REPORT

ADOLESCENT-FRIENDLY HEALTH SERVICES IN KENYA:

Healthcare Workers' Perspectives on Barriers & Services Offered (2022-2025)

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Solutions for Supporting Healthy Adolescents

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Healthcare Workers' Perspectives on Barriers & Services Offered (2022-2025)

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1. BACKGROUND

Access to sexual and reproductive health (SRH) services forms a crucial building block of health systems. Poor access to SRH services can result in early and unintended pregnancies, maternal mortality, HIV and sexually transmitted infections (STIs), as well as complications from untreated STIs, such as pelvic inflammation, specific types of cancer, and pregnancy and fertility issues. A health system is well equipped to provide SRH commodities and services when people are enabled to decide on pregnancy, have a healthy pregnancy and safe childbirth, protect themselves against STIs and HIV/AIDS, and are properly treated in a timely manner if transmission occurs. For a thriving society, it is also crucial that adolescents, a group often faced with additional challenges in accessing services, can access the SRH services they need to live healthy lives and protect themselves against key health risks.

Unfortunately, Kenya experiences many challenges with the adequate provision of adolescent-friendly SRH (AFSRH) services, especially in rural areas. This research was conducted to study the provision of AFSRH services and attitudes of healthcare workers (HCWs) in Isiolo, Mandera and Marsabit Counties in Kenya.

2. METHODOLOGY

This study was conducted by Access to Medicines Platform Kenya and Health Action International (HAI) as part of the Solutions for Supporting Healthy Adolescents and Rights Protection (SHARP) programme, funded by the European Union. The research was approved by the AMREF Ethics and Scientific Review Committee and National Commission for Science, Technology and Innovation (NACOSTI).

This study used an adjusted version of the HAI/World Health Organization (WHO) Methodology[1] and, through a cross-sectional survey design, gathered insight into the provision of AFSRH services in Kenyan health facilities. Teams of data collectors visited 86 health facilities in 2022 and 94 in 2025 from the public, private and faith-based sectors to assess:

1. The type of SRH services being offered at the health facility.
2. To whom these services were offered, and whether parent/guardian consent was needed.
3. The measures in place at the health facility to improve access to SRH services for adolescents.
4. The attitudes and perspectives of the HCW on AFSRH services.
5. Indicators on the general state of the health facility.

Health facilities that were included in the research ranged from health posts to county hospitals. One HCW in every health facility was requested to provide the above information. In addition, nine questions were answered by the data collector based on their observations at the health facility. HCWs were asked for their consent to participate in the study.

2.1 Sample

Table 1 shows the distribution of surveyed HCWs across sectors and urban/rural locations.

Table 1. Number of surveyed HCWs per sector and urban/rural location in 2022 and 2025

	Public		Private		Faith-based		Total	
	2022	2025	2022	2025	2022	2025	2022	2025
Urban	5	7	19	25	3	5	27	37
Rural	43	46	6	4	10	7	59	57
Total	48	53	25	29	13	12	86	94

[1] Measuring Medicine Prices, Availability, Affordability and Price Components. 2nd edition. World Health Organization, Health Action International. (2008). Geneva: Switzerland.

3. FINDINGS

3.1 Provision of Adolescent-friendly Services

In 2025, 81% of public sector HCWs indicated that their health facility had adolescent-friendly accreditation (see Table 2). This was an increase compared to 2022. Interestingly, 79% of HCWs in the public sector indicated they actually provided AFSRH services, which was also an increase compared to 2022. In the private and faith-based sectors, increases in accredited health facilities and offering of AFSRH were also observed.

Table 2. Health facilities accredited and offering AFSRH services in 2022 and 2025

	Public (%)		Private (%)		Faith-based (%)		Total (%)	
	2022	2025	2022	2025	2022	2025	2022	2025
Health facility is an accredited adolescent-friendly health facility	58	81	64	72	62	63	60	76
Health facility provides AFSRH services	65	79	80	93	69	88	70	84

Figure 1 lists some common characteristics of AFSRH services. Overall, comparing 2022 with 2025 reveals some of the indicators increased and some decreased. For example, in 2025, 75% of health facilities had dedicated staff offering adolescent-friendly SRH services, up from 67% in 2022. Similarly, slightly more facilities were open for AFSRH services during the evening and/or weekend (58% in 2022 versus 61% in 2025). Slight decreases were seen for the availability of private examination rooms (from 90% to 85%), the possibility to request to be seen by a same-sex HCW (76% to 72%) and to see a HCW without a formal appointment (93% to 90%). Table 3 disaggregates the data per sector, showing similar trends. Further, it seems that information about the SRH of adolescents is shared more often in 2025 than in 2022 across all three sectors. In 2025, for example, this information was shared with parents/guardians in 25% of public facilities, and even 62% of private facilities.

Figure 1. Adolescent-friendly organisation of care

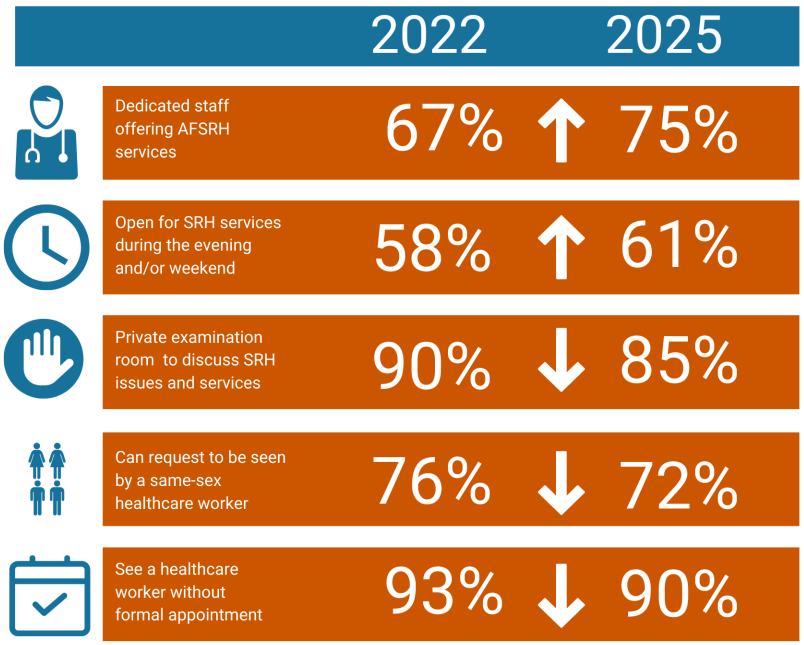
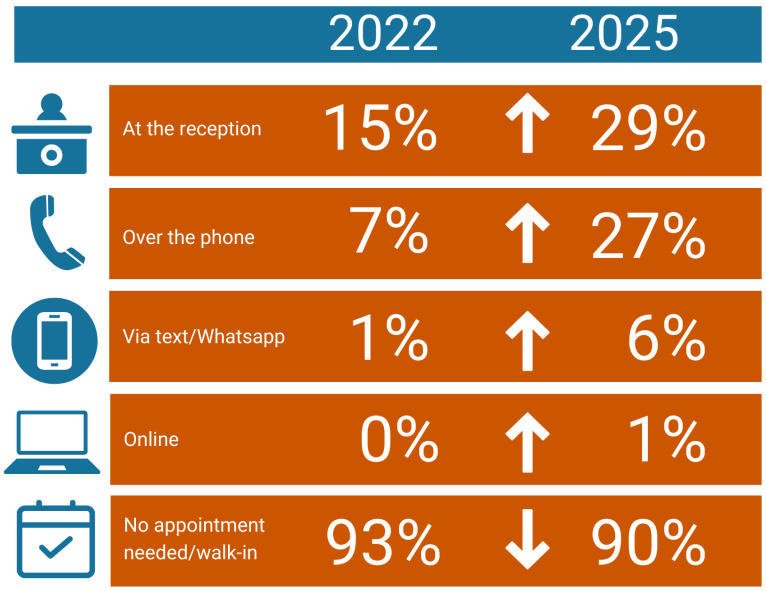


Table 3. Adolescent-friendly organisation of care, per sector

	Public (%)		Private (%)		Faith-based (%)	
	2022	2025	2022	2025	2022	2025
Dedicated staff offering AFSRH services	71	75 (↑)	68	76 (↑)	54	75 (↑)
Facility open for SRH services during the evening and/or weekend	33	52 (↑)	96	83 (↓)	77	38 (↓)
Adolescents can see a healthcare worker without formal appointment	94	90 (↓)	92	90 (↓)	92	88 (↓)
Adolescents can request to be seen by a same-sex healthcare worker	79	63 (↓)	68	90 (↑)	77	63 (↓)
Private examination room at the facility where healthcare workers meet with clients to discuss SRH issues and services	92	87 (↓)	80	100 (↑)	100	42 (↓)
Information about the SRH of adolescents who visit the health facilities is shared with:						
Their parents/guardians	13	25 (↑)	50	62 (↑)	0	25 (↑)
Their schools	7	7 (—)	28	10 (↓)	8	33 (↑)
Community/faith leaders	9	7 (↓)	24	10 (↓)	8	0 (↓)

When looking further into appointment possibilities, the 2025 research found that while in 90% of facilities no appointment was necessary, it was also possible to make appointments at the reception (29%), over the phone (27%), and to a lesser extent via text/WhatsApp (6%) and online (1%) (see Figure 2).

Figure 2. Ways in which clients can make appointments for SRH services



HCWs were also asked about their personal opinions on 11 different statements, and we have deliberately not made colour-coded value judgements on their legitimacy. That said, the data reveals that personal beliefs, be they faith-based or traditional values, pervade, and remain a barrier to access to FP and by the same token will likely have an impact on demand. Their perspectives on these statements can be seen in Table 4. Compared to 2022, in 2025 HCWs seemed to be more willing to provide contraceptives to women who are not married, with overall willingness increasing from 71% to 82%. In the public and private sectors, HCWs seemed to have become less willing to provide contraceptives to adolescents younger than 18 years. In the public sector, willingness decreased from 54% in 2022

to 46% in 2025, and in the private sector from 75% to 52%. For about half of HCWs, provision of contraceptives goes against their religion and they therefore feel they should not provide it to adolescents. Nevertheless, 89% still feel comfortable talking to adolescents about sexual health matters, even though this feeling did decrease in the public sector (from 98% in 2022 to 87% in 2025). In the opinion of HCWs long waiting times and lack of time to help adolescents seeking SRH services were an increasing issue between 2022 to 2025 . Related to this, they felt adolescents feel slightly less welcome and/or safe at the facility, and at ease to access SRH services (91% in 2022 to 80% in 2025).

Table 4. Perspectives of healthcare workers on AFSRH services

	Public (%)		Private (%)		Faith-based (%)		Total (%)	
	2022	2025	2022	2025	2022	2025	2022	2025
I advise adolescents to abstain from sex when they seek contraceptives at the health facility	49	65 (↑)	84	64 (↓)	69	71 (↑)	63	66 (↑)
Adolescents should not have sex	33	54 (↑)	40	55 (↑)	54	80 (↑)	38	57 (↑)
I am okay with providing contraceptives to women who are not married	72	78 (↑)	88	93 (↑)	38	67 (↑)	71	82 (↑)
I am okay with providing contraceptives to adolescents younger than 18 years	54	46 (↓)	75	52 (↓)	23	40 (↑)	55	47 (↓)
Contraceptive use goes against my religion and should therefore not be provided to adolescents	39	51 (↑)	42	41 (↓)	54	33 (↓)	42	46 (↑)
I feel comfortable talking about contraceptives and sexual health matters with adolescents	98	87 (↓)	96	100 (↑)	58	70 (↑)	91	89 (↓)
This facility is generally easily and safely accessible by foot or public transportation for adolescents	95	96 (↑)	100	96 (↓)	92	100 (↑)	96	96 (—)
Costs of SRH services are a barrier to adolescents at this facility	14	13 (↓)	54	24 (↓)	17	40 (↑)	26	20 (↓)
Waiting times at this facility to receive SRH services are a barrier to adolescents	12	26 (↑)	46	32 (↓)	8	30 (↑)	22	28 (↑)
Adolescents feel welcome and/or safe at this facility, and feel at ease to access SRH services	88	77 (↓)	100	84 (↓)	83	90 (↑)	91	80 (↓)
When offering SRH services to adolescents, I have enough time to sufficiently treat and answer their questions	93	91 (↓)	96	96 (—)	100	90 (↓)	95	93 (↓)

3.2 Provision of SRH Services

Table 5 shows the provision of a broad spectrum of SRH services in all surveyed health facilities. In 2025, overall, none of the 19 services were offered at 80% or more of health facilities. The most offered SRH services are information and counselling on SRH and issues (71%), family planning and contraceptive services (67%) and pregnancy testing (62%). The least offered services in 2025 were abortion care (22%), post-rape care (22%), HPV, breast and cervical cancer screening (19%), post-abortion/post-miscarriage care (16%).

Disaggregated per sector, 69% of public facilities offered information and counselling on SRH and issues in 2025, up from 58% in 2022. Family planning and contraceptive services were offered at 58% of public facilities, a slight decrease compared to 2022. Promotion of healthy sexual behaviour, menstruation care counselling and services, HIV counselling, testing and treatment services and pregnancy testing were offered at 54% of public facilities in 2025, and all saw an increase compared to 2022.

In the private sector, pregnancy testing was the most available service, increasing from 70% in 2022 to 79% in 2025. While family planning and contraceptive services and information and counselling on SRH and issues were the next most offered services, their availabilities (76% and 66%, respectively) had decreased in 2025 compared to 2022. Condom provision and promotion in the private sector saw an especially large decrease, going from 61% in 2022 to 17% in 2025. The faith-based sector seemed to offer most services more consistently. For example, in 2025 information and counselling on SRH and issues was offered at all surveyed facilities, promotion of healthy sexual behaviour through education was offered at 92% of facilities, HIV counselling, testing and treatment services also at 92%, and family planning and contraceptive services, as well as antenatal care at 83%. The availability of these services all increased compared to 2022.

Table 5. Percentage of health facilities offering specific SRH services

	Public (%)		Private (%)		Faith-based (%)		Total (%)	
	2022	2025	2022	2025	2022	2025	2022	2025
Information and counselling on sexual and reproductive health and issues	58	69 (↑)	78	66 (↓)	85	100 (↑)	68	71 (↑)
Promotion of healthy sexual behaviour through education	48	54 (↑)	78	38 (↓)	69	92 (↑)	60	54 (↓)
Family planning and contraceptive services (information, counselling, provision)	60	58 (↓)	78	76 (↓)	54	83 (↑)	64	67 (↑)
Condom promotion and provision	67	50 (↓)	61	17 (↓)	31	33 (↑)	60	38 (↓)
Menstruation care counselling and services	25	54 (↑)	61	38 (↓)	77	58 (↓)	43	49 (↑)
HIV counselling, testing and treatment services	50	54 (↑)	57	38 (↓)	69	92 (↑)	55	54 (↓)
Prevention of mother-to-child transmission of HIV	58	31 (↓)	52	28 (↓)	54	75 (↑)	56	35 (↓)
Screening/testing and treatment of STIs, and reproductive- and urinary tract infections	38	44 (↑)	61	45 (↓)	62	67 (↑)	48	47 (↓)
Abortion care	13	12 (↓)	26	28 (↑)	0	50 (↑)	14	22 (↑)
Post-abortion/post-miscarriage care	27	12 (↓)	39	24 (↓)	15	17 (↑)	29	16 (↓)
Pregnancy testing	46	54 (↑)	70	79 (↑)	77	58 (↓)	57	62 (↑)
Antenatal care (ANC)	58	38 (↓)	43	59 (↑)	62	83 (↑)	55	51 (↓)
Delivery services	35	23 (↓)	30	45 (↑)	38	42 (↑)	35	32 (↓)
Postnatal care (PNC) services	40	29 (↓)	35	38 (↑)	62	42 (↓)	42	33 (↓)
Screening services (HPV, breast and cervical cancer screening)	21	17 (↓)	35	21 (↓)	38	25 (↓)	27	19 (↓)
Screening, counselling and services for sexual and gender-based violence, and referrals to multi-sectoral response services	25	23 (↓)	17	34 (↑)	23	58 (↑)	23	31 (↑)
Post rape care	15	23 (↓)	13	17 (↑)	0	25 (↑)	12	22 (↑)
Voluntary medical male circumcision services	21	31 (↑)	35	41 (↑)	15	17 (↑)	24	32 (↑)
Referrals of clients in need of more specialised care to higher level facilities	65	44 (↓)	52	59 (↑)	92	50 (↓)	65	49 (↓)

For a few services, the research also asked if these services were offered to specific population groups. As can be seen in Table 6, not all services are offered to each population. Unmarried adult women, for example, were less likely to receive information and counselling on SRH and issues (71%), promotion of healthy sexual behaviour through education (76%), family planning and contraceptive services (76%) and condom promotion and prevention services

(83%) than their married counterparts (93%, 90%, 98% and 94%, respectively). In 2025 health facilities were more likely to provide all services, with the exception of condom promotion and provision, to adolescents under 18 than in 2022. Interestingly, for all services, unmarried and married girls were more likely to receive these services than boys.

Table 6. Provision of SRH services by health facilities to specific population groups

	Information and counselling on SRH and issues		Promotion of healthy sexual behaviour through education		Family planning and contraceptive services		Condom promotion and provision	
	2022	2025	2022	2025	2022	2025	2022	2025
HFs offering service (%)	68	71 (↑)	60	54 (↓)	64	67 (↑)	60	38 (↓)
HFs that offer the service, offer it without permission of guardian/spouse to (%):								
Unmarried women (18+)	80	71 (↓)	74	76 (↑)	75	76 (↑)	83	79 (↓)
Married women (18+)	98	93 (↓)	98	90 (↓)	94	98 (↑)	100	94 (↓)
HFs offering service to adolescents under 18 (%)	79	89 (↑)	78	85 (↑)	59	64 (↑)	66	50 (↓)
HFs that offer the service, offer it without permission of guardian/spouse to (%):								
Boys (10-17 years)	63	66 (↑)	65	54 (↓)	53	84 (↑)	91	71 (↓)
Married girls (10-17 years)	91	85 (↓)	89	88 (↓)	97	95 (↓)	84	94 (↑)
Unmarried girls (10-17 years)	74	73 (↓)	73	73 (—)	70	92 (↑)	69	94 (↑)

Table 7 displays for which SRH services clients have to pay. In 2025, while in the public sector 92% of HCWs indicated that all SRH services are offered for free in their health facilities, this number slightly decreased compared to 2022. In the private sector in 2025, clients had to pay for family planning, maternal health services and STI treatment services in 86% to 93% of facilities, which is comparable to the 2022 findings. Clients had to pay much less often for HIV/AIDS services in 2025 (14%) compared to 2022 (68%). In the faith-based sector clients had to pay most often for STI treatment services in 2025 (58% of facilities), and least often for family planning services (25%). Across the three sectors, clients had to pay most often for prescription medicines.

Table 7. Payment of services

	Public (%)		Private (%)		Faith-based (%)	
	2022	2025	2022	2025	2022	2025
SRH services at the facility which clients need to pay for						
Family planning	0	4 (↑)	92	93 (↑)	15	25 (↑)
Maternal health services	2	4 (↑)	84	90 (↑)	23	33 (↑)
STI treatment services	2	8 (↑)	96	86 (↓)	62	58 (↓)
HIV/AIDS services	0	4 (↑)	68	14 (↓)	8	42 (↑)
All of the services are for free	98	92 (↑)	4	0 (↓)	38	42 (↑)
If any, type of products clients have to pay for						
Prescription medications	0	100 (↑)	67	90 (↑)	100	100 (—)
Over the counter (non-prescription) medications	0	50 (↑)	67	59 (↓)	50	89 (↑)
Disposable medical equipment (gloves, needles, personal protective equipment)	0	25 (↑)	50	34 (↓)	25	67 (↑)
Consultation fee	0	25 (↑)	71	62 (↓)	63	33 (↓)
Day charges for hospitalisation	0	50 (↑)	83	59 (↓)	63	56 (↓)
Imaging diagnostics	0	50 (↑)	71	34 (↓)	13	22 (↑)
Surgical procedures	0	75 (↑)	88	72 (↓)	25	22 (↓)
Lab tests	100	100 (—)	83	86 (↑)	100	78 (↓)

Overall, while availability of copies of SRH guidelines or policies within health facilities increased from 2022 to 2025, on average only around 50% of facilities had copies available (see Table 8). In line with this, only around half of public and faith-based facilities had processes in place that ensure staff are updated and informed about changes when a new policy is developed. In the private sector this was the case in 72% of facilities. The study further found that monitoring of the health facility's SRH services by government officials was irregular. In 16% of facilities, government officials visit zero times during the year, and in 46% of health facilities, they visit one or two times per year. Furthermore, community committees that provide input into the facilities' services and activities were available at 75% of public health facilities in 2025, slightly down compared to 2022. The involvement of the community remained low in the private sector (28% of facilities), but noticeably increased in the faith-based sector, from 38% in 2022 to 88% in 2025. The involvement of adolescents in the design and implementation of SRH services unfortunately remained very low (10% of facilities).

Table 8. Policies and monitoring

	Public (%)		Private (%)		Faith-based (%)		Total (%)	
	2022	2025	2022	2025	2022	2025	2022	2025
The HF has soft or hard copies of the below guidelines/policies available for use								
National Guidelines for Provision of Adolescent and Youth Friendly Services in Kenya (2016)	24	29 (↑)	54	54 (—)	31	43 (↑)	34	38 (↑)
Management of Sexually Transmitted/ Reproductive Tract Infections (2009)	29	33 (↑)	57	52 (↓)	38	60 (↑)	38	42 (↑)
National Family Planning Guidelines for Service Providers (2016)	50	46 (↓)	64	62 (↓)	33	100 (↑)	51	58 (↑)
National Guidelines on Management of Sexual Violence in Kenya (2014)	29	29 (—)	38	46 (↑)	25	45 (↑)	31	37 (↑)
National Guidelines for Quality Obstetrics and Perinatal Care (2011)	35	33 (↓)	41	64 (↑)	23	18 (↓)	35	41 (↑)
National Guidelines for HIV Testing and Counselling in Kenya (2008)	41	50 (↑)	50	59 (↑)	54	80 (↑)	46	56 (↑)
Processes are in place at the HF to ensure that staff is updated and informed about changes when a new policy is developed	50	52 (↑)	72	72 (—)	69	50 (↓)	59	58 (↓)
Frequency at which a government official visits to monitor how the HF is performing with regards to SRH service provision								
Zero times during the year	15	13 (↓)	32	17 (↓)	23	25 (↑)	21	16 (↓)
One or two times during the year	19	54 (↑)	40	52 (↑)	23	8 (↓)	26	47 (↑)
Three times during the year	0	13 (↑)	0	7 (↑)	15	25 (↑)	2	13 (↑)
Four times during the year (quarterly)	21	8 (↓)	8	14 (↑)	23	33 (↑)	17	13 (↓)
Five or more times during the year	0	0 (—)	0	3 (↑)	0	17 (↑)	0	3 (↑)
At irregular intervals	29	4 (↓)	8	0 (↓)	8	0 (↓)	20	2 (↓)
Don't know	17	8 (↓)	12	7 (↓)	8	0 (↓)	14	6 (↓)
The HF has a community committee that provides input into the HF's services and activities	81	75 (↓)	32	28 (↓)	38	88 (↑)	60	61 (↑)
Adolescents are asked for input into or feedback on the design, planning, implementation and evaluation of SRH services at the HF	15	13 (↓)	12	7 (↓)	8	0 (↓)	13	10 (↓)

3.3 Training, Education and Outreach

Training, education and outreach indicators continued to show suboptimal performance (see Table 9). In 2025, 13% to 27% of facilities had provided refresher training in the past two years to their staff on how to provide AFSRH services. This was only a slight increase compared to 2022. Further, in 2025 only about a quarter of public facilities provided educational materials on SRH and healthy sexual behaviour targeted at adolescents or their parents/guardians. This was only slightly better in private or faith-based facilities. Only 17% of facilities provided outreach or education on SRH for adolescents within the community, and even less (15%) organised group discussions or talks for adolescents on SRH. Lastly, one-third of public health facilities worked with peer-educators to provide outreach services to other adolescents. Fewer facilities did so in the private and faith-based sectors.

Table 9. Training, education and outreach of the health facilities

	Public (%)		Private (%)		Faith-based (%)		Total (%)	
	2022	2025	2022	2025	2022	2025	2022	2025
Staff have received a refresher training on how to provide AFSRH services in the last 24 months	19	27 (↑)	24	24	8	13 (↑)	19	25 (↑)
Educational materials on SRH and healthy sexual behaviour, such as posters, pamphlets, videos or booklets, targeted at adolescents are available at this facility	21	25 (↑)	28	41 (↑)	15	50 (↑)	22	33 (↑)
Educational materials with key messages on adolescent SRH targeted at parents/ guardians to support adolescents to access services, are available at this facility	21	27 (↑)	32	38 (↑)	0	38 (↑)	21	31 (↑)
The facility provides outreach and/or education on SRH for adolescents within the community	21	15 (↓)	40	17 (↓)	8	25 (↑)	24	17 (↓)
The facility organises group discussions or talks for adolescents on SRH	21	21 (—)	28	7 (↓)	23	0 (↓)	23	15 (↓)
The facility works with adolescent peer educators to provide outreach services to other adolescents	19	33 (↑)	20	17 (↓)	0	25 (↑)	16	27 (↑)

3.4 The State of the Health Facility

The information in Table 10 was collected based on observations made by the data collectors when they visited the health facilities. It shows that while health facilities, overall, still scored highly, scores decreased in 2025 compared to 2022. In the public sector, the largest decreases in the state of the health facilities were seen for the cleanliness of the health facilities (98% in 2022 to 67% in 2025), the availability of private examination rooms (98% to 79%), and the availability of running water and soap (75% to 56%).

Table 10. Information on the state of the health facility based on observations of data collectors

	Public (%)		Private (%)		Faith-based (%)		Total (%)	
	2022	2025	2022	2025	2022	2025	2022	2025
Signage with services offered is available and visible at the health facility	85	71 (↓)	88	90 (↑)	100	100 (—)	88	80 (↓)
Signage with operating hours is available and visible at the health facility	85	73 (↓)	88	90 (↑)	100	100 (—)	88	81 (↓)
Materials targeted at adolescents on SRH are visible or provided at the facility (posters, leaflets, videos, etc.)	19	90 (↑)	44	93 (↑)	23	100 (↑)	27	92 (↑)
The health facility is clean	98	67 (↓)	96	66 (↓)	100	100 (—)	98	81 (↓)
The health facility has private rooms where consults are held	98	79 (↓)	100	100 (—)	100	100 (—)	99	88 (↓)
The health facility has electricity	77	77 (—)	100	100 (—)	100	88 (↓)	87	85 (↓)
The health facility has running (drinking) water sources	75	56 (↓)	92	100 (↑)	92	88 (↓)	83	73 (↓)
The health facility has soap for handwashing	75	56 (↓)	92	100 (↑)	92	88 (↓)	83	73 (↓)
The health facility has clean toilet facilities	83	67 (↓)	96	100 (↑)	100	88 (↓)	90	80 (↓)

3.5 Recommendations by Healthcare Workers

Healthcare workers were asked what they believe needs to happen to improve access to AFSRH services for adolescents. Recommendations from healthcare workers who saw the need and opportunity to improve access and expand services for adolescents included:

- Increase training and capacity building for staff on adolescent and youth SRH.
- Make all health facilities youth-friendly with designated rooms and equipped youth centres.
- Increase funding and staffing for youth programmes and services.
- Ensure consistent availability of SRH commodities (condoms, HIV self-test kits, family planning supplies, medicines).
- Change policies to allow under-18s to access youth-friendly and family planning services.
- Integrate mental health and sexual & gender-based violence services into youth SRH clinics.
- Strengthen youth awareness, sensitisation, and outreach programmes.
- Involve and accredit private facilities in adolescent SRH service delivery.
- Establish school-linked clinics and referral systems.
- Activate and expand youth programmes, especially in high-need areas.

4. KEY FINDINGS AND ADVOCACY RECOMMENDATIONS

4.1 Key Findings

1. Growing Recognition vs. Access Barriers

While accreditation of adolescent-friendly health facilities in the public sector rose noticeably from 58% to 81% between 2022 and 2025, actual service delivery remains inconsistent. No single SRH service was offered in more than 80% of surveyed facilities in 2025. The most available services are SRH counselling (71%) and family planning (67%), while critical services, such as post-abortion care (16%) and cancer screening (19%), remain largely unavailable.

2. Healthcare Worker (HCW) Perspectives and Moral Dilemmas

- *Contraceptive Bias:* While willingness to provide contraceptives to unmarried women increased to 82%, willingness to serve adolescents under 18 dropped in both public (54% to 46%) and private (75% to 52%) sectors.
- *Religious Influence:* Nearly half (46%) of HCWs feel that providing contraceptives to adolescents contradicts their religious beliefs.
- *Environment:* Adolescents are perceived to feel less safe or welcome at facilities, dropping from 91% in 2022 to 80% in 2025.

3. Declining Facility Infrastructure

Observed health facility standards in the public sector showed a concerning downward trend:

- *Cleanliness:* Dropped from 98% to 67%.
- *Water and Soap Availability:* Decreased from 75% to 56%.
- *Privacy:* Private examination rooms in public facilities decreased from 98% to 79%.

4. Policy and Monitoring Gaps

- *Low Policy Literacy:* Only about 50% of facilities have hard or soft copies of national SRH guidelines.
- *Lack of Supervision:* Government monitoring of health facilities is irregular; 16% of facilities received zero visits in a year, and 46% were visited only once or twice.
- *Youth Involvement:* Adolescent participation in the design or evaluation of services remains critically low at only 10%.

4.2 Advocacy Recommendations

1. Legal and Policy Reform	
Advocate for age of consent clarity	Review and harmonise policies to allow adolescents under 18 to access SRH and family planning services without undue gatekeeping. This is particularly critical for adolescent mothers.
Mandatory policy diffusion	Ensure every health facility, regardless of sector, has accessible copies of the National Guidelines for Provision of Adolescent and Youth Friendly Services.
2. Provider and Training Sensitisation	
Values clarification	Implement "Values Clarification and Attitudes Transformation" (VCAT) training for HCWs to decouple personal religious beliefs from professional service delivery obligations.
Refresher training	Standardise bi-annual refresher courses on AFSRH, as currently only 25% of staff have received such training in the last 24 months.
3. Infrastructure and Commodity Security	
Institutionalise hygiene standards	Prioritise budgeting for running water, soap, and facility cleanliness in public sectors to improve adolescents' trust in health systems.
Commodity "last-mile" push	Ensure consistent stocks of condoms, HIV self-test kits, and family planning supplies to prevent facilities from turning adolescents away.
4. Community and School Integration	
Youth-led design	Create formal mechanisms for adolescents to provide feedback on service delivery, moving beyond the current 10% involvement rate.
School-linked clinics	Establish formal referral systems between schools and health facilities to bridge the gap for rural youth. Further, provide seamless services and interventions for survivors of sexual and gender-based violence.

5. CONCLUSION

The report reveals a paradoxical landscape where formal accreditation of "adolescent-friendly" facilities is increasing, yet the quality of the environment and the willingness of providers to serve younger adolescents is regressing. Policy clarity on age of consent, value-based provider training, and prioritising "last-mile" infrastructure for commodities is required as an urgent measure. The persistent lack of essential SRH commodities, combined with religious and moral bias among providers, creates a "silent barrier" for youth. Without addressing the fundamental infrastructure needs (water, cleanliness, privacy) and the specific policy restrictions for minors, accreditation remains a label rather than a functional reality for Kenyan adolescents in the surveyed counties.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Solutions for Supporting Healthy Adolescents