya has had policies in place to strengthen the delivery of health services to AYA. Prior to the development of the WHO global standards, Kenya had

***Corresponding author: Lonnie Embleton**, MPH, PhD, Department of Global Health and Health System Design, Icahn School of Medicine at Mount Sinai, New York, NY, USA; and Arnhold Institute for Global Health, Icahn School of Medicine at Mount Sinai, 1216 Fifth Avenue, 5th Floor, New York, NY 10029, USA, E-mail: lonnie.embleton@gmail.com. https://orcid.org/0000-0002-9415-8903
Celestine Ashimosi and Sheila Kirwa, Academic Model Providing Access to Healthcare (AMPATH), Eldoret, Kenya
Ava Boal, Arnhold Institute for Global Health, Icahn School of Medicine at Mount Sinai, New York, NY, USA
Ashley Chory, Mary A. Ott and Rachel C. Vreeman, Department of Global Health and Health System Design, Icahn School of Medicine at Mount Sinai, New York, NY, USA; and Arnhold Institute for Global Health, Icahn School of Medicine at Mount Sinai, New York, NY, USA
Thiyasha Kodituwakku, Graduate School of Biomedical Sciences at Icahn School of Medicine at Mount Sinai, New York, NY, USA
Camila Johanek, Icahn School of Medicine at Mount Sinai, New York, NY, USA
Irene Marete, Academic Model Providing Access to Healthcare (AMPATH), Eldoret, Kenya; and Department of Child Health and Pediatrics, School of Medicine, Moi University, Eldoret, Kenya

established a strong Adolescent Reproductive Health and Development (ARHD) policy [4, 5]. A 2012 implementation assessment of the 2003 ARHD policy, found limited implementation of the policy due to factors such as a lack of awareness, low political will, financial constraints, limited stakeholder and youth involvement, and social-cultural norms, particularly religious beliefs and gender norms [6]. In 2016, Kenya established national guidelines for the provision of AYFHS in alignment with the eight WHO global standards, including an implementation framework [7].

Despite robust global standards and implementation guidelines, across sub-Saharan Africa, synthesized evidence demonstrates that AYFHS have been variably implemented with substantial gaps related to the eight global standards for quality healthcare services for adolescents [8]. A recent study undertaken in Uasin Gishu (UG) county, Kenya found substantial gaps in the implementation of AYFHS across all eight of the global standards in 18 sampled public health facilities located in urban, peri-urban, and rural settings [9]. Notably, the study identified that there were: 1) significant limitations in adolescent health literacy resulting in reduced service awareness among AYA (Standard 1); 2) limited community support, particularly for sexual and reproductive health services (Standard 2); 3) gaps in the availability of essential services, such as HIV testing, sexual and reproductive health, mental health, and immunizations (Standard 3); 4) few providers trained in the provision of AYA care (Standard 4); 5) limited dedicated space and privacy in facilities for AYA (Standard 5); 6) fees for services and accounts of ethnic discrimination (Standard 6); limited data collected and disaggregated by age and sex to support quality improvement (Standard 7); and minimal participation of adolescents in the planning, monitoring, and evaluation of health services (Standard 8). These findings suggest challenges in implementing the national guidelines for the provision of AYFHS in Uasin Gishu county.

Implementation research, can help identify, understand, and address implementation bottlenecks [10]. Contextual determinants of implementation can refer to an array of factors that influence an implementation effort; however, Nielson and Bernhardsson classify common dimensions of 'context' including organizational support, financial resources, social relations and support, leadership, and organizational culture and climate [11]. In Kenya, identifying and understanding contextual and systems-level implementation bottlenecks is essential given the devolved government structure, where county governments are responsible for management and delivery of health services [12]. To date, very few studies have rigorously examined and evaluated AYFHS in Kenyan public health facilities [6, 13–15], resulting in limited understanding of both if and how the standards are being implemented. In response to identifying substantial gaps in the implementation of AYFHS in alignment with the eight global standards and criteria in UG county, Kenya [9], we undertook a qualitative analysis to explore contextual challenges of implementing AYFHS from the perspectives of AYA aged 10–24 years, policymakers, caregivers of AYA, healthcare providers, peer mentors, and community leaders.

Methods

Study design

This analysis draws on a subset of qualitative data collected from January to June 2024 as part of a larger mixed methods study on AYFHS in UG county Kenya [9, 16, 17]. This qualitative analysis uses data from focus group discussions (FGDs) with Kenyan AYA aged 10–24 years living in urban/peri-urban and rural locations and in-depth interviews with a range of knowledge users, including policymakers, caregivers of AYA, healthcare providers, peer mentors, and community leaders (e.g., Chiefs and village elders).

Study setting

UG county is in western Kenya, and its administrative capital, Eldoret, is home to the Academic Model Providing Access to Healthcare (AMPATH), Moi University, and Moi Teaching and Referral Hospital [18]. Approximately, 35 % of the UG county population are AYA aged 10–24 years [19]. The administration of the health system is devolved to the county government. Health services delivery in UG county Kenya span six public health facility levels: community (1), dispensary (2), health centres (3), sub-county hospitals (4), county referral hospitals (5), and national referral hospitals (6) [12].

Study participants, sample size, sampling, and recruitment

Detailed information about study participants, sampling, and recruitment strategies have been published elsewhere [9, 16, 17]. We worked with the local county government to ascertain approvals and gain community entry, and collaborated with local Chiefs, village Elders, and community health volunteers (CHVs) in urban, peri-urban, and rural locations across the county to conduct community mobilization, study sensitization, and recruit a convenience sample of AYA and purposive sample of knowledge users. In total, we recruited 127 AYA aged 10–24 years to participate in

16 age- and gender-stratified FGDs. We also purposively sampled and recruited 40 knowledge users, which included 15 healthcare providers, 5 policymakers, 10 caregivers of AYA, 5 peer mentors, and 5 community leaders who were Chiefs or village elders.

Study procedures

FGDs with consented and assented AYA were conducted by the study Research Coordinator and Research Assistant in Swahili at local health facilities, in rural or urban settings. FGDs occurred in a private space in the health facility, were audio-recorded, and took 1–1.5 h. IDIs were conducted face-to-face by the study's Research Coordinator in a private space with consented participants. Interviews were conducted in Swahili or English depending on the participants' language preference, were audio-recorded, and took 40 min to 1 h. In-depth details about study procedures can be found elsewhere [9, 16, 17].

Sources of data

Interview guides were developed to ascertain rich qualitative data on AYFHS in the county, including health needs among AYA, access to care, preferences for health services delivery, and perceived barriers to and facilitators of implementing AYFHS. Specifically, participants were asked "*From your perspective as a [caregiver, stakeholder, healthcare provider, policymaker, or AYA] what are some the barriers to implementing adolescent and youth-friendly services in UG county*?". With follow-up probes to further understand barriers to implementation from the perspectives of participants. Data from interviews were transcribed, translated, and then reviewed by the study team who conducted the interviews to verify the quality of the transcription and translation.

Analysis

We conducted an inductive and deductive thematic analysis and iteratively produced a detailed codebook capturing a wide variety of codes that align with the WHO eight global standards, including implementation challenges [20, 21]. A team of five individuals collaboratively developed a codebook during an initial round of coding using Atlas.ti web. In our first round of coding, we broadly captured 'implementation challenges'. Subsequently, it became apparent through a reading of this code, participants were primarily discussing contextual and systems-level determinants of implementation. For the purposes of this analysis, we defined contextual determinants of implementation to include political, economic, social-cultural, and facility-level issues. We further analyzed the data captured under the major code 'implementation challenges', creating a series of codes capturing contextual and systems-level implementation challenges in the local context.

Results

Our analysis identified contextual challenges of implementation of AYFHS and generated four major themes: 1) priorities of political leadership and health systems management; 2) financial challenges; 3) human resources and facility infrastructure; and 4) social-cultural barriers.

Priorities of political leadership & health systems management

Participants discussed a variety of political contextual factors that were perceived to be obstacles to implementation of AYFHS, including county-level priorities, political will, and health systems management. Accounts from healthcare providers and policymakers emphasized limited political prioritization of AYFHS and inconsistent commitment from political leaders resulting in weak implementation structures at county level. The interest and determination of political leaders to establish and maintain AYFHS was reflected upon by one healthcare provider "*One could be that leadership, may not have that interest to support, such a friendly clinical service*." Two policymakers explained that competing priorities in the health system contribute to a lack of dedicated AYFHS, whereby other health issues take a priority as explicitly stated by a policymaker:

> So the challenges we have is, because we don't give priority [to youth], even us at the policy making level, when I say I want to create a room for youth here, I will be told 'And then what, where will I put children with diabetes, where will I put the diabetic…' maybe a child corner, some x-ray I need to put there…we've not changed our thinking to see even that youth deserves to sit there. (Policymaker 3)

These accounts suggest that AYFHS are often perceived as secondary to other pressing health system demands, limiting the extent to which AYFHS have become embedded within the county-level health system. This was expanded upon further by a policymaker who also discussed the political willingness to implement AYFHS and the implications of frequent changes in leadership:

> There should be also that…we call it what, goodwill, goodwill from the leadership's and all that. You know when there is goodwill, you can move far. But of course, I'm not saying there's no good way, but you know political leaderships are never permanent. We can have something that somebody has in heart today, and thereafter you have a change in guard, and everything is shut all of a sudden. (Policymaker 5)

Participants therefore portrayed implementation as heavily dependent on individual political champions, making AYFHS vulnerable to disruptions associated with leadership turnover and shifting political agendas. In conjunction with political will and leadership, several participants suggested there were systems-level issues impacting implementation as explained by a healthcare provider "*They have not put systems in place, number one starting from county or national to the county, from county to the ground level.*" Participants suggested there were a lack of '*structure*' or guidelines from the county health management teams to implement AYFHS.

These findings suggest there is a cascade-type effect driving contextual implementation challenges, starting at the political level, where county-level policymaker's control whether policy is translated into practice in the health system. A confluence of political challenges, including competing health system priorities, political will, and changing political leadership hinder the implementation of AYFHS at the county-level despite robust national guidelines. Even when AYFHS become a political priority, frequently changing county leadership may hinder moving implementation forward. Likewise, while a political leader may champion AYFHS as health system priority, the systems and guidance to implement AYFHS in accordance with national policy at the county-level may be inadequate as outlined by a healthcare provider. While the existing national guidelines offer an 'implementation framework', counties may require adapting and expanding upon this framework for their local context due to the devolved system of governance, which leaves counties accountable for health systems management.

Financial challenges

Financial constraints were consistently described as a major barrier to the implementation of AYFHS and were closely linked to broader political and health systems prioritization. Across participant groups, inadequate funding was perceived to limit the establishment of dedicated adolescent services, infrastructure, staffing, and service delivery capacity. Numerous participants stated that financial challenges were a leading barrier to the implementation of AYFHS in the county, as stated by a policymaker '*number one would be finances.*' Participants discussed that dispersion of funds from the county government was inadequate:

> I may say resources could be a big challenge, you'll find that maybe resources in terms of finance and in terms of labor. So, you will find that a facility, like that maybe that the resources provided by the county government may not be enough to create a specific clinic to assist a specific age bracket of a certain population. (Healthcare provider 09)

One urban adolescent girl, aged 14–16 years, suggested that unequal distribution of government funds was an important barrier: '*Money issue. The government is not…is not taking full reach as they do not consider some of these things, they only consider schools.*' Overall, healthcare providers, peer mentors, AYA, and policymakers were all in agreement that a lack of financial resources limited the ability to set up AYFHS and to ensure that there are adequate infrastructure, service providers, and commodities for service provision.

The allocation of financial resources to AYFHS within the health system ties directly to political prioritization and health systems management. Without AYFHS being a priority area identified for health systems strengthening by the county government, funds will not be adequately allocated within the health system to implement robust AYFHS in alignment with national-level policy. Participants across healthcare providers, policymakers, peer mentors, and adolescents linked insufficient financial investment to an inability to operationalize AYFHS within facilities. Financial limitations were described as constraining not only the physical establishment of youth-friendly spaces, but also the availability of trained personnel, equipment, and commodities required for service provision.

These findings ultimately suggest that financial barriers were not viewed as isolated resource shortages, but rather as consequences of how adolescent health was de-prioritized by policymakers working within devolved county health systems. Participants portrayed funding allocation as closely tied to political commitment, whereby AYFHS remained difficult to implement when adolescent health was not identified as a key area for county-level health systems strengthening.

Human resources and facility infrastructure

Several participants, primarily service providers, discussed human resources as a significant barrier to implementing AYFHS, as stated by a healthcare provider '*and other thing is we lacked staff, due to shortage of staff, we cannot offer that service*'. The issue of staff shortage was expanded upon by another provider who discussed how a lack of human

resources influences wait-times for care, young people's engagement in care, and ultimately providers' abilities to implement AYFHS:

> One, one of the barriers is the issue of staff…the staff…personnel, ratio of healthcare seekers to the health care providers as we speak is… it's wide, you will find every instance as an individual provider may be required to see 100 of them in day… Remember each individual, [the] time they require is individual-based, some may have a myriad of issues which require maybe time, greater time to probably alleviate such issues. So, by the time you are getting to number 100, probably they will have gone…they will have walked away and chances of them coming back again will be challenging. (Healthcare provider 12)

Staffing shortages therefore not only affect healthcare provider workload, but also influence adolescents' willingness and ability to seek and receive care. Long waiting times and overstretched providers were perceived to undermine the delivery of AYFHS. Gaps in staffing leave the few available providers fatigued and overwhelmed, resulting in no one thinking about implementing AYFHS as explained by another provider:

> There is that burnout. Yeah, there's a lot of work, so nobody's even thinking of creating extra time to address these issues or even look at the adolescents and the issues they have and give them the proper treatment. (Healthcare provider 15)

Healthcare providers discussed that a facility's infrastructure and supplies were also a barrier to implementing AYFHS, particularly space, as explained by one provider, "*that is the space… Because they will need somewhere which is private.*" This extended to a recognition of a lack of supplies and equipment to adequately implement these services as well, as stated by another provider "*I think we are lacking some of the equipment, like now, we might be willing to have youth friendly services, but we don't have an extra room to offer the services.*" Ultimately, a lack of human resources, facility infrastructure, and supplies intersect with political-economic determinants of implementation, given that the delivery of health services and health systems management rests with the county government. When adequate funds are not allocated to the health system, including to implement AYFHS, then there are inadequate numbers of trained healthcare providers and staff, space, and equipment to offer those services.

Taken together, participants portrayed human resource and infrastructure challenges as interconnected with broader political and economic determinants of implementation. Inadequate county-level investment in the health system was perceived to contribute to shortages in trained staff, limited physical space, and insufficient equipment, thereby constraining facilities' ability to operationalize AYFHS in practice.

Social-cultural barriers

Participants ranging from healthcare providers, policymakers, and peers brought up social-cultural norms related to sexual and reproductive health as a contextual barrier to implementing AYFHS. One healthcare provider explained that a common perception is that AYFHS equates with giving young people family planning "*so, the community…as in they take it negatively because they think when you are just putting up that structure of youth-friendly, you are coming there specifically to give the family planning*." As explained by another healthcare provider, the use of family planning by unmarried young people is considered forbidden:

> There is that culture. For example, when I was talking about family planning, you cannot go and do family planning…you cannot go and provide family planning services in the community to these children, adolescents. It is looked at as a taboo. It's not something that should be happening, ideally, in the community. So, there is… how do we call it? There is that culture thing. Yeah, the people's way of living. (Healthcare provider 15)

Two participants discussed it being a common belief in the community that young people should finish school and be married before using family planning. The intersection of cultural beliefs and religion works to impede implementation of AYFHS, as explained by a peer mentor:

> In the community there are cultures, like for contraceptives, some believe it is not good for the youth when you are not married so they give them traditional herbs they are advised against, another thing is religion, they are told not to go for services at the hospital they use traditional medicines, that's what hinders the implementation. (Peer 04)

This was also confirmed by one policymaker, who further explained how social-cultural attitudes about sexual and reproductive health were generally a product of religious beliefs:

> Yeah, of course the community is, as I said, from the onset, there is still those cultural beliefs, that people don't want this and even Christian… not necessarily Christian, but religious beliefs that are like against certain things, yeah, those are the barriers [to implementation]. (Policymaker 05)

Social-cultural norms in this context that influence a lack of community support for the delivery sexual and reproductive health services to AYA, likely intersect with and are interconnected to the political prioritization to implement AYFHS

in this context. Politicians are elected by local constituents, and prioritize their political platform, and policies they will implement to align with what will resonate with the electorate. If constituents in Uasin Gishu county are not supportive of AYFHS, then it leaves little incentive for politicians to prioritize the implementation of AYFHS at the county-level.

Participants therefore portrayed social-cultural resistance as extending beyond individual beliefs to broader community norms that shaped acceptability of AYFHS. These findings also suggest that political prioritization of AYFHS may be interconnected with community attitudes, as elected leaders may be less inclined to champion AYFHS when such services are perceived as conflicting with local cultural or religious values.

Discussion

This analysis highlights core contextual determinants of implementing AYFHS in UG county Kenya, demonstrating that political, economic, and social-cultural factors intersect and play a strong role hindering implementation. Approaches to intervene and address these barriers to implementing AYFHS will require multi-faceted and collaborative approaches across sectors to overcome these contextual-level determinants of implementation.

The management and delivery of health services in Kenya is a responsibility of county governments; however, the national government retains policy and regulatory roles [12]. Several challenges have been reported with the devolved healthcare system in Kenya, including inadequate resources/staff, medical and equipment supply issues, and financial challenges [12]. There is little evidence available related to the implementation of nationally developed health systems policies by county governments, such as the guidelines for the provision of AYFHS [7]. However, Okoth et al. recently found that policies for adolescent sexual and reproductive health 'evaporate' in practice with the devolved system of governance [22]. The limited implementation of AYFHS in UG county in alignment with national guidelines [7, 16], suggest the bottleneck rests with a failure to translate national-level policy into county-level practice. While participants in the present analysis, including policymakers, cited leadership, political will, and low prioritization of AYFHS as core political determinants influencing the implementation of AYFHS in UG county, if national-level policy exists, efforts should be made to facilitate guaranteeing health services managed and administered at the county-level are in alignment with national policy. It is clear that devolution of health services in Kenya represents formidable challenges to uniformly implementing AYFHS across counties in alignment with national policies and WHO guidelines [12, 22]. To uniformly implement AYFHS across Kenya and to reduce inequities in health services delivery to AYA across counties, there is a need to strengthen accountability mechanisms, provide technical assistance and capacity building, and launch robust monitoring and evaluation systems from a national-level to ensure county-level implementation. This process could be supported in collaboration with academic, non-governmental, and international institutions, while looking to cross-county collaboration as AYA health is a national concern, with Kenya's youthful population.

In association with governance, funding and allocation of funds were key barriers to implementation identified in this analysis. Funding for public health services delivery is budgeted and allocated by county-level governments [23]. Budget allocation not only impacts the delivery of health services, but staffing, infrastructure, and medical supplies and equipment. Financial challenges can only be resolved when AYFHS become a priority agenda item for county governments, who are responsible for budgeting and allocating funds within the health system. Private-public partnerships may be an avenue to grow the implementation of AYFHS in this context but should be considered cautiously given the limited evidence related to implementation, quality improvement, and improvements in population health associated with these partnerships [24].

Finally social-cultural factors represent a formidable challenging to implementing AYFHS in this context. As shown in this analysis, there is a community perspective that equates AYFHS solely with the provision of sexual and reproductive health services. Yet, AYFHS should provide holistic and comprehensive health services to AYA, encompassing mental health, sexual and reproductive health, HIV, nutrition and physical activities, injuries and violence, substance use, and immunization [1]. AYA in Kenya continue to disproportionately acquire HIV, have high levels of adolescent and unintended pregnancies, substantial mental health issues, and experience high levels of violence [25–28], suggesting they need comprehensive and tailored services for their diverse needs. Advocacy and education on youths' need for comprehensive health services in the community through traditional social-cultural structures, such as community barazas held by Chiefs and village elders, are a viable starting point to dispel myths and misconceptions about AYFHS to garner community support [29]. Given participants' emphasis on the role of religion, engaging support from religious leaders will also be critical to shift community perceptions. When the community is supportive of

delivering AYFHS, it can be a lever for activism to ascertain local political buy-in and ensuring AYFHS are a health system priority for county politicians.

This analysis has limitations as well as strengths. First, this analysis draws on a sub-set of data from a broader study on AYFHS in UG county and was not designed to measure or ascertain data on all facets of implementation challenges and therefore may not capture the breadth of implementation challenges that may hinder wide-scale adoption. Second, given that health is devolved to county governments, the contextual implementation challenges identified in this county may not be generalizable to other Kenyan counties. Nonetheless, this analysis draws on data collected from a wide range of knowledge users living in different geographic locations of UG county and identifies important barriers to implementation that are likely highly relevant to address to bridge the know-do gap. Finally, given that there is little evidence reported on the implementation of AYFHS in sub-Saharan Africa, this analysis makes an important contribution to the literature.

Conclusions

Investing in AYA health is critical in a context where young people make up a substantial portion of the population. AYA require health services that are tailored and responsive to their needs so they can achieve and maintain physical, mental, and social health throughout their life course, and have an economically productive future for the nation. To ensure AYA have the health services they require, it is critical to bridge the gap between national policy and county-level practice in Kenya. Addressing implementation determinants of AYFHS, including political, economic, and social-cultural barriers identified in this analysis, can enable adoption and facilitate implementation and scale of AYFHS that are a fundamental component of living healthy and productive lives for AYA in Kenya.

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Research ethics: This study received approval from the [Blinded for Peer Review] Institutional Review Board (IRB), the [Blinded for Peer Review] Institutional Research Ethics Committee (IREC) and a research permit from the National Commission for Science, Technology, and Innovation (NACOSTI). Additional approvals were sought from the UG County Commissioner and County Director of Health to gain access to facilities and communities.

Informed consent: Informed consent was sought from parents/guardians for adolescents aged 10–17 years. Emancipated minors (e.g., those married or living independently) and young adults aged 18–24 years provided their own informed consent. Informed assent was sought from all adolescents aged 10–17 years. Informed written consent was provided by all other participants. Participants received 500 Ksh and tea and snacks during interventions to thank them for their time.

Author contributions: LE and IM led the study's conceptualization, design, and oversaw study activities. CA and SK coordinated study activities, collected and verified data. AC, KT, CJ, conducted analyses. RCV and MAO contributed to the study's design. LE led the drafting the manuscript and the statistical and textual analyes. All authors have accepted responsibility for the entire content of this manuscript and approved its submission.

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